

QINMAC

Quality Improvement Network for Multi-Agency CAMHS

Learning Disability Standards

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Foreword

It is less than 40 years ago, within current working lifetimes, that most children with learning disabilities were deemed “ineducable” and it is only a few years since they were frequently excluded from local CAMHS Strategies. In many parts of the country, mental health services to meet their needs were completely lacking. Since 2001 that has significantly changed, with the advent of policy documents such as Valuing People and the NSF Standards for the Disabled Child and for the Mental Health and Psychological Well-being of Children and Young People. Supported by “A Comprehensive CAMHS” and Public Spending Agreement targets, these policy initiatives are leading commissioners to actively promote better services for children with learning disabilities.

Building on those policies, and on documents such as the “Count Us In” Inquiry report and the DOAS LD-CAMHS Pathway, the QINMAC Learning Disability Standards represent another significant step in that process.

The development of mental health services for children with learning disabilities has been sporadic and ad hoc, leading to a wide variety of service models in response to local circumstances and no clear “model service”. These Standards are therefore designed to apply to a range of Tier 2 and Tier 3 service delivery models found within mainstream CAMHS, Learning Disability services or specialist Learning Disability-CAMHS teams. The Standards will also have to change over time to reflect the emergence of Children’s Services, as driven by Every Child Matters.

The Standards present significant challenges for services to aspire to. Such aspirations are important, however, for this multiply disadvantaged group of children. Young people with learning disabilities are at greater risk of mental health problems and are more likely to live in childhood poverty, whilst their parents and carers report higher levels of stress or depression as a result of providing care within the current context of provision. Parents identify the need for better levels of expertise, better integration of service delivery between agencies, and reductions in waiting times. We hope that collaboration within the peer review framework of QINMAC will support such developments.

We are optimistic that future mental health services for children with learning disabilities can be significantly better than they have been in the past, and we look forward to services using these first QINMAC Learning Disability Standards to develop truly “Comprehensive Child and Adolescent Mental Health Services” that will include all our children and young people.

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Introduction

Background

In 2005, the Royal College of Psychiatrists' Research and Training Unit (CRTU) gained funding from the Department of Health to:

- Develop a set of standards for mental health services for young people with learning disabilities
- Establish a quality network that will support the improvement of these services

This work is being undertaken by the Quality Improvement Network for Multi-Agency CAMHS (QINMAC). QINMAC's new Learning Disability Network (QINMAC-LD) will support frontline staff in delivering comprehensive mental health services for children and young people with learning disabilities, in line with the current proxy measures for CAMHS.

The functions of the network

Mental health services for young people who have learning disabilities ('LD CAMHS'¹) may be provided by generic CAMHS, Learning Disability services, CAMHS Learning Disability teams and by liaison between key professionals. LD CAMHS are physically dispersed, complex and varied in structure. Consequently, quality improvement and innovation may often occur in isolation.

A central aim of QINMAC-LD is to provide a communication channel between these services. This supportive, peer-review network will facilitate professionally-led service improvements across LD CAMHS by:

- Developing and applying standards for LD CAMHS via a system of self- and external peer-review (see annual cycle below);
- Supporting local implementation of national policy, as identified in the QINMAC-LD standards;
- Producing reports for each service, highlighting areas of achievement and areas for improvement;
- Developing a national "benchmarking" service to allow services to compare their activity with other services;
- Facilitating information-sharing between staff in the network, e.g. regarding best practice; and
- Supporting routine data collection, e.g. regarding clinical and cost outcomes, and staff and patient census measures.

Like the highly successful Quality Network for In-patient CAMHS (QNIC), QINMAC-LD will belong to its members, and in particular to the frontline staff who work in member services.

The partners and the wider collaboration

QINMAC has worked closely with the following groups and organisations in the development of these standards:

¹ *Learning Disability Child and Adolescent Mental Health Services. 'LD CAMHS' is used throughout this document to refer to services at Tiers 2 and 3 that provide mental health provision to young people who have learning disabilities. See Glossary for a full definition.*

- The Foundation for People with Learning Disabilities (FPLD);
- Do Once and Share (DOAS) – a project set up to develop a national consensus on a care pathway for children with learning disabilities and mental health needs

QINMAC also works in collaboration with the following partners:

- The Royal College of Nursing;
- YoungMinds;
- The National Institute for Mental Health in England's National CAMHS Support Service (NCSS);
- The Department for Education and Skills (DfES);
- The CAMHS Outcomes and Research Consortium (CORC);
- The National Mental Health Partnership (NMHP); and
- The Welsh Assembly Government

The standards

How were the standards developed?

The QINMAC-LD standards have been adapted from QINMAC's existing standards for generic Tier 2 and 3 CAMHS (Ref: 73), successfully piloted in 2006. Standards relevant to LD CAMHS were retained and modified where necessary. In addition, over 80 new criteria have been introduced, which are specific to young people with mental health problems and learning disabilities.

The QINMAC-LD standards have also been informed by:

- An extensive review of existing standards and policy documents relevant to LD CAMHS.
- Interviews with frontline staff experienced in providing mental health services to young people with a learning disability (see Appendix A);
- The ideas and discussions of a Standards Workshop, held with professionals on 11th October 2006 (see Appendix B);
- Discussions held within the QINMAC Project team;
- Feedback from consultation with young people as outlined in the FPLD's guidelines, 'CAMHS Key Standards'; (Ref: 67) and
- A consultation exercise with key stakeholder groups. These included: the Royal College of Nursing; the Royal College of Paediatrics and Child Health; the British Psychological Society; the Foundation for People with Learning Disabilities; the Child and Adolescent Faculty of the Royal College of Psychiatrists; the Learning Disability Faculty of the Royal College of Psychiatrists; MENCAP; the National Children's Bureau; The Children's Society; the Department for Education and Skills (DfES); QINMAC member services; the FOCUS e-mail discussion group; the Quality Network for In-patient CAMHS e-mail discussion group; the Quality Improvement Network for Multi-Agency CAMHS e-mail discussion group; and the Do Once and Share workshop participants.

Which services do the standards apply to?

The QINMAC-LD standards focus on LD CAMHS that deliver the activities of Tiers 2 and 3². The standards are designed to apply to a range of services that offer mental health provision to young people with learning disabilities: they do not advocate one service model over another. However, due to the variety of service configurations amongst LD CAMHS the standards will not be relevant to all services. The standards are likely to be of most relevance to generic CAMHS that offer learning disability provision, CAMHS Learning Disability teams and Learning Disability services that offer mental health provision.

The 4 Tiers of Service

Tier 1 - Primary or direct contact services

Tier 2 - A level of service provided by uni-professional groups which relate to each other through a network rather than a team

Tier 3 - A specialised multi-disciplinary service for more severe, complex or persistent disorders

Tier 4 - Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units

Guiding Principles

The standards are guided by ten principles for providing an effective and comprehensive service for young people with learning disabilities and mental health problems. These principles are outlined in the DOAS Care Pathway (see Appendix C) and reflect the standards contained in such key documents as the National Service Framework for Children, Young People and Maternity Services (2004), Valuing People (2001), and Every Child Matters (2003). Above all, these values place children, young people and their families at the centre of service planning and delivery. The ten principles are centred on:

- Holistic services
- Child-centred planning
- A developmental framework
- Multi-agency commissioning and consideration of referrals
- Inclusion and equality of access
- Being pro-active and problem-solving
- Collaborative practice and consent
- Co-operative information sharing and communication
- Therapeutic and quality services
- Encompassing diversity

Sections 1-7: A children and young people's perspective: following the care pathway

"A particularly important quality of functioning as an intelligent network is that participants envisage the care pathways which children and young people may need to take, and then act with their partners in the network to make that pathway – and inter-agency transitions in particular – as smooth as possible" - *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care, Scottish Executive (Ref 23: pg 53)*.

² See Glossary. The CAMHS 4-Tier model represents a strategic and functional framework rather than a prescription of CAMHS structures (see NHS Health Advisory Service (1995) *Together We Stand*, pp 59-65). References to 'Tiers' throughout this document should be understood in the context of this functional definition.

The notion of the care pathway is central to adopting the perspective of children, young people and their families and in making patient-centred service improvements. Throughout sections 1-7, the QINMAC-LD standards are written from the perspective of children and young people (and, where appropriate, parents or carers) who may use LD CAMH services. The standards in these sections focus on the elements of service provision that children and young people with learning disabilities and their families should *experience* and the care that they should *receive* at each stage of the care pathway. These standards also outline the LD CAMHS activities and procedures required to bring about these outcomes.

The standards in these sections are written from the *perspective* of children and young people: however, as with the other sections they are designed to be used by CAMH professionals: they do not purport to be written in young people's *language*.

Sections 8 – 10: Equipping services to respond to young people's needs

Whilst sections 1-7 follow a care pathway focusing on the experiences of children, young people and their families, the final sections of the QINMAC-LD standards detail the staffing, joint-working and commissioning activities and resources required to respond to young people's needs.

Links to existing guidance and policy

Recent Government policy on inclusion, set out in the Valuing People white paper of 2001, states that wherever possible people with learning disabilities should be able to access the same mental health services as everyone else. In March 2005 additional proxy measures were added to the proxy targets for CAMHS which included providing a comprehensive service for young people with a learning disability by December 2006. The QINMAC-LD standards are therefore referenced against key policy documents that outline the quality of care that young people with learning disabilities should expect to receive, such as ***Valuing People*** and ***Every Child Matters***.

The QINMAC-LD standards are also mapped against the English and Welsh ***National Service Frameworks*** for Children, Young People and Maternity Services; the ***Clinical Negligence Scheme for Trusts: Mental Health and Learning Disability Clinical Risk Management Standards***; the Welsh Assembly Government's ***Healthcare Standards for Wales***; and The Department of Health's ***Standards for Better Health***. This will enable member services to demonstrate compliance against a range of guidance and may ultimately help to reduce the burden of inspection. The core standards in the Standards for Better Health represent a level of service that all patients should be able to expect. For reference purposes, the document used for mapping the standards is entitled 'Criteria for assessing core standards: Information for mental health services and learning disability services' (The Healthcare Commission, April 2005).

In addition the QINMAC-LD standards have been cross-referenced with the ***Do Once and Share (DOAS): National Care Pathway*** which has been developed as a guide for commissioners, managers, practitioners and users of LD CAMHS. The DOAS care pathway describes the processes involved in service delivery at each stage of the care pathway, including pre-referral, referral, assessment, interventions and what happens next. The QINMAC-LD standards cover these same stages, with the exception of pre-referral. The QINMAC-LD standards are designed to evaluate the quality of LD CAMHS at Tiers 2 and 3. Most activity at the pre-referral stage occurs prior to the involvement of these services and is largely beyond their locus of control. This stage is therefore considered to be beyond the scope of these standards.

Important notes – using the standards

This document is provided for reference and not for data collection. Data collection tools adapted from these standards will be provided with guidance notes to QINMAC-LD members. A selection of the standards will be measured.

The QINMAC-LD standards contain best practice statements and are aspirational in nature - consequently we would not expect services to meet every standard. While there are some statements that are based upon legal requirements, this document is not intended to act as a legal guide in any way. This is not intended to be a guide to any reviews conducted by regulatory bodies.

Mapping

The QINMAC-LD standards have been mapped so that, wherever a criterion may justifiably be seen as *contributing towards* compliance with other guidance, this is clearly highlighted. Meeting a QINMAC-LD criterion should not be taken as an automatic indication of compliance with the corresponding mapping source stated.

The abbreviations for the mapping sources used throughout the QINMAC-LD standards are as follows:

- **SBH** – The Department of Health’s *Standards for Better Health*
- **HSW** – The Welsh Assembly Government’s *Healthcare Standards for Wales*
- **English NSF** – The English *National Service Framework for Children, Young People and Maternity Services*
- **Welsh NSF** – The Welsh *National Service Framework for Children, Young People and Maternity Services*
- **CNST** – The *Clinical Negligence Scheme for Trusts: Mental Health and Learning Disability Clinical Risk Management Standards*
- **DOAS** – *Do Once & Share project: CAMHS Learning Disabilities – Developing a National Care Pathway*

These mapping references are shown in the right hand column of the QINMAC-LD standards. The numbers stated next to NSF references relate to the corresponding standard within the NSF for Children, Young People and Maternity Services. Where this is followed by a colon (:), the number which follows refers to a specific recommendation listed under that NSF standard.

Where QINMAC-LD standards have been derived from the generic QINMAC standards, this is marked by a ‘Q’ in the left hand column, followed by the corresponding QINMAC standard or criterion number.

Other definitions and abbreviations

To simplify the standards, some terms have been abbreviated or shortened (***please see glossary for all terms***). For clarification when reading the standards, the subsequent terms are defined as follows:

Young People – all people under the age of 18 years old

Parents – any person with parental responsibility³ for a young person

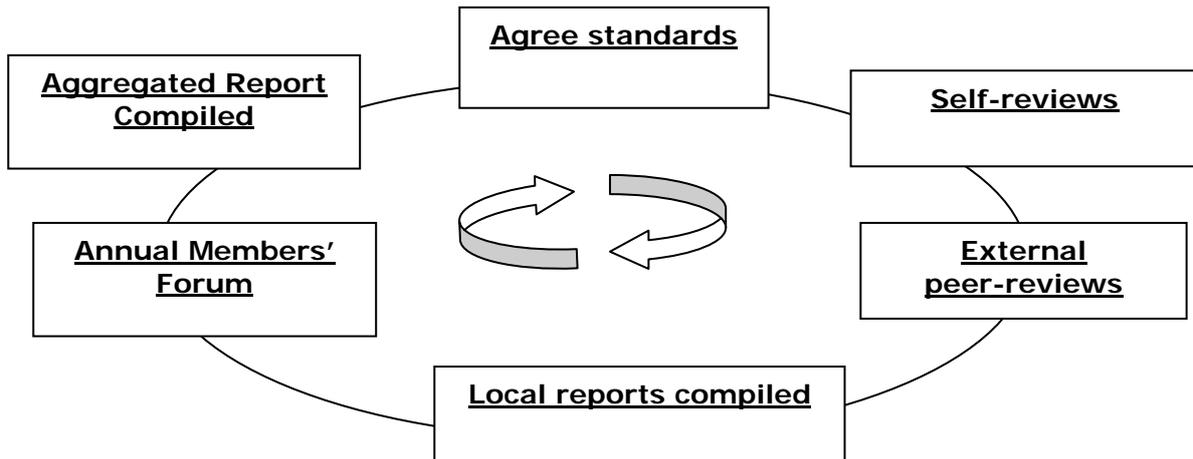
LD CAMHS – services that provide mental health provision to young people who have learning disabilities. For example, this may be provided by generic CAMHS, Learning Disability services or CAMHS Learning Disability teams. In the context of this document, LD CAMHS is used throughout to refer to services that deliver the functions of Tiers 2 and 3; LD CAMHS at Tier 4 are referred to explicitly as ‘Tier 4’.

³ Parental responsibility is defined according to the Children Act 1989: Ref 69

The QINMAC review process

The LD CAMHS standards represent just one part of the QINMAC-LD cycle; the real benefit for member services is in taking part in the review process. These reviews aim to gradually improve services using the principles of the clinical audit cycle (see below).

The annual cycle of reviews



Joining QINMAC

If you have any questions about these standards or are interested in joining the QINMAC-LD network please contact Otilie Dugmore, QINMAC Programme Manager on 020 7977 6681; email odugmore@cru.rcpsych.ac.uk

Section 1: Referral and Access

“No child should be excluded from receiving a mental health service on the grounds of having a learning disability. This is key to meeting the principles of accessibility, nondiscrimination and social inclusion”
National Assembly for Wales (Ref 49: pg 52, recommendation 7.5)

Referral

Standard:

1.1	LD CAMHS advise primary services and other relevant services on how to refer⁴ young people with learning disabilities and mental health needs
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Criteria:

1.1.1 Q1.2.1	LD CAMHS disseminate clear referral criteria to referrers to help them identify and appropriately refer young people <i>Guidance: Referrers may include GPs, social services, educational psychologists, paediatricians, learning disability teams, CAMHS, relevant voluntary support groups and other referrers</i>	SBH C6 Welsh NSF 2.20 HSW 12d
1.1.2	Web-based information about the LD CAMHS and its referral criteria is available e.g. on local government websites <ul style="list-style-type: none"> ▪ Ref 65: pg 25 	DOAS 6.1.4.1
1.1.3 Q1.2.5	The staff of LD CAMHS respond promptly to referrers and other relevant agencies, including when a referral has been made inappropriately <ul style="list-style-type: none"> ▪ Ref 65: pg 25 – “Difficulties in getting a service response can lead to ‘splatter gun’ referrals to several agencies for the same presenting difficulties – this irritates service providers and is an unnecessary burden on already sparse resources” 	SBH C6 Welsh NSF 4.7 DOAS 6.1.4.1
1.1.4 Q1.2.6	When inappropriate referrals are made to the LD CAMHS, staff inform the referrer of alternative options if necessary <ul style="list-style-type: none"> ▪ Ref 20: [Wales] pg 37, recommendation 4.7 – “When the referral is considered to be inappropriate, the referrer receives a response within two weeks of completion of the assessment and redirection to an appropriate service if necessary” ▪ Ref 8: pg 24, recommendation 18.6 	HSW 12d Welsh NSF 4.7

⁴ In line with the DOAS National Care Pathway (Ref: 65) ‘referral’ should be understood throughout this document as a ‘request for service’; whereby responsibility lies with the original referrer until a request for service is accepted.

Section 1: Referral and Access

Standard:		
1.2	<p>There are clear referral pathways for young people with mental health needs and learning disabilities</p> <ul style="list-style-type: none"> ▪ <i>Ref 57: pg 72</i> 	
Criteria:		
1.2.1	There are documented, up-to-date referral pathways for young people with learning disabilities which are agreed with other agencies and services	
1.2.2	<p>There are agreements between relevant services about how to deal with young people who do not fit current criteria or are at risk of being 'bounced' between services</p> <p>Guidance: <i>For example, agreements may involve LD CAMHS, Local Authority Children's Services departments, special schools, and challenging behaviour teams</i></p> <ul style="list-style-type: none"> ▪ <i>Ref 65: pg 25 – "Local protocols or pathways should be developed so that inappropriate referrals can be transferred to the most appropriate service to meet their needs without being 'bounced back'"</i> 	DOAS 6.1.4.1
1.2.3 Q1.2.3	<p>LD CAMHS have documented, up-to-date referral procedures for routine referrals which are agreed with other agencies and services</p> <p>Guidance: <i>It is recommended that referral procedures suggest that referrals are copied to GPs and community paediatricians by the referrer, to ensure they are kept informed</i></p> <ul style="list-style-type: none"> ▪ <i>Ref 2: pg 1, recommendation 2.1.1 – "There is a dated, documented procedure, written/reviewed within the last three years, on how to make routine referrals into the service"</i> 	SBH C6 HSW 12d SBH D11d
1.2.4 Q1.2.4	<p>LD CAMHS have documented, up-to-date referral procedures for urgent and emergency referrals, which are agreed with other agencies and services</p> <ul style="list-style-type: none"> ▪ <i>Ref 2: pg 1, recommendation 2.1.1 – "There is a dated, documented procedure, written/reviewed within the last three years, on how to make emergency referrals into the service, where applicable"</i> 	HSW 3 SBH C19
1.2.5 Q1.2.7	<p>LD CAMHS inform referrers and other relevant professionals when young people and their parents do not attend an initial appointment</p> <p>Guidance: <i>Relevant professionals are likely to include, for example, the young person's GP, and community paediatrician</i></p> <ul style="list-style-type: none"> ▪ <i>Ref 37: pg 98 – "A local system is in place to identify children or young people who do not attend an appointment following a referral for specialist care, so that the referrer is aware they have not attended and can take any follow-up action considered appropriate to ensure the child's needs are being met"</i> 	SBH C6 English NSF (3)

Section 1: Referral and Access

Standard:		
1.3	Young people and their parents are involved and informed during the referral process and know what to expect	
Criteria:		
1.3.1 Q1.3.1	LD CAMHS provide referrers with service information (e.g. leaflets) for young people and their families <ul style="list-style-type: none"> ▪ Ref 8: pg 39, recommendation 36.5 – “There is a leaflet giving general information about the [service] available to young people and parents before [assessment]” 	SBH C16 HSW 6a
1.3.2	Letters acknowledging acceptance of a referral are sent to the referrer, the family and to other agencies as appropriate <ul style="list-style-type: none"> ▪ Ref 65: pg 28 	DOAS 6.2.3.3
1.3.3 Q1.3.4	Appointment letters for assessments explain who young people and their parents will be seen by, where they will be seen and what the purpose of the assessment is	
1.3.4 Q1.3.5	The staff of the LD CAMHS make themselves available to answer any telephone queries that young people and their parents may have prior to the initial assessment	SBH C16 HSW 6a
Access		
Standard:		
1.4 Q1.4	All young people with learning disabilities have easy access to appropriate child and adolescent mental health services <ul style="list-style-type: none"> • Ref 49: pg 52, recommendation 7.5 • Ref 5: pg 5 • Ref 16: pg11, recommendation 9.6 	
Criteria:		
1.4.1 Q1.4.3	Young people with learning disabilities have access to mental health services in their local area <p>Guidance: The journey time for young people attending appointments is usually less than 45 minutes</p> <ul style="list-style-type: none"> ▪ Ref 57: pg 80 “Wherever possible services should be local. Recovery is more likely in a familiar environment where an individual feels safe and secure and does not lose touch with their social network” ▪ Ref 64: pg 22 - “Children with possible impairments have prompt access to a diagnostic and assessment facility that is as close to the child’s home as possible” 	SBH C18 HSW 2d English NSF (3) English NSF (8)

Section 1: Referral and Access

<p>1.4.2 Q1.4.4</p>	<p>Young people with learning disabilities and mental health needs are offered services in accessible community settings</p> <p>Guidance: <i>For example, services provide sessions at several sites to ensure easy access; services are offered in accessible community settings; home or school visits are offered where this forms a key part of an assessment</i></p> <ul style="list-style-type: none"> • Ref 64: <i>pg 22 - "Where appropriate, multi-agency assessments are carried out in convenient settings, such as the child's home or school"</i> • Ref 65: <i>pg 16 "Children and young people with LD prefer to have their needs met within a familiar environment (e.g. home or school), at primary care level (e.g. school), and by familiar people"</i> 	<p>SBH C18</p> <p>English NSF (9) 3</p> <p>English NSF (8)</p> <p>HSW 2d</p> <p>DOAS 4.2</p>
<p>1.4.3 Q1.4.6</p>	<p>Failures to attend initial appointments following referral are monitored and reviewed in order to identify where access difficulties may exist (<i>see also Care and Intervention 5.2.5 and Transitions 7.1.3</i>)</p> <ul style="list-style-type: none"> ▪ Ref 37: <i>pg 97 – "Failure to attend can be an indicator... that a service is difficult for families to access or considered inappropriate, and requires reviewing"</i> 	

Section 2: Environment and Facilities

“Creating an environment that is conducive to good communication is important, so improved physical environments, along with the use of appropriate communication skills and strategies by parents and carers will substantially benefit a young person with learning disabilities”

Foundation for People with Learning Disabilities (Ref 57: pg 26)

Standard:

2.1 Q2.1	Centres used for LD CAMHS work⁵ meet the needs of young people with learning disabilities
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Criteria:

2.1.1	Assessments and interventions are carried out in settings agreed with the young person and their parents prior to any consultation <i>Guidance: Settings should be agreed with the family and young person and other staff working in the building where appropriate. This is especially important for children and adolescents with moderate and severe learning disabilities</i>
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2.1.2	Assessments and interventions are carried out in settings that meet the needs of the consultation <i>Guidance: Different facilities are required for different types of assessment: for example, video facilities for diagnostic observation for ASD, tables and picture cards for speech and language assessments etc.</i>
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2.1.3	Centres used for LD CAMHS work provide low-stimulation environments for young people who require them, including designated quiet areas <i>Guidance: For example, waiting areas are kept tidy or materials can be easily put away; there is access to low stimulation areas for ‘quiet time’ if necessary</i>
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2.1.4 Q2.1.2	The environment meets the needs of people who have physical disabilities, and complies with current legislation on access to buildings for people who have a disability <ul style="list-style-type: none"> ▪ Ref 45: pg 18 <i>“Frequently, disabilities are multiple and so the accommodation should be appropriate, including, for example, wheelchair access”</i> ▪ Ref 16: pg 10 recommendation 10.i.v – <i>“Young people with physical disabilities and/or ill health are able to receive a full service”</i> 	SBH C21 C7e HSW 4b 10
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2.1.5 Q2.1.3	Centres used for LD CAMHS work are comfortable and maintained at high levels of cleanliness	HSW 5a SBH C21
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⁵ Children may be seen in various settings (home, school, children’s centres etc); all of these should be conducive to good communication

Section 2: Environment and Facilities

2.1.6 Q2.1.4	Centres used for LD CAMHS work have warm, welcoming atmospheres <ul style="list-style-type: none"> ▪ <i>Ref 8: pg 8, recommendation 1.1</i> 	HSW 4a SBH C21
2.1.7 Q2.1.5	Centres used for LD CAMHS work are developmentally-appropriate and young person-friendly	SBH C21 HSW 4a
2.1.8 Q2.1.6	Centres used for LD CAMHS work are parent-friendly <i>Guidance: For example, refreshments are available, the service provides baby-changing facilities</i>	English NSF (2)
2.1.9 Q2.1.8	Centres used for LD CAMHS work have spacious waiting areas <ul style="list-style-type: none"> ▪ <i>Ref 36: "Facilities not being cramped was thought by several of the group to be important in terms of helping to minimise the stress/anxiety of waiting to be seen"</i> 	
2.1.10 Q2.1.9	Centres used for LD CAMHS work have waiting areas that contain developmentally-appropriate play and reading material <ul style="list-style-type: none"> ▪ <i>Ref 8: pg 46, criterion 44.3 – "The [centre] is sensitive to the needs of different ages, for example, age appropriate recreational facilities are provided"</i> 	
2.1.11 Q2.1.10	Centres used for LD CAMHS work have waiting areas that contain culturally sensitive play and reading material	
2.1.12	Centres used for LD CAMHS work have sufficient car parking space for visitors, including allocated spaces for disabled access	
<u>Standard:</u>		
2.2 Q2.2	Centres used for LD CAMHS work are designed and managed so that the rights, privacy and dignity of young people and their families are respected	
<u>Criteria:</u>		
2.2.1 Q2.2.3	Young people and their families have consultations in private rooms where they cannot be overheard <ul style="list-style-type: none"> ▪ <i>Ref 9: pg 16</i> 	SBH C20b HSW 4b
2.2.2 Q2.2.4	Young people and their families and practitioners have adequate access to large and small rooms suitable for individual and family consultations <ul style="list-style-type: none"> ▪ <i>Ref 55: pg 30</i> 	SBH C20b HSW 4b

Section 2: Environment and Facilities

Standard:		
2.3 Q2.3	Centres used for LD CAMHS work provide safe environments	
Criteria:		
2.3.1 Q2.3.1	Entrances and exits are visibly monitored and/or restricted <ul style="list-style-type: none"> ▪ <i>Ref 37: pg 109</i> 	SBH C20a English NSF (3) HSW 4c 4d
2.3.2	When consultation takes place in a new setting, staff carry out a risk assessment regarding the safety of the environment and its suitability for meeting the needs of the consultation	
2.3.3 Q2.3.2	LD CAMH centres are separate from adult services Guidance: <i>For example, there are separate entrances for adults' and children's services</i> <ul style="list-style-type: none"> ▪ <i>Ref 37: pg 109 – "All agencies and organisations review the security arrangements for services they provide to children and young people to ensure that access is limited to those adults who need it"</i> 	SBH C20a English NSF (3) HSW 4c 4d

Section 3: Assessment

“Children and young people who are disabled or who have complex health needs receive co-ordinated, high-quality child and family-centred services which are based on assessed needs”

National Service Framework for Children, Young People and Maternity Services: Standard 8 (Ref 64: pg 5)

Standard:

3.1 Q3.1	Young people with learning disabilities receive timely mental health assessments	
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Criteria:

3.1.1 Q3.1.1	<p>Young people receive routine mental health assessments within nationally agreed timescales</p> <p>Guidance: England: 13 weeks; Wales: 4 weeks</p> <ul style="list-style-type: none"> ▪ Ref 8: pg 24, recommendation 19.1a – “Young people do not experience delay in assessment that leads to deterioration in health” ▪ Ref 9: pg 15 ▪ Ref 20: [Wales] pg 37, recommendation 4.7 – “Routine cases are seen by day care/community intensive care teams within 4 weeks of acceptance of a referral” 	<p>SBH C19</p> <p>Welsh NSF 4.7</p>
3.1.2 Q3.1.2	<p>Young people with urgent or emergency mental health needs receive specialist mental health assessments promptly and within nationally agreed timescales</p> <p>Guidance: In emergency cases, specialist mental health assessments are provided within 24 hours or the next working day</p> <ul style="list-style-type: none"> ▪ Ref 5: pg 5 recommendation 4 – “Children and young people are able to receive urgent mental health care when required, leading to a specialist mental health assessment where necessary within 24 hours or the next working day”. ▪ Ref 20: [Wales] pg 37, recommendation 4.7 – “Urgent cases are seen by day care/community intensive care teams within 3 working days of acceptance of a referral. Feedback to the referrer is provided within one working day of completion of the assessment, indicating case management advice” 	<p>SBH C19</p> <p>HSW 3</p> <p>English NSF (9) 4</p> <p>Welsh NSF 4.7</p>
3.1.3 Q3.1.3	<p>Protocols regarding criteria for urgent and emergency assessment are negotiated locally with referrers</p>	<p>SBH C6</p> <p>HSW 24b</p>

Section 3: Assessment

Standard:		
3.2 Q3.2	Young people and their parents are fully involved and informed before the assessment	
Criteria:		
3.2.1 Q4.3.1	<p>Staff provide young people and their parents with a welcome pack or introductory booklet about the service prior to or during their first attendance</p> <ul style="list-style-type: none"> ▪ Ref 8: pg 39, recommendation 36.5 – “There is a leaflet giving general information about the [service] available to young people and parents before [assessment]” 	<p>SBH C16</p> <p>HSW 6a</p>
3.2.2 Q3.2.1	<p>Staff check that young people and their parents understand the purpose of the assessment as fully as possible before it is conducted</p> <p>Guidance: For example, an assessment checklist is followed to ensure this</p> <ul style="list-style-type: none"> ▪ Ref 2: pg 7, recommendation 2.11.1 – “All assessments have a clear purpose which is explained to the child/young person and their carers” 	<p>SBH C16</p> <p>HSW 6c</p>
3.2.3 Q3.2.2	Young people and their parents are involved in a discussion about how long the assessment will last and who will be present	<p>SBH C16</p> <p>HSW 6c</p>
3.2.4 Q3.2.3	<p>Young people and their parents can express their opinion regarding who to bring to appointments and staff inform them of this at the initial assessment</p> <p>Guidance: Using a Health Action Plan is one way of ensuring that transactions with the young person are recorded</p>	<p>SBH C16</p> <p>HSW 6c</p>
Standard:		
3.3 Q3.3	<p>Assessments are effectively co-ordinated with other agencies so that young people and their parents are not repeatedly asked to give the same information</p> <ul style="list-style-type: none"> ▪ Ref 36: “There was notably strong support for this standard amongst the young people” ▪ Ref 37: pg 88, recommendation 3.5 – “Primary Care Trusts and Local Authorities work together with other agencies to develop a system so that information derived from an assessment of a child or young person and their family, can follow them and be accessible to them through their journey” 	<p>English NSF (3) 3.5</p> <p>English NSF (8)</p>

Section 3: Assessment

Criteria:		
3.3.1 Q3.3.1	<p>The service works within a joined-up approach to assessment so that multiple assessments of young people are minimised</p> <p>Guidance: <i>The assessment process should be co-ordinated across agencies where necessary. This may involve the service contributing towards the development and implementation of the Common Assessment Framework (England only) and/or its principles</i></p> <ul style="list-style-type: none"> ▪ Ref 37: <i>pg 88 - "A Common Assessment Framework is being developed to help reduce the duplication between agencies and provide an assessment tool used across all professionals working with children. It aims to reduce the time spent in repeated assessments of the same child by different practitioners, encourage multi-agency working, provide common language and initiate action where it is needed"</i> 	<p>SBH C6</p> <p>HSW 12d</p> <p>English NSF (3)</p>
3.3.2 Q3.3.2	<p>There is a system in place which enables professionals involved in the care of young people to identify whether they are receiving, or have received, care in any constituent part of the Trust</p> <ul style="list-style-type: none"> ▪ Ref 12: <i>pg 50, recommendation 4.1.3 (1)</i> 	<p>HSW 12d</p> <p>CNST 4.1.3 (1)</p>
3.3.3 Q3.3.3	<p>LD CAMHS staff have appropriate levels of access to unified clinical records for young people</p> <p>Guidance: <i>There may be access to one record, or a resume of key factors is available to avoid repetition of information</i></p> <ul style="list-style-type: none"> ▪ Ref 12: <i>pg 51, recommendation 4.2.3 (2) – "Professionals have access to unified clinical information. Either there is one record per patient Trust-wide or, if more than one record exists, then either all records (not just in-patient) are available at first new consultation or a resume of key factors is held in all records"</i> ▪ Ref 20: [Wales] <i>pg 9, recommendation 2.9 – " A common electronic health record is used so that organisations have access to assessment information, with the agreement of the child or young person and their parents/ carers, where appropriate, so that children and their carers do not need to give the same information many times"</i> 	<p>HSW 25</p> <p>Welsh NSF 2.9</p> <p>CNST 4.2.3 (2)</p>
3.3.4 Q3.3.4	<p>The number of forms that young people are required to complete on assessment are kept to a minimum</p> <ul style="list-style-type: none"> ▪ Ref 36 	
3.3.5 Q3.3.5	<p>Prior to any assessment, assessing practitioners familiarise themselves with all referral information that has been made available to them, including past assessments and existing knowledge⁶</p> <p>Guidance: <i>This is likely to include education information such as SEN Assessments; past Annual Educational Reviews; Looked After Children Reviews; other assessments such as completed CAFs, paediatric assessments, speech and language therapy and Child in Need</i></p> <ul style="list-style-type: none"> ▪ Ref 65: <i>pg 29 "[The assessment is supplemented with] existing knowledge and previously completed assessments (e.g. what has worked / is working and what has not / does not work)."</i> 	<p>DOAS 6.3.1.1</p>

⁶ Also see Section 4 on consent and confidentiality: Standards 4.2, 4.3, and 4.4

Section 3: Assessment

3.3.6	If additional information about the young person is required from the referrer, or from other agencies, assessing practitioners ensure that permission to access this is first sought from parents	
3.3.7	If liaison with other professionals involved in the young person's care is required prior to assessment, assessing practitioners seek permission from parents to do this	
<u>Standard:</u>		
3.4 Q3.4	Staff have the necessary competencies and resources to conduct assessments and arrange the next steps	
<u>Criteria:</u>		
3.4.1 Q3.4.1	<p>Young people are assessed by staff who have appropriate competencies in learning disability and mental health to conduct the assessment and co-ordinate next steps, or by staff who have appropriate supervision from professionals with these competencies</p> <ul style="list-style-type: none"> ▪ Ref 55: pg 20 – <i>“Special expertise and experience is required for accurate diagnosis, because of the atypical presentation of mental disorders, communication difficulties and the absence of subjective complaints”</i> 	<p>SBH C11a</p> <p>HSW 22a</p> <p>English NSF (3)</p>
3.4.2 Q3.4.2	Where assessments are made by a single practitioner, the clinician conducting the assessment is able to gain multi-disciplinary input on the case as needed	
3.4.3 Q3.4.4	<p>Staff who are involved in clinical assessments have an agreed pathway to facilitate prompt access to medical investigation</p> <p>Guidance: <i>This should include access to genetic investigations, brain imaging, and electroencephalography, in addition to all routine modern laboratory and investigative facilities</i></p> <ul style="list-style-type: none"> ▪ Ref 45: pg 18 	
3.4.4	<p>Staff follow established protocols and good practice (e.g. NICE guidelines) when assessing young people with learning disabilities and mental health problems</p> <ul style="list-style-type: none"> ▪ Ref 65: pg 4 	DOAS
<u>Standard:</u>		
3.5 Q3.5	Young people's assessments are individual and comprehensive, according to each young person's needs and those of their family	
<u>Criteria:</u>		
3.5.1	<p>Case notes show evidence that young people's assessments take into account the young person's specific communication needs</p> <ul style="list-style-type: none"> ▪ Ref 58: pg 20 – <i>“psychiatric diagnosis in patients with significant intellectual and communication difficulties can be difficult, and the phenomenology of their unusual experiences can easily be misunderstood”</i> 	

Section 3: Assessment

3.5.2	<p>Staff take advice from people who know the young person well about how best to modify assessments to meet the young person's needs</p> <p>Guidance: <i>For example, family, school staff, short break carers or other professionals who have worked with the child are asked for their advice</i></p>	
3.5.3 Q3.5.1	<p>Case notes show evidence that young people's assessments include identifying the other agencies involved in their care</p>	SBH C6 HSW 12d
3.5.4	<p>Case notes show evidence that young people's assessments include consideration of their general level of functioning</p>	
3.5.5 Q3.5.2	<p>Case notes show evidence that young people's assessments include consideration of their individual mental health needs, and of their social, physical, emotional, educational, cultural and spiritual needs</p> <ul style="list-style-type: none"> ▪ Ref 37: <i>pg 89, paragraph 2.1</i> 	HSW 12c English NSF (3)
3.5.6 Q3.5.3	<p>Case notes show evidence that young people's assessments include consideration of their family and community needs and context</p> <p>Guidance: <i>For example, assessments consider the needs and the impact of disability and mental health problems on parents and siblings</i></p> <ul style="list-style-type: none"> ▪ Ref 64: <i>pg 22 – "Assessments include parents' needs for support with caring for a child... They also address the support needs of siblings"</i> ▪ Ref 65: <i>pg 13 – "The full range of emotional, physical, social, educational and practical needs should be considered in the context of the family, with special attention paid to parents/carers' and siblings' needs"</i> 	English NSF (3&8) Welsh NSF 2.8 DOAS 4.1.1
3.5.7	<p>Case notes show evidence that young people's assessments consider their abilities and strengths as well as their difficulties</p> <ul style="list-style-type: none"> ▪ Ref 64: <i>pg 22</i> 	English NSF (8)
3.5.8 Q3.5.4	<p>Case notes show evidence that young people's assessments include identification and evaluation of relevant risks</p> <p>Guidance: <i>This should include evaluation of both clinical risk and any concerns about child protection.</i></p>	
<u>Standard:</u>		
3.6 Q3.6	<p>Young people and their parents experience assessment as collaborative and are fully involved in agreeing the next steps</p>	
<u>Criteria:</u>		
3.6.1 Q3.6.1	<p>During assessment young people's views, wishes, and feelings are actively sought and recorded by the assessing practitioner</p> <ul style="list-style-type: none"> ▪ Ref 2: <i>pg 8, recommendation 2.14 – "Children's views, wishes and feelings, on all aspects of their care are sought in a manner appropriate to their age and understanding"</i> 	HSW 6c

Section 3: Assessment

<p>3.6.2 Q3.6.2</p>	<p>Parents are encouraged to participate in the assessment and their views, wishes and feelings are actively sought and recorded by the assessing practitioner</p>	
<p>3.6.3 Q3.6.3</p>	<p>Young people and their parents and/or referrers are provided with feedback on the outcome of their assessment, including explanation of the nature of the young person's problems</p> <ul style="list-style-type: none"> ▪ Ref 12: pg 50, recommendation 3.2.4 (2) 	<p>SBH C16</p> <p>HSW 6b</p> <p>CNST 3.2.4 (2)</p>
<p>3.6.4 Q3.6.4</p>	<p>Plans for intervention or re-referral are discussed, developed and agreed with young people and their parents</p> <ul style="list-style-type: none"> ▪ Ref 12: pg 50, recommendation 3.2.4 (2) – <i>“The Trust is able to demonstrate that there is a process for providing information to service users and a discussion regarding the proposed treatment, and that there is a confirmation stage to ensure that the service user still wants to proceed”</i> 	<p>SBH C16</p> <p>HSW 6b 6c</p> <p>CNST 3.2.4 (2)</p>
<p>3.6.5 Q3.6.5</p>	<p>Where young people or their parents disagree with the professional opinion given on the nature of their problems or their formulation, staff inform them that they are entitled to challenge the opinion and explain the options that are available to them</p> <p>Guidance: <i>For example, young people and their families may discuss the outcome of the LD CAMHS assessment with their referrer before considering whether to proceed and how</i></p>	<p>SBH C16 C18</p> <p>HSW 6c</p>
<p>3.6.6 Q3.6.7</p>	<p>Staff provide guidance to young people and their parents on what they can do to start helping themselves whilst awaiting the next step</p> <p>Guidance: <i>For example, at a suitable point in the assessment or soon afterwards, staff tell families and individuals what other community resources are available to them, and provide them with leaflets or literature to read</i></p> <ul style="list-style-type: none"> ▪ Ref 28: pg 45 recommendation 30 – <i>“Give families something to do whilst waiting for the next step; books, handouts, community resources”</i> 	<p>SBH C16</p> <p>HSW 7</p>

Section 4: Information, Consent and Confidentiality

“Information has been shown to be one of the most valued aspects of families’ contacts with services, yet a substantial proportion of parents and disabled children and young people report that their needs for information remain unmet”
Department of Health (Ref 41. pg 145, recommendation 8)

Information format

Standard:

4.1 Q4.2	Young people and their parents are provided with information that is accessible and appropriate for their use⁷
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Criteria:

4.1.1 Q4.2.2	<p>Staff provide verbal information to young people and their parents and supplement this with written information</p> <ul style="list-style-type: none"> ▪ Ref 32: pg 146, recommendation 8 – “Research on parents’ experiences indicates that written information on its own is not enough. As noted above, parents want to receive information face-to-face from a professional who will guide them through it... A named worker with whom they have an ongoing relationship is the preferred source of information” 	<p>SBH C16</p> <p>HSW 6a 6b</p>
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4.1.2	<p>All information is provided in an accessible format which is suitable for young people with learning disabilities</p> <p>Guidance: This may involve using audio and video cassettes, accessible documentation (e.g. using symbols, plain English and pictures) communication passports, or signers or interpreters</p> <ul style="list-style-type: none"> ▪ Ref 38: pg 66, recommendation 6.25 – “Mental health promotion materials and information about services are provided in an accessible format for people with learning disabilities” ▪ Ref 37: pg 93 ▪ Ref 57: pg 38 	<p>SBH C16</p> <p>HSW 6a 6b</p> <p>English NSF (3)</p>
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4.1.3	<p>Staff use communication methods that are consistent with young people’s usual means of communication</p> <ul style="list-style-type: none"> ▪ Ref 64: pg 30 ▪ Ref 37: pg 91 ▪ Ref 57: pg 38 	<p>SBH C18</p> <p>HSW 10</p> <p>English NSF (3&8)</p>
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⁷ Standard 4.1 is overarching: criteria apply to all information that is provided for children, young people, parents and carers e.g. service information, intervention information, information on consent and confidentiality, rights and so on.

Section 4: Information, Consent and Confidentiality

<p>4.1.4 Q4.2.6</p>	<p>Parents are provided with clear information that is specifically produced for their needs</p> <ul style="list-style-type: none"> ▪ Ref 41: pg 146, recommendation 8- “Children identify parents themselves as important information sources, so ensuring that parents have access to information is crucial for children as well” ▪ Ref 37: pg 32, recommendation 3.12 	<p>SBH C16</p> <p>HSW 6a</p> <p>English NSF (1) 3.12</p>
<p>4.1.5</p>	<p>Siblings of young people with learning disabilities are provided with clear information that is specifically produced for their needs</p> <ul style="list-style-type: none"> ▪ Ref 64: pg 29 	<p>English NSF (8)</p>
<p>4.1.6 Q4.2.7</p>	<p>Young people and their families are provided with information that is available in a range of languages where needed, as identified from local population information/analysis on languages spoken⁸</p> <ul style="list-style-type: none"> ▪ Ref 20: [Wales] pg 8, recommendation 2.3 – “Accurate and timely information on services is provided to meet the needs of all children and young people, but particularly those from marginalised communities. ▪ Ref 37: pg 93 	<p>SBH C16 C7e</p> <p>Welsh NSF 2.3</p> <p>English NSF (3)</p> <p>HSW 6a 6b</p>
<p>4.1.7 Q4.2.8</p>	<p>Young people and their parents are provided with information that is culturally relevant and sensitive</p> <p>Guidance: For example, images used in posters and leaflets fully reflect the cultural diversity of the community</p> <ul style="list-style-type: none"> ▪ Ref 41: pg 146, recommendation 8 – “Parents from minority ethnic groups report particularly high levels of unmet needs for information about services for themselves and their child” ▪ Ref 37: pg 93 	<p>SBH C16 C7e</p> <p>English NSF (3)</p> <p>HSW 6a</p>
<p>4.1.8 Q4.2.9</p>	<p>Young people and their parents are consulted and involved in the production of information</p> <p>Guidance: Service information may usefully include quotes or narratives reflecting the real experiences of young people and parents who have used the service (see Ref: 36 below)</p> <ul style="list-style-type: none"> ▪ Ref 41: pg 146, recommendation 8 – “Parents’ involvement in the design of information helps to ensure that it is attractive and accessible” ▪ Ref 36: The group suggested that some information about what other young people have said about the service/how they rated what was offered would be an important part of the information that should be provided to young people 	<p>Welsh NSF 2.3</p>
<p>4.1.9</p>	<p>LD CAMHS facilitate initiatives in which young people with learning disabilities and/or mental health problems act as information sources for others with similar conditions</p> <ul style="list-style-type: none"> ▪ Ref 41: pg 146, recommendation 8 – “Children identify a number of issues to be addressed [including] provision of opportunities for contacts with other disabled children” 	

⁸ Services should be aware that a large number of people for whom English is not their first language are not literate in their own language (as is also the case among many for whom English is their first language). Therefore translated written materials may not have any value and interpreters should be used wherever possible to provide verbal explanations.

Section 4: Information, Consent and Confidentiality

Consent		
Standard:		
4.2 Q4.5	<p>Staff follow clear procedures for gaining consent and ensure that young people and their parents are well-informed of their rights regarding consent</p> <p>Guidance: Staff can refer to the Department of Health publication 'Seeking Consent' for professionals (Ref 70): http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Consent/ConsentGeneralInformation/fs/en</p> <ul style="list-style-type: none"> ▪ Ref 20: [Wales] pg 14, recommendation 2.26 – " All health professionals follow the Guidance about Consent for Examination or Treatment for the NHS in Wales18" 	<p>SBH C13b</p> <p>Welsh NSF 2.26</p>
Criteria:		
4.2.1 Q4.5.1	<p>The service has a documented policy relating to consent which includes a list of activities for which specific written consent is required</p> <p>Guidance: The policy should include reference to consent regarding interventions, examinations, video-recording etc</p> <ul style="list-style-type: none"> ▪ Ref 37: pg 94 – "Consent policies include what to do when there is disagreement between a competent young person and their parents, and also address the situation where health care professionals believe that a particular treatment is crucial for a child but the young person, parents refuse to give consent" 	<p>English NSF (3)</p>
4.2.2 Q4.5.3	<p>Young people and parents are informed by staff of their right to agree to or refuse intervention and the limits of this</p>	
4.2.3 Q4.5.4	<p>Consent for interventions is obtained by a practitioner who is competent and capable of performing the intervention, or by a person who has received specialist training on advising young people about the intervention</p> <ul style="list-style-type: none"> ▪ Ref 12: pg 50, recommendation 3.2.1 (2) – "The Trust is able to demonstrate that consent is obtained by a person competent and capable of performing the treatment / intervention or that the person obtaining consent has received specialist training in advising service users about the treatment / intervention, have been assessed, are aware of their own knowledge limitations and are subject to audit" ▪ Ref 17: pg 19, recommendation C13b 	<p>SBH C13b</p> <p>HSW 8c</p> <p>CNST 3.2.1 (2)</p>
4.2.4 Q4.5.5	<p>Consent is obtained in writing wherever appropriate, as outlined in law and Trust policy</p>	
4.2.5 Q4.5.6	<p>Where young people are assessed as having capacity, consent to interventions is obtained and recorded</p>	<p>SBH C13b</p> <p>HSW 8c</p>

Section 4: Information, Consent and Confidentiality

4.2.6	<p>Careful procedures are used to establish that a young person with learning disabilities has given informed consent</p> <p>Guidance: For example, staff check the young person's understanding of what they are consenting to by asking them to communicate this back to them</p> <ul style="list-style-type: none"> ▪ Ref 57: pg 64 – “Several studies have demonstrated that many people with learning disabilities have, at best, a partial understanding of what they are consenting to, with careful procedures necessary to establish that a person with learning disabilities has given informed consent” 	
4.2.7	<p>Staff take steps to facilitate understanding and development of capacity</p> <p>Guidance: For example, staff explore different communication methods to facilitate understanding</p>	
4.2.8 Q4.5.7	<p>Where young people are assessed as not having capacity, consent from someone with parental responsibility⁹ is obtained and recorded, and the views of the young person are taken into account and documented in their intervention plan</p> <p>Guidance: Parental responsibility is defined according to the Children Act 1989 (Ref 69). In circumstances where someone with parental responsibility is <u>not eligible</u> to give consent on behalf of the young person, their views should be taken into consideration and documented in the young person's care plan</p> <ul style="list-style-type: none"> ▪ Ref 39: pg 13, recommendation 61.38 – “The organisation must ensure that there are safeguards in place to protect patients/users unable to give consent due to mental incapacity” ▪ Ref 67 	<p>SBH C13b</p> <p>HSW 8c</p>
4.2.9 Q4.5.8	<p>Interventions are only conducted against the will of young people when it is deemed to be in the young person's best interests and all other options have been exhausted</p>	
4.2.10 Q4.5.9	<p>When a young person who is assessed as having capacity is treated against their will, this is conducted within the appropriate legal framework and is noted in their health record</p> <ul style="list-style-type: none"> ▪ Ref 8: pg 49, criteria 48.1 – “The [service] has clear guidance endorsed by the Trust on procedures for administering treatment without consent...” 	
Information-sharing and confidentiality		
Standard:		
4.3 Q4.6	<p>Personal information about young people is kept confidential unless this is detrimental to their well-being</p> <ul style="list-style-type: none"> ▪ Ref 17: pg 19, recommendation C13b – “Health care organisations have systems in place to ensure that staff treat patient information confidentially except where authorised by legislation to the contrary” 	SBH C13b

⁹ In the case of Looked After Children this would mean consent from a local authority designated person in a care order except when the young person is under Section 20 of the Children Act 1989 - see Department of Health, Seeking consent: Working with Children (Ref: 70)

Section 4: Information, Consent and Confidentiality

Criteria:		
4.3.1 Q4.6.1	<p>The service has an explicit policy on information-sharing and confidentiality</p> <p>Guidance: <i>This policy should address the requirements of the Caldicott Report on handling Patient Identifiable Information and the requirements of Government about information sharing. For example see the DfES document, "Information sharing: Practitioners' guide" (Ref 68): http://www.everychildmatters.gov.uk/resources-and-practice/IG00065/</i></p>	SBH C13b HSW 8d
4.3.2 Q4.6.3	<p>Personal information about young people is kept confidential and is only revealed in accordance with explicit protocols for information-sharing</p> <p>Guidance: <i>Confidentiality may be overridden in certain circumstances in order to protect the well-being of the child or young person (See Ref 68 and Appendix E). The reasons for decisions to share or not to share information should always be recorded.</i></p> <ul style="list-style-type: none"> ▪ Ref 68: pg 5 – "Where there is concern that the child may be suffering or is at risk of suffering significant harm, the child's safety and welfare must be the overriding consideration" ▪ Ref 8: pg 41, recommendation 39 	SBH C13b HSW 8d
4.3.3	<p>Letters to referrers and other agencies involved in the young person's care are copied to young people and their parents (<i>not applicable in Wales</i>)</p> <p>Guidance: <i>This may be overridden in certain circumstances, for example where there are child protection concerns</i></p>	
Standard:		
4.4 Q4.7	<p>Young people and their parents are well-informed about confidentiality and their rights to access information held about them</p> <ul style="list-style-type: none"> ▪ Ref 17: pg 19, recommendation C13b – "Patients, including those with language and/or communication support needs, are provided with information on the use and disclosure of confidential information held about them, in accordance with Confidentiality: NHS code of practice (Department of Health 2003)." 	SBH C13b
Criteria:		
4.4.1 Q4.7.1	<p>The service policy on information-sharing and confidentiality is made available to young people and parents on request</p> <ul style="list-style-type: none"> ▪ Ref 1: pg 46, recommendation 9 	SBH C13b C16

Section 4: Information, Consent and Confidentiality

<p>4.4.2 Q4.7.2</p>	<p>Young people and their parents are informed of their right to confidentiality and the limits of this</p> <p>Guidance: <i>Families should be informed through verbal explanations, supplemented by prominently displayed leaflets or posters</i></p> <ul style="list-style-type: none"> ▪ Ref 37: <i>pg 122 “Health, education, social care and other services for young people produce, and clearly display, a confidentiality policy which makes clear the duty of confidentiality and care to young people...”</i> 	<p>SBH C13b C16</p> <p>English NSF (4)</p>
<p>4.4.3 Q4.7.3</p>	<p>Young people and their parents are informed about their rights to see their (child’s) health records and the limitations on these rights</p>	<p>SBH C13b C16</p>
<p>4.4.4 Q4.7.7</p>	<p>Young people who are assessed as having capacity are asked to give or withhold consent before case material is disclosed to their parents</p> <p>Guidance: <i>i) This may be overridden in certain circumstances (see criterion 4.3.2 and Ref 68). ii) Where a child or young person is considered to <u>lack</u> capacity to make the decision in question, care should be taken to consider whether or not case material should be shared. There should also be consideration as to whether or not the interests of the child or young person and those of the persons with parental responsibility may have parted company. In such circumstances legal advice should be sought</i></p> <ul style="list-style-type: none"> ▪ Ref 68: <i>pg 5 – “You should, where possible, respect the wishes of children, young people or families who do not consent to share confidential information. You may still share information, if in your judgement on the facts of the case, there is sufficient need to override that lack of consent”</i> 	<p>SBH C13b C13c</p> <p>HSW 8c&d</p>
<p>4.4.5 Q4.7.8</p>	<p>Young people and their parents are informed (and their consent sought where appropriate) when confidential information about them is to be passed on to other services and agencies</p> <p>Guidance: <i>Staff should also explain the reasons why sharing the information is important to their continuing care. If consent is not given, there should be clear procedures for staff to follow</i></p> <ul style="list-style-type: none"> ▪ Ref 23 [Scot]: pg 51 <i>“Professionals discuss with parents, carers, children and young people the circumstances in which information will be shared, and seek their consent”</i> 	<p>SBH C13b C16</p>

Section 5: Care and Intervention

“Children and young people who are disabled or who have complex health needs receive co-ordinated, high-quality child and family-centred services which are based on assessed needs, which promote social inclusion and, where possible, which enable them and their families to live ordinary lives”

National Service Framework for Children and Young People and Maternity Services, Standard 8 (Ref 64: pg 5)

Standard:

5.1 Q5.1	<p>Young people are provided with a comprehensive and effective range of care and intervention, co-ordinated across agencies where necessary</p> <ul style="list-style-type: none"> ▪ Ref 64: pg 6 – <i>“Disabled children and young people who require ongoing health interventions have access to high quality, evidence-based care, delivered by staff who have the right skills for diagnosis, assessment, treatment and ongoing care and support”</i> 	<p>English NSF (8)</p>
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Criteria:

5.1.1 Q1.1.1	<p>LD CAMHS work with primary services and other relevant services to ensure young people with learning disabilities receive the care and intervention they need</p> <p>Guidance: <i>As a minimum, collaboration should involve providing advice or education to other agencies on how to manage young people with learning disabilities and mental health needs. More formalised collaborative arrangements should involve, for example joint care, CAMHS paediatric liaison etc</i></p> <ul style="list-style-type: none"> ▪ Ref 55: pg 32 – <i>“The mental health of intellectual disability team would provide advice and training support to the intellectual disability team, as well as to front-line staff working in community residential settings”</i> 	<p>English NSF (9)</p> <p>HSW 12d</p> <p>SBH C6</p>
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5.1.2 Q5.1.4	<p>LD CAMHS offer a comprehensive range of interventions according to the needs of young people with learning disabilities</p> <ul style="list-style-type: none"> ▪ Ref 52: pg 90, recommendation 53 - <i>“There should be a range of clinical services and treatments available... Successful and long-term therapeutic interventions will be those that avoid looking at only the specific problem behaviour”</i> 	<p>HSW 2b 24a</p>
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5.1.3	<p>Young people with learning disabilities are provided with interventions based on the available evidence base for this group</p> <ul style="list-style-type: none"> ▪ Ref 45: pg 14 – <i>“Although the evidence base for mental health work with young people of normal ability can be assumed to be applicable to young people with learning disabilities unless there is specific evidence to the contrary, adaptations will be necessary, for example because of communication and conceptual difficulties”</i> 	
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5.1.4 Q5.1.7	<p>When required, young people are offered access to further specialised services by referral from LD CAMHS</p>	
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Section 5: Care and Intervention

Standard:		
5.2 Q5.2	Young people and their families are provided with timely, flexible and reliable treatment sessions	
Criteria:		
5.2.1 Q5.2.1	<p>Young people receive timely treatment within nationally agreed timescales</p> <p>Guidance: England, Scotland and Northern Ireland: <i>Delivering an 18 week patient pathway from referral to the start of treatment by the end of 2008 is a key objective for the NHS (see http://www.18weeks.nhs.uk)</i></p> <p>Wales: <i>Delivering a 26 week patient pathway from referral to the start of treatment by the end of 2009 is a key objective for NHS Wales</i></p>	
5.2.2 Q5.2.1	<p>Treatment sessions are flexible and responsive to the complex needs of young people with learning disabilities and their families</p> <p>Guidance: <i>For example, families can choose a suitable appointment time and appointments can be offered out of school or college hours; home-based or school-based treatments are offered where appropriate; where multiple appointments are required, these can either be staggered or synchronised in one setting on the same day</i></p> <ul style="list-style-type: none"> ▪ Ref 20: <i>[Wales] pg 10 recommendation 2.13</i> ▪ Ref 63: <i>pg 52, recommendation 6.8 "Services should ensure that, wherever possible, treatment should be home-based and/or school-based..."</i> 	<p>SBH C18</p> <p>Welsh NSF 2.13</p> <p>HSW 2d</p>
5.2.3 Q5.2.3	<p>Young people and their parents do not have to wait for longer than 15 minutes beyond their appointment time without an explanation</p>	<p>Welsh NSF 2.13</p> <p>SBH C16</p> <p>HSW 6b</p>
5.2.4 Q5.2.4	<p>Appointments are not cancelled by staff without good cause and appropriate explanation to the young person or family concerned</p>	
5.2.5 Q5.2.5	<p>The service has a procedure that staff follow when young people and their families do not keep an appointment</p> <p>Guidance: <i>For example, when an appointment is missed there is a procedure whereby the young person's case manager contacts them to follow this up</i></p>	
Standard:		
5.3 Q5.4	Young people and their parents experience consistent contact with a named member of staff	

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Criteria:		
5.3.1 Q5.4.1	All young people with a learning disability have a named member of staff who co-ordinates their care ▪ <i>Ref 64: pg 28</i>	
5.3.2 Q5.4.2	Young people and their parents see the same clinician consistently, unless their preference or clinical need demands otherwise <i>Guidance: For example this may be their key worker or case manager</i>	
Planning interventions		
Standard:		
5.4 Q4.4	Young people and their parents are helped to make well-informed decisions about the interventions they are offered ▪ <i>Ref 37: pg 88, recommendation 3.1 - "Every child, young person and parent is actively involved in decisions about the child's health and well-being, based on appropriate information"</i>	SBH D9b SBH C16 English NSF (3) 3.1
Criteria:		
5.4.1 Q4.4.1	Young people and their parents are provided with information about the nature of their problems	SBH C16 HSW 6b
5.4.2 Q4.4.2	Young people and their parents are provided with information about the evidence base, risks, benefits and side effects of intervention options and of non-intervention <i>Guidance: For example, staff provide children, young people and their families with NICE/Cochrane guidelines about the treatment for particular conditions</i>	SBH C16 HSW 6b CNST 3.1.2 (1) English NSF (10) 4
5.4.3	Where interventions require a significant degree of parental involvement, staff provide parents with information about the nature and the extent of their proposed role before any decisions are made ▪ <i>Ref 63: pg 24, recommendation 3.8</i>	
5.4.4 Q4.4.4	Young people and their parents are informed about how to obtain additional information if they want it <i>Guidance: For example, contact details of helplines, national support organisations and advocacy services are clearly displayed in LD CAMHS centres</i>	SBH C16 CNST 3.2.2 (2)

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5.4.5 Q4.3.5	Staff provide young people and their parents with information about the roles played by key professionals <ul style="list-style-type: none"> ▪ Ref 41: pg 146, recommendation 8 	SBH C16 HSW 6a
5.4.6 Q4.3.6	Young people and their parents know the procedures for getting help in an emergency related to their mental health problem	
Standard:		
5.5 Q5.3	Young people and their parents are actively involved¹⁰ in developing plans for intervention <ul style="list-style-type: none"> ▪ Ref 37: pg 88, recommendation 3.1 - "Every child, young person and parent is actively involved in decisions about the child's health and well-being, based on appropriate information" ▪ Ref 31: [Wales] pg 8, recommendation 7 – "Patients and service users, including those with long-term conditions, are encouraged to contribute to their care plan..." 	SBH D10 English NSF (3) 3.1 HSW 6c 7
Criteria:		
5.5.1 Q5.3.1	Young people and their parents are actively involved in developing plans for intervention, including agreeing aims, and their views are recorded in their notes <ul style="list-style-type: none"> ▪ Ref 64: pg 6 – " Disabled children and young people and their families are routinely involved and supported in making informed decisions about their treatment, care and support, and in shaping services" 	English NSF (8) HSW 6c 7
5.5.2 Q5.3.3	Young people and their parents are enabled to be active partners in the decisions made about the medicines prescribed for them	English NSF (10) 5 HSW 6c
5.5.3 Q5.3.4	Depending on levels of case complexity, children and young people have a written plan for intervention	
5.5.4	Risk assessments and plans for intervention are reviewed at regular intervals <ul style="list-style-type: none"> ▪ Ref 63: pg 52, recommendation 6.8 – "Because treatment for children with challenging behaviour and learning disabilities often needs to be long-term, the Committee recommends that all services develop clear policies for the maintenance and review of all treatment interventions" 	HSW 6c 7
5.5.5 Q5.3.5	Young people and their parents are given a copy of any written plans for intervention or have ready access to them (with the young person's agreement) <ul style="list-style-type: none"> ▪ Ref 2, pg 10 recommendation 2.19 – "Any plan of work is negotiated with the child and family and all concerned should be given written information on the plan of work, the objectives, who is to be involved, the agreed tasks and responsibilities of respective parties..." 	SBH C16 HSW 6b

¹⁰ Levels of involvement may vary according to ability and can range from simply being informed to active decision making

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5.5.6 Q5.3.6	If appropriate, young people who have capacity sign their plans for intervention, or if young people do not have capacity, the plan is signed by a parent	SBH C13b HSW 6d
5.5.7 Q5.3.7	‘Joined-up’ care is facilitated by copying plans for intervention to young people’s care networks (<i>with appropriate consent – see criterion 4.4.5</i>)	SBH C6 HSW 12d
5.5.8 Q5.3.8	Formal care plans are used wherever appropriate (for example, as part of the Care Programme Approach) <ul style="list-style-type: none"> ▪ Ref 52: <i>pg 78, recommendation 16 - The Mental Welfare Commission’s Report made some far-reaching recommendations including that the Care Programme Approach should be used for people with learning disabilities who have complex needs. We agree with this recommendation</i> ▪ Ref 50: <i>pg 4, recommendation 2.6</i> 	
Standard:		
5.6	Intervention is person-centred, taking into account the individual needs of the young person and their family	
Criteria:		
5.6.1	Case notes show evidence that plans for intervention take into account individuals’ levels of functioning and communication difficulties and are adapted appropriately <ul style="list-style-type: none"> ▪ Ref 57: <i>pg 65 – “Talking therapies may prove problematic for many young people with severe learning disabilities because of problems expressing themselves and understanding others. Imaginative approaches are needed”¹¹</i> 	
5.6.2	Case notes show evidence that plans for intervention involve consideration of the young person’s individual mental health needs, and of their social, physical, emotional, educational, cultural and spiritual needs and context <ul style="list-style-type: none"> ▪ Ref 57: <i>pg 69 – “A holistic approach is needed in assessing and treating a young person. This involves not just thinking in terms of a learning disability or a mental illness but taking a rounded view of someone’s circumstances - their environment, their friends, their family, their activities - and the impact they have”</i> ▪ Ref 18: <i>“Team Around the Child places the emphasis firmly on the needs of the child, rather than on organisations or service providers”</i> 	HSW 12c English NSF (3) 2.1 Welsh NSF 2.8
5.6.3	Case notes show evidence that plans for intervention take into account the needs of the ‘whole’ family and their capacity to support interventions, particularly where these are home-based <p>Guidance: <i>For example, plans should take into account parents’ ability to carry out care and intervention and the possible impact of interventions on other family members</i></p> <ul style="list-style-type: none"> ▪ Ref 63: <i>pg 24, recommendation 3.8</i> 	

¹¹ See <http://www.rcpsych.ac.uk/publications/booksbeyondwords.aspx>

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5.6.4	<p>Case notes show evidence that plans for intervention include consideration of the capacity and willingness of other agencies to support the intervention</p> <p>Guidance: <i>For example staff may need to talk to schools, voluntary services, social services etc to establish their ability to support the intervention</i></p>	
5.6.5	<p>Intervention is provided to young people with learning disabilities for as long as is required and effective</p> <ul style="list-style-type: none"> ▪ Ref 63: <i>pg 52, recommendation 6.8 - "Service providers, purchasers, parents and children should be made aware that for some children very long-term interventions may be needed to prevent the child's behaviour challenging services at a later stage"</i> ▪ Ref 54: <i>pg 8, recommendation 3.2 – "Successful services are individualised, in a number of ways... they recognise that individuals need to experience well-coordinated services, committed to meeting their complex needs over the long term... they 'stick with' individuals in spite of the difficulties experienced in meeting their needs"</i> 	English NSF (9)
<u>Standard:</u>		
5.7	Interventions are monitored and adapted to meet the needs of young people with learning disabilities	
<u>Criteria:</u>		
5.7.1 Q5.1.5	<p>Staff monitor clinical outcomes, risk, and side effects at regular intervals, using validated outcome tools if these are appropriate and relevant</p> <p>Guidance: <i>For example, staff use SDQ, HoNOSCA, the Developmental Behaviour Checklist</i></p>	SBH C7a C7c HSW 11d
5.7.2	<p>Young people, parents, teachers and other caregivers are encouraged to play a key role in monitoring, evaluating and reporting the effects of interventions</p> <ul style="list-style-type: none"> ▪ Ref 61: <i>pg 838 – "...best practice dictates a well-targeted and intensive program of instruction and support for these individuals, coupled with careful and ongoing observation and progress monitoring. Just as physicians require feedback from patients and care providers during a medication trial, so, too, should parents and educators commit to evaluating progress during periods of focused instruction, documenting the child's response to intervention and making needed adjustments"</i> ▪ Ref 5: <i>pg 13 – "Clinical audit includes users' views in relation to individual outcomes and service provision"</i> 	English NSF (9)
5.7.3 Q5.5.1	<p>Young people are asked about their engagement or adherence to their interventions, and any problems are addressed and recorded</p>	SBH C16 HSW 31d

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5.7.4	<p>Use of medication is closely monitored by a qualified practitioner</p> <ul style="list-style-type: none"> ▪ Ref 45: pg 14 – “Children and adolescents with learning disabilities may have idiosyncratic responses to their medication because of the complexity of their condition and there may be difficulties in communication between them and others about side-effects. Specialist psychiatric advice is necessary in the prescription and monitoring of psychotropic medication for children with learning disabilities (British Paediatric Association, 1994)” ▪ Ref 57: pg 69 ▪ Ref 46: pg 44 	
5.7.5	<p>Where medication is used, it is started at a lower dosage and increased more gradually than for people who do not have learning disabilities</p> <ul style="list-style-type: none"> ▪ Ref 57: pg 64 – “Cerebral dysfunction can increase or decrease sensitivity to a drug’s effects. Having more than one disorder, such as epilepsy and cerebral palsy, can make people more vulnerable to adverse effects. Treatment should therefore start at a lower dosage and be increased more gradually than for people who do not have learning disabilities” 	
Standard:		
5.8 Q5.5	<p>Staff provide support and guidance to enable young people and their parents to help themselves</p> <ul style="list-style-type: none"> ▪ Ref 57: pg 69 - “Families need a range of support, including short breaks, appropriate information and practical help to enable them to continue to support their children with learning disabilities and mental health problems” ▪ Ref 9: pg 15, recommendation D10, -“Patients and service users, particularly those with long-term conditions, are helped to contribute to planning of their care and are provided with opportunities and resources to develop competence in self-care” 	SBH D10
Criteria:		
5.8.1 Q5.5.3	<p>Where relevant, young people, parents and other caregivers are guided in coping techniques and behaviour management techniques</p> <p>Guidance: This includes helping families and educational staff to understand children’s behaviour, facilitating the development of parenting skills, enhancing family coping mechanisms and promoting appropriate play, occupation and communication (Ref 45: pg 14). Challenging behaviour occurs across settings, so guidance needs to be shared with teachers and other caregivers to ensure consistency or compatibility of responses</p> <ul style="list-style-type: none"> ▪ Ref 62: pg 819 – “Cohen et al pointed out that when adults understand the underlying language difficulties and the cascading effect on family, peer, and school activities, they are less likely to interpret these behaviors in a negative light, as misbehavior. Teaching parents and teachers how to effectively employ structured, repetitive routines and visual cues, including visual representations of time, such as picture calendars, can make a major difference in the way in which a child manages in the classroom and at home” 	SBH C16 HSW 31d 7

Section 5: Care and Intervention

<p>5.8.2</p>	<p>LD CAMHS support the mental and emotional needs of parents and siblings</p> <p>Guidance: LD CAMHS should either offer support directly to families or provide contact details of local counselling/support services</p> <ul style="list-style-type: none"> ▪ Ref 45: pg 14 – “In addition to a range of multi-agency support, usually at Tier 1 level, a family will often require specific counselling (Bicknell, 1983)” ▪ Ref 41: pg 42 - “Group-based parenting programmes have been shown to reduce levels of maternal depression and anxiety/stress, raise maternal self-esteem and improve relationships with a partner in the short-term” 	
<p>5.8.3</p>	<p>Young people and their families are informed about local and national services, voluntary organisations, social support networks and self-help groups relevant to their mental health difficulty and learning disability</p> <p>Guidance: These should include culturally specific groups and organisations where relevant and promote opportunities for social integration and independence</p> <ul style="list-style-type: none"> ▪ Ref 41: pg 148, recommendation 8 - “Opportunities for children to meet and make friends and mix with children from the wider community were highlighted as important for services such as short breaks, and play and leisure services” ▪ Ref 63: pg 24, recommendation 3.8 – “Specialist services should seek to complement and reinforce informal support networks within local communities to reduce the potential isolation and marginalisation of families with a child with severe challenging behaviour” 	<p>SBH C16</p> <p>HSW 31d 7</p> <p>English NSF (8)</p>
<p><u>Standard:</u></p>		
<p>5.9 Q5.6</p>	<p>Young people with learning disabilities are helped to continue their school or college work throughout their treatment</p>	
<p><u>Criteria:</u></p>		
<p>5.9.1 Q5.6.1</p>	<p>Appointments are offered out of school or college hours if needed</p>	
<p>5.9.2 Q5.6.2</p>	<p>LD CAMHS liaise with education services to co-ordinate responses to young people’s mental health and education needs</p> <ul style="list-style-type: none"> ▪ Ref 64: pg 15 – “Strategies are developed with teachers who support the child’s full learning experience” ▪ Ref 57: pg 36 – “Outreach support from learning disability services... can be a help to teachers trying to support students in mainstream schools” 	<p>SBH C6</p> <p>HSW 12d</p>

Section 6: Rights, Safeguards and Child Protection

Rights

"The service has a philosophy of care that includes the rights outlined in the UN Convention on the Rights of the Child, The Children Act and the Patients Charter: Services for Children and Young People"
Health Quality Service & National Children's Bureau (Ref 2: pg 1, recommendation 1.2)

Standard:

6.1	Young people with learning disabilities are made aware of their rights and are able to express their wishes	
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Criteria:

6.1.1	Young people are afforded their rights as outlined in the UN Convention on the Rights of the Child <ul style="list-style-type: none"> ▪ Ref 2: pg 1, recommendation 1.2 – <i>"The service has a philosophy of care that includes the rights outlined in the UN Convention on the Rights of the Child, The Children Act and the Patients Charter: Services for Children and Young People"</i> 	
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6.1.2	Staff recognise that young people with learning disabilities may be less aware of their rights and less able to express their wishes than others their age <p>Guidance: <i>For example, staff have received specific education and awareness in this area</i></p>	
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6.1.3 Q4.3.3	Young people are helped by staff to understand their rights and what they can expect from the service as far as is possible	SBH C16
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6.1.4	Staff ask young people with learning disabilities for their opinions on decisions that affect them <ul style="list-style-type: none"> ▪ Ref 41: pg 146, recommendation 8 – <i>"Children identify a number of issues to be addressed [including] professionals taking time to listen to them and not just talking to their parents"</i> 	
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6.1.5	Staff offer families of young people with learning disabilities advice on using alternative methods of communication (e.g. non-verbal communication) <ul style="list-style-type: none"> ▪ Ref 57: pg 38 – <i>"Those with profound and complex learning difficulties, who rely on non-speaking forms of communication, are the least likely to be afforded the right to influence decisions at key points of transition in their lives, in part because staff and carers are not always skilled in facilitating alternative modes of communication"</i> 	
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Section 6: Rights, Safeguards and Child Protection

Standard:		
6.2 Q6.1	Young people can express their preferences about who they are seen by	
Criteria:		
6.2.1 Q6.1.1	Young people can ask to see a staff member on their own e.g. without other staff or family present ▪ <i>Ref 37: pg 121 – “When requested, professionals enable young people to attend part of a consultation without their parents present”</i>	English NSF (4)
6.2.2 Q6.1.2	Where the option is available, efforts are made to ensure that young people can see a staff member of the gender of their choice ▪ <i>Ref 37: pg 121</i>	English NSF (4)
Standard:		
6.3 Q6.2	Young people and their parents are treated with dignity and respect	
Criteria:		
6.3.1 Q6.2.1	Young people and their parents are treated with dignity and respect	SBH C13a HSW 8a
6.3.2 Q6.2.2	Staff are friendly and approachable	
6.3.3 Q6.2.4	Restrictive physical intervention is used only in exceptional circumstances and to the minimum extent necessary ¹² <i>Guidance: Exceptional circumstances may include situations in which immediate action is needed to prevent young people from significantly injuring themselves or others. Policies on restraint should:</i> <i>i) accord young people with learning disabilities the same rights as other young people</i> <i>ii) be in line with DH Guidance on restrictive physical interventions for people with LD and ASD 2002</i> <i>http://www.dh.gov.uk/assetRoot/04/06/84/61/04068461.pdf , and the British Institute of Learning Disability Code of Practice 2006</i> <i>iii) be based on individual assessment</i> <i>iv) give guidance on maintaining dignity</i>	
Standard:		
6.4 Q6.3	Young people and their parents are informed about how to raise concerns and to seek independent advice ▪ <i>Ref 37: pg 92 - “Children, young people and their families are informed about children’s rights and are able to make a complaint where necessary...”</i>	SBH C14a English NSF (3)

¹² Also see criterion 8.7.15 for staff training implications

Section 6: Rights, Safeguards and Child Protection

Criteria:		
6.4.1 Q6.3.1	<p>Complaints procedures are well-publicised and patient-friendly and help is given on how to follow them</p> <p>Guidance: <i>Complaints procedures should include the name of the person to contact in the event of a complaint, including the local Children's Complaints Officer</i></p> <ul style="list-style-type: none"> ▪ Ref 36: <i>"The young people suggested that the name of the person who young people could contact if they were unhappy with a service should be clearly displayed/available"</i> 	<p>SBH C14a</p> <p>HSW 15b</p>
6.4.2 Q6.3.4	<p>Young people and their parents are assured that their complaints will be taken seriously and that they will not be discriminated against if they complain</p>	<p>SBH C14c C14b</p>
6.4.3	<p>Young people and their parents have access to advocacy services and staff explain the benefits of using these services</p> <ul style="list-style-type: none"> ▪ Ref 2: <i>pg 7, recommendation 1.15</i> ▪ Ref 12: <i>pg 50, recommendation 3.2.2 (2) - As above for 4.4.3</i> ▪ Ref 20: <i>[Wales] pg 8, recommendation 2.6 – "Independent advocacy is freely available to all children and young people where and when needed and requested, in line with Welsh Assembly Government Standards 10"</i> 	<p>SBH C16</p> <p>HSW 6c 15c</p> <p>CNST 3.2.2 (2)</p> <p>Welsh NSF 2.6</p>
Standard:		
6.5 Q6.4	<p>The rights and individual needs of young people and their families are recognised and responded to, regardless of their gender, ethnicity, religion, ability, culture, or sexuality</p>	<p>English NSF (9) 2.11</p>
Criteria:		
6.5.1	<p>Young people with learning disabilities are accorded the same rights as other young people</p> <ul style="list-style-type: none"> ▪ Ref 55: <i>pg 20 – "Despite the fact that people with intellectual disabilities represent one of the most vulnerable groups in our society, the vast majority of those who are receiving psychiatric treatment within the specialist services are outside the remit of protective mental health and other legislation. It is clear that this matter needs to be addressed as a matter of urgency"</i> 	
6.5.2 Q6.4.1	<p>The specific needs of young people and parents from different ethnic, cultural or religious backgrounds are respected and responded to</p> <p>Guidance: <i>In particular, LD CAMHS need to demonstrate sensitivity to different cultural attitudes towards mental illness and disability</i></p> <ul style="list-style-type: none"> ▪ Ref 5: <i>pg 13, recommendation 5.3 – "Concepts of mental illness and the understanding of the origins of children's emotional and behavioural difficulties vary across cultures. Services need to be sensitive to these differences and ensure that staff are equipped with the knowledge to work effectively with the different groups represented in the community they serve"</i> ▪ Ref 45: <i>pg 13 – "Failure to take into account differences in cultural attitude to disability will compound problems further"</i> 	<p>SBH C13a</p> <p>HSW 10</p> <p>English NSF (9) 5.3</p> <p>Welsh NSF 2.5</p>

Section 6: Rights, Safeguards and Child Protection

6.5.3 Q6.4.2	<p>The specific needs of young people and parents who are refugees or asylum seekers are recognised and responded to</p> <p>Guidance: <i>For example, this may involve provision of interpreters or being put in touch with an advocacy service. LD CAMHS staff should take into account the particular circumstances of flight from the country of origin and the advice of specialist agencies where necessary</i></p> <ul style="list-style-type: none"> ▪ Ref 37: pg 9 ▪ Ref 13: pg 124, recommendation 2.7 – “Policies, procedures and practice takes full account of, and are appropriate to the needs of children newly arrived in this country or from nomadic families” 	SBH C18 English NSF (3) HSW 10
6.5.4 Q6.4.3	<p>Where needed, young people, parents and practitioners are offered access to professional interpreters, so that relatives are never used as sole interpreters</p> <ul style="list-style-type: none"> ▪ Ref 20: [Wales] pg 8, recommendation 2.4 – “When required, there are independent, appropriate translation services and sign language interpreters readily available wherever professionals have contact with children, young people and their families. Children and young people are never used as sole interpreter” ▪ Ref 37: pg 91 	SBH C18 C7e HSW 10 Welsh NSF 2.4 English NSF (3)
6.5.5 Q6.4.4	<p>Interpreters used by LD CAMHS have received training or guidance about children, learning disability and mental health matters and recognise the importance of full and accurate translation</p>	
Safeguarding, Child Protection and Risk		
Standard:		
6.6 Q6.5	<p>Young people are protected from abuse through clear safeguarding policies and procedures that are consistent with the Local Safeguarding Children Board</p> <ul style="list-style-type: none"> ▪ Ref 36: “The group strongly supported the standards regarding the recognition and handling of allegations of abuse” ▪ Ref 9: pg 10 recommendation C2 - “Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations” 	SBH C2 CNST 8.1.1. (1)
Criteria:		
6.6.1	<p>Staff recognise that young people with learning disabilities are at increased vulnerability to abuse and that greater vigilance is thereby required</p> <ul style="list-style-type: none"> ▪ Ref 22: pg 13, recommendation 3.5 – “...some children are more vulnerable than others because they are younger, less able to tell adults of their concerns, physically less able to move away from unwanted contact, more isolated (with fewer visitors) or less likely to be believed because they themselves have learning disabilities or mental health problems” ▪ Ref 45: pg 12 – “Child abuse, including neglect, emotional and sexual abuse – children with learning disabilities are at greater risk than others of certain kinds of abuse (Chamberlain et al, 1984)” 	

Section 6: Rights, Safeguards and Child Protection

<p>6.6.2</p>	<p>Staff receive regularly updated training in child protection with specific regard to young people with learning disabilities</p> <p>Guidance: <i>Staff should receive training as part of their induction and have access to in-house training and refresher courses on an annual basis</i></p>	
<p>6.6.3</p>	<p>The service has a whistleblowing policy that covers professional abuse</p> <ul style="list-style-type: none"> ▪ Ref 19: <i>pg 183 recommendation 21.5</i> 	
<p>6.6.4</p>	<p>Every member of staff receives written and verbal instruction of whistleblowing procedures and how to operate them</p> <ul style="list-style-type: none"> ▪ Ref 19: <i>pg 183 recommendation 21.6</i> 	
<p>6.6.5 Q6.5.1</p>	<p>Staff act in accordance with the procedures of the Local Safeguarding Children Board</p>	<p>SBH C2 HSW 17</p>
<p>6.6.6 Q6.5.2</p>	<p>Young people are informed of the procedures that will be followed if a disclosure of abuse is made, and they are reassured that what they say will be taken seriously</p>	<p>SBH C2 HSW 17</p>
<p>6.6.7</p>	<p>All disclosures are investigated as per LSCB procedure regardless of level of functioning</p> <ul style="list-style-type: none"> ▪ Ref 22: <i>pg 60, recommendation 5.60 – “Any child’s disclosure of misuse or an untoward event must be taken seriously. Neither immaturity nor a history of behaviour or psychiatric disorders renders a child’s disclosure incredible: each case must be judged singly and carefully on its merits. We are certain that all safeguards and standards that apply to children who are physically sick must apply equally to those with mental health problems and disorders or learning disabilities”</i> 	
<p>6.6.8 Q6.5.3</p>	<p>Young people who may be at risk of harm are referred to the appropriate team within the Local Authority (e.g. Social Services)</p>	<p>SBH C2 HSW 17</p>
<p>6.6.9 Q6.5.4</p>	<p>Where the Local Authority does not allocate a social worker, there is a procedure detailing what action should be taken to ensure young people’s needs are met</p> <p>Guidance: <i>For example, the staff of the LD CAMHS use the Local Safeguarding Children Board to highlight joint working problems</i></p>	<p>SBH C2 HSW 17</p>
<p>6.6.10 Q6.5.5</p>	<p>The specific safeguarding needs of young people who are Looked After are responded to through policies, procedures and practices that are designed to protect them</p> <ul style="list-style-type: none"> ▪ Ref 13: <i>pg 124, recommendation 2.7 – “Policies, procedures and practice takes full account of, and are appropriate to the specific safeguarding needs of children living away from home including bullying and self-harm...”</i> 	<p>SBH C2 HSW 17</p>

Section 6: Rights, Safeguards and Child Protection

<p>6.6.11 Q6.5.6</p>	<p>The Trust has a named doctor and a named nurse responsible for child protection and their contact details are made available to staff</p> <ul style="list-style-type: none"> ▪ Ref 12: pg 54, recommendation 8.1.2. (1) ▪ Ref 20: [Wales] pg 21, recommendation 2.53 - "There is a designated doctor and nurse for child protection nominated to each LHB by the NPHS, a named doctor, nurse and midwife in every NHS trust, and named child protection co-ordinators in social services and Local Education Authorities who take the lead in child protection matters. They are given protected time to fulfill this role" 	<p>SBH C2</p> <p>CNST 8.1.2. (1)</p> <p>Welsh NSF 2.53</p> <p>HSW 17</p>
<p>6.6.12 Q6.5.7</p>	<p>The safeguarding of young people is arranged and monitored across agencies and services</p> <p>Guidance: This will involve clear recording and sharing of safeguarding information for the explicit purpose of child protection – see Standard 4.3</p> <ul style="list-style-type: none"> ▪ Ref 13: pg 123, recommendation 2.2 – "Information relevant to the safeguarding of children is clearly recorded and shared between and within agencies, organisations and individual professionals" 	<p>SBH C2</p> <p>HSW 17</p>
<p>6.6.13 Q6.5.8</p>	<p>All staff who come into contact with young people or who have access to information about them are CRB checked before their appointment is offered and at regular intervals thereafter</p> <ul style="list-style-type: none"> ▪ Ref 8: pg 22, recommendation 16.4 ▪ Ref 37: pg 108 	<p>SBH C2</p> <p>HSW 17</p> <p>English NSF (3&5)</p>

Section 7: Transitions

“Poorly planned transition...can be associated with increased risk of non adherence to treatment and loss to follow-up, which can have serious consequences. There are measurable adverse consequences in terms of morbidity and mortality as well as in social and educational outcome”

National Service Framework for Children, Young People and Maternity Services: Transition: Getting it Right for Young People (Ref: 74, pg 12)

Arrangements for leaving the service

Standard:

7.1 Q7.1	Young people and their parents are involved in agreeing arrangements for leaving the service and know how to re-access help if they need it	
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Criteria:

7.1.1 Q7.1.1	Young people and their parents are involved in agreeing plans for leaving the service <ul style="list-style-type: none"> ▪ Ref 57: pg 87 – <i>“The transition from child and adolescent services must be seamless. Families and young people need to be fully informed about the timing of changes and future provision”</i> 	English NSF (4)
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7.1.2 Q7.1.2	On leaving the service, staff tell young people and their parents how they can get back in touch if they need help <p>Guidance: <i>For example, there is a named contact for ‘post-discharge’ support</i></p> <ul style="list-style-type: none"> ▪ Ref 36 – <i>“The group suggested that a standard for leaving a service should be provision of a named contact for post-discharge support”</i> 	SBH C16 HSW 6b
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7.1.3 Q7.1.3	If young people stop attending appointments before formal arrangements for this are made, there are procedures in place to facilitate their return to the service <p>Guidance: <i>For example, the keyworker or case manager contacts the referrer, family or young person to discuss their options and continuing needs</i></p>	
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Standard:

7.2 Q7.2	The service makes arrangements to ensure that young people experience continuity of care when they move on from the service	
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Section 7: Transitions

Criteria:		
7.2.1	LD CAMHS retain responsibility for mental health care until it is appropriate to transfer responsibility to another service <ul style="list-style-type: none"> ▪ Ref 65: pg 14 – “Referrals onto other services should be treated as requests for service provision. Responsibility for care, or liaison with new services, should be retained by the referring service until it is appropriate to transfer responsibility to another service” 	DOAS 4.1.6
7.2.2 Q7.2.1	When young people are to leave the service, their key worker or case manager takes responsibility for planning this <ul style="list-style-type: none"> ▪ Ref 2: pg 16, recommendation 2.36.1 	
7.2.3	When young people are to leave the service, the roles of the agencies involved in any subsequent care are clarified, agreed and documented beforehand	
7.2.4	When young people are to leave the service the Care Programme Approach is completed where appropriate <ul style="list-style-type: none"> ▪ Ref 65: pg 35 	DOAS 6.5.1
7.2.5	When young people leave the service, LD CAMHS provide an outline of the young person’s case to their GP, Community Paediatrics and any other agencies involved in their care <ul style="list-style-type: none"> ▪ Ref 65: pg 35 “Discharge from mental health input should be clearly co-ordinated between agencies using existing review procedures” 	SBH C6 HSW 12d DOAS 6.5.1
7.2.6 Q7.2.3	For young people who are Looked After, arrangements for their continuing care are planned in conjunction with the relevant Social Services Departments	SBH C6 HSW 12d
7.2.7 Q7.2.4	LD CAMHS take active steps to ensure that effective handovers of care take place when young people move to a new area <p>Guidance: For example, LD CAMH staff work closely with other agencies to ensure all relevant information is promptly passed on</p> <ul style="list-style-type: none"> ▪ Ref 36 – “The group suggested that, where young people are in transition, services should have in place a system for forwarding information to avoid young people having to ‘start all over again’ in a new area” ▪ Ref 37: pg 135 – “Where young people in special circumstances need to register with a new healthcare provider, Primary Care Trusts work with other agencies to ensure that systems are in place so that important clinical information accompanies the child or young person and there is continuity of health assessment and planning processes” 	SBH C6 English NSF (4)

Section 7: Transitions

7.2.8	<p>On leaving the service, there are agreements with other agencies for young people to re-access the service if needed, without following the initial referral pathway</p> <p>Guidance: <i>There may be exceptions where young people require a generic assessment and where it may be appropriate to follow the initial referral pathway</i></p> <ul style="list-style-type: none"> ▪ Ref 65: pg 35 – “If children and families need to re-access the mental health service, it is important to avoid replication of the first episode referral pathway and extensive re-assessments unless they add to the existing assessment information” 	DOAS 6.5.2
7.2.9	<p>If young people are placed out-of-area, there are agreements for young people to re-access care once they return to the local area</p> <p>Guidance: <i>For example, young people placed out of area for educational provision may require mental health support during holidays and should be able to re-access care when they return to the local area without needing to be re-referred</i></p>	
Inpatient care		
Standard:		
7.3 Q7.3	Young people who require inpatient care are referred to services that meet their individual needs¹³	
Criteria:		
7.3.1 Q7.3.1	<p>If inpatient care is required, primary emphasis is placed upon referring young people to a unit that meets their specific learning disability and mental health needs</p> <ul style="list-style-type: none"> ▪ Ref 52: pg 89 recommendation 48 – “There are appropriate arrangements for people with learning disabilities who have mental problems going into hospital” 	
7.3.2 Q7.3.2	<p>If inpatient care is required, young people are referred to a unit that is as accessible as possible so that contact with home and family is maintained</p> <ul style="list-style-type: none"> ▪ Ref 5: pg 19 	English NSF (9) SBH C18
7.3.3 Q7.3.3	<p>If inpatient care is required, young people are referred to a unit that meets their developmental needs</p> <ul style="list-style-type: none"> ▪ Ref 5: pg 5 ▪ Ref 20: pg 11, recommendation 2.18 	English NSF (9) Welsh NSF 2.18
7.3.4 Q7.3.4	<p>There are clear procedures for staff to follow in situations when in-patient beds are required but are not immediately available within the relevant service</p> <ul style="list-style-type: none"> ▪ Ref 12: pg 55, recommendation 8.2.4 (2) 	CNST 8.2.4 (2)

¹³ Intensive outreach and/or day-patient care may in many cases provide effective alternatives to in-patient care

Section 7: Transitions

Standard:		
7.4 Q7.4	LD CAMHS work closely with inpatient services to arrange effective handovers and joined-up provision of continuing care	
Criteria:		
7.4.1 Q7.4.1	If young people are admitted to inpatient services, the Tier 2 or 3 key worker or case manager works with the inpatient service and other organisations to agree the place of discharge before admission wherever possible	SBH C6 HSW 12d
7.4.2 Q7.4.2	The Tier 2 or 3 key worker or case manager attends review meetings (e.g. CPA meetings) of young people following their admission to inpatient settings and engages fully in joint discharge planning with the staff of the inpatient service <ul style="list-style-type: none"> ▪ Ref 5: pg 5, recommendation 10 – “When children and young people are discharged ... into the community and when young people are transferred from child to adult services, their continuity of care is ensured by use of the ‘care programme approach’” 	SBH C6 HSW 12d English NSF (9) 10
Adult services		
Standard:		
7.5 Q7.5	LD CAMHS work closely with adult services to arrange effective handovers of care	
Criteria:		
7.5.1 Q7.5.1	A local protocol is in force regarding the age for referral to adult services and there are working arrangements for this <ul style="list-style-type: none"> ▪ Ref 45: pg 8 – “It is important both that the cut-off points between various services are clearly defined and that they should overlap to allow a degree of flexibility in provision” 	HSW 12d
7.5.2 Q7.5.2	Young people aged below the locally agreed cut-off for referral to adult services are not referred to adult services unless in exceptional circumstances Guidance: This may be appropriate if there is good clinical cause which outweighs developmental and/or other needs <ul style="list-style-type: none"> ▪ Ref 5: pg 33 – “There is close collaboration and liaison with adult mental health services; transfer protocols between CAMHS and general adult psychiatric services are agreed and subject to audit” 	English NSF (9) Welsh NSF 2.18
7.5.3 Q7.5.3	Joint reviews of young people’s needs are held with adult services (e.g. using the CPA) to ensure that effective hand-over of care takes place <ul style="list-style-type: none"> ▪ Ref 5: pg 5, recommendation 10 – “When children and young people are discharged ... into the community and when young people are transferred from child to adult services, their continuity of care is ensured by use of the ‘care programme approach’” 	SBH C6 HSW 12d English NSF (9) 10

Section 7: Transitions

7.5.4 Q7.5.4	The service liaises with adult inpatient services to inform and monitor the developmental needs of young people who are placed on adult psychiatric wards	SBH C6 HSW 12d
Feedback		
Standard:		
7.6 Q7.6	LD CAMHS evaluate levels of satisfaction amongst those who use or have used the service	
Criteria:		
7.6.1 Q7.6.1	<p>On leaving the service, young people and parents are actively encouraged to give feedback on the service they have received, and there are effective means for them to do so</p> <p>Guidance: For example, this may take the form of suggestions boxes, discharge questionnaires, follow-up letters, satisfaction surveys, focus groups or patient consultation groups</p> <ul style="list-style-type: none"> ▪ Ref 2: pg 8, recommendation 8.17 	SBH C14a HSW 1 15a SBH C17 Welsh NSF 2.2
7.6.2	<p>If young people stop attending appointments before formal arrangements for this are made, there are procedures in place for monitoring and reviewing this to identify where problems may exist</p> <p>Guidance: For example, the key worker or case manager contacts the family or young person to discuss reasons for leaving and this is used to inform service evaluation and audit</p>	

Section 8: Enabling Frontline Staff

“Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake” **Standards for Better Health (Ref 17: pg 16 recommendation C11)**

Workforce Planning

Standard:

8.1 Q8.1	<p>There are sufficient numbers of appropriately skilled staff</p> <ul style="list-style-type: none"> ▪ Ref 20: pg 47, recommendation 5.11 – “Children with a learning disability have access to a network of appropriately skilled professionals, that can respond to both their mental health needs and learning disability, according to their assessed needs” 	<p>Welsh NSF 5.11</p> <p>English NSF (9) 8</p>
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Criteria:

8.1.1 Q8.1.1	<p>There are sufficient numbers of skilled staff to effectively meet the mental health needs of young people with learning disabilities in the locality</p> <ul style="list-style-type: none"> ▪ Ref 7: pg 49 	<p>SBH C11a</p> <p>HSW 24a</p>
8.1.2 Q8.1.2	<p>The numbers of qualified personnel and support staff are determined by analyses of demand and capacity, set against the core business agreed between the service and its commissioner(s)</p> <ul style="list-style-type: none"> ▪ Ref 28: pg 32, recommendation 16 	<p>HSW 24a</p>
8.1.3	<p>Capacity calculations take full account of the time-intensiveness of the multi-agency co-ordination that is often required when working with young people with learning disabilities and mental health problems¹⁴</p> <ul style="list-style-type: none"> ▪ Ref 65: pg 19-20 – “The intensity of the key working role needs to be recognised and supported by managers and commissioners. The coordination of care is likely to have an impact on the size of the individual professional’s caseload, with practitioners unlikely to be able to key work for more than a very few families” ▪ Ref 22: pg 115, recommendation 14.13 – “Lack of co-operation, which leads to children being passed between the agencies or neglected, appears to stem from many sources including over-tasking of the staff of current services resulting in individual agencies resorting to defining their own priorities unilaterally” 	<p>DOAS 5.4</p>

¹⁴ In their review of key-working in disabled services Greco et al. commented that, “Designated key workers commonly worked with between 20 and 40 families... non-designated key workers usually worked with between one and five families in addition to their usual role and other caseload” (**Ref 65** pg 20).

Section 8: Enabling Frontline Staff

<p>8.1.4 Q8.1.3</p>	<p>The numbers of qualified personnel and support staff are determined by conducting a skill mix review, set against the core business agreed between the service and its commissioner(s)</p> <ul style="list-style-type: none"> ▪ Ref 26: pg 9 – “Exact proportions of each skill will vary according to local need and commissioning arrangements” ▪ Ref 55: pg 30 – “In developing a multidisciplinary team attention is required to ensure an appropriate skill mix in order that a range of therapies can be offered” 	<p>HSW 24a</p>
<p>8.1.5</p>	<p>There are 5-6 staff per 100,000 total population who are designated to meet the needs of young people with learning disabilities</p> <ul style="list-style-type: none"> ▪ Ref 66: pg 1 – “...indicative staffing levels required for learning disability CAMHS are 5-6 specialist staff per 100,000 population...” 	
<p>8.1.6</p>	<p>There are 0.5 WTE psychiatrists per 100,000 total population who are designated to meet the needs of young people with learning disabilities</p> <p>Guidance: Based on Royal College of Psychiatrists recommendations of 0.2 WTE psychiatry time for severe learning disabilities and 0.3 WTE psychiatry time for mild learning disabilities per 100 000 population</p> <ul style="list-style-type: none"> ▪ Ref 45: pg 17 – “This level reflects the demands of the high prevalence of pathological disorders, the community orientation of the work and the substantial amount of time spent in multidisciplinary and multi-agency liaison” 	
<p>8.1.7 Q8.1.4</p>	<p>A review of staffing needs is held at defined intervals and when there are changes in service provision</p> <ul style="list-style-type: none"> ▪ Ref 2: 6.19.2 	<p>HSW 24a</p>
<p>8.1.8 Q8.1.5</p>	<p>Staffing levels reflect the commitments of staff to engage in training, supervision and mentoring and their requirements for continuing professional development</p>	<p>HSW 24a</p>
<p>8.1.9 Q8.1.6</p>	<p>Staffing levels reflect the commitments of staff who provide training and consultation to other services and who undertake additional duties</p> <p>Guidance: These duties may include work on local or national committees, and teaching, supervising and mentoring commitments</p> <ul style="list-style-type: none"> ▪ Ref 55: pg 32 “High-quality training requires adequate funding and support from management” ▪ Ref 2: pg 8, recommendation 6.20 and pg 5, recommendation 7.10 	<p>SBH C11a</p> <p>HSW 24a</p>
<p>8.1.10</p>	<p>When posts are vacant or in the event of long term sickness or maternity leave, prompt arrangements are made for staff cover</p>	<p>SBH C11a</p> <p>HSW 22a 24a</p>
<p>8.1.11 Q8.1.8</p>	<p>Effort is made to ensure the workforce is representative of the community served</p> <p>Guidance: For example, recruitment is guided by awareness of desirable gender and ethnic representation in the team</p>	<p>SBH C8b</p> <p>HSW 21c</p>

Section 8: Enabling Frontline Staff

Structure, roles and responsibility		
Standard:		
8.2 Q8.2	There is an up-to-date line management structure and clear and agreed lines of responsibility and accountability	
Criteria:		
8.2.1 Q8.2.1	<p>There is a clear, up-to-date line management structure which is made readily available to staff</p> <p>Guidance: <i>For example, all staff are provided with an up-to-date organisational chart for the service</i></p> <ul style="list-style-type: none"> ▪ Ref 8: pg 16, recommendation 10.1 ▪ Ref 2: pg 1, recommendation 6.2 	<p>SBH C5b C7</p> <p>HSW 11b</p>
8.2.2 Q8.2.3	<p>All staff have clearly defined, up-to-date and documented job descriptions, role profiles, and job plans</p> <ul style="list-style-type: none"> ▪ Ref 2: pg 7/8, recommendation 6.17 ▪ Ref 2: pg 8, recommendation 6.18 	
8.2.3 Q8.2.4	<p>There are clear and agreed lines of clinical responsibility for all staff</p> <ul style="list-style-type: none"> ▪ Ref 4: pg 25, recommendation 6.7.1 	<p>SBH C5b</p> <p>HSW 11b</p>
8.2.4 Q8.2.6	<p>Lines of accountability and responsibility are negotiated and agreed across agencies and disciplines, particularly if staff work in another organisation's facility</p> <ul style="list-style-type: none"> ▪ Ref 2: pg 4, recommendation 6.7 ▪ Ref 12: pg 55, recommendation 8.2.5 (2) 	<p>SBH C6</p> <p>HSW 12d</p> <p>CNST 8.2.5(2)</p>
Supervision and support mechanisms		
Standard:		
8.3 Q8.3	<p>Staff are regularly appraised and supervised and know how to gain additional advice and support when they need it</p> <ul style="list-style-type: none"> ▪ Ref 22: pg 128, recommendation 14.90 – <i>“Detailed appraisals, clinical review and corporate supervision should be developed for all grades of clinical staff working in child and adolescent mental health services”</i> 	<p>English NSF (9)</p>
Criteria:		
8.3.1 Q8.3.1	<p>All staff receive annual appraisal and annual review of their job plan</p>	<p>SBH C5b C8b</p> <p>HSW 23b 11b</p>

Section 8: Enabling Frontline Staff

<p>8.3.2 Q8.3.2</p>	<p>All staff receive regular supervision from a person with appropriate experience and qualifications, according to the guidelines of their respective professional body (where applicable)</p> <p>Guidance: <i>This should include access to specialist LD- trained staff</i></p> <ul style="list-style-type: none"> ▪ Ref 8: pg 21, recommendation 15 	<p>SBH C5b</p> <p>HSW 11b</p>
<p>8.3.3 Q8.3.3</p>	<p>All staff receive regular supervision totalling at least one hour per month</p> <ul style="list-style-type: none"> ▪ Ref 8: pg 21, recommendation 15.1 	<p>SBH C5b</p> <p>HSW 11b</p>
<p>8.3.4 Q8.3.4</p>	<p>Junior staff have regular supervision totalling at least one hour per week and are able to contact a senior colleague as necessary</p> <ul style="list-style-type: none"> ▪ Ref 8: pg 21, recommendation 15.2 	<p>SBH C5b</p> <p>HSW 11b</p>
<p>8.3.5</p>	<p>Staff have adequate emotional support</p> <p>Guidance: <i>For example, staff have access to a staff support group, counselling, an occupational health service</i></p> <ul style="list-style-type: none"> ▪ Ref 54: pg 11, recommendation 3.5 – “Emotional support, in recognition of the heavy demands that working with people who present very serious challenging behaviour make on staff, is equally important” 	
<p>8.3.6 Q8.3.6</p>	<p>There is a forum in which staff are able to express their concerns about the management of young people within the service, and such concerns are taken seriously</p> <ul style="list-style-type: none"> ▪ Ref 8: pg 16, recommendation 10.5 	<p>SBH C8a</p> <p>HSW 23a</p>
<p>8.3.7 Q4.1.1</p>	<p>Legal advice is available to staff on issues such as information sharing, confidentiality, consent, rights and child protection</p> <p>Guidance: <i>For example, staff have access to a solicitor on the Children Panel who is familiar with the service and can offer up-to-date legal advice</i></p> <ul style="list-style-type: none"> ▪ Ref 37: pg 94 	<p>English NSF (3)</p>
<p>8.3.8 Q8.3.7</p>	<p>All staff, particularly professionals who work for substantial periods on their own, are well-integrated within multi-disciplinary teams so that they do not become isolated</p> <ul style="list-style-type: none"> ▪ Ref 4: pg 3, recommendation 8.1.4 ▪ Ref 5: pg 12, recommendation 4.4 	<p>SBH C5b</p> <p>HSW 11b</p> <p>English NSF (9) 4.4</p>
<p>8.3.9 Q8.3.8</p>	<p>There are procedures in place to promote the safety of staff, including particular guidance or training on personal safety when working in the community and when attending homes of patients</p>	

Section 8: Enabling Frontline Staff

Standard:		
8.4 Q8.4	Staff morale is monitored by the clinical and general manager	SBH D7
Criteria:		
8.4.1 Q8.4.1	<p>Good staff morale is recognised as important and efforts to improve morale are made when necessary</p> <p><i>Guidance: For example, the levels of vacancies and sick leave are monitored and investigated and action is taken to address low morale</i></p> <ul style="list-style-type: none"> ▪ <i>Ref 8: pg 16, recommendation 10.3</i> 	
8.4.2 Q8.4.2	<p>There is a clear mechanism for formally recognising good performance e.g. at events, in newsletters or with achievement awards</p> <ul style="list-style-type: none"> ▪ <i>Ref 8: pg 21, recommendation 15.6</i> 	SBH 8b
8.4.3 Q8.4.4	<p>There is a clear grievance procedure for staff to use</p>	SBH C8a HSW 23a
Standard:		
8.5 Q8.5	Staff have sufficient office facilities and robust administrative and technological support systems, including ITC	HSW 25
Criteria:		
8.5.1 Q8.5.1	<p>Staff have sufficient office space to carry out their roles</p> <p><i>Guidance: Staff have sufficient space to do administrative work, make confidential phone calls etc</i></p> <ul style="list-style-type: none"> ▪ <i>Ref 55: pg 30 – “Cohesive and effective functioning of the mental health of intellectual disability team is enhanced by providing all the team members with their own offices and therapy rooms. This will maximise efficiency and output in regard to service delivery”</i> 	
8.5.2 Q8.5.2	<p>The clinical team has sufficient administrative and secretarial support</p>	
8.5.3 Q8.5.3	<p>There are sufficient computers available for staff</p>	
8.5.4 Q8.5.4	<p>There is an effective I.T. infrastructure which provides reliable e-mail and internet access, including access to electronic journals and papers</p> <ul style="list-style-type: none"> ▪ <i>Ref 16: pg 10, recommendation 8</i> 	HSW 25

Section 8: Enabling Frontline Staff

Induction and Training		
Standard:		
8.6	Continuing professional development is facilitated¹⁵	
Criteria:		
8.6.1 Q8.6.1	<p>The service has access to a staff training and development budget</p> <ul style="list-style-type: none"> ▪ Ref 2: pg 1, recommendation 7.1 This should represent at least 5 % of the total budget for CAMHS as recommended by Audit Commission report: "Children in Need". This includes cross-agency/ cross-disciplinary training and staff development programmes such as Investors in People ▪ Ref 8: pg 17, recommendation 11 	<p>SBH C11c</p> <p>HSW 22c</p>
8.6.2 Q8.6.2	Finance is available to meet the training and education needs of staff	SBH C11c
8.6.3 Q8.6.9	<p>Mechanisms are in place to advance and support teaching and research</p> <p>Guidance: For example, joint posts are developed with universities</p> <ul style="list-style-type: none"> ▪ Ref 55: pg 34 	
Standard:		
8.7 Q8.7	Staff have the necessary competencies and knowledge to work with young people who have learning disabilities and mental health needs	English NSF (9)
	<ul style="list-style-type: none"> ▪ Ref 5: pg 24 - "Currently, there is a shortfall of staff with the specific competencies to work with learning disabled children with mental health difficulties. This requirement for training will need to be addressed through initiatives such as the sharing of expertise by continuing professional development (CPD), consultation and supervision and the development of clinical networks" 	SBH C5c
Criteria:		
8.7.1 Q8.6.3	<p>All staff participate in a service induction programme within a specified timescale after appointment and before they have unsupervised access to young people</p> <ul style="list-style-type: none"> ▪ Ref 2: pg 3, recommendation 7.5 ▪ Ref 8: pg 21, recommendation 14.4 	<p>SBH C11b</p> <p>HSW 22b</p>
8.7.2 Q5.1.2	<p>The service undertakes pre-employment checks and ongoing monitoring to ensure that professional staff are registered with the appropriate bodies (for example, the General Medical Council)</p> <ul style="list-style-type: none"> ▪ Ref 17: pg 15, recommendation C10a ▪ Ref 2: pg 6, recommendation 6.15 ▪ Ref 12: pg 52, recommendation 5.1.3 (1) 	<p>SBH C10a</p> <p>HSW 21a</p> <p>CNST 5.1.3 (1)</p>

¹⁵ Wherever possible this should be on a multi-agency basis – see Section 9

Section 8: Enabling Frontline Staff

<p>8.7.3</p>	<p>Staff working with young people with learning disabilities and mental health problems have the necessary competencies in these areas</p> <p>Guidance: <i>i.e. staff have the necessary competencies relevant to practice in 1) learning disability; 2) mental health; 3) working with young people. See Ref 66 below:</i></p> <ul style="list-style-type: none"> ▪ Ref 66: pg 8 - <i>"The core competencies to identify mental health problems or carry out therapeutic interventions appear to be the same whether or not a child has learning disabilities. What staff providing Tier 1 services, or Tier 2/3 interventions, usually lack is experience in applying their existing skills and knowledge to children and adolescents with learning disabilities. The Learning Disabilities Sub-Group considered that opportunities for joint working and skill sharing is likely to be the most cost effective way to develop both individual competencies and shared understanding of services"</i> 	
<p>8.7.4</p>	<p>Staff are provided with opportunities to develop their skills and experience in working with young people with learning disabilities and mental health problems</p> <p>Guidance: <i>For example, this is achieved through joint-working, peer consultation, special interest groups and appropriate supervision (see criterion 8.3.2)</i></p> <ul style="list-style-type: none"> ▪ Ref 66: pg 8 	
<p>Staff receive regularly updated training and education in:</p>		
<p>8.7.5 Q8.7.1</p>	<p>Evidenced-based practices and value-based practices</p> <ul style="list-style-type: none"> ▪ Ref 9: pg 12, recommendation D2d – <i>"Patients receive effective treatment and care that is delivered by healthcare professionals who make clinical decisions based on evidence-based practice"</i> 	<p>SBH C5c D2d</p> <p>HSW 2c 11a 11c</p>
<p>8.7.6 Q8.7.2</p>	<p>A range of therapeutic interventions for use with young people with learning disabilities and their families</p>	<p>SBH C5c</p> <p>HSW 11c</p>
<p>8.7.7 Q8.7.3</p>	<p>A range of a pharmacological interventions for use with young people with learning disabilities (for those who prescribe, dispense or administer medicines to young people)</p> <ul style="list-style-type: none"> ▪ Ref 6: pg 11 – <i>"Individuals who prescribe, dispense or administer medicines to children are able to demonstrate competence in the use of medicines in children, including dose and infusion calculations; this is achieved through continuing professional development"</i> ▪ Ref 6: pg 5, recommendation 3 - <i>"Appropriate information and decision support is available for professionals who prescribe, dispense and administer medicines for children and young people"</i> 	<p>SBH C5c</p> <p>HSW 11c</p> <p>English NSF (10) 3</p> <p>Welsh NSF 2.31</p>
<p>8.7.8</p>	<p>Risk assessment and management, including specific guidance relating to young people with learning disabilities</p>	
<p>8.7.9 Q8.7.17</p>	<p>Providing first on-call services to young people presenting with acute psychiatric illness in emergency and out-of-hours services</p>	<p>SBH C5c</p>

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<p>8.7.10</p>	<p>Communicating with young people with specific communication needs</p> <p>Guidance: <i>Training should include use of specialist communication materials and aids, the importance of listening to young people's views, and how to gain access to and work with signers and interpreters</i></p> <ul style="list-style-type: none"> ▪ Ref 57: <i>pg 38 – “Staff and carers need to be aware of the range of modes of communication and to find out how individuals prefer to communicate”</i> 	<p>SBH C5c</p> <p>HSW 11c</p> <p>English NSF (8)</p>
<p>8.7.11 Q8.7.5</p>	<p>Gaining informed consent from young people with learning disabilities</p> <ul style="list-style-type: none"> ▪ Ref 2: <i>pg 5, recommendation 1.9 – “There is documented guidance for staff, written/ reviewed within the last three years, on consent to treatment. Procedures make clear issues such as from whom consent should be obtained and what happens when parental responsibility is shared...”</i> 	<p>SBH C5c C13b</p> <p>HSW 8c 11c</p>
<p>8.7.12</p>	<p>How to facilitate the participation of young people with learning disabilities in decision-making</p> <ul style="list-style-type: none"> ▪ Ref 57: <i>pg 38 – “Training for staff and carers is key to giving people with learning disabilities the chance to have a say over what is being planned for their lives”</i> 	
<p>8.7.13 Q8.7.6</p>	<p>Policies and procedures on information-sharing and confidentiality</p> <ul style="list-style-type: none"> ▪ Ref 20: [Wales] <i>pg 9, recommendation 2.12 – “Service providers have a nominated person who is responsible for implementing the recommendations of the Caldicott Committee Review¹¹ on patient identifiable information¹¹ and Data Protection Act 1998¹². The nominated person ensures professionals receive training about sharing information that is relevant to the well-being of children and young people, particularly at key transition stages, and following confidentiality guidelines</i> 	<p>SBH C5c C13c</p> <p>HSW 8d 11c</p> <p>Welsh NSF 2.12</p>
<p>8.7.14 Q8.7.7</p>	<p>The rights of young people with learning disabilities</p>	<p>SBH C13a</p> <p>HSW 8a</p>
<p>8.7.15 Q8.7.8</p>	<p>Legal frameworks and service procedures surrounding use of restrictive physical interventions, including specific guidance relating to young people with learning disabilities</p> <ul style="list-style-type: none"> ▪ Ref 63: <i>pg 66, recommendation 7.12 – “Information and training relating to the law on control and restraint as set out in the Mental Health Foundation’s guidance should be made available for all staff working with learning disabilities and severe challenging behaviour”</i> 	<p>SBH C13a C5c</p> <p>HSW 8a 11c</p>
<p>8.7.16 Q8.7.9</p>	<p>Recognising, and responding appropriately to, indicators of abuse amongst young people with learning disabilities</p> <ul style="list-style-type: none"> ▪ Ref 8: <i>pg 50, recommendation 50.3 , “Staff at the [service] know who the named professionals are, designated to be responsible for ensuring child protection supervision, and providing day to day advice and support”</i> 	<p>SBH C5c</p> <p>HSW 11c</p> <p>English NSF (8)</p>

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8.7.17 Q8.7.10	Culturally sensitive practice, disability awareness, and other diversity and equality issues <ul style="list-style-type: none"> ▪ Ref 5: pg 13, recommendation 5.3 – “Services need to be sensitive to these differences and ensure that staff are equipped with the knowledge to work effectively with the different groups represented in the community they serve” 	SBH C7e HSW 10 English NSF (8&9)
8.7.18	Multi-agency working and the availability and scope of local services Guidance: see Appendix D <ul style="list-style-type: none"> ▪ Ref 65: pg 18 – “...this networked approach to care is essential in supporting the delivery of effective mental health services to this client group. Networking requires knowledge of the network, skills in networking and time to facilitate liaison” 	English NSF (8) DOAS 5.3
8.7.19 Q8.7.12	How to engage and work with parents, carers and families	
8.7.20 Q8.7.13	How to engage young people and their families who have difficulty in gaining access to services, including those from black and minority ethnic groups	SBH C7e HSW 10
8.7.21 Q8.7.14	Legislation such as the Children Act 2004, Mental Health Act 1983 and its revised Code of Practice, Education Act 2002, and associated regulations <ul style="list-style-type: none"> ▪ Ref 5: pg 43 ▪ Ref 8: pg 19, recommendation 13.14 	English NSF (9) SBH C13a C5c HSW 8a 11c
8.7.22 Q8.7.15	The use of appropriate clinical outcome measures for use with young people with learning disabilities	SBH C5c HSW 11c
Team-working		
Standard:		
8.8 Q8.8	Staff work effectively as a team or network	
Criteria:		
8.8.1 Q8.8.1	There is a team or network of professionals from at least two different disciplines Guidance: The range of disciplines might include representatives from child and adolescent psychiatry; clinical child psychology; child mental health nursing; social work; and possibly other specialisms such as occupational therapy; art therapy; speech and language therapy	

Section 8: Enabling Frontline Staff

8.8.2 Q8.8.2	There are once weekly multi-disciplinary meetings for clinical matters and administration <ul style="list-style-type: none"> ▪ Ref 8: pg 16, recommendation 10.2 	
8.8.3 Q8.8.3	Notes of clinical meetings are kept and made available to all members of the team or network <ul style="list-style-type: none"> ▪ Ref 2: pg 6, recommendation 6.13 	
8.8.4 Q8.8.4	Communication between staff outside meetings is facilitated by administrative staff and communication systems <p>Guidance: Communication systems may include use of bulletin boards, communication books, email, up-to-date lists of contact numbers and times regularly worked at other sites, and formal systems for taking and relaying messages</p> <ul style="list-style-type: none"> ▪ Ref 2: pg 6, recommendation 6.14 	
8.8.5 Q8.8.6	Off-site and informal 'away days' are held to facilitate team building and service development	
Whistleblowing		
Standard:		
8.9 Q8.9	There are policies and procedures on whistleblowing <ul style="list-style-type: none"> ▪ Ref 17: pg 13, recommendation C8a – "Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services" 	SBH C8a
Criteria:		
8.9.1 Q8.9.1	There is a written whistleblowing policy that is communicated to all staff on reporting concerns about professional performance, conduct or any aspect of service delivery, both internally and between organisations <ul style="list-style-type: none"> ▪ Ref 12: pg 48, recommendation 1.2.7 (2) 	SBH C8a HSW 23a CNST 1.2.7 (2)
8.9.2 Q8.9.2	All staff are aware that they have a responsibility to critically challenge decisions that they feel may not be in the best interests of young people and their families <ul style="list-style-type: none"> ▪ Ref 20: pg 13, recommendation 2.23 	SBH C8a Welsh NSF 2.23 HSW 23a
8.9.3 Q8.9.3	Staff are able to raise concerns in confidence and without prejudicing their position in accordance with the Public Interest Disclosure Act	SBH C8a HSW 23a

Section 9: Multi-agency Working

"Disabled children and young people and their families have a range of different needs which cannot be met by one agency alone"
Department of Health (Ref 41: pg 140, recommendation 8)

Standard:

9.1 Q9.1	LD CAMH staff work closely with, and have good access to, a range of services and agencies to meet the needs of young people. These include the following:	SBH C6
	<ul style="list-style-type: none"> ▪ Ref 17: pg 10, recommendation C6 – <i>"Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met"</i> 	

Criteria:

9.1.1 Q9.1.1	General practitioners and other members of the primary health care team in the area	SBH C6 HSW 12d
9.1.2 Q9.1.2	Paediatric, child health and other children's services	SBH C6 HSW 12d
9.1.3	Speech and language professionals	SBH C6 HSW 12d
9.1.4	Occupational health professionals	SBH C6 HSW 12d
9.1.5 Q9.1.3	School health services including community paediatricians and school or college nurses	SBH C6 HSW 12d
9.1.6 Q9.1.4	Paediatric neurological services	SBH C6 HSW 12d
9.1.7 Q9.1.5	Social services	SBH C6 HSW 12d
	<ul style="list-style-type: none"> ▪ Ref 49: pg 38, recommendation 6.2 – <i>"There are strong crossovers in all directions between problems in learning, social disadvantage and social welfare and mental health. The parts to be played by the statutory education and social services departments in CAMHS are vital"</i> 	
9.1.8 Q9.1.6	Education and education support services	SBH C6 HSW 12d
9.1.9 Q9.1.7	Forensic mental health services	SBH C6 HSW 12d
9.1.10 Q9.1.8	Youth offending and youth justice services	SBH C6 HSW 12d

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9.1.11 Q9.1.9	Inpatient and day-patient child and adolescent mental health services	SBH C6 HSW 12d
9.1.12 Q9.1.10	Adult mental health services	SBH C6 HSW 12d
9.1.13 Q9.1.11	Learning disability services (for LD CAMHS not provided by a Learning Disability Service, e.g. mainstream Specialist CAMHS)	SBH C6 HSW 12d
9.1.14	Adult learning disability services	SBH C6 HSW 12d
9.1.15 Q9.1.12	Substance misuse services	SBH C6 HSW 12d
9.1.16 Q9.1.13	Smoking cessation clinics	SBH C6 HSW 12d
9.1.17 Q9.1.14	Laboratory and all diagnostic services	SBH C6 HSW 12d
9.1.18 Q9.1.15	Accident and emergency facilities in emergency departments	SBH C6 HSW 12d
9.1.19 Q9.1.16	Voluntary sector services	SBH C6 HSW 12d
9.1.20	Employment support agencies <i>Guidance: for example Connexions (England only)</i>	SBH C6 HSW 12d
Standard:		
9.2 Q9.2	The service has clear, up-to-date, documented agreements with a range of local services and agencies ▪ <i>Ref 2: pg 4, recommendation 2.7</i>	SBH C6 HSW 12d
Criteria:		
9.2.1 Q9.2.1	There are documented inter-agency or inter-service agreements that clearly state the roles and responsibilities that are allocated to each organisation	SBH C6 HSW 12d

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<p>9.2.2 Q9.2.6</p>	<p>In particular, there are documented protocols in place for collaboration and/or joint care between specialist learning disability services, paediatric services and specialist mental health services</p> <ul style="list-style-type: none"> ▪ Ref 71: pg 34 – “CAMHS Paediatric Liaison (CAMHS-PL) is concerned with providing a bridge between acute paediatrics and psychiatric and psychosocial care. This is an essential service...in cases where the presenting illness has a psychological component, or where psychological distress is caused as a result of the illness” ▪ Ref 38: pg 67, recommendation 6.25 ▪ Ref 52: pg 89, recommendation 48 	<p>English NSF (9)</p> <p>SBH C6</p> <p>HSW 12d</p>
<p>9.2.3 Q9.2.3</p>	<p>There are documented agreements that state the nature and extent of agreements to provide advice, consultation and training to other services and agencies, in particular Tier 1</p> <ul style="list-style-type: none"> ▪ Ref 2: pg 10, recommendation 7.21 	<p>SBH C6</p> <p>HSW 12d</p>
<p>9.2.4 Q9.2.4</p>	<p>Protocols for referral and early intervention are agreed between all services and agencies</p> <ul style="list-style-type: none"> ▪ Ref 5: pg 5, recommendation 2 ▪ Ref 4: pg 26, recommendation 7.2.2 – “There are clear protocols for referrals between services, which are available in written form and available to all agencies and service users” 	<p>English NSF (9) 2</p> <p>SBH C6</p> <p>HSW 12d</p>
<p>9.2.5</p>	<p>A common understanding of the terms and definitions regarding learning disability are established with relevant agencies and families to ensure that appropriate assessment and intervention takes place</p> <ul style="list-style-type: none"> ▪ Ref 7: pg 20, recommendation 2.21 	
<p>9.2.6 Q9.2.5</p>	<p>Joint protocols for out of hours cover have been agreed between relevant agencies to ensure that there is 24 hour cover for children and adolescents</p> <p>Guidance: These agencies are likely to include commissioners, primary healthcare services, paediatricians, adult psychiatry services, emergency medicine departments, social services and LD CAMHS</p> <ul style="list-style-type: none"> ▪ Ref 26: pg 40 - “It is vital that commissioners, CAMHS and adult mental health meet together to explore creative and realistic solutions to providing adequate and appropriate out of hours cover to this vulnerable group of young people” 	<p>SBH C6</p> <p>English NSF (9)</p>
<p>9.2.7 Q9.2.7</p>	<p>There is agreement across agencies about the age range covered by each agency which make clear the arrangements for the transfer of care from adolescent to adult mental health services, when young people reach the agreed “cut off” age</p> <ul style="list-style-type: none"> ▪ Ref 2: pg 2, recommendation 5.4 	<p>SBH C6</p> <p>HSW 12d</p>

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9.2.8 Q9.2.8	There are interagency agreements on the sharing of information <ul style="list-style-type: none"> ▪ Ref 12: pg 51, recommendation 4.2.4 (2) 	SBH C6 CNST 4.2.4 (2)
9.2.9	Information-sharing arrangements allow for the development and implementation of a locally based multi-agency database containing core data on disabled children ¹⁶ <ul style="list-style-type: none"> ▪ Ref 64: pg 39 ▪ Ref 7: pg 20, recommendation 2.21 - "Effective partnership working can be enhanced by the use of locally based and nationally compatible, multi-agency databases containing core data on disabled children, including shared and agreed definitions" 	English NSF (8&9)
9.2.10 Q9.2.9	There are joint protocols on involving or notifying other services or agencies when there is suspected abuse of young people <ul style="list-style-type: none"> ▪ Ref 13: pg 123, recommendation 2.2 – ""Child welfare concerns are responded to and assessed by the relevant agencies and professionals working in partnership, with clear identification of intended and actual outcomes from any response" 	SBH C6 HSW 12d
9.2.11 Q9.2.2	All documented agreements between organisations have been written or reviewed within the last three years	
<u>Standard:</u>		
9.3 Q9.3	Staff engage in activities and initiatives to improve joint-working and liaison <ul style="list-style-type: none"> ▪ Ref 5: pg 27 – "Face-to-face working and joint training is provided to overcome the barriers to co-operative working relationships" ▪ Ref 23: "the key message from the SNAP report is that local agencies and practioners need to 'engage in discussion about their differences, with a view to developing shared accounts of the young person's needs'" 	English NSF (9)
<u>Criteria</u>		
9.3.1	There are regular case meetings between local generic workers from all sectors, and specialist mental health and learning disability services <ul style="list-style-type: none"> ▪ Ref 72: pg 26-7, recommendation 4.26 – "Good liaison depends primarily on secure relationships between staff, who can rely on a quick response when required. This happens best in the context of regular meetings, where the daily work is discussed and staff themselves can be supported" 	SBH C6 HSW 12d

¹⁶ This should be carried out within the parameters stated in Standard 4.3 - 'Personal information about children and young people is kept confidential unless this is detrimental to their care'

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<p>9.3.2 Q9.3.1</p>	<p>There is regular strategic dialogue about the needs of local young people with learning disabilities, between local generic workers from all sectors, and specialist mental health and learning disability services</p> <p>Guidance: <i>For example, LD CAMHS representatives participate in local Children and Young People's Strategic Partnerships (or equivalents), Learning Disability Partnership Boards, CAMHS Partnerships, or Children's Trusts (where established)</i></p> <ul style="list-style-type: none"> ▪ Ref 26: <i>pg 41 "CAMHS professionals have an important role in influencing the commissioning process by ensuring that they participate in Children and Young People's Local Strategic Partnerships or the equivalent and make a contribution to the development of the local CAMHS strategy"</i> 	<p>SBH C6 C22c</p> <p>HSW 24b 29a</p> <p>English NSF (5) 5.1</p>
<p>9.3.3 Q9.3.2</p>	<p>There is joint training and professional development across the services and agencies involved in caring for young people with learning disabilities</p> <ul style="list-style-type: none"> ▪ Ref 5: <i>pg 42</i> 	<p>English NSF (8&9)</p> <p>SBH C6</p> <p>HSW 24b</p>
<p>9.3.4 Q9.3.3</p>	<p>There are informal and formal collaborative arrangements in place with adult services</p> <p>Guidance: <i>For example, this may include joint training between adult and children's staff; designated sessions to facilitate liaison between services</i></p> <ul style="list-style-type: none"> ▪ Ref 4: <i>pg4, recommendation 1.3.4 – "Joint training between adult and children's staff takes place, so that professionals who work primarily with children can recognise and identify parents' problems and the effects these may have on children, and professionals working with adults understand the impact that parental mental disorders may have on their children"</i> ▪ Ref 37: <i>pg 66, recommendation 2.5 – "Collaborative arrangements are in place between services for adults and those for children and families to ensure effective joint assessment and support/treatment to enhance parents' parenting capacity and protect and promote the well-being and welfare of the child"</i> 	<p>SBH C6</p> <p>HSW 24b</p> <p>English NSF (2) 2.5</p>
<p>9.3.5 Q9.3.4</p>	<p>There are opportunities for joint training across the agencies with respect to child protection and recognising the young people who may be at risk</p>	<p>SBH C2 C6</p> <p>HSW 17 24b</p>
<p>9.3.6 Q9.3.5</p>	<p>Joint working is facilitated through flexible recruitment and employment procedures</p> <p>Guidance: <i>For example, there are secondments between organisations, staff move between posts across organisations, joint posts and liaison posts are created</i></p>	<p>SBH C6</p> <p>HSW 12d</p>
<p>9.3.7 Q9.3.6</p>	<p>The service explores opportunities for co-location with other relevant children's services and agencies, in particular paediatrics</p>	<p>HSW 29a</p>

Section 10: Commissioning

"Families of disabled children have contact with an average of 10 different professionals and over 20 visits per year to hospitals and clinics. To achieve an integration of services that truly supports a child's journey, planning and commissioning needs to be more than usually focused on the goal or providing personalised, child-centred care.

National Service Framework for Children, Young People and Maternity Services: Standard 8 (Ref 64: pg 39)

Standard:

10.1 Q10.1	Commissioner-provider relationships are collaborative and effective	
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Criteria:

10.1.1	Service providers know who their commissioners are	
10.1.2 Q10.1.1	Commissioners work together with providers to achieve a strategic framework that is jointly developed and owned	
10.1.3 Q10.1.2	Effective commissioner-provider relationships are evidenced by: i) A long-term approach to service planning and development	
10.1.4 Q10.1.3	ii) Sustained relationships between commissioning and provider managers who meet regularly	
10.1.5 Q10.1.4	iii) Recognition of the differing organisational cultures of the providers from the various sectors and agencies	
10.1.6 Q10.1.5	iv) Joint approaches to service planning and development	
10.1.7 Q10.1.6	v) Clarity about which agency is responsible for which functions, at which of the Tiers	HSW 29a

Standard:

10.2 Q10.2	<p>There are mechanisms for joint commissioning and joint pooling of budgets across the relevant health, education and social services</p> <ul style="list-style-type: none"> ▪ <i>Ref 64: pg 39 – "There are arrangements which encourage multi-agency strategic planning of services for disabled children, possibly through a Children's Trust, including the joint commissioning and delivery of services, making maximum use of pooled budgets and other Health Act flexibilities"</i> 	English NSF (3&8)
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Criteria:

10.2.1 Q10.2.1	<p>There are mechanisms in place for joint commissioning</p> <p>Guidance: <i>For example, CAMH Services are commissioned by Children's Trusts, CAMHS partnerships or Learning Disability Partnership Boards where established or commissioning is otherwise co-ordinated with the commissioning of other children and young people's services</i></p>	HSW 29a English NSF (8)
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10.2.2 Q10.2.2	Facilities for pooling and creating joint budgets exist across health, education and social services ¹⁷ <ul style="list-style-type: none"> ▪ <i>Ref 65: pg 21 – “Pooling and rationalising inter-agency budgets as effectively as possible should minimise costly out-of-area placements, and preferably lead to local re-investment in services for children with complex needs”</i> 	English NSF (8) DOAS 5.6
Standard:		
10.3 Q10.3	Each commissioning agency can demonstrate that it has the organisational capacity necessary for effective commissioning	
Criteria:		
10.3.1 Q10.3.1	Each commissioning agency has an identified person who is dedicated to commissioning CAMHS and is well-informed about Learning Disability CAMHS, including national policy	
10.3.2 Q10.3.2	There is training available to commissioners in understanding Learning Disability CAMHS <p><i>Guidance: This may usefully include opportunities for commissioners to work within provider services</i></p> <ul style="list-style-type: none"> ▪ <i>Ref 5: pg 43</i> 	English NSF (9)
10.3.3	Commissioners and service providers are aware of their responsibilities under the Disability Discrimination Act 1995, the Special Educational Needs and Disability Act 2001 and the Children Act 1989 <ul style="list-style-type: none"> ▪ <i>Ref 64: pg 39</i> 	English NSF (8)
Commissioning Strategy		
Standard:		
10.4 Q10.4	There is a clear role for Learning Disability CAMHS that is explicitly set in the context of the four-tier strategic framework for CAMHS	
Criteria:		
10.4.1 Q10.4.1	There is a service level agreement or contract with the commissioning agencies which plainly states the core business of LD CAMHS and the functions that they are expected to deliver <ul style="list-style-type: none"> ▪ <i>Ref 26: pg 6 - “Evidence from the Office of National Statistics (ONS) and from service users and carers suggests that [Specialist CAMHS] should agree their core business and demand management mechanisms with their commissioners in order to ensure that services are as responsive as they can be and do not assign potential patients to substantial waiting lists for services that are not most appropriate to their needs”</i> 	
10.4.2	There is a service level agreement or contract with the commissioning agencies which plainly states how the LD CAMHS relates to Tiers 1 and 4	

¹⁷ In countries in which this is lawful and required by policy

Section 10: Commissioning

10.4.3 Q10.4.3	There is clear structure for commissioning all CAMHS, including the LD CAMHS, that reflects the sectors and agencies that should be involved	HSW 29a
10.4.4 Q10.4.4	The LD CAMHS has access to a strategy for all CAMHS and specifically for the LD CAMHS, that reflects national policy	
10.4.5 Q10.4.5	The values and principles that underpin the strategy and the commissioning plan are identified and clear	
<u>Standard:</u>		
10.5 Q10.5	A multi-agency commissioning strategy is in place to develop and improve services for young people with learning disabilities and mental disorders. This is based on a comprehensive, multi-agency assessment of need, capacity and effectiveness	HSW 2b 29a 29b
<u>Criteria:</u>		
10.5.1	There is a written multi-agency commissioning strategy to develop and improve services for young people with learning disabilities and mental disorders <i>Guidance: This should be linked to an overall strategy for children and young people's services. It is recommended that the strategy should incorporate plans for implementing the guidance set out in the National Care Pathway for Learning Disability CAMHS (Ref 65)</i>	
10.5.2	The LD CAMHS makes an active and effective contribution to the local CAMHS commissioning strategy	SBH C22
10.5.3	The commissioning strategy is based on shared understanding and definitions of need ▪ <i>Ref 63: pg 80, recommendation 8.14</i>	
10.5.4 Q10.5.1	The commissioning strategy is informed by analysis of locally adjusted epidemiological information on the prevalence of mental health disorders and learning disabilities ▪ <i>Ref 16: pg 3, recommendation 2</i>	SBH C23 HSW 2b 29a 29b
10.5.5 Q10.5.2	The commissioning strategy is informed by analysis of the needs of specific groups of children who are at risk ▪ <i>Ref 16: pg 3, recommendation 2</i>	SBH C18 HSW 2b 29a 29b

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<p>10.5.6 Q10.5.3</p>	<p>The commissioning strategy is based on analysis of the contributions of current services and awareness of unmet need and service gaps</p> <ul style="list-style-type: none"> ▪ Ref 16: pg 3, recommendation 2 ▪ Ref 5: pg 11 - <i>“Primary Care Trusts and Local Authorities ensure that local needs assessments identify children in special circumstances (including those who are homeless, those who misuse substances, asylum seekers, young people in young offenders institutions and looked after children) and that services are in place to meet their needs”</i> 	<p>SBH C18</p> <p>HSW 2b 29a 29b</p> <p>English NSF (9)</p>
<p>10.5.7 Q10.5.4</p>	<p>The commissioning strategy includes a service map showing what services are provided and how they are used and by whom</p> <ul style="list-style-type: none"> ▪ Ref 16: pg 3, recommendation 2 	
<p>10.5.8 Q10.5.5</p>	<p>The commissioning strategy takes evidence of effectiveness and efficacy of interventions and service models into account</p> <p>Guidance: <i>The strategy should make explicit reference to any evidence used to inform it</i></p> <ul style="list-style-type: none"> ▪ Ref 16: pg 3, recommendation 2 	<p>SBH C5d</p> <p>HSW 2c 12b 30b</p>
<p>10.5.9 Q10.5.6</p>	<p>The commissioning strategy incorporates commitment to current national and local priorities including National Service Frameworks, the National Autism Plan and, in relevant countries, implementation of NICE guidance</p> <ul style="list-style-type: none"> ▪ Ref 16: pg 3, recommendation 2 	<p>SBH C3</p> <p>HSW 12b 30b</p>
<p>10.5.10 Q10.5.7</p>	<p>The commissioning strategy outlines clear priorities for commissioning</p> <ul style="list-style-type: none"> ▪ Ref 16: pg 3, recommendation 2 	
<p>10.5.11 Q10.5.8</p>	<p>The commissioning strategy is informed by audit and mapping of workforce capacity, skills and workforce development strategy</p> <ul style="list-style-type: none"> ▪ Ref 16: pg 3, recommendation 2 ▪ Ref 66: pg <i>“Commissioners should map systematically the competencies available to local CAMH services. Having identified gaps, and they should plan the development of services, recruitment and training in order to meet these needs”</i> 	<p>HSW 24a</p>
<h3>Service provision and resources</h3>		
<p>Standard:</p>		
<p>10.6</p>	<p>Adequate resources are made available to meet the needs of young people with learning disability and mental health problems</p> <ul style="list-style-type: none"> ▪ Ref 63: pg 66, recommendation 7.12 - <i>“the Children Act (1989) provides a clear legal framework for the provision of services for children who are regarded as being 'in need' or who are disabled. We recommend that central and local government should urgently address the resourcing of such services and, in particular, the funding mechanisms to support children who have complex and therefore expensive special needs”</i> 	

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Criteria:		
10.6.1	<p>The level of resources available to the LD CAMHS matches the high degree of specialist support required by young people with learning disabilities</p> <ul style="list-style-type: none"> ▪ Ref 63: pg 80, recommendation 8.14 – “Purchasers and commissioners should recognise that many of these children will require highly expert and specialist support to sustain them and their families within the local community” ▪ Ref 42: pg 48, recommendation 20 – “...the ‘same’ mental health problem in a multiply disadvantaged child results in disproportionately greater social impairment or burden for others, and therefore warrants a disproportionately greater input in any case” 	
10.6.2	<p>There is commitment and financial support to conduct research into the effectiveness of interventions for young people with learning disabilities and mental health needs</p> <ul style="list-style-type: none"> ▪ Ref 45: pg 16 – “Many of the issues concerning the cause, nature and outcome of psychiatric problems in young people with learning disabilities are, as yet, poorly understood. There is a lack of evidence concerning the effectiveness of various treatment strategies in these young people, and little guidance as to which treatment should be used with which child. This needs to be addressed urgently through research and audit and requires an academic infrastructure to be put in place” 	
Standard:		
10.7 Q10.6	<p>Commissioners ensure that services are provided for young people with learning disabilities, including those who have particularly complex needs or who belong to specific at-risk or need groups</p> <ul style="list-style-type: none"> ▪ Ref 6: Annex C, “Access to CAMHS should be available to all children and young people regardless of their age, gender, race, religion, ability, class, culture, ethnicity or sexuality” ▪ Ref 34: pg 47, recommendation 4.50 – ▪ Ref 16: pg 7, recommendation 5 ▪ Ref 37: pg 98 	<p>HSW 2d 10</p> <p>English NSF (3)</p> <p>English NSF (10)</p>
Criteria:		
10.7.1	<p>Commissioners ensure that young people with learning disabilities have access to the general and specialist services available to those without learning disabilities</p> <ul style="list-style-type: none"> ▪ Ref 57: pg 75 	
10.7.2	<p>Commissioners of paediatric services and LD CAMHS collaborate to ensure that a Paediatric Liaison service is provided with agreed apportioning of costs to the relevant budgets</p> <p>Guidance: CAMHS paediatric liaison services are required, amongst other needs, to provide for the complex needs of children with learning disabilities, mental health problems and closely linked medical disorders such as epilepsy and life limiting disorders</p> <ul style="list-style-type: none"> ▪ Ref 71: pg 7 	English NSF (9)

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<p>10.7.3</p>	<p>Commissioners ensure that adequate in-patient beds and resources are available to meet the needs of young people with learning disabilities</p> <ul style="list-style-type: none"> ▪ Ref 45: pg 19 – <i>“In-patient resources complement (rather than replace) the community approach for young people. Commissioners should ensure that the beds they commission meet their need, with clear operational policies for the process”</i> 	
<p>10.7.4 Q10.6.1</p>	<p>Commissioners ensure that young people are not placed out of borough as a consequence of inadequate specialist support being provided to schools and colleges</p> <ul style="list-style-type: none"> ▪ Ref 59: pg 102 - <i>“The right level of support should be made available to schools to help keep children in-borough... The reason for the placement out of borough in 46% of cases was the need for specialist provision... The proportion of these children who also had mental health difficulties, which contributed to the placement, is not known; 46% had received mental health services at some point. Of the 18 children placed out of borough owing to mental health difficulties, only 61% accessed mental health services before out-of-borough placement. Mental health services were not considered early and there was poor inter-agency communication”</i> 	
<p>10.7.5 Q10.6.2</p>	<p>Commissioners ensure that services are provided for young people with mental disorders and learning disabilities who also have Autistic Spectrum Disorders</p>	
<p>10.7.6 Q10.6.3</p>	<p>Commissioners ensure that services are provided for young people with mental disorders and learning disabilities who are in transition, i.e. refugees or asylum seekers, homeless and travellers</p> <ul style="list-style-type: none"> ▪ Ref 37: pg 31 – <i>“Primary Care Trusts ensure that opportunities are taken to review the needs of children who have entered the country or those who have moved area”</i> 	<p>SBH C18 C6 C7e</p> <p>English NSF (1)</p> <p>HSW 2d</p>
<p>10.7.7 Q10.6.4</p>	<p>Commissioners ensure that services are provided for young people with mental disorders and learning disabilities who also misuse substances</p>	<p>SBH C18 C6</p> <p>HSW 2d</p>
<p>10.7.8 Q10.6.6</p>	<p>Commissioners ensure that services are provided for young people with mental disorders and learning disabilities who also are, or have been, involved in criminal offences</p>	<p>SBH C18 C6</p> <p>HSW 2d</p>
<p>10.7.9 Q10.6.7</p>	<p>Commissioners ensure that services are provided for young people with mental disorders and learning disabilities who are also Looked After and accommodated</p> <ul style="list-style-type: none"> ▪ Ref 33: pg 50 – <i>[Specialist CAMHS staff] “work with the local authority to plan and provide non-stigmatising and readily accessible counselling support for looked after and accommodated children and young people”</i> 	<p>SBH C18 C6</p> <p>HSW 2d</p>
<p>10.7.10 Q10.6.9</p>	<p>Commissioners ensure that services are provided for young people with mental disorders and learning disabilities who also have longer-term or complex needs that cannot be met by one agency</p>	<p>SBH C18 C6</p> <p>HSW 2d</p>

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10.7.11 Q10.6.7	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities who also have particular needs as a consequence of being members of minority ethnic group <ul style="list-style-type: none"> ▪ Ref 26: pg 24 – “The Race Relations (Amendment) Act (2000) requires that all NHS services put into effect an Equalities Policy. This includes the ethnic monitoring of service users” 	SBH C18 C6 C7e HSW 2d 10
10.7.12 Q10.6.9	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities who also have physical disabilities or illnesses	SBH C18 C6 C7e HSW 2d 10
10.7.13 Q10.6.10	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities who are aged 16 or over and are moving between CAMHS and adult services <p><i>Guidance: Local commissioning agreements should ensure there is adequate specialist mental health provision for those aged 16 or over and there are clear agreements as to who has responsibility for providing these services. There should be overlap to allow flexibility of provision.</i></p>	SBH C18 C6 HSW 2d 10
10.7.14	Where a particular service is not available locally, commissioners have identified a clear mechanism by which it can be accessed, for example by contract with a neighbouring trust <ul style="list-style-type: none"> ▪ Ref 45: pg 9 	
<h3>Consultation and review</h3>		
Standard:		
10.8 Q10.7	Young people and their parents are involved in commissioning the local services and are consulted about service delivery <ul style="list-style-type: none"> ▪ Ref 16: pg 3, recommendation 2 ▪ Ref 37: pg 112 – “Commissioning strategies empower children, young people, their families, carers and communities by reflecting their views about services and, where possible and appropriate, including representation from these groups in developing the strategy” 	SBH C17 HSW 1 English NSF (3)
Criteria:		
10.8.1 Q10.7.2	Children and parents are consulted about the design and delivery of local health, education and social care services, and responses to this are reported back to those consulted <ul style="list-style-type: none"> ▪ Ref 64: pg 16 – “Disabled children and their families are involved regularly in decisions about service planning, commissioning, innovation and re-design” 	SBH C17 HSW 1 English NSF (2) 2.7

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10.8.2 Q10.7.3	The service has means to ascertain the views of people from different religious, cultural and minority ethnic groups, whether or not they are patients of the service ▪ <i>Ref 2: pg 8 recommendation 8.19</i>	SBH C17 HSW 1
<u>Standard:</u>		
10.9 Q10.8	Frontline staff are involved in commissioning the local services and are consulted about service delivery	
<u>Criteria:</u>		
10.9.1 Q10.8.1	There are mechanisms in place to communicate key commissioning issues to frontline staff	
10.9.2 Q10.8.2	The commissioning strategy incorporates the opinions of service staff	Designed for Life
<u>Standard:</u>		
10.10 Q10.9	There is a clear framework for service review and performance management that is agreed between the commissioning and provider agencies	
<u>Criteria:</u>		
10.10.1 Q10.9.1	There is a review process involving commissioners and the service that takes place at least annually	SBH C6
10.10.2 Q10.9.2	Standards and/or other performance criteria which are set for the service are agreed by the commissioners and the provider agency	SBH C6
10.10.3 Q10.9.3	Standards and other performance criteria are informed by: i) the aims, objectives and principles agreed for CAMHS in the strategic framework	
10.10.4 Q10.9.4	ii) professional opinion	
10.10.5 Q10.9.5	iii) the opinions of patients and their carers	SBH C17 HSW 1
10.10.6 Q10.9.6	iv) policy and guidance e.g. The DOAS National Care Pathway (Ref 65)	
10.10.7 Q10.9.7	The performance management framework is reviewed annually and is compliant with the Service and Financial Framework (SaFF) processes and by the Balanced Scorecard Processes year on year	

Glossary

Many of these definitions are derived from existing documents, including Every Child Matters, the English and Welsh National Service Frameworks, Together We Stand, and the Standards for Better Health.

ASD (Autistic Spectrum Disorder) - children with autistic spectrum disorder have difficulty understanding what other people are saying, need help to play with other children, enjoy routines and find unfamiliar situations difficult.

Balanced Scorecard Processes - the Balanced Scorecard is a management system implemented in the NHS to enable services to clarify their vision and strategy and translate them into action. It provides feedback around both the internal business processes and external outcomes in order to continuously improve strategic performance and results.

Caldicott Report – a review of all patient-identifiable information which passes from National Health Service (NHS) organisations in England to other NHS or non-NHS bodies for purposes other than direct care, medical research, or where there is a statutory requirement for information.

CAMHS (Child and Adolescent Mental Health Services)

The term 'CAMHS' tends to be used in two different ways. It is often used as a broad concept that encompasses all services and agencies that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies.

The term is also used more specifically to refer only to '*Specialist CAMHS*' (in other words, services generally provided by the health sector and operating at Tiers 2, 3 and 4 of the four-tier strategic framework – see 'Tiers' below). QINMAC is primarily concerned with the LD CAMHS which deliver Tiers 2 and 3; however, QINMAC also evaluates these services within the context of the broader CAMHS definition.

Capacity – a person is deemed to have capacity if they demonstrate sufficient understanding and intelligence to make decisions regarding their treatment.

Care plan - a written document that outlines a patient's care needs and states what services will be provided with details of when, where and by whom. Care plans are required for all patients whose care is being managed via the Care Programme Approach.

CPA (Care Programme Approach) – the CPA involves a systematic assessment of a patient's health and social care needs, a care plan, a key worker and a regular review of progress.

Case manager – a nominated member of a CAMHS team who co-ordinates the intervention plan for the patient.

C-GAS (Children's Global Assessment Scale) - a routine outcome measurement tool developed to provide a global measure of level of functioning in children and adolescents.

Children Act 1989 - an Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Children Act 2004 - an Act to make provision for the establishment of a Children's Commissioner; to make provision about services provided to and for children and young people by local authorities and other persons; to make provision in relation to Wales about advisory and support services relating to family proceedings; to make provision about private fostering, child minding and day care, adoption review panels, the defence of reasonable punishment, the making of grants as respects children and families, child safety orders, the Children's Commissioner for Wales, the publication of material relating to children involved in certain legal proceedings and the disclosure by the Inland Revenue of information relating to children.

Children and Young People's Strategic Partnership - Children and Young Peoples Strategic Partnerships (CYPSPs) are multi-agency partnerships involving the responsible statutory and voluntary agencies that commission and/or provide services to children and young people.

Children Panel – the Children Panel, operated by the Law Society, offers access to specialist practitioners experienced in representing children and other parties under the Children Act 1989.

Children's Trust - Children's Trusts bring together all services for children and young people in an area, underpinned by the Children Act 2004 duty to cooperate, to focus on improving outcomes for all children and young people.

CNST (Clinical Negligence Scheme for Trusts: Mental Health and Learning Disability Clinical Risk Management Standards) - the NHS Litigation Authority's clinical risk standards (see bibliography).

Cochrane Guidelines - guidelines based on the best available information about healthcare interventions.

Common Assessment Framework - an assessment tool being developed for use across all professionals working with children. It aims to reduce the time spent in repeated assessments of the same child by different practitioners, encourage multi-agency working, provide common language and initiate action where it is needed.

Communication aids – alternatives to verbal communication, such as signs, pictures, photos or symbols.

Connexions – the English Government's support service for all young people aged 13 to 19. It aims to provide advice, guidance and access to personal development opportunities for this age group and to help them make a smooth transition to adulthood and working life.

Consent – voluntary agreement given in the context of a particular decision (e.g. to examination, intervention, sharing of information). Patients and carers need sufficient information before they can decide whether to give their consent: *informed consent* involves ensuring that an individual knows all of the risks and costs involved in a treatment before making a decision as to whether to agree to or refuse the treatment. In order for informed consent to be considered valid, the individual must be assessed as having capacity to agree to or refuse a particular treatment or intervention (see DH guidelines:

<http://www.wales.gov.uk/subihealth/content/keypubs/pdf/keypoints-e.pdf>)

CRB (Criminal Records Bureau) checks - checks against the Police National Computer (England and Wales) and records held by Department of Health and the Department for Education and Skills about people considered unsuitable to work with children and young people.

Data Protection Act - act for the regulation of the processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information.

Disability Discrimination Act 1995 - an Act making it unlawful to discriminate against disabled persons in connection with employment, the provision of goods, facilities and services or the disposal or management of premises; to make provision about the employment of disabled persons; and to establish a National Disability Council.

DOAS (Do Once and Share) – the Do Once and Share programme is being delivered by NHS Connecting for Health's Service Implementation team and implemented through action teams based in local health communities. The programme works to engage and enable clinicians, healthcare providers and patients to share their knowledge, skills and experience. The DOAS CAMHS Learning Disabilities action team has developed a national consensus on a care pathway for young people with learning disabilities and mental health needs. For more information see <http://www.informatics.nhs.uk/doas/index.html>

Education Act 2002 - an Act regarding provision about education, training and childcare.

Emergency referrals – referrals of patients who are deemed to require assessment within 24 hours or the next working day.

FPLD (Foundation for People with Learning Disabilities) – organisation that promotes the rights, quality of life and opportunities of people with learning disabilities and their families through working with them and those that support them.

General Medical Council - promotes and protects the health of the public by ensuring proper standards in medicine.

GP – General Practitioner.

Health Action Plan – Health Action Plans are personal plans that list what a person with a learning disability can do to be healthier. They include any help that the person may need to do this. They help to make sure people get the service and support they need to keep well. Plans can be started by the person themselves, a family carer, primary care or support services.

HoNOSCA (Health of the Nation Outcome Scales for Children and Adolescents) - a routine outcome measurement tool that assesses the behaviours, impairments, symptoms, and social functioning of children and adolescents with mental health problems.

HSW – the Welsh Assembly Government's *Healthcare Standards for Wales* (see bibliography).

Intervention – in this document, 'intervention' is used to refer to any therapies or medical procedures that form part of a child or young person's assessment or care e.g. this includes medical treatments, talking therapies and physical examination.

ITC – Information Technology and Communication.

Key worker – a named person who is both a source of support for children and young people with complex needs and their families, and a link by which other services are accessed and used effectively. Key workers have responsibility for working together with the family and with professionals from services, and for ensuring delivery of an inter-agency care plan for the child and family.

LD CAMHS – services that provide mental health provision to young people who have learning disabilities. For example, this may be provided by Learning Disability services, generic CAMHS, or specialist Learning Disability CAMHS teams. In the context of this document, LD CAMHS is used throughout to refer to services that deliver the functions of Tier 2 and 3; LD CAMHS Tier 4 services are referred to explicitly as 'Tier 4' (see below for definition of each of the 4 'Tiers').

Local Safeguarding Children Board (LSCB) - LSCBs have replaced the earlier Area Child Protection Committees (ACPC). The objective of LSCBs is to coordinate and to ensure the effectiveness of their member agencies in safeguarding and promoting the welfare of children. The core membership of LSCBs is set out in the Children Act 2004, and includes local authorities, health bodies, the police and others.

Looked After Child - a child or young person (less than 18 years old) who is in the care of a local authority under a care order by the courts, or accommodated under a voluntary arrangement as a result of there being no person who has parental responsibility, s/he is lost or abandoned, or the person caring for her/him being prevented from providing her/him with suitable accommodation or care.

Looked After Children (LAC) Review - it is a legal requirement that children who are looked after by the social services must be reviewed regularly. A LAC Review is a meeting which is held to get people together to share information and to make plans about a child's placement. The purpose of a LAC Review to make sure that the care plan for each child continues to be appropriate and that the child's needs are being met.

Mental Welfare Commissions Report - report outlining the joint NHS Borders and Scottish Borders Council response to the recommendations of the Mental Welfare Commission Investigation that were published in May 2004.

National Autism Plan (NAP) – a plan for the identification, assessment, diagnosis and access to early interventions for pre-school and primary school aged children with autism spectrum disorders (ASD).

NICE – The National Institute for Clinical Excellence is a special health authority for England and Wales. Its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on 'best practice'.

NSF (National Service Framework for Children, Young People and Maternity Services) - long term national strategy to improve children, young people and maternity services in England and Wales (see bibliography). The NSF sets measurable goals within set time frames.

Parents – any person with parental responsibility for a young person.

Primary Services – first-contact health services directly accessible to the public.

Public Interest Disclosure Act 1998 - an Act to protect individuals who make certain disclosures of information in the public interest; to allow such individuals to bring action in respect of victimisation; and for connected purposes.

Restrictive physical intervention – in this document restrictive physical intervention refers to any control or physical restraint used on a young person to prevent damage to self, others or property.

Risk Assessment - an estimation of the likelihood of particular adverse events occurring under particular circumstances within a specified period of time.

SBH – the Healthcare Commission's *Standards for Better Health* (see bibliography). The core standards represent a level of service that all patients should be able to expect.

SDQ (Strengths and Difficulties Questionnaire) - a routine outcome measurement tool used to assess 3-16 year olds.

SEN (Special Educational Needs) - learning difficulties or disabilities that make it harder for children to learn or access education than most children of the same age.

SEN and Disability Act 2001 - an Act to amend Part 4 of the Education Act 1996; to make further provision against discrimination, on grounds of disability, in schools and other educational establishments; and for connected purposes.

Service and Financial Framework – documents prepared by healthcare organisations (e.g. Local Health Boards, NHS Trusts) which set out their delivery plan to achieve national and local priorities and requirements for the coming financial year.

Service Level Agreement – a written agreement, generally between a provider of a service and the commissioner of that service, which determines the range and level of service to be provided and the fees agreed by both parties.

Specific communication needs – the specific needs of young people and other family members or carers who have a sensory impairment and/or learning disability, that need to be met to ensure effective communication.

Tiers - the CAMHS 4-Tier model represents a strategic and functional framework rather than a prescription of CAMHS organisational structures (see NHS Health Advisory Service (1995) *Together We Stand*, pp 59-65). References to 'Tiers' throughout this document should be understood in the context of this functional definition.

Tier 1 – primary or direct contact services. Professionals working in these services include, for example, social workers, general practitioners, voluntary workers, health visitors and teachers.

Tier 2 – 'Tier 2' refers to interventions offered by the individual staff of CAMHS. These professionals include, for example, primary mental health workers, community psychiatric nurses, occupational therapists, clinical and educational psychologists, psychotherapists, social workers and psychiatrists.

Tier 3 – 'Tier 3' refers to interventions offered by multi-disciplinary teams of staff from CAMHS. These often centre around particularly complex needs.

Tier 4 - these services offer very specialised CAMH interventions and care. They include In-patient Child and Adolescent Mental Health Services, Secure Mental Health Services, Specialised Neuro-Psychiatric Services and Highly Specialised Outpatient Services for Young People with Complex Disorders.

United Nations Convention on the Rights of the Child – convention consisting of 54 articles outlining the rights of every child. A “child” is defined as every human being below the age of 18.

Urgent referrals – referrals of patients who are deemed to require assessment within 5 working days.

Vulnerable children and young people – includes children in need, including disabled children and those looked after by a local authority, as well as care leavers.

WTE – Whole time equivalent.

Young People – all people under the age of 18 years old.

YOTs (Youth Offending Teams) - multi-agency teams encompassing local key agencies with a contribution to make to reduce offending by children and young people.

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Appendix A – Consultation with frontline staff

Method

To inform the QINMAC-LD standards and a separate research paper, consultation was carried out with frontline staff experienced in providing mental health services to young people with a learning disability. The key issues that staff face and the areas where young people's needs fail to be met were discussed. Interviews were conducted in person with staff from an inpatient unit and with twelve individuals via telephone consultation, including eleven members of staff representing nine community services supporting young people with mental health problems and learning disabilities. The telephone interviews were carried out with three consultant child and adolescent psychiatrists; four child and adolescent psychologists; two team managers; a senior occupational therapist; a learning disability nurse; and a researcher into learning disability and mental health in young people. Volunteers came from a range of services across the UK.

Interview questions covered the care pathway that a young person faces from the point of access through to discharge, staffing needs and issues around commissioning, and work with other agencies. The interviews were semi-structured, with open questions allowing the interviewee to highlight the key issues.

Appendix B – Acknowledgements

Standards Working Group

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Interviews with frontline staff

We would like to thank all those who took part in interviews in July and August 2006 (See Appendix A).

Appendix C – Ten Guiding Principles

The following principles are taken from the Do Once and Share (DOAS) project: CAMHS Learning Disabilities – Developing a National Care Pathway, and were used to guide the QINMAC- LD standards

4.1 Ten Guiding Principles for working with children who have learning disabilities and mental health problems

4.1.1 Holistic

The needs of the child with learning disability and mental health difficulties are central to any service planning and delivery. The full range of emotional, physical, social, educational and practical needs should be considered in the context of the family, with special attention paid to parents/carers' and siblings' needs.

4.1.2 Child-centred Planning

Service development and delivery should have the child's welfare as paramount (Children Act, 1989). There should be recognition that 'children are children first', regardless of the level of their learning disability and mental health difficulties. The intention should be to develop intervention plans to meet the child's needs rather than reflect service needs. In addition, as in any work with children, their welfare should be paramount, and careful attention should be paid to child protection issues.

4.1.3 Developmental framework

Throughout assessment and intervention, the difficulties presented by the child should be considered within a developmental framework. This should pay attention to both the child's chronological age and developmental level. Children with learning disabilities may show a more variable pattern of development than those without learning disabilities. For example, their verbal skills and emotional understanding may be above what might be expected given their cognitive developmental level.

4.1.4 Multi-agency commissioning and consideration of referrals

For care to be effective, it should be provided across health, social and educational agencies in a comprehensive and integrated manner. Avoiding duplication of service provision and ensuring effective communication between agencies is essential in offering care which is responsive to the child and family's needs.

4.1.5 Inclusion and equality of access

Children with a learning disability and their families should have equal access to the full range of services that children without learning disabilities have in respect to their mental health and other areas of health, social and educational support. They should be offered appropriate support to access ordinary services where possible, and specialist alternatives where inclusion into ordinary services is not indicated.

4.1.6 Pro-active and problem-solving

Services and individual professionals should take a pro-active and problem-solving approach in addressing the needs of children and their families. They should seek to equip themselves with any necessary knowledge base or skills to

meet the needs of the child. Working pro-actively will require services to be flexible in several regards:

(i) Referrals onto other services should be treated as requests for service provision. Responsibility for care or liaison with new services should be retained by the referring service until it is appropriate to transfer responsibility to another service;

(ii) It will be important to follow up with vigour those families who find it difficult to engage with services, recognising that families may be engaged with several services at once and may find attending appointments difficult. Appointments should be offered in places which are familiar and readily accessible to children and their families, for example, school or home;

(iii) Clinicians should draw upon other resources and support the co-ordination of care in circumstances where they cannot directly meet the child's needs.

4.1.7 Collaborative practice and consent

Service development and delivery should be committed to collaborative practice which empowers children, their families and advocates to overcome their difficulties and gain the support they need from service providers. Children's views should be actively sought throughout the care process, and information should be provided in a child-friendly manner to enable children to be informed about their care and participate in decision -making.

4.1.8 Co-operative information sharing and communication

Issues of consent, confidentiality and information sharing require careful consideration for children with complex inter-agency involvement. Information should be shared between service providers to meet the needs of the child, but this should be done collaboratively with children and families. Particular attention will need to be paid to information which may be 'sensitive' which might only be shared to protect the well-being of the child.

Further guidance is available from the Information Sharing Guidelines (2006) produced by DFES, with DH and others, as part of the Every Child Matters Programme.

<http://www.everychildmatters.gov.uk/resources-and-practice/IG00065/>

4.1.9 Encompassing diversity

Professionals should encompass diversity in their planning of services, and within service delivery and evaluation. Diversity relates to the child's level of disability, as well as any cultural or gender issues. Children from ethnic minority groups who have a learning disability may be more likely to face double discrimination in relation to service access.

4.1.10 Therapeutic and quality services

The pathway should enable children to access the best available local service to meet their needs. Such services should be timely, of high quality and therapeutic for the child and family, and offer both comprehensive assessments and interventions. It is recognised that services for children with learning disabilities and emotional / behavioural difficulties are currently undergoing considerable development. In developing services, one should be mindful of the above guiding principles, and should apply them in the monitoring of service quality.

Appendix D – Key Multi-Agency Links

To facilitate the development of a comprehensive network map for children with learning disabilities and mental health problems, families and practitioners should acquire information about the following people in their local area, and develop effective links with these service providers:

Health sector

- Health visitors
- General practitioners
- Community paediatricians
- Psychiatrists
- Clinical psychologists
- Primary mental health workers
- Learning disability community nurses
- Paediatric speech and language therapists
- Paediatric occupational therapists
- Paediatric physiotherapists

Social care sector

- Social workers in disability teams
- Short break (respite) providers
- Child protection social workers

Education sector

- Special needs schools/units
- Emotional and behavioural disorder schools
- Special educational needs co-ordinators
- Special needs teachers
- Behavioural support workers
- Educational psychologists
- Behaviour support teams (peripatetic behavioural services)

Voluntary sector

- Short break (respite) providers
- Family support services
- Advocacy services
- Social and recreational groups
- Play scheme providers

The NSF and Every Child Matters promote the development of locally managed care networks. Further guidance is available at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4114364&chk=ebDqj9

Source: Mental Health Services for Children with Learning Disabilities: National Care Pathway (Ref 65: pg 18)

Appendix E – Six Key Points on Information Sharing (DfES)

1. You should explain to children, young people and families at the outset, openly and honestly, what and how information will, or could be shared and why, and seek their agreement. The exception to this is where to do so would put that child, young person or others at increased risk of significant harm or an adult at risk of serious harm, or if it would undermine the prevention, detection or prosecution of a serious crime including where seeking consent might lead to interference with any potential investigation.
2. You must always consider the safety and welfare of a child or young person when making decisions on whether to share information about them. Where there is concern that the child may be suffering or is at risk of suffering significant harm, the child's safety and welfare must be the overriding consideration.
3. You should, where possible, respect the wishes of children, young people or families who do not consent to share confidential information. You may still share information, if in your judgement on the facts of the case, there is sufficient need to override that lack of consent.
4. You should seek advice where you are in doubt, especially where your doubt relates to a concern about possible significant harm to a child or serious harm to others.
5. You should ensure that the information you share is accurate and up-to-date, necessary for the purpose for which you are sharing it, shared only with those people who need to see it, and shared securely.
6. You should always record the reasons for your decision – whether it is to share information or not.

Source: Department for Education and Skills (2006) Information sharing: Practitioners' guide. London: DfES. (Ref 68: pg 5)
<http://www.everychildmatters.gov.uk/resources-and-practice/IG00065/>

Appendix F – QINMAC-LD Standards Order Form

Further copies of these standards can be obtained by photocopying and completing this form:

I would like to order ____ copies of the QINMAC-LD Standards at **£15** each

Title: (Dr, Mr, Mrs, Ms etc.):

First name:

Surname:

Job Title:

Organisation Name:

Address:

Postcode:

Tel:

Fax/E-mail:

Please indicate your preferred method of payment:

a) I enclose a cheque for £ _____ made payable to 'The Royal College of Psychiatrists'

b) Please invoice my organisation for £ _____

Today's Date: ____/____/____

Signed:

PLEASE RETURN TO: QINMAC, The Royal College of Psychiatrists' Research and Training Unit, 4th Floor, Standon House, 21 Mansell Street, London E1 8AA.

Tel: 020 7977 6680/81/83. Fax: 020 7481 4831. E-mail:
rhurcombe@cru.rcpsych.ac.uk

Appendix G – QINMAC-LD Standards Feedback Form

We hope you have found the QINMAC-LD standards useful and would appreciate your feedback. Your comments will be incorporated, with the approval of QINMAC members, into future editions of this publication.

1. Have you found these standards useful? Yes No

Comments:

2. Do you have suggestions for new sections/topic areas or new standards or criteria you would like to see included in future versions?

3. Do you have any general suggestions about this document that would improve its usefulness?

4. What is your profession?

Thank you for taking the time to complete this form. Your comments will be considered carefully.

Please photocopy and return to: QINMAC, Royal College of Psychiatrists' Research Unit, 4th Floor, Standon House, 21 Mansell Street, London E1 8AA. Fax: 020 7481 4831.

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