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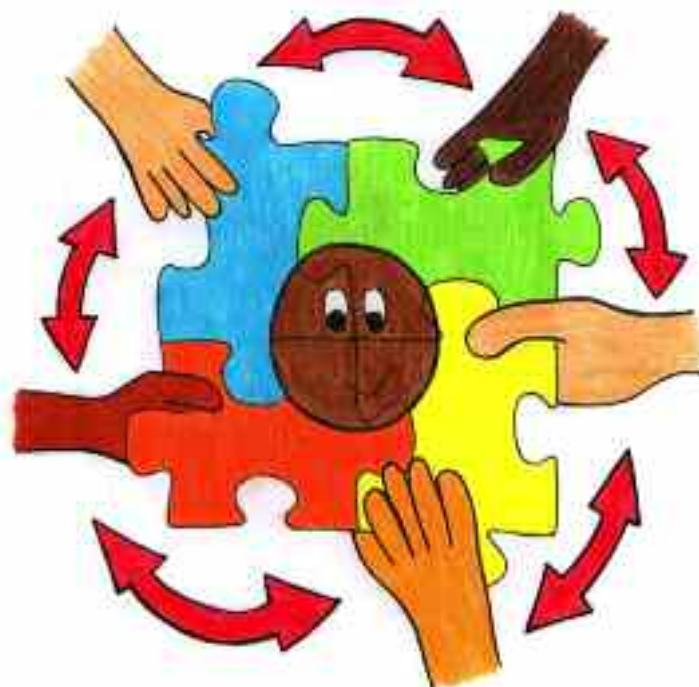


Division of
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Faculty for Children, Young People
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The Child & Family Clinical Psychology Review

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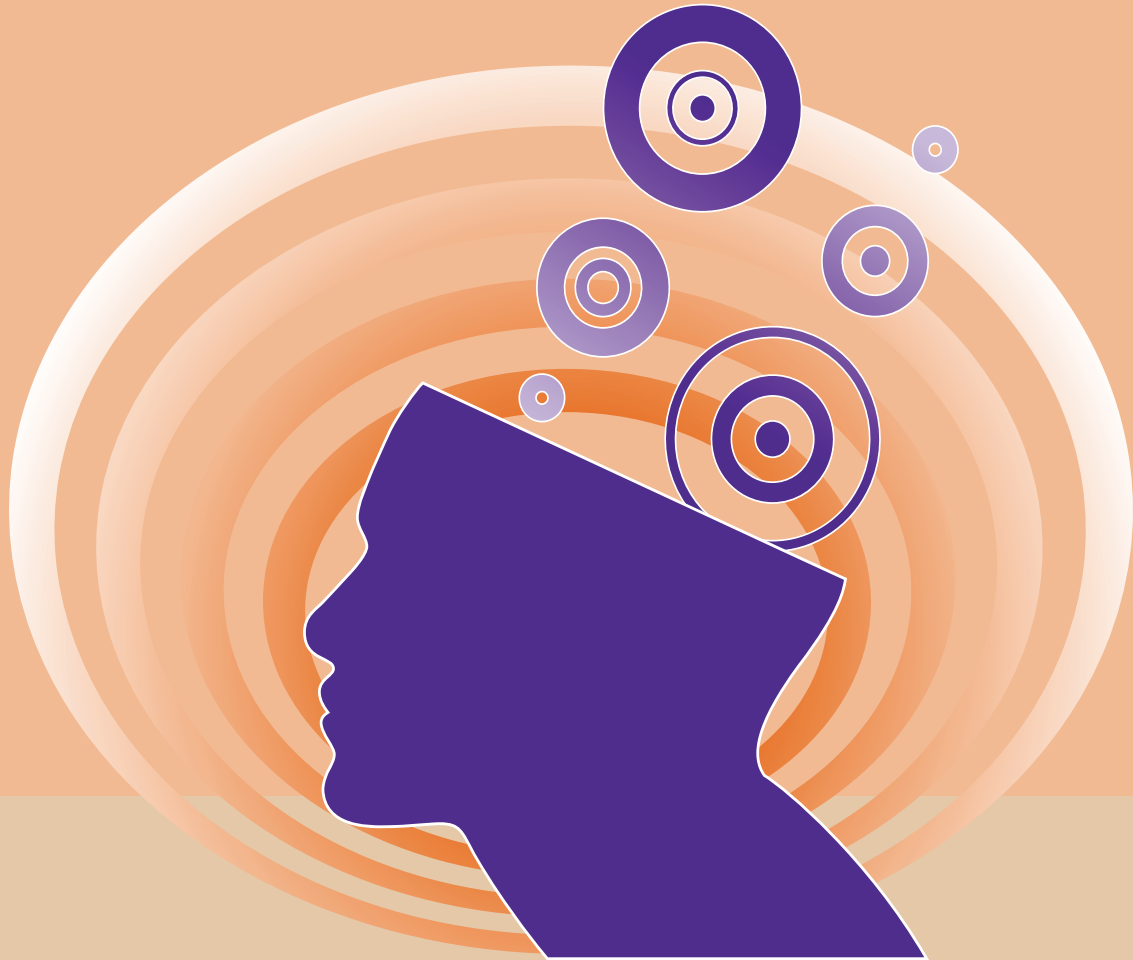
What good looks like in psychological services for children, young people and their families





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'Easy to access and free, and a mine of useful information for my work: what more could I want? I only wish I'd found this years ago!'
Dr Jennifer Wild, Consultant Clinical Psychologist & Senior Lecturer, Institute of Psychiatry

'The selection of papers suits my eclectic mind perfectly, and the quality and clarity of the synopses is uniformly excellent.'
Professor Guy Claxton, University of Bristol

Foreword

Many of us want to know what really good children and young people's mental health services should actually look and feel like. Young people and their families want to know what they can expect, commissioners want to know what their specifications should require, clinicians and practitioners want to be sure they are meeting expectations and need.

So, this edition of *The Child & Family Clinical Psychology Review* is particularly welcome and very timely.

The Future in Mind report has recently set out the road map for improving our children and young people's mental health and services. NHS England now expects CCGs to work with Health and Wellbeing Boards to create local Transformation Plans which will realise these ambitions and create services that work for children and young people. Only by satisfying these demands, and very quickly, will new monies flow into front line provision. So, the information contained here is vital intelligence for commissioners at this critical time.

This issue of *The Child & Family Clinical Psychology Review* provides concrete examples of 'what good looks like in psychological services for children, young people and their families' – so helpful when planning best practice. This should be essential reading for everyone remotely connected to funding, providing or advising children and young people's mental health services.

Sarah Brennan

Chief Executive, YoungMinds.

What is the Review?

Julia Faulconbridge, Duncan Law & Amanda Laffan

Future in Mind was published by the Department of Health in March 2015¹, heralding a new direction in the provision of services to support the psychological wellbeing and mental health of children, young people and their families. At the same time initiatives were announced by the Department for Education on promoting and supporting mental health in schools^{2,3}.

At the time of writing, CCGs are putting together 'Transformation Plans' to bid for a share of new monies coming into children and young people's mental health systems. One part of the plan needs to address the development of community eating disorder services – the blueprint for what these services need to look like is clearly addressed in the National Collaborating Centre for Mental Health (NCCMH)⁴ and so is not addressed in detail in this Review. The wider Transformation Plans need to show improved services across the whole child mental health system including Local Authorities, Schools, NHS and Voluntary sectors, and need to be developed with input from the whole system and from children, young people and families. Good improvement plans will address prevention, health promotion, early intervention, support and care, as well as leading to improvements in psychological interventions.

In response to these developments, the Division of Clinical Psychology Faculty for Children, Young People and their Families has produced this Review to provide much-needed guidance on the provision of good quality psychological services and the roles that clinical psychologists and other psychological practitioners can play in those services.

The Review consists of:

- Part I: An overview of the key issues in all psychological service provision together with a paper on the role of clinical psychologists and workforce issues.
- Part II: A set of papers addressing the specific issues pertinent to a range of settings and conditions where psychological services should make a major contribution. These papers have been written by authors who are all highly experienced experts in their field.

As part of the process of developing the Review, all draft papers were discussed with young people and staff from YoungMinds and their comments were incorporated into the final papers. The drafts were also reviewed by three commissioners, and two clinical psychologists

who specialise in issues of diversity and inclusivity. Again, those comments were incorporated into the final versions.

In recent years there has been an increasing trend towards reducing the numbers of clinical psychologists working in NHS services in some parts of the country, particularly the more senior and highly experienced grades. The drivers for this trend are primarily economic and the impact of such changes on the capacity of services to deliver good quality psychological care may not be immediately apparent to those decision makers. This publication lays out the roles that only clinical psychologists can play in service provision whilst also describing how those roles should be part of appropriately skill-mixed models that are both effective and cost-efficient.

Clinical psychologists working with children, young people and their families are not just trained in helping when difficulties have developed, although this is a key aspect of their work. They have all studied for a degree in psychology that covers the whole range of human development and psychological understandings of people in their contexts before undertaking a post-graduate doctoral degree. Thus all clinical psychologists working with children have a thorough knowledge of child development, family structures and relationships, resilience and risk, the interaction between children and their social world, amongst many other factors. In addition their applied training ensures similar knowledge of the multifactorial causes of psychological difficulties across the lifespan including the impact of difficult family relationships, adverse life events and circumstances, developmental difficulties and trauma.

As a result, clinical psychologists have a keen interest in developing systems and services that support positive child development and those which can intervene early when difficulties start to emerge. This emphasis on the promotion of positive development to prevent difficulties together with early intervention when difficulties arise is a theme running through the specialist papers in this Review.

Clinical psychologists are trained in psychological research methods at undergraduate and postgraduate levels and may also have spent time in academic roles. They have a commitment to developing and working from the evidence and to evaluation as part of everything they do. The majority of the research in

developing and providing the evidence base for psychological services has come from a combination of applied and academic psychologists. In this publication we aim to distil that evidence into an accessible form to facilitate its use.

Who is the Review for?

The contents of this Review will be of interest to everyone who has a professional or personal interest in the psychological wellbeing of our children and young people and the families and organisations which support them.

In particular, it will be of value to policy makers, commissioners and providers who wish to better understand what a good psychological service can look like and to implement that knowledge to improve the lives of our children and young people, helping them to develop, to reach their potential and lead happy and productive lives.

It is also intended to provide a blueprint to help regulators like the Care Quality Commission and Ofsted to make judgements about the quality of services and organisations that they are inspecting.

Context for the Review and the need to change

This review is written in the particular economic and social climate of 2015 and reflects the impact on services over the last few years that has led to reductions in provisions for child psychological wellbeing and mental health in many parts of the UK.

In particular, there has been significant loss of prevention and early intervention provision together with CAMHS providers tending to raise their thresholds in order to manage the increasing demand for help from children, young people and families whose difficulties have reached crisis point as a result. In these difficult times, it is often over-pressed services that get blamed when it is actually shortfalls in funding that are causing the problems.

In the current economic climate, where there is some new money but it is very limited and often ring-fenced for particular difficulties, there is a need for creativity and innovation in how services work, based upon the evidence available. Indeed, there may need to be radical change in how the whole system works together to maximise the benefit that can accrue through increased integration and efficiency.

This may lead to internal tensions of how services should be structured and funded in the future. There is a need to think beyond traditional NHS providers and include Local Authorities, Education and the Voluntary

Sector in planning and providing a whole systems model of mental health. This will impact on the future workforce and training models – what is delivered by whom.

In turn this may mean that clinical psychology needs to rethink where it adds most value. For some this may mean giving up some traditional psychology roles that can be delivered more cost-effectively by other parts of the workforce, with a move to areas where the considerable skills and knowledge that clinical psychology training provides can be deployed to maximum effect. This poses a challenge to psychologists, psychological practitioners, managers and commissioners across agencies to work together to provide the best services and systems for families.

The focus must unerringly be on how to provide better care for children and young people – the only real test of a service's quality is that children and young people tell us that their lives are improved.

We would particularly like to thank the following:

- All of our authors who gave much of their own time to write the specialist papers within a short time frame.
- Laurie Olivia, Petra Velzeboer, Elizabeth Raynor, and YoungMinds activists for feedback from the viewpoint of young people.
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- Leanne Walker, GIFT young sessional worker for providing artwork.
- The Committee of the Faculty for Children, Young People and their Families for all their input and support.
- The Division of Neuropsychology and the Division of Educational and Child Psychology for their support.

Whatever your interest and reason for reading the review we hope that it takes you another step forward to improving psychological services that are properly resourced and enable children, young people and their families to lead full and fulfilled lives – that is what good looks like.

Julia Faulconbridge, Duncan Law & Amanda Laffan

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A brief note about the language used in this Review

We are aware that there is a lot of debate around how best to describe some of the experiences discussed in this report. The use of diagnostic and medical language is often considered problematic in psychological services, and we have tried to use non-medical language in as much of this publication as possible. There are some instances, however, when we have used medical language (such as when discussing other published work which has used a medical framework). Using these terms does not mean that we support medical explanations of mental health difficulties in children and young people.

For more detailed discussion of these issues please see:

- DCP Position Statement ‘Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift’ (May 2013); and
- DCP Guidelines on Language in Relation to Functional Psychiatric Diagnosis (March 2015);

both available from:

<http://www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology/publications>

A brief note about the professional titles used in this Review

We have used the following terms to describe people using a psychological approach to work with children, young people and their families.

Applied psychologists qualified to work with children, young people and their families:

- These are qualified psychologists from specialities such as clinical, educational, health, forensic, neuropsychological and counselling psychology with specific training in work with children and young people.
- Applied psychologists will have completed at least a three-year undergraduate training in psychological knowledge and theory and additional training at Master’s/Doctoral level leading to registration as a Practitioner Psychologist with the Health & Care Professions Council (HCPC).

- Depending on the nature of their qualification, they will have specific areas of expertise and competency that may determine the settings in which they can work and the type of work they can undertake.
- When the term ‘applied psychologists’ is used in this Review it means that any applied psychologists so qualified would be able to take on the work.
- Applied psychologists should be registered with the HCPC as Practitioner Psychologists. The latest standards of proficiency (1 July 2015) detail both the common standards and those specific to particular professions. For more detail please see: www.hpc-uk.org/assets/documents/10002963sop_practitioner_psychologists.pdf.

Clinical psychologists:

Clinical psychologists have completed doctoral level training that is across the lifespan and across a wide range of psychological and physical health issues. They aim to reduce psychological distress and enhance and promote psychological wellbeing. Clinical psychologists are qualified to work with all ages and some will choose to specialise in work with children, young people and their families.

More detail on the work of clinical psychologists, and particularly on their training as applied scientists, can be found in Part I, Paper 2: ‘Using clinical and other applied psychologists effectively in the delivery of Child and Adolescent Mental Health Services (CAMHS) – recommendations about numbers, gradings and leadership’.

Psychological practitioners:

Both applied psychologists (as defined above) and those professionals who are not qualified psychologists but who have qualifications in one or more aspects of psychological provision. Examples of this would be psychological therapists and staff from other professional backgrounds (e.g. nursing, social work, occupational therapy) who are working using a psychological approach.

Part I:

Overview of the key issues

Paper 1

What good looks like in psychological services for children, young people and their families: Introduction

Duncan Law, Julia Faulconbridge & Amanda Laffan

In this introduction we discuss the key issues and overarching themes in psychological services for children, young people and their families. These will then be discussed in greater detail in the papers in Part II that discuss setting and condition specific services.

Within this introduction we often use the language of mental health as this has become the current common conceptual framework for national and local discussion. We use this language here to facilitate the understanding of the knowledge and evidence in this set of papers within the context of current policy initiatives and service models.

However, we are concerned that the conceptualisation of psychological experiences in these terms can covertly dictate the terms of the debate and skew the discussion towards thinking about what needs to be done when difficulties, then described as mental health problems or psychiatric diagnoses, arise. Moving towards a debate based on the concept of psychological wellbeing creates a fundamentally different way of approaching the issues. Instead of thinking about how to help when problems arise, we can think about what we need to do as a society, as organisations, as communities and as families to promote the positive development, psychological wellbeing and resilience of all our children and young people. Thus primary prevention and early intervention can become the core activity for psychological services in future.

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Section 1: How big an issue is children and young people's mental health?

Duncan Law, Julia Faulconbridge & Amanda Laffan

1. Introduction

Childhood is the time of the greatest psychological development in any person's life; the things that a child experiences during the early years of their lives will have a major and lasting impact on them and the people around them. As they grow up, these experiences will affect how they bring up their own children and, in turn, this will affect the emotional lives of their children's children. Before reaching adulthood, all children and young people will experience many episodes of psychological distress – from a bruised knee, through the loss of a favourite toy, to falling-out with a friend. The psychological impact of these events will depend largely on the environment in which the child lives, and the quality of care they receive from the people around them. For most children the distress they encounter will be mild and relatively short lived particularly for those protected by good social support from family and friends, and in environments that provide physical and economic security. In these environments the minor emotional upsets, although distressing, can help a person become more resilient and help them learn to manage bigger upsets later in life.

For some children the magnitude or frequency of distress will be so great that it has the potential to have a negative impact on the rest of their lives, unless they get the right help and support. It is not just the size of the event that matters, but also the number of negative events a young person experiences that impacts on their psychological wellbeing. Many children growing up in adverse social circumstances including poverty, domestic violence, or parental substance misuse, will experience a number of the factors which are known to be harmful to good psychological development, more likely resulting in complex patterns of difficulties.

To give children the best start in life it is important to promote emotionally healthy environments and prevent emotional harm by reducing as many of the factors that can lead to mental ill-health and, for those children who need it, ensure there are services and systems that can provide best psychological care and intervention, in the right place, at the right time. Mental health and psychological wellbeing must be promoted and delivered in whole community systems that integrate health, social care, schools and the voluntary sectors. These systems must reach out and deliver services that are acceptable and accessible to all children, young people and families across all communities, regardless of ethnicity, gender, sexual orientation or social class.

2. How many children and young people have psychological difficulties (mental health problems)?

Children and young people (those aged 0 to 19 years) make up approximately 24 per cent of the UK population¹. 'Mental health problems' can be defined as conditions which affect a person's mood, thinking and behaviour to such a degree that they have a significant effect on their ability to function as they would like to within different areas of their lives'. While the majority of children and young people will not experience mental health problems, a significant number will. It is difficult to accurately estimate the numbers of children and young people who experience mental health problems, with reports of prevalence varying throughout the literature. The most recent systematic survey in the UK was carried out over 10 years ago², and estimated that at any time point at least one-in-10 children between the ages of 5 and 16 years will have a diagnosable mental

health problem. Other authors have suggested that as many as one-in-three children will have at least one episode of mental health difficulties before the age of 16³, and the prevalence increases further still if we extend the age range up to 25 years, and for those in social care (48 per cent)⁴ or the criminal justice system (65 to 70 per cent)⁵. There is a clear need to maintain a regular systematic national review of mental health in children and young people to get up-to-date and accurate figures on the levels of mental health difficulties in the UK today. This will allow need to be more accurately mapped, and services properly tailored and funded to meet the need.

The most common mental health difficulties reported in children and young people are conduct disorders, anxiety, depression and hyperkinetic disorders². Where the information is available, figures suggest that the number of children and young people presenting with mental health difficulties is increasing⁶. This is particularly apparent for children and young people with eating disorders, self-harm and Attention Deficit Hyperactivity Disorder (ADHD). Some difficulties have been demonstrated to increase with age, such as social anxiety, panic, depression and substance abuse³, and there is a clear correlation between social deprivation and the prevalence of mental health difficulties in children⁷. As children grow older, their mental health difficulties are more likely to be accompanied by other problems that affect their lives³, and are likely to have significant impact on their physical health, educational achievement, employment prospects, risk of involvement with the criminal justice system and life expectancy⁸.

At a time of global economic austerity with the numbers of families living in poverty increasing⁹, a continued rise in mental health problems in children and young people is likely.

3. Barriers to children and young people with psychological difficulties getting help

Without effective intervention, the likelihood of mental health problems continuing into adulthood is significant, and it is vital that interventions are right first time to prevent the likelihood of lifelong mental health difficulties⁶. Currently around 50 per cent of lifelong mental health problems develop before the age of 14 years, with 75 per cent developing before the age of 25 years^{10,11}. Yet, only 25 to 40 per cent of children and young people with mental health difficulties receive input from a mental health professional at all², or at a sufficiently early age¹².

The reasons for this chronic lack of help for children with mental health issues is due to a number of factors:

(a) Lack of resource in the system

We know from studies and from the experiences of young people and families that the provision in help available falls seriously short of meeting the level of need in the community. In a consultation with young people from YoungMinds, as part of the preparation for this publication, they told us that access to help is the biggest single issue.

Despite the need, and the wider social, emotional and economic impact of children and young people's mental health, in 2012/13 children and young people's mental health services received only around six per cent of the entire mental health budget, with total mental health funding itself being only 11 per cent of total NHS spending⁸. These figures need to be further considered in light of the cuts in NHS spending on children's mental health services in England, with reports suggesting funding has fallen by almost £50 million in real terms since 2010¹³. The *Future in Mind* report on the state of CAMHS⁸ acknowledged the lack of resource in the system.

In July 2015 a welcome £1.25 billion of new money over five years was announced for the children and young people's mental health system. Whilst this may seem a substantial amount it only represents a two per cent increase in total spending on child mental health – and there is no guarantee that this will continue into a new governmental term.

The issues of lack of resource are further exacerbated by the reduction of other support and social services being cut around CAMHS, for example, the closure of Sure Start services and the reduction in local authority spend on youth services¹⁴. Where once these services may have provided effective support for families and young people at risk, their reduction has correlated with increased referrals to mental health services.

Work to improve access to services and reduce stigma is likely to lead to an increase in presentations to child mental health services – putting further strain on an already under-resourced system. Truly integrated mental health systems are only likely when there is high level integration of policy at a national level and pooled NHS and Local Authority budgets locally.

(b) Lack of psychological health promotion, primary prevention and early intervention provision

In situations where there is a lack of resources to meet needs, provision frequently becomes skewed to the children and young people who have already developed serious difficulties and away from services that can help with positive psychological development, prevent harm, and those which are designed to intervene early – such as those used in supporting positive attachment between parents and premature babies in Special Care Baby Units, in developing social and group activities for

young carers to support them with their responsibilities and connect them to others in similar situations, and in whole school approaches to preventing depression¹⁵.

(c) Lack of recognition of mental health problems

There remains a wide spread lack of understanding and recognition of mental health problems in children in society as a whole, resulting in children's mental health problems, at best going unnoticed by the adults around them, or at worst with young people being labelled as 'bad' and being on the receiving end of unhelpful and punitive responses at home, at school and in the criminal justice system. The online learning resource MindEd¹⁶ is a useful tool trying to address this lack of understanding in adults who come into contact with children in their professional lives.

(d) Stigma

Even if mental health issues are correctly identified, the stigma attached to having a mental health problem and seeking help often get in the way of children and families seeking appropriate help – the extent and nature of the stigma varies across cultures. Campaigns that seek to normalise help-seeking and mental health issues such as 'time for change' have helped a great deal with this issue. However, there is no one route to tackling stigma and much more still needs to be done.

4. The social and economic impact of the lack of sufficient provision

Whatever the actual extent of the problem, we do know that mental health difficulties are one of the biggest problems facing children today⁸ and, for those over five years old, mental health problems are by far the most serious health problem¹⁷. It is important to recognise that it is not only the individual child who is adversely affected by their difficulties, the associated distress and disruption has an impact on those around them both financially and emotionally – with, for example, time off work to care for children. The human argument for early intervention is compelling, but so too are the growing economic arguments for better-funded services with best estimates showing a 10-fold saving where effective parenting interventions are delivered¹⁸. Without appropriate help, children with conduct disorders are estimated to cost the economy £260,000 each by the time they reach 28 years of age¹⁹. The estimated saving for effective treatments for anxiety and depression range from savings of around £2 up to £32 for every £1 spent on treatment²⁰.

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Section 2: Understanding healthy psychological development and the causes of psychological difficulties

Duncan Law, Julia Faulconbridge & Amanda Laffan

For non-psychologists, a description of the basic psychological models for understanding mental health has been provided in Appendix 1.

1. Introduction

As children and young people are still developing cognitively, emotionally and behaviourally, it is important that any mental health difficulties they experience are thought about in terms of their development, as well as which adverse life experiences may have caused them. This approach, has an unhelpfully jargonised title: ‘developmental psychopathology’^{1,2}, but has four helpful principles:

- we must take into account the role of development when interpreting someone’s difficulties, trying to understand what has led to these difficulties and how they have changed over time;
- mental health difficulties in children and young people must be thought about in terms of what ‘normal’ development looks like and what the major developmental tasks and changes are as children grow up;
- we must study the very earliest signs of mental health difficulties in children and young people;
- we must remember that there are lots of different pathways to both ‘normal’ and ‘abnormal’ adjustment over the course of development.

We must also remember that everyone responds differently to the many challenges they face over time. All children and young people will face difficult situations and, for some people, these may lead to them experiencing mental health difficulties. The more difficulties a child faces, the more likely they are to experience mental health difficulties³. Facing life’s difficulties is important though as this is the way children and young

people learn how to cope with future problems (as they develop greater ‘resilience’). Resilience, the ability to face life’s difficulties without being overwhelmed by them, tends to be greatest when a person has:

- a supportive family environment;
- support from people outside their immediate family;
- positive individual attributes.

2. Factors that support positive psychological development

An understanding of the factors that support positive psychological development can be powerful in promoting environments that are more likely to promote psychological health and wellbeing.

The World Health Organization⁴ identify the following as factors that support positive psychological development and are psychological protective factors:

- Social circumstances
 - Social support of family and friends
 - Good parenting/family interaction
 - Physical security and safety
 - Economic security
 - Scholastic achievement
- Environmental factors
 - Equality of access to basic services
 - Social justice, tolerance, integration
 - Social and gender equality
 - Physical security and safety
- Individual attributes (which are largely dependent on the above)
 - Self-esteem and confidence

- The ability to problem solve and manage stress or adversity
- Communication skills
- Physical health and fitness

3. Risk factors for children that can lead to psychological difficulties

(a) Introduction

Knowledge of risk factors can lead to powerful effective interventions as well as enabling psychological practitioners to understand and help children with mental health difficulties. By understanding the factors likely to lead to psychological harm, public health strategies can be applied to tackle these causes – reducing bullying in schools, better safeguarding structures in social care, economic policies that reduce inequalities – all these should be seen as mental health interventions. Effective mental health systems should always be working at the level of primary prevention.

There are many factors that may lead to the development of mental health difficulties in children and young people. In the World Health Organisation⁴ list these include:

- Social circumstances: like loneliness, bereavement and neglect;
- Environmental factors: like injustice, discrimination and exposure to trauma;
- Individual factors: like cognitive/emotional immaturity and medical illness.

For the full list, see Appendix 2.

The relationship between risk factors and mental health problems is complex and the impact of exposure to the risk will vary from child to child – but all children exposed to potential causes of psychological harm will have an increased chance of developing mental health problems either in childhood or later in life.

(b) The impact of child maltreatment

Child maltreatment is now known to be one of the biggest risk factors for children and young people developing mental health difficulties. Maltreatment can take a number of different forms, including neglect, emotional abuse, physical abuse and sexual abuse⁵. Maltreatment, in all its forms, can lead to a number of different outcomes, both immediately and years later, with its impact tending to be greatest if the maltreatment has taken place over longer periods of time and been in more than one form⁶. Maltreatment can also be a risk factor for later difficulties, which means the child or young person is more likely to have worse outcomes following other difficult experiences later in their life.

Over recent years there has been a growing awareness of the extent of child sexual exploitation and

sexual trafficking in the UK, and the serious negative impact this has on the wellbeing of the children and young people involved⁷. The children and young people caught up in these situations are usually those who have already experienced a number of adverse circumstances and so helping them is resource intensive and highly specialist. Services have frequently struggled to meet the needs of young people who have suffered sexual abuse in the past and the numbers now known to be involved in sexual exploitation poses a significant challenge.

The harm caused by child maltreatment can have wide ranging effects on the child or young person's emotional, psychological, behavioural and interpersonal functioning⁸. This is linked with accumulating evidence that the stress caused by maltreatment has harmful effects on a child's developing brain and thus their developmental pathway⁹. This is discussed in more detail in Appendix 3.

The following list provides just some examples of the increased risk for maltreated children and young people:

- Development of Post-Traumatic Stress disorder (PTSD);
- Self-harming behaviours;
- Depression, suicidal thoughts and behaviours;
- Problematic drug and alcohol use;
- Violent crimes;
- Health-risking sexual behaviours.

For more detail, please see Appendix 3.

(c) Insecure attachments

Child maltreatment is also likely to have a negative effect on the quality of the relationships a child is able to make with people close to them or the quality of attachment relationship the child forms with their caregiver¹⁰, although insecure attachments can form without there having been any maltreatment at all. There is evidence that children who do not form secure attachments to their caregivers are more likely to experience mental health difficulties. In particular:

- When difficult life events happen, children or young people may not have had the opportunity to develop resilience, or to learn how to manage their emotions, which can then seem overwhelming and lead to a range of difficulties¹¹;
- Children may not have had the opportunity to learn how to relate to other people, and so may have difficulties forming healthy relationships as they grow up¹¹;
- Young people with insecure parental and peer attachments are more likely to engage in self-harming behaviours and have poorer problem solving skills¹².

(d) Social isolation and bullying

The importance of having friends, and feeling accepted by other children or young people of the same age, cannot be overstated. Children who feel rejected by their peers can experience a range of difficulties because of this, as well as feeling isolated and lonely¹³. Social isolation also means that a young person will have fewer resources to help them deal with any difficulties in their lives, as they will not be able to turn to those around them for advice or support.

Being bullied, including online bullying, as a child or young person can also have very negative effects, such as:

- Being more likely to experience PTSD¹⁴;
- Being more likely to experience suicidal thoughts or behaviours¹⁵;
- Being more likely to engage in self-harming behaviours¹⁶;
- Being more likely to experience 'psychosis'^{16,17}.

(e) Bereavement and loss

A loved one dying is an experience that many children and young people are likely to face. Feelings of loss and grief are, of course, completely natural and understandable reactions to losing someone, although everyone responds differently in such times and there is no 'right way' to respond to someone dying. In the majority of cases, the feelings of sadness and grief tend to ease over time and with the support of friends and family. However, for some children and young people, following the loss of certain people in their lives, these feelings can feel overwhelming for a lengthy period of time, leading to significant difficulties in them moving on with their lives. In particular, the death of a parent or sibling has been shown to lead to mental health difficulties in around 25 per cent of bereaved children, who experience more 'internalising problems' (such as major depressive episodes)¹⁸.

(f) Poverty and social inequality

There is substantial evidence¹⁹ that poverty is a major risk factor for developing mental health problems in childhood. A number of national and international health and social care policy reports (e.g. ^{20,21}) have discussed the relationship between social inequalities, physical and mental health. People live their lives within structures of society that give more power and privileges to some people, while giving less power and more constraints to others. The fact that some people have less money and less social resources around them explains some of the reason why those people are more likely to experience mental health difficulties^{22,23}. This can be particularly the case for people from minority ethnic backgrounds who have experienced social exclusion due to prejudice and racism and as a result may

feel powerless²⁴. Furthermore, children are more likely to experience abuse or neglect if their family lives in adverse social circumstances²⁵, which can lead to the difficulties outlined above.

(g) Vulnerable groups and communities

Although psychological difficulties affect all parts of society, some groups and communities are known to be more at risk than others.

Children with specific learning difficulties or other neurological difficulties (please see Part II, Paper 11: 'Delivering psychological services for children and young people with neurodevelopmental difficulties and their families') have a greater risk of experiencing difficulties in school as they struggle to cope in the classroom²⁶. They may develop disruptive behaviour patterns which serve to distract attention from their academic difficulties, particularly if these have not been recognised. Similarly, poor self-esteem can result from having specific learning difficulties.

Children with physical health problems and disabilities are also at greater risk of experiencing psychological difficulties (please see Part II, Paper 5: 'Delivering psychological services for children and young people with physical health needs and their families' and Paper 12: 'Delivering psychological services for children and young people with learning disabilities and their families').

The significant issues for Looked After Children and young people involved in the criminal justice system are discussed in Part II, Paper 9: 'Delivering psychological services for children, young people and families with complex social care needs' and Paper 10: 'Delivering psychological services for children and young people involved with the criminal justice system, those at risk of involvement, and their families'.

Children and young people who are carers for family members have been found to be significantly more likely to experience psychological difficulties^{27,28,29}. They often miss out on opportunities that other children have to play and learn and become isolated with no relief from the pressures at home and no chance to enjoy a normal childhood. The pressures of caring for parents and living their own lives frequently leads to anxiety, feelings of anger, frustration, guilt, resentment and stress. Young carers are likely to experience problems with school such as difficulties completing assignments on time, disruptive behaviour, difficulty making friends, being bullied and leaving without any formal qualifications³⁰.

The risk of experiencing psychological difficulties is also greater for children and young people who are refugees or asylum seekers^{31,32}, those who are homeless³³ and those who are exposed to gang culture and violence (including sexual exploitation)^{34,35}.

The children and young people's mental health and wellbeing taskforce³⁶ makes specific reference and recommendations about service provision for these vulnerable groups.

In addition there is evidence to suggest that the social and environmental disadvantages experienced by many children and young people from Black and Asian and Minority Ethnic (BAME) backgrounds increases their risk of experiencing psychological difficulties³⁷. Further to this increased risk, mental health or early intervention and prevention services for children and young people are also less likely to engage with families from BAME backgrounds³⁷, meaning that difficulties are more likely to have escalated by the time effective interventions are offered.

Other studies suggest that children and young people who identify with a minority sexual orientation are also more at risk of experiencing psychological difficulties^{38,39,40,41}. Experiences of prejudice, bullying, exclusion and violence (which can sometimes lead to an internalised sense of shame)⁴¹, can all be important factors in increasing risk.

For all these groups, the association with increased mental health difficulties is complex and very much dependent on their family and social experiences. More research is needed here to better understand the mechanisms involved. What is clear is that services need to work particularly hard to mitigate against the increased risks and improve the mental health and wellbeing for all, and especially for the more vulnerable groups.

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Section 3: Delivering effective psychological help in different parts of the system

Duncan Law, Julia Faulconbridge & Amanda Laffan

1. Introduction

Psychological theory and support can be effectively applied in different parts of a mental health and psychological wellbeing system to provide the best help in the best way depending on the needs of the child and community.

The familiar four tier CAMHS model was originally described in *Together We Stand*¹. Since then most systems adopted, or tried to adopt, this model to commission and deliver services. This was never a comfortable fit between service need and service delivery, and services have begun to move away from the tiered model. The recent *Future in Mind* document² produced by the Children and Young People's Mental Health Taskforce is clear that the tiered model has served its purpose and is out-dated. Recently models have emerged that try to fit the help provided to the needs of the child, and not just to levels of severity of problem: for example, THRIVE³. THRIVE takes a whole system approach to the delivery of services and advocates the need to apply psychological approaches effectively in a range of settings and contexts.

2. Primary prevention and mental health promotion

This is an area of psychological help largely neglected by mental health professionals and commissioners over recent years, but one where the potential impact could be greatest. The pressures on resources has meant that many services which used to exist have been lost as limited funding is redeployed to help with serious difficulties which have already developed. However, the need for provision for more serious, complex and crisis-driven problems is exacerbated by the loss of primary prevention and early intervention services.

As described earlier (Section 2), by understanding the factors likely to lead to psychological harm, services can apply strategies to tackle these causes and prevent harm to individual children and young people. This requires rigorous understanding of the environmental causes of potential harm to children and young people's psychological health, and the active application of strategies to try and reduce or remove these as far as possible before they impact on a child's emotional wellbeing: primary prevention. Such prevention strategies are best provided through local community-based services that the young person or family are already connected to, such as community centres, schools, and spiritual centres.

Services should also help increase awareness and promote positive psychological development at a whole community level through the application of evidence-based psychological approaches. There is much work to be done to expand the role of mental health professionals into this realm of mental health promotion⁴. This will involve awareness raising, consultation and training that is not focused on a particular child or family. This is discussed in more detail in Part II, Paper 6: 'Working with whole communities: delivering community psychology approaches with children, young people and families'.

Examples of whole community approaches to improving psychological wellbeing include 'The Big Noise', adapted from the 'El Sistema' movement⁵. It encourages whole communities to become empowered and take an active role in their lives and community. The vehicle for this change is music, giving instruments to children and encouraging them to put on concerts, pulling together the community and fostering feelings of self-efficacy and wellbeing⁶.

There is the potential for national and global interventions that apply psychological theory to advise governments and international organisations on health, social and economic policy to facilitate good mental health and wellbeing in children, and advise on those policies that are likely to increase risk to psychological wellbeing.

3. Community-based early intervention

Psychological provision should be designed to enhance the services which are already involved with families to both prevent the development of psychological difficulties, and to recognise if they are starting to develop and to intervene early. There will be many examples in the subsequent papers, particularly in those dealing with Early Years, community psychology approaches and schools. A community-based psychological service should operate in a variety of other community networks – health, social care and voluntary provisions. Within Health, working with Community Paediatricians, Health Visitors and School Nurses is very valuable. This is particularly true in work with parents of very young children where good services can have a major impact on creating a positive future for the infant. This is discussed in more detail in Part II, Paper 7: ‘Delivering psychological services for children and families in Early Years Mental Health and Emotional Wellbeing settings’.

Psychological services can deliver early intervention with individuals, with families and with groups according to the most effective input.

- Working at the group level can be particularly positive as it can build up community support structures for families. Studies of evidence-based parenting groups for parents whose children are showing behaviour problems consistently find significant improvements in parental mental health in addition to the improvements for their children⁷.
- The work of psychological practitioners in community settings will also involve the provision of direct assessment and therapeutic work with individual children, young people and their families.

Psychological practitioners can support the staff working in universal services and this can be achieved in a number of ways:

- Provision of training and ongoing support and supervision, for example, Family Nurse Partnership⁸. A core element of this model is that each FNP team is provided with an appropriately qualified and skilled psychological consultant offering monthly consultancy;
- Some training can be delivered at a large scale using online resources such as the MindEd e-learning platform⁹;

- Provision of consultation both for individuals and in groups. Group consultation with staff has many advantages including supporting the development of teams, sharing learning within and across professional groups, and providing emotional support in stressful cases¹⁰;
- Joint working, for example, in antenatal and postnatal work with vulnerable groups like teenage mothers or developing parenting groups with a school¹¹;
- Embedding psychologists and psychological practitioners in universal provisions as part of the team, as in TaMHS¹², and Sure Start or Children’s Centres. This will facilitate early intervention work as well as supporting the rest of the team.

Universal staff delivering these community-based early interventions do not necessarily need extensive psychological training, but do need high levels of support from fully trained psychological practitioners.

The levels of training and experience needed for psychological practitioners to be able to work in community settings are as high as for those in specialist clinic-based provision. They will often be working single-handed in the various settings and so a cohesive, well-supervised service structure including access to applied psychologists for consultation and supervision is vital to manage risk and support staff. The work of applied psychologists in community settings will require them to be adaptable and innovative with high-level assessment and consultation skills, as well as knowledge of a wide range of psychological presentations and the ability to determine the right intervention domain.

Monitoring of outcomes needs to be based on the impact on other staff and organisations, not just on the results of individual interventions.

4. Specialist therapeutic interventions

For children where attempts to prevent the development of mental health issues have not been effective, there is a need to deliver more specialist psychological interventions. These too can be delivered at a number of different levels in the system and by a range of different professionals – good services will always be mindful of which intervention is most likely to work for whom¹³, and who is best placed to deliver interventions and in what setting. Most will be delivered in clinics and other community-based settings but these are by no means the only venues to deliver therapeutic interventions. What is important is that, where there is evidence of effectiveness, these therapies are considered to be delivered as the first line of treatment (see also the section below on evidence informed interventions and the paper on specialist services in Part II, Paper 3:

‘Delivering psychological services for children and young people with emotional and behavioural difficulties, and their families, in specialist CAMHS settings’).

The workforce providing interventions to this part of the system need specific mental health training. Those delivering specific manualised interventions may only need training in that one model, for example, parenting, CBT, etc., but with supervision and support from practitioners who are able to provide more sophisticated and bespoke interventions to those with more complex needs (see Paper 2 on workforce and staffing structures below). Although, for the majority of mental health problems in children and young people, psychological therapies are known to be the most effective treatments, some best practice requires the combination or ‘blending’ of psychological therapies with psychiatry colleagues administering drug treatments.

For some children and young people, first line, evidence-based treatments will not be effective – services need to rigorously monitor progress through therapy, make appropriate changes along the way, and closely monitor clinical outcomes. Some children may need to have more intensive therapy; however, for others it may be that more therapy will not make any further differences to their lives. This latter group may still have needs – often significantly so, but what may be most helpful for them is psychologically informed care and support (see the next Section). We must be careful to ensure that a lack of availability of appropriate therapy is not used as an excuse for not delivering a service to children and young people who may benefit.

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5. Caring and risk support

For a number of children with mental health problems therapy may not be helpful, either because no effective treatments exist, or the right approach is not accessible, or for some reason the child or family are not wanting to access services. This group will still benefit from psychologically informed input, but applied to help them cope to best effect with their ongoing difficulties and/or to manage risk³. This group of children may be being cared for at home, or in social care or secure settings. The role of the psychological practitioner is to apply their knowledge to support the carers in direct contact with the child (see Part II, Paper 9: ‘Delivering psychological services for children, young people and families with complex social care needs’, and Paper 10: ‘Delivering psychological services for children and young people involved with the criminal justice system, those at risk of involvement, and their families’ for more detail).

Care must be taken to ensure that this kind of ‘risk support’ is not used where effective interventions could be available given sufficient funding (e.g. MST), or used to blame or stigmatise young people as being ‘resistant’ or ‘hard to reach’.



Section 4: Types of intervention

Julia Faulconbridge, Duncan Law & Amanda Laffan

1. The building blocks of a psychological approach

There are three basic steps to good psychological models of help or intervention. All three steps are essential to ensure that the child, young person or family are fully engaged in the process and that the first plans for treatment are as appropriate as possible with the best chance of success.

For some problems, particularly at the stage of early intervention, the causes and treatment plans may be relatively simple. However, many difficulties which may originally appear simple are found to be more complex if assessed appropriately. Undertaking a full assessment before deciding on intervention is essential if the right course of action is to be developed first time with the best chance of a positive outcome.

Step 1: Assessment

A psychological assessment is based on our scientific knowledge about child development and the ways in which biological, psychological and social factors come together for an individual child or family. As such, it will cover the child's developmental history and collect evidence about their social experiences with family and friends, significant life events and physical health. The child's experience in school is a key area of investigation, as are the social and economic family circumstances. The views and ideas of the child, young person and family/carers, and the meaning of their experiences to them from a personal and cultural perspective, are a crucial part of the assessment, along with the goals and wishes of the family and young person. All need to be weighed against what is known about child development.

The length and extent of an assessment will vary depending on the need, from brief initial assessments which may take less than an hour and can be completed by one practitioner, though to complex multi-disciplinary assessments that may include formal cognitive, and other psychological, assessments and may take many hours to complete. The crucial thing is to get enough of an understanding of the problem to complete the next step in the model: formulation. Assessment is not a one-off event, but is a continuous process throughout an intervention as new information inevitably emerges.

Step 2: Formulation

A formulation is a joint enterprise between the young person and/or family and the psychological practitioner. It summarises the child or young person's difficulties based on the information gathered at assessment, and takes into account possible biological factors, psychological factors and social factors that may be impacting on their mental health. A good formulation combines all these factors to explain why problems may be happening, and begins to identify options for appropriate ways to help – combining the evidence base with the unique context in which the particular child's problems are occurring and takes into account their views and wishes. A formulation is developed initially through the assessment process and represents a shared understanding which, like assessment, will continue to evolve through any ongoing involvement.

Formulation may include a diagnosis, of an autistic spectrum disorder, for example, but is fundamentally a psychological understanding of the nature and causes of the difficulties.

The agreed formulation then points to an individual intervention or treatment plan. The formulations and treatment plan must consider all aspects of the system that could be helpful to the child and should point to where different agencies might offer different parts of an intervention package, and consider how these interventions should be organised and integrated.

Step 3: Personalised evidence-based treatment for young people and families

The formulation may indicate that a particular form of treatment is most appropriate for a child or young person, for example CBT work for an anxiety problem, and this can then be carried out by a practitioner qualified in that approach.

The formulation may indicate that more than one approach may be helpful, perhaps at the same time, for example, CBT for the child alongside changes to education provision. This will require either multi-modally trained staff and/or a team approach within and across agencies.

For children and young people with more complex problems or where there are difficulties in developing and sustaining the necessary relationships, highly qualified multi-modally trained practitioners will be needed to work developmentally to craft systematic therapeutic and support work to meet the needs. This should involve the system around the child to meet their whole needs and not be simply symptom-based treatment.

Evidence-based practice incorporates within and between session outcome monitoring and joint ongoing review of the treatment plans, which may lead to modification of the formulation and the therapy – these changes should always be discussed with the young person and/or family in a process of ongoing discussion and agreement about how best to proceed – this should be led by the young person and guided and advised by the therapist, as best suits the wishes of the young person.

There will also be times when a psychological approach is required to understand problems in organisations, networks and systems. The same three basic steps would underpin a psychological approach assessing the nature of the systemic problems in their complexity, agreeing a formulation with the people in the system and then developing solutions with them, combining psychological knowledge with their in depth working knowledge.

Whatever domain, or part of a system, a psychological practitioner is working in, psychological interventions and care can be delivered in a variety of ways – direct therapy should not be thought of as the only, or indeed the best, way to intervene¹. This next Section looks at the different methods of intervention and care.

2. Direct involvement with a young person or family

As will be discussed in each of the specialist papers in Part II, there is a growing evidence base of what types of therapy work best for particular problems. However, it must be recognised that few children, especially in specialist services, have only one problem and that making decisions on, and delivering, the best care is often a complex process requiring a holistic approach. Indeed, the need for further research and the development of new evaluated approaches is pressing if we are to improve the psychological wellbeing of our children. However, all psychological services should have practitioners who, across the team, are able to deliver the evidence-based treatments, as well as those who are able to develop the plans for those with complex needs.

Whilst individual work alone may be appropriate for some young people, with younger age groups the evidence indicates that work is best if parents and families are included. There may also be individual work with a child, but this should not stand alone out of the context of the wider system.

It should also be recognised that for some young people, long-term support as they grow up is what is needed to enable them to understand and cope with the adverse circumstances in which they live, for example, parental mental health problems. This support functions to prevent the development of more serious long-lasting psychological problems. But it must be stressed, the primary aim of any intervention in the system should be to change the difficult context in which a child lives and not to help them cope with intolerable life circumstances.

Other families and young people may need to dip in and out of direct work over the course of their development. One example of this can be children with neurodevelopmental difficulties whose parents may need input at intervals depending on other factors in the child's life, for example, when there is additional stress like transition to secondary school, or changes in presentation like new and problematic rituals.

3. Consultation, support and supervision to those who are better placed to work with the family

Many young people and families are best supported in settings in their own communities and by people with whom they already have relationships. Others, whilst they would benefit from more specialist support, will not take it up, even when access is made easier. In these cases it may be more productive to support the people who are already involved with them to provide appropriate psychological help. This may also be the best pathway to helping the family or young person access more specialist help later.

Children and young people who are being seen by psychological services may be causing difficulties in other settings, for example, nurseries and schools. The provision of consultation and support as part of a treatment package will not only enable those settings to understand and, therefore, work with the child more appropriately and possibly enable them to maintain their presence there, but also positively support the more specialist work.

One model of consultation and support that could be developed much more is peer group support. This is specifically endorsed in *Future in Mind* and there are a number of examples of such work in schools, particularly around bullying. Psychological practitioners can take the lead in developing such approaches with other organisations like schools and youth services but will also need to maintain ongoing involvement to reduce risk to the young people receiving and providing the service.

All psychological services should contain a significant capacity to undertake consultation, support and supervision to other settings and services. This not only helps with the individuals discussed, but also increases the psychological understanding and the capacity of those staff to help a much larger population than can be seen individually by psychological practitioners.

There will be concrete examples of this type of work in the specialist papers.

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4. Psycho-education

This type of work is valuable in all settings, both as a prevention strategy and as an effective aspect of therapeutic work.

An example of its use as a prevention strategy would be inviting parents whose children have been newly-diagnosed with a particular condition, like Down's syndrome or ASD, to a series of workshops to help them understand the nature of the condition, likely issues and helpful strategies².

Within therapeutic work it may be a formal part of the therapy, for example, in CBT. It can also be combined with group work approaches, for example, for parents whose children are struggling in school, home and socially as a result of ADHD symptoms³.



Section 5: The core requirements of good services

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1. Introduction

There has been a growing interest in the best way to deliver services to make them both effective and efficient. Some of the changes have grown from a grass roots interest in service improvement such as the Choice and Partnership Approach (CAPA)¹, with its focus on collaboration and goal focused interventions to increase efficiency and improve flow through the system, and the Child Outcomes Research Consortium (CORC)², and OO-CAMHS³, with their focus on the use of feedback and clinical outcomes tools to facilitate better practice.

More recently still, changes have come from the centre with the roll out of Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT)⁴. CYP-IAPT builds on the foundations of CAPA and CORC and expands the models to include evidence-based practice and authentic service user participation, in an attempt to make services both accessible and acceptable to children and young people and their families and, as importantly, effective and transparent in their delivery. Further influence has been driven by regulatory bodies such as the Care Quality Commission (CQC). New models of service delivery are organised around treatment and care domains: THRIVE⁵.

It is hard to give a clear blue print for the ideal service, as the ideal service model is one that delivers its service to best suit the children, young people and families it seeks to serve. As this need will vary across different cultures, communities and across different presenting difficulties, so too will the shape of the model vary (these specific issues of service delivery models are picked up in the papers that follow in Part II of this Review).

Nonetheless, there are broad principles that all good delivery models should incorporate; these principles are not discrete but are rather a set of overlapping ideas that, used well, form a coherent model of practice that enhances efficiency and clinical effectiveness of services. These principles are described in the sections below.

2. Services that are configured around ease of access and reaching out

(a) *Referral processes and access*

Services need to be accessible in ways that suit the needs of the children and families they serve – but are all too often configured around organisational structures. *Future in Mind*⁶ recommends the development of a single point of access to mental health systems. That is an attempt to create a laudable 'no wrong door for help' culture – but multiple access points to help, that reach into communities are better and more accessible than single points of access that create bottle necks and narrow entry points. The key is the integration of these into a coherent, interlinked and mutually supportive system.

Once a system is accessed, services often develop quite complex decision-making processes before the offer of an appointment is even sent out, which tend to build delay into the system and thus reduce the number of children who actually get seen. Delays caused by seeking more information from referrers or rejecting referrals only to have to accept them at a later date should be avoided. Systems that use rapid initial assessment meetings, particularly where these focus on the goals and wishes of families like CAPA, are more effective.

tive and efficient. All families referred are offered an early appointment that enables information to be gained first hand; this needs to be done by a skilled and experienced psychological practitioner. This establishes a positive relationship with the family and enables decisions about the best option to be made quickly, avoiding damaging intermediate steps, capitalising on motivational momentum for therapy and reducing the risk of unnecessary deterioration.

Self-referral routes should also be created either into generic services or through the development of specific self-referral services. As an example, in Nottingham a self-referral Teenage Clinic was developed which was run in the city centre in the early evenings. This contained sexual health and family planning services alongside a clinical psychology service that was integrated with the community psychology service which operated as part of Community Child Health⁷.

The development of consultation options before referral is recommended. This can be done through face-to-face activity in groups, or in bookable sessions. However, telephone advice lines for both other professionals and for parents, carers and young people themselves have proved very helpful for both improving the referral process and in supporting those who telephone in. A survey of schools found that over 50 per cent of respondents reported dissatisfaction with referral systems and many teachers valued the opportunity to discuss concerns and ask advice from CAMHS clinicians on an informal basis and with a named person⁸. An example of how this can be done is the CAMHS Advisory Line run by Leicester CAMHS, offering telephone consultation and advice to referrers.

The development of web-based consultation and advice should also be explored, especially for young people, as recommended in *Future in Mind*⁶.

(b) Locations

Whilst it may be necessary for some specialist provisions, such as systemic family therapy, to be provided in a centralised situation where the facilities are available, the norm for provision should be in community settings. This may be more resource intensive due to travel requirements, but ease of access needs to be a primary aim of any psychological service. Where good evidence exists of their value, locations may helpfully be virtual with interventions and information being made available online.

Careful thought and planning is needed to determine the types of setting which are most appropriate. As examples, for young people these may be schools, community health settings, youth services; and for parents may be in Children's Centres or in their homes, especially if there are child care issues. Ease of transport, public and private, should always be considered

and may dictate suitable locations. Services should be located where the need is greatest and ensure access from communities that may consider themselves on the fringes of society: refugees, travelling families, and families in extreme poverty.

There may be significant sensitivities within local areas which need to be understood and worked with. For some young people and families going to an appointment in a neighbouring locality may feel like entering hostile territory and will deter them from attending, or in some cultures, the taboo of women attending services staffed by men needs to be considered.

For clinicians, the settings may fall short of the supported offices they are familiar with in traditional CAMHS settings but these can be accommodated to. For most young people and families ease of access outweighs issues of less comfortable settings, although making settings child and young person friendly is a clear aspiration. However, privacy and confidentiality cannot be compromised on.

(c) Timing of appointments

Traditional clinic timings are very disruptive for families and young people as they can prevent adults attending due to work demands and may have a significant impact on schooling. An accessible service must operate at times which are convenient for young people and families, and have the scope to be flexible and configure around individual circumstances. This will mean some evening and weekend working for staff.

(d) Being non-stigmatising

Services must not only remove barriers to access of services, but also work to ensure that mental health and mental health services are non-stigmatising. For more information please see YoungMinds⁹ and Time To Change¹⁰.

(e) Reaching out

No matter how convenient and pleasant a setting is provided, many of the young people and families who are most in need will not access them through traditional routes. Currently, even if they are referred, they become DNA statistics. Local services need to research the marginalised groups in their geographical area and develop strategies for reaching out to them. This could mean simple measures like co-location of provision with other services or settings where the people already go. At the more complex level it may mean developing a specialist service designed for a particular group, or services going out into the places where young people or parents are to develop relationships with them. Two examples of how this can be done are Building Bridges¹¹ and MAC-UK¹². Some of these models are discussed more fully in other papers.

3. Services that embrace diversity and work to avoid marginalisation

(a) *Cultural sensitivity and inclusivity*

It is important that services develop a sophisticated understanding of the needs of the communities which they serve and where necessary work collaboratively with local communities to develop a better shared understanding of the need for mental health care, consider different perspectives on what constitutes a mental health problem and what might be useful. For clinicians it is important to maintain a stance of respectful curiosity and enquiry whilst acknowledging gaps in knowledge and the need for families and young people to guide the clinicians' understanding of the presenting problem in the context of their cultural background.

Services need to adopt a number of core principles in their delivery. The concept of culturally competent services has become important in shaping the way services understand how to remain sensitive to the needs of differing populations.

Evidence suggests that many Black and Minority Ethnic communities do not access mental health services at the rates that would be predicted¹³ and that practitioners might be reluctant to discuss issues of culture and ethnicity with service users but that service users value such discussion¹⁴.

It is essential that psychological practitioners in community CAMHS have a robust knowledge of the demographic make-up of the districts they serve, and crucially, are able to maintain core values of respect, curiosity and openness to the range of diversity in any given area. Some services employ clinicians with a specific remit to work with minority groups and target resource to work with populations who may otherwise struggle to access services or who are disenfranchised for various reasons including language, cultural norms, economics or dominant narratives about how services are sought and engaged with.

Core training for psychological practitioners should provide the opportunity to develop skills of cultural competency, whilst services themselves have a duty to continually examine and develop how they deliver to diverse populations, as outlined in the Department of Health's five-year action plan 'Delivering Race Equality in Mental Health Care'¹⁵. However, what exactly comprises the 'culturally competent' practitioner remains unclear and 'attempts at delivering culturally competent services are still not meeting the challenges of the multi-cultural, multi-faith society in the UK'¹⁶ (p.27). Part of the problem is that attempts to achieve cultural competence are often delivered through one off training sessions rather than ongoing attention to building long-term multi-ethnic partnerships through representative service user participation and legacy

building initiatives such as the Global Health Exchange¹⁷.

Another challenge that we need to meet in order to seriously address issues of inclusivity is to address the lack of representation amongst all psychological practitioners, including applied psychologists. We need to embrace the widening participation agenda and populate our services with people who reflect their communities. This needs to be a co-ordinated effort and engagement with marginalised groups needs to start as early as primary school in order to establish pathways to applied psychology training for those with the potential to be valuable clinicians but who currently lack the educational and social opportunities to achieve this. Currently groups such as the British Psychological Society's 'Social Justice and Inclusion Task Force' are committed to realising these goals¹⁸.

(b) *Accessibility*

In addition to location, timing and reaching out, services need to consider how they make their buildings truly accessible for those with disabilities. Since the implementation of disability discrimination legislation^{19,20}, organisations/institutions have been required to make reasonable adjustments to allow access for all to their services, but that access is often by another route, such as a side entrance, or may require specific assistance, both of which reinforces the status of the individual with a disability as 'different'. Similarly, once inside buildings, those of us with a disability often experience a lack of 'user-friendliness' as relatively simple adjustments such as grab rails, touch legible signs and visual/audio alarm systems are often lacking. To those for whom accessibility and mobility is not a problem, these details may seem small but the accumulative message to those with a disability when services are not adaptive to their needs is 'you do not belong here'.

(c) *Acknowledging structural barriers to inclusivity*

A determined engagement with issues of inclusivity and accessibility essentially means that a service is more likely to provide effective and efficient provision for the local community. However, it must be acknowledged that there are barriers to inclusivity which are not within the control of individual services to address. There are incidences that show the NHS can operate as a structurally racist, sexist, hetero-centric and excluding organisation. These conclusions are typically reached following a high profile case of 'failure', for example, the Independent Inquiry into the death of David Bennett²¹ concluded in 2003 that 'Institutional racism has been present in mental health services and the NHS for many years and greater effort is needed to combat it' (p.45). As a result of such enquiries, over recent years there have been many laws introduced in

the UK aimed at changing the culture of organisations with particular regard for the rights of people from minority groups. The most recent of these is the Equality Act 2010²⁰ which aims to provide ‘a modern, single legal framework with clear, streamlined law to more effectively tackle disadvantage and discrimination’. While such legislation is welcome in terms of enshrining the rights of those deemed to have one or more ‘protected characteristics’ (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation) there is a continued need for initiatives which tackle the root causes of prejudice within the NHS in order for the organisation to become genuinely inclusive.

4. Services that get children and young people involved in making better services

In order for services to be truly acceptable and accessible to the children and young people and families they are commissioned to serve, they should be shaped in line with the views of children and young people. All good services should work to hear the voices of service users and potential service users alike, to understand what works well about services and, more importantly, to hear and understand what works less well and change it. Authentic participation is participation that impacts on every aspect of service delivery and development from the boardroom to the clinical encounter. CYP-IAPT has authentic participation as a core principle of good psychological services.

There are varying degrees of participation from being assigned but informed, through adults initiating but sharing decisions, to children and young people and adults initiating and sharing decisions together²². There are also different approaches from consultation to advisory or reference groups. Finally, there are specific guidelines and standards for specific service models such as MYAPT’s 9 Participation Priorities²³. It has benefits for the organisation, for young people and for commissioners²⁴, as follows:

- For the organisation, authentic participation allows the development of a more accessible and responsive service and informed planning and service development.
- For young people, there is the opportunity to shape the service that they receive, recognition that their views count and subsequently, a positive impact on their sense of empowerment and control over their own wellbeing.
- Importantly, for commissioners, participation delivers evidence of service user satisfaction and acknowledgement of service strengths and limitations along with how a service is addressing these.

Overall, authentic participation is participation that impacts on every aspect of service delivery and supports service users to go from passive recipients of services to active contributors to service design and delivery (see ²⁴ for models of good participation in CYPMH).

5. Services that are integrated, co-operative and collaborative with other services and settings

Over recent years, different commissioning systems with different budgets and priorities, together with reduced finances, have led to an increasingly fragmented set of provision. This not only means that many children and young people fall through the gaps, but also that there is waste built into the system. If all the provision is integrated into collaborative care pathways then the overall provision will be more therapeutically effective and cost effective.

In particular, attention needs to be paid to integration with the following:

(a) Early intervention and supportive community services with specialist provision

The effectiveness of specialist psychological services is dependent on the availability and cohesiveness of early intervention. In their absence, specialist services easily become crisis services and children and young people are only seen once their condition has deteriorated sufficiently to meet the threshold criteria and, by definition, are more difficult to help.

Good integrated pathways with high quality assessment at the beginning means that children and young people are seen where it is most appropriate for them first time. Whilst there will always be times when a child initially seen in an early intervention service will need onward referral to more specialist services, the aim should be for this to be the exception rather than the rule as the effectiveness of treatment tends to be reduced by previous unsuccessful experiences.

Integration also enables consultation, supervision and shared planning to be a foundation of the local plan. It is important to recognise that this works both ways; that specialist services will learn from the knowledge and experience of early intervention practitioners as well as providing more specialist consultation. Models of staff working in rotational schemes or on secondments to other services can be very beneficial in supporting integrated models.

(b) Social care

Social Care and NHS CAMHS services already work closely in some geographical areas and with some client groups, such as Looked After Children. However, with the loss of the CAMHS grant there seems to have been a reduction in the amount of joint working in many areas, to the detriment of families. Whilst safeguarding

is an obvious example of where social care and psychological services need to work together, there are many examples of where they could work together, such as parenting support and children in need. In Manchester, CCGs, Local Authorities and NHS providers are working together to prepare for the devolution of health and social care funding from April 2016 with the expectation of better-integrated health and social care services.

(c) Physical health – community and acute

Children and young people with ongoing physical health problems and their families are significantly more likely to develop psychological problems, and the opportunities to prevent and intervene with those will be discussed in the specialist physical health paper (see Part II, Paper 5). Integrating the provision of services in hospitals with that in the community into care pathways will be of clear benefit.

Community paediatricians have different roles in different parts of the country, but in many places are the key practitioners for children with neurodevelopmental disorders, learning difficulties, physical health and disability problems. They are, therefore, a key element of any effective care pathway for these children and also for the assessment of children who are shown through psychological assessment to need paediatric assessment.

Midwives, health visitors and school nurses are also core components of any pathways looking at prevention and early intervention of psychological problems and this will be discussed in more detail in the Early Years and schools specialist papers (please see Part II, Papers 7 and 8).

(d) Adult mental health

Parental mental health problems are a recognised risk factor for their children's psychological development but all too often the Adult Mental Health Services (AMHS) do not recognise or take full account of the impact of parental difficulties on their families. In addition, when previously unrecognised parental difficulties are found in the assessment of their children, it can often be very difficult accessing or co-ordinating support for them. In some instances the co-location of some adult mental health provision in children's services can be effective and vice versa.

In July 2009, the Social Care Institute for Excellence (SCIE) published a guide entitled *Think child, think parent, think family: A guide to parental mental health and child welfare*²⁵ which discussed many of these issues and proposed guidelines for improvement. An evaluation of its implementation in five pilot sites was published in 2012²⁶.

The importance of positive relationships with AMHS provision for successful transition is discussed later.

6. Services that use evidence-based practice

There is good and growing evidence that some forms of treatment and intervention are likely to be more effective than others in certain contexts²⁷. Additionally, there is growing evidence that some interventions are likely to be detrimental or slow recovery, such as 'Holding Therapy' (restraint and aversive stimulation, as well as forced regression techniques such as re-birthing) for children who have experienced maltreatment²⁸.

Good evidence-based practice is not a simple application of NICE recommended treatments based on simple diagnoses. Instead it:

- combines the information derived from research;
- fits with the family and their context;
- monitors progress throughout an intervention using appropriate feedback and outcomes tools;
- starts with a sophisticated formulation that takes into account the problem and the context in which it presents, the cultural understanding of the difficulties, and the families' own goals, wishes and aspirations for treatment²⁹.

We must also be mindful that however skilled and sophisticated services and clinicians get in psychological interventions, there will be some young people who will not be helped²⁷, not because the right intervention has not been offered, but because the right intervention, for that young person at that time, does not yet exist. Services need to be thoughtful about when they have realistically done as much as they can therapeutically and consider stopping therapy and moving to another realm of support. Services that simply do more, and more often, when treatment is not working are likely to be doing young people a disservice, as discussed in the previous section on service delivery models.

CYP-IAPT has been instrumental in rolling out further training for practitioners in certain key evidence-based interventions.

7. Services that have effective care pathways

Good services should have care pathways that take into account the best evidence and best evidence-based practice – delivering what works and avoiding that which does not work or is damaging. Pathways need to take into account the unique context in which the child or young person lives and the problems that occur. Good care pathways should guide clinicians to best practice and empower service users to understand what a range of good interventions might look like for their difficulties. These pathways must be integrated across the whole mental health system²⁹.

It is not possible for individual clinicians and practitioners in a service to be able to offer the full range of evidence-based interventions. For pathways to function

well, all members of a team need to be aware of the value and evidence of the range of different interventions and be able to have informed discussions with children and young people and families about the best approach for them. This will require matching the therapist to the child or young person based on their needs, goals and wishes, as well as the evidence-based intervention that is likely to be the most helpful. More information on psychological workforce can be found in Paper 2 and throughout the papers covering specific delivery models.

8. Services that use outcome measures and feedback tools

There is much interest in quality of services for children and young people's mental health, and yet the children's mental health system has been historically poor in collecting evidence of quality in a meaningful way, and therefore has not been able to use good data to improve services. In the past, much of the emphasis has been on measures of services that focused on *quantity* of provision: how many children are seen, how soon, and for how long. Whilst these are useful measures of a service's accessibility, and help to understand the demands on a service, they say nothing about the *quality* of a service. Measures of quality should focus on whether children get better, or are helped to maintain their best level of psychological health, as appropriate to their circumstances, as a result of input from services. In no other area of health would *quantity* be valued over *quality*.

Good services must be able to measure the clinical outcomes of the interventions they offer. Both CORC and CYP-IAPT have developed guidance on how this should be done in a way that adds value to the clinicians and young person, as well as helps collect good data on the quality of services³⁰. The data from the use of feedback and outcomes tools collected and used in this way have been shown to improve practice³¹.

A more detailed discussion of outcome monitoring is to be found in Appendix 4.

9. Services that are flexible over transitions (between parts of the systems as well as into adult mental health)

A number of young people still need support or ongoing treatment when they reach the upper age threshold for the service – for CAMHS this has traditionally been the young person's 18th birthday. There are long-standing concerns about the difficulties which frequently surround transition, meaning that many young people are lost to services at this time and, if they do move onto adult services, experience a drawn out and very difficult process at a time of significantly increased vulnerability.

However, barriers to transition are not restricted to age boundaries alone. Historically, CAMHS has provided treatment to young people who may not be presenting with a diagnosable mental health problem, but whose psychological difficulties are having a significant impact on their life and are likely to become worse if not helped. AMHS are traditionally more based on a diagnosis led model.

Within CAMHS the child or young person is assessed and treated within the context of their family, care system and community. In contrast, the focus within AMHS is centred more on the needs of the client, with carer involvement considered at the client's request.

Certain groups of children are at higher risk of developing mental health problems in adult life; this group of children include those with neurodevelopmental disorders such as ADHD and ASD, learning disabilities and Looked After Children. Despite their vulnerability and the complexity of their needs, they may fall below the eligibility criterion to access continued support from AMHS.

These issues were clearly recognised in the Government Task Force Report *Future in Mind* (pp.48–50)⁶, which lays out the case for increased flexibility to meet needs.

Positive transition improves clinical, educational, economic and social outcomes for young people. In contrast, poor transition leads to disruption in care which can be associated with increased risk of non-adherence to treatment and loss to follow up. At a time when young people need to access support, it is also evident they are at greatest risk of disengaging from services³².

Good services have flexible, tapered transitions that fit the needs and wishes of young people and their families rather than hard, age related, cut-offs.

A more detailed discussion of transitions is found in Appendix 5.

10. Services that are effectively resourced

Subsection 3 in Section 1 sets out the lack of resources as a major barrier in children and young people accessing services and how CAMHS is a system that is chronically underfunded to meet the needs in the population. Services need to be properly funded if they are to genuinely meet local need. These funding arrangements must be based on current prevalence data (which we have identified is also a problem in the UK) and rely on services and practitioners providing interventions and treatments that offer best value. Good services will involve psychological therapists in the strategic planning of services to ensure that clinical experience and evidence is incorporated into the design process. However, services must be pragmatic.

Although we should continue to press the case for new money, services will, in the short to medium term at least, have to design systems that are as effective as possible given the limited resources, that is, do more for less.

11. Steps to transforming services

At the time of writing, all CCGs are being asked to produce 'Transformation Plans' to show how they intend to improve the access and effectiveness of the whole CAMHS system. These are to be guided by the 49 proposals set out in the *Future in Mind*⁶ report. The values and standards of good services are available through the 'Delivering With, Delivering Well' framework³³. The framework guides CAMHS systems to the areas that need attention to improve service quality. It

is likely that for many parts of the CAMHS system, changes, some of which will be quite radical, will be needed to make best use of the limited resources available. Although the current drivers for change might be economic, the changes needed to improve efficiency and effectiveness in services are, at the same time, the changes needed to improve the quality and effectiveness of therapy and care. Service leaders need to be equipped with the knowledge and skills to implement change in organisations^{34,35}.

Applied psychologists are specifically trained to facilitate and manage change in the families that they work with, they should be seen as vital resources in planning and implementing organisational change and are vital in the planning and delivery of transformation plans.

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Appendix 1: Psychological understanding of mental health

Amanda Laffan, Duncan Law & Julia Faulconbridge

Psychological models tend to view the causes of mental health difficulties as being completely normal and understandable reactions to difficult or traumatic life experiences. Similarly, psychological models tend to view any ‘symptoms’ of mental health difficulties as being normal and understandable reactions to the difficulties a person is facing.

There are a number of different types of psychological models that can be used to explain mental health difficulties, although most of them are based on this view. Some of the main models that are used include behavioural, cognitive, systemic and psychodynamic. All of these models have similarities between them, but differ in the focus of the understanding and, therefore, have different ideas about how best to help:

- **Behavioural** models tend to explain mental health difficulties in terms of the reactions an individual has learned to certain situations. For example, a behavioural model may explain a phobia as occurring because the individual has learnt to associate the thing they are scared of with a traumatic event – such as being bitten by a dog leading someone to have a phobia of dogs. The task of therapy is to break the unhelpful links and replace them with more helpful associations.
- **Cognitive** models tend to see mental health difficulties as resulting from people having developed ways of thinking that, rather than helping them get on with life, get in the way. These thinking patterns or styles can seem quite irrational, even to someone who knows the child well, but make sense to the child and their beliefs. For example, a young person might develop elaborate and time consuming rituals or patterns of behaviour, like hand washing, with the idea that they need to do these things to keep themselves and others safe from harm. Like behavioural models, it is thought that these thinking patterns develop over time based on a young person’s experiences. The task of therapy is to help a person recognise these unhelpful thinking styles and develop better ones that work for them.
- **Systemic** models tend to explain mental health difficulties as resulting from patterns or difficulties within an individual’s relationships, both with the

people close to them and in the wider environment. For example, a systemic model may explain self-harm in a teenager as a consequence of difficult family relationships creating feelings that cannot be talked about in the family, and need to be expressed or managed in more risky, and less helpful, ways. The task here is to change the relationships within the family so that feelings can be expressed and dealt with better as a family unit, so that the young person will no longer need to self-harm.

- **Psychodynamic** models tend to explain mental health difficulties as resulting from largely unconscious ways of thinking and experiencing the world that cause problems in young people’s lives. Again it is felt that these patterns develop over time as a result of experiences a young person has, particularly with parents and carers, but the child is believed to be largely unaware of the patterns and thoughts that cause these difficulties. For example, a young person may feel depressed because of poor care they received in early life, but not be aware of this reason. The steps in child psychotherapy are to work to uncover the unconscious thoughts, feelings and patterns that lead to the depression, giving a young person choices and ways to deal with life and relationships differently.
- **Emerging** models – new therapy models are being developed based on recent psychological theory and research evidence, and combining elements of the traditional interventions are showing great promise in delivering effective interventions to children and young people, such as Interpersonal Psycho-Therapy for Adolescents (IPT-A)¹, Mentalisation Based Treatment (MBT)² and Multi-Systemic Therapy (MST)³.

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Appendix 2: Risk factors for mental health

Julia Faulconbridge, Duncan Law & Amanda Laffan

The World Health Organization¹ lists these as:

Individual factors

- Low self-esteem
- Cognitive/emotional immaturity
- Ability to solve problems
- Difficulties in communicating
- Medical illness
- Substance misuse

Social circumstances

- Loneliness
- Bereavement
- Neglect
- Family conflict
- Exposure to violence/abuse
- Low income and poverty
- Difficulties or failure at school

Environmental factors

- Poor access to basic services
- Injustice and discrimination
- Social and gender inequalities
- Exposure to war or disaster

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Appendix 3: Child maltreatment

Amanda Laffan, Julia Faulconbridge & Duncan Law

The harm caused by child maltreatment can have wide ranging effects on the child or young person's emotional, psychological, behavioural and interpersonal functioning¹. The following list provides just some examples of this:

- Adolescents can develop PTSD following physical or sexual abuse or neglect²;
- Adolescents are more likely to engage in self-harming behaviours³, or have suicidal thoughts and behaviours⁴, following sexual or physical abuse;
- Adolescents are more likely to engage in problematic drug use and to experience depression and suicidal thoughts following physical or sexual abuse or neglect when they were children⁵;
- Adolescents are more likely to engage in violent crimes, problematic drug and alcohol use, and health-risking sexual behaviours, and to experience suicidal thoughts, following maltreatment in adolescence⁵, with the likelihood of engaging in violent crimes being greater the more types of maltreatment a young person has experienced⁶;
- The stress caused by maltreatment can also have harmful effects on a child's developing brain^{7,8,9}, as:
 - neglect can deprive the child of experiences necessary for the brain's ordinary development;
 - repeated exposure to particular experiences will lead to the development of particular synaptic connections (for instance, repeated exposure to aggression will lead to a child recognising aggression, and responding aggressively, more readily);
 - the effects of stress on the hypothalamic-pituitary-adrenal axis, morning cortisol levels, the oxytocin-vasopressin affiliative system and the sympathetic nervous system will affect levels of arousal, behaviour, interpersonal relating and emotional states¹.

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Appendix 4: Outcome monitoring in children and young people's mental health systems

Duncan Law, Julia Faulconbridge & Amanda Laffan

Good services must be able to measure the clinical outcomes of the interventions they offer. Both CORC¹ and CYP-IAPT² have developed guidance on how this should be done in a way that adds value to the clinicians and young person, as well as helps collect good data on the quality of services³. The data from the use of feedback and outcomes tools collected and used in this way have been shown to improve practice⁴.

Routine Outcome Measures (ROMs), or feedback and outcome measures, are usually short questionnaires that help gather information about: the difficulties a person is experiencing, or the impact of a problem on a young person's life; the things they want to change and goals they want to reach; or their satisfaction with a service or clinician. There is not one tool or measure that can capture clinical change – good models use a range of different tools and measures – ideally these should include:

- **Goals** – measures that capture changes to the unique goals a child or young person wants to change as a result of a service intervention, using tools such as the Goals Based Outcome (GBO) tools⁵;
- **A measure of problem change or impact** – a measure that captures the child or young person and/or family's view of changes in the problems, and/or changes in the impact the problems are having on their lives, such as the SDQ⁶, RCADS⁷ or ORS⁸;
- **Experience of service** – the tools to capture change should be used alongside a measure of service satisfaction and experience of the service, using tools such as the CHI-ESQ⁹ or SRS¹⁰;
- **Clinical view** – in addition, some services may wish to add a clinical view of change, using tools such as the CGAS¹¹ – but systems that capture only clinicians' ratings of outcomes should never be solely relied upon due to the more likely openness to 'gaming': the pressure to manipulate results due to pressures on services.

Whatever tools are used, they must fit with the clinical needs of the child or young person/family, as well as their cultural understanding and developmental level. Practitioners must be careful to use tools in a clinically and culturally sensitive way to avoid the imposition of white Western medicalised views of mental health that may be alien and unhelpful to some^{12,13}. There is a

wider cultural issue here as many of the ROMs were developed with populations that do not reflect the diversity of children and young people seen in services. Personal testimony and qualitative data in general, used alongside quantitative data, promotes better inclusion of outcomes and voice across communities.

Young people with experience using feedback and outcomes tools have reported generally positive experiences when the tools have been used in a clinically meaningful way and embedded within the intervention (rather than a bolt on administrative task that is never used). Young people have summed up the utility of measures as:

'Outcome measures, if used correctly and appropriately, can provide service users with a more definite goal and focus. Therapy of whatever kind can seem abstract and users can sometimes be left feeling as though their therapy is in one place and their real life another. Outcome measures and tools can help to align these by showing users and their therapists where they are heading, where they have come from and what they are achieving. They can feel tedious but they are also a great way to see how things are going and how areas of a service can be improved. From a young person's point of view, they can make them feel listened to and make the sessions feel much more worthwhile.' (Young Sessional Workers from the GIFT Team (Charlotte Green, Bethany Taylor, Rhiannon Dunlop, Jonathan Davies, Rachel Vowden and Olivia Stanley) and Cathy Street – in ³, p.27).

In good services the information received from outcome and feedback tools from children and young people will be used, along with other information, at a number of different levels:

- **Individual children and young people/families** – discussions with children and young people to guide therapy, to share information on presenting difficulties and progress (or otherwise) in therapy, and as a record of change for the young person and the people around them;
- **Clinician** – to reflect on their own practice, to spot interventions that may be moving 'off-track' and mitigate against potential drop-out, and as information to guide self-reflection and learning;
- **Supervision** – to facilitate clinicians' self-reflection and learning, to guide intervention planning, and to bring the children and young people/families' voices into supervision more strongly;

- **Team/Service** – to reflect on the overall impact of the team – what it does well and where it may wish to improve; and monitor the impact of service changes;
- **Commissioning** – data of this sort should be the basis of contract discussions between providers and commissioners. As with clinical work, the data should facilitate dialogue;
- **Nationally** – at a national level there is the opportunity for the analysis of data to help build practice-based evidence of the types of interventions that work in real world children and young people's mental health settings.

At all of these levels, the data needs to be interpreted with great caution and always must be understood in context – the numbers from any of these data sources should only be seen as guides to facilitate discussion, and never seen as facts that speak for themselves. Wolpert et al.¹⁴ propose a 'MINDFUL' model to help facilitate meaningful discussion based around outcomes data.

From January 2016, the Mental Health Services Data Set (MHSDS) will flow nationally, all IT suppliers to the NHS will have to make their data systems comply with the MHSDS and all services will have to share the data they collect. There is a real opportunity, in developing IT systems that comply with the MHSDS, to also make sure that they are effective in collecting good quality data that can also be used to improve clinical practice. Whilst central data flow is important in helping us understand CAMHS, it is essential to ensure local data collection is based on clinical need and is relevant to children, young people and families, and that this data is used in a meaningful way in clinical settings and to inform service improvement. This will drive good clinical practice and, by making data 'useful', we are more likely to get better data to use nationally.

To collect and use data effectively, IT systems must be able to:

- **Support the collection of data in clinic sessions** in a way that is acceptable and understandable to families, young people and clinicians – this is best done through the use of tablets, laptops and other electronic data devices that facilitate the completion of ROMs in electronic form that are user friendly;
- **Support the instant analysis of data** – systems should support analysis of data, scoring ROMs instantly and making the scores available to clinicians in real time;
- **Support the clinical use of ROMs data** – the systems should ensure the data is presented in forms that are accessible, acceptable and understandable by children and young people and their families and clinicians, to be used to feedback information from ROMs. These should include presentation of data in user friendly forms: charts and graphs, with statistical cut-off and other clinically helpful information included on the charts, where available.

The way the data is presented needs careful thought too, particularly if being used to compare services or teams. Data quality issues can easily skew data in a way that can lead to misinterpretations – this should always be borne in mind when looking at data. Methods such as funnel plots, that present data in a way that takes account of data quality, can help to protect against over interpretation¹⁵.

Over the coming years, good services will work with children and young people and their families to create better tools and IT systems to collect and monitor outcomes, to improve how useful and helpful they are to clinicians and young people, and in measuring how effective services are.

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Appendix 5: Facilitating transition

Julia Faulconbridge, Duncan Law & Amanda Laffan

Factors identified in promoting or facilitating effective transition have included:

- ‘Personalisation’ of care plans, where young people take an active role in shaping decisions about their needs and support;
- The appointment of a trusted adult to act as a key worker or co-ordinator and to be the single point of contact for the young person or family, who understands the needs of the young person and their family, and can co-ordinate the agreed plans and ensure these are reviewed regularly¹.

Forbes et al.² identified a number of process issues including:

- preparation for transition;
- case management;
- strong therapeutic relationships;
- information for both the young person and their family;
- advocacy;
- joint management of care;
- flexibility regarding point of transfer;
- regular audit of service provision.

Successful transition planning is also dependent on the collaboration between CAMHS and AMHS. Richards and Vostanis³ concluded on the basis of their research that there was no clear evidence to show that one model of transition was superior, and recommended any structure, or a combination of structures, including:

- designated transition workers, who are trained in adolescent work and seconded to adult teams;
- designated transition service;
- designated team within a service.

Singh, Evans, Sireling and Stuart⁴ recommend that Early Intervention in Psychosis (EIP) services which already span the 14 to 35 age range may provide a ‘template for other youth and adult services dealing with a broader range of disorders’ (p.293). They recommend the secondment of staff from CAMHS to AMHS for two sessions a week and vice versa in order to build on the interface between services.

There are now models of service emerging (examples are found in Birmingham and Norfolk) which take young people up to the age of 25, and this fits with the new SEND (Special Educational Needs and Disability) Code of Practice⁵.

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Using clinical and other applied psychologists effectively in the delivery of Child and Adolescent Mental Health Services (CAMHS) – recommendations about numbers, gradings and leadership

Jenny Taylor

In order for providers to deliver good CAMH services in the most effective and efficient way, they need staff with a range of skills to be able to offer high quality assessments, and the best therapeutic interventions supported by excellent supervision and clinical leadership. The workforce should be made up of staff who can draw on a range of scientific theories and design and apply tailored interventions to the complex group of children and young people who present to services, as well as staff who are trained to deliver evidence-based interventions for a range of more straightforward presenting problems. Without this skills mix children are likely to be offered inappropriate interventions that are likely to lead to ineffective or longer treatments. The complexity of children presenting to a service will require a different blending of skills to meet the need.

Understanding the workforce – applied scientists and specialist therapists

Delivering good quality CAMH services includes two important components amongst others: having staff with the right skills to improve children's mental health effectively, and using those staff efficiently to maximise the resources available in the highly resource-tight environment in which these services currently operate. CAMHS staff tend to have a range of crossover skills, and clinical opinion favours multidisciplinary team working with a view to broader, more holistic formulations and intervention planning. However, getting the number and balance of staff right to enable expert scientific leadership and responsive and effective intervention delivery is a work in progress. In order to do this, commissioners and managers of services need to have a clear understanding of the training, skills and expertise of the staff they employ. These introductory comments aim to provide this information with regard to clinical and other^a applied psychology staff and thus assist in determining their most appropriate use within a CAMH service.

In order to understand the appropriate use of clinical psychologists in child mental health services, or indeed any other field, it is helpful to be aware that the NHS trains them, as it does psychiatrists, to be applied scientists rather than therapists. Feibleman¹ defines applied science as 'the use of pure science for some practical human purpose'. Scientists, whether pure or applied, initially undertake a comprehensive study of

their particular scientific discipline, usually at degree level, including studying different types of scientific method. Applied scientists then go on to further studies, focusing on using scientific method to accurately assess and understand situations, learning how to apply the underlying scientific knowledge base to a particular field of endeavour, and learning how to examine experimentally the impact of their application.

For example, someone working as an engineer (an applied physicist!) would not just be able to work out that the knowledge base of physics suggests that a particular material has properties that might make it useful for a particular building project – they would also be able to determine experimentally whether their hypothesis was correct. Likewise, psychiatrists and clinical, and other applied, psychologists are expected to be able to work out from their underlying studies (medicine and psychology) innovative methods of intervening biologically or psychologically and to research the impact of these innovations. But when it comes to actually building a specific bridge, it is likely that the builder will have more experience and more skill in the actual delivery than the engineer. Likewise in mental health, whilst psychiatrists and psychologists may be best placed to undertake complex assessments (for example, psychologists have specialist skills in neuropsychological assessments), we have a number of professional groups who have significant training in the delivery of specific interventions, whose skills in these areas may surpass those of the psychiatrist or psychologist.

^a There are various postgraduate specialisms in applied psychology that follow the training structure described below – this paper focuses on clinical psychologists, as these are the applied psychologists trained by the NHS to meet the clinical needs of the NHS population, but it is worth noting that other types of applied psychologists trained outside the NHS may also contribute effectively to the CAMHS workforce.

In addition, for an applied scientist to remain able to apply the latest findings of their science to their particular endeavour, it is key that they remain up to date with changes in the underlying knowledge base, and able to critically analyse the implications of these for their particular field. For example, a medical doctor does not just learn the state of understanding of human biology in the 1960s and then continue to apply that knowledge for the next 50 years – she is expected to keep up-to-date with changes in knowledge of human biology on a regular basis, so that her application of that knowledge has the greatest chance of achieving the ends she is aiming for. Likewise a clinical psychologist does not expect to simply apply the interventions that were the key evidence-based interventions at the time of his training, but rather to keep alert to the developments in the psychological knowledge base and the associated changes in potential interventions.

When thinking about service structure, it is important to give some thought to the particular skills and training of applied scientists as opposed to those of specialist therapists, and, therefore, when it is best to use which. Specialist therapists are staff who have focused their education and training on developing skills in the delivery of one particular therapeutic intervention – in the case of psychological interventions, the specialist therapists most commonly found in Specialist CAMHS are Systemic Psychotherapists, CBT Therapists and Child Psychotherapists. Alongside them typically will be Mental Health Nurses and Clinical Social Workers who have usually undertaken training in particular therapeutic techniques, and are, therefore, also able to work as specialist therapists. Community or voluntary sector services may include other specialist therapists such as Counsellors or Art Therapists.

As an analogy when thinking about applied scientists and specialist therapists, in physical health care a medical doctor may take the lead in clarifying the nature of a complex presentation, and deducing the most appropriate interventions, but those interventions may then be more appropriately delivered by a specialist therapist (such as a physiotherapist) who has developed skills in administering that particular intervention (although the doctor would be expected to understand the principles of physiotherapy and to have correctly deduced the need for it). Applied scientists in health care are trained to have high level skills in analysing and understanding presenting problems, and clarifying whether there is a relevant evidence-based intervention for that problem. If a specific intervention is required, those who have trained in that particular type of intervention delivery as their main professional training may have the greater skills in the delivery of that intervention.

This means that there are significant potential advantages to a service in employing specialist psychological therapists as well as psychologists and psychiatrists, in terms of both expertise and the usually comparatively lower cost of specialist therapists who have not had to undertake such extensive doctoral level study across the whole scientific knowledge base. However, one difficulty that arises is that the evidence base is likely to change over time whilst single modality therapists usually remain wedded to their particular model. For example, if it becomes clear that CBT is less effective across the range of disorders than a newly developed alternative approach, such as Interpersonal Psychotherapy for Adolescents (IPT-A), our CBT therapists would need to retrain as a new type of therapist, and thus completely change their professional identity. In contrast, the identity of applied scientists is specifically bound up with their applying the current up-to-date version of their science – as the science changes, so does their practice. A doctor does not stop being a doctor when one type of medical intervention is superseded by another, nor does a psychologist when one type of psychological intervention is superseded by another. There is no counter-incentive for these professions to moving with the evidence base.

An important specific use of applied scientists is in situations where there is not as yet one particular intervention clearly indicated from the evidence base, or where the recommended intervention has proved ineffective for this particular client (a very common situation – the evidence base tells us what will work for a significant number of, but never all, clients with that particular problem). In medical practice, for example, if a problem presents unusually, such that: (a) there is no standard intervention; or (b) the standard intervention has not worked or is unlikely to work, the medical doctor is then likely to have to go back to first principles of medicine to tailor-make an intervention suitable for this presentation, for example, to prescribe ‘off-book’. Likewise, in psychological health care, where a presenting problem does not fit into a particular category with a specific evidence-based intervention, or where that intervention has been tried and not been successful, a psychological doctor is likely to be necessary to take the lead in the design of a tailor-made intervention for that particular client.

Finally, the broad theoretical training that psychological doctors (clinical psychologists) undertake equips them to support others, via training, consultation and supervision, to deliver a range of interventions from health promotion and primary prevention through to management of complex cases, thus helping to expand what can be delivered to children and

families both within CAMH services and in the broader community (see MAS Report, 1989^{b,2}).

In summary, as children are both biological and psychological beings, it is essential that services aiming to meet their needs have doctors of both biology and psychology (as well as a range of specialist therapists) to ensure care is based on up-to-date scientific knowledge in both fields and thus give our children and young people the best chance of recovery.

Without clinical psychologists, services will not have access to:

Psychological assessments of complex family presentations which require cross life-span and cross theoretical speciality knowledge.

Neuropsychological assessment capacity required to comprehensively assess children who may have intellectual disabilities, autistic spectrum disorders, acquired brain injury, etc.

Expert-designed interventions based on the whole knowledge base of psychology (rather than the modification of an existing therapy) for presentations where no specific therapy is indicated.

Expert-designed interventions in cases where specific therapies have not proved effective.

Consultation, training and supervisory capacity across specific therapeutic modalities.

Consultation, training and supervisory capacity outside of specific therapeutic modalities.

Doctoral-level psychological research skills to interrogate the evidence base and ensure that services remain at the cutting edge in terms of their treatment delivery.

Staffing requirement per 100,000 total population

Coming to conclusions regarding staffing requirements per head of population has a number of complications. Firstly, not all areas have comparable populations, so for the purposes of the below discussion we are going to describe recommendations per 100,000 total population, with no particular skew in terms of socio-economic status or other factors that might affect service delivery. Secondly there is the method used to arrive at the recommendations. The two main approaches are

clinical estimates (based on current service delivery and best practice) or conducting formal calculations based on the epidemiology of the most common presentations, the recommended interventions for those presentations according to current national guidance, and the implications this has for type and quantity of staff. Even this second approach still requires making a considerable number of estimates about likely attendance rate, likely length of treatment, most suitable staff to undertake treatment and most vexingly of all the issue of how to calculate the work required to intervene effectively with presentations that do not fit neatly into a diagnostic box with associated intervention guidance.

Finally, there is the issue of the comprehensiveness of the service being proposed – published calculations vary from those required for services only delivering care up to the age of 16 years (no longer a tenable position for most CAMH services) to those that calculate service delivery excluding particular groups, such as children with conduct disorders, or children experiencing distress as the result of abuse or neglect, or those that exclude delivery of, for example, a hospital liaison service.

In reaching the conclusions in this guidance we have reviewed the seminal documents (Davey & Littlewood³, Goodman⁴, Kelvin⁵, Royal College of Psychiatrists⁶) that have guided much of the modern debate about overall CAMH staffing requirements. With the exception of the Davey and Littlewood paper, these estimates are all based on transparent calculations using the method of epidemiology x likely attendance x intervention requirements. In general they use an expected attendance of around 20 per cent for less severe disorders, rising to 90 per cent for more severe presentations such as psychosis. Overall the expectation of most of these models is that even with the staffing levels recommended they would only service about 25 per cent of the population with child mental health disorders – the rest remaining under primary care services. With the exception of the Davey and Littlewood paper they have generally restricted their recommendations about the specifics of staffing to suggested ratios of medically qualified to psychologically qualified staff. All recommend a preponderance of psychologically

^b The Management Advisory Service developed a model of psychological skills in its 1989 government-commissioned report as follows:

Level 1 included basic psychology activities such as establishing, maintaining and supporting relationships with patients and relatives, using some simple techniques (for example, basic stress management).

Level 2 included undertaking specific 'prescribed' psychological activities, for example, behavioural or emotional interventions outlined in a protocol. At this level there should be awareness of the criteria for onward referral to an applied psychologist.

Level 3 included activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which need to draw on a multiple theoretical base, to devise an individually tailored strategy for a complicated presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

The MAS Report noted that clinical psychologists were the only profession to operate across all three key levels of activities of psychological knowledge and skills.

Table 1: Education of Doctors of Psychology and Psychiatry.

Years		Clinical Psychology	Psychiatry
1	Begin undergraduate study	Psychology degree – basis in psychological science	Medical degree – basis in human biology and start of education in clinical application
2			
3			
4			
5			
6		Assistant Psychologist (Band 4-5)	Qualified Doctor: Foundation Years
7			
8			
9	Earliest possible qualification as a consultant	Postgraduate study in clinical application (Band 6)	CT 1-3: beginning of mental health training
10			
11			
12			
13			
14	Earliest possible qualification as a consultant	Qualified Clinical Psychologist (Band 7, 8a, 8b)	ST 4-6
10			
11			
12			
13			
14	Earliest possible qualification as a consultant	Consultant Clinical Psychologist (Band 8c, 8d, 9)	Consultant Psychiatrist
10			
11			
12			
13			

 Indicates years where study/placements focused on mental health

qualified staff, in keeping with the greater evidence base for psychological interventions rather than pharmacological interventions for child mental health presentations, and with the principle of restricting the use of the most costly staff to tasks where their unique skills are essential. As Goodman puts it, whilst acknowledging that many medically qualified staff will have additional training in some psychological interventions, ‘the key issue is whether doctor’s unique skills (and uniquely high costs) are called for. If not, these problems would more appropriately be tackled by professionals with less expensive or more relevant training’.

The 2013 Royal College of Psychiatrist’s paper ‘Building a Sustainable CAMHS’ helpfully summarises the various foregoing papers and adds in one of its appendices Kelvin’s calculation of the staffing levels required to provide a comprehensive service to 16- to 17-year-olds, including input to youth offending services and substance misuse services for adolescents.

Whilst Kelvin’s calculations are by far the most detailed and clearly aligned to national guidance, some of his assumptions about service delivery are open to debate. Whilst we would welcome his recommendation that all suitably qualified staff share responsibility for risk management in the service, given the relatively

higher cost and lower numbers of medically qualified staff proposed, we would question the sensibleness of them taking on 50 per cent of the self harm assessments, as these do not require specific medical skills. We would also question the assumption that 70 per cent of young people seen in CAMH services for depression would need medication, given the 2015 NICE guidance on the treatment of depression in children clearly indicates that medication is not recommended at all for mild depression and is only recommended for moderate to severe depression if it is unresponsive to psychological therapy.

NICE Guidance CG28 March 2015⁷

1.6.2.4 Following multidisciplinary review, offer fluoxetine[3] if moderate to severe depression in a young person (12–18 years) is unresponsive to a specific psychological therapy after four to six sessions. [2015]

1.6.2.5 Following multidisciplinary review, cautiously consider fluoxetine[4] if moderate to severe depression in a child (5–11 years) is unresponsive to a specific psychological therapy after four to six sessions, although the evidence for fluoxetine’s effectiveness in this age group is not established. [2015]

Despite these and other caveats regarding some of the assumptions used, we would broadly support Kelvin's calculations as being the most detailed and clearly justified figures available so far on which to base estimates of staffing provision.

Whole Time Equivalent (WTE) Staffing (Kelvin 2005) required to provide Tier 2–3 CAMH services to a population of 100,000 up to their 17th birthday.

2.5 WTE medically qualified staff (consultant level)^c

13.5 WTE psychologically qualified staff (range of levels)

Extrapolated staffing (based on Kelvin, 2005 and RCPsych, 2013) for a comprehensive Tier 2–3 CAMH service to a population of 100,000 up to their 18th birthday, including input to youth offending and substance misuse services.^d

3.9 WTE medically qualified staff (consultant level)^c

21.6 WTE psychologically qualified staff (range of levels)

Skill mix

Working then, on the basis of 21.6 WTE psychologically qualified staff per 100,000 head of population (of median socioeconomic status) the next question is what proportion of these should be clinical psychologists and what proportion specialist therapists/nurses with training in psychological therapy. It is a key component of training and a requirement for statutory registration that a clinical psychologist be competent in the delivery of the main evidence-based psychological interventions for the population which they serve. In the case of children and young people, this would mean that any qualified clinical psychologist would be able to deliver behavioural interventions, behavioural parenting work, cognitive and cognitive behavioural individual interventions, and systemic work, as well as psychoeducation and liaison with other agencies around the range of childhood mental health presentations. In addition, clinical psychologists have specialist skills in the neuropsychological assessments necessary to understand and work effectively with children with a range of neurodevelopmental impairments. Whilst it could be argued that it would, therefore, in principle be possible

for clinical psychologists to make up the majority of the psychological therapies workforce, this would be misguided for two main reasons.

Firstly, whilst proficient in the full range of evidence-based approaches, specialist therapy staff may be more expert in the delivery of any one particular type of therapy than a clinical psychologist. Secondly, whilst junior psychological staff represent good value for money in terms of their range of expertise at a relatively low banding, as with medical consultants, for each consultant psychologist position it needs to be asked whether, even though the consultant psychologist would be able to carry out the task, it is the best use of their specific and relatively high costs to use them to do so.

The studies to date do not claim to have a methodology for identifying how many of which particular type of *professional* is required to deliver psychological interventions, mainly because of the degree of crossover of skill amongst CAMHs professionals. Instead, Goodman, for example, discusses the need for staff with *skills* in Behavioural, Cognitive and Interpersonal (BCI) interventions and staff with skills in Family (FT) interventions, in the ratio of 2:1 BCI skilled staff to FT skilled staff. Psychologists, CBT therapists, and nurses with CBT training could all potentially deliver BCI interventions. Likewise, psychologists, systemic therapists, and nurses with systemic training could all potentially deliver FT interventions. There is a case to be made for specifically employing CBT therapists and systemic therapists to match the anticipated need for those types of provision, as these specialised therapists are likely to have highly developed skills in these particular types of provision. The counter-argument is that specialist therapists are usually not equipped to deliver other types of therapeutic intervention and, therefore, there is the risk of redundancy of skill if the level of need for that particular intervention is calculated incorrectly.

One of the key issues to bear in mind when predicting the number of specialist therapists required for a balanced CAMH service is the high proportion of children presenting at most CAMH services who do not fall into any specific diagnostic category and for whom there is, therefore, no one particular evidence based intervention implicated, but who nonetheless are experiencing sufficient distress or maladjustment that they are accepted as in need of a specialist CAMH service. For example, a diagnostic audit of all children on the caseload of CAMHS in Hammersmith & Fulham in

^c As these staff are at consultant level they will bring with them centrally funded junior medical staff undertaking their psychiatric training.

^d These figures are derived as follows: Kelvin estimates 12 staff are needed (1.45 medic: 10.55 psych) to provide a comprehensive service, including youth offending and substance misuse, to 16- and 17-year-olds (RCPsych, 2013). As his original calculations (2.5:13.5, see above) included 16-year-olds but not 17-year-olds, and didn't include provision to youth offending and substance misuse services for either age, we have added 75 per cent of Kelvin's 16- to 17-year-old staffing ($0.75 \times 1.45 = 1.1$, $0.75 \times 10.55 = 7.9$), retaining his ratios, to the base estimate. (These estimates would need to be further revised upwards for services up to 25).

November 2012⁸ showed that 36 per cent did have a particular diagnosis recorded, 11 per cent were being seen due to problems with primary support or social circumstances, nine per cent due to problems related to upbringing or life events, and a further two per cent described as being seen due to problems related to family history (see Table 2). Fifty-eight per cent of the children are, therefore, recorded as not having a diagnosable disorder and, therefore, no obvious specific intervention would be recommended for these children. Even if we assume that all of the ‘no diagnosis’ children are in that category due to failure to record rather than not fitting a diagnostic category, we would still have a figure of 35 per cent of children where the CAMH professional had recorded a category, but was clear it was not a diagnostic category with an associated specific evidence based intervention. These figures are in line with national trends. As discussed above, clinical psychologists are uniquely well placed to design interventions to meet these children’s needs – and to monitor, review and adapt the intervention as it proceeds.

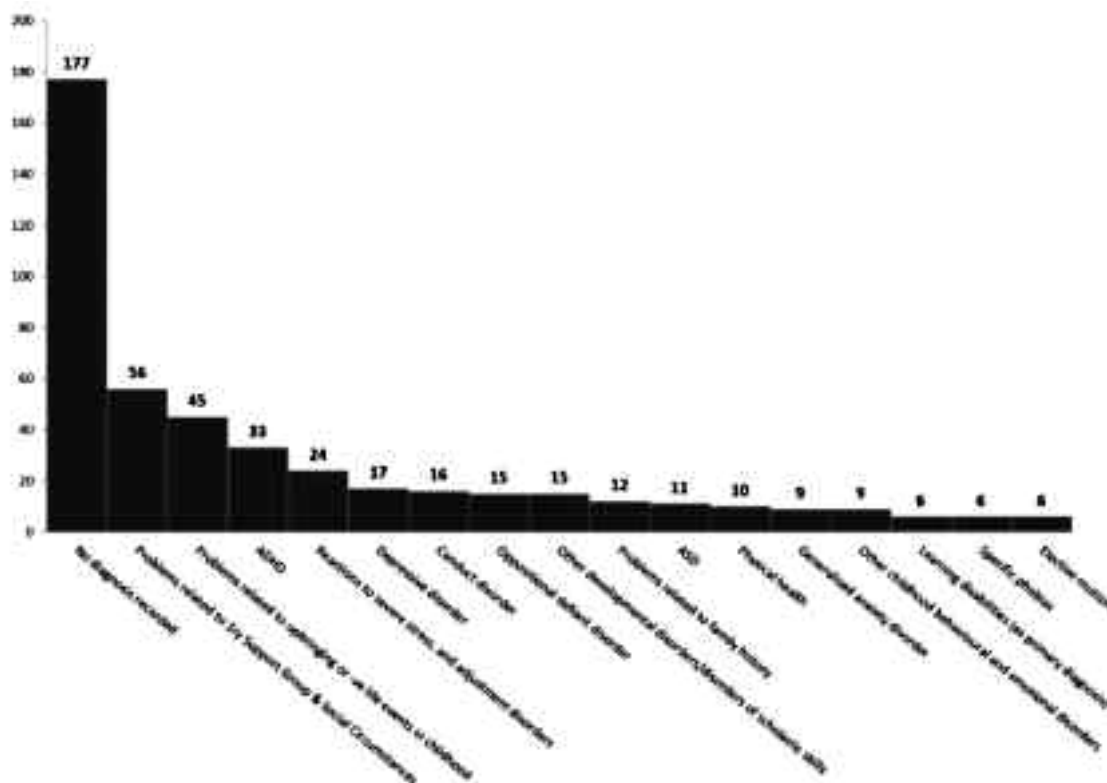
The second specific group which require the unique skills of clinical psychologists are children where a cognitive or neuropsychological assessment is essential to understanding their presentation and, where relevant, providing an intervention. These include children with both global and specific intellectual disabilities, children with autistic spectrum disor-

ders, and children with physical conditions that are impairing their psychological functioning – continuing with the Hammersmith and Fulham example above (excluding the children for whom no diagnosis was recorded) this comes to 10 per cent of the referrals to the service.

The final specific group that clinical psychologists are uniquely well-placed to serve are children and families with specific disorders with specific associated interventions, but where those children have not responded well to the interventions recommended in national guidance and where, therefore, the next stage is a tailored formulation driven approach, akin to experimental interventions in physical health care. The clinical psychologist, with their overall training in developmental and pathological psychology as well as their doctoral level research skills is uniquely well placed to provide and monitor individualised experimental approaches.

Taking the conservative estimate of 36 per cent of children not falling into a specific diagnostic category, adding on the 10 per cent of children requiring expertise in neuropsychology, and rounding this up to 50 per cent to allow for the need for experimental care planning for children unresponsive to existing treatments, we would recommend that at least 50 per cent of the psychological workforce within CAMHS be comprised of qualified applied psychologists.

Table 2.



Clinical Psychologists as proportion of psychologically qualified staff $\geq 50\%$.

Per 100,000 total population based on Royal College of Psychiatrist figures for a comprehensive CAMHS – minimum 10.5 WTE qualified psychologists.

The remainder of the staff should be recruited from amongst specialist therapists and nurses for their specific expertise in the relevant behavioural/cognitive or systemic approaches, in a ratio of 2:1 in line with Goodman’s estimates and the current evidence base.

Gradings

The 2013 RCPsych document recommends a ratio of 1:7 consultant level to non-consultant-level staff, although it is rare in clinical practice for one consultant psychiatrist to be supporting seven junior doctors. In fact using the principle of 1:7 would lead to an imbalance of four consultant medics to three consultant psychological staff in our hypothetical comprehensive service for a population of 100,000. Given the considerably greater volume of psychological as opposed to medical therapy in CAMHS (in line with national guidance), it would seem appropriate to have significantly more rather than less consultant level psychological staff as compared with consultant level medical staff. If we were to have at least double the proportion of consultant psychological staff to consultant medical staff (as would follow from the care delivery) the proposal of four consultant medics in Kelvin’s example would suggest that eight consultant psychological staff would be proportionate. However, this would lead to our service having 12 consultant level staff which is considerably higher than current clinical practice and probably financially non-viable in the current context. We would, therefore, revise this down to two medical consultants and four psychological consultants for a population of 100,000. For the purposes of good clinical governance across the employed professions, it would seem appropriate for these to include consultant level staff in nursing and systemic therapy as well as psychology. In terms of the balance of gradings from consultant to newly qualified psychologists, we would recommend multiplications of a ‘christmas tree’ formation (see Table 3 below).

Finally, particularly in the face of limited resources, we would highlight the importance of both psychologists themselves and NHS management recognising that the role of psychologists above a basic grade must include increasing proportions of time spent in clinical leadership, management, service development, supervision, consultation and training responsibilities in order to ensure that the significant resource which is a senior psychologist is used to full capacity.

Use of trainees and unqualified staff

As a core NHS profession, clinical psychologists, like nurses and doctors, have an obligation to take on trainees as part of the NHS training of those staff. This is to be welcomed as it provides an additional 0.5 wte capacity per 1 wte clinical psychologist, although, as with psychiatric and nursing staff, these staff are considered supernumerary and so not included in the core calculations. In addition, in order to ensure a continued source of appropriately experienced candidates for training, it is important that CAMH services have established assistant psychology posts. A ratio of one assistant psychologist per 10 psychologically qualified staff would be recommended – this level has a minimal financial implication whilst providing support for the staff within the service and thus increasing output across the service.

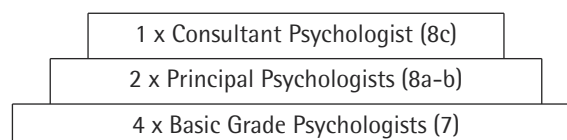
Leadership of services

For the reasons stated in the introductory section, and because the broad training of clinical psychologists allows them to provide integrated supervision and clinical leadership across psychological therapy modalities, we would strongly recommend that for any CAMH service to ensure delivery of high quality, evidence-based medical and psychological interventions, it needs joint leadership at the highest level by applied scientists in psychology and medicine. We would, therefore, recommend that the clinical leadership of any CAMH service involve a partnership between a Consultant Clinical Psychologist and a Consultant Psychiatrist.

Provisos

As discussed in the Goodman and Davey paper, there are additional considerations to be borne in mind when scaling up or down. For example, were a CAMH

Table 3.



service to be so small that it was only able to employ less than five psychologically qualified staff, we would recommend a higher ratio of qualified clinical psychologists than the 50 per cent recommended above. This is due to the greater need for flexibility of formulation and intervention delivery where the resources are so constrained.

Other specific considerations in terms of numbers include uplifting for populations with higher than average levels of deprivation, or higher than average levels of children with specific risk factors such as those detailed in Table 4 below.

Finally, the modelling above is, out of expediency, based on Tier 2 and 3 CAMH service delivery as it is generally currently provided – we would not suggest current models of service provision are the only or best way to meet the needs of children and families, and we would be open to revision of these recommendations as new models of delivery develop.

Conclusion

To deliver good quality CAMH services within our financial envelopes requires that considerable consideration be given to use and number of staff. This chapter aims to help the reader understand the role the NHS has trained clinical psychologists to undertake, and thus help ensure they are used constructively and efficiently in the joint endeavour of delivering high quality services.

Table 4 (HM Government, 2010⁹).

Risk group	Degree of risk	Prevalence of risk
Children with learning disability	6.5 fold increased risk of mental health problem.	2.6% of pupils have learning disabilities.
Children with physical illness	2 fold increased risk of emotional/ conduct disorders over a three-year period.	5 to 6% of children (600,000) report/are reported by parents as being in 'fair or poor' health.
Homeless young people	8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation.	Between 36,000 to 52,000 homeless young people in England.
Young LGBT	7 fold increased risk of suicide attempts in young lesbians. 18 fold increased risk of suicide attempts in young gay men.	Estimated 6% of population are LGBT.
Young offenders	18 fold increased risk of suicide for men in custody aged 15 to 17. 4 fold increased risk of anxiety/ depression. 3 fold increased risk of mental disorders.	Over 6000 children aged under 18 entering custody during a year – the vast majority are boys. 10% of 10- to 25-year-olds report committing a serious offence in previous year.
Looked after children	5 fold increased risk of any childhood mental disorder. 6 to 7 fold increased risk of conduct disorder. 4 to 5 fold increased risk of suicide attempt as an adult.	64,400 children (0.5% of under 18-year-olds) are 'looked after' in England.
Children of prisoners	3 fold increased risk of antisocial-delinquent outcomes.	160,000 children and young people per year have a parent in prison.

Key recommendations

Joint clinical leadership of CAMH services by doctors of psychiatry and psychology to ensure safe and effective delivery of both medical and psychological interventions.

Minimum 10.5 WTE qualified CAMHS psychologists per 100,000 total population to meet the needs for complex psychological assessments and interventions in line with the known profile of non-specific and treatment-resistant presenting issues in CAMH services.

Proportion of psychological/psychiatric consultant level staffing in keeping with volume of staff delivering psychological/psychiatric interventions to ensure best value and best matched leadership knowledge.

Trainee and Assistant Psychologist posts embedded in service structure to maximise psychological delivery capacity.

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Part II:
**Specific papers addressing a range of
settings and conditions**

Delivering psychological services for children and young people with emotional and behavioural difficulties, and their families, in specialist CAMHS settings

Paul Wallis, Jo Potier, Gordon Milson & Andrew Beck

Summary:

A service providing good quality psychological provision in specialist CAMHS should include the following:

- *Cover for children and young people aged from 0 to 18 or up to 25 years in some instances, and working with a range of complexity.*
- *Evidence-based/evidence-informed psychological assessments and interventions for a wide range of presenting problems. These are supported by a developmental and bio-psycho-social framework and, where appropriate, incorporate NICE guidelines.*
- *Interventions including work with groups, individuals, staff training/supervision and intensive work. Innovation, audit and service based research would be seen as an important part of staff roles.*
- *A robust organisational structure, either integrated with other providers or with clear and developing pathways between agencies to ensure smooth transition of care in any given district.*
- *Strong relationships with Commissioners, other local services and users and carers. Commissioners should recognise the strengths of psychology to provide not just direct clinical services, but teaching, training, consultation and support to others, and commission this.*
- *The infrastructure to collect and analyse routine feedback and outcome measures, and the means to use these to inform service development and to facilitate better collaborative practice and shared decision making in clinical interventions.*
- *An appropriate grade structure to cover all levels of complexity informed by local and national workforce and service development reviews.*
- *Clear protocols and practices that facilitate smooth, user led transitions between services and between child and Adult Mental Health Services (AMHS).*

Introduction

The main focus of this paper will be on the provision of psychological services – including Clinical Psychology – within specialist Child and Adolescent Mental Health Services (CAMHS) up to the age of 18 years.

It will make reference to the interface with mental health services delivering to other age groups, and where appropriate (and available) services providing to targeted or specialist populations. The term ‘CAMHS’ is used in a broad sense to define all of those services which provide to the emotional/mental health needs of children and young people at either Tier 2, 3 and some 4 (this tiered model is the current way that CAMHS is structured although we recognise this model needs to be updated in line with recommendations in *Future in Mind* (DH, 2015)). The vast majority of CAMHS teams are health-led and will sit within an NHS provider trust. Within teams Clinical Psychologists and Psychological Practitioners may be offering services in many different ways, for example, as part of a clinic-based multi-disciplinary team, or as part of a standalone psychological services team, working in parallel to other professionals.

The authors are aware that in some areas there will be targeted services for early years, for example, under-5 services (see Paper 7 for more details), as well as dedicated adolescent services for 16/17-year-olds. In some areas additional funding has allowed for specialist teams to develop, for example, for Looked After Children, or Children with Disabilities. However, the CAMHS Taskforce and Future in Mind have clearly highlighted the variable nature of CAMHS provision nationally. Despite the promise of future funding, in some areas resources may be extremely stretched and struggle to meet current needs. As a result many district provisions are struggling to provide adequate services even in the context of high thresholds and emergency presentations.

One of the proposals in *Future in Mind* is that services should look to extend their reach from 0 to 25 in order to address some of the ongoing difficulties encountered by young people transitioning into adult services. Whilst a few areas have started to trial this model with some including a tapered transition between CAMHS and AMHS, rather than a hard age

related cut-off, it is not in the scope of this paper to evaluate these developments at this early stage. We do acknowledge, however, that this model has many strengths, but may also present significant operational challenges particularly if these developments are not properly funded.

Given the diversity in which CAMHS provision has developed historically across the UK there are challenges in trying to capture the main issues for those delivering psychological services to children, young people and their families. One key issue is the current drive to change models of service delivery to meet rising demand. This comes in the context of austerity where there is a clear reduction in many of the core Tier 2 and community-based services that would otherwise enable children, young people and families to remain 'well' without intervention from specialist services. This also comes in the context of a recognised lack of dedicated funding for child and adolescent mental health services with approximately only six per cent of the total national mental health spend being available to children and young people. These issues are summarised clearly in the *Future in Mind* report. At the same time that services are looking to increase thresholds to meet demand, *Future in Mind* and many other documents highlight the importance of early intervention and prevention. This presents a real challenge to specialist CAMHS in terms of how early intervention services can be adequately resourced when there is a clear rise in the number of children presenting with more complex difficulties requiring multi-disciplinary intervention. This is part of a long-standing tension within specialist CAMHS between a longer term, invest-to-save model and more short-term imperatives relating to social, financial and political concerns. The authors recognise that early intervention and prevention in district services has a clear theoretical and pragmatic basis but that this does not necessarily produce immediate and measurable gains or reduce the acute pressures on teams, unless both aspects are adequately funded. This topic will be covered in depth elsewhere (see Papers 6 and 7).

In summary this paper will attempt to reflect some of the diversity of psychological services in district and community CAMHS provision and provide recommendations for good practice.

Age range and scope of need

The 2004 National Service Framework (NSF) specified that CAMHS services should provide until the age of 18 and although the majority of CAMHS teams have extended their service to include this age range there remain a small number of services which do not. The way that some services have responded to the need to offer provision up to the 18th birthday is to develop

teams with remits to work with specific age ranges. For example, some areas will have early-years services, often focussing on parenting and early intervention strategies, adolescent mental health teams working with children from 13- or 14-years-old upwards or dedicated 16- to 17-year-old teams specialising in supporting transition to adult services. Transition into adult service will not be necessary for the majority of young people who access CAMHS. However, existing models of care based on transitioning at 18 years of age are increasingly seen as problematic and are leading to clearer consideration of integrating mental health provision up to the age of 25. Interfaces with schools, paediatrics teams, primary care, public health services and adult mental health also vary considerably from team to team. The lack of uniformity in provision can lead to neighbouring districts offering very different services, and establishing parity of services nationally is highlighted as a recommendation from *Future in Mind*.

Good Practice Recommendation:

Clinical Psychologists and Psychological Practitioners are a key part of the workforce in community CAMHS working with young people across the age range. Given the diversity of presentation within community CAMHS settings it is essential that clinicians have a thorough understanding of developmental processes. Clinical Psychologists in particular should have this as a core component of training and know how to utilise this knowledge in developing formulations and interventions.

Commissioning priorities

The *Future in Mind* report recently made proposals in relation to specialist CAMHS commissioning. Thus in dealing with the issue of responsibility for commissioning and creating a clearer commissioning pathway, the Taskforce proposed the following:

- Increase co-commissioning for specialist and inpatient care with a view to moving away from the tiered model.
- Identify a local lead who is accountable to the commissioning body who manages a single separate identifiable budget for children and young people's mental health.
- That services design and implement a local plan for children and young people's mental health in each commissioning area with inputs from all agencies, children and young people and their parents.
- That there is increased commissioning of home treatment and other flexible services.

The relationship between service providers and commissioners also varies considerably across the country and this disparity may mean that those purchasing services may not be fully aware of the

clinical information necessary to aid good commissioning choices. This process can also be influenced by local historical relationships and may mean that the voice representing psychological services may not always be heard. The Division of Clinical Psychology have separately funded a project to address the ways in which Clinical Psychologists can develop both an awareness of and skills in informing commissioning and taking a lead role in service development and transformation planning. It is increasingly important in financially challenging times that leaders in psychological services are stepping forward to liaise and negotiate with commissioners.

In some areas, as demand on services has increased and funding has reduced, services have revised thresholds to work with families presenting with greater need or adopted leaner models of working such as the Choice and Partnership Approach (CAPA) model. CAPA places greater emphasis on rapid assessment, the use of self-help literature, computer-based and online resources, and a model which involves increased consultation to the family about how they might best meet the needs of their child.

It is key that young people are included in the process of informing commissioners regarding choices about psychological services. Many young people and their families express concern about the overuse of inpatient beds, when services should ideally remain located in their community. There is often a recognition from service users that CAMHS is stretched, and whilst services, along with commissioners, may have developed ways of managing with depleted resources, young people and families also highlight that initiatives which focus too much on brief, time-limited, self-help interventions, may not fully address their needs. Accessibility remains a significant issue, and commissioning of services which are flexible in their delivery model, in terms of time, location and length of treatment are all key factors commonly highlighted by parents and young people.

Good Practice Recommendation:

Psychological Practitioners from specialist CAMHS settings need to be involved in the commissioning arena. Clinical Psychologists in particular have expert skills and knowledge in terms of how psychological approaches can be tailored to the needs of children, young people and their families, as well as wider skills in how to develop services and work with the psychological needs of communities. Commissioners need to be aware of the key value of high quality psychological therapy provision and the added value of involving clinicians in decision-making.

Political landscape

In many areas specialist CAMHS saw increases in funding through the 2000's. Much of this funding was focussed on delivering to priorities set out in the National Service Framework and Every Child Matters. In some localities this led to the development of targeted services, for example, for Looked After Children (LAC), children with moderate to severe Learning Disabilities and children with specific physical health problems. In recent years as funding has become less available and services are facing retrenchment, for some there has been a move back to delivery of core specialist CAMHS activity and an increasing focus on psychiatric and/or acute definitions of mental health problems. This has meant that many areas are once again moving away from delivering high quality psychological services, towards emergency responding and there is a real danger that the considerable investment involved in the Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) will not lead to the wider provision of evidence-based interventions as services prioritise acute risk assessment and management at the expense of treatment.

The future political landscape going to press looks mixed. There have been clear commitments by the Department of Health to continue to fund the roll out of CYP-IAPT which seeks to improve the quality of existing services through training in evidence-based therapies, service transformation through improving IT infrastructure, the use of outcome measures as routine practice and increased service user participation.

Potential funding for CAMHS has also been earmarked to support the delivery of *Future in Mind* through CCG led 'Transformation Plans' that bring together the whole CAMH system: schools, voluntary sector, Local Authority and NHS providers. This will certainly be welcomed, if delivered upon, but even with modest additional investment ongoing public sector financial constraints across Health, Social Care and other sectors are still likely to impact on delivery of CAMHS services. It is already the case that contraction in third sector organisations, which have otherwise provided aspects of work which support child mental health upstream, have led to increased pressure on CAMHS to fill this gap. In addition in some areas third sector and private organisations have become direct competitors in provision of care historically offered by health-based specialist CAMHS teams. It remains to be seen whether these offer good value in terms of evidence-based interventions and good levels of service user satisfaction.

Good Practice Recommendation:

Psychological Practitioners need to be fully engaged with the political landscape of the NHS and the communities in which they work. Service leads and commissioners need to ensure that all areas of provision are given sufficient/equal weighting and enable services to develop flexible, accessible approaches to early intervention, and understand the complex reasons behind the apparent increase in demand on services.

Poverty and social influences

Children's social and emotional development often reflects what they experience, with poverty creating the setting conditions for increases in adverse childhood experiences, affecting brain development and associated emotional, behavioural, cognitive and social functioning. Poverty and inequality lead to a further double disadvantage whereby families and communities find it harder to access and make use of activities that promote resilience (e.g. education, leisure opportunities, safe neighbourhoods, etc.).

There is substantial evidence (Yoshikawa et al., 2012) that poverty is a major risk factor for developing mental health problems in childhood and adolescence and thus it is of little surprise that many specialist CAMHS services are located in less economically developed areas of the country. Although the population served is universal, the predominance of presentations to CAMHS services are of children and young people from less advantaged backgrounds. This brings with it a challenge for the delivery, location and personnel employed by specialist CAMHS. The challenge remains to develop equitable services, bringing parity to service provision across the country, without disadvantaging already well-functioning services.

Diversity

Specialist CAMHS provides services to a culturally diverse range of populations across many areas of the UK. The particular needs of these populations will not be covered in this paper but it is clear that services need to adopt a number of core principles in their delivery. The concept of culturally competent services has become important in shaping the way in which services understand how to remain sensitive to the needs of differing populations. In specialist CAMHS, clinicians will engage with children, young people and their families from a broad range of backgrounds, in terms of ethnicity, culture and religion, gender and sexuality. Working within these intersecting factors, which are likely to increase marginalisation and discrimination, practitioners need to be aware of the relevant research literature in terms of the mental health needs of these populations and be reflective in terms of their own

work. It is essential that as much as possible the CAMHS workforce actually reflects the diversity of the communities they serve. It is important that services develop a sophisticated understanding of the needs of the communities and work collaboratively with local communities to develop a better shared understanding of the need for mental health care and consider different perspectives on what constitutes a mental health problem and what might be useful.

Good Practice Recommendation:

It is essential that Psychological Practitioners in specialist CAMHS have a robust knowledge of the demographic make-up of the districts they serve and, crucially, are able to maintain core values of respect, curiosity and openness to the range of diversity in any given area. Core training for Clinical Psychologists in particular will provide the opportunity to develop these skills, whilst specialist CAMHS themselves have a duty to continually examine and develop how they deliver to diverse populations.

Service configuration

Some services operate as full Multi-Disciplinary Teams (MDTs) with a general management structure, whilst some psychological services are co-located along with psychiatry teams, but with separate lines of accountability and responsibility. In other areas teams operate under a different management infrastructure altogether, and rarely come together in a MDT fashion. Each configuration can bring its challenges and opportunities but one of the most salient is the issue of how MDTs are staffed. There has been an increasing tendency towards a 'one-of-each' model of workforce configuration, as an apparent drive to establish parity and limit professional hierarchies. However, it is important that teams are configured according to local need and a careful appreciation of skill mix required to meet this need, rather than based on simplistic views of multi-disciplinary working (see Paper 2). Psychological services may be fully integrated within a multi-disciplinary structure, or operate as uni-disciplinary groups, but it is key that there is clear and effective leadership at all levels, clear pathways across organisations, and that Psychological Practitioners retain clinical independence and strong cultures of supervision and cohesion within teams.

Specialist CAMHS psychological services can be located in a range of organisational infrastructures, including specialist mental health providers or acute medical settings, such as a Children's Hospitals, Community Trusts or Local Authorities, amongst others. This paper proposes that this is best delivered either within one health trust or via jointly commissioned arrangements across agencies, setting out

referral routes, staffing requirements, and pathways of care. This model may facilitate agreed management structures ensuring that psychological services are appropriately and robustly represented, and can work collaboratively with partners from other disciplines/agencies. However, in recognition of a changing landscape where demand is increasing, and resources and expertise may reside in a range of agencies, the latter model suggests that in all areas joint commissioning arrangements are developed to deliver CAMHS psychological services in collaboration with partners from Health, Education, Social Care and the third sector.

Good Practice Case Study:

One example of establishing reciprocal links across statutory, voluntary and educational providers has been developed in Manchester where specialist CAMHS has linked up with a well-established youth counselling service to facilitate the training of one of their staff on the CYP-IAPT course. This staff member successfully completed the training in CBT taking a mixture of casework from both CAMHS and their host agency, receiving regular supervision from Clinical Psychologists. This led to a reciprocal agreement that this clinician be part seconded into CAMHS to offer CBT interventions whilst also delivering evidence-based interventions into the youth service which previously had limited access to this approach. This has led to creative discussions about the respective roles of each service in meeting the needs of young people, and there is now much closer collaboration in establishing pathways between services. These types of cross agency arrangements exist in many services across the country but there is a need for greater collaboration across agencies to meet the challenge of truly jointly commissioned CAMHS.

Why psychological approaches are necessary

Psychological Practitioners in specialist CAMHS will see a wide range of presentations including the following:

- Anxiety and depression;
- Conduct problems;
- Post-traumatic stress;
- Attention Deficit/Hyperactivity Disorder;
- Psychotic disorders;
- Social communication difficulties;
- Self-harming problems;
- Children with physical symptoms.

Biological mechanisms play an important role in the aetiology and maintenance of some presenting problems within specialist CAMHS and for Clinical Psychologists and Psychological Practitioners it is important to acknowledge and assess for neuro-development problems such as Autism, ADHD and learning difficulties as part of any initial assessment. However, even where these problems are identified it is often the case that there is a clear need for psychological intervention to help the child and family manage the behavioural and emotional consequences of these conditions. Thus whatever the causal factors leading to attendance at specialist CAMHS it is most often the case that the final common outcome is one of psychosocial difficulties, whether in the form of repeating cycles of behaviour, thinking or interpersonal relating, affecting the individual, the family/carers and/or the system surrounding the referred child (Kinderman, 2005). This can have wide ranging effects on emotional well-being, peer relationships, school attendance, academic achievement and future development of enduring mental health difficulties.

Whilst psychopharmacological approaches have an important role to play in the treatment of a number of presentations, psychological approaches have a major role in treatment within specialist CAMHS. This is evidenced by the wide range of NICE guidance in relation to child and adolescent mental health, overwhelmingly placing psychological treatments at the core of work with this population.

In their comprehensive review of what works for whom across the field of child mental health, Fonagy et al. (2015) highlight the overwhelming evidence for psychological interventions in a wide range of conditions. Such reviews have guided the development of the CYP-IAPT curriculum with the focus on training a wider workforce in interventions which are increasingly being considered as the mainstay of CAMHS delivery, alongside evidence-based interventions for many other presentations:

- CBT for anxiety disorders and depression;
- Interpersonal psychotherapy for depression;
- Systemic family practice for self-harm, eating disorders, depression and conduct problems;
- Evidence based parenting programmes for oppositional defiant behaviour and conduct disorder.

Psychological approaches place the presenting difficulty in its own unique context, using formulation to guide the intervention. Although children are 'referred', it is more often that the intervention will be with the family, carers or system in order to effect the greatest change.

Good Practice Recommendation:

It is essential that psychological services in specialist settings reflect a depth and breadth of knowledge about psychological issues for children, young people and their families. This may not mean that it is possible for services to be staffed by expert practitioners in every modality of treatment. However, services need to continually examine both the evidence-base and good practice guidance and develop the workforce to provide an optimal level of treatment options, as tailored to the individual needs and wants of the population served. Clinical psychology training ensures that practitioners are skilled in examining the evidence of what works for whom, and developing flexible formulations and treatments for a wide range of clients. As such, they can be seen as the prototypical clinician to deliver psychological interventions, consultation and training to the range and complexity of CAMHS.

Intervening at different levels*Care pathways integration*

There is not scope to review the range of guidelines that exist around the treatment of mental health problems as they present to CAMHS. However, as highlighted above, services should continually seek to integrate current knowledge and evidence-based approaches to all aspects of care. Psychological services particularly need to be aware of current and changing guidance on best practice, whilst striving to innovate and generate practice-based evidence. NICE guidance focuses on single conditions, whereas children usually present with a range of difficulties. As such clinicians working in specialist settings should be capable of critically evaluating evidence as it pertains to the individual presentations of children and adolescents accessing services.

CAMHS will be referred a wide range of presenting difficulties and clinicians need to be skilled in assessing need, determining strengths and resilience in clients and efficiently determining if a specialist CAMHS is the right fit for a client's needs at this time. The Choice and Partnership Approach (CAPA; York & Kingsbury, 2009) has provided a framework for such a process in recent years, outlining guidance on caseloads, throughput, intake/triaging, treatment pathways, better choice and setting collaborative goals for therapy. Some services have adopted CAPA both as a means to manage increasing waiting lists but also to frame their general delivery. This approach is based on having a workforce who are sufficiently skilled at assessment and treatment and which have the capacity within the service to deliver follow-up appointments in a timely fashion. Due to increasing demands and challenges on capacity

some services report that despite incorporating CAPA, its wholesale adoption is challenging, as reductions in staffing can deplete the ability of a service to offer follow-on appointments and resource comprehensive treatment pathways. Other services have devised their own systems for managing throughput utilising care pathways as the means to ensure cases are appropriately identified and channelled into treatment with the right clinician.

Care Aims reflects a philosophy of care where interventions are aimed at enabling families and others around the child to maintain and exercise their duty of care. Emphasis is placed on current functioning rather than symptoms, and on doing more 'upstream' work to enable this to happen. It can help to articulate the goals of intervention, for example, not solely focusing on people getting 'better'. For some it is about helping to stabilise and reduce further deterioration, for others it is about helping them to participate more fully in their lives.

Such systems are inevitably constrained by capacity issues, which may lead to clinicians offering sub-optimal psychological interventions, and crucially young people themselves often highlight that what is lost is a 'patient-centred' approach with children and young people discharged precipitously and/or before they are ready.

Good Practice Recommendation:

Psychological services need to ensure that systems designed to increase throughput, efficiency and meet targets do not adversely impact on the efficacy and integrity of treatment approaches which rely on fidelity of delivery. At the same time it is important to recognise that brief interventions which focus on recovery and resilience can be highly effective if delivered by skilled clinicians, such as clinical psychologists, who are able to rapidly synthesise complex information and work with families and young people to capitalise on their own strengths and develop flexible solutions.

Tier 1 interface

The NHS Five Year Forward View has introduced the idea of Community Specialty Providers. Whilst this does not specifically reference CAMHS, many teams have long recognised the value of offering services in community settings. Although the traditional model of delivery is usually a hub/clinic-based approach, with all clinicians usually working in one location, increasingly services may negotiate to run services in local health centres, Sure Start centres or schools. This can ultimately depend on factors such as capacity and local availability of appropriate clinical space.

Targeted help

Psychological Practitioners may work in different domains in CAMHS. In more traditional Tier 2/3 CAMHS services they may be offering a range of both targeted and specialist interventions. The THRIVE model provides a useful framework for describing this activity. The THRIVE model outlines a range of domains in which Psychological Practitioners in a community setting may be working: Thriving, Coping, Getting Help, Getting More Help and Risk Support (Wolpert et al., 2014).

There is a clear role for Psychological Practitioners in supporting all domains in the model. For many practitioners the domains of Getting Help, and Getting More Help may most closely map onto their everyday practice and training experiences whereby clinicians are delivering time-limited, pathway or evidence-driven interventions, usually based on an individualised formulation of the young person/family's presentation. Although some work of this type may be manualised and/or follow a routine or predictable course, many young people working with one clinician will require lengthier periods of intervention. Considerable liaison skills are required to interface with other professionals around the young person and the flexible modification of treatment approaches as required. Clinicians also need to understand the network of services around children, young people and their families, including other specialist teams, for example, LAC, LD, early years, and adult services.

Good Practice Recommendation:

CAMHS need to ensure that they have a sufficient workforce able to efficiently operate as autonomous skilled clinicians, who can provide targeted interventions with a wide range of common presenting issues. It is essential that skill mix is examined but that any drive for reducing costs does not compromise the availability of comprehensive, formulation-driven interventions, delivered efficiently by sole-practising clinicians. Whilst other Psychological Practitioners may have training in one particular treatment approach, clinical psychologists are specifically trained to take on this role of synthesising psychological theory to intervene with many presentations, and, therefore, present as good value for money.

Specialist help – complex needs, higher support level

For most Psychological Practitioners their work is located within a multi-disciplinary context. There is considerable variation in both the make-up and management of multi-disciplinary teams and although it is often argued to be the most effective approach to delivering services, it is suggested that considerable

duplication of task and blurring of accountability can occur.

Some young people require higher levels of support due to issues of risk and/or complexity. Some CAMHS offer assertive outreach teams to assist in supporting young people who require help at a high level in order to maintain their wellbeing in the community. At times, admission to inpatient units for children may be required (see Paper 4). If this is to be the case, and care co-ordination is retained by Tier 3 CAMHS services, then maintenance of the therapeutic relationship and case management ought to be prioritised to assist when the young person is deemed able to return to community settings. The period following discharge from inpatient settings is established as one of heightened risk and psychological approaches to understanding and managing this transitional process are essential to ensure the safety and progress of the young person.

Whichever services are required, care-co-ordination needs to ensure that the young person remains at the centre of the process and the system surrounding them. Young people have themselves stated that an area of concern is how services working with them communicate with one another (YoungMinds, 2014). Good psychological services ensure that not only are care plans in place to support young people who present with risk concerns, but also effective strategies to facilitate communication with all services and people involved in the support and care of young people. If higher levels of support are required due to concerns regarding risk, effective communication and consistency between practitioners is essential in order to best support the young person. An example of this is for young people with a presentation suggestive of potential emerging borderline personality disorder (EBPD) where evidence indicates that one of most effective interventions is having a stable, available and consistent adult irrespective of the intervention.

Good Practice Recommendation:

It is essential that services are clear in their understanding of multi-disciplinary working and ensure that Psychological Practitioners are afforded respect in their individual clinical training and expertise, ensuring that there is adequate opportunity and space to deliver a mix of team and targeted psychological interventions, and avoid a one size-fits-all approach to service delivery. Psychological Practitioners need to be skilled to work flexibly alongside colleagues, recognising the strengths and limits of the range of professionals and approaches (including their own) within specialist CAMHS.

Risk support/maintenance

Clinical Psychologists have highly valuable skills in working with children and young people who present with increased levels of need due to their risk. The key skills in assessing and formulating using standardised measures in addition to the development of an individualised risk formulation have been identified as areas which require improvement in research into clinical practice involving risk management (NCISH 2013). The dynamic nature of risk and the mechanisms by which it is mediated are often largely psychosocial in nature, so good psychological services will have systems in place by which psychological approaches are embedded within the process of risk management. Good psychological services in CAMHS need to consider the needs of young people out of hours and ensure that robust policies exist in terms of accountability for out-of-hours and emergency support. These ought to act as continuations of their care plans rather than separate interventions to facilitate a feeling of continuation of care for young people in crisis. Increasing demand on services and the acknowledgement of the valuable skills offered by Psychological Practitioners means that many clinicians will also be offering on-call/duty as part of their overall job-plan.

Psychological services support young people who present with acute levels of risk including those who have presented to emergency services due to significant harm to self. These young people often require an assessment to establish the most appropriate support package and whether further support within hospital is required. An understanding of the factors which are impacting on the young person including those internal to the young person, within their family or support network and wider social factors such as school stress and relationship difficulties can be brought by the Psychological Practitioner in order to ensure that appropriate plans are in place to support the young person.

Good Practice Recommendation:

It is essential that Psychological Practitioners are skilled in assessing the range of risks presenting in CAMHS, with a robust knowledge of safeguarding policies, and risk management procedures. Some practitioners will be included in on-call/duty systems, and services need to recognise the added value that Psychological Practitioners bring to a broader formulation of need when young people are at risk.

Core components of a psychological approach***Evidence-based practice***

Psychological services ought to be able to integrate best evidence but retain a person-centred approach to care. Evidence-based practice is 'the integration of clinical

expertise, patient values and the best research evidence into the decision making process for patient care. Clinical expertise refers to the clinician's accumulated experience, education and clinical skills' (Sackett, 2002). Psychological services should utilise the clinical expertise available within the team via formal and informal channels and always ensure that a collaborative approach to care is taken, accessing the strengths and preferences of the young person, their family or carer as a fundamental part of their care pathways.

Assessment

Psychological Practitioners in core services should have a broad and flexible knowledge base to enable assessment of a wide-range of presenting issues. Assessment should include a multi-modal approach taking into account the full range of predisposing, precipitating, maintaining and contextual factors. At the same time, and in line with models such as CAPA, it is useful for practitioners to be mindful of ensuring that the service can meet with the needs, motivations and expectations of the service user. As such, practitioners need to be aware that although they may already be formulating ideas for intervention at assessment, a brief, focused or even sign-posting function may be adequate for some cases. This process can be supported by the initial assessment including the time to develop a clear understanding of the service user's goals and expectations, and for the clinician to address the degree to which these can be met within CAMHS by the end of the initial assessment.

Formulation (Bio-Psycho-Social)

Psychological Practitioners should draw on a broad range of theoretically-derived, evidence-based conceptualisations when developing formulations. This approach needs to recognise that cognitive-behavioural, psychodynamic and systemic approaches to understanding functioning can all have a role in formulation. Psychological services should promote and reflect this integrated model of practice in workforce planning and support mechanisms such as supervision and CPD.

An integrated approach within CAMHS settings allows practitioners to remain flexible and curious about the diverse presentations seen. Formulation should enable practitioners to make sense of multiple sources of information, by developing a more coherent explanation or narrative of how issues have emerged and are sustained. Alongside a broad appreciation of psychological theory, practitioners also need to have a framework for deciding how to intervene, and in particular to be sensitive to client choice in determining how to proceed.

Given the diverse nature of presentations to CAMHS practitioners, formulation also needs to reflect

a broad understanding of the social, economic, and political context for children, young people and their families. This may be acquired both through experience and learning from other clinicians and stakeholders, but most crucially from service users themselves.

It is also important that CAMHS practitioners have the confidence to undertake assessments which are concerned with neurodevelopmental problems such as Autistic Spectrum Disorders or ADHD either alone or as part of an MDT. Practitioners should be familiar with the screening and assessment tools used in their service and make use of these as part of the initial assessment where indicated.

Intervention/treatment plans (including consultation, and promoting knowledge and awareness)

In specialist CAMHS settings practitioners may often be constrained in the number of sessions they are able to offer. In practice this often means that formulation will act as a fluid, flexible guiding framework as treatment commences. Practitioners may have to quickly acquire skills in deferring the completion of a full assessment/formulation, transitioning into offering solution-based interventions soon after contact with a family begins. Clients may benefit most from earlier interventions with the greatest treatment effects often occurring in the initial sessions. Therefore, practitioners need to be equipped to offer straightforward advice, sign-posting and interventions from the earliest sessions. Formulation can guide treatment plans, and aid in making pragmatic decisions about what evidence-based intervention is likely to have the best chance of reducing impairment and improving the day to day functioning of the service user. However, restrictions on the number of sessions offered in services may not fit with the needs/wants of services users, and as highlighted above decisions about access to care also need to be made in the context of a person-centred approach.

Formulation should be used as a guiding principle to construct meaningful, tailored, and achievable approaches to treatment and where there is limited improvement re-formulation can be used with children and families to reconsider maintaining factors. Formulations can include straightforward disorder specific descriptions of the presenting problem but can also include a consideration of the impact of neurodevelopmental problems, poverty and social exclusion, the experience of discrimination and challenges relating to acculturation and migration, as well as incorporating the service user's culture bound beliefs about the nature of the presenting problem.

Psychological Practitioners might incorporate the following into their work with service users:

- Establishing SMART goals in the initial assessment.

- Goal-based assessment supported by goal tracking measures.
- Motivational assessment for change and motivational enhancement interventions.
- Knowledge and understanding of flexibly using NICE/BPE guidelines to choose and structure interventions.
- Re-formulation where new evidence is discovered or the initial formulation does not lead to progress.
- The use of systematic/manualised or bespoke/client-led interventions as appropriate.
- Role of liaison/consultation with wider network including schools, children's services and medical teams.
- Either a single-practitioner or joint-working approach.
- Drawing on skills within the MDT to augment work. This might include referral for specific interventions such as Family Therapy/DBT/Parent-Child game, etc.
- To gain the support of peers/management/supervisors in reviewing progress and working towards closure.
- To develop relapse prevention plans which might include signposting resources, books or other services.
- To provide top-up sessions where appropriate.
- Letter writing and reporting – good practice.

Good Practice Recommendation:

Psychological Practitioners in CAMHS need to be sufficiently trained in core skills of assessment, formulation, intervention and evaluation. These skills are key to ensure that treatments are delivered in a coherent, consistent manner, whilst flexing to the needs of individual service users. Clinical psychology training in particular provides a robust framework for ensuring that practitioners in whichever therapeutic modality are using the key principles outlined above.

Outcome monitoring and evaluation

Through training, Clinical Psychologists particularly will have acquired a good grounding in the use of outcome measures for a range of presentations. The Child Outcome Research Consortium (CORC) has provided a framework for assessing outcomes in CAMHS, and there has been an increasing focus on both session-by-session and whole service evaluation of progress. Whilst this paper will not focus on the ongoing debate over the utility and sensitivity of outcome measurement for CYPF, there is nevertheless an emerging consensus that measurement of progress and outcome can aid engagement as well as provide important data for a range of audiences.

Good Practice Recommendation:

It is essential that psychological services use tracking and outcome measurement to guide and evidence efficacy of interventions, most importantly in collaboration with services users, but also for communication with service managers and commissioners. Although the use of outcome measures has not been systematically required until recently, with the introduction of CYP-IAPT and much greater scrutiny of service outcomes, clinical psychologists are in a particularly strong position to lead on this agenda, having historically been at the forefront of the development and use of outcomes measures in mental health settings. Psychological Practitioners need to be central in demonstrating leadership around integrating outcome measurement into day-to-day practice.

Helping the whole service work as well as possible

Supervision

Supervision is a key requirement for the delivery of safe, high quality psychological services. The Francis Report provided evidence that lack of supervision and support for practitioners can have significant consequences on service delivery and patient care. Supervision can be used to promote smarter working, reduce therapy drift, promote staff morale/support and thus prevent staff burnout and support the acquisition and development of skills.

Given the diversity of presentation to CAMHS teams it is imperative that supervision remains flexible to allow for model specific discussions as well as offering an integrated/multi-modal approach. Thus the requirements of the CYP-IAPT curriculum mean that practitioners are increasingly offering specified, time-limited, manualised treatments such as CBT or IPT-A and, as such, supervision should be on offer from experienced practitioners to allow trainees and novice clinicians to reflect upon and practice new skills. At the same time practitioners may be working with other complex cases which, whilst benefitting from a focussed, client-specific case conceptualisation, may also require a broader integration of psychological theory in the design of intervention strategies. Supervisors may often be moving between models of therapy and be employing a range of skills. It is suggested that supervision skills in themselves are prioritised to ensure that sufficient expertise is available to teams to address the diversity of presenting problems. Clinical Psychologists may, therefore, play a key role in offering such case-based clinical supervision across a range of professional groups and therapy modalities. This may be offered in groups or individually and can focus on general practice or be specific to individual cases.

Good Practice Recommendation:

Well-functioning psychological services in specialist CAMHS should prioritise supervision, although it is acknowledged that demand and capacity have become increasingly strong drivers, potentially limiting the intervention focus of some CAMHS teams. Clinical supervision is a key means to ensure quality in a developing, reflective workforce, and in containing staff during uncertain times where change and anxiety have become more common.

Leadership

There are variations in the infrastructure of CAMHS management throughout the country. In some areas the traditional model of professional line and clinical management is being challenged and may already have been dismantled. There are a number of benefits to professional groups remaining line managed and clinically managed by one's own profession, including the use of a common language, shared history of training and expectations around professional development. However, increasingly issues of both parity and finance are challenging this model and for some services there have been longstanding divisions between line and clinical management, since the introduction of general management into CAMHS. In many services, financial constraints have led to long-standing service-leads leaving services, and as such there are risks that Psychological Practitioners are not appropriately represented at leadership levels within an organisation. This may leave services with more junior staff, lacking the experience to liaise with senior managers and commissioners.

Good Practice Recommendation:

At times of change and pressure on services and staff, the availability of high quality leadership is paramount in order to ensure that the ethos of providing evidence-based psychological therapies and good adherence to models of therapy delivery is maintained. Psychological Practitioners need to be represented at the highest levels within the organisation and in relationships with commissioners, and staff need to have a clear line of communication to the leadership team regarding their ideas or concerns. Services need to encourage training in leadership and consider these needs as part of continuing professional development to ensure that staff who work psychologically within CAMHS are represented within leadership roles. In addition, service leads need to ensure that an appropriate grade structure for the service is maintained to cover all levels of input and complexity, and service development and review (see Paper 2).

Developing the workforce – teaching and training

CAMHS teams encompass a range of professionals, with differing professional and development needs. For Psychological Practitioners there is a need for service leads to attend to the ongoing training and supervision of staff. Many services continue to be constrained by cuts in training budgets, which can mean that practitioners, once qualified, may struggle to access ongoing CPD.

Good Practice Recommendation:

Specialist psychological services need to offer training opportunities to the workforce to ensure that practitioners are delivering up to date approaches to treatment. This may increasingly include in-house opportunities, as funding reduces, or capitalising on the expansion of CYP-IAPT. For more senior clinicians there is a requirement to attend to CPD, and CAMHS has a responsibility to ensure that all clinicians at whichever level of seniority have access to appropriate training.

Research, audit and clinical governance

Clinical Psychologists and other Psychological Practitioners have valuable skill sets in terms of promoting a culture of research, service evaluation and clinical audit. Trainee Clinical Psychologists remain an invaluable resource whose training needs can be aligned with the information needs of teams. However, setting up research projects and supervising these can be resource intensive and it is important that services allocate adequate time to essential research, service evaluation and audit.

Good Practice Recommendation:

Given the constraints on capacity in the context of rising demand it is crucial that research, audit and clinical governance are given sufficient weighting, with dedicated time being made available for such activity in clinician job plans. However it is also important to ensure that such activity is linked to clear outcomes which benefit the wider service. Clinical Psychologists in particular are well placed to take on leadership roles around clinical audit and the promotion of evidence-based practice within teams.

Service and organisational development

Psychologists have considerable expertise in the application of psychological models to understanding change processes both at the level of individuals and systems. Where the CAMHS landscape has become characterised by what seems like permanent change processes, applied psychological models (many of which have been developed in organisational psychology) should be used to support these processes

and ensure that staff and organisational wellbeing are maintained and enhanced.

Good Practice Recommendation:

Psychological Practitioners who are trained in, for example, organisational dynamics can bring a great deal of awareness of the psychology of working with children and families who are seeking support whilst maintaining an approach to their role which supports and encourages staff teams.

Getting feedback from children and young people – user participation and involvement

The inclusion of service users at all levels of CAMHS is increasingly recognised as being a core priority for services. The CYP-IAPT service transformation agenda clearly places participation at the core of its philosophy of organisational transformation. Further details about involving service users across all areas in CAMHS is covered elsewhere in this review, with many core concepts being applicable across the range, including specialist CAMHS.

Good Practice Recommendation:

Psychological Practitioners in CAMHS need to have a core appreciation of the value of involving young people in service delivery and design. This may include: gathering regular feedback on features of the CAMHS environment; using standardised measures such as those recommended by CYP-IAPT to monitor acceptability and engagement with interventions; involvement of young people and their families on appointment panels; consulting young people in the process of service reorganisation. This is by no means an exhaustive list, but it is especially important for CAMHS, in the context of high volume provision, that participation is meaningful and doesn't become tokenistic.

Conclusions

This paper necessarily reflects the largest, most varied area of mental health work with children, young people and their families. As highlighted, many of the recommendations relate to ensuring services understand and support the presence of Psychological Practitioners, recognising the added value of Clinical Psychologists and other clinicians. The recommendations also relate to how practitioner professional groups ensure that standards of practice and integrity are maintained in whichever configuration of service. For some groups of practitioners, such as Clinical Psychologists, there are professional bodies to both guide and regulate clinicians in the workplace, although there are still many examples of organisations struggling to recognise the unique skill set of Clinical Psychologists, leading to a

worrying diminution of the role of these highly trained professionals. It is essential that services maintain a clear focus on quality, by ensuring that professional registration is maintained, providing regular opportunities for supervision, training and appraisal.

Specialist CAMHS needs to evolve to meet the challenge of new commissioning environments, where there is a welcome move to joint commissioning of services, between previously largely separate agencies. There is an ongoing risk that CAMHS teams continue to struggle with capacity and resources and as a result fall back to providing a reactive, urgent-care model, squeezing out the place of psychological services. Existing services and commissioners need to work closely together to ensure that this does not happen, and that the value of highly trained Psychological Practitioners can and should be working at all levels of the system around children, young people, families and the communities in which they live. Whilst there is undoubtedly a key role for Psychological Practitioners in such teams, (which may ultimately still mean that most often they remain health based), specialist CAMHS needs to be commissioned to have a stronger role outside of a traditional clinic base.

Accounting for its complexity, agency collaboration between health, social care, education and the voluntary sector is essential to ensure that young people are accessing help earlier, in schools, in community spaces, from a wide range of professionals. To ensure that this is sustainable those designing services need to appreciate

that Psychological Practitioners can be integrally located at all levels of the system. This might include providing consultation and training in schools, consulting with community leaders to garner the broadest level of engagement in decision-making, or directly enabling communities to support any of their children who are struggling. Clinical Psychologists and other Psychological Practitioners are, therefore, key in helping to build robust community circles of support around children and young people and their parents or carers. Psychological Practitioners in CAMHS also have the skills and expertise to lead the way in innovating new models of service delivery, interventions and community engagement, and need to be seen as an integral source of knowledge and expertise, and included in all levels of delivery and decision-making.

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Delivering psychological services for children, young people and their families in inpatient settings

Paul Abeles, Vivienne Crosbie & Gordon Milson

Summary:

- *Inpatient CAMHS units provide essential 24/7 psychological multi-disciplinary care to the most complex, needy and challenging CAMHS service users and families in a variety of specialised unit types, which cater across various age groupings (up to 18).*
- *Inpatient stays are effective at looking after young people who cannot be cared for in the community by providing a safe treatment climate with normalising and developmental perspectives.*
- *Inpatient psychological services need to work closely with young people, families and local agencies to assist in all stages of the admission and discharge processes, to shorten the length of admission and aid transition processes.*
- *Psychological formulations should be generated during an admission to bring together historical and current assessments in order to guide inpatient treatment.*
- *Individualised psychological therapeutic interventions need to be delivered at various levels within the inpatient service.*
- *Individual and aggregated outcome measures in inpatient units are essential tools to measure individual clinical changes as well as evaluating in how effective a way a service is meeting the needs of the young people it looks after.*
- *Psychological aspects of young people in inpatient units need to be held in mind at all times: ways clinical psychologists can support the system and team with this include supervision, consultation, leadership, promoting knowledge and awareness, and service development and delivery.*

Introduction

Demographics and categories of Unit

The National Inpatient Child and Adolescent Psychiatry Study (NICAPS) estimated that there are likely to be over 2100 admissions to inpatient CAMHS units per year of children and young people in England and Wales (O’Herlihy et al., 2001). The number of young people being admitted to inpatient units may appear to be relatively small. However, this is undoubtedly offset by the very significant impact on these individuals of the severe and prolonged conditions that require them to be hospitalised, in the context of the intense levels of resources required to look after them whilst they are in hospital.

The primary requirement of Tier 4 CAMHS inpatient units is to serve the needs of children and adolescents with complex mental health, developmental and risk difficulties. These children and young people will usually have already received a service from a Tier 3 (community) multi-disciplinary CAMHS team, but will typically have been assessed as too complex (e.g. individuals with multiple presenting difficulties) or too risky to manage on an outpatient basis in Tier 3 community CAMHS services, or they may require more intense therapeutic interventions or assessments that are simply not available or deliverable in community services.

Until April 2013, most Tier 4 CAMHS units were commissioned in the NHS by ‘Primary Care Trusts’, but since then all Inpatient CAMHS services have been nationally commissioned by NHS England. When there are no beds available in NHS run units, patients are

placed in units in the private sector. NHS England recently reviewed all Tier 4 CAMHS services (NHS England, 2014) in order to map current provisions and to grapple with some of the issues that have arisen since they took over commissioning. The Review identified specific improvements that are required as an immediate and urgent priority through national commissioning, and recommended an increase of about 50 beds across the country due to the rising demand for inpatient care. It also highlighted staffing shortages, discharge delays and bed closures as particular challenges to the current inpatient services landscape.

Inpatient CAMHS units typically provide between 14 and 16 beds. The main presenting problems of young people in inpatient units are: emotional disorders, eating disorders, psychotic disorders, autistic spectrum disorders and developmental disorders (NHS England, 2014). There are different subtypes of inpatient units that cater to specific age ranges (Children’s unit – up to 13 years, versus Adolescent unit), different levels of security (Open units versus different levels of ‘Secure’ Forensic units) and different types and levels of specialism (‘Generic’ units versus Eating Disorder units, Learning Disability and Deaf CAMHS). Another important distinction is whether a unit specialises in acute admissions (e.g. for 30 days) to assess and stabilise, or whether it caters for planned admissions that can last anything from six weeks to two years (having much more of a focus on detailed assessment, treatment and rehabilitation). There are a range of

additional services that inpatient units can offer from within the Tier 4 Inpatient CAMHS resource including intensive outreach, 'day' provision, community-based crisis support, and home treatment services (known as 'Tier 3 plus' or 'step-down' services – but we would claim they are much better described as 'Tier 4 minus' services¹).

Data from the COSICAPS study (Tulloch et al., 2008) found that inpatients tend to be females (66 per cent) and tend to be aged between 15- and 17-years-old (76 per cent). Almost one in five (19 per cent) young people in Inpatient CAMHS units belonged to a Black or Minority Ethnic (BME) group, suggesting that these groups are somewhat over-represented in inpatient units.²

The inpatient pathway – CPA framework

Although the CPA (Care Programme Approach, DoH, 2008) was initially introduced for adult mental health services, most inpatient CAMHS services now use this as a useful and guiding framework for all admissions (Sergeant, 2009). The CPA process should essentially provide a care pathway model to ensure that the inpatient referral, admission and discharge processes all seamlessly integrate and interface with the local team, and with the home environment from where a young person originates. The aim is to keep in mind right from the outset the planning of the transition of the young person back into the community and to ensure that the benefits of continued admission outweigh the costs of remaining away from home. This is achieved through CPA meetings (CPA reviews) which are held jointly between the inpatient team, the family and local professionals at the start and end of admission. In addition, during the course of the admission regular CPA reviews take place where a young person's progress during the previous six weeks is reviewed and plans are explicitly agreed for the next six weeks (including discharge planning).

Evidence base and treatment

It should be noted that there are relatively few studies evaluating the efficacy of Inpatient CAMHS treatment due to the complex nature of what is being delivered to inpatients during an admission (see Green & Jacobs, 1998, pp.333–346, for a useful summary of the methodological issues). Notwithstanding the challenges of assessing the effectiveness of the Inpatient CAMHS experience, the CHYPIE (Jacobs et al., 2004) and COSICAPS (Tulloch et al., 2008) studies have argued convincingly for the clinical benefit to young people who have an Inpatient CAMHS admission. Both studies found that longer length of stay and greater clinical severity at admission are associated with greater improvement in clinical severity, and the better the treatment climate (or 'ward atmosphere' – see Box 1), the better the clinical outcome. The studies also demonstrated that clinical severity measures improved substantially from admission to discharge for most types of condition, to a level similar to those of young people receiving care from community CAMHS (Gowers et al., 1999). This parallels the notion that, rather than 'curing' the problems of a young person who is being hospitalised, it is more that the inpatient admission essentially 'transforms' the young person's difficulties to a level that can be dealt with (once again) within the community. The implication of this is that on discharge the young person will require continued ongoing treatment, and this will need to be nestled within a co-ordinated local plan held by the community professionals.

Inpatient CAMH services house a variety of professionals who work together to provide for the psychological and physical health needs of the young people they are looking after. The staff mix includes key professional groups such as Nursing, Psychiatry, Clinical Psychology, Occupational Therapy, Education, Dietetics and Family Therapy. The provision of care within an inpatient CAMHS unit requires 'dynamic group activity' by these professionals working together for the benefit of the

Box 1: Ingredients that improve the treatment climate (adapted from Tulloch et al., 2008).

- The young people's involvement in therapeutic rather than counter therapeutic activities, and positive aspects of the peer group culture.
- Mutual support within the staff team, capacity to reflect together during care planning and a sense of coherence of work as part of a team.
- The quality of therapeutic relationships between the staff team and the group of admitted young people, with staff retaining an empathic therapeutic orientation rather than a sense of hopelessness or rejection.
- The personal feelings of the staff: feeling secure and in control at work, enthusiastic about their activities, and the levels of stress that they might carry over into their private lives.

¹ This is to convey the view that in our experience, staff and expertise from within Inpatient CAMHS or Tier 4 are better equipped to 'step down' (Tier 4 minus) relative to Tier 3 staff's capacity to 'step up' (Tier 3 plus).

² This is evidenced by the fact that the UK 2011 census found that only 12.9 per cent of the general population belonged to an ethnic minority.

unit's admitted young people (Green & Jacobs, 1998, p.180). Green and Jacobs go on to summarise the key issues in this area (see Box 2).

Staff in good inpatient CAMHS create a 'therapeutic milieu' for the young people that itself is used as an instrument for treatment. The young person is nurtured by immediate feedback from caring staff, within a safe environment rich with social opportunities. Their experience on the unit features normalising and developmental perspectives within structures of daily routines, activities and consistent rules. The environment also helps teach young people how 'to fit in' both socially and emotionally, and in turn helps them to better understand themselves and the way they relate to others.

YP Quote: *'Thanks for treating me as more than a mental illness.'*

Quality standards

The Quality Network for Inpatient CAMHS (QNIC) was initiated following the findings from the NICAPS study (O'Herlihy et al., 2001), and over the last 10 to 15 years QNIC has been instrumental in developing a way to ensure that units are meeting essential standards of good quality inpatient CAMHS care, including excellent psychological care. The QNIC standards are widely used, and form the basis for the annual standards-based self and peer reviews carried out by QNIC members (QNIC, 2014). The QNIC standards themselves have been developed through a 'bottom-up' process by QNIC inpatient unit members, with the involvement of users/carers and the standards are all reviewed biennially. Furthermore, the QNIC standards map onto Care

Quality Commission (CQC) 'You're Welcome' criteria and Monitor quality standards. QNIC standards cover the main areas listed in Box 3.

Most units in the country subscribe to the standard QNIC peer review processes and many have opted for the more rigorous QNIC accreditation (at the time of writing this paper about 20 units are 'accredited' or 'accredited with excellence'). Although all QNIC standards are intended to provide for the psychological wellbeing of inpatients, there are very specific standards pertaining to the provision of psychological services within units, some of which will be discussed and referenced later.

Intervening at different levels

Care pathways integration

A key role of psychological services is understanding and assisting in the pathways into and out of inpatient settings. Good services have intensive outreach teams which work closely with inpatient and community services. The CAMHS Tier 4 Review (NHS England, 2014) indicated that units which operated with an intensive outreach team show a consistently lower length of stay. However, most units (64 per cent) do not have intensive outreach services.

There is considerable variation in the management of discharge. The Review indicated that 80 per cent of services stated there was reduced or variable ability to arrange discharge into Tier 3 services. Due to the demand on inpatient services and the lack of provision available from community services, greater emphasis is being placed on the delivery of psychological services within inpatient settings. This was cited by units in the Review as the most common factor to impact on the

Box 2: Key issues around multi-disciplinary team working on an Inpatient CAMHS (adapted from Green & Jacobs, 1998).

1. The clarity of the team around the tasks involved in a young person's admission.
2. The need for well differentiated roles within the team with respect to these tasks.
3. The presence of clinical leadership roles to generate protocols to define the tasks into a common purpose.
4. Making clear decisions about who manages key events in the admission process (e.g. admission, discharge, treatment choice).
5. A sense of humour when working through role conflicts.

Box 3: The seven areas of QNIC standards.

1. Environment and facilities.
2. Staffing and staff training.
3. Access, admission and discharge.
4. Care and treatment.
5. Information, consent and confidentiality.
6. Young people's rights and safeguarding children.
7. Clinical governance.

care pathways in and out of inpatient services. The communication and co-working between community services and inpatient services is also adversely affected when young people are placed geographically out of their area. This can make continuation of care challenging. Good psychological services prioritise the need to maintain contact with young people out of area and explore ways to ensure that this core feature of ongoing care co-ordination is addressed. Modern innovations can assist in this by the use of SKYPE and web-enabled conferencing technologies, however, more modest means such as telephone calls can ensure that contact with the young person in hospital is maintained which will assist in the transition back to community services when the time comes. When this placement is out of area it is imperative that the family is supported as much as possible to be able to visit the young person and maintain contact. Good psychological services are aware of the additional stress that can be caused to a young person experiencing significant mental health difficulties by being disconnected from their family. Formal processes should be considered as part of the young person's care plan to maintain vital support networks.

There are currently no standard guidelines on managing transitions into and out of inpatient services. However, evidence regarding the level of risk involved in this is available and is discussed below.

Liaison and support across and within teams

There are many interfaces at which inpatient services operate. Community CAMHS teams are the most common interface, others include home treatment teams, crisis resolution teams – and at times children and young people come to inpatient services via emergency pathways without having active community involvement. Good services offer psychologically informed consultation to community colleagues to consider the pros and cons of an inpatient admission for a young person, and ensure the smooth flow of information about the young person from community to inpatient teams. In a recent report by YoungMinds (2014), entitled 'Report on Children, Young People and Family Engagement', 47 per cent of children and young people report feeling that services involved in their care worked together poorly. Clinical psychologists are well placed to advise on the psychological impact of Inpatient CAMHS admission, and how best to offer appropriate levels of support and work with families to create a consistent and predictable approach to the care of children and young people, utilising this in developing care inter-agency plans and pathways.

Inpatient services by their nature see young people with multiple and complex needs. The co-ordinated interaction and information sharing between staff is

vital so young people do not have to 'tell their story' multiple times (YoungMinds 2014). Inpatient services also liaise with additional specialisms such as Speech and Language Therapy, Dietetics, Specialist Learning Disability services, Paediatric services, and Paediatric Neurology. Psychological practitioners have an important role in ensuring that psychological understandings of the young people they work with are communicated to receiving services.

Risk support/maintenance

The significant change in environment that an inpatient setting brings has a significant impact on risk. However, factors such as exposure to peers engaging in high-risk behaviours, and separation from family and core support networks, bring their own potential risks. Clinical psychologists have valuable skills and knowledge in the assessment and formulation, and the dynamic factors involved in the management, of risk. Psychological approaches are essential in understanding the mechanisms by which the level of risk was deemed too high for safe support in the community, how it can be managed in the unit and how it can be reduced to allow discharge back into the community.

Research has found that risk of suicide is high in the weeks following discharge and risk management plans based on a psychological formulation are recommended to promote safety (NCISH, 2013). Risk formulation is one area which requires improvement, with 26 per cent of risk formulations and 38 per cent of risk management plans assessed as being unsatisfactory by the National Confidential Inquiry into Suicide and Homicide (2013).

Developing the workforce – teaching and training

Clinical psychologists are trained to draw on a range of theory and research to understand and support children and young people with complex mental health problems. However, many clinicians and health workers do not receive training in these areas during their own professional training. Behavioural interventions and attachment-based interventions are two valuable areas in which many nursing staff do not receive formal training. Furthermore, knowledge of the impact of trauma on young people and how this may manifest in the interactions between the young people and staff is one area which could increase resilience and compassion of staff towards children and young people exhibiting behaviours they find challenging or exhibiting high levels of distress. Clinical psychologists can effectively share their knowledge through training, supervision and consultation to other unit staff. An example of how this has been applied is described in Box 4.

Box 4: Induction package designed to equip staff to deal with patient interactions.

Staff who are undergoing induction receive a week of training from the existing staff team. This comprises practical elements such as observations and governance but also a majority of the training is based on psychological approaches such as Dialectical Behavioural Therapy, Family therapy approaches, trauma, hearing voices, attachment, psychological approaches to understanding self-harm and understanding difficult interactions with distressed young people. The staff report this as being extremely useful as part of their formal induction package.

The specific role and expertise of clinical psychologists

One of the key challenges in inpatient CAMHS is the sheer clinical complexity of cases in the context of the sometimes limited window of time available to work with families before discharge. Clinicians must also be able to deliver and adapt evidence-based interventions at the same time as keeping discharge and community integration in mind. This requires the clinician to take a flexible and adaptable approach that can adequately communicate and monitor important clinical and therapeutic markers and goals to those both inside and outside the inpatient unit. There is a need to work across different kinds of teams within health, education and social care at different intensities during the admission. Depending on the admission stage this may involve fact finding, liaison or even co-working close to discharge. Clinical psychologists have a wealth of experience working across various agencies and by nature of their training are able to communicate with a high level of competence, while thinking about the different perspectives at play (young person, family members, inpatient team members, local social care, education and health).

Working in an Inpatient CAMHS setting requires the psychological service to work with some of the most complex and challenging cases in the health care system. As it is not always possible to provide an 'off-the-shelf', manualised intervention, more tailored and highly bespoke interventions are required which are based on complex formulations. This needs to draw on a range of different therapy models and theories and approaches and therefore needs very skilled and experienced staff to devise highly complex formulations and interventions. There is, therefore, clearly a need for professionals who have training and experience in a range of therapeutic approaches and models and who are able to use the application of a scientific approach across a range of complex and novel contexts. Clinical psychologists operate at a high level of expertise, are capable of both autonomous and team working, and are well placed by virtue of their comprehensive training to provide clinical leadership. They ensure that their work communities have the opportunity to benefit

from the latest developments in scientifically derived assessments, formulations, and interventions.

The clinical psychologist's presence in the team can ensure that the child and young person's problems are properly understood, formulated and appropriate interventions offered. The skills of the clinical psychologist and the breadth of knowledge beyond one particular therapy approach can ensure that this intervention is properly evaluated and modified if needed. The clinical psychologist is also well trained and well placed to ensure that the theory-to-practice and practice-to-theory link that is crucial to evidence based practice is maintained by appropriate audit and research.

Specific areas of excellence include the ability of the clinical psychologist or psychological therapist to conduct a psychological assessment which generates a psychological formulation that can then drive all aspects of the admission. Putting the young person's psychological formulation at the heart of their admission involves co-ordinating formulation meetings and working with other team members to ensure that the psychological formulation informs all management and care plans (see quotes below).

Staff member: *I've really benefited from attending team formulation to help feel supported by the team when working with challenging clients. It has definitely helped me to develop a better understanding of the clients and brought together the therapeutic work.'*

YP: *'...a useful technique to use to communicate and should be used more often for mine and others' recovery.'*

A second area of excellence where psychological practitioners can work is with staff to provide psychological support. This is necessary due to the intensity of distress faced by professionals looking after some of the most highly disturbed and traumatised youth.

A third area of excellence is in creating and working with the therapeutic milieu/environment on the ward in relation to individual young people's difficulties. This requires a sophisticated knowledge of general psychological principles together with an understanding of systemic and organisational processes.

Core components of a psychological approach

The core components of a psychological approach include:

- Assessment;
- Formulation;
- Intervention;
- Evaluation and research.

These components can all be used at and across the levels of individual, service, organisation and community/society. A clinical case example (Box 5) is provided to illustrate how these tasks can translate into clinical practice within a Tier 4 Inpatient CAMHS service.

Assessment

Assessment undertaken at a Tier 4 level should be interdisciplinary, so is started together by clinicians from different clinical backgrounds. This might be undertaken over a short period, such as a few days if the difficulties have suddenly emerged or the risk has suddenly increased, or might be a prolonged intensive assessment undertaken over a longer period, such as four to six weeks when the task is to obtain a detailed assessment for services in the community to provide guidance about how best they can support and provide input. A variety of evaluation methods are used to complete a comprehensive assessment, with unit staff being uniquely able to provide observations of young people and children 24 hours a day. Key assessment methods include the use of:

- Psychological assessment tools including psychometric assessments of cognitive and neuropsychological function, emotional assessments, risk assessments, symptom specific assessments and personality based assessments. Many of these can only be administered and interpreted by an applied psychologist.
- Focused psychological assessment methods including behavioural observation, functional assessment, developmental assessments and clinical interviews.
- Specific engagement skills to promote positive therapeutic alliances with young people and children including motivational techniques, models of normalisation, Socratic questioning and continuum models of wellbeing.
- Analysis of complex information gathered from all aspects of the Tier 4 setting, for example, interpersonal interactions, against the broad psychological knowledge base to extract critical themes of evidence.

Prior to inpatient admission, an outpatient assessment is conducted to consider whether there are alternatives to an inpatient assessment and to think about what will be the psychological impact upon a young person of being away from their family, friends, school and local community. If the decision is that an inpatient admission will be the best way forward, the assessment would then consider how best to support the young person

Box 5: Case study.

M was admitted to a unit for young people with a diagnosis of schizophrenia after exhibiting unusual behaviour at college such as feeling that others were controlling her, having sleep difficulties and being unable to talk coherently about her difficulties. She had been previously admitted to another service and started on medication. M's family were concerned that her problems were due to physical reasons with an increase in difficulties at the time of her menstrual cycle. She did not respond to the medication and was difficult to engage on the ward in therapeutic activities.

The unit clinical psychologist undertook a full assessment of M, observations were recorded by the nursing team, and previous notes were reviewed. A full developmental assessment was undertaken with M's parents and sessions with M herself focused on her understanding of her difficulties and why she was in hospital.

The information gathered from the developmental assessment, previous assessments using specific measures of mood and symptoms and current assessments and observations highlighted that M's difficulties were more likely to be a result of her having difficulty in functioning related to an Autistic Spectrum presentation.

Her current presentation and difficulties were felt to be that of someone who was experiencing high levels of anxiety but struggling to make sense of and express the experience of this. Drawing on the clinical psychologist's comprehensive training in developmental psychopathology, neurodevelopmental disorders, emotional expression of people with ASD and the assessment of acute mental illness, a full formulation was drawn up and shared.

Her difficulties did in fact seem to become more pronounced during her menstrual cycle, but after medical examinations did not reveal any difficulty it was formulated with the family and M that the exacerbation was down to an emotional change in M which she struggled to manage rather than a biological imbalance.

M's family were happy with the formulation and gave feedback that they felt they had a good understanding of the nature of her problems. Following this formulation, M was slowly taken off medication and her symptoms became less problematic. Family reported that she was functioning at a level higher than they had seen for many years. Links were made with community services to further support M and her family in managing her anxiety and support plans devised regarding accessing education.

and family to manage the admission. The assessment should consider what the young person and family are hoping to gain from an inpatient admission and to also consider what the systems around the young person are asking. Within an inpatient setting the team will set goals to reflect this.

Bio-psycho-social Formulation

The information gathered through the assessment enables the inpatient service to draw upon information about the biological, psychological and social aspects and to make sense of why things have become difficult for the young person, what is keeping things difficult and what might be the helpful factors – the formulation. The ability to construct and share complex formulations with the young people themselves, their families³ and other professionals is a central role within psychological services of inpatient units. Key tasks include:

- Drawing upon a range of psychological models and theory in order to inform the current understanding, development and maintenance of the presenting problem.
- Identifying treatment options that will interrupt the development of the problem and/or remove the maintaining factors.
- Identify how the presenting problem may manifest and impact in the Tier 4 environment, other domains of service provision, the family, school and other systems to which the child or young person belongs.

The formulation is then used as a whole service to think about how best to support and provide the most helpful treatment to the young person and family. This enables the whole team to have a joined up understanding of the young person and ensures effective team working.

Intervention

An important part of the intervention within an inpatient unit is the care that is delivered on a day-to-day basis by the whole team, the therapeutic milieu of the unit mentioned previously.

The QNIC standards highlight the need for inpatient units to provide access to evidence based interventions: individual therapy, group therapy and family interventions. This is a 'Type 1' standard (which a unit must have to become accredited). These interventions are delivered by clinical psychologists and other therapists on the unit, with interventions being tailored to the needs of the young person and family. This can often mean that young people and children are

accessing a variety of different modes of therapy over the course of their inpatient admission, with the staff group meeting often to discuss a young person's package of care to ensure that all elements of the treatment are working together and fit with the formulation.

The complexity of the difficulties young people and children might be experiencing means that inpatient units provide intervention at different levels:

- Providing different models of intervention including consultation, group, and one-to-one.
- Providing direct and indirect input.
- Devising individualised plans, for example, behavioural interventions.
- Delivering uni-modal therapy for example, CBT, Psychodynamic, Systemic, CRT (Tchanturia & Hambrook, 2009).
- Supervising manualised interventions delivered by other staff.

A care planning approach is used within inpatient units, which means that the assessment and formulation guide how care will be provided. These plans are developed collaboratively with young people and children and their parents/carers⁴. A further focus when thinking about intervention is to consider the transition back to community services and how to support young people and children and families with the step down from an intensive service. *Future in Mind*, a document produced jointly by the Department of Health and NHS England (2015), highlights the importance of having clear pathways for young people and children when leaving inpatient care to shorten the time young people and children stay as an inpatient and to make the transition out of inpatient care easier.

Outcome monitoring (for individual cases)

Objectively assessing the improvement in the young person's functioning, presenting difficulties and risk within an inpatient assessment should be routinely undertaken by clinical staff, with the perspective of the young person, parents/carers and unit clinical staff all being sought. This information is gathered at regular time intervals (at admission and at discharge, but preferably at CPA review meetings or every two to six weeks). The aim of collecting this information is to ensure that the service is making a positive difference to young people and children. Both quantitative and qualitative information is collected, with young people, children and their parents/carers also being asked about their satisfaction with the service they have received. QNIC collect and collate the outcome data and produce a report that provides a summary of the

³ Although some young people may prefer for their family not to be involved, or to have control over what information is shared with the family. This clearly requires careful negotiation and discussion by the psychological practitioner.

⁴ See previous footnote.

clinical outcomes of inpatient units (called the 'QNIC-ROM'). It is vital for the unit to have suitably qualified staff who can select, administer and interpret these measures. This is recognised in various QNIC Standards, for example, 4.7 'Outcome measurement is undertaken routinely using validated outcome tools', 4.7.5 'Aggregated outcome data is used as part of service management, staff supervision and caseload feedback', and 4.7.7 'A designated person is in place to lead on outcome measurement work'.

Helping the whole service work as well as possible

Current evidence-based models of mental health interventions are predominantly psychological. Within an inpatient CAMHS unit there are a variety of different staff with different levels of training, from health care workers and support workers to qualified Nurses, Therapists, Dieticians, Clinical Psychologists and Psychiatrists. The majority of staff within an inpatient setting are Nurses and Psychiatrists, whose training is predominantly within a medical framework. It is, therefore, important that the psychological aspects of the young person are also held in mind throughout the patient journey and that there is psychological thinking throughout the whole system and team. This is critical to the effective delivery of a comprehensive Tier 4 CAMHS. There are a variety of ways to support the system and team with this, and this section will focus upon supervision, consultation, leadership, promoting knowledge and awareness, and service development and delivery.

Supervision

Supervision provides a space for a clinician to reflect upon the understanding of a young person's presenting difficulties and to also think about the impact of the intensity of the work. This is particularly important in an inpatient setting when the team are working closely together with young people and children with complex difficulties and needs. Supervision is usually provided individually and in group and team settings. The group and team supervision ensures that the team are able to think together and work well together, generating consistency of care and providing staff with a shared view of the formulation of a young person's presenta-

tion. Tensions or disagreements regarding care in a staff group would impact negatively upon young people and children and the care they receive. The task of supervision is also to ensure that all aspects of the young person are held in mind in the care delivered by the team.

Within an inpatient unit, young people and children can at times present as a risk to themselves or others and at these times staff having a space to make sense of and to talk through the impact that the young person's presentation has upon them is important and enables staff to provide better care.

Consultation

Children and young people experiencing difficulties with emotional wellbeing encounter a great many people in service provision roles. It is essential to create a physical, social and psychological environment that promotes feelings of safety for young people and children. Within an inpatient unit, consultation can be provided to the staff group or to professionals from other services. The key tasks of consultation are described in Box 6. Research by Barton and Crosbie (2013) has evidenced how a high proportion of a clinical psychologist's time is usefully spent in consultation and supporting the nursing and support staff, and that the percentage of time spent on consultation increases with seniority.

Leadership

Leadership skills are a core competency within the doctoral training of clinical psychologists and the BPS has provided a breakdown of the nine competencies within this area (see Box 7).

Within the setting of a CAMHS ward this core competency, together with the comprehensive training in psychological knowledge and its application to clinical problems, places clinical psychologists in the position of being an expert source of knowledge, guidance and therefore leadership in the clinical team.

Traditionally, consultant psychiatrists have provided the clinical leadership within inpatient services. Recent documents, such as New Ways of Working, National Service Framework and NICE guidance, have highlighted the importance of the need to ensure that the leadership team has strengths across all areas of inter-

Box 6: Key components of consultation.

- Communicating complex presentations.
- Communicating the personal needs of the young people and children.
- Linking the presentation and specific needs with the specific roles of service providers.
- Communicating the scientifically derived knowledge base of psychology in an understandable and relevant manner.
- Helping other professionals make links to relevant aspects of psychological evidence.

Box 7: Leadership skills (from BPS, 2014).

1. Awareness of the legislative and national planning contexts for service delivery and clinical practice.
2. Capacity to adapt practice to different organisational contexts for service delivery. This should include a variety of settings such as inpatient and community, primary, secondary and tertiary care and may include work with providers outside of the NHS.
3. Providing supervision at an appropriate level within own sphere of competence.
4. Indirect influence of service delivery including through consultancy, training and working effectively in multidisciplinary and cross-professional teams. Bringing psychological influence to bear in the service delivery of others.
5. Understanding of leadership theories and models, and their application to service development and delivery. Demonstrating leadership qualities such as being aware of and working with interpersonal processes, proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams.
6. Working with users and carers to facilitate their involvement in service planning and delivery.
7. Understanding of change processes in service delivery systems.
8. Understanding and working with quality assurance principles and processes including informatics systems which may determine the relevance of clinical psychology work within health care systems.
9. Being able to recognise malpractice or unethical practice in systems and organisations and knowing how to respond to this, and being familiar with 'whistleblowing' policies and issues.

vention. This can be achieved by clinical psychologists working together with psychiatrists in order to offer expert clinical leadership in inpatient services.

Promoting knowledge and awareness

In order for inpatient services to provide comprehensive care to children and young people and their families, staff having access to up-to-date teaching and training is vital. The Foundation for Professionals in Services to Adolescents (FPSA, 2011) commissioned a research project to look at the training needs of front line staff within inpatient CAMHS. The project concluded that within inpatient units there are key areas that teaching and training should focus upon to ensure that the staff maintain a holistic view of the young person and family and enhance the psychological understanding of the staff group. These areas were:

- Theoretical topics – concerning relevant aspects of psychology (e.g. child and adolescent development) or specific disorders (e.g. self-harm).
- Skill-based topics – concerning skills specific to the mental health context (e.g. managing suicidal risk); skills for therapeutic intervention (e.g. family therapy); and more generic skills (e.g. active listening).
- Other topics, such as risk assessment, child protection and managing transitions.

The QNIC standards for inpatient units require 'all qualified staff to receive at least five days training and continuing professional development activities per year, in addition to mandatory training' (Standard 2.5.1).

Research, evaluation and audit

There exists little specific research evidence for the impact of psychological interventions within inpatient settings for children and young people. Likewise there is a lack of research evaluating the effectiveness of services as a whole; this may be due, in part, to a lack of inpatient specific outcome measures, that capture the complexity of change units are aiming to achieve. Most of the tools used in inpatient CAMHS are adapted from instruments developed with young people living in the community, and so may not be as sensitive or relevant to the particular symptoms and experiences when residing on an inpatient unit. One exception to this is the CAMHS-AID (Abeles et al., 2007), which specifically measures the dependency (or level of unit resource uptake) of young people on a CAMHS inpatient unit, rather than their general clinical progress. An example of an innovative study that tracked the dependency levels of inpatients measured by the CAMHS-AID, and then related this to the ward atmosphere, found that as the total dependency of patients on the unit increased, the ward atmosphere decreased (Besani & Kavanagh, 2013). The CAMHS-AID has also been used to gauge the needs of admitted young people in relation to the necessary staffing to adequately care for the group. Inpatient CAMHS specific measures would not only allow better measurement of outcomes for young people, but it would allow better comparison of outcomes across units.

However, in order to continue to be a service that provides a good standard of care, the undertaking of research, evaluation and audit is vital. It is often the clinical psychologist on the unit that takes the lead in

this area, and will be involved in ongoing evaluation and research in order to make links between theory and practice. Key tasks include:

- Auditing clinical effectiveness.
- Identifying and critically appraising research evidence relevant to practice.
- Conducting service evaluation and small cases studies.
- Conducting collaborative research.
- Planning and conducting independent research.
- Reporting outcomes and identifying appropriate pathways for communicating these.
- Service and organisational development.

Research in this area would be particularly enhanced by the inclusion of service users and carers in developing and implementing the research – through consultation at the early stages of research design and the formation of reference and steering groups to guide the process. Similarly, longer-term outcomes of ex-inpatients (e.g. at age 25) would be very useful to help understand the impact of admissions.

Participation, service and organisational development

Good psychological services ensure that any service or organisation has the voice and the views of the service user at the heart. Within inpatient services there has been a drive to ensure that young people and children and their families are able to contribute to the development of the service. This has included young people and children being on interview panels for the selection of staff. Young people are also employed as advisors to QNIC, attending reviews of individual units. As a part of the reviews, the views and experiences of young people, children and their parents/carers that access the unit are sought. An example of organisational service development is described in Box 8.

A further example of how user participation can shape services can be illustrated by the involvement of young people who were admitted to an inpatient service in the north of England. The service users contributed to every stage of the development of a unique outdoor space and tree house. From the outset, the bid to the King's Fund was largely written by the young people and they also wrote a letter to accompany the bid. The bidding contractors were assessed by the young people and the design of the tree house was reviewed, and feedback given by young people at every stage of the process. The resulting tree house and surrounding area provide a relaxing space out of the ward setting for young people and is utilised for a range of activities. A possible way forward to enhance psychological wellbeing in inpatient CAMHS would be to consider the feasibility of integrating a young person advisor into the inpatient staff team. This could bring a valuable perspective to many aspects of understanding and dealing with the young people's predicaments. This would add strength to the increasing use of Advocacy services in inpatient units, which empower young people to express their views about their treatment.

Conclusion

In conclusion, inpatient settings work with children and young people who present with the most complex and risky mental health difficulties. Units need to have a workforce who can deal with every aspect of the young person's life, and provide a range of appropriate care and interventions. Highly specialist psychological skills and knowledge are needed to develop the sophisticated understanding of the difficulties with which young people present, in order to devise and deliver the bespoke interventions and treatment plans required to meet a young person's needs.

Box 8: An example of organisational service development.

A clinical psychologist working in an inpatient CAMHS initiated a project that focused on effective team-working within MDT staff. The remit of the work included the development of a technique to evaluate staff communication and teamwork, which was then re-employed as a basis to facilitate a communication workshop with the staff group. The clinical psychologist evolved this work into co-ordinating a staff-based steering group which has ownership for a twice-monthly communication meeting for all staff. The clinical psychologist then negotiated the funding and involvement of an outside facilitator to both attend the communication group and to consult to the steering group. The aim of the group is to provide support to the staff group in relation to organisational dynamics and the challenges of working with an inpatient client group, as well as to help represent all of the staff's views (see Abeles, 2008, for further details). Since the commencement of the group, it is very well attended by a range of professions on the unit, and staff members report that it has been very successful in supporting them through difficult times on the ward.

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Delivering psychological services for children and young people with physical health needs and their families

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Summary:

Good psychological services for children and young people with physical health needs and their families will:

- *Demonstrate the delivery of psychological interventions at different levels to improve patient resilience, prevent psychological difficulties, treat complex psychological issues and provide a cost effective service.*
- *Deliver hospital and community teaching, develop information resources and patient pathways, attend work/steering groups and multi-disciplinary team meetings, and provide consultation, supervision and targeted services to staff; plus highly specialist psychological assessments and interventions with CYPF.*
- *Demonstrate a non-stigmatising, collaborative approach, prioritising children, young people and families' goals for intervention, encouraging feedback and working in partnership with Child and Adolescent Mental Health and Community Paediatric Services.*
- *Demonstrate good governance of psychological treatments provided by psychology and non-psychology staff including CNSs, counsellors, hospital play specialists and community health teams.*
- *Implement goal-based outcomes for interventions with CYPF and staff and evaluate consultation, supervision and teaching.*
- *Be proactive in learning from referrals and the involvement of service users both in developing policies and implementing changes to the wider service.*
- *Anticipate vulnerabilities and deliver preventative interventions, for example, group work.*
- *Provide value for money, with a mix of grades, and a range of skills, stratifying referral complexity and making use (through supervision) of the skills of other professionals.*
- *Play a central collaborative role in research and audit.*
- *Work closely with commissioners of physical health services and psychology colleagues at national, regional and local levels to develop care standards and integrated care pathways.*

Introduction

Paediatric psychology is a field of research and practice that considers a wide variety of factors in the relationship between the psychological and physical wellbeing of children and young people (C&YP). This includes the behavioural and emotional impact of disease, illness and acute physical trauma on C&YP, their families, and the staff who care for them.

Between 10 and 30 per cent of children and young people in the UK have a chronic illness or physical health need (Kush & Campo, 1998) and 10 per cent of all young people under 19 are admitted to hospital every year (DoH, 2000). 'Families facing serious paediatric illness are essentially ordinary families facing extraordinary stressors' (Kazak, 1997). However, Children, Young People and their Families (CYPF) with health conditions experience four times more psychological distress than their healthy peers (Hysing et al., 2007). This increases the risk of developing psychological and behavioural difficulties which impact on their emotional, social and educational development; and future occupational opportunities (Glazebrook et

al., 2003; Meltzer et al., 2000). This vulnerability increases if the child's brain or central nervous system is involved.

The long-term process of adjusting to and coping with a medical condition, managing its demands and treatment, coping with setbacks and changes in health status, and navigating complex medical systems is a challenge. Each child and young person and their family reacts differently depending on their experience of health and health care systems, personality, relationships, social and family support, cultural factors, religious and spiritual beliefs and coping styles. Other issues such as financial worries, including poverty and debt, and the demands of treatment such as medicines, procedures and special dietary needs, frequent hospital visits or admissions, involving family disruption, days off work and school, and additional child care arrangements for siblings, can be an added burden. For this reason parental adjustment and coping, from acute distress to parental mental health difficulties, need to be identified and addressed as they can have a significant impact on children's ability to cope.

This group of children are a diverse and often disadvantaged and stigmatised population. Their condition can interfere with their access to education and in maintaining friendships. Having a different diet, doing self-care such as blood monitoring or catheterising, looking 'different', and having mobility problems can lead to further social exclusion, lower self-esteem and, often, bullying. Many children with long-term health conditions have developmental or learning difficulties, either in addition to (e.g. an autistic spectrum disorder) or associated with (e.g. Down's syndrome, Di George Syndrome) their health needs. Sometimes the stigma and bullying extends to siblings, who can experience high levels of behavioural and emotional distress.

*'When my sister got it I was really scared
'cos the Doctors said you can die from cancer.'*

As with all children and families, there are many factors which either help develop resilience or increase vulnerability. Recognising the uniqueness and the strengths of CYPF and intervening early, in relation to vulnerabilities, maximises both physical and emotional wellbeing and enables C&YP to achieve their full potential.

Medical diagnosis is not always straightforward and physical symptoms can be accompanied by and/or exacerbated by psychological reactions. Children and young people with 'Medically Unexplained Symptoms' (MUS), for example, pain syndromes or chronic fatigue, often have associated causative or maintaining psychological factors. These youngsters often see multiple medical teams, have unnecessary investigations and, in some cases, even surgery in the search for a diagnosis. A well co-ordinated, psychologically informed care pathway reduces unnecessary use of resources, worry and potential harm. Presenting an acceptable alternative formulation or 'diagnosis' that illustrates the interaction between psychological factors and physical experience, to the CYPF, can lead to some resolution of the difficulties and facilitate return to normal life.

Another group who benefit from a psychological service are those admitted to hospital following acute illness or physical trauma. They include C&YP with encephalitis or meningitis; severe burn injuries or road traffic accidents; or those admitted to neonatal or intensive care units and whose survival is precarious. The threat of an infant not surviving can interfere with bonding. One-third of children (and their parents) admitted to paediatric intensive care (PICU) have symptoms of Post-Traumatic Stress Disorder (PTSD) after discharge and one-in-10 go on to develop clinically significant PTSD (Colville, 2008; Lewis et al., 2014).

Psychological interventions to reduce distress and increase coping help CYPF make sense of their experiences and can significantly reduce the risk of trauma from PICU admission or surgical treatment (Kazak et al., 2006).

With advances in medical science, many more young people with chronic and/or life threatening conditions (e.g. Childhood Cancers, Cystic Fibrosis, End Stage Renal Failure and Complex Cardiac Conditions) are now surviving into adulthood. If the psychological needs of this population, and those who care for them, are not identified and treated, they can exacerbate medical symptoms and problems that persist into adulthood. For example, high levels of anxiety and/or low mood influences adherence to treatment (Gray et al., 2012). This leads to worsening of the illness or condition in the short and sometimes longer-term, increased hospital visits, reduced independence, further anxiety, low mood and learned helplessness.

Sadly, despite the increasing numbers of C&YP surviving, many will require palliative care. Attending to the psychological needs of the C&YP and their families can help achieve a 'good death' and for bereavement to be a little more bearable.

Health care staff, including doctors and nurses, and those in the wider MDT such as physiotherapists, dieticians, speech therapists and hospital social workers, all have a role in delivering psychosocial care. Through joint-working, consultation, supervision and teaching by clinical psychologists, staff benefit from time to reflect on and make sense of a C&YP's or family's presentation. This also helps staff to reflect on their own beliefs, attitudes, behaviours and emotional wellbeing and how these impact on their work with CYP&F's, helping them to deliver more compassionate, patient-centred care (European Association for Children in Hospital; EACH Charter).

In the paediatric services described below, the knowledge and skills of the clinical psychologists, embedded in medical multi-disciplinary teams, not only facilitates access to highly specialist intervention and indirect delivery of psychological interventions through the MDT, it also enables system-wide prevention, early identification and remediation of difficulties in a non-stigmatising setting.

Depending upon the complexity, severity and rarity of the CYP's condition, some CYP will be cared for solely in a specialist tertiary hospital, some in a District General Hospital and many will have shared care between both of these and/or community paediatrics. In order to ensure that all CYP with physical health needs have access to a timely and holistic service, it is important that the psychological service model facilitates the integration of physical and psychological need, as well as hospital and community care.

Many of NHS England’s service specification documents advising commissioners about specific medical specialties recommend that a clinical psychologist (with specialist training in paediatrics or clinical health psychology) is central and embedded in the MDT. In Scotland the National Delivery Plan (2009) highlighted that psychological services should be an integral part of children’s medical health care. Various condition-specific guidelines have gone further and specified the level of psychological care recommended to meet patient need, for example, BPS (2013) and PPN (2008). For the past 30 years, in most of the large paediatric centres in the UK, and some in the community linked to local hospitals, clinical psychologists have developed successful, evidence-based and effective services in this way. Significant gains, including financial, can be achieved by co-locating psychological and physical health services (King’s Fund, 2012). However, there continues to be considerable disparity in service provision across the UK. Opportunities exist for imaginative new models with integrated pathways between tertiary, DGH and community services.

Intervening at different levels

Figure 1 (below) illustrates a whole systems approach to service provision. The inner semi-circle demonstrates what is provided and the outer semi-circle to whom. A comprehensive psychological service aims to utilise expertise to enhance the quality of experience of all CYPFs, and improve the psychological competence of staff and provide governance for psychological interventions delivered by non-psychology staff. It should also educate and skill up front line staff across agencies

and along the whole patient pathway, by providing training, consultation and psycho-education. Finally for the minority of CYPF’s who require highly specialist psychological intervention, this should be easily accessible to CYP and their families and delivered in a timely fashion. The service CYP receive should be flexible and adaptive. Each element of this model is discussed below.

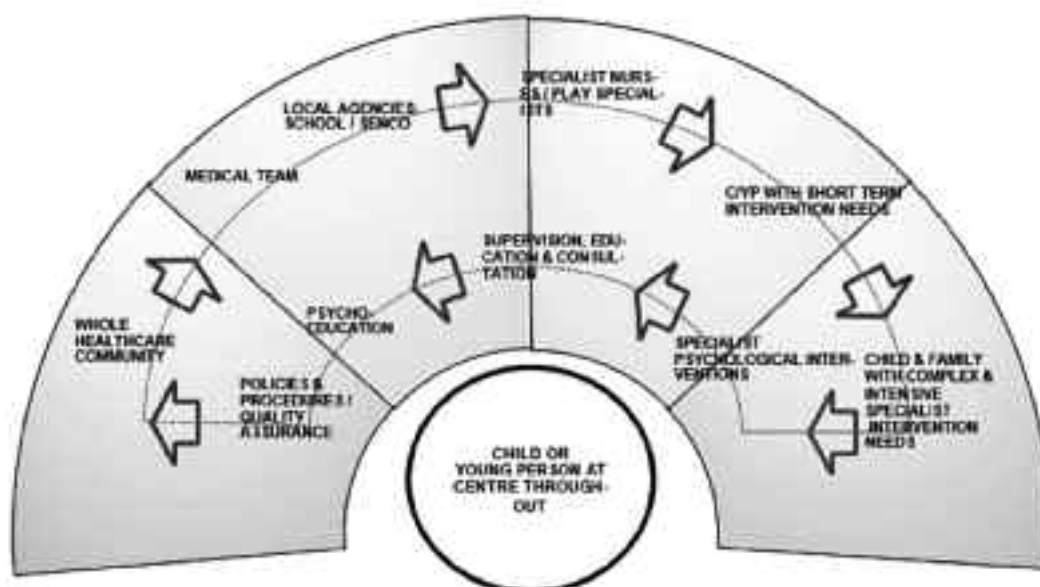
Care pathways

For psychological provision to be effective, care pathways should address a CYPF’s psychological needs across the entire journey, between medical specialties, from hospital to community, and all involved agencies. Good communication, joint working and regular liaison between professionals, and between families and professionals, is one of the key components of best practice identified by a variety of charities representing children and families, for example, in Action for Sick Children’s Charter.

Whole systems approach

Repeated hospitalisation and invasive procedures put CYP at increased risk of developing procedural anxiety and post-traumatic symptoms (National Child Traumatic Stress Network, 2005). Putting psychological wellbeing at the heart of CYP services can ensure that harm is reduced and improve CYP’s experiences of health care, which will, in turn, influence their interactions with health services in the future (Doyle, 2013). A positive experience of treatment and care is rightly viewed as an important health outcome in itself (Evans, 2014).

Figure 1: Psychological Services Model (Griggs & Mercer, 2015).



Prevention and support, online and community resources

CYPF routinely seek information from the **internet**. It is important that this is of high quality. Clinical psychologists can and do contribute to the development of accessible **psycho-education**, for example, 'MindEd', a universally available e-learning portal. Clinical psychologists also contribute information to online support groups for specific conditions, organised by parents and young people or condition-specific charities, which can be particularly useful for CYP with rare conditions.

The use of **technology-based therapy interventions** has increased in popularity with both internet and telephone-based interventions (Chi & Demeris, 2014). Innovative practice includes: a home-based behavioural health intervention for managing adherence in Type 1 Diabetes (Adkins, 2006); computerised CBT for chronic pain (Velleman et al., 2010); and the Hospital Passport Coping Kit rolled out nationally across Scotland. The latter, soon to be available as an app, teaches CYPF and staff psychological strategies to reduce hospital and procedure related anxiety, improve communication and involve them more effectively in decision making.

CYPF meet multiple professionals in both community (e.g. GPs, Health Visitors and School Nurses) and hospital settings (Physicians, Surgeons, Physiotherapists, Orthodontists, Hospital Play Specialists and Nurses). All professionals have a role to play in maximising psychological wellbeing, and providing compassionate care. All professions' core training should, therefore, include education about psychological issues, including developmental theory and how to identify both resilience and vulnerability factors.

Supervision and consultation: A clinical psychologist can support front line clinicians in their role, and enable them to safely use psychosocial strategies for managing common difficulties such as adherence and procedural distress, improving overall patient centred care (e.g. Child in Mind, 2002; NHS Education for Scotland, 2010).

'Psycho-social' meetings: The aim of a psycho-social meeting is to formulate the CYPF's presenting difficulties, co-ordinate and evaluate interventions and manage risk. Psychologists help the MDT to consider a wide range of psychological, social, emotional, cognitive, developmental and systemic factors and generate hypotheses to plan and test out different ways of working with the child and family. Sometimes the presenting concern is about difficulties in the communication or relationship between CYPF and the staff team and the psychologist will then use the formulation to facilitate a resolution and help everyone to move forward.

Staff wellbeing and stress has been directly linked with families' experience of care, staff sickness and absence, and retention of staff (Care Quality Commis-

sion (CQC), NHS Employers, 2009). Staff who are confronted with issues of life and death, reduced quality of life, and children in pain and distress are at risk of feeling burned out and disempowered, and working with emotionally overwhelmed families and stressed colleagues can diminish the professional's own capacity to cope (Gehring et al., 2002). The importance of staff support and training for coping with stress is well established (Board & Ryan-Wenger, 2000) and both doctors and nurses view multi-disciplinary team supervision from psycho-social colleagues as essential in coping (Gehring et al., 2002). The importance of creating a caring culture is reported by Berwick (2014). The consequences of not doing so are tragically illustrated by Francis (2013).

Promoting good psychological care as part of Trusts' policies, procedures and pathways enhances the CYPF's experience, governance and helps the organisation to meet CQC standards. For example, embedding evidence-based and developmentally appropriate approaches to consent to treatment, managing distressing behaviour, procedural anxiety and preparation for surgery. Some national multi-disciplinary pathways require psychological and/or cognitive assessment at key points; for example, pre-transplant (kidney, heart and liver), pre-surgery for epilepsy or Bone Marrow Transplant.

Development of a coherent policy and practice in the **process of transition to adult services** is crucial. The best timing for transition depends on the course and phase of a YP's condition, their psychological, social and cultural uniqueness and their preparedness in terms of level of dependence and motivation. There are particular challenges for YP including a need to understand their condition and treatment and to develop skills in managing complex medical regimes and consultations without their parents. YP also need to co-ordinate their own care, which might involve multiple medical teams in multiple settings. They also have normal developmental tasks and transitions such as going to college, university or starting work. These all occur in the context of what is a particularly challenging period of adolescent brain development, emotional responses to leaving long established relationships with their paediatric team and developing a relationship with both their GP as their care co-ordinator and the adult medical team(s).

'I wish someone had advised me to get to know my GP before I moved to the adult hospital.'

Targeted help: prevention and support

Screening for vulnerability: Many specialties (e.g. Diabetes, Asthma, and Cystic Fibrosis) annually review the children in their care on standardised measures to

identify and remediate early difficulties. Providing holistic care including psycho-social interventions is central to the SIGN guidelines for both diabetes (2010) and asthma (2011). Often this screening and early intervention is provided by health professionals under the supervision of the clinical psychologist.

Anticipating vulnerability: CYP who have experienced brain trauma, for example, due to accidents, tumours or lack of oxygen, are at risk of falling behind at school and struggling with peer relationships. Cognitive assessment can help identify and remediate cognitive deficits by ensuring that schools have the information to support learning and reduce the potential negative impact on a CYP's education and quality of life. Anticipating additional functional vulnerability can be done by the whole team through psychosocial meetings that identify problems in coping, parenting stress, sibling distress and so on.

Admission to PICU or surgical treatment are potential stressors for the whole family. Timely psychological interventions help CYPF make sense of their experiences and can significantly reduce the risk of trauma (Kazak et al., 2006). The NICE guidelines on PTSD (NICE, 2005) recommend screening those at risk of PTSD one month after their experiences. These CYP may not meet criteria for mental health services until the problem becomes more entrenched and intractable.

'Jason' is a 3-year-old boy who was attacked by a guard dog on his grandparents' farm. His grandmother managed to get the dog away from him, but Jason had extensive and serious bite injuries to both legs and arms and needed skin grafts. Jason needed to stay in hospital for at least three weeks. The role for psychology was initially to provide information for all concerned, including the treating team, about what should be expected as a 'normal' reaction to trauma for a 3-year-old child, and also to consider the trauma to his grandmother. Further work was planned to meet with the family to facilitate the adults to express guilt, anger, and anxieties about what had happened, and to address how to repair and restore their previously good relationships. Information about building an account of the incident that is honest and age-appropriate was provided for Jason, which could be developed over time as his understanding progressed. Individual work with Jason was arranged to help him to cope with the immediate emotional impact of his scars. This work took three sessions, with feedback from staff that the boy and family were more settled and ward staff found it easier to give treatment and so were less stressed.

Many expectant parents are aware that their child will be born with a specific genetic syndrome or some form of disability. Some only become aware at birth. A number of these babies' lives are perilous and they will need surgery and/or neonatal intensive care. Early psycho-social interventions can facilitate bonding and parent-child interaction, thus influencing infant brain development and reducing stress (McCusker et al., 2007). Opportunities for parents and siblings to make sense of their experiences and express complex or negative emotions can reduce the long-term traumatic impact of these events and improve adjustment to bereavement.

Finally, there are increasing numbers of CYP with Medically Unexplained Symptoms. By working closely with the medical team, a psychological assessment can help staff and CYPF to develop an alternative narrative for symptoms, drawing on a bio-psycho-social model. This serves not only to reduce unnecessary further testing but also introduces the idea that psychological factors play a role in maintaining their symptoms, thereby helping the CYPF gain control and return to normal functioning.

'Stefan' is a 14-year-old with Ehlers-Danlos Syndrome, which affects connective tissues and some organs. During one year, he presented 61 times to A&E with partial dislocations, and tens of times to each of the medical specialties whose care he was under. He was referred to a paediatric clinical psychologist who helped him make sense of when the dislocations occurred, what factors in his early experience and current situation played a part in his presentation, and to develop coping skills. Within four sessions he was back at school full time; six months on he had no further admissions to A&E.

Specialist help for highly complex needs

Timely access to specialist intervention: When clinical psychologists are embedded in, or closely linked to, the medical MDT a '**whole systems approach**' can be developed, providing preventative interventions and improving access through timely assessment and intervention on the ward or in clinic. Moreover, embedding a psychologist in the team reduces any stigma associated with accessing support. Presenting problems can be understood as a normal response to CYP's experience, treatment or condition and the whole team can support a therapeutic intervention.

There is a rapidly growing evidence base for the efficiency and effectiveness of psychological interventions in paediatric populations such as Cognitive Behavioural Therapy (CBT), Motivational Interviewing, Family Therapy, and Acceptance and Commitment Therapy

(BPS, 2009; NHS Education for Scotland, 2012, 2015; Spirito & Kazak, 2006, and <http://www.societyofpediatricpsychology.org/evidence>). Their impact can also save money across the local, regional and national health services by addressing adherence issues, reducing demands on services (for example, when CYPF are anxious about their condition or where anxiety symptoms mimic or exacerbate medical symptoms) and reducing the need for unnecessary treatment or investigations. Furthermore, NICE promote a number of therapies for the treatment of anxiety, depression, behavioural difficulties and PTSD, all of which can co-occur with long term conditions or hospitalisation. These interventions include CBT, Parent Training and Systemic Therapy. Although much of the research is with physically healthy populations, these interventions also have utility and efficacy in paediatric settings (Fonagy, 2015).

'Amina' is 16-years-old with multiple Arteriovenous Malformations (AVMs) problems with blood flow. She has a 10-year history of increasing social anxiety and social isolation. Amina has a distinctive appearance and needs to manage curious questions and teasing from others, in addition to comments about her religion and culture. She has missed school due to multiple surgical procedures and so has had limited opportunities to socialise. Her family is socially isolated within their community. Amina now doesn't recognise faces (prosopagnosia) and her surgeon needs to check for cerebral AVM. Prosopagnosia is also likely to contribute to social anxiety. If cerebral AVM is diagnosed then this may have implications for life expectancy and/or deteriorating neuropsychological function. A culturally sensitive assessment, including neuropsychology, and psychological intervention, was required in order to develop a psychological formulation to point to an intervention plan.

Assessment of risk; for example, a young person with diabetes can self-harm by manipulating their insulin, resulting in frequent hospitalisation and intensive care. A child undergoing potentially life-saving, but painful treatment with multiple side effects might (understandably) refuse treatment.

'Paula', aged 15, has Leukaemia; her parents are divorced and argue constantly. Paula's 13-year-old sister has started to self-harm. Paula won't get out of the car at the hospital, refusing chemotherapy. The Oncologist wants to sedate her and is talking to legal services.

A referral is made to clinical psychology to assess the situation, provide a holistic formulation and make recommendations about interventions. A treatment package is designed which can both assist the treating team with their care plan and also support the family to improve their communication and relationships, develop parenting strategies to keep the girls safe, provide positive coping strategies for managing procedural distress, and help Paula to explore her feelings and choices.

Providing containment at times of great anguish also forms part of the specialist inter-vention for the most distressed and vulnerable CYP and families, and supports front line staff in their role. When a child or YP's life is threatened it is important to take account of the very personal, potentially religious, existential and spiritual aspects of the despair and anguish this engenders. The focus here is in 'being with' rather than 'doing to' and takes a very skilled practitioner. Through modelling, teaching and consultation, this knowledge and skill can be disseminated to the wider staff team, who can support CYPF and triage more complex presentations.

Core components of a psychological approach

One of the crucial over-riding principles is taking a '**whole child and whole family approach**', and patient-centred approach (*Future in Mind*, 2014; Healthcare Quality Strategy for NHS Scotland, 2010; Getting It Right For Every Child (GIRFEC), 2009). Children and young people with a long-term condition are children first, with their own unique interests, needs, hopes and aspirations.

Assessment

In the physical health settings, a thorough assessment takes into account bio-psycho-social and treatment factors in the development and maintenance of the presenting problem and explores strengths, motivation and coping strategies in both the individual CYP and their family. For example:

Parenting and family factors – parenting capacity and style, plus inter-generational attachment issues. Nature of the family; for example, two parent household, single parent, step-family with shared care of the child, and foster or adoptive parents, availability of extended family members for support, and the quality of relationships.

Social factors – the child and family’s culture, religion, spiritual beliefs, economic situation, school, college and work context, extended family and neighbourhood support. Sexuality factors are also considered if relevant.

Psychological factors – CYPF’s previous experiences of hospital and illness, levels of stress/distress, anxiety, low mood, ability to tolerate change and ambiguity, cope with setbacks, their health beliefs and attitudes, coping strategies, locus of control, ability to articulate/assert concerns, and developmental stage of child and family. The young person’s and parents’ level of understanding (and wish to know or not) about their condition and prognosis.

Biological factors – impact of the illness on the child’s mobility and independent living skills, and/or cognitive functioning; the physical and mental health of other family members.

Condition-related factors – prognosis and predicted course (e.g. progressive loss of mobility), nature of treatment which could be painful and traumatic, anticipated surgery, and frequent hospitalisations, complex medical regimens.

Wider system factors – for example, relationships with medical team, experience of communication and mutual understanding across professional networks including health, education and social care.

The assessment can include the use of standardised questionnaires such as anxiety or self-esteem scales. It can also involve a neuropsychological/cognitive assessment to determine whether a child or young person’s presentation or behaviour is due to impaired function in systems such as attention, memory, perception or impulse control.

Formulation

Taking a holistic view as described above and carefully listening to the uniqueness of the child and family can in itself be therapeutic and allows everyone to take stock in a context which often only focuses on the latest physical symptom. Collaboratively considering these interacting factors leads to a shared psychological formulation of the difficulties, which draws on psychological theory and research and provides a number of hypotheses and treatment options. These can be shared with the MDT, where appropriate, to promote a shared understanding and intervention. Making sense of the interplay between psychological and physical wellbeing normalises the experience and gives CYPF a sense of control over the condition. The hypotheses proposed can be tested and a reformulation of the difficulties are shared as situations change and develop.

Within agreed boundaries of confidentiality, this coherent psychological explanation can: help the CYPF

feel understood and contained; encourage collaborative work and consistent team approaches; challenge unfounded beliefs; reduce negative staff perceptions; and minimise disagreement and blame within and between teams, thus increasing understanding, empathy and reflection.

‘No one has ever understood me before... (crying).

I can see there are reasons why I feel the way I do and why I’m so afraid, I’m not crazy.’

A young woman’s experience of a formulation.

Psychological formulations offer coherent psychological explanations of the presenting difficulties, in multiple contexts. Rather than reducing a person’s experience to a category, or diagnosis, a psychological formulation functions to communicate the complexity of their difficulties in an understandable way (Mason, 2014).

Intervention and treatment plans

One of the biggest challenges for practitioners working in medical settings is that, due to time constraints (a clinic visit or inpatient stay), they may have to assess, formulate and treat a presenting difficulty within a single session. It takes a very skilled and experienced practitioner to do this competently.

Responding to fear and anguish

Attending to the often existential/spiritual aspects of life threatening illnesses or physical trauma is a key element. The profound fear, anguish and guilt of all family members needs to be acknowledged in a contained way. There are a number of potentially helpful models, including: Acceptance and Commitment Therapy (ACT), Mentalisation, Compassionate Mindfulness and psychodynamically informed psychotherapy. Being trained to work across the life span is crucial, in order that parental distress and despair can be given a voice within a family based approach. Staff responses to the CYPF’s distress need to be processed to facilitate compassionate care.

‘Some people’s lives are long novels. My child’s life is a short story with just as much meaning.’

Responding to emotional disturbance

Psychological interventions to support young people live with their condition or potentially disfiguring trauma is important to prevent additional distress or disability. Regardless of which medical speciality they inhabit, the emotional and psychological response is similar (Fonagy et al., 2015) and there is good evidence that psychological treatments are effective.

'Alice', aged 13, has idiopathic chronic pain syndrome, frequently attends her GP, paediatrician and local A&E. There is no medical treatment for her disability. She has stopped going to school, has limited mobility, disrupted sleep, panic attacks and low mood. Her mother has given up work to look after her and the whole family has adapted to her disability.

The intervention helped Alice learn psychological methods to tolerate her pain, and recognise psychosocial triggers which intensified her pain experience. Anxiety management and self-hypnosis resulted in better sleep, and liaising with her school facilitated her return, initially on a part-time basis.

With additional training and ongoing supervision from the psychological service, **front line staff** (e.g. Nurse Specialists, Physiotherapists and Play Specialists) can deliver some psychological interventions based on Cognitive Behaviour Therapy (CBT) and basic counselling. These approaches include: problem solving, goal planning, anxiety management techniques, psycho-education and good listening skills. Gaining psychological knowledge enhances staff roles and promotes ongoing positive relationships with their patients. These professionals are often best placed to deliver an intervention.

'Michael', aged 6, has recently been diagnosed with an aggressive form of Juvenile Arthritis requiring weekly Methotrexate injections and monthly blood tests. Every time, it takes over two hours for him to have his injections. Michael is frightened. He screams and struggles. His mother becomes upset and tearful while his father gets angry. The Play Specialist requests a consultation from psychology. Following detailed observation of the process, the psychologist advised Michael, his parents and staff on how to approach the procedure to minimise anxiety and trauma. Michael left proudly with his bravery sticker and his parents left feeling more confident.

Embedding and co-locating psychological services within the medical/surgical MDT is recommended in a growing number of NHS England service specifications. Working together facilitates indirect psychological interventions as described above, ensures appropriate governance of psychological treatments and enables triaging of referrals for complex psychological interventions, ensuring efficient and effective use of psychological resources.

Responding to neurological changes

It is important to recognise that neurological changes (caused by, for example, RTA, smoke inhalation, chemotherapy, tumours, multiple surgery, acute illness and progressive neurological conditions) can impact on cognitive ability, personality and behaviour. The effects may develop over time and long-term follow-up is often required. Neuro-psychological (psychometric) assessments, alongside full psychological investigation, can assist the child, family and school to identify significant changes due to neurological impairment. Psychologically informed interventions can be developed to include both the family and school, aimed at improving function to help the CYP achieve their full potential. With an individual learning programme at school and psychological support at home the CYP's experience can be positive.

'Now I understand my child's memory problems and how to help him. I don't blame him or myself for some of his behaviour; it's to do with brain injury... he still needs boundaries though.'

Some specialist centres are developing pathways to address this need. However, lack of resources often means that these vulnerable children do not receive specialist assessments. Misunderstanding of their presentation at school and at home may negatively impact on their relationships, learning and self-esteem.

Responding to behavioural challenges including parenting and sibling work

Many children (with or without physical health difficulties) communicate their distress through their behaviour. Families and parents may find it hard to be consistent with a child with physical health needs or who is potentially dying. Acknowledging parental fear and worry as well as encouraging consistency, boundaries, and routine is important. NICE guidelines refer to various parenting programmes which, if adapted for this setting, can provide guidance. Given the unpredictable nature of chronic conditions, it is unlikely that parents will attend weekly groups so interventions need to be adapted to their needs. Work with individual parents, couples and the extended family can help develop both a consistent and caring approach to managing behaviour.

CYP's distressing or disruptive behaviour on the ward can put themselves or others at risk, for example, pulling at their central line or hitting out at staff. Managing this behaviour needs to be informed by a psychological formulation of the difficulty, so that the CYP is helped to express their desperation in more adaptive ways, and a defined group of key staff along with parents can agree and provide a consistent approach.

Brothers and sisters are often separated from one or both parents for periods of time, while their sick sibling is in hospital. Research indicates that they are often very distressed, experiencing feelings of loss, frustration, anxiety, post-traumatic stress and jealousy. The experience can also have a maturing effect and siblings are sometimes rated as more pro-social than their peers. Distressed siblings should be offered individual or group work before their difficulties become entrenched.

Risk assessment and self-harm

Sometimes distress becomes overwhelming, either relating to the enduring demands of the condition, or associated experiences such as bullying or social exclusion. The young person might self-harm using their condition as a vehicle, for example, manipulating insulin in diabetes, or not adhering to dietary restrictions in renal disease. Risk assessment and psychological formulation informs the intervention with the individual young person, family, medical team and school. This can reduce psychological distress and prevent potentially serious physical consequences of non-adherence and self-harm. A good psychological service will work jointly with the wider mental health system to provide continuity for the CYPF and manage risk where there is a psychiatric presentation in the CYP or parent.

Enhancing complex decision making

Often difficult complex decisions are necessary, for example, potentially life-saving but risky surgery. A psychological approach is crucial, taking account of the child's developmental stage and level of understanding, the parents' perspective and working alongside medical staff; considering all perspectives to ensure agreement with the decision whatever the outcome. Medical staff can benefit from a confidential space to explore their thoughts and feelings formally or informally. Being able to 'off-load' to an experienced clinical psychologist promotes resilience and the medical leader remains resilient, which impacts on the whole team.

For children on long-term pathways (e.g. Cleft palate repair), the psychologist often facilitates discussions with young people about whether they want further elective surgery. This can involve systemic (family therapy) approaches to managing differences of opinion between parents, the medical team and the YP.

Responding to adult mental health

Children look to their parents to gauge their emotional response and contain their own feelings. It is important, therefore, that psychological care extends to parents experiencing clinically significant levels of anxiety and low mood, including PTSD symptoms. Psycho-socially skilled services anticipate this and

provide information and reassurance. If symptoms emerge, psychological treatments address the symptoms and improve coping, thereby improving family wellbeing and long term mental health.

'My daughter has always been a bit shy and awkward, and a bit of a worrier, so I was worried when my grandson became ill that she wouldn't cope. It's good she has support too.'

Ensuring continuation of psychological care

While many tertiary/specialist hospitals have well established paediatric psychology services, follow-up care to maintain progress can be challenging for those CYPF living some distance from the specialist centre. It is important, therefore, to ensure their psychological care continues, either provided by locally-based community or DGH services and/or from the tertiary hospital using telephone calls and video conferencing. There are also internet-based approaches referred to earlier.

Schools are crucial in the wellbeing of children. It is now a legal requirement for schools to support children with medical conditions, both physically and psychologically (Supporting Pupils at School with Medical Conditions, Dept. of Education, 2014; Additional Support for Learning Act Scotland, 2009). Advocacy for the CYP may be necessary to ensure this occurs.

Too often there is no local appropriate psychological service when the child is discharged from, or lives a long way from, a tertiary paediatric centre. Despite national policies and drivers recognising the need for psychological care embedded within physical care ('no health without mental health'), there is disparate and patchy provision of locally-based paediatric psychology services across the UK. This results in **many children and families having no service at all**.

Some of the challenges at local level for this group of CYPF include the increased referral threshold for many CAMHS, not wishing to access a 'mental health' service with its accompanying stigma and mental health record, CAMHS clinic-based mental health clinicians rarely having experience of their medical condition, and a lack of continuity with the CYPs' medical teams.

Outcome monitoring (PROMS PREMS)

A good paediatric psychology service will demonstrate that psychological treatment outcomes are developed in collaboration with the CYPF. These Patient Reported Outcomes take the form of goals, unique to each CYPF and can change over the course of treatment. For some, these may include psychological and behavioural changes such as: being able to understand and tolerate their distress, developing coping strategies for pain management or procedural anxiety, or a more realistic understanding of their condition, and increased

communication within the family. Outcomes may also include concrete changes such as improved blood results for diabetes, fewer hospital admissions or being able to participate more in normal life.

Some goals can be monitored by standardised questionnaires, for example, to evaluate quality of life, self-esteem, anxiety, PTSD symptoms or low mood. These can provide useful feedback to CYPFs as an adjunct to their self-determined goals.

Sometimes the goal might not be to achieve change. For the family the goal could be to talk and be with each other in a developmentally sensitive manner when their child's prognosis is poor and death is imminent.

The CYPF's experience of psychological intervention is crucial and is itself an outcome. Research continues to demonstrate that the therapeutic relationship is key. **Patient Reported Experience Measures (PREMS)** reflect the quality of the experience; and how understood and respected CYPF's felt. In short, was the clinician sufficiently compassionate, qualified and experienced to provide a sense of containment and safety?

'...really helpful service much needed in long-term situations where your life completely changes.' (Mother)

Many services use the **Experience of Service Questionnaire (ESQ)** which has different sections for children, young people and parents. In addition to answering set questions there is an open-ended section for further comment and advice. Feedback helps services improve and adapt.

'I was listened to and she helps me calm down when I'm panicking.' (9-year-old child)

Finally, it is also important to monitor the outcomes of interventions provided by front line staff, and their experience of supervision and consultation.

Helping the whole service work as well as possible

In order to help the whole service work as well as possible a number of key factors are fundamental.

Listening to CYPFs is fundamental to the whole service working well. Feedback about direct therapeutic interventions, as well as from Children's and Parent's forums or councils should inform service policy, development and co-ordination, thereby improving the patient experience. For example, Kennedy (2010) recommended that CYPF should not have to repeat their 'story' and should have better access to co-ordinated pathways and programmes of care with various appointments in the same place, on the same day.

Accountable leadership at a sufficiently senior level (e.g. Consultant Clinical Psychologist) is required to champion psychological care at the highest level across the organisation or network. This leader should be responsible for the governance of a Paediatric Psychology Service of psychological practitioners, providing psychological care embedded within various medical specialties.

Governance systems to support and monitor psychological care provided by front line staff as well as psychologically qualified staff. Recruitment of appropriately qualified practitioners to provide a skills mix across a broad range of competencies ensures quality. For example, Children's Congenital Heart Services Psychology Standards (BPS, 2013).

Research, evaluation and audit: Research, evaluation and audit in health care settings is informed by psychological theory and the evidence base. Collaboration between medical/nursing researchers, patient participation groups and clinical psychologists can further inform service delivery. For example, a psychological service that takes the evidence that CYPF with visible difference experience bullying and teasing could provide proactive groups to help CYP practice social and emotional coping skills, thereby improving adjustment in the longer term.

Evidencing the cost/savings benefit: In addition to the human cost, there is a clear economic argument for good psychological services; psychological intervention in pain management is a helpful example. Pain significantly impacts on quality of life and brings considerable economic cost for both families and health services alike. Slead et al. (2005) calculated the mean treatment cost per adolescent with chronic pain to be £8000, amounting to a national economic burden of adolescent pain of approximately £3840 million in one year! There is a strong evidence base for the effectiveness of psychological therapies in chronic pain (Eccleston et al., 2014; Fisher et al., 2014), either working alongside medical and physiotherapy interventions or, in the case of medically unexplained pain, on its own.

Conclusions

Most tertiary paediatric centres in the UK have long established psychological services departments led by clinical psychologists, integrated into medical or surgical teams. This is often required to achieve specialist centre status (e.g. Oncology) or Best Practice Tariff (e.g. Diabetes or CF). The evidence-based success of these services is no doubt reflected in the growing number of NHS England commissioning documents and Scottish National Strategies that specify clinical psychology as part of a medical/surgical team. However, this does not apply to all medical conditions and has led to a serious inequality in access to psycho-

logical support. A further issue is that there are only a small number of community-based paediatric psychology teams and some services are only provided on a sessional basis by CAMHS psychologists, which means that highly complex, face-to-face psychological interventions are frequently privileged over preventa-

tive work and consultation. Close working with **commissioners** at local and regional levels to develop **integrated services** across hospital and community settings would deliver **efficiencies and significant savings** in the health economy as listed below.

Outcomes of addressing psychological needs.

- **Improved adherence to treatment** = shorter and fewer hospital stays, reduced risk of morbidity and mortality.
- **Individualised preparation for surgery/ medical procedure** = less anxiety, faster recovery and improves patient flow.
- **Psychological pain management** = less anxiety, less reliance on medication, faster recovery, earlier discharge.
- **Identifying cognitive changes** = better understanding, rehabilitation, behaviour management and education plans plus evaluation of the impact of treatment (e.g. brain tumours, radio and/or chemotherapy).
- **Prevention/reduction in PTSD** due to trauma of injury or repeated (necessary) treatment = better long-term mental health for child and parents.
- **Early intervention for very vulnerable families** = improved adherence, improved physical and psychological health and the development of positive health behaviours.
- **Psychological support for complex decision-making** in relation to surgical and medical interventions = CYPF fully participating in their own health treatment.
- **Psychologically trained and supervised MDT** = broad-based psychological interventions, delivered to more families, leading to fewer referrals for complex therapy.
- **Well supported staff** = better able to care, therefore fewer complaints and increased compassionate working practices.

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Working with whole communities: Delivering community psychology approaches with children, young people and families

Laura Casale, Sally Zlotowitz & Olive Moloney

Summary:

What does 'good' look like in psychological services for children and young people in which a community psychological approach is utilised?

- *A service which at its core is driven by the values of social justice and transformational change using evidence-based and practice-based research.*
- *A service that proactively addresses the multiple levels that impact on the mental health of children and young people in its design, delivery and evaluation, from the individual through to the community and wider social context.*
- *A service that works with local communities, and particularly those from excluded groups, to define challenges and needs and co-produce solutions.*
- *A service in which practitioners and community members are empowered to create transformational social change to prevent future distress and exclusion; this may require developing learning practices and governance that enable this.*
- *A service that build alliances and networks to share learning and approaches.*
- *A service which works to have a positive impact on the most vulnerable and marginalised young people in society.*

Introduction

This paper considers the role of community psychology in providing for the needs of children and young people in our communities. This paper will attempt to explain how this approach might look, and share experiences of applying it to services for children and young people in the UK. The details of service planning, delivery and evaluation will be outlined and some key challenges explored. Many commissioners, mental health service staff and other readers will already be familiar with what is described throughout this paper, others may want to introduce steps in this direction. We have, therefore, tried to provide examples across a continuum. This includes examples for those who are interested in introducing small-scale community psychology practice into existing services, those who want to develop multi-level community psychology practice in existing services and those who are interested in developing new services and systems using a community psychology approach. For any point on the continuum the long-term goal of incorporating more of this practice is to increase community capacity and reduce the high demand for more traditional reactive services.

The World Health Organization name 'social, cultural, economic, political and environmental factors such as national policies, social protection, standards of living, working conditions, and community support' as some of the *key determinants* of mental ill health (WHO, 2014). Yet most UK mental health services focus on working with the individual, their family or school systems. Many clinical psychologists and other clini-

cians have become concerned that whilst being well-meaning in intentions and actions, they are working as part of a system which maintains, or makes little difference to these wider community and societal determinants of health, which could have a bigger impact on wellbeing (e.g. Kagan, 2008). Recent UK health care policy has responded to this concern by calling for an increase in prevention and public health services; for example the recent NHS Five Years Forward report (2014) called for '*a radical upgrade in prevention and public health*' in order to deliver better '*future health for millions of children, sustainability of the NHS, and the economic prosperity of Britain*', a sentiment echoed by the recent taskforce on Child and Adolescent Mental Health (DH, 2015). Community psychology is increasingly being turned to as a way of shaping our services to address these factors and within the field of clinical psychology this approach is becoming increasingly recognised and promoted (e.g. BPS, 2011).

What is community psychology and why is it relevant?

'It is no measure of health to be well adjusted to a profoundly sick society.'

Jiddu Krishnamurti

Community psychology is a field of psychology concerned with understanding people in their social context and how wider structural and societal arrangements impact on people's health and wellbeing. One useful definition of community psychology proposed by experienced practitioners in the UK is:

‘It is “community” psychology because it emphasises a level of analysis and intervention other than the individual and their immediate interpersonal context. It is community “psychology” because it is nevertheless concerned with how people feel, think, experience and act as they work together, resisting oppression and struggling to create a better world.’ (Burton et al., 2007, p.219)

At the heart of the approach is understanding how forces such as oppression, discrimination, exclusion, powerlessness and inequality impact on human experience. Community psychology is, therefore, explicitly value-led with social justice as a core value (e.g. Orford, 1992). Community psychology is action-orientated, working in partnership with marginalised, vulnerable and disempowered groups (Prilleltensky, Nelson & Peirson, 2001). Interventions aim to change the conditions and systems that produce oppressive and disempowering experiences which contribute to distress (Fryer, 2004; Kagan & Burton, 2001). Because of this, it is worth emphasising that community psychology is not simply psychology practiced in more community-type settings. The focus of the work moves from individual or family-focused talking therapies towards preventative and community-led change.

Community psychology services often reflect an asset-focused approach. In practice this means that services would look for resources at all levels of a system which could both protect against possible negative outcomes and promote wellbeing (Glasgow Centre for Population Health Briefing Paper 9, 2011). The emphasis is on balancing the two aspects of work (meeting current needs and nurturing strengths and resources) in order to improve quality of life, whilst also working to address the structural causes of health inequalities.

The pictures below are the outcome of a small community psychology interaction. They were drawn by a young person with impressive artistic skills together with a professional artist. With the authors of the paper they developed the pictures to demonstrate the transition from traditional practice (picture 1) to that which includes more context yet remains clinic-focused and reactive (picture 2) and finally to a community psychology approach where therapist and client work together with local community members in a way that creates change for both the young person and the community (picture 3). Both artists were paid for their time and the young person was pleased to be given the opportunity to work with an experienced artist. In return the authors were given artwork which provides an alternative method of communicating some of the ideas in this paper.

There are three key reasons why shifts towards this approach are necessary at this time. The first is because services need to continually consider the impact of

social context and, therefore, be able to intervene at wider system levels. Rogers and Pilgrim (2003) argue that the current approach of *‘individual diagnosis and treatment... disconnects personal problems from the social contexts in which they arise’* (p.99). It is known that poor mental health and wellbeing is consistently and markedly associated with indicators of social context, such as levels of unemployment, inequality and low income (Melzer, Fryers & Jenkins, 2004; WHO, 2014). Services that additionally intervene at this level of context can, therefore, have a greater impact on poor mental health, as with public health approaches.

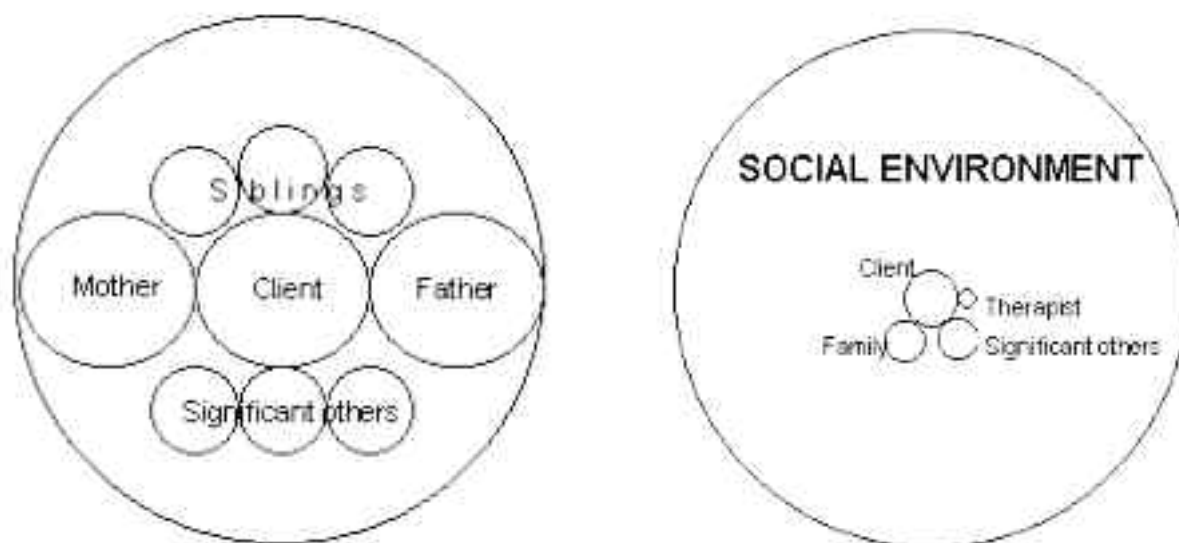
The second is because services benefit from being more accessible, appealing, asset-focused and non-stigmatising. It is well recognised that there is differential levels of access to statutory CAMH services in the UK. More specifically, there is under-representation of certain excluded groups within lower tier mental health services and over-representation of BME groups within inpatient secure services (Care Quality Commission, 2011; Keating, 2007; Rogers & Pilgrim, 2002). Research has demonstrated that adolescents are particularly reluctant help-seekers of conventional services and even more so if they are part of marginalised groups (e.g. Oetzel & Scherer, 2003). Stigma, mistrust, lack of flexibility, unknown professionals and requirements such as needing a GP or having a fixed abode can all partly explain why some services can be ‘hard-to-reach’ (Flanagan & Hancock, 2010; CAMHS review, Fountain, Patel & Buffin, 2007). Even those services which attempt to engage the community differently, such as parenting programmes, can struggle to engage with some groups. Mothers reporting greater stress from life events, families at greater socio-economic disadvantage, teenage mothers or mothers from ethnic minorities have higher drop-out rates from parenting groups (e.g. Kazdin, 1990; Lavigne & Cameron, 1990). However, as the ‘Better Beginnings’ programme described below illustrates, often barriers to engagement can be improved by community-led and co-production approaches.

The third is so that services can become increasingly proactive, preventative and financially sustainable. In the recent social context of austerity in the UK evidence suggests that mental health problems are increasing in line with increasing inequality, whilst funding for services is in real terms reducing (McGrath, Griffin & Mundy, 2015). Community provisions for issues such as domestic violence have been reduced, potentially increasing mental distress for the future (McGrath, Griffin & Mundy, 2015). There is, therefore, increasing pressure to create services that reduce health and social inequalities and thus demand on services. This is also a major commissioning priority for Clinical Commissioning Groups and Local Authorities because of the

Figure 1: The transition from traditional to community practice.



Figure 2: A Change in Perspective
(Smail, 1999).



Health and Social Care Act 2012 that places a legal duty on CCGs to tackle health inequalities. Commissioners will be aware of the call to action by NHS England (2013) that highlights the many benefits and needs for preventative services.

Core components of a community psychology approach

'Rise up with me against the organisation of misery.'

Pablo Neruda

Within community psychology, assessment, formulation and evaluation can all form part of the intervention, so this is a somewhat arbitrary distinction. However, we have separated the core components according to these categories so it is recognisable in practice. There is a growing evidence base for the core components outlined below, for example, the NICE Guidelines for Community Engagement (2008) provide recommendations about how to reach out to communities and be more inclusive. One recommendation, for example, is that services should *'identify and change practices that can exclude or discriminate against certain sectors of the community, for example, short-term funding, organisational style and timing of meetings'*.

(a) Core features of a community psychology approach

1. Intervenes at multiple levels.
2. Partnership-builds and co-produces.
3. Asset-focused.
4. Involves 'conscientisation' and liberatory practice.
 - Conscientisation is a social concept that focuses on achieving an in-depth understanding of the world, leading to a better awareness and

exposure of perceived social and political contradictions and injustice.

- Liberatory Practice is any practice that works against oppression.
5. Value-led, for example, social justice, stewardship.
 6. Preventative.
 7. Transformative through social change.
 8. Driven by participatory action research.

For further details we refer the reader to Kagan et al. (2011); Nelson and Prilleltensky (2010); and Orford (2008).

(b) Assessment and formulation

David Smail (1999) suggests that we must *'switch our "clinical gaze" from the individual to the individual's world'* (see Figure 2 above) and notice the enormous impact of the wider social environment, beyond the school and family. The clinician joins with the child, young person or group to identify the needs in their social environment and support the development of possible solutions. Community members become co-producers of services and interventions, because those with lived experience offer unique and important knowledge to shape solutions. Indeed, a useful statement to emphasise this throughout the approach is, *'nothing about us without us'* (Charlton, 1998); which reminds us that the approach relies on including the 'bottom-up approach' of community collaboration and co-production of solutions at all stages. These processes both encourage social context change but are, in and of themselves, interventions that improve psychological wellbeing. They do so by positively impacting on feelings of helplessness and hopelessness; the process empowers and enables the individual or family to become agents of

change partly and allows people to take a different perspective on their difficulties. This new 'gaze' means that clinicians meaningfully *'incorporate societal and cultural factors in their formulations'* (BPS, 2010), including the wider context of social inequalities and power (Miller & McClelland, 2006). To do this, community psychology approaches often apply the Ecological Systems framework of Bronfenbrenner (1979) to assessment and formulation, in which an individual is understood as developing in the context of all levels of their system, ranging from the micro-system (e.g. the child's home) through to the macro-system (e.g. the economic system). Other frameworks which are useful are Burton and Kagan's socio-economic formulation (2008) and Nelson and Prilleltensky's personal, relational and collective level framework (2010).

There are various approaches, tools and methods, which are easily available and support community psychology assessments and formulations. These include action research, community audits, mappings and walks, power mapping, stakeholder analyses and suggested guiding questions. For further details we would recommend the following references: Hagan and Smail (1997); Kagan et al., 2011; and Scott-Villiers, Scott-Villiers and Wilson (2012), as well as the websites www.photovoice.org/lookout-uk/ and www.rootsandshoots.org/mapping among others.

Stages of the assessment process (e.g. topics to cover in assessment, measures used, recording responses, and letters to referrer) include community-level items as standard. Young people and their networks have forums for co-designing and providing feedback on what outcome measures to use.

(c) Intervention and evaluation

Collective interventions are often created together as an outcome of assessing and formulating according to the frameworks above. An example of a collective level intervention is provided in Kagan et al. (2011, p.191), in which they describe 'The Federation of Local Supported Living Groups'. This group was formed by groups of parents who became aware, through facilitated dialogue with community psychologists, that the systems around them limited their children's hopes and life chances through structures and social attitudes. Then aware of their disempowerment, together parents formed alliances in north-west England and designed, innovated and planned new forms of support for their children with learning disabilities (Morris, 2002). As this example demonstrates, access to employment, welfare, community networks and secure housing is crucial to wellbeing for all children, young people and families (e.g. Fryer & McCormack, 2013; Marmot, 2010); these are areas of intervention for services.

The process of dialogue described above is an essential tool emerging from the concept of 'conscientisation', in which there is the development of critical consciousness about the impact of societal arrangements on wellbeing (Nelson & Prilleltensky, 2010). Conscientisation shifts the dominant discourse from 'you are to blame for your circumstances and you must individually solve your problems with my expert help' to 'certain social arrangements maintain particular groups in powerful and powerless positions, so let's act together to change them'. By necessity, this changes the role of a clinician. An example of this is given by Sue Holland, who developed the 'social action model of psychotherapy' (Holland, 1992). Working alongside single mothers from a housing estate in London who were struggling with psychological difficulties, Holland formulated the impact of social and economic conditions on their experience. Much like the work of Brown and Harris (1978), Holland and the group actively identified the social determinants of their wellbeing and then created a pathway from individual treatment to socio-political action. Women moved through a path from 'patients on pills', to one-to-one psychological therapy, to group sessions and finally collective social action on issues such as the state of their housing.

As with public health practice, evaluating interventions can be challenging for a variety of reasons. In particular when intervening at a community or policy level, change is cumulative and can be difficult to identify, it can take time to show across different levels of a community, and it is not always possible to attribute change to a particular intervention or variable. In line with these challenges, questionnaire evaluations may be rejected by community psychologists as insufficient, on the grounds that they often reflect the needs of the service more than its users, especially with excluded groups who may not want to complete such measures. In community psychology evaluations, the subjective is embraced through action research and is led by the community. As Fryer (2003) writes, *'most community psychologists... try to develop and use research methods which engage with others' subjective experience and which allow them to use their own subjectivity as a resource, rather than to exclude it as a liability'*. This philosophical difference in how research is performed, moving to *'research with'* rather than *'research on'*, is a core tension for services to face. Examples below adopt evaluations that sit along a continuum of conventional to community psychology approaches, often incorporating both.

Examples in practice

Below are some examples of community psychology practice which demonstrate some of the core components described above:

(a) MAC-UK, UK

The 'Integrate' approach was developed by the charity MAC-UK in partnership with excluded young people facing multiple challenges in the community. The flexibility of the approach means that everything is an opportunity for young people to participate in and try to create change for themselves and their community. To engage with the young people, practitioners initially partnered with local community gatekeepers and spent time in the community.

The staff team includes experts by experience who can be graduates of the MAC-UK projects. The project works across levels. For example, at the personal level staff engage in 'street therapy' discussions around young people's use of cannabis for relief of depression. They support young people to set up and lead interest groups for peers, and use motivational interviewing to discuss young people's decision-making processes. At a relational level staff have supported young people to actively engage in youth-led activities, worked with young people to improve communication between their professional networks or have co-led training sessions for related organisations or professionals. At a collective level staff have supported a young person to lead an action group for preventing the closure of a local youth centre, have used guidance from young people to lobby government to improve statutory health provision for excluded young people and have developed relationships with local health and wellbeing boards to improve health provision for young people.

An evaluation of the above approach to engaging young people (e.g. those involved in gangs) who find conventional psychological services 'hard-to-reach', found it had psychological benefits across multiple levels (Zlotowitz, 2010). The Integrate approach is now widely acclaimed at a national policy level within the UK, including within the recent CAMHS Taskforce report (DH, 2015). Further evaluations of the approach are from external partners, The Centre for Mental Health. The Integrate Movement is a sister organisation to MAC-UK, established to take the learning from this approach to facilitate transformation of statutory services to more holistically meet the needs of excluded young people.

(b) Define Normal, UK

Social change can be effective at a small scale and local level. For instance, psychologists Danny Taggart and Wendy Franks, in partnership with young people from an inpatient mental health unit, co-produced an experiential training exercise for mental health professions (Taggart & Define Normal Project Team, 2011). The project was entitled 'Define Normal' and the team created a drama piece demonstrating the experience of what being diagnosed with a mental health problem is

like from the young people's perspective. It allowed staff they trained to gain a new perspective on the lived experience of feeling judged, stigmatised, confused and harmed by the mental health system, with the aim of changing aspects of the way services work.

(c) Better Beginnings, Canada

Internationally, there are examples of evidence-based multilevel interventions. Better Beginnings (Worton et al., 2014) aims to promote healthy child and family development in socially deprived communities. It is based on the principles of being community-led, holistic, integrated and universally available. Improved outcomes included fewer childhood behavioural problems, increased participation in the community, increased access to local services and neighbourhood satisfaction. Each step has involved families within their communities and has shown to be a cost effective approach. It is now a highly recommended approach by UNESCO.

(d) Youth Action Research for Prevention (YARP), USA

YARP (Berg et al., 2009) is a facilitated youth-led intervention with excluded young people to try and reduce drug and sexual health risk. Through action research processes, groups of excluded young people explored their community and group identity. They devised interventions at the group and community level including developing their own social action on issues important to them (e.g. within school and with local policy-makers). Using sophisticated multi-method research methods, this multi-level and conscientising approach demonstrated beneficial outcomes for individuals and an increase in collective efficacy, as well as transformational changes that would prevent adolescent health risks.

Key issues and complexities

With the introduction or development of community psychology practice there are a variety of issues that can arise. We have outlined a few which appear to present most often, with responses collected from those working in community psychology services.

(a) It can be hard to hold on to a community psychology approach particularly with current service/structural pressures and constraints, and some services find themselves continuing the same traditional practice just in a different location. Responses to this include:

- Develop a network of people who between them are enthusiastic and knowledgeable about this approach and who care about the community you are considering. They can work in your direct community or you can connect with the wider community online to share ideas.

- Find ways of joining with others who share the views and aims of this approach such as the BPS Community Psychology Section, and use online internet platforms for further resources and networks (see www.communitypsychologyuk.ning.com).
- Have local community members, and ideally young local people, as core members of this approach as early as possible (ideally through paid employment); they express perspectives not considered, carry great influence in promoting changes in services and keep the team focused.
- Working in this way engages communities and harnesses their capacity to solve problems and mobilise resources that would otherwise not be available.

(b) It is a challenge to work at multiple levels simultaneously and to plan for prevention rather than react to need. This is particularly the case during periods of increased demand and financial cuts when services can find themselves overwhelmed with responding to the increased demand for individual work and with little space to think proactively. The systems in place (such as IT databases and risk policies) are also often set up to support this approach and make it more challenging to shift to a community psychology approach. Responses to this challenge include:

- Include each level in a service's strategy and return to the strategy regularly. Adapt administrative tools and policies to support the strategy. For example, IT systems might be non-diagnostic, outcome measures could record wider community and systems change, and risk policies might be balanced towards taking community-informed defensible risks.
- Give clear responsibilities to members of the team to encourage focus at different levels. For example, a member of staff could be appointed as keyworker for the community and another could be responsible for community relationship building or policy-level work. Empower those staff to work alongside members of the community to identify responses to challenges.
- Develop structures that promote this work (i.e. community mapping meetings, budget time allocated to be in the community, salaries for community members).

(c) Supporting wider societal change through social action can be within the remit of a community psychological service. However, it raises questions as to how mental health services and staff adapt to this approach. For example, at the BPS Community Psychology Section Festival in November 2014, campaigners from the Focus E15 Mothers campaign (www.focusE15.org) spoke about their experiences as social activists who

brought the UK's social housing crisis to the public's attention. Questions which arose after included how, and why, should psychologists become involved in their campaign or wider housing crisis issues? How can the tools, resources and knowledge of psychology be used to support the transformation of the social and material causes of distress? How can we join alongside such campaigns and groups in a wanted and useful way as psychologists? In this example the community psychology perspective sees social injustice as directly linked to mental ill-health. Therefore, by supporting the community to fight injustice and inequality, psychologists are applying psychological knowledge to improve health on a large, community scale rather than on a small, individual scale. These are questions psychologists and others involved in reducing psychological distress will continue to discuss in the future.

(d) Finally, meaningful community member involvement (including employment of members) may reduce the need for, or power of, professional staff. This poses a challenge to those at all levels of a service who will need to overcome professional and personal interest issues to enable services to draw on different forms of knowledge to develop responsive, locally-relevant solutions. Psychologists are often considered to be a useful resource, possibly due to being trained to be adept at holding different roles and multiple perspectives, as well as being able to conduct robust evaluations and audits, all of which are useful for this approach. Smail (1998) suggests that psychologists use '*...a relevant, critical, empirical knowledge base to try to make sense of our clients' distress, formulate its causes, measure attempts at change, calculate the possibilities of prevention as well as "cure" and provide explanations where neither proves possible*'. However, community psychologists acknowledge that they must question the need for their profession and involvement as much as every other staff member. The importance is to apply knowledge to do what works, rather than keep existing structures that may now be ineffective.

Helping the whole system

The Department of Health produced guidelines on community engagement (2010). Their Five Elements of Community Engagement Model outlines what is required for a whole service approach:

1. **Grassroots and community work:** Defining the need from the ground up: As described earlier in the paper, community psychology services place an emphasis on working with communities to co-define challenges and co-produce solutions to these.
2. **Community infrastructure:** Community psychology approaches recognise the importance of commissioners, statutory and non-statutory organisations and residents building connections across a commu-

nity. This improvement in infrastructure can have many positive effects, including improved information sharing, facilitated learning and increased efficiency by reducing repetition of work and increasing joint action on common initiatives.

3. **Professional infrastructure:** Community psychology services invite commissioners to consider who is needed to support a service to achieve its goals and to draw on the whole community for potential resource. Experience and local knowledge are valued as much as mainstream qualifications, with the knowledge that this has led to highly effective services elsewhere. The NHS Five Year Forward View (NHS England, 2014) asks us to harness the *'renewable energy represented by patients and communities'*. It explicates the need to *'engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services'*.
4. **Organisation development:** Leadership enabling change: The infrastructure of an organisation can enable or disable its capacity for growth, change, evolution, and transformative work. Services which adopt community psychology approaches must have the processes, strategies and leadership in place to enable meaningful community engagement, and have clear mechanisms so that findings can influence the development of services. Governance is as important in a community-led project as in any other, and there may be different ideas to work through to come to shared understandings of boundaries, safety and service practices.
5. **Overview and co-ordination:** Different areas need to be inter-dependent and mutually inter-connected in an effective, strategic approach to community engagement. Each element may involve different people or 'teams' (virtual or real) leading or co-ordinating, often based in different parts of an organisation, in different sectors, and/or community-based. As such, integrated commissioning plays a key part across public health, mental health, justice and social care to take a preventative approach to mental health. This is crucial if community engagement is to be systematic and planned, rather than ad hoc and only impacting on small-scale change.

Below are examples of how to implement these elements in practice. They include key elements of any service provision, such as supervision, identifying need, staffing, service user involvement, the promotion of knowledge and awareness, and evaluation. We have made suggestions across a continuum of service development as discussed in the introduction.

Stage One – Introducing community psychology practice

- Joint Strategic Needs Assessments are conducted across Local Authorities and Clinical Commis-

sioning Groups. Commissioners engage directly on the ground with the community of local people. The community including commissioners then organise themselves around issues that matter to them. Once needs and gaps are identified, this may lead to the development of new groups to address these issues.

- Population-based approaches to needs analyses are completed, and lead to more specific geographical or problem-focused targeted services to enable access to resources (e.g. Gender Identity Clinics; Learning Disabilities; Supported Accommodation system).
- Communities engage with mental health services through networks that are represented by different community groups, such as service-user groups and spiritual groups. These networks can be rich in resources, and have a huge influence on communities.
- Commissioners are clear with educators and employers about the need to change their policies and selection processes to ensure that a wide range of skills and experiences are being sought out and developed, to competently work within a broad range of communities.
- Young people and their families are meaningfully involved in recruitment, training and appraisal of staff.
- Services employ people in lead roles for youth participation, community engagement or social equality. Job descriptions might set out roles as developing, enabling and supporting the workforce in these areas.
- Supervision is viewed as core to safe working with communities and includes social, economic and political contexts.
- Services engage with each other to enhance understanding and service provision with communities.
- Staff meetings include regular community resource updates so all staff are aware of what is available locally for young people and families. They also include the sharing of local and community changes, for example, new local and national government policies, opportunities or resource changes which impact on the service and its users.

Stage Two – Further developing community psychology practice

- Assessment includes analysis of the general population needs and the local population level needs. Needs are approached at cross-borough levels and through prevention and early intervention services.
- Record systems are designed to capture patterns of referrals, that is, from particular referrers, schools, related to the same issue (such as online bullying). Regular audits then identify these patterns, which can be used to direct areas of community-level work.

- Community psychology assessment tools are utilised, that is, community walks and mapping, both to understand local issues and identify/develop the means to respond to these effectively.
 - Community-led needs analysis or petitioning about issues that matter to the community influences the policy and practice of organisations and services, even if they do not appear to be 'about' mental health directly.
 - At the point of service commissioning, a key strategic goal is *how the service will reduce the demand or need for that service over time* (Boyle, 2014).
 - All roles have job descriptions and contracts that outline the responsibilities of all workers for community and youth participation.
 - Alternative philosophical approaches to identifying and addressing needs within and by communities are explored in training, as well as political values, to support the development of this level of awareness in thinking and practice.
 - Youth participation is embedded throughout the system through a variety of processes. Services involve users on their board and directorships, creating space for voices to be heard in a shared decision making process. Organisations invite users to strategic or operational partnerships to steer the direction of their work.
 - Organisations question their commitments to transforming social situations impacted by austerity measures, and stand behind their political ideals.
 - Leadership provides a collaborative ethos where managers and service leads give permission to staff and users of services to take leadership positions, to be innovative, to engage in service development, to work alongside people who use services and to co-create projects.
- Stage Three – Engaging in community psychology practice**
- Communities organise themselves into groups or initiatives based on the identities and needs of their own communities. Commissioners support these community-led initiatives by engaging and resourcing these groups in line with their own key outcomes.
 - Community work is led, developed and delivered by communities. This is enabled by trust, empowerment and facilitation from commissioners and professionals.
 - A workforce is willing to genuinely learn from and value other forms of knowledge, to be willing to handover power, act with humility, to take one-down position of non-expert in multiple domains, alongside having its own valuable skills and knowledges to offer.
 - Professionals consider the language of dependency and acknowledge that services staffed and led solely by professional staff create environments in which staff have a vested interest in the continuation of the services, to meet their own needs for salaries, pensions, purpose, stability and identity affirmation.
 - Staff join with communities in their communities, and engage with their political values in their work, in order to further the health of the communities they work with.
 - Services are framed as spaces for interdependent collaboration, in which creative thinking, helping and help-seeking are more related on a continuum. They are seen as a space in which both professionals and service users are facilitators for community transformation.
 - Services are successful if they embed their skills in the community and are no longer needed after a period of time. This might require staff to see service users as assets within their service, to work with users to facilitate their working towards qualifications or gaining experience that means they can take up these roles. This cultural shift moves beyond gestures towards youth participation, to young people that services learn from and employ.
 - Roles are less defined and developed to begin with, grow and evolve as the service evolves, and can be based on interests and strengths. Different people can take up roles that are seen to be necessary and useful; people share workloads and practices despite having designated areas of practice, in a 'we are all in it together' culture.
 - Services engage with the tension inherent in sharing psychological understanding and knowledges, and the potential to privilege this understanding above other experiences or knowledge bases.
 - Training and induction of staff occurs in the local community resources and spaces, includes the culture of the community as a topic, and is led both by staff and service users.
 - Supervision of both staff and service users who are involved in the work of a service remains a core and protected practice in order to maintain perspective on the power operating in the work, on the implementation of values and principles, on language and its implications and impact, and in sharing psychology in politically useful ways as defined by the community.
 - Appraisals include the voices of the community in services' work and development.
 - Organisations share their ideas, success, mistakes, and learning with others through virtual or physical learning networks.

Examples of whole service approaches to community psychology

The below examples further illustrate the ideas shared above.

Minding the Gap, UK

A Borough in London has established a service partnership working group, where partners from all sectors have joined with young people to develop and design new services for children and young people across the transition age of 16 to 25, to better meet the needs of the communities in which they reside and participate.

The King's Fund Leadership Programme, UK

The King's Fund, a health and social care policy think-tank, has recently launched a leadership programme which must be attended by a 'clinical leader' and 'patient leader' from each service. Its aim is to teach these partners how they could meaningfully lead in a collaborative manner and to develop their skills to do so. Services who sign up to the programme are, therefore, required to send a clinical/medical leader and a patient leader together. See <http://www.kingsfund.org.uk/leadership/leading-collaboratively-patients-and-communities> for further details.

Conclusion

In the words of a World Health Organization report on mental health: '*...levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice*' (Friedl, 2009, p.111). Conceptualising mental health in this way may seem relatively far away from our current statutory mental health system. However, we are far from alone in advocating that mental health professionals move towards this way of working. Again the World Health Organization (2014) makes the point well: '*In countries around the world, a shift of emphasis is needed towards preventing common mental disorders such as anxiety and depression by action on the social determinants of health, as well as improving treatment of existing conditions.*

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Action is needed as many of the causes and triggers of mental disorder lie in social, economic, and political spheres – in the conditions of daily life.'

This is not typically an easy journey, as it asks people to take different positions than they may be used to, to do things differently, to question their own values in relation to their work, perhaps to move from working with people who are deemed in need of help, to working together with people, recognising the part everyone in a community can play in transformational change.

Services can help by being more community-led, empowering staff and service users alike, leading their work together towards a path of transformational change. We believe that community psychology offers the tools and values to create this shift and we invite you to be part of the collective leadership required to make the transition.

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Delivering psychological services for children and families in Early Years mental health and emotional wellbeing settings

Michael Galbraith, Robin Balbernie & Caroline White

Summary:

Good psychological services for families with babies and preschool children will:

- *Have good connections with antenatal services to support the identification and referral of families where there is a lack of positive relationship with baby in utero, and to support maternity services in managing the emotional processes in pregnancy and birth.*
- *Have strong working relationships with health visiting, child care and social care services to share expertise at considering the social and emotional needs of babies and toddlers.*
- *Provide a range of interventions (with individual families and groups, helping parents process past relational trauma and connect with their baby), always with a focus on the relationship with baby, using video feedback and behavioural interventions amongst others, taking the family's cultural background into account.*
- *Have accessible services offered in children's centres and families' homes.*
- *Have ways of evaluating services according to professional and service user perspectives, and including parents' views in service development and delivery.*

Introduction

There have been several reports and papers highlighting the value and need for Early Years services recently (Allen, 2011; Allen & Duncan Smith, 2008; Conception to age 2 years – the age of opportunity, 1001 Critical Days Manifesto, NSPCC, 2011). Collectively these papers make the case for early intervention starting early in the life of the child and not just early in the life of the problem. Perhaps so-called Early Intervention services for adolescents and adults could be called Rapid Reaction services.

The purpose of this paper is not to review the evidence and arguments about whether to spend money on Early Years services. It is assumed this is a vital thing to do. This paper suggests some principles and structures that may be helpful in designing and developing services for families with babies and toddlers.

This paper is not a literature review for particular interventions, but will refer to other reviews (principally by NICE and the Healthy Child Programme). Interestingly, NICE guidelines regarding parenting groups comes under the heading of preventing and treating anti-social and conduct disorder (CG158) and refers to children aged 3- to 11-years-old. Parenting of younger children comes under 'Social and emotional wellbeing of vulnerable children under the age of 5' (PH40) which focuses on the role of midwives and health visitors, but does say that they should 'work in partnership with other early years practitioners to ensure that families receive co-ordinated support'.

In this paper, 'Early Years services' will be taken to mean mental health and emotional wellbeing services who work with families with children under the age of 5 years from conception.

However specific commissioning advice for perinatal aspects; pregnancy and early postpartum are contained in Perinatal Clinical Psychology: A briefing paper for NHS Commissioners (2015) produced by the Perinatal Clinical Psychology Faculty and now under consideration by the BPS¹.

Considering the 'organisational contexts' in which teams and Early Years services exist, the single biggest revolution in Early Years services occurred in 1998 with the setting up and development of Sure Start local programmes (Glass, 1999). The initial programmes had four bold aims:

- to help families support their child's development in three areas –
 - physical,
 - learning/cognitive, and
 - social-emotional,
- and fourthly to strengthen families and communities.

Sure Start local programmes brought together teams of people (some qualified by training, others experts by experience) whom had either not worked together before, or hadn't been based together before, for example, community parents, nursery staff, health visitors, midwives, teachers, speech and language thera-

¹ A copy of this draft guidance can be obtained from pauline.slade@liverpool.ac.uk

pists, psychologists and psychotherapists. This allowed a 'progressive universal' type of service that was less stigmatising for families and for professionals as access was based on where you lived, not how vulnerable/risky you were.

One gap from Sure Start local programmes and Children's Centres is the involvement of adult mental health. The provision of family mental health services that comprehensively address the needs of all family members remains elusive. This model of multi-expertise (by training and by experience), locally based within communities, low threshold, high-endurance (for sticking with families) remains the benchmark for Early Years services. The original Sure Start local programmes suffered from significant variation between programmes (related to their local responsiveness) which made them very difficult to evaluate, and in some cases a lack of professional specialisms (i.e. staff with higher formal qualifications). Currently there is a parallel trend within general Child and Adolescent Mental Health Services (CAMHS) to employ staff with less experience and fewer or no specialist qualifications, presumably as a cost cutting measure. This seems to miss the point that if mental health really is everybody's business then in any area there are thousands of child mental health workers... teachers, midwives, health visitors, GPs, social workers and adult mental health staff to name a few. So to be effective in making a difference, child and adolescent mental health staff need to bring something additional and different to the table. Otherwise we end up with the paradox of unqualified and totally inexperienced staff offering consultations to teachers with 20 years' experience of doing pastoral work.

In terms of who has 'additional difference' within Early Years services there are a number of options. We will make the point throughout this paper that the work in this age range is relational. It focuses on the relationship between carers and babies. It tries to do this through the medium of the relationship between the worker and the family. It helps family systems to recover and move on from past emotional-relational traumas (which sometimes happened so early in someone's life they cannot be recalled consciously but play out in the intensity of early parenthood). Three professional trainings fit this requirement.

- Systemic psychotherapists specialise in working with families but have tended to focus on families with adolescents. The recent leaning within systemic practice towards narrative models that may emphasis more rational and semantic models of change may be less suited to parent-infant work. Some systemic psychotherapists may have less of a grounding in child development according to their original training.

- Parent-infant psychotherapists (who will usually be from a child psychotherapy or clinical psychology background) have specific training in working with this population. Those from a child psychotherapy background may have less experience of adult mental health work and working with parents and children with learning/developmental disabilities.
- Clinical psychologists have the benefit of a core training that spans all age and ability ranges, integrating neuropsychological understandings into therapeutic models. Some psychologists will have had a more systemic training and some will have done early years work as a specialist placement. Clinical psychologists also bring skills of research, evaluation and psychometric assessment.

Early Years developmental stages and demands on parents and services

This main section will be divided into four age-related parts. In each part we will outline:

- some of the developmental tasks and achievements connected with that age range;
- challenges that these tasks bring to services;
- issues of diversity and accessibility;
- participation practices;
- recommended interventions;
- a proposal for service structures with this age range.

Stage

Antenatal – Conception to birth – Growing and being

Developmental tasks and demands

The developmental 'task' of the unborn baby is to grow as fully and in as healthy a way as possible. To do this almost all babies are completely dependent on their mother's behaviour (the rare exceptions being where babies receive medical treatment in utero). The most obvious demands this puts on expectant mothers (and less directly on dads/their partners too) are regarding diet, exercise, alcohol and cigarette consumption and managing stress. These are all aspects of healthy lifestyle choices common to all age ranges – but what is intensified in pregnancy are the effects of some people (mum, dad and those around mum) on the child. The behaviour of parents and significant others is affected by their beliefs, feelings and attitudes to the pregnancy and to the baby. In other words their relationship with baby in utero.

Challenges to services

The challenges at this stage concern issues of identification for both parents and professionals, and service responsiveness.

Pregnancy begins the process of earlier experiences/beliefs/scripts/internal working models being

activated in parents, especially pregnant mums. If your experience of being parented was not good or you are feeling negative or critical of yourself generally then the prospect of becoming a parent can be daunting and in some cases overwhelmingly anxiety provoking. Some parents cope with this by denying the pregnancy, either partially or entirely. If you deny being pregnant or the impact you have on your baby then there is no reason to change your behaviour to meet the baby's needs.

The challenge for services is to identify families where relationship with baby in utero is poor when these services are very physically health focussed. One way of tackling this is to offer training to maternity services (parental services?) on the social and emotional aspects of conception, pregnancy, birth and early parenthood, and on risk factors like teenage pregnancy, poverty and domestic violence. Ideally this should be followed up by reflective practice sessions to help staff put theory into practice and practice into theory, and most importantly to provide a space for them to reflect on their own emotional processes in relation to the work (Morrell et al., 2009).

The challenge for Early Years services is to find ways of engaging parents who were not looking for a service – and quickly. Very rarely do parents look for psychological support for their relationship with baby in utero, more often it is someone else (midwife, children's centre worker or perhaps GP) who suggests there may be a need. The first task in meeting a family is, therefore, to engage them and see if they have any concerns or goals that fit with Early Years services. The usual fears about children being taken into care if a parent says how they are feeling may be around, but also the wishful thinking that maybe this is just a passing phase with pregnancy and everything will be okay when the baby is born (see O'Donnell et al. [2014] for evidence of long-term effects of prenatal maternal mood).

Issues of diversity and accessibility

Conception (especially a first pregnancy) is a milestone in an adult's life. Henceforth they will always be a parent. As well as the 'ghosts and angels' in the nursery (being revisited by unresolved emotional processes from one's own infancy), there are also the socio-cultural factors – reproduction as the fulfilment of individual roles and/or of a marriage/partnership, the growth and expansion of a family/community, the double edged issue of increased resource/ economic demands initially which might lead to more security in the future, to name a few. The meaning of the pregnancy may be highly dependent on the characteristics of the child (i.e. regarding gender, appearance, physical abilities or 'intelligence'), and reflects the social context of the parent(s). Taken together these factors

mean it is not possible to put a single unitary value on 'becoming pregnant'. Same-sex couples have probably overcome additional obstacles to become pregnant (e.g. limited access to NHS fertility services) and so may be additionally nervous about the loss of a pregnancy.

The diversity in the meaning of conception is mirrored in the habits and practices in pregnancy. How pregnant women are expected to behave, and how they are cared for antenatally differs hugely from one country, and one culture, to another.

A key difference with this developmental stage is that there is less of a 'captive audience', that is, parents may be working and not allowed time off work for more appointments on top of those for their physical health care needs. For this reason many maternity and children's centre services run antenatal classes in the evening, which may be unusual for mental health and emotional wellbeing services, but increasingly required in a 24/7 NHS.

At a very practical level, services need to take into account the reduced mobility of mum, especially in the latter stages of pregnancy (particularly with twins or more, or if there are complications like pelvic pain). The need for services that are accessible to parents with physical or sensory disabilities remains as significant as ever, but may be complicated by parents themselves adapting to ever changing physical demands.

Participation practices

The major challenge in this age range is the small, moving window of time to identify, engage and work with parents antenatally, and then include them in participation work. There are three ways of addressing this issue. Firstly it emphasises the need for everyday practice to be participative – what are this individual family's goals and what support do they want, from whom, in working towards them? Participation can take many forms from checking with families about how a meeting is going, to having the involvement of parents and young people (and children as far as possible) involved in the design, development, evaluation and delivery of services. Both are necessary and useful – and at this stage participation embedded in day-to-day practice is more feasible than separate participation meetings.

The second way of tackling the problem of having such a transient antenatal client group is to include parents who were in contact with the service in pregnancy and have now had their child. These parents can reflect on their needs and wishes in pregnancy and their recent experience of the service. Obviously as time goes by their views of the antenatal EYMHEW service becomes increasingly out of date (but if they are still receiving a service their focus may turn to participation in relation to that part of the service).

The third approach to doing participation work is to link with other groups who also have an interest in this developmental period, one example being the local Maternity Services Liaison Committee. Another possibility is a steering group with parent representatives attached to Children's Centres. These parents could give views on the likely acceptability and usefulness of plans and processes, although they might not have first-hand experience of the actual service being delivered.

Interventions

Antenatal preparation for parenthood programmes

'Antenatal programmes that focus on the transition to parenthood in high-risk couples and aim to alleviate pressures on the couple's relationship are effective in reducing relationship deterioration and strengthening parenting roles after the birth of a first child. The strongest effect is for home-based interventions for couples with multiple difficulties, so since they are expensive they are recommended as part of a stepped care approach (i.e. moving from practice-based assessment and advice to more intensive support).' (Healthy Child Programme, p.21).

See Table 1 for parenting programmes that work with parents in the antenatal period.

Note in particular the Family Nurse Partnership programme (Olds, 2013) which has a particularly strong evidence base for use with a vulnerable population (teenage parents) through intensive manualised work over a prolonged period by highly trained staff.

Service structures that help or hinder

A recurring theme in this subsection is going to be service structures which protect time to do work with each developmental stage. Parents and maternity services have not previously made many referrals for psychological and emotional work in pregnancy, partly due to low awareness of these needs and partly due to the lack of availability of services. Considerable ground-work needs to be done building links and lines of communication with people and services who are seeing parents in pregnancy.

Where an Early Years antenatal service is based, both physically and organisationally, symbolises some of the dilemmas in the work itself. Being based within a maternity service may facilitate contact with midwives, although many antenatal services are being moved out of hospitals and into the community. An Early Years psychology focused service could follow suit and be based in community/primary care settings, facilitating co-ordination with GP's and Health Visitors as well. Organisationally, an alternative to being part of a foundation trust is to be based within a third sector/charitable/social enterprise organisation,

Regarding the work itself (training frontline staff, offering consultation, running groups with parents and seeing particular families), a range of professional backgrounds and qualifications may be suitable. Core competencies include: an ability to understand the developmental needs of the baby and the family, an ability to think about and work with the family in their social and cultural context, similarly being able to think and work with staff in their organisational context, and the ability to contain a range of feelings related to the fundamental experiences of giving birth and being born (and sometimes also dying). These competencies are held by clinical psychologists, systemic psychotherapists and parent-infant psychotherapists. Given the likelihood of working remotely in multi-agency contexts, experience and seniority is required.

Stage

Aged 0 to 1 year – Being, connecting and doing

Developmental tasks and demands

David Attenborough was recently asked what he thinks is the most remarkable creature on earth and he said 'a 9-month-old human infant – because of their capacity for learning'. As the field of epigenetics is demonstrating, babies soak up experiences and these become the connections in their developing brains. And in order to try to ensure that they receive the appropriate levels of stimulation and protection, babies first of all make an attachment with their carer(s). Just as parents need to keep babies in a 'goldilocks zone' of temperature, not too hot and not too cold, so they need to do the same in terms of stimulation and arousal, not too excited/stressed and not too bored/neglected. For parents the demands of the first six months can feel all consuming – indeed it has been argued that an obsession with baby by the primary care giver is normal and healthy (Winnicott, 1956). Certainly parents can feel like they are in a 'babyhood bubble', in a cycle of feeding, winding, changing, sleeping and playing. Some parents (especially those who have had no contact with babies, or who like being in control of their own lives, or who don't feel that they have any control in their lives) can find these demands overwhelming – 'this isn't what I signed up for'.

Between six and 12 months of a baby's life the emphasis changes to what they can do and to some extent what they can explore. Cognitive, physical and social development interact with one another, so advances in the motor control that allows babies to sit up, look around, reach for and grab things also allows the testing out of ideas like object permanence (objects, including people, continue to exist even when you can't see them), and the nature of relationships, for example, how many times will a parent retrieve a toy

that I drop over the side of my high-chair? Weaning often happens in this period (or at least is suggested by the World Health Organization) with issues of who gets to choose what baby eats, how, when and how much. This symbolises some of the recurrent dilemmas and challenges of parenthood – how to recognise that baby (child, adolescent or adult) has moved on to a different stage, and how to facilitate their autonomy while staying connected in a supportive way.

Challenges to services

Some of the challenges in this period carry over from pregnancy – other people may perceive a problem/difficulty in the parent-baby relationship when the parents don't. Early Years services need to support frontline services to recognise these problems and share concerns with parents in a way that parents feel cared for and not criticised. There then need to be good enough relationships between professionals that frontline services can introduce families to Early Years teams.

In many ways Early Years services are dependent on the quality of the relationship that frontline services have with families – if families are not connected to these services they won't identify difficulties and make the introductions for more in-depth work. Changes in both midwifery and child health services (and sometimes in General Practice) are relevant in this regard. Some services have moved to 'corporate caseloads' where the next available member of staff picks up the next case that needs to be seen, whether they have seen them before or not. This is a significant change to the principle of continuity where a professional would get to know a family over many meetings (and sometimes over several children, or even two or more generations). Early Years may be able to offer reflective practice at a strategic level about the emotional drivers towards more 'avoidant' service structures (that de-emphasise relationships) to put alongside the economic and business drivers.

Maintaining a focus on the parental relationships with baby can be difficult but is vital. Work in this stage often involves identifying and exorcising the 'ghosts in the nursery' (Fraiberg, Adelson & Shapiro, 1975) – those memories and feelings from parents' own childhoods (and more recent experiences) that are brought flooding back by the arrival of a baby. These ghosts distort how parents see their baby – so parents end up reacting to their own unresolved past rather than to the real baby in front of them. Early Years services need to help parents process these past experiences to the extent that they are disrupting the relationship with baby. Parents may also want or need more help with these unresolved traumas from their past than an Early

Years service can provide – so the service should also help parents identify alternative sources of therapy or support.

Issues of diversity and accessibility

Families with small children find it harder to get to appointments, have more appointments to get to (peak times of use of the NHS in life-cycle are in infancy and in older age) and have more illnesses as well. Services who operate a 'two strikes (missed appointments) and you're out (discharged)' policy will effectively get rid of families with babies. Careful consideration needs to be given about how far families are expected to travel to appointments – perhaps look at how easy it is for one parent to bring a baby and a toddler to an appointment by public transport. Services might decide that it is more appropriate for professionals to travel to the family, or offer a service within 'pram pushing distance' of families. This raises issues like pram access and storage, baby changing facilities and breastfeeding friendly spaces.

How a baby's arrival is celebrated and supported by parents and their wider systems varies widely from one culture to another, for example, some mums are waited on and encouraged to rest, while others are left to be with baby by themselves for extended 'bonding' time. The arrival of a baby will highlight moves in the family, especially if parents are now separated from their own parents (especially their mothers) cutting off inter-generational support and guidance. This cut-off-ness is compounded if there are significant differences between a parent's culture of origin and the culture that they are now living in. One basic difference is the individualism of Western industrialised countries versus the collectivism of less-industrialised, closer to the land (often southern hemisphere) countries (Triandis et al., 1988). Services need to be sensitive to the additional stress that families who have undergone migration are under, cultural assumptions (e.g. regarding sleeping arrangements, weaning practices) and what other sources of support and community there are for families without a local network.

Participation practices

Families in this stage may have been in contact with Early Years services since pregnancy, allowing time to build relationships and engage in participation activities. At least some (all?) of these activities need to be baby friendly – fun things for families with young children to do – at which conversations about how to improve services can take place. Babies and their parents don't tend to do committee meetings or focus groups!

Interventions

See Table 1 for parenting interventions.

Baby massage

'There is no evidence to support the use of infant massage on a population basis, but some evidence to support its use with disadvantaged and depressed mothers of babies' (Health Child Programme, p.22).

Video feedback

There is good evidence to suggest that video-feedback and Video-feedback Intervention to promote Positive Parenting (VIPP) can improve parental sensitivity and improve secure attachment. There is also evidence of improvement in both internalising and externalising problems in older children. VIPP can also improve emotional availability, child behaviour, and family environment. There is also evidence of improved attachment security in highly (but not moderately) irritable infants (Healthy Child Programme, p.22).

Other interventions listed by the Healthy Child Programme with less evidence at present are: mentalisation-based programmes; home visiting programmes; sensitivity-focused interventions for pre-term infants; and parent-infant psychotherapy.

Service structures that help or hinder

The obvious place for Early Years services to be based is within Children's Centres, as they are intended to be the hubs for services for preschool children. Whether the clinicians in Early Years teams would be employed by the organisations who run the centres (typically local authority or third sector companies) may depend on whether their time could be ring-fenced for doing the prevention/early intervention work that is needed.

The work with families with a child aged 0 to 1 year is inherently systemic. It is always about the relationship and family context in which the child is living and developing. The trainings that cover this kind of approach in most detail are systemic psychotherapy and parent-infant psychotherapy. Some of the programmes that are used in this age range, for example, ViG and baby massage and the parenting programmes, do not require a particular professional qualification and following suitable training and supervision can be delivered by staff from non-clinical backgrounds and also experts by experience. However, it is vital to have staff who can engage, assess, formulate/hypothesise with families about a wide range of experiences, forms of distress and coping strategies – partly to help identify which families will benefit from which kinds of intervention and what to do when an intervention hasn't worked as hoped. Trainings which provide these skills include clinical psychology in addition to those mentioned above. Given that the work is on, with and

through relationships, there is no need for medical approaches.

Stage

1 to 2 years of age – Doing, exploring and socialising – Growing selfhood and pseudo-independence – Growing freedom within safe limits

Developmental tasks and demands

If the first year of life is about making emotional connections with loved and loving ones, then the second year is about using these to extend one's social network and understanding of the world. The inter-lacing of development across areas (physical, cognitive, social and emotional) continues in an increased way. Babies are often crawling by one year of age and by 18-months-old most are walking. This opens up new worlds to them in terms of where and what they can explore, and their closeness to other people. Parents need to adjust to toddlers getting into everything. For some parents this is a difficult transition as it needs them to encourage their child to go and explore as well as to welcome them back at times of anxiety.

Babies' language is usually blossoming at this time – more so if the child has had a rich exposure to language so far. With this growing language (mostly receptive language initially) the child is able to develop shared understandings which are more particular than the earlier 'emotional tone communication'.

Challenges to services

As babies turn into toddlers and start to test their independence and individuality, some parents may start to say 'there is something wrong with my child'. The 'wrongness' may be described as naughtiness, stubbornness or ADHD. So parents start to self-identify, albeit in a way that Early Years services might put differently. The challenge is, therefore, to find ways of connecting with these parents, validating their feelings and their wish for things to be different without colluding with pathologising young children.

The pattern of who is in contact with the families of one year olds starts to shift. There are fewer scheduled visits with health visitors (unless they have concerns). More children in this age range will be in nursery and some families will be making regular use of children's centre services. GPs may also become aware of situations when parents present with stress and related complaints. Having close links with this growing number of frontline services becomes increasingly difficult – although the co-location of services or appointments may at least help to keep professionals in each other's minds. Having clear information about what an Early Years service offers for referrers and families

becomes increasingly important, as is clarity about referral pathways and processes.

A third challenge to services working with 1- to 2-year-olds is how to include them meaningfully and appropriately in the therapeutic work. They need a different range of toys and also an adapted approach – the work is still relational between the parent and the toddler, but some of the conversations that one could have in front of a baby about the parents ‘ghosts’ become more difficult in the presence of a more verbally able child. For this reason some work may be done without the child present, or when they are present is more focussed on the here-and-now.

Issues of diversity and accessibility

As children grow from 1 to 2 years of age, differences in parenting styles between cultural groups are highlighted. What is safe (and normal) in one culture is not in another (and is disapproved of), and vice versa. How much and how far to allow children to roam and explore depends on parents’ perception of risk and this varies culturally. A stark illustration of this comes in relation to corporal punishment/smacking – parents may use it as an attempt to rapidly change children’s behaviour, and in contexts where there are significant physical dangers to children this may (possibly) be most efficient. However, when used in a UK context where there are generally fewer physical dangers it is discouraged and may be seen as abusive. Not knowing what the expectations are in terms of child-rearing, health care and education may make recently arrived families vulnerable to criticism and, ultimately, safeguarding processes. Early Years services may have a role in helping families from other backgrounds know what the norms are before problems arise.

Participation practices

On top of the participation principles mentioned previously, consideration should also be given (for all age ranges) to families who are not in contact with the service but for whom it might be suitable. In the past these families might have been called ‘hard to reach’ (or for whom services are inaccessible). The issue here is that if you only ask people who are using the service how easy it is to reach and use, you will only hear from those that have successfully done that. Again it may be possible to make contact through services and structures that have more connections with a particular group, or one off events (e.g. World Mental Health Day) may give the chance to talk with a cross section of the population.

Interventions

See Table 1.

Parenting programmes

A review of targeted self-administered programmes for parents of children aged 2 years found that self-administered programmes led to outcomes similar to those achieved with more intensive therapist input. The evidence supports the use of targeted group-based parenting programmes to improve the emotional and behavioural adjustment of children aged 0 to 3 years and reduce conduct problems in that age group. The relative effectiveness of different parenting programmes (e.g. group-based versus self-administered) requires more research (Healthy Child Programme, p.25).

Service structures that help or hinder

Early Years services for 1- to 2-year-olds need to have a number of paths to their front door, which services need to establish and maintain. These lead from Health Visitors, GPs, Children’s Centres, various child-care providers and ideally from parents themselves. Services may fear being swamped if they open the doors to families referring themselves. Experience suggests that in this age range this doesn’t happen, and when parents do self-refer it demonstrates they are ready and willing to engage in reviewing their situation.

This age range may also particularly benefit from information and access points online. For parents who are online (which is, of course, not all) web browsers and internet forums may be the ‘friend’ that they turn to if they have a query, concern or crisis with their toddler. These virtual friends are available 24 hours a day, are anonymous and confidential, and have ‘peer-validity’. So making links between these online ‘parent-toddler groups’ and Early Years services is also important. Whether web-based information and advice about parenting makes a difference to what parents do with their children and their relationships remains to be seen – arguably the way to help repair and develop healthier relationships requires work through a relationship with a sensitive person.

There remains a need at this age range for staff who can assess and formulate with whole families, and who can provide training, consultation and supervision of frontline and Early Years staff from a broad psychological knowledge base. Suitable qualifications remain clinical psychology, systemic and parent-infant psychotherapy. There is also an increasing opportunity for a diversity of staff, staff trained in one or two approaches rather than having wider qualifications, as the problems that families are managing are more likely to have been visible for a while, so more open to single ‘modality’ interventions.

Stage

2 to 5 years of age – Socialising and refining understandings – ‘Why?’ – Inter-family relationships

Developmental tasks and demands

Development in the range of 2 to 5 years obviously builds on what has gone before, not least of all in terms of the explosion of social skills (e.g. theory of mind) following on from the social and emotional development in earlier stages. A combination of empathy and theory of mind underpins many of our social skills not just in childhood but also in adulthood. This stage also covers a huge growth in cognitive development. The leapfrogging in terms of language and conceptual development that began aged 1 to 2 years takes off in this period in a fluid and creative way. Physically, children refine their gross and fine motor skills. Children tend to achieve continence in this period, although a significant minority (usually boys) don't, to the disappointment of educational settings.

The demands that children aged 2 to 5 years bring are an intensification of the tension between the desire for autonomy and freedom on the one hand and the wish and need for comfort, help and guidance on the other. On average 3-year-old children are more aggressive than at any other time in life, and 2-year-olds can incline towards non-compliance. Obviously this is a challenge for care-givers and how it is managed can set a pattern for future development. Educational practices can reflect this dynamic from teacher led instruction (which starts sooner in this country than in other industrialised ones) to child-centred play. Parents can also experience this tension, becoming tired of their children's attempts to find things out for themselves and tired of offering help and supervision. It is also the stage where some developmental concerns may arise if a child is struggling with language, social relationships or learning, which may need assessment.

Challenges to services

Children in the 2 to 5 years range are easier to find than younger children as most will be spending at least some of the time in nursery (in the current UK context). The task then becomes to work with nursery staff on: how they invite parents to share concerns with staff, how nursery staff spot children showing distress or whose development (especially social-emotional) is delayed or uneven, how they work with the child and parent(s) to try to improve this, and how to refer on to Early Years services for those families where there are ongoing concerns.

There will be some children who don't attend nursery, or where families do not want to share concerns with nursery staff – other routes to specialist help need to remain open, principally through the GP.

In some ways the 2 to 5 years age range is 'late early intervention'. If there are difficulties, either in terms of a parent's feelings or behaviour towards a child, or in terms of an unusual pattern of development, this may have been going on for at least a couple of years, and the child will have been going down a particular developmental pathway. In a way it is now too late for primary prevention (Rapoport, 1961), that is, stopping a problem ever occurring. But secondary prevention (reducing the recurrence of a problem) is much easier at this stage than in subsequent years. The challenge for services, therefore, is to 'gee themselves up' to work with families as fully as possible, even though the child may be showing lots of signs of intergenerational patterns and there may be a temptation in some places to wait and see how things turn out in the future... 'maybe things will get better when they go to school'.

Issues of diversity and accessibility

As children deepen their social skills and their social world they are exposed to more of the culture(s) that they live in, and are expected to reflect that culture back to the adults in care-taking roles. This can lead to significant conflict (at least in the child's head) if the culture at home is different to that in nursery. For example, British nurseries encourage children from an early age to develop self-care skills; washing their hands, putting shoes on and feeding themselves. This makes sense in a context of having a high ratio of children to adults. In other cultures doing these kinds of care tasks for children is a sign of love and commitment to the child – expecting or even allowing them to do these things for themselves could be experienced as neglectful or shameful. Early Years services may end up in the role of arbitrator between what child-care settings see as 'normal' and a family's own values.

Most children are born into households with both parents (84 per cent – Office of National Statistics, 2013). As time passes more parents separate and children may live between two homes, or at least have contact with a non-resident parent. This poses a major challenge to services. Each parent is entitled to a service in their own right, and neither can veto the possibility of the other receiving therapy/support. How far should services try to contact and engage the second parent if the first doesn't want to have joint sessions but is happy for the service to contact them? Services need to strive to be accessible to both parents, when this doesn't contravene a parent's right to confidentiality.

Participation practices

Given the larger age range being considered in this section it is easier to complete a full spectrum of participation activities, including parental involvement in the delivery of services as well as the evaluation and

redesign of services. As for other kinds of participation work, parents will need support to participate meaningfully in service delivery, making sure that they are clear and comfortable in the role they are undertaking, alongside staff members. Examples of potential roles include training to staff, co-facilitation of group programmes and running focus groups with other parents about their experiences.

The increased verbal abilities of 2- to 5-year-olds opens the possibility of involving them in participation activities. Obviously the way this is done and consideration of their developmental stage, interests and experiences needs careful planning. Such participation may be with children who have first-hand experience of the service (commenting on the activities in these meetings), or with a cross-section of children in this age range about their priorities and preferences.

Interventions

See Table 1.

Service structures that help or hinder

As always the time boundaries around this stage need to be clearly commissioned and managed, both to protect this stage and to stop it spilling into younger age ranges.

Given that a large percentage of 2- to 5-year-old children attend nursery it makes sense that at least part of the Early Years services are offered in these places (as was often the case in the Sure Start local programmes). Local circumstances will dictate whether there is enough space and whether they can sustain appropriately inter-dependent relationships with early education services. Emotional Wellbeing services may also want/need to be able to offer services in other locations; GP surgeries, neighbourhood health centres and local authority premises are traditional alternatives. Other options might include libraries, shopping centres and leisure facilities (e.g. hands-on parenting work in a soft-play area – free entrance with every class!).

This age range contains the starting point for Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT), which explicitly covers the 3 to 10 years age range in terms of 'parenting programmes for 3- to 10-year-olds for conduct disorder', and perhaps also 'systemic family practice for conduct disorder, eating disorder and depression' (CYP-IAPT website). The stated aim of CYP-IAPT is to transform Child and Adolescent Mental Health Services through better use of evidence-based practice, better collaborative practice, authentic participation and better accountability of services through the use of clinical outcomes measures. This includes additional training for some staff (although not to qualifying level,

for example, in systemic psychotherapy) co-ordination of services, more participation work and some core psychological skills. The question then arises: how many of these staff are needed versus staff proficient and/or expert in a range of modalities? Three areas where the latter are needed: holistic assessments arriving at full formulations/rich descriptions taking into account children's emotional states and developmental stages, parental mental health, intergenerational patterns and the interaction of all of these; crisis resolution or 'problem shooting' when an intervention has not worked in the way that it was expected to (requiring a return to underlying psychological principles); and in the supervision of other staff. There appears no need for staff from a medical background.

Outcomes and measures

Recalling that the nature of Early Years work is relational then it follows that it is the relationship (between carer and baby) that it is important to measure.

Self-report measures are easy to administer (to the parent!), but it needs to be born in mind that by definition the parent will not see their own blind-spots in their relationship with baby. In pregnancy it is not possible to observe the interaction between parent and baby so measures like the Maternal Antenatal Attachment Scale (Condon, 1997) help to assess mother's view of her relationship with the child in utero.

Once children are born it becomes possible to observe the interaction between carers and babies, how each picks up and responds to the other's expressions, movements and vocalisations. There are a number of coding schemes for quantifying these interactional processes. It is not possible to review them here but they include: the CARE Index (Crittenden, 2005), Keys to Interactive Parenting Scale – KIPS (Comfort & Gordon, 2006), and the Parent-Infant Interaction Observation Scale – PIIOS (Svanberg, Barlow & Tigbe, 2013). Each system has pros and cons – the CARE Index is arguably more detailed, looking at adult sensitivity and infant responsiveness separately, but takes longer and is more expensive to train in. KIPS has the virtue that the training can be on-line, but doesn't account for what Crittenden calls compulsive behaviours (child does what it thinks the adult wants/needs them to do). The PIIOS is validated for babies up to 8 months only.

It is important in assessing the outcomes and outputs of Early Years services that attention is paid to indirect work as well as the direct therapeutic work with families. Consultations with frontline staff need to be counted in terms of the number, the range of professionals and topics, and an assessment of the usefulness of the consultation by the consultee. Similarly, training needs to be assessed in terms of time delivered to the

number and variety of professionals, the topics covered and participants' satisfaction with the training.

Children with difficulties

Some parents will know from birth or even earlier that their child has health problems, some of which could be life-threatening. This obviously places huge strain on the family which can impact upon attachment and all other aspects of caring for the baby. Similarly significant physical health problems can develop throughout the early years, which may impact on the rest of the child's life. There is some discussion of this in Paper 5, especially the psychological support which is needed from hospital services. However, there is a real need for community-based support for families in this situation. An Early Years service could play a key role in this, working with GPs, community nursing staff and community paediatricians.

A similar role could be played when a child seems to be having developmental difficulties. Whilst some causes of developmental delay are known from birth, for example, Down's syndrome, in many cases it is the parents' growing anxiety that all is not well which leads to identification. Many parents describe having to make numerous attempts before health professionals take their concerns seriously and instigate an assessment. This can be due to the difficulties in actually determining whether the delay or unusual behaviour is really outside the normal range. However, there can be a tendency to label such concerns as parental anxiety which makes the parent feel even worse. This could also be a key role for an Early Years service, both in training and supervision of frontline staff and in providing support to the families. There is some discussion on this in Papers 11 and 12.

Being based in universal services and working with all the key providers in the area would enable Early Years services to meet the needs of these families:

- to help with the psychological adaptation to their circumstances;
- to provide psycho-education and coping strategies;
- to use group work to reduce the isolation families often feel and help develop mutual community support.

Summary and conclusions

This paper has tried to highlight how families at different developmental stages (and the services they use) have different needs and responsibilities. If this is true within the age range from conception up to 5 years of age it is even truer in terms of general child and adolescent mental health services. Historically this has been evidenced by the exclusion of under fives or their marginalisation within these services. The implication

here is that there needs to be protected time for the younger age range, and probably protected time within this age range (3- and 4-year-olds can crowd out babies in the same way that adolescents will do to them).

A second theme in the paper is the need for a variety of methods and approaches at each stage. There is no perfect programme/intervention for the Early Years, so to meet the widest range of needs and preferences a range of models should be offered. This in turn implies that staff from a range of backgrounds and qualifications have a useful role to play. The challenges that families face at this age are relational, between parents and babies, between the parents themselves, or between a parent and their memories of care givers. These challenges raise issues in the family's relationships with professionals and the services around them. This means that Early Years mental health and emotional wellbeing services need at least a proportion of staff who can assess, conceptualise/hypothesise/formulate and work with these degrees of complexity alongside staff who may be trained in one particular methodology.

Where a service is located (geographically and organisationally) has been considered in each of the stages – with options having different merits at different stages – local opportunities will always be important. If looking at the conception to 5 years age range there will need to be a significant degree of flexibility about where services are delivered out of, in to and alongside.

Service models (e.g. CAMHS 4 tiered model, THRIVE, Choice and Partnership Approach and CARE AIMS) have not been discussed in this paper. These models were developed with services for older children in mind – possibly with the exception of the CARE AIMS model (Malcolm, 2005) – and so there is a tendency to focus on the risk in an individual rather than a relationship. Risk and complexity in Early Years services are a function of the child's temperament and needs, parent/carer feelings and beliefs about the child, their motivation and capacity for change and the protective factors in the wider system (family and professional). This role of the professional system in keeping children safe and well emphasises the value of consultation and training to frontline staff about psychological and emotional processes. Maintaining relationships with front line services in an era of service re-organisations and re-designs can be difficult.

Early Years Mental Health and Emotional Wellbeing services exist in a wider socio-economic context – they reflect the value placed on early emotional experience by society, and in years to come society will reflect the quality of people's earliest experiences. The problem babies and preschool children have is that it is possible to ignore them at the moment and the people who

Table 1: Parenting Programmes Ratings by Early Intervention Foundation
<http://guidebook.eif.org.uk/>

Age Range	Programme	Rating
<0-2	Family Nurse Partnership	4
<0-2	Family Foundations	3
<0-5	Mellow Parenting	2
0-1	New Beginnings	3
0-3	Parents as First Teachers (PAFT)	2
0-5	Born to move – active learner project	2
0-11	Parents as Partners in the UK	3
0-12	Pathways Triple P (level 5)	3
1-3	Incredible Years Toddler Basic	3
1-6	Parents Plus Early Years	3
1-11	Triple P (Standard, group and Stepping Stones)	4
2-8	Incredible Years Child Training Programme	3
3-5	Incredible Years Basic Preschool	4
3-8	Helping the non-compliant child	3
3-11	Families and Schools Together	4
3-11	Promoting Alternative Thinking Strategies	4
3-11	New Forest Parenting Programme	3
3-11	5 Pillars of Parenting	2

Research Rating key:

- 4 Multiple RCT's across a range of populations with positive impact
- 3 Single RCT with positive impact
- 2 Lesser quality (not RCT or QED) showing better outcomes

suffer the most are themselves – they don't disrupt classrooms, get in trouble with the police, or harm themselves. Yet. It is possible to make economic arguments in favour of early intervention (see Early Intervention Foundation paper on cost-effectiveness). It is also possible to make the ethical argument that tackling distress and promoting joy in babyhood is as relevant and valuable as at other ages.

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Delivering psychological services in schools to maximise emotional wellbeing and early intervention

Denise McConnellogue, Joe Hickey, Waveney Patel & Anna Picciotto

Summary:

A good psychological service within schools will be:

- *Well co-ordinated and integrated into the school context, and able to provide effective early intervention and an accessible entry point to mental health services for children and families.*
- *Able to deliver broad-based multi-factorial assessment and formulation, and to develop evidence-based interventions that focus on both universal, whole school and targeted approaches both directly to children, young people and parents/carers, and indirectly to school staff, contributing to the overall school culture.*
- *Provided by appropriately qualified staff who can understand a child's difficulties in the context of individual development, models of psychological change, relationships and their broader community and contexts, allowing interventions to be tailored to the needs of the individual within the context of that wider system.*
- *Well-governanced, with clear structures for practice, supervision and management to ensure provision of a safe and effective service.*
- *Responsive to feedback from service users, school staff and commissioners to provide a service that can adapt in acknowledgment of context and need. Progress and change for all interventions is tracked and impact evaluated to ensure an effective service is provided.*

In this paper, we will:

- *Discuss recent government guidance, which focuses on child and adolescent mental health, wellbeing and resilience.*
- *Discuss the positioning of applied psychology services in schools to address those issues.*
- *Outline the core components of a psychological approach to supporting students and staff in schools.*
- *Present the different levels at which interventions may be targeted.*
- *Outline recommendations for good practice.*

Introduction

Attending school is a fact of childhood life. All children and young people between the ages of 5 and 16 are legally required to attend school or college, with full-time education or training compulsory up to 18 years in England. Primary-age children in England receive an average of 861 hours of compulsory teaching each year, rising to 912 hours in secondary school (OECD, 2014). A growing number of children also attend out-of-hours provision at school, such as breakfast or homework clubs. Outside of the home, school is often the most important ongoing influence on children's development. Given the influence of school on children and young people's lives, and considerable evidence that applied psychology is effective in schools, there is a great opportunity for high-quality psychological services to promote resilience and wellbeing and minimise adversity in the school environment.

Recent guidance from Government requires all schools to promote the wellbeing of their young people and staff by using ideas and interventions from applied psychology (Department for Education, 2015; National Institute for Health and Care Excellence [NICE], 2008a, 2009; Public Health England, 2015). The House

of Commons Health Committee (2014) recommended more mental health training for teachers, and that OFSTED routinely assess the mental health provisions within schools. The UK Government's recent *Future in Mind* report (Department of Health, 2015) argued for closer links between schools and mental health services, including the creation of a dedicated liaison role with NHS Child and Adolescent Mental Health Services (CAMHS) in every school (Department of Health, 2015).

The increased focus on psychological health and wellbeing in schools is consistent with their primary function as places of learning, because health and education outcomes are closely related (Bradley & Greene, 2013; Suhrcke & de Paz Nieves, 2011). Children with mental health difficulties have more time off school, are more frequently excluded from school, and more likely to be significantly behind in their learning (Green et al., 2005). Schools are likely to admit more pupils with poor mental health and complex needs in future, as these difficulties are expected to continue to rise generally in the population under 18-years-old.

Whole school approaches to wellbeing

Every school or college should now adopt a whole school approach to promoting emotional health and wellbeing (Public Health England, 2015). Psychological intervention is a critical part of delivering this strategy, and consists of two related activities: universal approaches to maximise the social and emotional wellbeing of everyone in the school, and targeted support including group work for children and young people with mental health needs (Weare, 2015).

Universal support involves all school staff in activities such as monitoring pupil wellbeing, teaching social and emotional skills and pastoral care. Targeted support, by contrast, is often carried out by non-teaching professionals including applied psychologists, school nurses, community paediatricians, art therapists, family therapists, cognitive behavioural therapists, child psychotherapists and counsellors. Many professional disciplines carry out both universal and targeted work in schools. A wide range of providers contribute targeted interventions, including the NHS, services commissioned by local authorities or individual schools, voluntary agencies, charities and for-profit companies.

Co-ordination at school level is essential to allocate resources efficiently and prevent children and young people being offered inappropriate support. In schools, where typically a small number of helping professionals support a large population of children, it is important to offer support to the right young people at the right time. The range of psychological practitioners and providers in schools also brings many different models of conceptualising and intervening in psychological difficulties, as well as multiple thresholds for support and referral pathways. For a minority of children with significant additional needs, an Education, Health and Care Plan (formerly a Statement of Special Educational Needs) formally co-ordinates support at an individual level. This can include specific psychological interventions such as therapy or consultation to staff.

Applied psychologists in schools

Access to specialist input from qualified applied psychologists is an important part of a whole school approach to wellbeing (Public Health England, 2015). Two disciplines of applied psychology, clinical and educational, provide most specialist mental health input to schools. The availability of these professionals to schools is currently limited and variable, between and within local authorities.

Educational psychologists provide a broad portfolio of services that contribute to the education and wellbeing of children and young people. The role and func-

tion of educational psychologists varies across the country. Following the development of academies and free schools, some educational psychologists are employed independently, though the majority remain directly contracted to local authorities. Educational psychologists typically serve a number of schools on a sessional basis, rather than being based in a single school. Most educational psychologists become involved in mental health provision alongside a focus on the educational impact of children's difficulties, and helping the school to manage teaching and learning. They support vulnerable groups of children and young people, both through developing whole school approaches and through more targeted work at a group or individual level. Educational psychologists have played a strong role in developing evidence-based strategies and practice-based evidence to promote resilience and wellbeing in partnership with other colleagues, and in providing support to schools to develop positive learning environments.

Clinical psychologists in schools and colleges work to reduce psychological distress in children and young people affected by mental or physical health problems. They often provide specialist assessment, using observation, clinical interviewing or psychometric testing. From the assessment and their formulation of the difficulties (discussed below), clinical psychologists may then offer advice, consultation, individual or group therapy, interventions for parents or carers or onward referral to other clinical and community services. Clinical psychologists in schools are typically employed in the NHS through CAMHS, but an increasing number work independently and are commissioned directly by schools.

Clinical and educational psychologists working in schools share some common skills and approaches and also contribute different specialist skills so their work is most effective if it is integrated. The common factor in applied psychologists' work with schools is understanding a child's problems or symptoms in context, rather than solely at an individual level. In schools and colleges, relevant contexts – which can maintain psychological problems or support positive change – often include a child's classroom environment, peer group, parental mental health, poverty and a great range of other possible influences. Psychological interventions may target one or more of these contexts with little or no individual work with the child (so-called 'indirect interventions'). When direct work with the child is indicated, significant engagement with the child's school and family network is the norm. A flexible approach to different levels of intervention often means that a school-based psychology service will be offering more than one of these interventions simultaneously.

Theoretical frameworks for psychological wellbeing in schools

Children in the same school clearly do not all have the same experiences, and will respond very differently to the environment they share. Developmental psychopathology – the study of how psychological problems develop over time – suggests that it is the interplay of risk and protective factors across different areas of life that shapes outcomes for individual children (Cicchetti, 1989; Rutter, 1985, 2013). In other words, school will influence children's development in the context of their unique combination of genes, physical health, temperament, coping style, family relationships, social and other factors. Some positive features of a school, such as a well-managed classroom, will be beneficial for all children concerned. Other factors, such as a strong attachment bond with a teacher, may exert a particular protective effect for vulnerable children facing adversity elsewhere in life (Verschuere & Koomen, 2012).

Schools may also contribute unique risk factors to some children's wellbeing and development. Examination stress is well documented to affect some students and to have a negative impact on their mental health as well as their academic attainment (Hutchings, 2015; Putwain, 2009). Large, long-term studies from the UK and the US have recently found that young people bullied by peers were twice as likely to become depressed in young adulthood, relative to those never victimised (Bowes et al., 2015). Peer bullying may even place young people at greater risk of later mental health problems than physical, emotional or sexual abuse (Lereya et al., 2015).

Resilience – successful adaptation in the presence of adversity – is a framework for understanding some of the great variability in outcomes that is the experience of most professionals working in schools (Masten, 2001). Resilience is an ongoing and interactive process between the child and the risk or protective factors in its environment, rather than a stable or innate characteristic (Masten, 2007). The idea that resilience can and should be promoted at the level of institutions or social systems is receiving growing research attention. For example, the UK Resilience Project reported the positive impact of a universal, manualised programme of resilience workshops on the psychological wellbeing of pupils in Year 7 (i.e. 11- or 12-years-old; Challen et al., 2011).

When adapting to adversity is impossible or incomplete, and psychological difficulties ensue for the child, it can often seem that problems at school go hand-in-hand with difficulties at home. Research on developmental 'cascades' has shown how functioning in one area affects other domains over time (Cicchetti & Masten, 2010). Furthermore, when there are multiple

sources of adversity in a child's life their effect can be cumulative (Evans, Lee & Whipple, 2013). The corollary is that successful intervention in one area of a child's wellbeing can have positive effects more widely in their life.

From theory to intervention

Most models of intervention used by clinical and educational psychologists with children and young people take account of context and relationships. Systemic psychotherapy is predicated on the idea that psychological difficulties or symptoms have relational or interpersonal causes and resolutions. Cognitive behaviour therapy (CBT) has become a dominant approach in the NHS for people affected by anxiety or depressive difficulties. CBT with young people involves working with the whole family's patterns of emotions, behaviour and thinking, not just the child's (Fuggle, Dunsmuir & Curry, 2012), with parents significantly involved in the therapeutic work (Creswell & Cartwright-Hatton, 2007).

In clinical practice, psychologists use psychological models to develop a formulation of a young person's psychological difficulties (BPS, 2011). A psychological formulation states hypotheses about the development and maintenance of the problem, and is developed in part or in whole with the young person and their family. The value of a formulation-based approach in schools' work is the ability to integrate information from many different sources, and produce a coherent plan for targeted work with a young person, incorporating their family or school staff as needed.

Evidence base for applied psychology in schools

There is clear evidence that psychological services to schools have beneficial effects. Large-scale reviews of research evidence support the efficacy of whole-school approaches to wellbeing (Adi, Killoran et al., 2007; Adi, Schrader McMillan et al., 2007). Psychological interventions have been shown to improve behaviour, reduce exclusions, improve attendance and reduce emotional and behavioural symptoms (Ballard, Sander & Klimes-Dougan, 2014; Wolpert et al., 2013). NICE treatment guidelines, based on systematic reviews of research evidence, recommend school-based direct and indirect interventions for difficulties including depression, ADHD and conduct problems (NICE, 2008b, 2013, 2015).

Besides large-scale reviews or clinical trials, there is also a wealth of practice-based evidence for the efficacy of psychological services in schools. Local service evaluations of school-based CAMHS or clinical psychology input have found positive effects on wellbeing in primary and secondary schools (Faulconbridge & Hunt, 2010; Neave & Patel, 2014; Picciotto, 2014).

Early intervention in mental health problems, and improving access to specialist services, are key recommendations of the *Future in Mind* report (Department of Health, 2015). Early intervention can reduce clinical symptoms and the need for more expensive interventions later. Some of the most effective interventions are made in the preschool and primary years (Greenberg et al., 2001). A recent review found that most school-based prevention and early intervention programmes for anxiety achieve significant reductions in difficulties (Neil & Christensen, 2009). Unfortunately, as many as 70 per cent of children and young people who experience clinically significant psychological difficulties do not have access to appropriate interventions at a sufficiently early age (Department of Health, 2015).

Access to psychological support

The issue of access is important because some children, young people and families referred to clinic-based applied psychology provision (e.g. CAMHS) do not engage with the service offered. This problem disproportionately affects families with high levels of need (Scott et al., 2014). There are many potential barriers to engagement with clinic-based services, including parental mental or physical health difficulties, substance or alcohol addiction, concern about the young person missing school and practical constraints such as travel, work or other family commitments.

Linking specialist mental health services more closely with schools and colleges is a valuable way to increase young people's choice about where they are seen. Locating applied psychological services in schools means that help can be provided in a familiar setting (Children and Young People's Mental Health and Well-being Task Force, 2015).

Community psychology proposes that psychologists should work with children and young people as near as possible to their relevant everyday social contexts (Orford, 1992). This enables services and professionals to work with clients as a person-in-context, as part of their social networks and systems, and facilitates exploration of how these wider factors impact on current wellbeing and behaviour (Orford 1992; Williams & Zlotowitz, 2013). See Paper 6 for more information on community psychology interventions.

For some young people, however, school may not be an environment where they feel safe to be open about their mental health concerns (Department of Health, 2015). It is, therefore, crucial to give the child, young person and family choice in where they can gain psychological support.

Summary

Psychological interventions in schools are feasible, effective and acceptable to users of the service and can be directed at different levels of a school system, both universal and targeted. Psychologists use formulation skills to understand young people's psychological difficulties in context, incorporating developmental science, models of psychological change and mental health expertise, allowing interventions to be tailored to the needs of the individual within the context of the wider system.

Core components of a psychological approach in schools

Broad-based, multifactorial assessment in schools

Conducting psychological assessments in schools has many benefits, including improved interagency communication, higher ecological validity of observations and increased accessibility of services for harder to engage families. Access to rapid, high quality, psychological assessment is essential in order to provide an accurate and informed formulation, and to identify any risk of harm to the self or others as soon as possible. Assessment should be multi-modal (using questionnaires, observations and clinical interviews with child, parent and teacher) and multi-informant (obtaining the views of child, parent, school and other agencies involved) and consider the child across all relevant contexts. Risk assessments should be thorough, reviewed regularly and lead to achievable, clear crisis plans where necessary. Risks and associated plans should be shared with the network around the child or young person, including family members, carers, school staff and other agencies involved.

Formulation in schools

Formulation is a core skill for clinical psychologists (BPS, 2011) and is likely to be particularly useful when working with young people and the systems around them as it ties together the work of multiple people within a framework. Being based in schools increases the scope of a comprehensive and collaborative understanding of the difficulties a young person may face.

Communicating this formulation to young people, parents, schools and networks is essential and can be an intervention in itself as it can allow key people to view difficulties in a different way and feel more empowered to effect change. Sharing formulations helps to make links between emotional wellbeing and learning more explicit, which can be helpful for school staff to understand.

Case example. Abdullah (age 6) was referred for a clinical psychology assessment because his school reported that he was having difficulties with friendships and was displaying “attention seeking and disruptive behaviour” in the classroom, impacting on the learning of the rest of the class. The clinical psychologist met his teacher, who reported feeling worn out and increasingly deskilled by Abdullah’s behaviour. Abdullah’s mother reported that her husband had experienced significant mental health difficulties and she was now caring for Abdullah on her own following domestic violence and fleeing the family home. This information was integrated with observations and direct assessment sessions in school and a shared formulation of Abdullah’s difficulties was developed. The formulation hypothesised that Abdullah’s early attachment experiences had influenced his current relationships and expectations of adults. He had learned he could not always rely on adults to be reliable, consistent or predictable and had learned to escalate his behaviour to ensure he received the attention he needed to feel safe. The formulation was shared with the teacher and management staff at school, used to reflect on the meaning and function of his behaviour, and adapt Abdullah’s Individual Education Plan (IEP). Recommendations included having a key identified adult allocated to Abdullah, consistent management of his behaviour and prioritising the development of peer relationships. It was also recommended that there would be meetings between the clinical psychologist and the teacher to provide a space to think about the presenting difficulties and the emotional impact on the teacher.

Evidence-based practice in schools

Evidence-based practice is advocated for work in schools (*Future in Mind*, 2015) where the best available research is addressed, client preference is considered and the individual’s context is taken into consideration (Murphy & Fonagy, 2012). Recent Government guidelines on the provision of counselling services in schools advocated strongly for practice more robustly informed by an evidence base (Department for Education, 2015).

Applied psychologists utilise the range of therapeutic approaches at their disposal and their knowledge and experience to tailor interventions for the young person, parent or school as relevant. This may include adapting an established evidence-based approach for specific groups such as looked after children, young carers or asylum seekers. In order to provide an evidence-based mental health service, staff and clinicians need to be able to intervene beyond the individual child or young person alone.

Evaluation in schools

Applied psychologists collect service user feedback from young people, families and schools about their views of the service received alongside goal based measures, screening questionnaires and objective outcomes measures. This progress and outcome data should be collected regularly and should be ‘used in a positive, thoughtful and meaningful way’ (Law & Wolpert, 2014) and with the child or young person exercising choice in the measures and how they are used. There is evidence to suggest such measurement can improve outcomes for young people (Bickman et al., 2001).

Outcomes can be evaluated using readily-available validated questionnaire measures, such as the Strengths and Difficulties Questionnaire (Goodman, 1997), Revised Childhood Anxiety and Depression Scale (Chorpita et al., 2000) and others that are feasible for use in routine practice (Berry, Khan & Patel, 2013; Faulconbridge & Hunt, 2010; Neave & Patel, 2014; Patel & Aveyard, 2007). Outcome evaluation should also consider indicators of wider improvements directly relevant to schools, such as increased school attendance, reduced school exclusions or increased understanding of a child’s difficulties for staff. It is also important to get feedback from the schools to assess their satisfaction with the service offered, adapting this where necessary.

Intervening at different levels

Locating applied psychological services for children, young people and families in schools offers a unique opportunity to offer specialist, interconnected interventions at a universal and a targeted level and both directly (to children, young people and parents/carers) and indirectly (to school staff).

As well as working with school staff, it also offers more opportunities for applied psychological services to work jointly with other agencies connected to child and adolescent mental health in schools. This includes Local Authority services such as Children’s Social Care, Behaviour Support services, Public Health England and the Health and Wellbeing Service, as well as lower intensity school counselling services (including Place 2 Be and art therapy).

The process of deciding at what level to intervene (directly/indirectly, lower or higher intensity) should be done collaboratively and should integrate assessment, research evidence, family or young person’s preference, clinical expertise and formulation.

Universal work

Examples of direct universal work

Interventions offered to all children, young people and parents or carers:

- **Mental health screens of cohorts or year groups.** Although they have clear cost/resource implications, they can identify universal themes on which to base whole class or year group work on child and adolescent mental health. Topics might include psycho-education on bullying, sleep hygiene, managing exam stress, healthy eating habits, self-harm and eating disorders. They can also identify children or young people with or at risk of developing mental health difficulties who need targeted interventions from school staff (such as school counsellors or Learning Mentors) or specialist mental health services (such as school-based psychologists and CAMHS).
- **Universal groups for children.** These can be groups using specific evidence-based therapeutic approaches (for example, mindfulness-based approaches [Weare, 2013]) or can be groups focusing on specific topics (such as transitions, promoting good mental health, anxiety management, bullying, friendship). Although these groups function as a universal intervention, they can also provide signposting information for young people about where to get targeted help.
- **Workshops and training.** These may be offered to parents on universal topics such as separation anxiety, managing behavioural difficulties, sleep difficulties, managing exam stress, managing access to technology.
- **Pre-referral or 'drop in' sessions for parents.** These allow parents to discuss worries about their child's needs and facilitate early identification of mental health difficulties.

Case example. A girls' secondary school had a high level of concern about the mental health of their Year 11 cohort. Six young people had been hospitalised for mental health-related reasons in the run-up to their GCSEs. At the start of the next academic year, the school's pastoral care team, which included CAMHS clinicians, Learning Mentors and school staff, worked together to identify the needs of that year's Year 11 students and create a package of support at different levels. The 126 students in the year were screened using the Beck Youth Inventory, a validated set of questionnaires (Beck, Beck & Jolly, 2001). Seventy-three students were identified with significant emotional and/or behavioural difficulties. Of those, 10 were considered high risk and were followed up by school CAMHS staff within 48 hours. The

remaining 63 were given follow-up interviews over the next month. The follow-up interviews enabled the pastoral care team to put together a package of care for the year group at different levels:

- Universal support. Sleep difficulties and exam stress were widely reported. Voluntary, drop-in sleep hygiene and stress management workshops were offered throughout the academic year, run jointly by the school's CAMHS clinician and a school Learning Mentor.
- Targeted support. From their individual follow up interviews, students' levels of psychological distress were assessed and formulated and they were offered tailored psychological interventions accordingly. These ranged from half-termly 'check-in' sessions with an identified school Learning Mentor, referral to the school CAMHS team for individual or family work and referral to central CAMHS for more specialist interventions including psychiatric assessment and treatment. There was one brief, preventative hospital admission that year.

A repeat of the screen towards the end of the school year indicated significantly improved mood. A similar range of interventions is now offered to Year 11 each year.

Examples of indirect universal work

Interventions targeted at the whole school population that do not involve face-to-face contact with children or parents can include:

- **Training of school staff.** Few school staff have specific training on emotional wellbeing and mental health (University of Nottingham Centre for Special Needs Education and Research, 2007). Training can be for whole school staff teams and for smaller, specific group such as pastoral care teams, early years and senior management. Effective trainings in school include:
 - Solihull Approach Training: The School Years (Douglas, 2011). This is a whole school staff training in understanding early infant and child development, attachment theory, children and young people's behaviour and emotional blocks to learning.
 - Child and Adolescent Mental Health, including risk and preventative factors and the early identification of mental health difficulties.
 - Topic-based trainings for staff, for example on ADHD and classroom management, Autistic Spectrum Disorder, attachment difficulties, identification of risk including eating disorders, self-harm and prevention of suicide, courses for staff in mindfulness (Weare, 2014) and stress management.

- **Regular consultation to, or supervision of, school staff** focusing on students or groups of students who are of concern to staff. These informal discussions are easier and more productive if the psychologist has a regular presence in the school and staff feel comfortable to approach him/her. Gowers, Thomas and Deeley (2015) surveyed schools and found that over 50 per cent of respondents reported dissatisfaction with referral systems and many teachers valued the opportunity to discuss concerns and ask advice from CAMHS clinicians on an informal basis and with a named person.

Consultation with school staff is a key activity, given reports that 81.2 per cent of teachers reported experiencing stress, anxiety or depression (NUT, 2013) which is likely to reduce their own resilience and capacity when teaching children with complex needs. Evaluation reports from CAMHS and Clinical Psychology Services in schools (Faulconbridge & Hunt, 2010; Picciotto, 2014) and research (van Roosmalen, Gardner-Ellen & Day, 2012) have highlighted the importance of consultation to school teams to support staff. Staff in Islington commented:

We have also developed the use of CAMHS consultation as a reflective space for teachers and classroom teams. This has complemented the referral pathway by providing CAMHS support when a direct intervention with the family is not appropriate. Teachers and TAs have used these consultations to think together about dilemmas or difficulties in their work with a peer group or whole class. (Picciotto, 2014).

- **Working with school health services.** Although the pattern of provision varies across the country, school nurses and community paediatricians can be a very valuable part of psychological services in schools. They can have a particularly important role in supporting psychological wellbeing in relation to physical health, sexual health, neurodevelopmental disorders, physical and learning disabilities, in conjunction with psychological practitioners.
- **Contributing to school culture.** Applied psychologists in schools can have an active role in service and organisational development, pioneering and implementing improvements connected to mental health. This may include developing services and knowledge in the whole school and wider community based on feedback from children and young people, outcomes and progress data, and family and school feedback. They can provide support to the school but can also challenge the established system when change may be beneficial.
- **Contributing to joined-up initiatives on promoting mental health and resilience in schools.** These may be led by other bodies such as Public Health England or the Health and Wellbeing Service.

Targeted work

Schools are expected to work actively with parents and carers, to embed clear systems for identifying mental health needs and develop a cycle of support for vulnerable pupils using an ‘assessment, plan, do, review’ process (DFE, 2015). Targeted interventions by psychology services can be utilised for individuals and groups identified as having, or being at risk of developing, mental health difficulties. They will be identified in different ways: by their presentation in school, by the presence of known risk factors, through mental health screens and via multi-agency discussions, for example in Team Around the School (TAS) meetings.

Examples of direct targeted work

Psychological assessments and interventions with children, young people, parents/carers and family work in schools can include:

- **Screening and assessment of developmental and neurodevelopmental conditions** where observation of the child or young person within the school context forms a key part of the assessment.
- **Assessment and treatment of school-based difficulties** where there is a social, emotional and/or behavioural component, where intervening in school is clinically relevant and evidence-based.

Case example. Jenny (aged 10) was referred to her primary school’s CAMHS clinical psychologist following a long history of poor attendance, concerns about academic progress and several exclusions for aggressive behaviour towards staff. Social care and attendance officers had been involved intermittently without sustained progress, and the relationship between school and Jenny’s mother had become very strained. Following a clinical psychology assessment and formulation, the psychologist began working with Jenny’s mother. The psychologist provided a safe, trusting, non-blaming relationship so Jenny’s mother could begin to explore her own experiences and beliefs about schooling and parenting, and how these impacted on Jenny’s attitude towards school. A network meeting was then arranged and Jenny’s mother was able to outline some new strategies she was willing to try. This created a shift in the previously stuck and polarised positions of family and school, enabling a renewed enthusiasm for working together to support Jenny’s education. Outcomes of this formulation-led intervention included improved communication and collaborative working between school and Jenny’s mother and a greater understanding of the other’s perspectives. This consistent approach between home and school led to improved attendance for Jenny and an improvement in her attainment. Jenny’s aggressive behaviour towards staff also decreased.

- **Assessment and ongoing therapy** for an often complex population that has been or would be unable to access traditional clinic-based services.

Case example. A referral was made to central CAMHS by the GP of a young woman in Year 10 suffering from anxiety. As the school Learning Mentor had previously discussed this young person with their school's CAMHS clinician during their regular consultation meetings they agreed that the CAMHS clinician would offer an initial assessment at school. The Learning Mentor knew this student well and had a good relationship with her. She said that the student was unsure about meeting with CAMHS and had a number of questions about mental health and stigma seemed an issue. A joint meeting with the Learning Mentor was arranged, to facilitate engagement so the student had a trusted adult to support her during the initial meeting. The clinician then met with her parents to discuss their concerns and what support they would like for their daughter. The young person, parents and CAMHS clinician agreed to offer ongoing CBT for her anxiety in the school, with regular reviews with the Learning Mentor and parents.

Parents accessing a school-based psychology service give positive feedback (Picciotto, 2014). One commented that the professional they worked with 'Explained everything and talked me through different solutions to the problem. I think all schools should have this service.' Another said that their clinician 'has worked tirelessly with the school and [child] to ensure a positive outcome.'

- **Preventative work for children and young people** likely to struggle with an educational transition, for example from early years provision to primary school, or from primary to secondary school or college. This may be group or individual work.

Case example. A primary school had a general focus on how to improve the transition from the Early Years/Foundation Stage to Key Stage 1. The aim was to narrow the gap between the stages so children were more prepared for the learning demands of Year 1, and to identify difficulties the children might have as early as possible. At the beginning of the autumn term, the Year 1 teacher, in discussion with the Inclusion Manager and the clinician, identified the children most likely to benefit from this intervention. The clinician then met with parents to think about their concerns and what might realistically be achieved. She co-ran the group with an assistant child psychotherapist from

CAMHS – weekly sessions over the autumn and spring terms. Some children flourished in the group, with growing emotional maturity and a new focus and engagement in the classroom. Others remained quite stuck but the group was useful in pinpointing the nature of their difficulties and providing information for the school about where best to concentrate resources to support them. The CAMHS clinician started providing some individual sessions for the parent of a child with serious difficulties to support his thinking about his child. She offered occasional sessions to another of the parents to think about the impact of recent adverse life events on her child.

- **Evidence-based group work** for specific difficulties or diagnoses, such as CBT for anxiety.
- **Targeted parenting groups** located in schools (e.g. The Incredible Years, Webster-Stratton, 1998).

Examples of indirect targeted work

This aims to improve early identification of mental health difficulties and increases the 'reach' of clinical psychology and mental health services, in order to benefit a greater number of pupils. It can include:

- **Attendance at school Pastoral Care or Team Around the School (TAS) meetings**, ensuring a psychological and mental health perspective to school and/or multi-agency discussions about children, young people and families identified as being of concern to the school.
- **Sharing the formulation** and understanding of a child's difficulties and recommendations with those best placed to intervene in a positive way on a day-to-day basis.
- **Signposting** to CAMHS and other services for children and families with identified difficulties and acting as a 'bridge' between Health and Education services.
- **Consultation to school staff** about identified and/or referred children.
- **Contributing to Common Assessment Frameworks (CAFs).**
- **Contributing to Education, Health and Social Care (EHSC) plans.**
- **Attendance at Team Around the Child (TAC) meetings.**

Helping the whole service work as well as possible

Currently, psychological services in schools may be provided by NHS, local authority, charitable and independent sectors and have different funding streams (from individual schools, local authorities, Clinical Commissioning Groups [CCGs] and central govern-

ment). This can make provision of mental health services in schools fragmented and inequitable.

Young people and parents have reported poorly integrated services and poor joint working between services (YoungMinds, 2014; Children and Young People's Mental Health and Wellbeing Task Force, 2015). The TaMHS initiative (TaMHS, 2008) advocated for all agencies to work together to deliver flexible, responsive and effective early intervention mental health services linked to a school base. Integrating applied psychological services in schools provides an accessible context for children and young people to be seen (Targeted Mental Health in Schools (TaMHS), 2008).

Responsibility for providing accessible, integrated, well-functioning mental health provision in schools lies with multiple agencies:

Commissioners

- Should ensure all schools have access to high and low intensity mental health interventions, including those provided by applied psychologists.

Schools

- Should identify a designated individual, possibly teacher, responsible for mental health in schools who acts as a champion for such issues and should be responsible for (and will be trained in) taking the lead with mental health initiatives and innovation (Department of Health, 2015).
- Should ensure that, in accordance with recent guidance which has suggested that mental health support in schools should be provided by a service with 'good links to specialist mental health services' (Department for Education, 2015), psychological services based within a school are also part of, or are closely affiliated to, CAMH services.
- Should ensure that professional registration and the use of protected titles amongst applied psychological service providers are checked, along with other linked governance structures such as belonging to an established CAMH service or organisation. Some support is available to schools to develop skills in this area (Youth Wellbeing Directory, YoungMinds website).

Providers of applied psychology services in schools

- Should advise and consult to the designated mental health champion in the school and multiagency meetings. Collaborative and co-ordinated working can maximise the links between health, educational, charitable and voluntary sectors.
- Should support schools to know when, where and at what level to intervene most effectively in mental health difficulties, based on assessment, formulation and application of the evidence base, and to provide mental health interventions for a child, young person and their family in context.

- Should provide a good quality and well-governed service to schools. Applied psychologists delivering specialist mental health interventions should be appropriately trained, qualified and managed (Department for Education, 2015).
- Should be provided with effective clinical supervision to maintain good practice. Applied psychologists working in schools will see a full spectrum of behavioural, social and emotional and mental health difficulties in children and parents. In addition to providing early intervention for lower threshold difficulties, often they will see the most complex families who struggle to engage in clinic based services (Massie, 2008; van Roosmalen, Gardner-Elahi & Day, 2012).
- Should be rigorous in assessing the service and interventions, evaluating efficacy of service provision, and respond to service user feedback. Best practice should ensure that schools and clinicians are given regular opportunities to review and evaluate how the service is working, understanding that 'one size will not fit all' and to be open to adapting the service in response to the context and need.

Service examples

- **Clinical Psychology in Schools (CLiPS) in Ealing.** Clinical psychologists work one day a week in commissioning schools in the Borough with children who have been identified by their school. Clinical Psychologists complete a thorough assessment and develop a formulation of the difficulties and an appropriate intervention. These include: individual sessions with the child, input with the parent, referral to CAMHS for specialised assessments and ongoing formulation with the school to help them understand difficulties the child may be presenting with. Common presenting difficulties are around behaviour, anxiety, low mood, bereavement and attachment. There are good links with the multi-disciplinary specialist CAMHS ensuring a collaborative approach when specialised assessments are necessary.
- **Islington CAMHS school-based service.** Following the successful local evaluation of the TaMHS project in Islington, the Education Authorities commissioned Islington CAMHS to base clinicians in all of its 46 primary schools, 10 secondary schools and three special schools. The CAMHS clinicians provide a time-limited resource to the schools (half a day a fortnight to primaries and one day a week to secondary schools). Some schools independently commission additional time. Clinicians are from different disciplines (Clinical Psychology, Systemic Psychotherapy and Child Psychotherapy), all based in the central CAMHS team which provides multi-

disciplinary support including psychiatry to the schools-based work. The service operates a flexible model of service delivery. Schools are given a menu of interventions and negotiate how to use their CAMHS time each year, through a contracting and review process.

- **The Primary Behaviour Service in Ealing.** A service for children who have significant behavioural difficulties and are at risk of exclusion. Although children are referred because of difficulties managing their behaviour, emotional and social issues may underlie this behaviour. Specialist teachers and clinical psychologists provide an outreach service to primary schools which includes thorough assessment, formulation and intervention. Interventions are formulation led and may include working with the young person or parent, school consultation, referral for specialist assessment or further training for schools. Children can be educated at the PBS for two days a week or full time if they are permanently excluded from school. These children receive more intensive input, including termly formulation meetings with staff and additional therapeutic input such as mindfulness sessions as part of the curriculum. There are good links with the multi-disciplinary specialist CAMHS ensuring a collaborative approach.
- **Clinical Psychology in Schools, Nottinghamshire.** Two clinical psychologists are employed by a secondary academy for one day/fortnight. The majority of time is used in consultation meetings with the school counsellor, pastoral team, SENCO, learning support team and school nurse discussing the students who are causing concern. They aim to formulate an understanding of the pupil's difficulties to guide any interventions in school and without. This may lead to referrals for specialist assessment and support to community paediatricians, CAMHS or Social Care. The psychologists may undertake direct assessments of the child and family and occasionally engage in some short-term solution focused therapy. They have helped develop a peer-mentoring scheme to combat bullying and are working to expand this into a student-led advisory group, to shape a whole school approach to promoting psychological wellbeing. They work closely with the educational psychologist and CAMHS.

Conclusions

The provision of psychological services in schools presents an exciting opportunity to develop innovative services that improve and facilitate early intervention and an increased reach of psychological services for children and young people. This is supported by guidance from Government that places the emotional health and wellbeing of pupils in school as a high priority. Psychological knowledge can be shared more widely in schools through training, contributing to collaborative plans developed with young people, and maximising the use of existing resources in the education, health and voluntary sectors. Consultation and promoting whole school approaches can help build capacity in the school and surrounding community and systems. In a climate of limited resource, there is clear and growing evidence that embedding psychological services in schools is an effective way of identifying and working with children and young people's mental health needs.

A deputy head teacher of a secondary school commented:

'What stands out is the girls' readiness to come and see [the CAMHS clinician] and their acceptance of the support. There is no stigma or avoidance, they feel heard and that they have a voice. It has an impact on the individuals and they are more positive about school. Their resilience is growing and they are more hopeful about their futures.'

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Delivering psychological services for children, young people and families with complex social care needs

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Summary:

- *Services for children and young people within the social care system must also provide support to these children's carers to be effective as most therapeutic change comes within their relationships.*
- *Services should focus on promoting the carer's understanding of the impact of complex developmental trauma on young people and their own ability to manage and respond to this in a skilled and attuned manner.*
- *Barriers should be removed to young people accessing support from CAMHS and other Tier 2/3 provision and consideration given to how difficult access can be for young people in the looked after system. Specialist support is also required.*
- *Issues of cross sector or cross border funding should be planned for to avoid unnecessary delays in accessing local services for young people placed far from their area of origin.*
- *Services should be proactive – offering support and training as standard in order to try to prevent crises leading to placement breakdown.*
- *More robust evidence in relation to interventions for this population needs to be developed.*
- *Formulations need to take into account the multiple interwoven neurodevelopmental, biological, psychological and social factors that impact upon these young people, and offer more than just 'good enough' placements and sporadic therapeutic input determined by what is available in the locality.*
- *The health economic case indicates that investing in these young people during childhood pays dividends in adulthood, and these services require much greater investment in the future.*

Introduction

Levels of need

Children who have experienced maltreatment in their family of origin have complex and multiple needs, including a very high incidence of mental health difficulties. Numerous studies show early exposure to trauma, neglect and abuse and the absence of a secure attachment relationship have a profound impact on later mental and physical health (Feeney, 2000). The Adverse Childhood Experiences (ACE) study by Kaiser Permanente looked at adverse childhood experiences, including childhood abuse, neglect, and family dysfunction, and found that isolated trauma produced PTSD, whilst chronic and multiple traumas changed the whole path of neurological development.

The study found a highly significant relationship between adverse childhood experiences and later depression, suicide attempts, alcoholism, drug abuse, sexual risk taking, domestic violence, cigarette smoking, obesity, physical inactivity, and sexually transmitted diseases. In addition, the more adverse childhood experiences reported, the more likely a person was to develop heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease. There are also dramatic increases in the use of medical, correctional, social and mental health services. People with childhood histories of trauma, abuse and neglect make up almost our entire criminal justice population and a large proportion of users of mental health services. The Prison Reform Trust (2014) evidences that 39 per

cent of the prison population were on the Child Protection Register as children, and Minnis et al. (2006) suggest that 80 per cent of the prison population have attachment difficulties.

The protective factors associated with good attachments, such as impulse control, empathy, good educational and career prospects, are lacking for those children who grow up without experiencing secure attachments. The draft NICE Children's Attachment Guidelines (2015, in review process) identify that attachment difficulties lead to increased incidence of anxiety, depression, conduct problems and aggression, drug misuse, sexual risk taking, substance misuse, impaired cognitive ability and poor emotion management.

As Child and Adolescent Mental Health Services (CAMHS) have become increasingly focused on diagnosable mental health disorders, as a way to deal with funding pressure, the emotional, psychological and developmental consequences of maltreatment are frequently excluded from health services, thus much of this work happens in the voluntary sector, with variable levels of knowledge, skill and clinical governance.

Increasingly, another absence within the NHS are services to promote effective parenting, which have predominantly moved to being provided in the voluntary sector or by Local Authorities, with much less mental health input.

Adult mental health services and those working with substance misuse are often disconnected from the task

of parenting, and rarely consider the needs of the child or family as being within their scope, except in the perinatal period. This absence is particularly disappointing given the strong evidence base for psychological interventions with parents having a lasting impact on the outcomes for their children, and a persuasive health economic case for early intervention. The draft NICE Guidelines for Children's Attachment (2015, in review process) highlight evidence-based parenting support as one of the most promising interventions to prevent and treat attachment difficulties.

Looked After and Adopted Children

Local Authority Social Care departments have a statutory responsibility to protect children.

They work with some families requiring support where children are 'in need', Sometimes a multi-agency group including social care, education and health (typically primary care professionals) are gathered to form a Common Assessment Framework (CAF) plan to address their needs. Where children have been harmed, or are at high risk of significant harm, a child protection plan may be made up to protect them. There are evident benefits of psychological knowledge to inform this work with Children in Need and those on the edge of Care, though very few social care services have access to this at present. Often, emotional neglect or abuse of children is ongoing for significant periods of time before threshold is considered to be reached. *Future in Mind* (DH, 2015) emphasises the importance of promoting resilience, early intervention, and prevention. Provision of services to support emotional well-being and sensitive, attuned care earlier in the process may help to promote better outcomes for these children and families.

If the professional network needs to take immediate action to safeguard a child or children, or if it has not been possible to work with a family to make the child/ren safe, then they might be removed to a placement with alternative carers. Decisions need to be made about whether the children can be returned to their birth families, and what support might make this possible. Psychological expertise can help to inform this decision (Silver, 2014).

The number of children and young people in the care system has risen in recent years. In March 2014, there were approximately 90,000 Looked After Children and young people in the UK.

A range of legal orders are available which can help children to be raised within the extended birth family, both allowing for stability of identity whilst reducing the numbers of children looked after, an apparent 'win-win'. Unfortunately the potency of this can be reduced by overstretched services that find it difficult to provide the level of support that these well-intentioned family

members need, and in some cases maltreatment can continue or be replicated in the new placement within the family. The relative age of grandparents, or complexity of mixed family units for relatives with birth children can make this a particularly challenging parenting role. Issues such as loss of previous relationship, conflict of loyalty or unresolved anger towards the birth parents, along with unresolved feelings about their own role in the abuse or neglect, or recognition of the deficits in their care of the parent, can make this a particularly challenging parenting task. Provision of comprehensive, proactive, accessible psychologically informed support to these familial care givers would likely support more positive outcomes in this type of placement, preventing further moves out of the family into foster care.

Adoption is the placement choice associated with best outcomes where children are permanently removed from their family of origin at a young age. The evidence base for adoption positively changing the outcomes for children is overwhelming (van Ijzendoorn & Juffer, 2006) and adoptions are much more secure than any other form of placement, with less than five per cent of children who are adopted returning to the care system (Selwyn et al., 2014). Where adopted children continue to have difficulties, adoptive parents can often feel a sense of failure and as a consequence can be slow seeking help (Rushton, 2004). Studies which have explored adoptive parents' experience of services reveal that they often feel judged or blamed for the child's continuing problems with practitioners failing to recognise the extent of parenting challenge presented by the children. Dedicated services for these families within multi-agency teams can support these children and families with their more complex life journeys, ensuring that they do not need to reach crisis point to access support. Again, provision of comprehensive, proactive, accessible psychologically informed support may make it easier for these families to access help – if it is provided as standard, there is no narrative of 'failure' associated with engaging with professionals.

The majority of Looked After Children are placed in foster placements, where they are cared for by unqualified caregivers with limited professional input. A small minority whose needs are the most complex, or where there have been multiple breakdowns of foster placements, end up in residential care homes. The staff in these homes are typically low paid and most have minimal qualifications.

Thus across all types of placements, the caregivers and social care professionals who look after these children have a varied and rarely in depth level of knowledge of child development, psychology, therapy, neuroscience, multi-modal impact of trauma and varied levels of understanding of, or ability to access, the rele-

vant evidence base. Parents, adoptive parents, special guardians and kinship carers may often have limited preparation or training in how to care for a child with complex needs, and even paid and employed foster carers and residential carers are typically unqualified.

The level of skill and knowledge of residential care workers – those providing day to day care for children with the most vulnerabilities and offering the most challenges – is often concerning and can vary widely due to the fragmentation of this provision across local authority, charitable, social enterprise, and private providers. Ofsted (2015) suggest that their new Standards for the Inspection of Children’s Homes have been developed to focus more on outcomes and quality and less on policy and procedure, further stating that they want to see leaders, managers, and staff teams who know the difference they are making to children and young people’s lives.

Research demonstrates that placement disruption is most commonly a consequence of the lack of confidence carers have in managing challenging behavioural presentations (Sinclair, Wilson & Gibbs, 2005). Thus it is essential for carers to have access to clinical psychologists and other health professionals who have expertise about the impact of maltreatment on child development, neuroscience and the evidence base for various interventions and can inform the way they care for the children by providing high quality, ongoing training, consultation and supervision. Support via consultation, training, group work and individual parenting advice can ensure that carers are appropriately informed and armed with therapeutic parenting approaches which can reduce their lack of confidence and increase their sense of efficacy (Golding, 2010; 2014). This insight can be invaluable.

From an adoptive parent: *‘I felt like we were alone in the dark, but your input has let us see the light at the end of the tunnel. We’ve started to recognise the meaning in her behaviour and begin to enjoy caring for our daughter again.’ And ‘Now I step back and assess situations before reacting – showing and giving empathy.’*

From a residential care worker: *‘Since the clinical psychologist talked to us, so much has just clicked into place. I wish I knew this information in time to have worked differently with the young people who have lived here before.’*

And from a social work service manager in relation to consultations with a clinical psychologist: *‘I only hear positives about the added value they offer and the accessibility. They reduce disruption, and carers want more. The way psychology is delivered feels empowering to social workers and carers. It doesn’t take a problem away to fix, the input is collaborative and the advice concrete and practical.’*

Looked After Children: Attachment, mental health and long-term prognosis

Looked After children are at significant risk for lifelong difficulties in a range of areas and are over-represented in poor outcome groups. In terms of mental health, Tarren-Sweeney (2010) reviewed studies from across the Western world, concluding that more than half of children living in care have clinically significant mental health problems with a further quarter having difficulties approaching clinical significance. These mental health difficulties have considerable effects on the child and their surrounding support network, and Looked After children’s mental health issues were described as having significant impacts on almost 50 per cent of a sample of carers and schools (McCarthy et al., 2003; Teggart & Menary, 2005).

In addition to this prevalence of mental health issues, Richardson and Joughin (2000) detail a number of other problems experienced by Looked After Children; Looked After Children (LAC) in foster care were seven to eight times more likely to be physically abused and six times more likely to be sexually abused than those in the general population (Hobbs, Hanks & Wynne, 1999). Research has shown that in terms of education, Looked After children are several times more likely to have a statement of special needs (now EHCs), be excluded from school and to leave school with no qualifications. Rose et al. (2006) found that Looked After children are three times more likely to be cautioned or convicted of an offence than others, and care leavers are 50 times more likely to go to prison and 88 times more likely to be involved in drug use than people not looked after; they are also 60 times more likely to be homeless (Barnardos et al., 2000).

Repeated changes of primary caregiver, or neglectful and maltreating behaviour from primary caregivers who do not meet the child’s attachment needs, are the main contributors to attachment difficulties. Thus there is a lot of overlap between child abuse and attachment difficulties. Within the care system, some children continue to experience changes of caregiver as placements break down. This can compound difficulties with attachment, poor self-esteem and behaviour.

Extensive change in children’s lives, such as multiple placement moves, is associated with a number of negative outcomes. This includes having a negative impact on access to health care (Ward et al., 2002) and education services (Social Exclusion Unit, 2003), as well as impacting negatively on young people’s identity (Unrau, Seita & Putney, 2008) and self-esteem (Skuse & Ward, 2003) and leading to adverse attachment patterns (Ward, Munro & Dearden, 2006). Placement moves are common for children looked after by the Local Authority. Moyers and Mason (1995) found that

children not in the care system moved on average three times before they reached adulthood, in comparison data published by the Department for Children, Schools and Families (2008) shows that children in the care system can move that many times in a year. Ward (2009) found that in their sample, 57 per cent of all placements lasted less than six months. They found that most moves were due to the case management process, with some of these being attributed to poor planning. It was noted that disruptions to placements were more common where the child had emotional or behavioural difficulties. Changes of placement, especially when unplanned, disrupts the child's typical developmental trajectory on a number of levels. Continuity of family or carer relationships is compromised, often along with peer group friendships, sense of place and belonging, and access to familiar community settings and experiences.

Key issues and complexities

This is a group where the children, young people and families have needs that span between agencies and may find it hard to access traditional services. Multi-agency working and partnership working is essential although not always easy to achieve, particularly as services have become more fractured and more financially stretched over the past few years. *Future in Mind* (DH, 2015) recommendation 21 highlights the importance of joined up working across services; this is particularly pertinent for this population, where joining up may mean not only working across different organisations, but also working across different Local Authority or Trust/Health Board boundaries, and increasingly in the current public services landscape, across different types of provision (public, private, charitable, social enterprise). Cross-service and cross-border financial constraints hinder *Future in Mind's* aspiration of providing services at the 'right time, right place, right offer' (DH, 2015, p.42).

Clearly the need for a safe and stable placement is paramount, but this is also a group where proactive, timely and appropriately skilled psychological services can help young people to access more normative placements (whether within the birth family, or through adoption or long-term fostering, or even in residential rather than secure care). Specialist parenting support is needed to help traumatised children to learn to regulate their level of physiological arousal, alongside more established interventions for managing behaviour problems.

Carers need a high level of resilience based on good understanding, openness to support, high levels of compassion to self, and the capacity to retain mentalisation ability when under stress. Mentalisation can be described as the ability to understand and hold in mind

the perspective and motivations of another: mind-mindedness. This provides the foundation for providing a therapeutic approach to parenting for the children that will allow healing from past hurts alongside the development of trust and security (Golding & Gurney-Smith, 2015).

Additionally the emotional impact of caring for a traumatised child and whose neurodevelopment has been altered by previous parenting cannot be underestimated. Risk of blocked care (where a carer reaches an emotional/psychological position where he or she is no longer able to make a healthy connection with the child), secondary traumatisation and the triggering of past unresolved relationship difficulties in the carers cannot be underestimated (Baylin, 2015; Hughes, 2015; Hughes & Baylin, 2012). This means that parenting support must focus on the psychological health of the carers as well as on ensuring the provision of appropriate parenting advice. Greater joining up of child and family and adult mental health services could be advantageous. Caring for a child with exceptional nurture needs must be better than 'good enough' to make a difference to that child's trajectory.

It is critical not to make artificial distinctions between organic and acquired impairments, social and psychological problems or between mental health difficulties and the outcomes of adverse experiences when gatekeeping access to services for this client group. Regardless of the aetiology, all difficulties with behaviour, emotional wellbeing, ability to form healthy relationships, identity and functioning can impair a child's ability to live within a family, engage with education, keep themselves safe, and have hope and positive aspirations for the future. This 'whole person' approach is in keeping with the emphasis of *Future in Mind* (DH, 2015).

A whole population at high risk of a broad range of mental health and emotional wellbeing difficulties presents a challenge to services which are provided on the basis of diagnosis of specific mental health problems. Early intervention, focus on resilience building, and providing appropriate support for caregivers and teachers alongside specialised psychological interventions is needed from highly specialist mental health practitioners with a good understanding of childhood trauma, the impact of abuse, neglect, separation and loss, and the experience of growing up in care. More proactive targeted outreach services should ideally be developed. These might include either embedded clinicians or teams within social care teams/units, or joined up health and social care provision. Such services have been developed in some parts of the UK but are not universally available, and there are threats to any resources that are not part of the core CAMHS contract in the current economic climate.

Why psychological approaches are necessary

This population of children present a cluster of difficulties for which there is no medical treatment – neither attachment difficulties nor recovery from maltreatment are assisted by any form of medication. Therefore the scope for pharmacological interventions is limited to reducing levels of physiological arousal (readiness for fight or flight), improving attention/concentration and treating co-occurring conditions. However, social and psychological interventions, which are informed by our understanding of the impact of complex developmental trauma, separation and loss on the growing child, have a developing evidence base for improving outcomes in this client group. The importance of interventions which are broad in scope has been emphasised by Bruce Perry in order to build on skill and resilience as well as reducing emotional difficulties that are impacting upon quality of life. In addition, models of intervention which are multi-modal have been demonstrated to be successful in reducing the effects of traumatisation for young people through enhancing relationships, building resilience, providing regulatory support, targeting neurodevelopmental deficits and increasing capacity for reflection (e.g. Blaustein & Kinniburgh, 2007; Briere & Lanktree, 2013; Perry, 2006; Perry & Hambrick, 2006).

There are promising developments in terms of specific interventions for children in care or adopted from care, although most of these do not have a substantive evidence base yet. They have been developed based on research about what happens in healthy attachments and how this can be replicated with older children who have missed out on these experiences. For example, for younger children the Attachment and Bio-behavioural Catch-up programme can help children achieve more security of attachment (Dozier, 2003). Other promising interventions include Theraplay (Jernberg & Booth, 2001), Dyadic Developmental Psychotherapy (Hughes, 2011) and the Neurosequential Model of Therapeutics (Perry, 2006). Other interventions have a robust evidence base, but may need to be adapted to meet the needs of this client group. For example, traditional cognitive and behavioural interventions may be less effective when they do not take into account the biological impact of trauma on arousal levels (Howe, 2005; Perry, 2006) and specific trauma-focussed interventions, such as eye movement desensitisation reprocessing (EMDR) would need to be targeted at complex trauma rather than a single traumatic event (Korn, 2009). Similarly some elements of Dialectical Behaviour Therapy (DBT) may be helpful for this population in terms of coping with high levels of distress.

Systemic interventions are often most effective in this group. There are a number of needs that need to be met in order for the child to be in a position to effectively join with the therapeutic process, including a sense of safety and the existence of positive nurturing relationships. In the absence of these, psychological interventions with the systems around the child, especially those providing day-to-day care, are likely to prove most beneficial.

Future in Mind (DH, 2015) sets out how treatments should be provided for children and young people presenting with emotional distress based on the best evidence. Due to the high levels of distress, and the impact of behaviours such as self harm, violence and aggression, criminality, sexual risk taking, drug and alcohol use seen within this population, there is often a strong drive to provide some form of psychotherapeutic intervention.

However, research evidence within this population is sparse, and services are limited and this can often lead to a wide range of un-evidenced, poor quality and even harmful interventions being promoted by those with inadequate skills and training. For example, there is wide use of non-directive therapies such as play therapy with individual children who have experienced maltreatment, without any evidence that this is beneficial. There have even been methods promoted for this population that could be considered abusive, and have resulted in deaths and serious injuries, such as 'Holding Therapy', which involves restraint and aversive stimulation as well as forced regression techniques such as re-birthing; again without any evidence of efficacy (APSAC, <https://depts.washington.edu/hcsats/PDF/AttachmentTaskForceAPSAC.pdf>).

Ofsted's new Standards for The Inspection of Children's Homes (2015) emphasise the importance of any therapeutic interventions offered being fully accredited by the appropriate recognised professional bodies and delivered by staff who are appropriately trained and supervised.

It is essential that robust outcome studies are completed to inform which types of therapy are used with this population. It is important that interventions are developed based on our increasing knowledge about the impact of trauma, separation and loss on the children and young people, and clinicians are actively supported to develop research- and practice-based evidence.

Future in Mind (DH, 2015) emphasises the importance not only of appropriate evidence-based interventions, but also the importance of appropriately specialised training for front line staff working with high need populations.

Case study: Thomas came into the care system aged 6-years-old following a severe episode of domestic violence which he witnessed. Thomas had experienced both neglect of his emotional needs and physical abuse. An early referral was made to the local CAMHS recognising that Thomas was at high risk of being traumatised by his early experience. The local specialist Looked After team offered an initial consultation to the foster carers and professional network, including relevant social workers and education staff. Despite reports that Thomas was settling well and not posing any immediate problems, the clinical psychologist recognised early signs that Thomas was displaying an avoidant style of relating to his new parents, and a dissociative response to experiences of emotional arousal. This early consultation allowed an intervention plan to be put in place that provided support for carers, social work team and school, allowing trauma needs to be monitored and timely interventions to be provided. Regular, termly network meetings were held to ensure that the carers and practitioners shared understanding and a way forward for Thomas. The carers received parenting support and advice to help them to implement a regulatory parenting approach with Thomas that would meet his needs to overcome his fear and emotionally connect with his carers, whilst also having appropriate discipline and boundaries in place. Additional support was provided to the school as needed, especially to support Thomas at times of change and transition. Whilst opportunities were provided for Thomas to receive a therapeutic intervention aimed at reducing his trauma response, his extreme avoidance of emotional awareness meant that he could not engage with this work. The foster carers were, therefore, supported to help Thomas understand his life experience at a pace he could manage, and to help him maintain some link with birth family through letter contact.

The clinical psychologist supported the carers to gently work with Thomas so that over time he became more tolerant of high emotional arousal and more able to elicit support and comfort from his caregivers. Without the continuing support of specialist mental health practitioners it is likely that his experience would have been less positive, with a high likelihood of further placement moves and a poor prognosis in adulthood.

Elements needed for a good psychological service

Intervenes at different levels – care pathways integration

Looked After Children experience a vast array of adversity throughout their lives, and need to be a priority for professional intervention. *Future in Mind* (DH, 2015) recommendation 20 highlights the importance of

recognising lack of engagement with a service as a need for proactive inclusion work, rather than a reason to withdraw that service. This is a client group with such high levels of need that we must proactively deliver services to the whole population group, rather than expect them to be referred into mainstream CAMHS. We must be willing to go out to where young people are placed and take time to build up relationships with young people, carers, organisations and agencies.

Future in Mind (DH, 2015) emphasises the importance of simplifying and improving access to services. Mental health services are difficult to access for this population of children and their carers because of a shortage of available services and difficulties in accessing those services that are provided (CAMHS Review, 2008). This review highlighted problems in awareness of mental health needs by their carers on the one hand, and long waiting lists and overburdened services on the other. In addition inflexible rules for accessing services such as stability of placement can leave children's mental health insufficiently supported for too long a time. Evidence suggests that instability in care can cause or exacerbate mental health problems (Rubin et al., 2007; Ward et al., 2008). This emphasises the need for Health and Social Care services to work closely together with a joint focus on stabilising placement and improving mental health. Too often there are ideological and practical splits between Health and Social Care, with each expecting the other to solve the problems for the child.

Psychological input must be delivered at an organisational and systemic level, as well as through psycho-educational groups and attachment-informed training for caregivers and professionals, with those with the greatest need also receiving direct specialist therapeutic input when this is appropriate. With this client group it is important to take time to build up relationships, to do work with the systems around the child and their caregivers rather than directly with the young person wherever possible.

One of the key tasks for the systems charged with the care of a Looked After child is supporting the development of an attachment bond for that child to an appropriate adult and work will often need to be focused on establishing this bond between the child and the relevant carer, rather than the child and the therapist. When working with the young person directly, there are significant advantages to working with the dyad of child and carer/s together to increase the child's feelings of safety and security and to ensure that placement is therapeutic to allow healing from past trauma as well as reparative developmental opportunities. Displaced children such as those in placements far from home lose access to the frameworks for developing their sense of self necessary for successful negoti-

ation of adolescence, they need extra input and services to ensure access to community events, normative peer groups, and access to settings outside of their immediate family/educational setting in order to optimise their developmental potential.

A good service will ensure expert psychological as well as medical advice is available to placement and adoptive panels, as well as part of the recruitment, evaluation and training of adoptive parents and foster carers, and the annual health care assessment. Psychological input can help to ensure that placements are well-planned and supported, to reduce the risk of unplanned placement breakdowns.

We must ensure that all children, young people and their parents/carers get equal access to interventions to assist recovery from maltreatment and address attach-

ment difficulties regardless of their placement (foster, special guardianship, kinship or residential care), whether they are on the edge of care or adopted from care, or they are from the UK or overseas.

We need to also be mindful of the small but extremely complex and distinct populations of young people requiring secure care, those who have been involved in sexual exploitation, those who are unaccompanied asylum seekers or victims of trafficking, children temporarily brought to the UK for medical treatment and those placed in residential special schools (particularly those specialising in emotional and behavioural difficulties) and the overlap with children and young people who require crisis and/or inpatient mental health services.

Figure 1: An example of integrated systemic provision.



*MTFC – Multi-Dimensional Treatment Foster Care.

Outcome monitoring and evaluation

Currently there is no systematic approach to detailed mental health assessment for children in care (Chambers et al. 2010), despite the advice that joined up health and care planning can improve care planning and identify need for referral to services (Anderson et al., 2004; Blower et al., 2004). The complexity of the difficulties experienced means that traditional outcome measurements, such as the SDQ, are too limited for monitoring change.

There is a need to validate norm specific measures for this client group, and to evaluate whether routine outcome measurement has as positive an effect with this client group as it does in most other contexts (Boswell et al., 2013). Tarren-Sweeney (2010) emphasises the importance of appropriately trained and experienced mental health practitioners contributing to such assessment, and has developed assessment tools for this purpose. Another example of a more holistic screening of Behaviour, Emotional-wellbeing, Risk, Relationships and Indicators of conditions that may need further assessment or diagnosis has been developed (see www.BERRI.org.uk).

There is also a wider need for more research, evaluation and audit with this population. Social care has lagged behind health in the implementation of appropriate governance systems, and clinical psychologists are well placed to assist with their implementation in this context.

Leadership and managing complexity

Clinical psychologists can be a lynchpin in helping the whole service work as well as possible, by providing supervision and leadership. This draws on their ability to formulate cases involving a high level of complexity and multiple bio-psycho-social factors. They are additionally able to help with promoting knowledge and awareness, and developing the workforce through teaching and training. They can contribute to higher support levels such as multi-agency strategies and interventions. When it comes to direct therapeutic work, clinical psychologists are particularly well-suited to understanding the interaction of experience and development. They are very mindful of the issues of diversity, culture and belonging which are evoked in this client group, who often have complex histories involving multiple sources of trauma and maltreatment and may feel displaced and unable to be authentic, or to express their needs directly. Very few other professional groups are able to formulate in a way that draws in all of these multiple strands, and to work therapeutically where there may not be certainty about the child's experience (or even the longer term plan for them). Thus, clinical psychologists can also provide specialist help for young people and families where there are complex needs that cannot be met by other professional groups.

This is a particularly complex client group, and one in which the accumulated knowledge and skills of experienced clinicians is particularly valuable. Thus the trend currently of removing more experienced, specialised and expensive clinicians within the NHS and replacing them with lower paid clinicians who have less experience, training and less access to experienced clinicians to guide them, is particularly worrying in the context of this client group.

Risk support/maintenance

Having structured risk assessments, and strategies to manage behaviours that could break down placements or place the child or others around them in danger, is the top priority for children who challenge service provision. These young people can often be passed from one placement to another, or have historically been left to 'make their own choices' in ways that end up with them being exploited or further maltreated. It is a sad fact that not only does trauma and maltreatment have a direct impact on the prognosis for young people, but it has secondary effects on their ongoing health, wellbeing and functioning, with high risks of involvement in the criminal justice system, exploitation, substance abuse, self-harm, and mental and physical health problems. Thus highly skilled clinicians need to be available to consult with care providers to help them to address the immediate issues of risk and to identify and intervene in the underlying issues that make these young people particularly vulnerable.

Service and organisational development

A recent review of research and evidence focused on promoting wellbeing of children in care included recommendations for meeting mental health needs specifically (Golding, 2014). These recommendations included the need to intervene early to ensure that children are placed in stable homes meeting their emotional needs, with access to services that can support mental health and emotional wellbeing. This can be achieved through specialist, multi-disciplinary assessment provided in a timely manner and good partnership working between all agencies, as well as good training and preparation for the prospective carers to ensure that identified needs are met. Children in care need dedicated mental health services with appropriately trained staff working within a multi-agency approach. In this way mental health support is part of good care planning, and alongside education support. In addition the mental health services need a broad focus which can move beyond symptom reduction to also build emotional resilience. This emphasises the importance of carer and school support as well as therapeutic interventions for the child or young person. This will require the provision of a range of interventions provided for children, families, schools and

professional networks. Multi-agency working is key; the mental health professionals have an important role in partnership working to enable children and young people to experience stable placements, within which their mental, emotional, social, educational and spiritual needs can be met. Clinical psychologists alongside other mental health, education and social care practitioners, need to work together to ensure that this support is provided for all children growing up in care in a timely fashion and for as long as needed.

User participation and involvement

Those who have lived in the looked-after system tell us that each loss of caregiver or placement is a big change. Even where the feelings are not evident to an observer or manifested through behavioural expression such as violence, aggression, self harm, risk taking or criminal behaviour, these are losses that lead to a grieving process. Having nobody that you can trust and confide in becomes a fact of life, and you learn to invest less in each subsequent relationship. To the child, it feels like the problems are all because of something wrong with him or her, leading to intense feelings of shame, sadness, anger or isolation. Learning to trust enough in relationships again to share their experiences and feelings is a very slow and often painful process that needs to be given time and support. But it is the most important thing in the world for these young people.

Bazalgette (2014) conducted in-depth 'life story' interviews with children experiencing, or having left, care. These young people were able to articulate the benefits of care as well as difficulties that they had encountered. Young people recognise that their life chances were enhanced because of the increased safety, support to engage with education and opportunities for close relationships that the care system provided for them. They also describe, however, too many changes of relationship with foster carers, children's homes or social workers. These young people had strong views about the need to be heard and have more control over important decisions. Young people need more information about advocacy and complaints services; the young people wished to have stronger relationships with their social workers arising from being able to spend more time with them; and they wanted increased emotional support provided to them in a range of ways with opportunities for counselling, befriending, mentoring and recreational activities according to individual need. Leaving care was viewed as a difficult transition which required more support and for a longer time. The young people also wanted public understanding of the care system to be increased.

Sensitive services are adaptive to the needs of those who use them, and involve users in a way that is developmentally appropriate and respectful to their indi-

vidual circumstances, rather than prescriptively to tick boxes for a service specification.

Case example: A 14-year-old boy, James, had been in a foster placement for seven years, but his carer continued to find his behaviour quite challenging and felt unappreciated as he was defensive about his birth family and did not seem to recognise all that she was doing for him. The clinical psychologist used a 'brick wall exercise' (see Silver, 2013) with the foster carer in a psycho-educational group. She felt that James might be willing to participate in a similar activity. The clinical psychologist spent a session with James and his carer using this exercise to explore what young people need to experience in their early childhood to develop well. James was able to use this exercise to express his current and past experiences of care. His foster carer was moved to know that James recognised that her care was good, and better than he had experienced before, having a positive impact on their relationship.

Care Leaver perspective: When looking through my files as a care leaver, I came across a comment about having two older brothers who I had never heard of before and social services never thought to tell me! It also says in my files that I didn't trust social workers... I think this finding shows exactly why I didn't trust them. Having information and photographs related to your family and story is so important when you are trying to find your identity. It would have been useful to have photos of my carers and my bedrooms stored in my files too because I can't remember most of them! I also think only the more experienced social workers or other specialist professionals like psychologists should go through life story work – it can be very harmful [if done badly] and in an ideal world should only be done in a therapeutic environment. – Áine Kelly, DPhil student at the University of Oxford who was previously in care.

Transitions

Addressing the needs of care leavers and the transition to adulthood is a significant issue. There is an ongoing need for support as these young adults develop their own identity, particularly for those with the most complex trauma histories and/or multiple changes of placement or placements outside of a family (such as in residential homes or secure units). The teenage years can be a test even to stable placements, with young adults often seeking out contact with their birth families or testing out more risky behaviour just as professional support falls away. Social care obligations have

been extended into early adulthood (e.g. placements and funding that may last to the age of 21, and the use of Personal Advisors for care leavers), whilst most CAMHS provision ends at 18th birthday. Good services will consider transitions more thoughtfully and have extended age ranges of cover.

Conclusions

To be effective, services need to be able to intervene at multiple levels, with organisations, care-givers and professionals as well with direct clinical work. The unique skill-set of clinical psychologists can make a particularly significant impact: taking a leadership role, providing training and encouraging clinical governance, supervision of other professional staff involved in provision of these services, the use of routine outcome measurements and evidence-based interventions.

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Delivering psychological services for children and young people involved with the criminal justice system, those at risk of involvement, and their families

Jackie Preston, Matthew Lister & Lisa Shostak

Summary:

- *A psychological approach is helpful to fully assess and describe the complexity of young people involved in the CJS.*
- *Access to services should be based on psychological understanding of need rather than meeting diagnostic criteria. Services should view offending behaviour and an individual's needs as inextricably linked.*
- *Psychological formulation is a vital tool in making sense of complexity and understanding functions of behaviour, enabling more targeted and effective interventions.*
- *Psychologists can have a key role at all levels: guiding commissioning of services, providing consultation, training and supervision to those working directly with young people and intervening with young people and families directly in the most complex cases.*
- *Senior psychological leadership is important to ensure the best possible services are provided to this complex and vulnerable population of young people and families.*
- *There needs to be a consistent national strategy for commissioning services to meet the needs of young people across the country, including Forensic Community CAMHS services, with strong psychological leadership.*
- *A consistent psychological approach to service delivery across services can deliver a more co-ordinated pathway.*

Introduction

The diverse group of young people who come into contact with the criminal justice system are consistently seen to have complex needs in terms of their emotional health and education, work and social/familial relationships (e.g. Chitsabesan & Bailey, 2006). There is also clear evidence indicating that many of these needs go unmet within this population of young people and their families (e.g. Chitsabesan et al., 2006). These complex needs, and the historic failure of services to meet them, provides a strong argument for the importance of using psychological thinking, wherever appropriate and possible, to enhance efforts to reverse this pattern.

This group of young people and their families are often, over time, involved with, and offered interventions by, multiple agencies in a variety of different settings (e.g. Barrett et al., 2006). The various organisations and settings will have different remits for public protection, offender management, and health or social care aspects of presenting difficulties, and input can be offered either within the community or within specialist residential provision. The services may be criminal justice services such as Youth Offending Services (YOS), Secure Training Centres (STCs) or Young Offenders Institutions (YOIs), health services such as CAMHS, specialist Community Forensic CAMHS or secure hospitals, social care settings such as community social service provision or Secure Children's Homes (SCHs), and a wide range of educational services.

Due to many of the individuals in the justice system being at high risk of harm (to self and others) and further offending and having complex needs, safeguarding is a key concern for this group and their friends/families. Hence in the community involvement of social care is common, and an awareness of the social care system and joined up thinking both in terms of individual care but also in terms of commissioning is vital. Consideration of risk and how to manage it should be an integral part of any assessment and individual psychological formulation of young people's difficulties.

While the concerns and difficulties of the young people across these settings are similar, differences exist in both how behaviours are understood and what interventions are offered depending on the type of service provision (e.g. Harrington et al., 2005). Behaviours that may bring young people into contact with the Criminal Justice System (CJS) can include violent and aggressive behaviours and behaviours that challenge the system that is caring for them, which often complicates the consistency and clarity of their care. Psychological provision within these services is highly variable.

Young people from some Black and Minority Ethnic (BME) communities are disproportionately represented in the CJS and tend to have longer sentences (House of Commons Home Affairs Committee, 2007). Whilst the number of young people in custody from White British backgrounds has reduced by 70 per cent

in the past 10 years, this number has only reduced by 37 per cent for young people from BME communities, and 41 per cent of those currently in custody are from BME communities (Ministry of Justice, 2015). Awareness of such a significant level of inequality across ethnic groups, in addition to the known strong relationship between low social-economic status and likelihood of being involved in the CJS (e.g. Farrington et al., 2012), is very important when planning and developing services as well as understanding the impact this has on individual young people within the system.

This chapter summarises the specialist and complex needs of young people in contact with the CJS and the systems around them, and the key role that applied psychologists and psychological formulation can have in meeting these.

Why are young people in contact with the justice system seen as ‘complex’?

Young people coming into contact with the justice system often **pose a high risk to others, but also a high risk to themselves**. They often have **multifaceted health, family, social, economic and educational needs and there is a complex interplay between the mental health needs, the risk posed, and behaviours which bring young people into contact with the justice system (often referred to as ‘offending behaviour’** (e.g. Chitsabesan & Bailey, 2006). The young people using these services typically have histories of disrupted early attachments, trauma and loss (Bailey, Thornton & Weaver, 1994; Casswell, French & Rogers, 2012; Chitsabesan et al., 2006; Snodgrass & Preston, 2015). As a result, **it is essential that those working in this field are able to consider a number of theories of development and offending and be able to synthesise different theories** in order to improve the understanding of the young people. Rogers, Harvey, Law and Taylor (2015, p.2) state that the **‘Psychological needs of young people (and their care systems) should not be separated from an understanding of their offending behaviour; the two are inextricably linked.’**

Many young people in these services may attract a status of ‘hard to engage’ (either by their refusal or disengagement), and their trust in professionals can be broken or variable. **Young people themselves report histories of their needs being ignored or poorly met by professionals and as a result many view professionals, especially social workers and the police, with ‘deep negativity’** (Uservoice, 2011).

Service User example: One young person interviewed for the User Voice report of 2011: What’s your story: Youth Offenders’ Insights into Tackling Youth Crime and it’s Causes, stated:

‘Mental health services, social services, all the services from my school, all of them in one way, shape or form have failed me, and I know there are 1000s of people out there who have been failed by those services. They’ve let so many people down. If people that have been let down by social services were given a voice, the whole system would have to be radically changed because so many people have been let down.’ (User Voice, 2011, p.12)

The health services that exist to meet the emotional health needs of this population are often organised around psychiatric diagnostics, a system which can be criticised and challenged (Pilgrim, 2014). This is because the diagnostic system prioritises different explanations of the difficulties depending on the assessment. The consequence of this is that the young people being referred to services may be seen to meet the criteria for a number of diagnostic categories, the diagnosis may change over time, or diagnoses are not clear. Debates regarding whether a young person meets specific diagnostic criteria can not only delay access to interventions but also prevent access entirely due to strict acceptance criteria in some services. **We will describe how a clear and well developed psychological formulation can much more effectively enable services to work collaboratively both with young people and others involved and develop more effective and targeted interventions.**

Example: A young person who was part of the User Voice (2011) project stated:

‘My mum tried to get me help from the child and mental health services: they saw me once or twice but they didn’t feel that there was anything they could help me with at the time. I had a lot of mental health problems and diagnoses that were eventually made.’ (User Voice, 2011, p.15)

The opposite of this can also happen, in that, in the community, assessment of many young people will focus predominantly on the offending behaviour with mental health needs being overlooked or viewed as secondary and interventions that might be helpful are, therefore, not offered (Callaghan et al., 2003; Stallard, Thomason, & Churchyard, 2003; Wasserman et al., 2008).

As a consequence of engagement and diagnostic problems, many young people struggle to access services, such as mainstream CAMHS, as they do not effectively meet their needs. This increases the likelihood of them engaging in ongoing offending behaviour and increased contact with the youth justice system (Bradley, 2009).

Complexity of the systems

The systems that the young people encounter are themselves highly complex. **Young people can be involved in mental and physical health, social care, education, and criminal justice systems and there is different legislation that is associated with each system** (e.g. Mental Health Act, Children's Act, Criminal Justice Act) which **all professionals working with the young people need to be aware of**. These legislations and systems may sometimes have complementary, but at other times competing, functions and priorities. Services need to have an understanding of a young person's developmental needs, they need to understand and manage risk to ensure safety of the young people, staff and the public, and meet the needs, build on strengths and address the vulnerabilities of young people.

Example: The Service Standards for the National Secure Mental Health Service for Young People states that care and treatment needs to balance the following three principles:

- as an adolescent service it has to provide developmentally appropriate care attuned to the complex needs this population typically presents with and it needs to facilitate the young person's emotional, cognitive, moral, educational and social development;
- as a forensic service it has to provide a secure and safe environment that can effectively manage high-risk and often high cost behaviours and at the same time manage high levels of vulnerability;
- as a mental health service it has to provide comprehensive multifaceted evidence-based treatments and evaluate their effectiveness. (National Commissioning Board, 2013, p.21)

Young people may have a number of professionals from multidisciplinary backgrounds, working within different organisations, with a range of demands and priorities. There is an acknowledgement that effective working within a multi-professional network is vital. The Munroe Review of Child Protection (2011) places great emphasis on safeguarding, and on services working together, and welfare is seen as an important route of support for young people. New service developments such as the liaison and diversion programme also emphasise the importance of close joint working.

In all settings an individual psychologically informed formulation can be a hugely valuable tool in integrating the multidisciplinary perspectives with the clear voice of the young person at the fore. The process should be collaborative with the young person and across the various systems and organisations involved with the young person, including the family when possible. In terms of professional views this may include

social care, education, health, youth offending and police perspectives, and also multidisciplinary perspectives within teams. Each profession may well have their hypotheses, remits and focus, and so creating a shared understanding of strengths and difficulties, including risks and protective factors, requires a clear and structured process. **Developing such a formulation can often be a difficult task but is essential to ensure not only effective planning and safeguarding when in the community, but also effective interventions to facilitate change.**

Psychologists are particularly well placed to bring together these different perspectives, however any professional trained in the model of individual psychologically informed formulation could be equally well placed. The key is to create a shared understanding of what is going on for the young person so that interventions can be targeted effectively. **It is also important that one professional (ideally the person who developed the formulation with the young person) offers a leadership role in co-ordinating clinical opinion and developing co-ordinated approaches and interventions. It is logical to suggest that improving the structure of services around a young person will also have an impact on how they feel and manage their behaviour, and may provide a sense of containment for them.**

Impact on young people cared for in complex systems

There are additional challenges for young people with highly complex needs being looked after within these complex systems. **It is important to consider the impact of being in trouble on their development, attachments, trauma, peer group and socialisation.** Pro-social opportunities are quickly reduced once a young person gets into trouble – school arrangements change, opportunities are reduced more generally and any strengths are not necessarily nurtured (Henggeler et al., 1998). By the time a young person is within an institution they are often housed with a peer group with difficulties and the relationships with others, including staff, are likely to have an impact (e.g. Biggam & Power, 1997). **Psychological understandings can be a useful aid in thinking about these issues.**

Young people who are engaged in offending behaviour have often experienced multiple transitions and associated losses of relationships, friendships, activities, and education (Paton, Crouch & Camic, 2009). Our clinical experience suggests that transitions that occur between services for young people can be well coordinated and planned, involving the young person and their families, or alternatively they can be sudden and abrupt, and a young person may be placed far from home, family, friends and the services working with them. Transitions may be a time when young people are particularly vulnerable, and our clinical experience

suggests there is a lack of adequate community provision, particularly after a young person has been detained in secure residential provision. **If there is a clear assessment of complexity, along with a psychological formulation, which can travel with the young person and continue to be developed as they transition between services, their care and treatment can remain coordinated and lead to a sense of containment for the young person. If the system of care around the young person has this understanding, then this can potentially mitigate against further placement breakdown and additional transitions.**

Example: There are particular needs of girls who reside in secure institutional settings, whose presentation can be characterised by emotional instability, self-harm and aggression towards staff, and who may have acquired diagnoses of Mixed Disorder of Conduct and Emotions or ‘emerging’ Borderline Personality Disorder. Their typical trajectory is that they have become increasingly violent to the staff caring for them and increasing levels of security have been used to manage them, and it may be argued that this increasing severity is a response to increasing restrictive practices as young people progress through hospital or social care settings. These young people tend to display significantly higher numbers of incidents and clinical activity than male young people (Hill et al., 2012) and have longer lengths of stay (Hill et al., 2014). As violence can be directed at frontline staff, this can pose particular challenges for the staff team caring for them. For this group the role of the applied psychologist is to be part of the emotional containment and support structures for staff, and to use clinical formulation to provide a framework to understand and work out the best ways to intervene. This group of young people are often best understood within psychological (rather than diagnostic) frameworks and most successful interventions are often seen as being based in the relationships with staff (Bateman & Krawitz, 2013; NICE, 2009).

Why psychological approaches are necessary within services

When young people are involved with the criminal justice system and a network of other services, this may provide an opportunity to fully assess their needs (Royal College of Paediatrics and Child Health, 2013) and provide early opportunity for interventions that may change their trajectory and reduce risk of further offending.

Psychologically informed approaches can:

- guide service delivery: a psychological model of care can enable more seamless transitions and co-ordinate the system of care around the young person;
- provide direction as to how clinicians practice within services: helping services function and work with young people.

Psychologists would argue that services need a clinical model which utilises psychological approaches. **Central to a psychological model is an individual psychologically informed formulation, drawing from multiple theoretical perspectives, which can help make sense of the level of complexity and interplay between past experiences and current concerns** (BPS, 2011; Hollingworth & Johnstone, 2014). Consideration of context such as culture and the impact of this and wider diversity issues on both the young person and the decisions that have been made about them (e.g. their pathway through services) would be a vital part of this. Within a psychologically informed formulation model, offending is viewed as a complex behaviour, which like any complex behaviour is inextricably linked with multiple factors including past experiences, current context, individual thinking and emotions. Therefore any intervention, regardless of who is offering it, should aim to address the factors that impact on the behaviour occurring (Henggeler et al., 1998).

Example: There are opportunities for secure residential settings to be seen as Psychologically Informed Environments (PIE) (Johnson & Haigh 2010). This means that **services may use an overarching framework of a model of care that provides a coherent structure and theoretical underpinning to the work of the unit and provides guidance for frontline staff to work in a psychologically informed manner.** Snodgrass and Preston (2015, p.90) highlight why psychological approaches are needed in secure residential settings and in particular they note that ‘The relationships formed between professional caregivers and the young people can be viewed as the key agent of change’. A psychologically informed system of care, with a well supported staff team who are equipped with knowledge of psychological theory and an understanding of the developmental needs of young people, can enable a culture that can support young people to develop a sense of safety. Feeling physically and emotionally safe is seen as a key requisite to be able to benefit from any further intervention (Snodgrass & Preston, 2015). This understanding of developmental and psychological needs continues to be of vital importance as the young person later transitions or is discharged back to the community (Altshuler & Brash, 2004; Steinber, Chung & Little, 2004).

An awareness of developmental considerations is vital when designing and implementing services to support young people (e.g. Steinberg, Chung & Little, 2004). Psychological theories and constructs such as attachment theory (e.g. Ansbro, 2008) can also help services tailor interventions and approaches more sensitively. These help professionals hold in mind the biological and social developmental needs of young people, avoiding what can be a common pitfall of agencies falling into treating young people in contact with the CJS as ‘mini-adults’.

Example: The psychologists in the National Secure Forensic Mental Health Service for Young People have described a psychologically informed model of care that forms part of the service specification (National Commissioning Board, 2013, p.21). The aim is for a psychological approach to underpin every aspect of care, therapy and security. The aim of the model is to develop psychological mindedness within the system of care and for the therapeutic culture in the service to:

- Be delivered and maintained by staff who have a psychological understanding of their work and who are well supported and trained.
- Actively recognise the importance of the quality of relationships and interactions.
- Be informed by clinical formulation drawing from a range of theoretical perspectives.
- Be young person and family centred, and to aim to maintain good links with the young person’s wider support network.
- Promote wellbeing, the development of adaptive skills, forming and maintaining better relationships, and reduce problematic, challenging, or risky behaviours.
- Promote positive-risk taking using thorough risk assessment and risk management strategies.

This is achieved through training, clinical supervision and reflective practice, clinical and risk assessment, clinical formulation, psychologically informed interventions and evaluation and measuring outcomes.

In community settings, psychologically informed services are possible but rely more on local arrangements. Whilst there are national and local developments all the time to improve services it is important to note that these are not always psychologically informed. For example, the new initiative of a coherent Criminal Justice Liaison and Diversion Service, which is being rolled out nationally following Bradley’s (2009) recommendations to support earlier intervention in the justice system, is designed to improve access. However, there is no guarantee that this will increase access and reach the ‘right’ people, and it is possible to critique

the model as being process led at the expense of using clinical knowledge and practices such as formulation to improve outcomes (Lister, 2014).

Furthermore, there are **no clear commissioning arrangements for forensic community services and as a result provision varies around the country** (Dent et al., 2012). Some areas have more psychological focus than others. **Arguably psychologically rich or even psychologically led teams are likely to do better in creating a nuanced understanding of the difficulties young people present with.** The recent expansion of the IAPT remit into young people’s services has seen services increase their psychological working, in terms of increased therapy provision under supervision and routine use of outcome measures, but this initiative doesn’t guarantee psychologically informed services.

Examples: The forensic CAMH service in the Thames Valley is well established and a tiered consultation and assessment/intervention service is outlined in order to provide input to high-risk cases, whilst also supporting those working with concerning cases where the level of risk or need may not be clear. Consultation in the community creates psychologically informed formulation of cases, and community services can support this through regular consultation and supervision arrangements around case working with external services.

In Scotland, a recent project (the IVY project) used a consultation model to offer a psychological approach to assessment which then informed subsequent intervention and risk management of high risk complex cases, and advocated for the improved case formulation and coherent risk management plans which resulted (Dyer & Gregory, 2014).

Intervening at different levels

Leadership to inform care pathway integration

Leadership can be seen as an inherently psychological task (Lewellyn & Cuthbertson, 2012) which, amongst other things promotes values and vision, and demands oversight and support of others. **If services for young people involved with the CJS are to be provided in psychologically informed ways, where psychological understanding is at the heart of the services’ philosophy of care, then psychological leadership is of paramount importance.**

Psychological leadership in informing service delivery can ensure consistency of psychological approach, and advise on the staffing structure and level of experience required to inform a psychologically informed model of service. Psychological representation at senior level is not always present, and thus there

is a missed opportunity to think about how a consistent psychological approach can help structure services or manage transitions between them. As young people may move in and out of residential settings, and are supported by a number of community services over time, there is an opportunity for embedding a psychologically informed approach across these systems. Doing so enables a shared and consistent approach to provide for a more comprehensive and streamlined pathway between services. In the community, psychological case consultation can support this and a well-placed applied psychologist can maintain an oversight of the care and treatment of young people as they move between settings.

Example: Mental health in-reach to Secure Children's Homes and Secure Training Centres is now commissioned by NHS England (HM Government, 2011). This should help services work towards a more coherent pathway. A need for a coherent, equitable and unified approach is highlighted in Healthcare Standards (RCPCH, 2013). **Applied psychologists are in a good position to work at a strategic level to inform commissioners of the benefits to young people and services of a psychological approach, or as services come out for tender, to propose psychologically informed service models.**

There is also an opportunity for applied psychologists to take leadership roles, as members of Clinical Reference Groups (CRGs). CRGs provide guidance to commissioners including writing service specifications. Applied psychologists can have a role in advising commissioners on a more consistent psychologically informed approach to service delivery across services and teams. There is a lack of integrated care pathway between medium and low secure hospitals, partly because medium secure hospitals have been commissioned as a network, but low secure have been commissioned in a piecemeal way and are often provided by the independent sector to meet market demands. The current commissioning arrangements mean that all secure hospitals are now overseen by the Secure CAMHS CRG. Applied psychologists are represented on the CRG and can, therefore, influence the service standards to include consistent psychological models of care.

Developing the workforce – teaching and training

In order for the systems of care to be psychologically informed, there is a role for applied psychologists to deliver training to develop the skills of those working most closely with the young people. This enables these staff to understand behaviours and their function, to make links between the influence of the young person's complex histories on the presenting needs, and

provides guidance on how those working most closely may provide key interventions to meet these needs.

There is also a role for applied psychologists to provide training to staff as part of the transition process to subsequent placements to help staff in the placement understand and meet the mental health needs of the young people and help to maintain a consistent approach.

Within community settings each organisation will have its own training focus related to its remit, and there will be local variations. **Whilst organisations such as the Youth Justice Board are helpful in recommending training to Youth Justice Services, or producing guidelines on best practice, there is no coherent national commissioning (therefore standard) of training for community forensic services as provided by applied psychologists.** Smith and colleagues (2013) note that there are variations in interagency practice relating to safeguarding and criminal justice practice despite the existence of a number of guidelines. Hackett (2014) has argued that there needs to be a national strategy for how sexually harmful and inappropriate behaviours are dealt with by agencies.

Within the residential provision, there are also variations. Many areas may have dedicated services or 'in-reach' arrangements, but these are dependent on local commissioning. Commissioning arrangements may support training within the service, or contributing to training of other services, and this is helpful.

Examples: In Oxfordshire and Buckinghamshire, the child and adolescent harmful behaviour service (CAHBS) is asked to provide training on sexually harmful behaviour to local partner agencies in conjunction with the local safeguarding boards under its commissioning arrangements. This training supports increased awareness of child sexual development, assessment of problematic behaviour and basic interventions, and not only helps support professionals in their work, it means that referrals are more appropriate and concerns are more clearly identified.

The Medium Secure Service Standards state that training programmes for nursing staff should include topics on: attachment theory and attachment/ trauma approach to care, adolescent development, skills necessary to engage young people including communication skills, listening skills, de-escalation skills, disorders of conduct, personality disorder, mental disorders specific to adolescence, and learning disability. Commissioners require that services report on the delivery of this training. Applied psychologists are well placed to support or lead these training programmes. As part of the Bluebird House Medium Secure Service for Young People Attachment and Trauma Model of Care,

the unit psychologists run two-day training for all clinical staff, managers and commissioners to provide a shared understanding through which all young people are viewed. The aim is to help those working with complex young people have a clear focus on the task with the young person at this point in their journey.

Core components of a psychological approach

Assessment

Completing an assessment with a young person that results in a full understanding of the needs and factors relating to their offending behaviour requires significant skill. Experience and training are required to a high level so that a wide range of possible issues can be considered, including social and developmental difficulties such as Autism and learning disabilities. Often it takes time to get a better assessment of someone's needs and minimisation or denial of emotional problems will mean that some things may get 'missed'. **There is significant evidence that the mental health needs and learning disabilities within this population are both under-diagnosed and poorly met** (e.g. Chitsabesan et al., 2006; Herrington, 2009; Young et al., 2011).

An assessment should be based on core areas that are familiar to psychologists working in any field. **Additionally, experience with psychometrics which can measure aspects of mental health, personality, learning disabilities or offending related factors is useful when working with this group of young people.** Examples include measures of empathy, resilience, mood, anger and multifactor assessment such as the Millon Adolescent Clinical Inventory (MACI). **Consideration of contextual factors is also important and systemic ideas form a vital part of the assessment.** There is growing evidence that creating long-term change for this group of complex young people is best done via multi-systemic thinking and intervention (Butler et al., 2011). **Assessment would also require an element of risk assessment.** This is usually done by using evidence-based structured clinical judgement approaches such as the Structured Assessment of Violence and Risk in Youth (SAVRY), the Assessment Intervention and Moving on (AIM2) or the Juvenile Sexual Offender Protocol (JSOAP-II), and it is important to balance risk factors with protective factors (see Structured Assessment of Protective Factors – Youth Version (SAPROF-YV) and SAVRY) to enable strengths-based approaches. **These assessments are used to inform interventions in order to reduce risk factors and increase protective factors as recent evidence suggests that both are important** (Hilterman, Nicholls & van Nieuwenhuizen, 2014).

Biopsychosocial formulation

As stressed throughout this chapter, **our view is that individualised psychologically informed formulation is an essential tool when working with young people presenting as high risk to others and/or themselves.** Formulations should be collaborative, multidisciplinary, and wherever possible, involve the young person and their parents and carers. Rogers et al. (2015) state that formulations 'should integrate a wide range of psychological, biological, social, systemic and cultural factors... in the context of their developmental trajectory' (p.2) and it is important that formulations include protective factors, which can sometimes be overlooked when clinicians are problem focused.

A formulation approach **can provide a framework that holds and understands the complexity of the young people and an individualised understanding of needs and risk is considered more useful than understanding based on diagnostic category, offence or social care need alone** (Snodgrass & Preston, 2015). Young people themselves value their offending being seen in the context of 'the violence, deprivation, poverty and exclusion of their childhoods' (User Voice, 2011).

A formulation approach also **helps the system of care around the young person hold a shared understanding of the young person and can transition and adapt as a young person moves between services and provide the young person with a more consistent and coherent package of care.** They can help make sense of high-risk behaviours that a young person may present with. They can provide an understanding of how behaviours may be adaptive to young people, given what may have been early experiences of trauma and disrupted attachments, financial and social disadvantage or inequality, and challenging familial or community environments; but that these behaviours may also be harmful to themselves/others (Rogers et al., 2015). This understanding can help those working with young people have increased compassion and empathy.

Biopsychosocial formulations enable a formulation of the risks posed (risk formulation) and clinical needs (clinical formulation) to be integrated. **An integrated risk and clinical formulation can help services balance their approach, so that services can both focus on measures that can reduce risk and increase protective factors for and of young people.** Formulation also offers a clear way to facilitate the sharing of risk information between services in a manner that encourages understanding of, and engagement with, the young person and their needs (Hollingworth & Johnstone, 2014).

Finally, formulations can help guide the complex systems and professionals working with young people as to a shared understanding of the key therapeutic tasks and interventions to meet the needs of the young people. **Formulation guides not just interventions**

targeting the individual, but also can suggest how the context and environment can best meet the young person's needs and reduce risks.

Intervention – consultation and promoting knowledge and awareness

Snodgrass and Preston (2015) note four levels of psychological intervention. These are: psychologically informed practice, psychological assessment and formulation, single modality psychological intervention (which is focused on the present and aims to build skills) and psychological therapy. It is important that interventions have the right focus at the right time, to ensure that resources are used when and where they will be most effective (Saxe et al., 2005). Psychological formulation can be an essential tool to ensure that the most appropriate interventions are offered and are therefore more likely to be successful. The core tasks of interventions can be seen as stabilisation of any current crisis, followed by building relationships, helping a young person to build skills and resilience, and lastly, for a small number of young people, developing reflectivity. While an applied psychologist would be well placed to oversee all of these tasks, single modality intervention can be carried out by anyone appropriately trained in delivering the intervention, with regular supervision from an applied psychologist. Our clinical experience suggests that young people engage best in these interventions when they are individualised, rather than manualised.

It is helpful to consider how services can structure their interventions in a tiered way. This means that young people may be offered routine interventions from practitioners of psychological therapies, in order to target a specific aspect of their difficulties, but this needs to be done with a clear formulation in mind and a review built in. Supervision of this work will be necessary to ensure complexity is held in mind. This intervention may be with the individual, but may also be with the family. There have been calls for this over the years for tiered services around, for example, harmful sexual behaviour, but little evidence of implementation (Hackett, 2015). **Psychologists can help services consider this due to their use of consultation and ability to offer supervision and training.**

As we have outlined, **the young people who are coming into contact with the youth justice system are unlikely to benefit from standardised treatment ‘packages’.** They need interventions to be tailored to them. Furthermore there are high rates of learning disabilities and educational needs within this population, meaning that interventions need to be adapted. The treatment interventions that have slowly growing evidence bases as being effective in creating change for these young people, such as Multi-Systemic Therapy, all

work from the assumption of a need for individualised formulation and integrative models of intervention, even within a licensed treatment package (Henggeler et al., 1998). The applied psychologist, therefore, has a crucial role in designing and delivering or overseeing the delivery of a tailor-made intervention, driven by psychological science and the resulting formulation (Rogers et al., 2015).

Consultation is commonly used within services and has a variety of different meanings in practice and can be seen as one type of ‘intervention’ (Llewelyn & Cuthbertson, 2012). It can be seen as a key skill for psychologists to emphasise and use in their services. Provision of consultation can be to nursing team, multidisciplinary team, and outside agencies to inform care planning or provide clear input into specific issues. **Consultation can support psychologically informed care planning and improve the understanding of the function of behaviour.**

Case example: Community services

J is a 15-year-old boy who had previously been offered some emotional regulation work at CAMHS when 13 but he had disengaged. He was referred on this occasion following an incident of carrying a blade in public and concerns about his mood. He had previously carried out an assault at school. He was being schooled in a special education provision and struggled there with temper outbursts and disruption, although is seen as a likeable boy with possible ADHD. Liaison revealed that the family situation was of concern to school. He was initially unwilling to attend an assessment but was encouraged to do so by the Youth Offending worker. At assessment he presented as possibly experiencing concentration difficulties, but he was able to speak of low mood following bereavements over the last two years. His behaviour during the incident appeared to be linked to feeling unsafe and some peer pressure, and consideration of the SAVRY risk assessment highlighted that there were not many risk factors present. He was accepted for further assessment at mainstream CAMHS with ongoing forensic team consultation to aid the formulation of his difficulties and risk to others.

Helping the whole service work as well as possible

Supervision

Supervision is especially important for staff working with young people who are considered a risk to themselves and others and has a number of important functions. **Supervision can help provide emotional containment for the high levels of anxiety and fear that staff may experience.** In residential settings, staff can face a risk of assault. In community settings, staff may

be acutely aware of the potential risk of harm that a young person may pose to others or themselves. **Supervision can help staff consider the needs and vulnerabilities of the young people, and the risk they pose to others. Supervision can also provide opportunities to help staff make links between psychologically informed teaching programmes and everyday clinical practice.**

Group supervision is commonplace in residential settings (BPS, 2007). Psychologists have advantages in facilitating group supervision and reflective practice meetings as they are both inside and outside of the team and are able to both hold a different perspective and emotional containment as they are one step away, but also close enough to develop relationships with frontline staff and may have good first-hand knowledge of the young people. Overall, supervision is seen as a core skill of psychologists as they are trained and have experience of a number of supervision models and types. **Supervision to outside agencies is also important and shows how to support interventions to young people with complex difficulties.** This supervision may help a professional maintain engagement, become clearer in their work and thus increase the likelihood of a positive outcome.

Outcome monitoring, evaluation, audit and research

It is worth noting that psychologists are trained to a high level in research and audit skills in terms of their qualifications. These skills are not always 'used' by services, but psychologists often take a lead in service evaluation, and where there is time or remit, research.

Outcome monitoring can be difficult as commissioners may want frequency or quantity measures, whereas clinicians are usually more interested in quality. It can be a challenge to select measures that capture the complexity, and which are sensitive enough to capture small, yet clinically significant, changes. Measuring quality or impact of multifaceted interventions for complex young people demands a range of measures which draws on a range of data, and psychologists can help services frame their outcomes in accessible ways.

Service user and carer experience surveys are useful in that they draw attention to quality and experience (over quantity), and psychologists are well placed to support these initiatives. The medium secure services have worked together to ask the same questions of carers to enable wider themes to be addressed at a national level as well as unit level, and the Secure CAMHS CRG worked with YoungMinds to gain feedback from service users and carers. The use of service user surveys is becoming almost routine in practice, and the IAPT initiative has supported this in the community by encouraging use of routine outcome measures and evaluation tools.

Services may benefit from working together to provide larger numbers when looking at outcomes and also to allow services to benchmark themselves against similar services.

Example: The Medium Secure Services use Quality Network of Inpatient CAMHS Routine Outcome Measures service (QNIC-Rom) to collate outcome measures from across the national network. Bespoke analysis means individual services can compare their means with the means of data from the network as a whole. The data showed that the services demonstrated good outcomes on clinician rated measures, but there were no significant differences on young person rated measures (Strengths and Difficulties Questionnaire, SDQ). Psychologists often take a lead on implementing the system of collecting and reporting outcome measures.

Competencies needed

As psychological approaches to young people who are involved with the CJS is becoming more commonplace and commissioners/providers of services become more aware of the benefits to young people of these approaches, it is important to define what level of psychological provision is needed and the competencies that applied psychologists require. Psychological provision will need to be able demonstrate competencies in:

1. Understanding the complexities of the educational, social, health and criminal justice systems that the young people are part of.
2. Leadership in developing a psychologically informed model of care including delivering training programmes and providing clinical supervision.
3. Developing complex clinical and risk formulations that take into account the interplay between developmental stage, mental health, and offending behaviour and draw from multiple theoretical perspectives.
4. Administering and interpreting specialist psychometric assessments and evidence-based risk assessment tools.

Psychologists need to be embedded within the service/unit/team culture to ensure co-ordination of care. Medium secure inpatient services require that psychologists at consultant grade are part of the staffing configuration in order for the psychological approaches to be held at a strategic and service development level. Finally, it is important to consult with psychologists in general about services which aim to be psychologically informed, staffed or modelled.

Conclusions and ways forward

Psychologists are usually well received in forensic services, precisely due to the range of contributions made to services as outlined in this chapter. There remain opportunities to further develop upon these. For example, if there is a more co-ordinated and consistent approach across services (using a psychologically informed approach) this can help transitions between what can be quite fragmented systems and a fragmented care pathway. Psychology is well placed to assist the thinking on this.

Without doubt, those who work in the community would argue that we need more Community Forensic Services (with key senior psychological dedicated time), and a national network and clear national commissioning arrangements for this are being argued for (Dent et al., 2012).

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Further reading

For further reading on this matter we recommend:

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Delivering psychological services for children and young people with neurodevelopmental difficulties and their families

Katie Hunt & Jaime Craig

So, what does 'good' look like in psychological services for children and young people with neuro-developmental difficulties, their families and the networks around them?

These are services that:

- *Understand the contribution of neurodevelopmental difficulties to behaviour and recognise that children can present to services at any age.*
- *Understand that having more than one neurodevelopmental difficulty is the norm, and organise services so that children can access clinicians with expertise and knowledge of neurodevelopmental difficulties at all service levels, not just in services organised around specific 'disorders'.*
- *Recognise that the essential competencies for working with this group cannot be delivered by someone trained in one theoretical model.*
- *Recognise that services for this group span child health and CAMHS services, and minimise gaps in service provision firstly by working in a joined up and child/family focused way across organisations, particularly with colleagues in Paediatrics, and Speech and Language Therapy services, and, secondly, by offering consultation to other professionals working with children (including schools) in order to foster better understandings of typical and atypical development, and what it might mean.*
- *Link with commissioners to promote understanding of complexity for children with neurodevelopmental difficulties, the kinds of services they need, and the barriers families face in accessing services on the same basis as typically developing children.*
- *Deliver inclusive services for all children experiencing the distress associated with poor mental health regardless of whether they also have neurodevelopmental difficulties.*
- *Provide assessments that are both comprehensive and multidisciplinary, joined up with other services, and which try to anticipate where delays in the assessment process can occur and work proactively to minimise the length of the assessment process, and associated stress for children and families.*
- *Understand the contributions of contextual factors (including culture) to family and clinician views though the assessment process, and understand that a child's presentation will change over time, and that parents and children may want different things from a service.*
- *Sit 'diagnoses' within a wider psychological formulation of the child and family's difficulties and strengths to promote a shared understanding of the child, and offer evidence-based interventions based on these formulations.*
- *Support parents and children after the assessment has finished.*

Introduction

What we mean by 'neurodevelopmental'

When we talk about 'neurodevelopmental difficulties' we mean a wide range of difficulties experienced by some children and young people which are understood to have a neurodevelopmental basis. The term is not well defined but we use it to mean difficulties that are thought to have an onset very early in life but with consequences not seen until many years later. They are not solely caused by something that has happened in a child's brain: genetics, environment, family, gestational and perinatal environments and experiences; childhood experiences and more are risk factors that contribute to some children demonstrating neurodevelopmental difficulties (see Bishop & Rutter, 2009; Pennington, 2009); it is important to note that the presence of risk factors does not mean that difficulties are inevitable or that all children will show difficulties in the same way, even if they share a diagnostic label.

Children with neurodevelopmental difficulties do not necessarily have intellectual difficulties (also known as learning difficulties; see also Paper 12).

Neurodevelopmental difficulties include autism spectrum conditions, attention deficit conditions (ADHD, ADD), social communication difficulties, foetal alcohol spectrum disorders, Tourette's syndrome, and motor co-ordination difficulties; we are not discussing children with acquired brain injury here as they are included in the paediatrics service paper in this collection (see Paper 5).

Language

The language used to talk about some behaviours that cause concern is important. There are increasing concerns about the validity of current diagnostic systems based on a disease model, and a move towards a system that takes a psychological perspective

(DCP, 2015). With this in mind, in this paper we talk about difficulties rather than ‘disorders’, and refer to ‘people who have been given a diagnosis of’ rather than people who ‘suffer from’/‘have’ a particular diagnostic label. We use the term ‘children with neurodevelopment difficulties’ to mean children and young people whose difficulties are thought to have a neurodevelopmental basis. This approach can be problematic, however, since terms such as ‘autism’ and ‘disorder’ are in common use.

Lots of factors can put pressure on the assessment process – ‘diagnoses’ and explanations inform how young people see themselves, how others see them, and how they and their behaviour are understood. These labels have social meaning and value, particularly if there are financial implications (benefits, housing, etc.) or eligibility for services and support (e.g. access to teaching assistant support within education) and it is crucial that this dynamic is held in mind and considered in the psychological assessment of the young person, paying attention to the context.

It is also important that we are aware that communities of people with neurodevelopmental difficulties may not see themselves as having any ‘problems’ at all. As an example, people with a diagnosis of Asperger’s syndrome may see their way of thinking and behaving as different from the majority, but equally valid and in some ways superior (Clarke & van Ameron, 2008; Wing, 2005). Caution is necessary before labelling behaviour as ‘difficulties’ from our powerful positions as clinicians, especially when working with children whose views are often subsumed beneath those of parents and other adults within systems that value conformity, and when such labels can have a powerful meaning for carers who feel criticised in their care of their child. Research also suggests a complex interaction between narratives around diagnoses and young people’s identity, and the potential to increase or decrease blame/stigma and impact on agency (e.g. Brady, 2005; Huws & Jones, 2008).

Clinicians also need to be aware of the potential for behaviours to be mis-labelled or even falsified/exaggerated in some cases (e.g. Rittner, Poulos & Lennon, 2005).

Diagnostic complications

Children with neurodevelopmental conditions are the largest group of disabled children in the UK (Chief Medical Officer, 2012); recent prevalence estimates are 1.7 per cent of children for autism spectrum disorders, 1.4 per cent for ADHD (Russell et al., 2014), and 2 to 5 per cent for foetal alcohol spectrum disorders (May et al., 2009), although some children have no formal diag-

nostic label that would apply. We know that having just one neurodevelopmental condition is rare and co-existing conditions appear to be the norm (Gillberg, 2010; Lundstrom et al., 2015)¹, highlighting the need for comprehensive assessment and tailored intervention.

Assessment is not a one-off event and a child assessed as meeting the criteria for a neurodevelopmental disorder at one point in time may not fulfil those criteria later on (see, for example, Fein et al., 2013; Suter et al., 2007); we know that some children will be able to manage their difficulties so that they no longer cause significant problems as they get older.

Children and families, however, need ways to talk about a child’s difficulties and what they mean both now and in the future; the debate about deciding what to call the difficulties that children are presenting with highlights the value of a formulation based approach.

Why psychological approaches are needed

Psychological approaches are key to understanding the difficulties of children with neurodevelopmental conditions, however we choose to conceptualise them. Assessment is largely based on clinical judgements of children’s observable behaviour which can be problematic for many reasons: all children are different and any two children with the same ‘diagnosis’ might have very different difficulties in everyday life, with many of the behaviours of concern also seen in typical development. A formulation may be better than a diagnostic label at capturing the key difficulties and protective factors for a child, particularly when children may have several different labels that are attempting to describe their difficulties; formulation can also provide a different level of explanation for a child’s difficulties, personalising the assessment to better fit the child. Diagnosis alone is rarely sufficient to inform an effective intervention plan and does not always take account of a child and family’s strengths.

There is debate about whether formulations and diagnoses are compatible (e.g. DCP, 2013), but the reality is that children with neurodevelopmental difficulties are generally seen in services which use a diagnostic model, where not having a diagnosis can create difficulties for the very children and families who come to us seeking a different framework for understanding their child. A psychological approach which considers behaviour in its wider context (e.g. social, cultural, gender, class and race) is important, as some children who appear on first assessment to have neurodevelopmental difficulties may, in fact, have attachment difficulties; this is particularly so for children where there is no reliable early history, such as looked after children, where there is a risk of a ‘false positive’ conclusion of

¹ We prefer the terms ‘co-occurrence’ or ‘co-existing difficulties’ rather than comorbidity.

neurodevelopmental difficulties leading to ineffective interventions (see Moran, 2010).

Children with neurodevelopmental difficulties are complex, and a key role for services is to communicate this complexity (and what it indicates in terms of service organisation) to service managers and, crucially, to service commissioners.

Intervening at different levels: Including consultation and promoting knowledge and awareness

The vast majority of children with neurodevelopmental difficulties, their families and those who support them, will require interventions/management plans and strategies to support their wellbeing that are primarily psychological/behavioural in nature, even when medication is indicated (e.g. Verdellen et al., 2011).

These interventions include support to learn new skills and compensatory strategies, helping those in caring and education roles to understand and respond to behaviour, recognising and supporting systemic contributions to the development and maintenance of difficulties, and working with the system to adjust and improve these at times with complex competing needs and dynamics at play.

All professionals working with children require a solid grounding in typical and atypical development that goes beyond descriptions of individual diagnostic labels, fostering a broader understanding of neurodevelopmental difficulties in different contexts. This is of particular importance for early years and education staff.

Provision for children with neurodevelopmental difficulties spans child health, CAMHS and local authority services/education, leading to gaps and barriers in accessing help. We can support early identification by the children's workforce having access to skilled consultation/joint working from professionals with expertise in typical and atypical development, child and parent psychological difficulties and the ability to help others make adaptations in light of assessed neurodevelopmental difficulties as they emerge. Clinical psychologists, used to working within and across complex systems, across the lifespan, and with expertise in child development are well placed to deliver this.

Core components of a psychological service

Assessment

Assessment is at the core of any good service and in this paper we concentrate on some key principles of assessment for all children where there may be neurodevelopmental difficulties, pulling together essential core features to inform an understanding of the psychological competencies required, regardless of context or service structure.

Early identification leads to better outcomes (e.g. Dawson et al., 2010), but identifying children with neurodevelopmental difficulties is not straightforward: children access services in different ways and at different ages, service structures vary, and linguistic and cultural factors also affect service access, leading to delays in recognition of difficulties, subsequent assessment and access to specialist services. A young woman whose difficulties are only identified in sixth form will need a different model of service delivery with very different skills compared to a 3-year-old with difficulties identified in nursery. This is a complex challenge for services which are likely to have a focus on children in the early years.

Once a child's behaviour has been identified as being of concern, the child's route through services may be driven by what problem was noted first and where, leading to assessment 'dead-ends'; Gillberg (2010) describes how wider developmental difficulties can be initially missed by a narrower focus on the initial presenting problem; this is important as a large proportion of children identified in the preschool period with, for example, language impairment, will go on to meet criteria for autism spectrum disorder (Gillberg, 2010).

Assessment is essential to the process of formulation and psychological intervention (BPS, 2008) and should be a comprehensive process. What constitutes a good assessment will vary according to the presenting concerns and difficulties, but should be comprehensive enough to decide firstly if the child's difficulties are neurodevelopmental in nature, and secondly whether they can be understood in a coherent way in terms of a 'diagnosis' – which to be of value should sit within, and not replace, a psychological formulation. Even when difficulties are not seen as neurodevelopmental a formulation should be the minimum outcome, with an explanation of underlying difficulties and suggested ways to address them in order to help direct young people and their families to services that can support them.

A skilled psychological perspective is crucial to assessment, including child, parent, and family assessment, formal psychological assessments, and understanding the behaviour of children in different settings. It requires a solid understanding of both typical and atypical development, what atypical development might signify and what assessment may be needed. These are some of the core skills of applied psychologists working with children, and cognitive assessment with children in particular is only carried out by clinical or educational psychologists.

Assessment should be multidisciplinary

Most available guidelines² highlight the comprehensive and time consuming nature of assessments and the need for professionals undertaking them to be experienced and trained. Assessments are necessarily multidisciplinary, since no one professional would possess all the relevant skills required in assessment of the breadth of often subtle behaviours associated with neurodevelopmental conditions (e.g. Gillberg, 2010; Taylor et al., 2004).

The professionals involved in assessment will vary, depending on the child's presenting difficulties, but typically include a paediatrician or child psychiatrist, an applied psychologist (clinical psychologist, educational psychologist or clinical neuropsychologist), and a speech and language therapist; specialist occupational therapists (skilled in sensory assessment) may also be involved.

These professionals should be available in all geographical areas, but are unlikely to be situated in one team/agency/NHS trust; which can lead to difficulties when different services have different access criteria, and where collaborative working may be problematic if it is seen to take staff away from the 'core business' of their own service, something that can be averted by creative commissioning.

The risk is delays in the component parts of the assessment, with some aspects out of date before others have started. This disadvantages children who need the outcome of the assessment to inform their education, wellbeing, and access to other services, and exacerbates an already stressful process for families.

Parents wait around a year from first noticing difficulties to seeking help; the average time between seeking help and a resulting diagnosis of an autism spectrum condition is 3.6 years (Crane et al., 2015). One parent is quoted as saying:

'the time waiting for screening and the diagnosis was a year – a long time spent wondering what was wrong.'
(Crane et al., 2015)

Good services should, therefore, ensure that assessments are completed in a timely manner.

Assessment should be comprehensive

Due to the high rates of concurrence of neurodevelopmental conditions, a key principle is that assessment should be comprehensive (Lundstrom et al., 2015), should seek to identify strengths and protective factors for the child and family in order to inform the clinical formulation, and should include:

Clinical interview and developmental history

Structured discussion with parents including a formal developmental history spanning from pre-conception to the present. Parents may have already talked to another professional about their child's development, but formal clinical history taking is more specialised.

'Diagnostic instruments' for autism (e.g. ADOS (Lord et al., 2000), 3di (Skuse et al., 2004)) which may form part of a comprehensive assessment to help in structuring information, are not diagnostic by themselves and none would detect all children who meet diagnostic criteria (Charman & Gotham 2003); despite this, parents report their child being found not to fulfil criteria for autism based on one instrument.

Clinical observations of the child

In a clinic setting and in another setting (e.g. school) in order to include social interaction with peers.

Gathering information from more than one source

Through discussions with school, use of structured questionnaires, or both.

Clinical interview and assessment with the child

- *Assessments of mental health and behaviour* – children with neurodevelopmental difficulties are more at risk of other clinically recognisable difficulties.
- *Assessment of communication* – generally by an experienced speech and language therapist.
- *Assessment of cognition* – assessment of **intellectual ability** helps frame the interpretation of other observations about the child, is associated with adaptive functioning and outcome (Ozonoff et al., 2005). Assessment of **achievement** may be indicated but is limited in terms of explanatory value in the absence of an assessment of ability – there may be many factors impacting on attainment.

Assessment of **neuropsychological functioning** may be needed due to the complex presentations of children with neurodevelopmental conditions (Murphy & Muter, 2012). A child's cognitive/neuropsychological profile can help explain issues as diverse as self-esteem, behaviour and learning, is important in tracking progress and informing decision making (Tonks et al., 2014). Assessment should take a hypothesis testing approach (e.g. Frampton, 2008) due to resource limitations in CAMHS, and include formal assessment of e.g. memory, speed of information processing, attention, and executive functioning.

² For example, Cath et al., 2011; Chudley et al., 2005; Le Couteur, 2003; SIGN, 2007; Taylor et al., 2004.

Assessment of **adaptive functioning** – good practice in all assessments that include intellectual assessment, is a core requirement for identifying intellectual difficulties, and important for realistic goal setting, and predictive of outcome (BPS, 2000; Ozonoff et al., 2005).

Medical and biomedical investigations – for example, to rule out genetic conditions.

Other assessments as required – based on the child's presentation.

Not all children will need all of these assessment components and it follows that with increasing complexity a greater number of components are likely to be needed to reach a reliable understanding – particularly when there are competing explanations/different presentations in different contexts (which is relatively common) or co-occurrence.

Due to the complexity of neurodevelopmental conditions, assessment by questionnaires alone is insufficient; clinical interview is crucial. Without a good enough assessment children's difficulties remain poorly understood, and systems are not able to see behaviours of concern as having a neurodevelopmental basis, to the detriment of children and families, at the risk of stigmatising children's behaviour, and preventing access to the appropriate services.

Influences on assessment: The example of culture

Although we may assume that indicators of neurodevelopmental difficulties are similar across cultures, families may assign very different meanings to these behaviours (Bernier et al., 2010; Daley, 2002), leading to different assessment outcomes.

Beliefs about the course and cause of neurodevelopmental difficulties are influenced by culture (Mandell & Novak, 2005), as are those behaviours first noted as problematic (Daley, 2002), the labels that difficulties may attract (Kang-Yi et al., 2013) and the timing of access to services (Thomas et al., 2007) resulting in later identification of difficulties in some groups (Mandell et al., 2002).

Clinician factors are also important, with some children's difficulties seen as related to culture and language rather than neurodevelopment (e.g. Begeer et al., 2009). Using structured assessment processes may improve quality of assessment (Risi et al., 2006), although the use of psychometric instruments across cultures is not straightforward (Fatimilehin & Hunt, 2013).

Outcomes of assessment

We would expect the views of different people in the system around the child to vary because children's behaviour varies across settings, but children, parents,

and professionals need ways to talk together about a child's neurodevelopmental difficulties, whether this is at the level of diagnosis or formulation; as a minimum, assessment should aim to bring together the views of children, families, and professionals to reach a shared understanding about the child and family's difficulties and protective factors.

Assessments are sometimes referred to as 'diagnostic assessments' but they are, in fact, assessments of a child's strengths and difficulties; assessment and diagnosis are not the same thing. Not all parents enter the assessment process expecting to leave with a diagnosis, most but not all seek an intervention, and an assessment that only concludes that a child does or does not meet the criteria for a given 'disorder' is likely to be only partially helpful. Regardless of whether the difficulties are felt to be neurodevelopmental in nature, assessments should lead to tailored intervention/management plans.

This is crucial as research highlights the increased challenges for parents raising a child with a neurodevelopmental condition and the reciprocal relationship this has with parents' low mood and parenting stress (e.g. van Steijn et al., 2014).

Post assessment work/intervention and management plans

An important outcome of assessment should be consideration of work with parents and young people about what the assessment has found (a formulation, including, when appropriate, diagnosis). There is a process of adjustment and acceptance for parents after being told their child has a neurodevelopmental condition, but post-assessment support can be focused on the child rather than the parents (Blackledge & Hayes, 2006), despite the increased risk of psychological difficulties for parents of children with neurodevelopmental conditions (Bromley et al., 2004).

Intervention for these children may require co-ordination across agencies, including third sector, and call on the skills of a number of different professionals. Psychological input may be provided by services or virtual teams. Psychological interventions can be delivered by a range of psychological practitioners who have been trained in appropriate methodologies. The role for applied psychologists will be in working with complex cases and supervising and supporting the work of others undertaking the direct work.

The experience of parents

Parents report the assessment process as long and stressful (Crane et al., 2015) and when the outcome is a 'diagnosis' of a neurodevelopmental condition this can be crushing. Despite this, 35 per cent of parents report being offered no help post-diagnosis.

'One of the biggest issues is that you get the diagnosis and as a parent, you are just left to deal with it.' (Crane et al., 2015)

Parents of young children with autism report being left in the dark after being given a diagnosis for their child, and felt that professionals needed more training (Pellicano et al., 2014).

'We need to understand the impact on families supporting a child with autism and how they can be further supported. An educated and empowered parent actually reduces the need (and then cost) on public services as they are less likely to need regular ongoing outside help.'

(Pellicano et al., 2014, p.765)

This reinforces the position that diagnosis/assessment needs to be the starting point of a good service and not the end point.

The experience of young people

There is a pressing need for more research on the views of children and young people with neurodevelopmental difficulties; it is clear that young people and their caregivers do not always agree about behaviours of concern or their meaning (Hogue et al., 2014), and may have different views about seeking assessment; Clarke and van Ameron (2008), for example, found that young people with Asperger's syndrome argued against a pathologising and medicalising view, whereas parents had sought assessment to provide a medical definition, help and, in some cases a cure. One young person commented:

'autistics don't "suffer". There is nothing bad at all with being autistic. We're not "disordered"; we're just different. That's all.' (Clarke & van Ameron, 2008, p95)

It is clear that not all young people feel engaged in the process of neurodevelopmental assessment (Brinkman et al., 2012), but once a 'diagnosis' has been given, young people's responses will vary and change over time. Initial feelings of anger or denial (e.g. Jones, 2001) may change to more positive feelings, including developing a retrospective understanding of previous life events, and an enhanced awareness of why some situations give rise to difficulties, leading to more informed future choices. New opportunities may open, there may be access to literature and sources of advice enabling the development of new strategies and an awareness that others have similar difficulties (Huws & Jones, 2008; Jones, 2001).

'...One of my strongest defences against all my disabilities is the awareness of exactly where my problems lie.' (Hale (1998) p.130, cited in Jones, 2001).

It is, however, clear that other young people may feel that being 'labelled' opens them up to prejudice from others, and is experienced as engulfing by some (Huws & Jones, 2008).

Intervention/treatment plans

Better understanding leads to better management and ways of relating to a young person which, in turn, is likely to reduce the risk of additional mental health difficulties for young people. To be effective any intervention should be driven by formulation and is likely to require joined up consultation to both education staff and parents/carers. When there is behaviour that challenges any interventions should be informed by functional analysis of behaviour.

One of the most significant systemic interventions is psycho-education (see McAleese, Lavery & Dyer, 2013; Montoya et al., 2011); this can be delivered to parents and within education to peers and to teachers (Nussey et al., 2014) across different neurodevelopmental conditions. Psycho-education increases parent understanding of social, cognitive and behavioural difficulties associated with neurodevelopmental conditions, parental understanding and engagement with strategies used to support their child, and enhances parent self-efficacy.

Interventions for core features – for children with neurodevelopmental difficulties many of the challenges are social and behavioural. Interventions are typically combinations of behavioural approaches, psychosocial interventions and modifying the child's environment at school and at home. These include:

- parent-training/education programmes drawing heavily on social learning theory;
- social-communication interventions;
- CBT and/or social skills training for the child (including social skills with peers, problem solving, self-control, listening skills and dealing with and expressing feelings).

Children with a range of neurodevelopmental difficulties benefit from intervention models devised with other groups; as an example Social Stories and Comic Strip Conversations, which were developed to help young people with a diagnosis of ASD to promote an understanding of social situations, may be equally valuable for other young people presenting with interpersonal difficulties, including ADHD (see Uekermann et al., 2010), and Foetal Alcohol syndrome (Niccols, 2007).

Creating accessible services

We know that children with neurodevelopmental difficulties tend to have other co-occurring difficulties and this can present barriers to services in a number of ways.

1. Helping the whole service work as well as possible

Services can inadvertently work against the needs of children with neurodevelopmental conditions:

- Services organised along disorder specific lines (e.g. ADHD or autism teams) can limit access to clinicians with the necessary skills outside of these teams,

presenting clear problems for children with co-occurring conditions. Gillberg et al. (2004) comment that the rates of co-occurrence of ADHD with other neuropsychiatric conditions suggest that 'single disorder' services are not appropriate.

- Children with neurodevelopmental difficulties commonly present first with behavioural difficulties but some CAMHS exclude these presentations without the opportunity to consider the impact of neurodevelopmental factors. Ideally 'screening' of children with behavioural difficulties would be undertaken by professionals with the skills to identify neurodevelopmental difficulties. Meeting the right professional early in the process is likely to lead to better outcomes, fewer onward referrals and a better experience of services. It also reduces the risk of families being signposted to services without the skills to identify and meet the child/families' needs.
- Children with neurodevelopmental difficulties who do not have intellectual difficulties are unable to access Learning Disability CAMHS where staff have the skills to understand neurodevelopmental difficulties. Ideally services would work together across such boundaries to share skills and expertise – a strong argument for better integration of services to meet the needs of children and young people across agencies/sectors.
- Children may require their difficulties to be framed in terms of mental health difficulties in order to meet service entry criteria or, in the areas of poorest provision, a 'mental illness'. This is clearly problematic for children whose difficulties are conceptualised as neurodevelopmental and creates unnecessary gaps between services.

2. Mental health and neurodevelopmental difficulties

Children with neurodevelopmental difficulties are far more likely than the general population to also experience poor mental health (e.g. Van Steensel et al., 2011; White et al., 2009) leading to additional social and developmental difficulties, above and beyond those associated with the child's neurodevelopmental condition (e.g. Kim et al., 2000; Tannock, 2000).

There can, however, be difficulties in seeing beyond the neurodevelopmental, with CAMHS tending to view anxiety as inherent for young people with a 'diagnosis' of autism and, therefore, not accepting referrals; this is reported by parents, young people and CAMHS professionals (Read & Schofield, 2010). There are obvious risks in overlooking behavioural signs of psychological distress when behavioural challenges are seen as 'core' symptoms, for example, ADHD. It is clearly something that should be challenged since, whilst there are some CAMHS where interventions are not offered to young

people with neurodevelopmental difficulties, other services manage things very differently.

Good services are those that can deliver inclusive services that reduce the distress associated with poor mental health, regardless of whether the young person in question also has neurodevelopmental difficulties; this requires a broader understanding of emotional health and wellbeing that goes beyond 'mental health'.

Interventions for young people with neurodevelopmental conditions and mental health difficulties that draw on evidence-based approaches for typically developing young people have yielded positive results: modified CBT interventions have been shown to be effective in reducing anxiety (e.g. McNally et al., 2013), and there is also promise in the utility of Interpersonal Therapy for adolescents for depression (IPT-A; Mufson et al., 2004) who also have neurodevelopmental difficulties. The focus is at the interpersonal level and includes practicing effective interpersonal, emotional and organisational strategies, and affect regulation.

There are important lessons from the research base about how such approaches are best augmented. For example, additional skill development in affective education (see, for example, www.tonyattwood.com.au) and the importance of including carers in 'co-therapist' roles, are particularly relevant to this population, though we would argue also important to most therapeutic work with children when adapting what are essentially adult therapeutic interventions. The importance of an assessment of neurodevelopmental difficulties to enable such interventions to be effective is clear.

When psychological interventions are delivered by clinicians with expertise in neurodevelopmental difficulties the feedback is positive (Kingston et al., 2013), however, the challenge appears to be that access to these skills is limited. Gillberg (2010), in his discussion of ESSENCE difficulties, notes the need for children to be seen and assessed by a sufficient range of professionals with the appropriate skills and competencies, but raises concerns about how often this happens in practice.

The ability to effectively identify and address the needs of children/young people with neurodevelopmental and mental health difficulties links back to the core skills for working with this client group in any capacity, that is, thorough understanding of normal and atypical development, ability to formulate difficulties across modalities and psychological models; this cannot be delivered by someone trained in one model alone.

Outcome monitoring and evaluation

For this population there is a clear need to focus on agreed measurable goals developed in collaboration with families and young people themselves. There are limitations to the use of measures standardised on typically developing children to monitor change in

response to the various biomedical, educational, developmental, behavioural or other interventions used with children with neurodevelopmental difficulties; their appropriateness can be compromised by the highly variable patterns of development in children with neurodevelopmental conditions, and where there can be problems in measuring change in symptomatology over extended periods (Magiati et al., 2011).

However, these challenges do not negate the need for routine outcome monitoring particularly when the focus is on intervening to improve emotional difficulties, for example, low mood or anxiety. The task for the clinician is to choose meaningful and accessible language or tools to capture this, and for psychologists to continue to work to develop reliable measures.

Case study

The following case study illustrates the complexity of service access for children with neurodevelopmental difficulties, the number of different services typically involved, and the need for cross service working.

Sam (8) is a White British boy who lives with his mother and younger sister; his parents separated when he was 3 and he sees his father at weekends. Sam's mother has always found him challenging, but until recently was able to manage his behaviour; he attends mainstream school.

Concerns were first raised at preschool; the Health Visitor advised Sam's mum to 'watch and wait' as it was unclear how much the concerns related to his summer birthday, and his parents' separation.

Concerns at preschool

- poor relationships with other children;
- harder to manage than others in the group;
- needing more adult attention to stay focused.

Once at school, Sam continued to struggle but managed through the first two years as his behaviour was of less concern than that of another child in the class; the class also had a teaching assistant.

Concerns at infant school

- difficulties with general behaviour, especially at carpet time and playtime;
- falling behind peers in learning;
- needing considerable adult support.

Concerns at junior school

- difficulties keeping friends;
- aggressive behaviour when faced with new situations;
- concerns about learning and remaining on task;
- increasing difficulties at unstructured times.

In Year 3, a new teacher felt that his behaviour was of continuing concern; his mother was asked to see the

GP for a referral to the local Community Paediatrician, with the following outcome:

- a. Sam was assessed over two sessions by the paediatrician including: discussion of concerns with Sam's mother, formal developmental history, information about school's concerns, observations of Sam.
- b. Referral to the local multi-agency autism team for further assessment.
- c. Assessment by the autism team (Paediatrician, Speech and Language Therapist, Clinical Psychologist) including cognitive and play based assessments; all aspects of the assessment were reviewed by the team together with Sam's mother.
 - The team concluded Sam's difficulties were best described as falling within the autism spectrum with associated mild intellectual difficulties, marked anxiety in new situations, and overactive behaviour; it was evident that anxiety played a significant role in Sam's difficulties at school and at home, contributing to significant behavioural outbursts. He was referred to CAMHS for intervention around anxiety and consideration of whether he had attention deficit problems.
- d. Sam was assessed by a Clinical Psychologist in CAMHS, including adding a formal assessment of attention to the existing cognitive assessment; this showed no significant impairment of attention relative either to his other skills or the population of same age peers. The following intervention was delivered in conjunction with other services.
 - *work with school:*
 - psychological consultation to school staff to assist how Sam could be understood and supported within school with the aim of making school less anxiety provoking and more predictable, specifically around managing transitions within the school day, implementing mechanisms to assist him in anticipating changes (e.g. visual timetabling), and strategies to help him communicate distress early alongside agreed ways for him to come out of situations to help regulate his emotions. The overactive behaviour reduced as Sam's anxiety decreased and there was an improvement in his ability to concentrate.
 - *work with parents:*
 - an autism psycho-education group for parents to explore, alongside parents in a similar position, the types of difficulties children with a diagnosis of an autism spectrum condition typically experience and to link them in with the local voluntary support agencies.
- e. Sam was referred to Speech and Language Therapy for strategies to support the development of social skills and pragmatics of communication.

Service case studies

These service examples highlight good practice in multidisciplinary and comprehensive assessment, all in one place, with strong links to other services, and offering intervention for the whole system around the child and family.

1. Complex Neurodevelopmental Disorders Service for Children and Young People (CNDS)

A nationally commissioned service providing a second opinion for children and young people who may have an Autism Spectrum Disorder and other complex mental health or neurodevelopmental problems. It provides a number of services including diagnostic assessment and interventions from a multidisciplinary team consisting of Paediatrics and Psychiatry, Clinical Psychology, Occupational therapy, Speech and Language therapy, and other specialist staff.

Assessments include standardised developmental history taking, neuropsychological assessment, speech and language and occupational therapy assessments, specialist advice and information for families and professionals, and mental state examination.

Importantly, although a second opinion service, this service offers, and supports other services to offer, interventions that pay attention to the wider factors including family relationship difficulties and adult mental health difficulties. The advice available is to the whole system, including education, and intensive early years interventions are offered – which has received positive feedback from parents involved.

2. The Behaviour and Family Support Team (BFST)

A multidisciplinary specialist CAMHS service for children with learning disabilities and/or autism spectrum conditions; the clinical team includes Clinical Psychology, Speech and Language therapy, Occupational therapy, and Psychiatry. It is a specialist team that sits separately from the CAMHS team, allowing a focused and intensive remit.

The service has an emphasis on intervention rather than diagnostic assessment and was set up to provide therapeutic input for children presenting with behavioural and/or emotional difficulties post diagnosis. Referred problems include developmental issues, behaviours that challenge, and impacts on the family. The service is set up to include parent participation and partnership, is positioned alongside the Children's Disability Social Service team within the local authority, adopts a flexible approach, an intervention focus, an appropriate staff mix, resourcing and time for reflective practice (Gregory et al., 2013).

Conclusions

It is evident that there is a significant role for applied psychologists working with children in both identifying and responding to the needs of children and families with neurodevelopmental difficulties. What is also evident is the challenge of finding ways in which services and pathways can access this input in a timely and flexible way.

In looking for examples of good practice, what was most striking was that, whilst we were able to identify models of delivery that exemplified working in the integrated and flexible manner we describe, with proactive joint working across mental health, child health and education – on further exploration these services either no longer existed or have had to alter their service remit, reducing the possibility for this way of working. It is, however, clear that good services are comprehensive, joined up with other services, and able to work with the child and family truly at the centre of the process. We also know that it is possible for services to work across agencies (CAMHS, education, health, etc.) to the benefit of children and families. Whilst such services need to include clinical and possibly other applied psychologists, they also need a good skill-mix to ensure that they are able to deliver the most cost-effective inputs to children and families and thus be able to meet the needs of greater numbers across the range of need.

There is, however, variable access to skilled psychological assessment and intervention; Parr et al. (2013) found that the number of child development teams with clinical psychologists available has reduced by 15 per cent since 1999, despite the value of clinical psychologists in identifying children's cognitive ability and devising/providing interventions. There are, however, pilot models of professionals coming together to provide the necessary skill mix in more fluid ways (e.g. Simpson et al., 2012); often they are around specific diagnoses but they provide useful templates and learning for broader integration as services necessarily reshape in light of *Future in Mind* (DH, 2015).

Clinical psychologists have the necessary specialist training to be able to make comprehensive assessments and formulations to indicate what good looks like for children and families with neurodevelopmental difficulties, and have the necessary skills to offer their expertise in order to innovate and to question the barriers to developing effective approaches and services/ pathways that benefit children and families. They can also work with local commissioners to inform the understanding of how services across sectors can better meet the needs of children and families affected by neurodevelopmental difficulties.

Good is certainly possible for this group, but requires creative working across agencies and services with both commissioning and provision on an equal footing with that for typically developing children.

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Delivering psychological services for children and young people with learning disabilities and their families and networks

Ro Rossiter & Heather Armstrong with contributions from
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Summary

'Good' in psychological services for children and young people with learning disabilities, their families and networks means services that:

- Cover the whole age range from 0 to 18/25 years across a range of levels and layers of complexity.
- Offer evidence-based/evidence-informed psychological approaches using a developmental/contextual bio-psycho-social framework, with robust access to Positive Behaviour Support, for a range of interventions – groups, individuals, protocols, staff training/supervision, intensive work; and encourages innovation and research.
- Collect routine feedback and outcome measures, sharing and learning from them.
- Are integrated with local social care, education and voluntary sector services and parent groups.
- Link across various health provisions – Child Development Centres, Paediatrics, CAMHS; ensuring that the children and young people with learning disabilities have access to appropriate physical and mental health care.
- Have strong relationships with Commissioners who recognise the strengths of psychology to provide not just direct clinical services, but teaching, training, consultation and support to others, and commission for this.
- Maintain an appropriate grade structure to cover all levels of input and complexity, and service development and review.

'Because of the help I received from the clinical psychologists, my son is still at home and not in residential care.'
Parent¹ (p.20).

Understanding Learning Disabilities

Definitions

Definitions of *Learning Disability/Learning Disabilities* include reference to:

- impairment of intelligence (typically a score lower than two standard deviations below the mean on a validated test of general cognitive functioning/ equivalent to an IQ score of less than 70);
- impairment of social functioning;
- and onset in the developmental phase.

Learning disabilities is used, in the plural form, to denote a range of abilities/disabilities in a range of people. Some learning disabilities have an identifiable cause, for example a genetic condition such as Down Syndrome, which may be recognised at birth. Recognition may come with delayed/disordered development as the child or young person matures. Children and young people with learning disabilities present with a wide spectrum of health, social, psychological and educational needs from those with very substantial physical, cognitive and communication impairments (often with significant and complex health issues) who are totally dependent on others for all aspects of care, to those with milder impairments. Across the range, there is tremendous variation of developmental

strengths and weaknesses, with some good areas of development, such as physical and motor skills and mostly robust health, yet with some very special health needs associated with epilepsy, behavioural and mental health problems.

There are a range of definitional issues and confusions between terms (learning disabilities/learning difficulties/intellectual disability/developmental delay/neurodevelopmental disorders), between published formal and less formal classification systems, and levels (mild/moderate/severe/ profound). Some services provide helpful summaries and explanations across agencies, professionals and families to assist consistency and understanding for individuals and service planning such as Oxford Health Swindon and Coventry and Warwickshire Partnership NHS Trust.

Frequency and complexity

Traditionally, reported figures have given 2 per cent as the number of people with mild learning disabilities, and 0.5 per cent for those with more severe learning disabilities. Recent figures indicate increases in the prevalence of children and young people with Complex

Learning Difficulties and Disabilities (CLDD)^{2,3}. This reflects increased survival of babies born very prematurely, and/or with complex health needs, and also those exposed to environmental risks such as parental alcohol and drug misuse (<http://complexld.ssatrust.org.uk>). This has implications for general and specialist service provision.

Causes of, and co-occurring difficulties found in, learning disabilities/developmental disorders are complex. They can be psychosocial, genetic, from infections and/or toxins (e.g. drugs, alcohol) and often include Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) as part of their profiles⁴. Turk⁴ reports that of children with ASD, 70 per cent have a non-verbal IQ below 70; 50 per cent have a non-verbal IQ below 50 and only 5 per cent of children with ASD have an IQ above 100 (high functioning autism). The degree of learning/intellectual disability is related to the likelihood of having ASD and to the severity of autistic features, and up to 50 per cent of individuals with 'severe learning disabilities' have an autistic spectrum disorder.

Children and young people with learning disabilities experience significant health and social inequalities. They have higher rates of mental health, emotional and behavioural disorders than children and young people without learning disabilities^{5,6}, yet have lower referral and access, and higher barriers, to mental and physical health care^{7,8,9}. This is part of a wider experience of health and social inequalities for them, including increased experience of poverty, bullying¹⁰ and risks of being a Looked After Child. Over one-in-five Looked After Children have SEN associated with learning disabilities, with risks rising as ability levels fall. The risk per 1000 children of being looked after continuously for at least 12 months by the Local Authority (31 March 2012) was:

- 1.1 per 1000 for children with no SEN,
- 19.9 per 1000 for children with Mild Learning Disability
- 25.1 per 1000 for children with Severe Learning Disability
- 31.2 per 1000 for children with Profound and Multiple Learning Disability¹¹.

Learning difficulties/disabilities often go unrecognised in mental health, care, education and criminal justice settings^{7,12,13}. Simonoff et al.¹⁴ found only 15 per cent of those with a measured IQ < 70 had a statement of special educational needs in the sample. They found a much higher than accepted prevalence rate of 2 per cent, with rates of 5.8 per cent to 10.6 per cent, depending on basis of calculation. In describing clinical psychology services within schools, Faulconbridge et al.¹⁵ reported 'a surprisingly high number of children discussed in consultation meetings needed to be

referred for specialist assessment for suspected developmental disorder... which proved correct in the majority of cases following assessment'.

If learning disabilities/neurodevelopmental disorders are not recognised, then education, health or social interventions cannot be adapted to be appropriate. Alternatively, when learning disabilities are recognised, children and young people may be excluded from services, innovation or research as professionals report not having the appropriate knowledge and skills^{16,17}. Given the number of children and young people with learning disabilities across a range of health, education, welfare and youth justice, all practitioners should have sufficient skills and knowledge to adapt approaches to meet their needs, with close links across different psychology specialities, Child Health and Paediatrics, Looked After Children, CAMHS, inpatient and forensic services and schools.

Psychological Service Delivery Models

The role of clinical psychologists (and other applied psychologists qualified to work with children and young people)

Clinical psychologists working in this area embrace a rich and diverse application of psychological knowledge and skills. This includes psychological (broad developmental and more specific neurodevelopmental, behavioural, emotional), environmental, interpersonal and social (and associated cultural and economic) issues. This also covers psychological aspects of health (impairments, illness, long-term conditions). Clinical psychologists contribute by working though and with others – families, staff, networks, services and communities. Psychology is applied across multiple levels; assessments and interventions need to be creatively adapted and individualised whilst maintaining our scientist-practitioner framework (i.e. applying scientific methods in our practice).

This breadth of activity is something that clinical psychologists working in services with children and young people with learning disabilities have striven to deliver to maximise psychological services' impact, efficiency and effectiveness: themes which pre-date, and resonate with, recent health policies such as 'No Health without Mental Health'¹⁸, the Chief Medical Officer's Annual Report⁶, development of Health and Wellbeing Boards and *Future in Mind*¹⁹.

The value of psychological approaches

Psychological approaches are particularly necessary for children and young people with learning disabilities, primarily a developmental/psychological condition. Hall²⁰ highlighted the significance of early psychological research in learning disabilities, in revisiting the impact of a key text *Mental Deficiency: The Changing Outlook*²¹, 50 years after it was published, noting:

‘psychologists in Britain, from the early 1950s, carried out groundbreaking research into the extent to which people with learning disabilities could learn.’ (p.1006)

This research contributed significantly to changing the model and methods of care and education from the medicalised, separatist model to a social, developmental, educational model, and to changing policy and legislation.

Hall describes how these developments in research and clinical practice by psychologists demonstrated the utility of a psychological analysis of ‘mental deficiency’ and theory and data-driven research and practice on psychological and social aspects of peoples’ lives. It yielded practical guidance showing how learning difficulties and social problems of people with a learning disability could be ameliorated through applied psychology and illustrated the ‘intimate, reciprocal and enriching relationship between theory and practice’, a core skill of clinical psychologists.

This focus on the broad application of psychology, especially through others, resonates with the recent Chief Medical Officer’s Annual Report⁶ ‘Our Children Deserve Better: Prevention Pays’. This report recognised that to reduce health and social inequalities that negatively impact on quality of life, wellbeing and life chances, services need to apply *‘proportionate universalism’*.

‘If we act early, we can prevent harm. To address these issues, we need to take a population health perspective – to think about what benefits the most. Key principles of public health are also fundamental. This means ‘proportionate universalism’ – improving the lives of all, *with proportionately greater resources targeted at the more disadvantaged groups.*’ (our italics)

‘Proportionate universalism’ is a useful ‘concept to inform psychological services for children and young people with learning disabilities and their families.

Positive Behaviour Support (PBS)

The multi-component framework of PBS has been identified by recent NICE guidance²², and the Early Intervention Project Evidence Briefing paper and Data Supplement^{23,24} as the key evidence-based framework for use with children and young people with learning disabilities and behaviours described as challenging. Gore and colleagues (2013) define and describe PBS as a multi-component framework which combines the value-base of person-centred planning in developing valued social-roles and skills, and draws on developmental theory, applied behaviour analysis and other evidence-based approaches. PBS uses functional assessment to develop a multi-component support plan, which is implemented and monitored over the long-term.

PBS incorporates 10 core elements across three domains as below.

Values

1. Prevention and reduction of challenging behaviour occurs within the context of increased quality of life, inclusion, participation, and the defence and support of valued social-roles.
2. Constructional approaches to intervention-design builds stakeholder skills and opportunities and eschews aversive and restrictive practices.
3. Stakeholder participation informs, implements and validates assessment and intervention practices.

Theory and evidence base

4. An understanding that challenging behaviour develops to serve important functions for people.
5. The primary use of applied behaviour analysis to assess and support behaviour change.
6. The secondary use of other complementary, evidence-based approaches to support behaviour change at multiple levels of a system.

Process

7. A data-driven approach to decision making at every stage.
8. Functional assessment to inform function-based intervention.
9. Multicomponent interventions to change behaviour (proactively) and manage behaviour (reactively).
10. Implementation support, monitoring and evaluation of interventions over the long term.

PBS may be implemented in a range of ways, in a variety of settings and to support people with a variety of needs. The recently published Competence Framework for PBS²⁵ gives further information.

The importance of early intervention

Investment in early intervention and prevention services as the bedrock of an integrated pathway of care is essential from both a clinical and an economic standpoint.

The Early Intervention Project’s Paving the Way¹ presents a multilevel *Path to Better Outcomes* model (p.8). The Path includes the right support, right from the start (including early years, early identification of problems and rapid response, through integrated multi-agency support and crisis planning and prevention), highlighting good practice principles and services to help commissioners, providers and families (Table 1).

Embedding early intervention in a stepped system of service provision can enable specialist services to collaborate with/consult to more ‘mainstream’ services. This increases effectiveness by increasing

Table 1: The Path to Better Outcomes model.

Establish a person-centred approach, right from the start, supported by a key-worker or team around the child.	Identify problems early and respond rapidly using an integrated, multi-disciplinary approach to ensure all needs are met.	Provide evidence-based interventions for children and families such as parenting programmes.	Establish a local positive behavioural support service, working across homes and school.	Develop a local approach to crisis response so children can stay nearby when there is a crisis.
1. Wolverhampton Special Needs Early Years Service.	2. Coventry and Warwickshire.	3. Brighton and Hove.	4. Bristol Positive Behaviour Support Service.	5. Ealing Intensive Therapeutic Short Break Service.

capacity, assisting workforce development and using existing relationships children, young people and families have with services.

Examples of early intervention services highlighted (see also Section 3) include:

Coventry and Warwickshire's early identification of problems and rapid response including:

- Parent training workshops: covering autism, understanding behaviour, parent wellbeing and sleep;
- Stepping Stones Triple P parenting programme – in group settings or one-to-one;
- Individual work with parents, including post-diagnosis support;
- Individual work with children including understanding sensory processing difficulties and communication difficulties, management of complex sleep difficulties, complex epilepsy and anxiety. (p.14)

Bristol Positive Behaviour Support Service (PBSS) is a local positive behavioural support service working across homes and school to provide effective local services with complex children and young people:

... 'Working in partnership with schools, the PBSS helps children and their families move their lives forward positively, by providing the best evidenced interventions, tailored to their individual needs.' (Freddy Jackson-Brown, Clinical Psychologist, p.18)

The Ealing Intensive Therapeutic Short Break Service (ITSBS) supports young people with learning disabilities who display behaviour described as challenging at risk of residential placement. It aims to enable the young person to remain at family home accessing community settings. ITSBS provides families with intensive interventions (and follow-up support), combining a carefully tailored package of additional short breaks and intensive clinical psychology therapy to reduce

challenging behaviours and provide a break for the parents/young person. It uses a Positive Behaviour Support (PBS) approach. Following a successful pilot, the ITSBS became a permanent service. The service is staffed by a Clinical Psychologist, an Assistant Psychologist and a Social Worker, with part time input from an Occupational Therapist.

'The best thing was that they helped me find my own solutions.' (Parent)

'As a result of the work our child is now sleeping at night, she is calmer, happier, and levels of self-injurious behaviour have reduced a lot. The whole family feel happier and less stressed now – it has had a positive effect on all of us.' (Parent)

Policy context

For over 40 years, policy has recommended both individual and population-based needs-led planning for interventions and services for children and young people with learning disabilities and their families, which are community-based and co-ordinated across health, education, social services and voluntary sector. From *Better Services for the Mentally Handicapped*²⁶, through National Development Team guidance through the 1970s to Every Child Matters²⁷, National Service Framework for Children, Young People and Maternity Services²⁸ and more recent generic and specific policy such as Mental Health Care Pathway for Children and Young People with Learning Disabilities²⁹, No Health without Mental Health³⁰ and Better Health, Better Lives: European Declaration on the Health of Children and Young People with Intellectual Disabilities and their Families³¹, lack of progress is noted time after time, and the need for action for service development and delivery is emphasised, particularly focusing on unmet needs associated with displaying behaviour which challenges and mental health issues.

The seriousness of the lack of progress was demonstrated in 2011, in Winterbourne View. Though this led to renewed calls for action to improve services in Transforming Care³², the Learning Disabilities inpatient Censuses³³ show continued lack of progress.

Key policy documents and guidance

1. Ensuring quality services: Core principles for the commissioning of services for children, young people, adults and older people with learning disabilities and/or autism who display or are at risk of displaying behaviour that challenges³⁴.

2. Early Intervention Evidence Briefing paper and Data Supplement^{23,24}. For ensuring quality standards, based on current best evidence, the use of Positive Behaviour Support is identified as the framework for practice and services. The pyramidal, multilevel intervention model presented incorporates programmes for behavioural difficulties in mainstream early years at the base, early identification of challenging behaviour and rapid response at the next level, and specialist evidence-based behavioural interventions at the apex.

3. The Early Intervention Project, Paving the Way¹ – above, Section 2d.

4. NICE guidelines for people with learning disabilities published for prevention and interventions with Challenging Behaviour in 2015²². Mental Health guidelines are in development for 2016. In the absence of specific LD NICE guidance, services look to generic NICE guidance, aiming to deliver in line with/adapt as necessary. The National Professional Senate for Learning Disabilities link currently with NICE to ensure future guidance includes people with learning disabilities.

5. The National Professional Senate has a subgroup on children and young people with learning disabilities and their families that is currently drafting Commissioning Guidance on Health Team Support. This is broader than the focus on services for children with LD who display challenging behaviour, looking to five essential roles of Community Learning Disabilities Health Teams previously identified³⁵:

- Supporting positive access to and responses from mainstream services;
- Enabling others to provide effective person-centred support to people with learning disabilities;
- Direct specialist clinical therapeutic support for people with complex needs;
- Responding positively and effectively to crisis and quality assurance;
- Service development in support of commissioners.

6. The Children and Families Act³⁶, particularly the Special Educational Needs and Disability (SEND) elements, outlines responsibilities, duties and guidance for coordinated Education, Health and Care Planning (EHCP's) as well as duties for Information, Support and Advice, specifying the Local Offer and Joint Commissioning.

7. Future in Mind¹⁹, highlights issues of particular importance for children and young people with learning disabilities. These include:

- the need to provide services incorporating both physical and mental health, especially for long-term conditions (p.26);
- disability being recognised as a factor in 'highly vulnerable groups' (p.31, vii);
- schools are recognised as key settings for promoting resilience, and early interventions to promote mental and physical health (pp.36–37);
- use of residential care for people with learning disabilities (p.47, 5.20);
- the National Group on Sexual Violence against Children and Vulnerable Adults (p.52) and need for specialist services for children and young people who have been sexually abused are noted (there is a higher prevalence of children and young people with learning disabilities amongst these groups), in reducing health inequalities 'Commissioners and providers across education, health, social care and youth justice... ensuring those with protected characteristics such as learning disabilities are not turned away' (²¹, p.55).

The current picture of services nationally

Despite the wealth of policy documents and guidelines, the provision for children with learning disabilities and their families remains woefully inadequate:

- Often there are small, isolated services not linked together and with little support. Behaviour and mental health of children and young people with learning disabilities can deteriorate, requiring more expensive, residential/inpatient services.
- Services may be provided 'notionally' by a number of health services, for example, CAMHS/Child Development Centre, who may not have sufficient skill, or none.
- As there have been few published outcome measures for services, there are challenges in gaining and reporting feedback and evaluation, and no current agreement on 'standard dataset' for services by which we could better know which services are good.
- There are significant difficulties in developing guidance on evidence-based interventions for behaviour which challenges/mental health in learning disabil-

ities. NICE guidance is in development, more practice consensus/sharing resources is needed.

- Lack of services which match the developing policy guidance on service models – see National Learning Disabilities Professional Senate, from 2014, which has a subgroup on children and young people.
- Insufficient research on what works.
- Lack of appropriately trained staff, and reduced impact on training for broad workforce and clinical psychologists (e.g. on PBS).

Key elements and examples of good psychological services

Elements of a good service include the framework outlined in *Paving the Way*¹ (see Section 2d) of:

- Establishing a person-centred approach, right from the start, with key-working/team around the child/family.
- Early identification and rapid integrated, multi-disciplinary response.
- Provision of evidence-based interventions.
- Establishing local services working across settings, for example, homes and school.
- Developing a local approach to crises.

We give examples of good practice from the individual level, to service level through to national collaboratives.

Work with children, their families and networks

The two examples below illustrate:

- the importance of high quality multifactorial assessment in very complex situations;
- the adaptation of evidence-based interventions to meet the needs of children and young people with learning disabilities;
- interventions which work with the child, the family and their networks;
- multiagency working, including involvement of community resources;
- the use of clinical psychology time to lead assessment, formulation, planning and supervise the practitioner doing the direct interventions;
- joint work with CAMHS where appropriate.

Example 1:

Shaheen is a 6-year-old girl with severe learning disabilities. She lives with her parents who came to the UK just after her birth, her younger brother and sister, and also her uncle's family, in a flat above the family shop. She was referred to an Intensive Support Service with increased 'aggressive' incidents (throwing objects, hitting out, grabbing hair), self-injurious behaviour (slapping own head, biting own right hand to an open wound), and sleep problems. She was at risk of school exclusion and there were safeguarding concerns, relating to risks to younger siblings.

The initial phase focused on engagement and assessments – trying to understand the family's hopes and fears, expectations and understanding of Shaheen and their interactions. It was undertaken through discussions and detailed observations, developmental and behavioural recordings across home and school. Local faith leaders were involved to support the family and professionals in cultural and practical discussions giving more confidence and authority to the family who were feeling exhausted and demoralised. The assessment showed that expectations, language and activities were often at too advanced a level developmentally and that Shaheen's challenging behaviours could signal confusion, boredom, frustration, avoidance, desire for action and/or seeking sensory or interactional input. A health review led to changes in Shaheen's anti-epilepsy medication.

Interventions, across 10 months, were undertaken by a Behaviour Support Specialist, working closely with the short-breaks provider. The work was closely supervised by a clinical psychologist. It drew on a culturally-sensitive use of the Solihull Approach³⁷ which builds strong relationships between practitioners and families to strengthen parent/child relationships through integrating behavioural management with containment and reciprocity, and 'Technique is not enough'³⁸ which considers how to make parenting interventions socially inclusive. These helped develop the relationship with, and between, Shaheen's parents, and their confidence and skills. The Positive Behaviour Support framework informed the formulation and in devising interventions including:

- an activity 'schedule' incorporating energetic activities (both outdoor and indoor such as mini trampoline, Shaheen's version of dancing, bath time);
- access to sensory activities (safe 'fiddle' toys she can be left for quiet time with, rocking chair, personal music selections for calming, energy, etc.);
- use of visual timetable to signal order and timing of activities and objects of reference to signal transitions;
- supported play with siblings to develop appropriate interaction and play skills;
- developing turn-taking/listen/look/wait skills along with 'hands quiet' and some routine action rhymes, 'Head, shoulders, knees and toes' and 'Simon Says', to replace some of her difficult behaviours;
- sleep routine and low fuss response to night waking and returning to her bed.

Outcomes. Shaheen's difficult behaviours reduced, her skills improved as measured by goal-based outcomes, and the family are able to access community activities not

previously possible. Shaheen is seen as fun loving, energetic and curious, rather than dangerous and uncontrollable, and parents, school and short-term breaks are all more confident. Safeguarding concerns were addressed. Wellbeing and quality of life improved for all.

Example 2:

Sam was 14-years-old and lived with his African-Caribbean mother and younger brother, having been rehoused to a new area for protection from a violent partner. He attended a school for pupils with mild-moderate learning disabilities and was referred to a Community Team for Children and Young People with Learning Disabilities, for assessment and advice regarding:

- high anxiety;
- unusual mannerisms;
- growing preoccupation with churches;
- safeguarding concerns – risks from lack of support and supervision from his single mother who had severe physical and mental health issues, aggressive/out of control younger brother and bullying at school and in neighbourhood.

Initial phase. Assessment and formulation, drew on Carr's³⁹ developmental and contextual framework.

Interventions were mainly carried out by a community support worker from the local authority, supervised by a clinical psychologist. They included adapted Cognitive Behavioural Therapy for anxiety and preoccupations including:

- simplified exploration of thoughts-feelings-behaviour links with cartoons;
- personalised relaxation and 'chill' activities and practice;
- replacing time spent with violent films and music to a wider range;
- developing other interests and activities such as drawing, comics;
- developing skills and confidence – going to the shops, managing money, transport.

There were also family sessions to increase understanding, engagement and support from Sam's mother and younger brother. The community support worker also led networking across school and home for consistency.

Outcome. Sam was discharged after reductions in anxiety and increases in confidence, social, self-help and community activities and skills, measured by goal-based measures across settings.

Second phase. Sam was re-referred at nearly 16 years, with concerns about:

- decrease in skills and engagement at school;

- significant increase in talking about burning churches and harming church-men (followed the deterioration of Sam's mother's physical and mental health, illness then death of his much-loved great-grandmother);
- 'befriending'/bullying of Sam by new, more able pupil, excluded from mainstream school;
- Sam's brother being excluded from school, becoming involved with stealing, drinking, drugs and becoming aggressive to his mother and Sam, necessitating police involvement.

The team reviewed earlier interventions alongside re-assessment of Sam's current mood, preoccupations and behaviours, in conjunction with family and school. They used a number of assessment techniques including:

- Comic Strip conversations⁴⁰ and 'Think-feel-do' cartoons and body maps to explore physical signs, thoughts, feelings, 'dreams' and 'voices'.
- Consultation with the Early Intervention in Psychosis Service (EIP) and joint assessment led to a shared plan of further assessment and intervention planning.
- Photos of different churches, priests, religious objects and rituals were used to assess the nature and intensity of Sam's current and past distress and thoughts, dreams, voices and beliefs associated with churches and church people.
- Card sort activities enabled him to sort pictures into OK/not OK, and a 'thermometer' card sort (low, medium, high) enabled him to rate intensity of distress.
- Cultural aspects were explored, with 'voices' often containing racial comments and linked with re-playing traumatic experiences of racial abuse/bullying.

Interventions included a variety of relaxation strategies (trial and practice in-sessions, compact discs). An adapted, personalised Distress Tolerance prompt-sheet based on Dialectical Behaviour Therapy⁴¹ was made for home use. Activity scheduling and environmental changes to reduce triggers, and behavioural experiments were designed to test ideas such as control over 'voices' and thoughts. Family, school and network meetings shared assessment, formulation, planning, trialling interventions and maintaining effective ones. Personalised coping plans and visual prompts/supports were shared with family and school to enhance generalisation. Further description of this adapted therapeutic approach and associated issues can be found in Rossiter and Holmes⁴².

Outcomes. Sam's distress about, and frequency of, 'voices' reduced (measured by self-report, family and school reports and behavioural/mood observations)

and he developed some successful use of coping strategies. Psychiatric support transferred from EIP to CAMHS with joint assessment and review sessions prepared for and managed using Sam's familiar visual materials to aid communication and comprehension.

Service examples

The examples below demonstrate the basic requirements of a good service structure and organisation:

- Are multidisciplinary with appropriate skill mix.
- Are integrated with other agencies in the local area including local authority and third sector.
- If not part of a CAMHS service, close links are in place.
- Actively involve parents/carers and children and young people in developing the service.
- Work closely with other settings, for example, schools, short-breaks.
- Are accessible and responsive.
- Have qualified staff who are able to undertake further training as needed.
- Have a range of support and supervision structures for all staff.
- Are able to support other community providers and CAMHS with guidance, training and supervision to enhance what they can provide to children and young people with learning disabilities.
- Review and use the growing evidence-base, modifying practice as needed.
- Use a range of outcome measures as routine and evaluate the service on the basis of these.
- Have clinical psychologists in leadership roles who are able to direct and maintain a comprehensive psychological service.

Example 1:

CAMHS-LD/Family Intensive Support Service (FISS), Sussex Partnership NHS Foundation Trust, is a multidisciplinary team working with children with moderate to severe learning disabilities and behaviour that challenges and their families. It was developed by a clinical psychologist and has psychology at its centre and includes Speech and Language Therapists, Family Support Workers, Psychiatrist, Learning Disability Nurse, Team leader with Social Work background.

It is amongst the longest established CYP-LD services, having grown and developed over 16 years. The key factors contributing to its evolution and longevity include:

- By starting small, and focusing on working directly with a few families in a small area of East Sussex, the model for practice could be evaluated and evolve. Since 2008, CAMHS-LD/FISS covers the whole of Sussex, but have still retained a clear focus on working with a reasonably small number of the most

complex children with moderate to severe levels of LD.

- CAMHS-LD/FISS built relationships with Commissioners, other local services and local parent groups. It demonstrated the strengths of CAMHS-LD/FISS and psychology providing not just direct clinical services, but also teaching, training, consultation and support to others as a key part of commissioned work.
- Utilising the Family Partnership Model which underpins the collaborative approach with families and other services and the integrative approach above.
- Has changed and adapted, developing new ways of working (see Woodlands Family Days below).
- Has maintained a mixed and appropriate grade structure (to cover all levels of input and complexity, service delivery, development and review).
- Has prioritised collection of outcome data and evaluation, encouraging feedback on all aspects of its work, celebrates successes and strengths and collects and submits plaudits to managers.

The roles of the clinical psychologist at a range of levels include direct clinical work with families, working very closely with other agencies and services as well as other types of work such as the examples below:

- supervision of Family Support Workers;
- supporting the formulation/planning, implementation and review of a wide range of interventions drawing on diverse models (Family Partnership Model⁴³; systemic, family work and ecological models⁴⁴; Positive Behavioural Support⁴⁵; attachment and child development; community psychology, resilience, stress and coping);
- developing and systematically trialling evaluation and outcome measures⁴⁶, innovation and evaluation (such as new Parent Groups-PBS and All About You-see below);
- establishing a consultation service for staff across the county;
- collaborating in broader evaluation and research, for example adapting the evidence-based FRIENDS for Life mental health promotion programme^{47,48} to be accessible and appropriate for children and young people with severe learning disabilities (Foundation for People with Learning Disabilities www.learningdisabilities.org.uk/content/assets/pdf/publications/friends-for-life-guide.pdf) collaborating on seeking funding from NIHR (National Institute for Health Research) for its feasibility study and disseminating this at conferences, and on the national work on Feedback and Outcome Tools for children and young people with LD CORC.

It has developed new ways of working with alternative therapeutic groups in conjunction with community groups:

Woodlands Family Days:

Most families describe their lives as very restricted, due to the displays of challenging behaviours their child/young person show out in the community. Regular woodland 'Reaching to the outdoors' Family Days for all children and families using CAMHS-LD/FISS were trialled three years ago staffed jointly by CAMHS-LD/FISS and Circle of Life (COL) Rediscovery (a local Community Interest Company).

The Woodlands provide a safe environment to learn, play, create, explore and have a positive time together as a family. Activities include building a fire, cooking and woodcraft. Spending time in a new environment, away from usual routines, provides a space for the family to interact with each other in a different way. Parents have support from all staff to prepare, manage and support all the family, so they are able to relax and engage with their children in a way that is not always possible in everyday life. Importantly, parents are also able to connect with other parents. The activities also provide opportunities for siblings to find things they enjoy doing together. Staff find the Woodland days offer a unique opportunity to get to know the family in a way that is not possible in the course of routine clinical work. It facilitates relationship building with the family, and opportunities to experience family dynamics in a more natural, unobtrusive way. Staff work in partnership with the families in a very practical way and experience behaviours first hand so these days provide opportunities for problem solving and exploring alternative ways of managing behaviours in real time. Being in the woods with the family provides a wealth of concrete examples of behaviours and strategies that can be referred back to and used as points for learning, exploration and illustrating ideas in future meetings with parents.

Feedback from families: *'Real sense of adventure'; 'be together as a family'; 'a real treasure of a day'; 'with the right support, she achieved something'; 'I have never seen her so calm'; 'It's nice to get together with people in the same situation.'*

Feedback from children and young people: though this is difficult to capture with their very significant communication needs, their engagement and expressions can be seen in videos illustrating activities at:

www.youtube.com/watch?v=X_YqIYavYuk and
www.youtube.com/watch?v=b21pH_vHMgg

● Rythmix Music Groups:

CAMHS-LD/FISS join with local music charity, Rythmix, to provide music sessions for the children in school holidays, giving opportunities for children/young people to participate in making music, learning skills in sharing, turn taking, having fun with others and developing confidence and self-esteem. Their parents and workers see sides of them that they do not see in other settings. The sessions give opportunities for problem solving, resilience building and developing relationships with families – all essential ingredients of successful clinical work in mental health.

● Positive Behavioural Support Group for parents (12 weeks):

Run by a Clinical Psychologist and Speech and Language Therapist; parents learn about the Positive Behavioural Support framework, and then develop and apply their own PBS plan and are supported to implement this at home. Importantly, they also get to meet other parents and share experience and knowledge with each other, reducing isolation and developing social networks.

● All About You Group (5 weeks):

Run by a Clinical Psychologist and Family Support Worker; parents are supported to focus on ways of looking after themselves, using a combination of mindfulness, stress management, relaxation techniques and group activities.

Example 2:

Ferndene is an integrated regional and inpatient service for children and young people in Northumberland where three of the four units offer services for children and young people with learning disabilities. The units assess and provide interventions for children and young people who present with complex comorbidities of a range of severe behavioural or emotional/mental health issues.

Key aspects include:

● Use of evidence-based therapeutic models:

A psychology-led audit of admission reasons and review of the care-model led to the introduction of Positive Behaviour Support (PBS) as the strongest evidence-based approach for children and young people with learning disabilities showing physical aggression, self-injurious behaviour, and deterioration in behaviour – the most common reasons for referral. In the PBS framework, applied behaviour analysis leads to understanding behaviours that challenge and capable environments which deliver appropriate supports. In capable environments, children and young people develop new skills aiding their emotional, social and general development. The PBS framework integrates other evidence-based interventions within the inpatient

services such as anger management (Temper Diary) and anxiety management (Worry Diary) based on adapted CBT with more emphasis on the behavioural components. Pre and post measures and feedback from the children and young people indicate these approaches are helpful. Future evaluation of the use of adapted Dialectical Behaviour Therapy is planned.

- **Evaluation and research:**

There is evaluation of both the efficiency and effectiveness of assessment and intervention to ensure admission away from family is as short as possible. An example of research has been investigating 'mediating variables' – attitudes/beliefs/knowledge of parents/carers/staff which can impact on the success of PBS interventions⁴⁹ and developing practice using this as below.

- **Community and family engagement:**

Where an inpatient admission is needed, for more intensive intervention within a safe environment for a time-limited period, engaging and involving with their families and communities is crucial.

Behaviour Support plans are developed with parents, through sessions which look at both an understanding of the child's behaviour, and parental beliefs. The pathways also now incorporate more work into the family home during admission where PBS plans are completed with parents, and spends more time working with parents in the family home towards the end of the admission.

- **Training and supervision:**

There is a need for clear PBS skills learning and supervision structures. In Northumberland, Tyne and Wear (NTW) clinical psychologists supervise staff undertaking PBS training. They have contributed to the development of a strategy within NTW Child and Young Peoples Services for staff to access these courses, collaborated with colleagues in adult services to develop in-house Foundation Level PBS training, and have been developing the PBS and Applied Behaviour Analysis teaching on post-graduate training courses. In the UK, a recent set of core competencies for PBS60 has been published to enable a strategic approach and quality assurance to the range of training routes and development of PBS skills within the workforce.

The next and final two examples illustrate clinical psychologists driving good practice-development and using research skills to evaluate developments across a range of professions at a national level within multidisciplinary services.

The work on the use of Routine Outcome Measures (ROM's) and feedback tools with Children and Young People with Learning Disabilities (LD), their families and networks. Clinical psychology represent this work-strand on the CYP-IAPT Outcomes and Evaluation Group, and have worked with others to develop guidance on using ROMs with children and families with LD. For more information see: www.corc.uk.net/ldworkshop/. This will pave the way for more systematic data collection across LD services.

Another national initiative is ySOTSEC-ID (Young Sex Offender Treatment Services Collaborative-Intellectual Disability), a practice and research collaborative focusing on children and young people with learning disabilities who display harmful sexual behaviours, formed in 2012 by clinical psychologists. Research has shown that children and young people with learning disabilities are proportionally over-represented in referrals (37 per cent⁵⁰) and are more likely to have been victims of abuse themselves (a priority of Future in Mind, 2015), have additional complex developmental, mental health and social difficulties, but are less likely to receive a service⁵¹. A group intervention, Keep Safe, has been developed and is under feasibility trial, see www.kent.ac.uk/tizard/sotsec/ySOTSEC/ySOTSEC.html

Pote and Goodban's²⁹ *Mental Health Care Pathway for Children and Young People with Learning Disabilities – A Resource Pack for Service Planners and Practitioners* provides additional examples and has proved useful for commissioners and providers.

In conclusion, 'good' in psychological services for children and young people with learning disabilities, their families and networks includes services that covers the ranges of age (from 0 to 18/25 years) and levels and layers of complexity in the child, family and service system, using a developmental/contextual bio-psychosocial framework to offer evidence-based/evidence-informed psychological approaches across the system.

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