# Eligibility Criteria
# For
# Somerset Child and Adolescent Mental Health Service (CAMHS)

Somerset Partnership NHS Foundation Trust is commissioned to deliver the CAMHS service in Somerset. The CAMHS service comprises 3 multidisciplinary teams in Taunton, Wells and Yeovil, a county wide outreach Team, a dedicated Community Eating Disorder Team as well as a dedicated Single Point of Access Team and a Primary Mental Health Link Worker Team. Together they offer an assessment and treatment service for young people experiencing moderate to severe mental health difficulties. They work closely with other professionals working with children, young people and their families and can offer them advice, consultation and training on issues to do with child and adolescent mental health. This document aims to detail the criteria for referral to CAMHS and in doing so to provide some guidance about other services that are available to children young people and their families who do not meet these criteria.

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Head of Communications on 01278 43200

## Summary Guidance for referrers

1. The Single Point of Access Team (SPA) will accept referrals of:
   - young people (under 18) in Somerset with significant mental health needs
   - in addition they may have a learning disability and or a pervasive developmental disorder such as an Autistic Spectrum condition; however this should not be the primary reason for referral.

   ***Please note***: Behavioural disturbance may be evident but may not necessarily constitute a mental health disorder

2. Before referral you are required to gain the consent and agreement of the young person and their parent/carer and to complete a referral form, detailed letter or EHA (Guidance notes for making a good referral and referral form available on http://www.sompar.nhs.uk/what-we-do/children-and-young-people/professional/child-and-adolescent-mental-health-service-camhs/referrals/)

3. Referrals can be made to CAMHS SPA by telephone 0300 1245 012 and email CAMHSSPA@sompar.nhs.uk or letter at Single Point of Access Team, Foundation House, Wellsprings Road, Taunton, TA2 7PQ

4. Emergency assessments are carried out by the Enhanced Outreach Team within 24 hours. This may be required if you are concerned that there is an immediate risk of harm to self or others due to:

   - symptoms of severe depression with current suicidal thoughts, intention and/or history
   - severe psychotic symptoms.

   In such cases you should consider if an immediate call to the police or ambulance service is needed in the first instance to keep the young person or others safe.

   Where there is a presentation of Anorexia Nervosa with a physical presentation that suggests a possible risk to life, urgent admission to an acute paediatric ward should be sought as well as referral to the Community Eating Disorder Service (CEDS) via SPA. The CEDS team is able to see emergency referrals within 24 hours and these assessments can be carried out on the pediatric wards if necessary. Please see MARSIPAN guidance for further information on risk indicators: http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr189.aspx

5. All referrals are screened on a daily basis for urgency. For routine referrals, referrers are informed if the referral has been accepted, more information is required or whether an alternative service is felt to be appropriate. Routine referrals are offered an appointment within 6 weeks.

6. Referrals to CEDS will be triaged for urgency with emergency referrals seen within 24 hours, urgent referrals seen within 1 week, and routine referrals seen within 4 weeks.

7. The detailed referral criteria below should help potential referrers assess if the threshold for referral to CAMHS is met.

## General factors to consider include

- The severity of the current difficulty.
- The complexity of the young person's history.
- Whether there have been enduring difficulties over a period of time.
- The level of commitment from the young person and their family to engage with the service.
- Whether the Early Help Assessment (EHA) identifies significant mental health concerns.
- Whether the mental health/emotional needs of the child can be met by the professionals currently involved or whether a range of primary mental health interventions have been tried and proved unsuccessful.
- When a parent is struggling with a severe mental illness.

## Specific information required for an eating disorders

### Weight Loss

- Current weight (kg):
- Current height (cm):
- Weight before difficulties (kg) (if known – or approximate/clothing size):

Or

- Weight loss trajectory (estimated loss over what period):

### Eating Disorder 'Symptoms' (please detail)

- Restricted food/fluid intake:
- Compensatory behaviours (e.g. laxatives, purging, exercise):
- Any bingeing:
- Evidence of significant eating disordered cognitions regarding weight and shape:
- Does eating difficulty appear to be primary difficulty? (e.g. not loss of appetite due to low mood or restrictive eating due to social anxiety):
- Any other significant background information or contextual factors? (please note)

### Medical
### Physical symptoms: (please tick)

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| i. | Weakness/fatigue | | ☐ |
| ii. | Dizziness/faintness | | ☐ |
| iii. | Impaired concentration | | ☐ |
| iv. | Frequent sore throats | | ☐ |
| v. | Non-focal abdo pain | | ☐ |
| vi. | Diarrhoea | | ☐ |
| vii. | Constipation | | ☐ |
| viii. | Muscle pain/cramps/weakness | | ☐ |
| ix. | Bone pain | | ☐ |
| x. | Shortness of breath | | ☐ |
| xi. | Palpitations | | ☐ |
| xii. | Chest pain | | ☐ |
| xiii. | Amenhorroea | (periods stopped) | ☐ |
| xiv. | Cold intolerance | | ☐ |
| xv. | Cold extremities | | ☐ |
| xvi. | Hair loss | | ☐ |

Other physical worries:

Whilst all members of The Single Point of Access team can provide consultation, the Primary Mental Health Link Workers (PMHLWs) in the team also provide consultation to Universal (tier 1) and Targeted Services (tier 2) where a child or young person is not known to CAMHS and is aged between 11 – 18 years old. The PMHLWs can be contacted via the Single Point of Access Team on 0300 1245 012.

For young people known to the Youth Offending Team, or at risk of offending, the YOT Clinical Psychologist can provide consultation, advice and some direct work and can be contacted via the central YOT base on 01458 440820.

Once a case is open to CAMHS then the locality teams can be contacted on the numbers and addressed below.

## Contact details of CAMHS teams

CAMHS Single Point of Access
Foundation House
Wellsprings Road
Taunton TA2 7PQ
Tel: 0300 1245 012
Email: CAMHSSPA@sompar.nhs.uk

CAMHS East (Mendip)
Priory House
Priory Health Park
Wells BA5 1XL
Tel: 01749 836561 Fax: 01749 836563
Email: CAMHSMendip@sompar.nhs.uk

CAMHS Enhanced Outreach Team
Wessex House, Broadway Health Park,
Barclay Street, Bridgwater, TA6 5LX
Tel: 0300 124 5013
Email: CAMHSOutreach@sompar.nhs.uk

Primary Mental Health Link Work Team
Foundation House
Wellsprings Road
Taunton TA2 7PQ
Email: CAMHSLW@sompar.nhs.uk

CAMHS East (Yeovil)
Balidon Centre
Preston Road
Yeovil BA20 2BX
Tel: 01935 384140 Fax: 01935 411723
Email: CAMHSBalidon@sompar.nhs.uk

CAMHS Eating Disorders Team
Broadway Health Park, Barclay Street,
Bridgwater, TA6 5LX
Tel: 07770 571966
Email: CAMHSCEDS@sompar.nhs.uk

CAMHS West
Foundation House
Wellsprings Road
Taunton TA2 7PQ
Tel: 01823 368368 Fax: 01823 368552/4
Email: CAMHSWest@sompar.nhs.uk

National Deaf CAMHS
Foundation House
Wellsprings Road
Taunton TA2 7PQ
Tel: 01823 368525
Email: ndcamhstaunton@sompar.nhs.uk

The table below is provided as a guide to services available for children and young people presenting with particular areas of difficulty. Where it refers to universal (tier 1) and targeted services (tier 2) these include the following: health visiting, school nursing, parent and family support services (available via most schools) and Get Set (early help) services. Where it refers to Primary

Mental Health Link workers (PMHLWS) these are CAMHS professionals based across Somerset. To contact please ring your Single Point of Access on 0300 1245 012.

| Working formulation | Brief Description | Initial intervention from other Tier 1 /2 services (Universal and Targeted services) prior to CAMHS involvement | Service provided by Child & Adolescent Mental Health Service –Tier 3 |
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| Anxiety based disorders, generalised anxiety, social anxiety, panic attacks | Anxiety is the feeling of fear or panic. It is quite normal to feel anxiety when faced with something stressful, or a problematic situation however once the difficult situation is over you usually feel better. Anxiety becomes a problem when the worry, fear and feelings of panic do not go away once the fearful situation is gone, where it leads to feelings of depression, poor sleep and eating difficulties.<br><br>Physical symptoms of nausea, trembling, dry mouth etc are often associated with anxiety.<br><br>Anxiety can be linked to a family history of anxiety, a trauma or a physical or additional mental health difficulty. | Self help literature<br>www.rcpsych.ac.uk/mentalhealthinfo<br>www.anxietyuk.org.uk/<br>www.youngminds.org.uk/<br>Guided Self help literature available from PMHLWs. Can be used by PFSAs or LSAs in schools to run groups.<br>Mindful online counselling<br>www.mindful.org<br>Support and intervention from PFSA, School nurse or School counsellor where one is available.<br>Involvement of an Educational Psychologist.<br><br>Professionals can discuss concerns with Primary Mental Health Linkworkers (PMHLWS). | Where there are severe and persistent symptoms that have not responded to intervention at tier 2 or that are having a significant impact on the life of the young person, will be assessed by CAMHS and offered Cognitive behavioural therapy (CBT) based group interventions and individual therapy. |
| Obsessive Compulsive Disorder and Body Dysmorphic disorder | Many young people will have an “obsessive” interest in something or be compulsive in their behaviours. This may not be a problem but when this urge to do things repeatedly becomes a necessity and causes significant anxiety if they do not act on the obsession or compulsion then they may be developing OCD.<br><br>The most common obsessions focus on contamination, disasters and symmetry. | Self help literature<br>www.rcpsych.ac.uk/mentalhealthinfo<br>www.anxietyuk.org.uk/<br>www.youngminds.org.uk/<br><br>Guided Self help literature available from PMHLWs. Can be used by PFSAs or LSAs in schools to run groups.<br><br>Mindful online counselling<br>www.mindfull.org<br><br>Support and intervention from PFSA, School nurse or School counsellor where one is available | Where there is a moderate to severe impact on daily living, CAMHS will provide assessment and intervention as indicated. |

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| | The most common compulsions may involve rituals, washing or cleaning, checking or repetitive behaviours.<br><br>Body Dysmorphic disorder is an anxiety disorder where a person experiences such severe concerns about their appearance that it causes significant anxiety and leads to the development of routines and obsessive and compulsive behaviours. | Involvement of an Educational Psychologist.<br><br>Professionals can discuss concerns with Primary Mental Health Linkworkers (PMHLWS) | |
| Phobias | A phobia is a fear that results in substantial distress and in avoidance that impacts significantly on the young person's everyday life. | Self help literature<br>www.rcpsych.ac.uk/mentalhealthinfo<br>www.anxietyuk.org.uk/<br>www.youngminds.org.uk/<br><br>Support and intervention from PFSA or School nurse.<br><br>School counsellor where one is available.<br><br>Involvement of an Educational Psychologist.<br><br>Professionals can discuss concerns with Primary Mental Health Linkworkers (PMHLWS). | Severe and persistent symptoms, which are having a significant impact on daily functioning, that are identified through consultation or following direct intervention from Tier 2 will be assessed by CAMHS and appropriate advice and treatment offered. |
| School Refusal | Some young people have difficulties in attending school and have frequent and regular, or prolonged, absences and/or lateness. This can be due to numerous factors including bullying, poor self-esteem, worries about school work (possibly including unidentified learning difficulties) or worries about things at home leading to anxiety (including separation anxiety), angry outbursts or low mood. | Any issues around school attendance need to be discussed with the school first and any issues such as bullying or learning difficulties addressed. Support and intervention from the PFSA or Educational Psychologist can be helpful.<br><br>The school may wish to Initiate a EHA (Early Help Assessment) to co-ordinate support around a child or family find EHA webpage.<br><br>If problems persist concerns can be discussed with PMHLWs. | Where there are severe and persistent symptoms that have not responded to intervention at tier 2 or that are having a significant impact on the life of the young person, will be assessed by CAMHS. |

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| | | Where moderate to severe anxiety is identified as an underlying area of difficulty and the interventions offered by tier 2 professionals are not having enough impact then referral to CAMHS could be considered. | |
| **Depression** | Most young people experience times when their mood is low due to events going on in their lives. Some young people feel sad, lonely, down, anxious or stressed for prolonged periods of time and this can then impact on their everyday life to the extent that they develop depression. Symptoms include; not wanting to do things they previously enjoyed, avoiding friends and family, sleeping more or less than normal, eating more or less than normal, being irritable, upset and lonely, feeling hopeless, self critical, feeling tired all the time and perhaps wanting to self harm. Young children may present with regression in milestones, challenging behaviour or medically unexplained physical symptoms | Self help literature<br>www.rcpsych.ac.uk/mentalhealthinfo<br>www.anxietyuk.org.uk/<br>www.youngminds.org.uk/<br><br>Guided Self help literature available from PMHLWs. Can be used by PFSAs or LSAs in schools to run groups.<br><br>Mindful online counselling<br>www.mindfull.org<br><br>Support and intervention from PFSA, School nurse or School counsellor where one is available. Involvement of an Educational Psychologist.<br><br>Professionals can discuss concerns with Primary Mental Health Linkworkers (PMHLWS).<br><br>Mild symptoms - monitoring by universal Tier 1/2 professionals. | Where depression persists and does not respond to interventions at tier 2, or where symptoms are such that the impact on everyday life is severe or where there are concerns about extent of self harm or suicidal thinking persists then refer to CAMHS<br>CAMHS will provide assessment & intervention if indicated, including access to appropriate talking therapies<br>Medication may be initiated by a Consultant Child Psychiatrist, in consultation with young person, their family and other CAMHS practitioners who may be working with the young person. The GP will be informed. |
| Self-harm / self injury | Self-harm is a way of dealing with very difficult feelings that build up inside the child or young person and which they find hard to express or deal with in any other way. It can take a number of forms but most commonly presents as cutting or burning, bruising, taking an overdose of tablets, hair pulling or picking skin. | Most school nurses, PFSAs and school counsellors provide support for children and young people who self-harm as a way of coping with strong emotions and difficult experiences, where the self harm is mild to moderate, there is limited risk, and no underlying mental health difficulty (i.e. depression).<br><br>Training is provided to tier 2 professionals by the PMHLWs . training can be accessed via<br>https://www.learning-curve.co.uk/<br><br>Self help literature<br>www.rcpsych.ac.uk/mentalhealthinfo | Any self-harm or self injury that presents an actual or possible risk to life should be referred immediately to the Accident and Emergency Department. The jointly agreed protocol for the management of self-harm will be followed.<br><br>Where there is significant self harm or self injury related to moderate to severe depression or anxiety, refer to CAMHS. |

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| | | www.anxietyuk.org.uk/<br>www.youngminds.org.uk/<br><br>Useful websites:<br>National self harm network<br>www.nshn.co.uk | Assessment & treatment will be offered as required |
| Suicidal behaviour | Suicide is still a relatively rare occurrence however all people are susceptible to thoughts and feelings that can place them at risk of suicide. Young people who are depressed and/ or who have strong feelings of hopelessness and anger can have thoughts of suicide. | Professionals at tier 2 will talk with a child or young person experiencing suicidal thoughts and be able to support them if these thoughts are fleeting and not accompanied by an associated wish to die.<br><br>Sometimes suicidal thoughts are expressed, particularly by younger children when they are angry and upset because they are not allowed to do something.<br><br>When in doubt a professional should contact CAMHS directly or contact their primary mental health linkworker for advice.<br><br>ASIST training (Applied Suicide Intervention Skills Training) is an internationally recognised suicide prevention training program available in Somerset. For details of how to apply contact: | Where there is an expressed wish to take own life accompanied by corresponding risk taking behaviours and articulated plan and access to method this will require urgent assessment by CAMHS and may require a mental health act assessment. If there is felt to be an immediate risk to life then emergency services should be called. |
| Bi-polar Affective Disorder | Bi polar disorder is a serious condition associated with severe mood swings. These usually last several weeks or months and are far beyond what most people experience. It usually starts during the late teenage years or more often in adult hood. A person experiences feelings of intense depression or despair and feelings of extreme happiness and elation. It is not clear what causes bi polar disorder but it seems to be associated with genes. | GP assessment to exclude medical causes and to assess whether symptoms are severe or rather the more common experience of fluctuating mood that is noticed by many adolescents. | If significant numbers of indicators are present CAMHS will provide assessment & intervention as appropriate. |

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| Emerging borderline personality disorder | Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour | Please see sections relevant to clinical presentation such as self harm, suicidal behaviour, depression etc. | Assessment and treatment of co-morbid disorders will be undertaken by CAMHS or where there is significant risk to life or others. |
| Trauma and Post traumatic stress Disorder | Young people may develop PTSD if they experience something where they feel very frightened, helpless and fear they might die. Many young people who experience horrible things recover without experiencing PTSD but some go on to experience some troubling symptoms including: flashbacks or nightmares, behaviour changes such that they keep busy or preoccupied with other things to avoid having to think about the traumatic event, poor sleep, anxiety, irritability and fearfulness, hyper-vigilance, loss of appetite and depression. Young children may repetitively re-enact the trauma in play, | It is normal to experience symptoms of PTSD in the first few weeks following a trauma. "Debriefing" immediately after the trauma can make things worse. However keeping things as normal as possible, maintaining the usual routines, engaging in relaxing activities, exercising and spending time with family and friends all help.<br><br>Where symptoms are mild then professionals should "Watch and wait" offer support for 4-6 months before considering a referral.<br><br>If symptoms increase and despite a period of time since the trauma, the problems persist, then refer to CAMHS.<br><br>If related to domestic violence, consider involving the independent domestic violence advocate (for 16 years and over) 0800 6949 999.<br><br>If related to sexual abuse consider referral to Somerset and Avon rape and sexual abuse support service 0117 9250680. | Where symptoms persist and are having a significant impact on the young person's life or mental state, or the young person is felt to be depressed or having strong suicidal thoughts, then CAMHS will assess and offer treatment as indicated. |
| Feeding and Eating Difficulties and disordered eating Developmental or Emotional based eating Difficulties | Food Refusal, Restricted Eating or other developmental concerns | Early intervention is key to the successful treatment of an eating disorder so, GPs, and parents play an important role in identifying an emerging eating disorder.<br><br>If concerned about a possible eating disorder the GP should do a physical health check including a height, weight calculation as junior Marsipan guidelines See below (www.rcpsych@ac.uk/files/pdfversion/CR168.pdf) | CAMHS to provide assessment. |

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| Low weight as a result of other mental health difficulty (e.g. low mood, anxiety, vomit phobia)<br><br>ARFID | | | |
| Anorexia Nervosa (AN)<br><br>Bulimia Nervosa (BN)<br><br>Eating Disorder Not Otherwise Specified (EDNOS)<br><br>NB:<br>CEDS does not treat Obesity unless there is a co- existing mental disorder that is specified | Restriction of energy intake relative to requirement, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.<br><br>Intense fear of gaining weight or of becoming fat or persistent behaviour that interferes with weight gain, even though at a significantly low weight.<br><br>Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight. Bulimia nervosa is characterised by a persistent pre-occupation with eating and periods of over eating in which large amounts of food are consumed in short periods of time. Associated symptoms include - self-induced vomiting, purgative abuse, alternating periods of starvation, and use of drugs such as appetite suppressants. | Early intervention is key to the successful treatment of an eating disorder so, GPs, and parents play an important role in identifying an emerging eating disorder.<br><br>If concerned about a possible eating disorder the GP should do a physical health check including a height, weight calculation as junior Marsipan guidelines See below (www.rcpsych@ac.uk/files/pdfversion/CR168.pdf) | Possible referral to local paediatric service for medical review, which may result in short term admission on to paediatric ward if required, depending on concerns and severity.<br><br>The young person will be offered a CEDS assessment and from this a care and treatment plan will be developed and implemented.<br><br>A CEDS Care Co-ordinator will be appointed who will carry out medical monitoring of weight and BP.<br><br>Referral for appropriate psychological therapies.<br><br>CAMHS CEDS Consultant involved for medical review.<br><br>Referral to the CAMHS Outreach and Home Treatment Service if intensive home treatment is required inc medical monitoring, psycho education, meal planning and liaising with other service. |

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| Psychosis | Psychosis is a symptom of a serious mental illness. A person experiencing psychosis looses touch with what is accepted as reality, they may feel paranoid, hallucinate, hear voices or have delusions. It is associated with severe stress or depression, with a family history of serious mental illness and can be triggered by drug and/or alcohol use. People who develop psychosis usually have their first episode in their teens or early 20s. | Professional concerned that a young person may be experiencing a psychosis can contact the Somerset Team for early intervention is Psychosis on 01823 368555.<br><br>Young people with a first presentation of sustained psychotic symptoms, or symptoms causing severe distress, impacting on risk or associated with depression or manic symptoms can be referred to STEP or CAMHS and a joint assessment will be undertaken. | CAMHS will assess jointly with STEP and involve the CAMHS Psychiatrist. They will formulate a care and treatment plan as a result. |

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| Attention Deficit Hyperactivity Disorder (ADD / ADHD) | ADHD is a condition in which children find it very difficult to focus their attention or control their behaviour. They often act on impulse without thinking. All children behave in this way sometimes but with ADHD this behaviour is persistent, happens in every setting the child is in and starts usually when the child is a toddler and always before the age of six or seven.<br>There may be other reasons a child acts in this way. The child may be anxious or there may be problems at home or school. ADHD is a distinct condition, part of the make up of the child. | **West Somerset, Taunton Deane and Sedgemoor districts**: If child is 11 or below refer to Paediatricians at MPH for assessment.<br><br>**Mendip and South Somerset districts**: If presentation is mild to moderate with no other complicating factors then refer to Paediatricians at YDH. Schools may wish to involve the Social, Emotional and Behaviour Support advisory teachers or Educational Psychology Service. There is also an ADHD Guidance pack available.<br><br>**Mild emotional and behavioural difficulties**<br>Schools may wish to involve the Social, Emotional and Behaviour Support advisory teachers or Educational Psychology Service.<br><br>**Moderate-severe disturbance**<br>Schools may wish to involve the Social, Emotional and Behaviour Support advisory teachers or Educational Psychology Service. In addition parents should initially be advised to attend a Triple P parenting programme.<br><br>Professionals can discuss concerns with Primary Mental Health Linkworkers (PMHLWS). | **West Somerset, Taunton Deane and Sedgemoor districts**<br>For children between the ages of 11-18 (inclusive) CAMHS will provide an assessment & intervention if there are severe symptoms of ADHD which are having a significant impact on the child, his/her functioning and the social, educational and home environment, or where there are other mental health problems present as well.<br>Children aged 0-11 should be referred to the Paediatric Team at Musgrove Park Hospital for ADHD assessment.<br><br>**Mendip and South Somerset districts**<br>CAMHS will offer an assessment for children of any age where there are severe symptoms of ADHD which are having a significant impact on the child, his/her functioning and the social, educational l and home environment or where there are other mental health problems present as well. |
| Tic Disorders including Tourette's Syndrome | Tics are commonly experienced by young children and most tics subside as the child grows older. Some may persist and a young person may develop Tourettes syndrome. This is a physical condition characterised by chronic motor and vocal tics | Where the tics are mild and of short duration which are not having a significant impact on the child or young person take a watch and wait approach.<br>Where tics are mild but having some impact the child or young person may benefit from intervention from a tier 2 worker able to offer advice around stress management and relaxation.<br>Consultation with CAMHS Primary mental health linkworkers is available to support tier 2 staff with this work. | Where the tics are severe and symptoms are having a severe impact on the young person's life then referral to CAMHS may be appropriate for consideration of cognitive behavioural therapy (CBT) to help the young person control thoughts and emotions that may make the tics worse. |

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| | | For diagnosis discuss with your GP who may refer to a paediatrician to ensure there is no other underlying physical cause and would give a diagnosis if appropriate. | Severe tic disorders may need medication which may be prescribed by a CAMHS Consultant.<br><br>Complex Tourettes with a co-morbidity will be assesses and treated by CAMHS. |
| Mild Emotional and Behavioural difficulties | Generalised emotional and behavioural difficulties that are causing concern or distress or are impacting on health, development and welfare. | Universal and Targeted Services to offer assessment and support and access to Triple p or other parenting training program.<br><br>Access through Get Set services. | |
| Moderate – Severe disturbance of mental health and/or significantly challenging behaviour associated with intellectual impairment, genetic conditions or acquired brain injury | Learning disability is a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development. Challenging behaviour (including self-injurious behaviour) - culturally abnormal behaviours of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities. | Assessment and intervention by specialist/allocated school nurses | Where there are concerns that there is a significant mental health difficulty as well as the learning disability and/or challenging behaviour then a referral to CAMHS should be made. |
| Sexually harmful Behaviour (SHB) | Sexually harmful behaviour can be described as persistent sexual behaviour that infringes the rights of others. | Where the police have taken action in response to SHB YOT will lead on assessment and intervention planning and provision. | Where co-existing mental health difficulties are present, CAMHS practitioner or YOT psychologist may joint work with service leading on response to SHB. |

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| | | Where safeguarding concerns regarding SHB are present, and there is no police involved, children's social care will lead on assessment and intervention, in liaison with YOT.<br><br>Advice can be sought from the YOT regarding plan for assessment and intervention via universal and targeted services. | |
| Autistic Spectrum Condition (ASC) or other social Communication Difficulty | Autistic spectrum disorders are characterised by:<br><br>Social impairment which includes; qualitative impairments in reciprocal social interaction, inadequate appreciation of socio-emotional cues, lack of responses to other peoples emotions, lack of modulation of behaviour according to social context, poor use of social signals and lack of social emotional reciprocity. Communication impairment which includes; lack of social usage of language skills, impairment in make-belief and social imitative play, lack of reciprocity in conversational interchange, poor flexibility in language expression, lack of creativity and fantasy and thought processes.<br><br>Restricted and repetitive activities and interests, which include: resistance to change, insistence on routines and rituals, hand flapping and other stereotypy's, ordering play, attachment to unusual objects, fascination with unusual aspects of the world and | Advice can be sought from Autism, Speech, language and Communication Team advisory teachers.<br><br>Where there is evidence of impairment in the three areas mentioned in the description then a referral for a stage 2 assessment by the Community can be made.<br><br>Initial assessment of children referred re possible autism, see Appendix 1. | A CAMHS psychologist contributes to stage 3 assessments for the most complex children and young people. The decision to move from a stage 2 to a stage 3 assessment is made by the Pediatrician and specialist ASD following a stage 2 assessment. |

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| | consuming preoccupations with restricted subjects. | | |

Where the conditions below have been identified there would also need to be a co-existing mental health problem as listed above for a referral to CAMHS to be appropriate.

| **Working formulation** | **Brief Description** | **Interventions available from Tier 1 /2** | **Child & Adolescent Mental Health Service –Tier 3** |
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| Oppositional Defiant Disorder, (ODD) Conduct Disorder & Challenging behaviour | ODD is characterised by behaviours such as: a child or young person often loses their temper, argues with adults, defies adult requests, deliberately annoys others, shifts blame to others, touchy, easily annoyed, angry, resentful, spiteful or vindictive.<br><br>Conduct disorder and Challenging behaviour in this context can include: self-injurious behaviour, culturally abnormal behaviours of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities. | Children aged 7-11 can be referred to the Incredible Years parenting programme being piloted in the Health Visiting service.<br><br>Refer to a parent training course via the Get Set services.<br>For younger children Paediatric assessment may be indicated.<br>In complex cases, including those where the challenging behaviour is linked to cognitive impairment, consultation for children and young people aged 11 – 18 PMHLW can be sought to determine whether the client meets the referral to CAMHS due to the presence of a co-morbid mental health difficulty or because the behaviour is believed to be the way in which the client demonstrates mental distress. GPs and social workers can seek advice via the advice line. Behaviours believed to be primarily the result of a learning disability or a social communication difficulty will not warrant a referral in themselves. | |
| Enuresis and Faecal soiling | Enuresis: A disorder characterised by uncontrolled urinating, by day and/or by night, which is abnormal in relation to the child or young person's developmental stage and which is not a consequence of a neurological disorder, epileptic attacks or to structural abnormality of the urinary tract. | Initial physical screen by GP, Early stage of presentation should be signposted to Health Visitor or School Nurse for intervention. Referral to paediatrics and via them to the continence Nurse team. | |

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| | In primary enuresis children have never acquired normal bladder control, whereas a child who acquires bladder control for at least 6 months and then loses it again is said to have secondary enuresis.<br><br>Faecal soiling: Repeated voluntary or involuntary passage of faeces, in places not appropriate for that purpose in the child's own social cultural setting. Soiling more than once a month after the age of 4 is generally regarded as an elimination disorder. | | |
| Chronic Fatigue Syndrome (or ME) | An onset of unexplained, persistent fatigue unrelated to exertion and not substantially relieved by rest that causes a significant reduction in previous activity levels. | All suspected cases of CFS initially to be referred to General Paediatrics for medical physical assessment. This may result in referral on to the specialist CFS service and the involvement of the specialist OT.<br><br>Issues related to sleep and diet to be addressed by specialist OT. | For treatment of a co-existing mental health difficulty a baseline minimum of 4 hours needs to have been achieved for young person to be able to access treatment. |
| Substance Misuse | Problematic drug and alcohol use. | Young people presenting with drug or alcohol intoxication refer to substance misuse service SDAS http://www.somersetdap.org.uk/story/2014/02/03/making-a-referral-to-sdas/17/ | If the substance misuse is co-existing with a possible mental health difficulty, CAMHS will provide assessment and intervention as appropriate and co-work with specialist substance worker. |
| Palliative care | Emotional or psychological disturbance in response to a life limiting/life threatening condition in a child/young person. | Children with a diagnosis of diabetes across Somerset, cancer and cystic fibrosis who receive their care from Musgrove Park Hospital and children with diagnosed chronic conditions who receive their care from Yeovil District Hospital and are experiencing psychological distress into any aspect of their condition will be seen by the Paediatric psychologist. The Psychologist will refer onto | |

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| | | CAMHS where the distress/ mental health issue is not related to their condition.<br><br>Compass Team: 01823 344693 | |
| Emotional Distress around parental separation & Divorce | Emotional and behavioural disturbance around parental disharmony, separation and divorce – over several years. | Tier 2 professionals to advice and support. | |
| Bereavement | Abnormal or prolonged grief that has not responded to targeted interventions (severe and complex presentations). | Targeted Services to provide support and intervention. Eg CRUSE<br>Barnardos Mandala project (Michael Hammond 07584 347291).<br><br>Educational Psychology Services provide support for schools through Critical Incident support if needed and also provide training on this (ie planning for) and on bereavement.<br><br>Consider referral to PFSA and school counsellor. | If difficulties persist after a reasonable period of readjustment, refer to Tier 3 for assessment and treatment of co-morbid mental health problem or request a complex case consultation with the PMHLW. |
| Somatoform Disorder | Where there is a suspicion of actual or potential safeguarding concern (around neglect or emotional, physical or sexual abuse). | Refer immediately to Somerset Direct: **0300 123 2224**.<br>childrens@somerset.gov.uk<br>Text phone: 07781482858 | |
| Attachment Difficulties | Is characterised by persistent abnormalities in the child's pattern of social relationships, which are associated with emotional disturbance and reactive to changes in environmental circumstances. Fearfulness and hyper-vigilance that do not respond to comforting are characteristic, poor social interaction with peers is typical. Aggression towards to self and others is very frequent, misery is usual. The disorder occurs as a direct result of severe parental neglect, abuse, or serious mishandling. These children show strong contradictory | 0-8yrs Health Visiting service to work with the family using the Solihull approach.<br>Support and intervention from EP, including training from Educational Psychology Service on Attachment and Resilience.<br>Also Nurture Group training.<br>Consider initiating a EHA.<br>For adopted children referral to Somerset adoption support service and consider referral to Somerset consultation service: 0800 587 9900. | |

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| | or ambivalent responses that may be most evident at times of partings and reunions. In disinhibited attachment disorder children show an unusual spread of selective attachments during the first five years and this is associated with generally clinging behaviour in infancy and/or indiscriminately friendly, attention seeking behaviour in early or middle childhood. | | |

## Other useful links

Somerset Local Offer
http://somerset.local-offer.org

Somerset Education Support Services
https://slp.somerset.org.uk/sites/ess/SitePages/Home.aspx

Somerset Mental Health Tool Kit
http://www.somersethealthinschools.co.uk/index.php?page=mht