

Core Child and Adolescent Mental Health Services (C-CAMHS)

Referral Support and Guidance





Contents

Section One – Overview of C-CAMHS

Section Two – CYP Emotional Health & Wellbeing

Section Three – Pan-Dorset C-CAMH teams

Section Four – Making a referral to C-CAMHS

Section Five – Other Pan-Dorset CYP services

Section Six – Engagement and choice

Section Seven – C-CAMH Screening Criteria

Section Eight – C-CAMH referral screening checklist

Section Nine – C-CAMH referral guidance

Section One

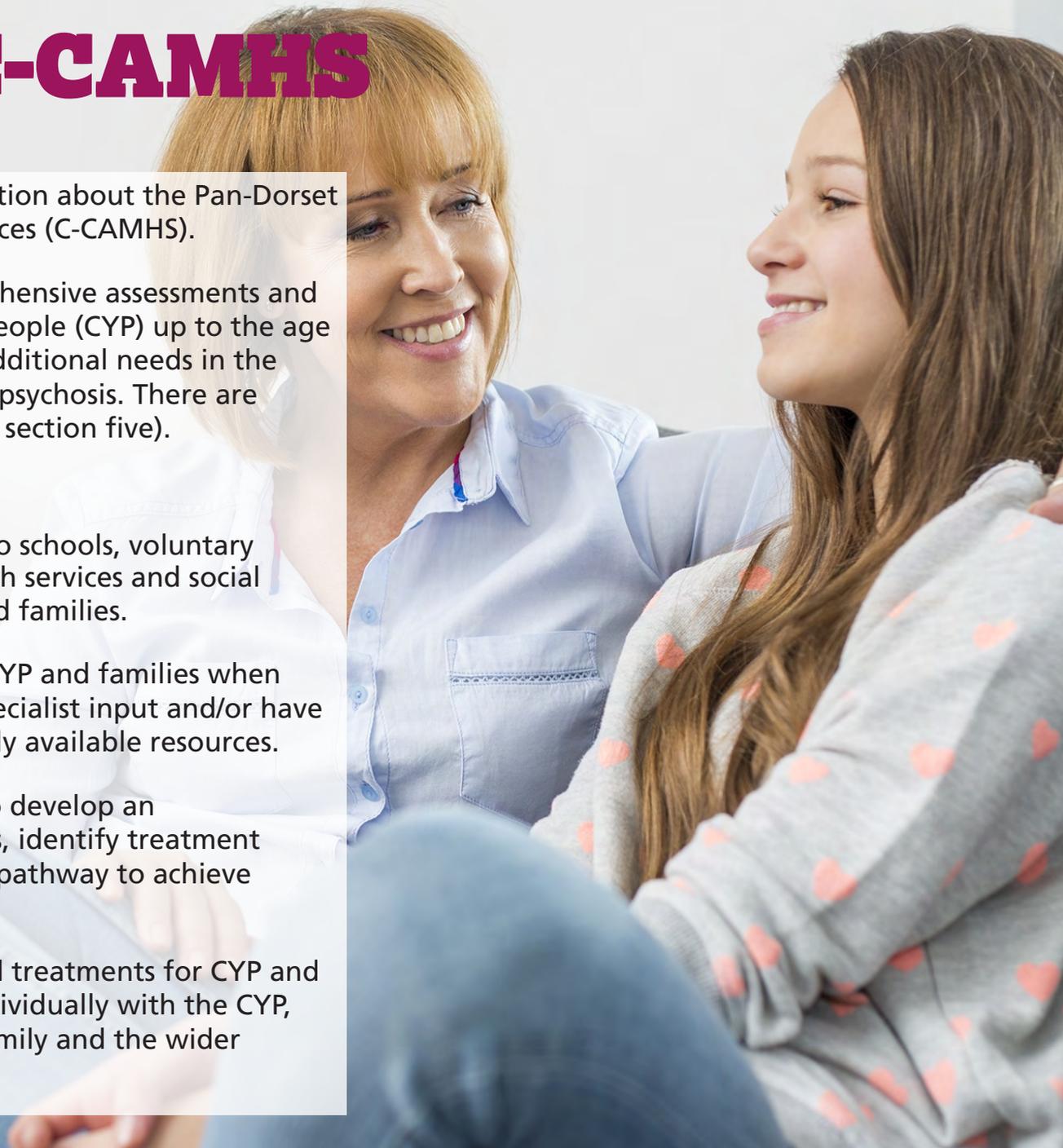
Overview of C-CAMHS

This document provides guidance and information about the Pan-Dorset Core Child and Adolescent Mental Health services (C-CAMHS).

The C-CAMH service provides specialist comprehensive assessments and therapeutic interventions for Children, Young People (CYP) up to the age of 18 yrs and their families who do not have additional needs in the areas of: eating disorder, learning disability or psychosis. There are specialist services for each of these groups (see section five).

What does C-CAMHS do?

- Offers specialist consultation and training to schools, voluntary organisations, primary care, children's health services and social care on mental health needs of children and families.
- Provides comprehensive assessments with CYP and families when the emotional health difficulties require specialist input and/or have not responded to support from immediately available resources.
- Works jointly with CYP and their families to develop an understanding of the presenting difficulties, identify treatment goals and select the most appropriate care pathway to achieve these goals.
- Offers specialist therapeutic evidence-based treatments for CYP and their families. This may involve working individually with the CYP, or with parents/carers or with the whole family and the wider system around the child.



Section Two

CYP Emotional Health & Wellbeing

- The Pan-Dorset C-CAMH service has adopted the THRIVE model of care, and has moved away from the tiered model of care (tiers 2 to 4).
- The THRIVE model looks to provide a service based on need. The model was designed by the Tavistock and Portman clinic, and has been embraced as a transformed model of C-CAMH service delivery and treatment. The principles of the THRIVE model are shown below:



- Adopting the THRIVE model across Pan-Dorset C-CAMHS aims to steer services towards promoting resilience and early intervention. Moving away from a tiered model helps to remove the largely artificial divisions between providers (schools, health and community). Subsequently, a comprehensive network of community and 3rd sector providers become central elements of the model, and partnership working is reinforced.

Section Three

Pan-Dorset C-CAMHS teams

Pan-Dorset C-CAMHS provides a specialist multidisciplinary mental health service to children, adolescents and their families. There are six teams:

North

Blandford Community Hospital
Betty Highwood Unit
Milldown Road
DT11 7DD
01258 394149

West

Children's Centre
Damer's Road
Dorchester
DT1 2LB
01305 255705

Weymouth & Portland

Weymouth Community Hospital
Chalbury Ward
3 Melcombe Avenue
Weymouth
DT4 7TB
01305 762810

Bournemouth & Christchurch

Shelley Clinic
22 Tower Rd
Boscombe
BH1 4LB
01202 646300

East

Delphwood
Ashdown Close
Poole
BH17 8WG
01202 605882/605883

Poole

Poole Community Health Clinic
Shaftesbury Road
Poole
BH15 2NT
01202 584600



Section Four

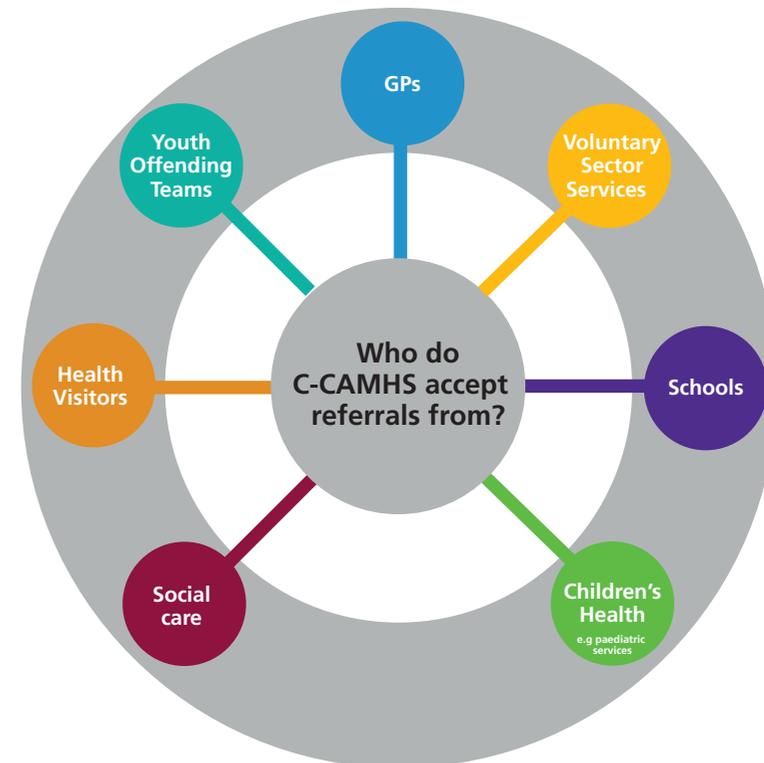
Making a referral to C-CAMHS

When making a referral, the Pan-Dorset C-CAMH service expect that:

- The referrer has met the child
- The child and/or family have given consent for the referral to be made
- The referrer has made some assessment of the child/ young person and family's motivation to engage in a therapeutic service
- First-line interventions e.g. support from school, community-based parenting support, local youth groups have been tried and the difficulties remain unchanged and/or have worsened
- If there are any safeguarding concerns, the referrer has completed an assessment and/or made a referral to MASH (Multi-agency Safeguarding Hub).

The preferred referral route is to use the online form found at www.dorsethealthcare.nhs.uk/CAMHS but written referrals will also be accepted. Once received the referral will be reviewed by a screening team.

All accepted referrals will be offered an assessment appointment within 8 weeks. Emergency referrals where there is a likelihood of significant harm will be prioritised and be seen sooner according to need.



Section Five

Other Pan-Dorset CYP services

Core CAMHS is part of a wider network of children's emotional health and wellbeing services. For information about specific referral guidance and service contacts, please see the table below:

Service	Contact information
Young People's Eating Disorder Service (YPEDS) Service information website: http://www.dorsethealthcare.nhs.uk/services/pages/children-and-families/eating-disorders-service-young-people.htm	Kimmeridge Court St Ann's Hospital 69 Haven Rd, Poole, BH13 7LN Tel: 01202 492415 Email: dhc.eatingdisorders@nhs.net
CYP Early Intervention Psychosis Service (EIS) *For young people 14+ Service information website: http://www.dorsethealthcare.nhs.uk/services/pages/children-and-families/early-intervention-and-family-work.htm	49 Alumhurst Rd Westbourne, BH8 4EP Tel: 01202 584336 Email: dhc.EIS@nhs.net

Service	Contact information
<p>CAMHS Learning Disability Service http://www.dorsethealthcare.nhs.uk/learning-disability/contact-us/children-ld-services/east-dorset.htm</p>	<p>Seastone House 49 Alumhurst Rd Westbourne, BH8 4EP</p> <p>Tel: 01202 584353 Email: dhc.clds@nhs.net</p>
<p>CAMHS SWIFTS - Outreach Community Service *Learning disability with behaviours that challenge</p> <p>http://www.dorsethealthcare.nhs.uk/learning-disability/contact-us/children-ld-services/west-dorset.htm</p>	<p>Marvin House Winterbourne Monkton Dorchester, DT2 9PS</p> <p>Tel:01305 228981 Email: dhc.swifts.dorchester@nhs.net</p>
<p>CAMHS Inpatient Service Referrals cannot be made directly to this service</p> <p>http://www.dorsethealthcare.nhs.uk/services/pages/children-and-families/pebble-lodge-in-patient-service.htm</p>	<p>Pebble Lodge 49 Alumhurst Rd Westbourne, BH8 4EP</p> <p>Tel: 01202 545400</p>

Section Six

Engagement and choice

In the majority of cases the choice about whether to accept an appointment to be seen in C-CAMHS lies solely with the child/young person. In cases where there is considerable risk, or the CYP lacks capacity (e.g. experiencing psychosis) decision-making may need to be deferred to appropriate adults. Support and provision may be delivered indirectly in such cases if the CYP is unable, or unwilling to engage but stabilisation is crucial.

We will always make every effort to encourage children and young people to meet with a member of the C-CAMHS team, and we are mindful that they may feel anxious about this. If, despite our efforts, the child/young person says they do not want help from C-CAMHS, we will respect this.

Additional support can be offered to parents/carers, and to the wider system, e.g. schools, if that is felt useful as an indirect way of supporting the child/young person.



Section Seven

C-CAMHS Screening Criteria

- The THRIVE model identifies interventions based on level of need, and seeks to establish partnership working where that is the most useful approach for the child and family.
- The C-CAMHS team will allocate an assessment appointment based on need, judged by:
 - The IMPACT of the symptoms/difficulties
 - The DURATION of the symptoms/difficulties
 - The CONTEXT of the symptoms/difficulties

The level of need is assessed against each of these areas, as shown below.

IMPACT

- The emotional health and wellbeing difficulties need to have a noticeable and substantial impact on a number of areas of functioning.
- Interventions for single symptom presentations (e.g. sleeping difficulties, minor eating problems, toileting issues) would not meet C-CAMHS criteria and should be provided by universal or targeted services (e.g. primary care, local service teams) in the first instance.

DURATION

- Where the child/young person's symptoms have been present for less than 3 months, an intervention at universal or targeted level of service should be tried first (which may include advice or consultation from specialist C-CAMHS).
- Where the child/young person's symptoms persist beyond this time, and/or they are non-responsive to first line interventions (e.g. school support, community services) they should be referred to C-CAMHS
- NB: A child/young person should be seen urgently if there is a reported sudden onset of symptoms, symptoms are causing substantial distress or there is probable risk of harm to self or others due to level of difficulty.

CONTEXT

- We will consider systemic or complex risk factors such as parental mental health, history of abuse, family disruption, care status (to include unaccompanied asylum-seeking children).
- Understandable or time-limited reaction to external stresses (e.g. bereavement, family breakdown, physical illness) should be addressed in universal or targeted services.

Section Eight

C-CAMHS referral screening checklist

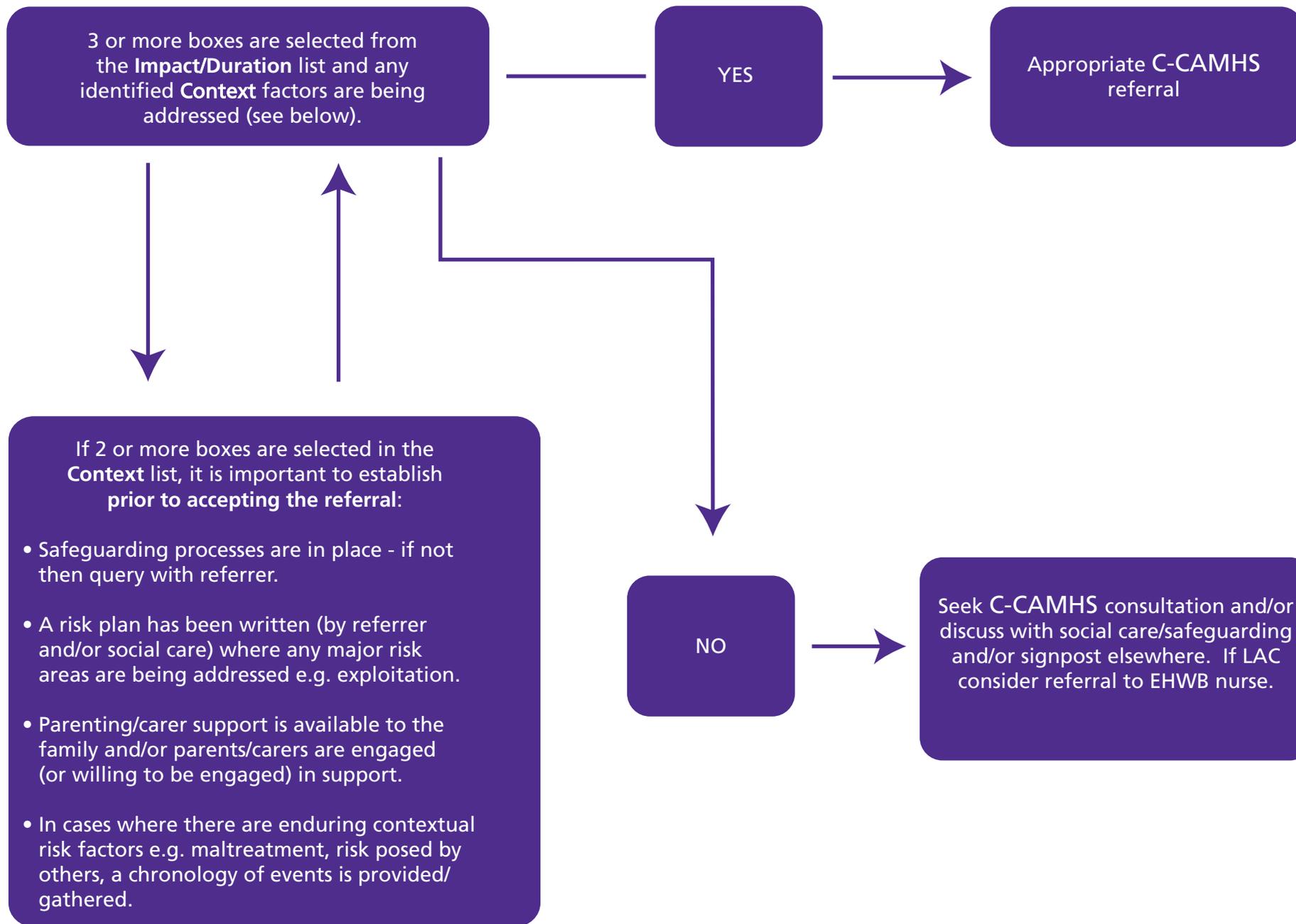
The checklist below can be used at the point of referral and/or screening to establish what the level of need is, and whether involvement from C-CAMHS would be beneficial for the child/young person and family.

Impact and Duration

- Difficulties in emotional and behavioural wellbeing have been present for 3 months or more (not in high risk cases and/or where dramatic change in mood or behaviour has been evident)
- Evidence to show that the difficulties are having a definite, noticeable and ongoing impact on the child's functioning
- Evidence that the difficulties are present in a number of areas of functioning: e.g. school, home and social situations
- Difficulties are worsening/persisting despite front line interventions being in place e.g. ELSA in school, community parenting support, GP directed self help

Context

- Evidence of difficulty (acute or chronic) within the family system e.g. parental mental health issues, maltreatment, social deprivation, social isolation
- Evidence of recent typical external stressors e.g. family breakdown, bereavement, exams, hospital visits (past or impending) where sufficient time has been allowed for the child to adjust and/or recover with help from immediately available resources
- Concerns of risk that is ongoing e.g. domestic abuse, physical chastisement, significant substance use, exploitation, risks posed by significant others
- Child is an unaccompanied asylum seeker (UASC) and/or is a looked after child (LAC)



Section Nine

C-CAMH referral guidance

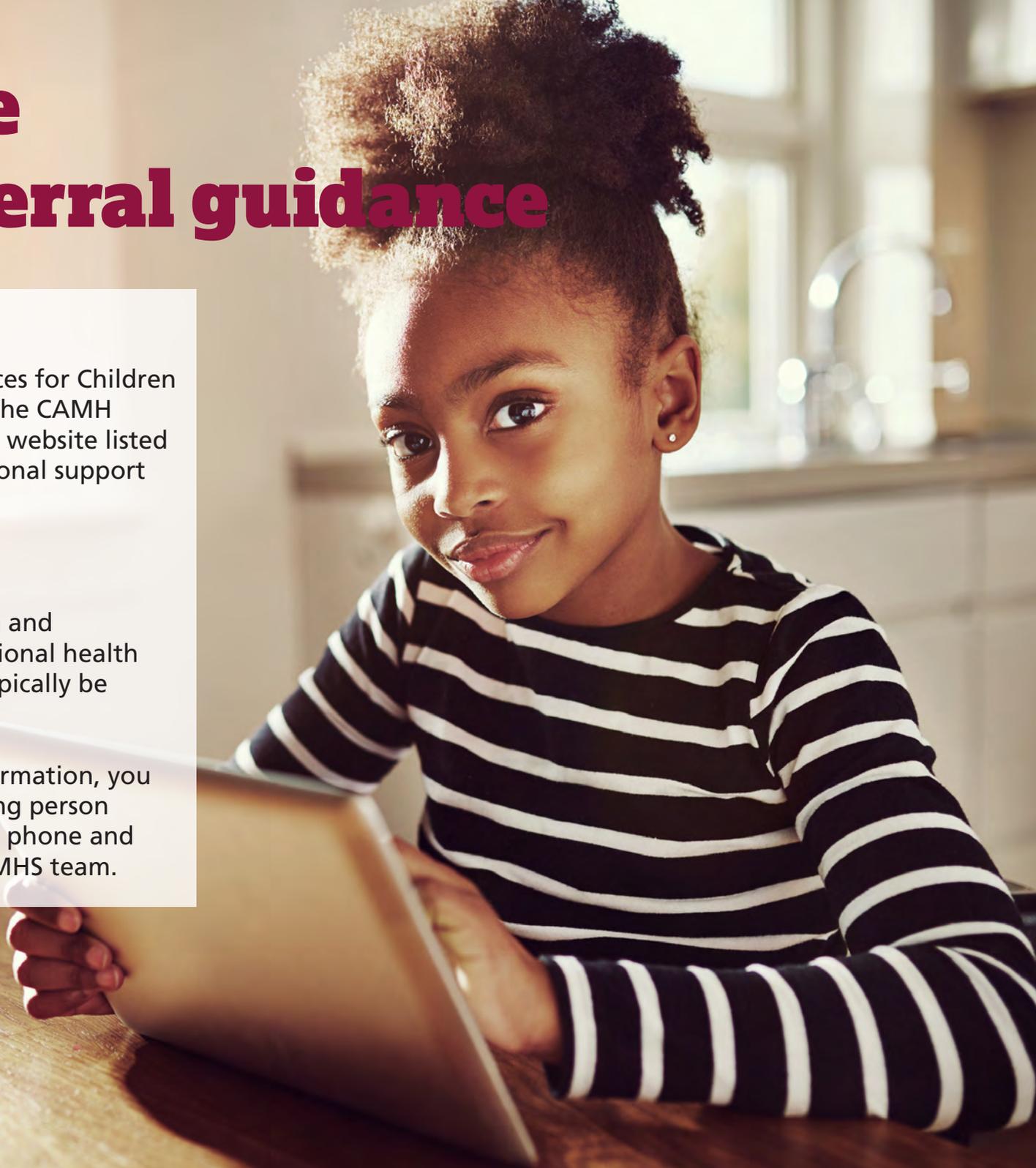
Referral Guidance

For further information regarding services for Children and Young People in Dorset, including the CAMH teams and provision, please refer to the website listed below to provide information on additional support services:

www.dorsethealthcare.nhs.uk/CAMHS

The table overleaf provides information and guidance about the different CYP emotional health and wellbeing difficulties that would typically be assessed and treated by C-CAMHS.

If, after reviewing all the following information, you are still uncertain about whether a young person meets the C-CAMHS criteria then please phone and discuss this with a member of the C-CAMHS team.



Area of need – Anxiety

Persistent worries and fears expressed verbally, could relate to health, social settings, separation from a care giver. Phobias about specific objects or environments.

Persistent worries and fears can be expressed non-verbally:

- Agitation and/or aggression
- Avoidance
- Physical symptoms without a medical cause
- Change to sleep pattern and appetite

Generalised anxiety disorder is characterised by excessive worry about a number of different events, associated with increased tension, restlessness, sleep problems and problems concentrating. Symptoms should be present for at least 6 months.

See also:

- Neurodevelopmental difficulties
- Attachment difficulties

Guidance for referrer

Anxiety and worry is an extremely normal emotional response to a range of situations e.g. change in school, exams, hospital visits etc and in most cases will resolve with time and support from family, friends and schools.

Social anxiety is assessed differently to include consideration of fear, avoidance, distress and functional impairment. Note overlap with avoidant personality disorder, autistic spectrum conditions, substance use and psychosis.

Give consideration to long-term conditions if health anxiety suspected e.g. diabetes.

Additional sources of support:

www.youngminds.org.uk

www.anxietyuk.org.uk

www.moodjuice.scot.nhs.uk/anxiety.asp

www.minded.org.uk

www.anxietybc.com

Mindshift is an excellent website and downloadable App for young people - NICE: QS53 and CG159 (social anxiety)

Area of need – Attachment Difficulties

In the context of child development where early developmental core needs are not adequately met e.g. food/water, safety, stimulation, comfort. Developmental traumas evident e.g. chronic illness, parental mental health, abuse/maltreatment/neglect

CYP does not communicate their needs in a clear and effective manner. Emotional dysregulation evident and poor coping mechanisms for managing emotions.

Persistent and repetitive pattern of maladaptive interpersonal deficits causing significant barriers in forming functional relationships with others. See also:

- PTSD
- OCD
- Neurodevelopmental difficulties

Guidance for referrer

Attachment difficulties can be difficult to identify, especially CYP who adopt largely avoidant strategies and therefore make attempts to hide/ suppress their emotions. A comprehensive assessment is required.

Establish presence and/or possibility of the availability of a secure base prior to commencing any therapeutic programmes with the child. Many interventions do not directly involve the child as involve parents/carers solely.

The context of the CYP provides evidence that core needs have not been appropriately and consistently met.

NICE: NG26 and CG89

Area of need – Bipolar Disorder

The following difficulties must be evident:

- Mania: episodes of over-activity, disinhibition (episodic and sustained behaviour changes)
- Euphoria must be present, on most days, for most of the time for a period of 7 days.

A risk assessment should be completed if risk areas are present.

See also:

- ADHD
- Psychosis

Guidance for referrer

A diagnosis of BD in young people should be made after an intensive and long period of monitoring. Irritability is not a core diagnostic criterion.

A diagnosis should not be made on the evidence of a depressive state with a family history of bipolar disorder. If BD is suspected in a child <14yrs, refer straight to CAMHS. For a young person 14yrs + then they may be seen by CAMHS or the EIS if there is a query around psychosis underlying the mood disorder (see section five for contact details).

www.youngminds.org.uk

www.minded.org.uk

www.rcpsych.ac.uk

www.moodjuice.scot.nhs.uk/depression.asp

NICE: CG185 and QS102

Area of need – Conduct Disorder

Children from aged 3yrs (childhood onset) or from 13yrs (adolescent onset)

Repetitive and persistent pattern of behaviours in which the basic rights of others are violated, with at least 3 of the following criteria evident in the past 12 months and at least one in the past 6mths:

- Physical aggression/intimidation
- Use of weapons
- Physical cruelty to people and/or animals
- Theft while confronting a victim e.g. mugging
- Forced someone into sexual activity
- Destruction of property e.g. fire setting, deliberate damage
- Deceitfulness or theft
- Serious violation of rules: running away from home, truant (before aged 13yrs)

See also: • PTSD • Attachment difficulties
• Neurodevelopmental difficulties

Guidance for referrer

The behavioural problems are not associated with learning difficulties and/or pure neurodevelopmental difficulties. Explore whether a language assessment has been completed, based on research highlighting difficulties in reading ability. Refer to SaLT if not completed. It is important to complete a comprehensive assessment for children and families with a suspected diagnosis of CD. Research has repeatedly demonstrated a strong link between CD behaviours and trauma, maltreatment, attachment difficulties and chronic disruption. Children demonstrating behavioural difficulties that are independent from chronic and debilitating emotional health issues would not be suitable for C-CAMHS. In such cases, please contact Action for Children who also offer family support and parenting programmes.

www.actionforchildren.org.uk

www.youngminds.org.uk/psaytoolkit

Parenting & Family support: www.familylives.org.uk

Parentline offers free 24/7 helpline & web info (parenting advice and guidance: www.parentlineplus.org.uk

NICE: CG158

Area of need – Depression

Typical symptoms:

- Loss of interest in previously enjoyed activities
- Reduced energy/increased tiredness
- Low mood

Common symptoms

- Reduced concentration and attention
- Reduced self-esteem and confidence
- Ideas of guilt
- Bleak and pessimistic views of the future
- Ideas or acts of self-harm or attempted suicide
- Disturbed sleep
- Reduced appetite
- Agitation
- A feeling of being slowed down (psychomotor retardation)

For a diagnosis: symptoms must be present for 2 weeks

Guidance for referrer

Depression in children and young people can be a serious issue, but it is also important to distinguish between low mood and associated behavioural disturbance (which can be quite typical in young people) and signs of a more serious mental health difficulty. Relationship difficulties, falling out with friends, bullying, not doing well at school and in exams/assessments, difficulties at home (with parents or siblings), the loss of someone close, hormone and bodily changes, moving home/school, low self-esteem are all typical events that may impact mood.

For more information for young people on mental health see:
www.beatingtheblues.co.uk (please note that charges apply)
www.youngminds.org.uk www.minded.org.uk

Explore evidence of more serious events happening such as:
Experience of abuse, exploitation, significant substance use.
NICE: QS48 and CG28
Self-Help guide: www.moodjuice.scot.nhs.uk/depression.asp

Area of need – Eating Disorder

There is a specialist YPEDS service for CYP who fulfil the following diagnostic criteria and all cases should be discussed with YPEDS before allocation:

- Excessive restrictions over diet
- Excessive exercise/laxative use
- Body Dysmorphic Disorder
- Anorexia Nervosa
- Bulimia
- Please complete medical investigations and include these details in the referral which **must** be made using specific YPEDS referral form.
 - o Height
 - o BMI
 - o Current weight and previous weights if known
 - o Bloods (FBC, U&E, LFT, Bone, TFT, Magnesium, Phosphate)

Guidance for referrer

Criteria for Urgent (to be seen within 48 hours)

- Severely physically compromised
 - o Abnormal bloods
 - o Abnormal examination
 - o Abnormal ECG
- Rapid weight loss - <1kg per week
- Weight for height <80%

Refer to YPEDS (see section 5 for contact details).

A thorough assessment is required. CYP who are fussy eaters would not meet criteria, but such behaviour could mask a more significant mental health issue. If hoarding behaviours are evident and/or binge eating that does not meet urgent criteria, explore past traumas, loss and disruption. See relevant pathways. Further information see: UK Eating Disorders Association
www.b-eat.co.uk www.youngminds.org.uk
www.youthheathtalk.org/young
NICE: CG189, CG9 (8yrs+) and CG31 (BDD)

Area of need – Gender Identity Disorder

- Uncertainties around own gender and identity
- Requests to be called by another name that more suitably represents the preferred gender/changes in appearance to reflect gender choice.
- Anxiety and/or depression in the context of uncertainties, distress and family response.

Guidance for referrer

A number of CYP experience uncertainties around their gender, which should be normalised and appropriate community support services identified. Specialist services are warranted for severe and enduring cases, where a referral is made to the specialist clinic at the Tavistock and Portman Hospital.

For information & advice:

The Queer Youth Network is a national organisation run by and for young people with questions about their gender and sexuality. www.queeryouth.org.uk

www.youngminds.org.uk

Mermaids supports young people up to the age of 19 who are trying to cope with gender identity issues and their families and carers. www.mermaidsuk.org.uk

The Gender Identity Research and Education Society - www.gires.org.uk

Various informative leaflets can be downloaded, including Gender Dysphoria – An Introductory Guide for GPs and Health Professionals from www.gendertrust.org.uk

Area of need – Neurodevelopmental Difficulties (NDD)

This may include:

- Autistic spectrum conditions (ASC)
- ADHD
- FASD
- Tics and Tourette's

If ASC are suspected, then the following should be evident:

- Social communication difficulties
- Impairments in non-verbal language capacity e.g. lack of eye contact, incongruent body language
- Rigid and structured patterns of behaviour that create distress if are interrupted/changed (and are separate from controlling type behaviours due to significant anxiety)
- Developmental delay (evident when taking early history)

If ADHD is suspected then symptoms of hyperactivity/impulsivity and/or inattention should be:

- associated with at least moderate psychological, social and/or educational or occupational impairment
- pervasive; occurring in two or more important settings e.g. school and home.

If FASD suspected, evidence of maternal alcohol use during pregnancy is required.

See also:

- Attachment difficulties
- PTSD
- Social Anxiety

Guidance for referrer

If NDD are queried, then co-morbid emotional wellbeing difficulties **must** also be present to fulfil criteria for a C-CAMHS intervention. These may include:

- Anxiety
- Depression
- PTSD
- OCD
- Panic

As part of the diagnostic process for ADHD, include an assessment of the person's needs, co-existing conditions, social, familiar and education/occupational circumstances and physical health.

For children and young people there should also be an assessment of the parent/carers mental health.

The symptom criteria for ADHD should be adjusted for age-appropriate changes in behaviour.

Additional web support services:

www.autismwessex.org.uk

www.fasdtrust.co.uk

www.autism.org.uk

www.tourettes-action.org.uk

www.youngminds.org.uk

www.tourettes-action.org.uk

NICE: QS51 (ASC) QS39/CG72 (ADHD)

Area of need – Obsessive Compulsive Disorder (OCD)

Characterised by repetitive and rigid behaviours (compulsions) in the context of a fixed set of thoughts (obsessive ruminations/intrusions).

Behaviours significantly interfere with successful functioning e.g. rituals may take several hours.

The ruminations and compulsions are unwanted, and create a high level of distress and/or are disabling for the child.

Guidance for referrer

Children and young people can develop OCD type behaviours when going through a transition e.g. new school, or if a big change has occurred e.g. family breakdown, loss. Children who experience ongoing disruption in their lives can also display repetitive and restricted behaviours, but wouldn't be diagnosed with OCD as they are driven by a need to be in control.

In cases of disrupted routines, establishing normal routines may be very effective - www.ocdyouth.ipo.kcl.ac.uk

The key element to evidence a diagnosis of OCD is the function of the rituals and/or compulsions that the child feels driven to perform.

The function is typically to prevent/promote the occurrence of an event, and/or to reduce the anxiety associated with this belief. If not evident, consider attachment and/or anxiety.

For further information visit: www.ocduk.org
www.youngminds.org.uk; OCD Action (www.ocdaction.org.uk)

Area of need – Panic Disorder

Evidence of recurring, unforeseen panic attacks followed by at last 1 month of persistent worry about having another panic attack. Evidence of concerns about the consequences of a panic attack i.e. fear of dying, losing control.

At least 2 unexpected panic attacks are necessary for a diagnosis.

See also:

- Anxiety
- PTSD

Guidance for referrer

Panic is momentary and mostly lasts up to 10 minutes maximum. It can be very frightening but symptoms lasting longer than this timeframe are indicative of a different area of need e.g. anxiety.

Evidence of significant behaviour change following a panic attack. Symptoms can be triggered by a fear of vomiting, or social fears.

www.youngminds.org.uk
www.MindEd.org.uk
www.nopanic.org.uk

Area of need – Post Traumatic Stress Disorder (PTSD)

PTSD can develop following a highly stressful and/or traumatic event/s where the child perceives that significant danger and/or harm could occur.

For a diagnosis of PTSD, the following must be evident:

1. Hypervigilance and/or emotional numbing
2. Avoidance behaviours
3. Flashbacks/intrusions of the trauma

The above elements may be evidenced by:

- Disturbances to sleep (sleep avoidance, nightmares, early waking)
- Resistance to going to particular places where the event happened
- Avoidance of feared stimuli e.g. car (if trauma was a car crash)
- Reliving the event as if it was happening/re-enactment through play (for younger children)
- Physical symptoms with no medical cause
- Substance use

See also:

- Anxiety
- Depression

Guidance for referrer

Events that are difficult and stressful such as divorce, loss, failing an exam would not be considered to be sufficient for a diagnosis of PTSD. Mild symptoms that have been present for less than 4 weeks would not warrant a C-CAMHS intervention and a period of watchful waiting is advised. Follow-up to be arranged within 1 month.

Interventions for PTSD should not be withheld or delayed because of court proceedings or applications for compensation. For those children/young people who are considered high risk of developing PTSD (e.g. asylum seeking children) a brief screening tool e.g. Impact of Events Scale should be used at 1 month after the traumatic event/s.

There is a need to consider the developmental stages: younger children may display fewer avoidance behaviour or re-enactment and their distress is demonstrated by more behavioural symptoms e.g. aggression, sleep disturbance. Treatment for co-morbid difficulties such as anxiety, depression and substance use where there is also a trauma event are as important for the treatment of PTSD.

Is there evidence that the child/young person is still exposed to the stressor/trauma e.g. living in a household where domestic violence occurs, having contact with perpetrator etc. If so, contact social care and recommend interventions to provide a safe place for the child before any therapeutic intervention can commence.

Info for young people on mental health: www.youngminds.org.uk
Assistance Support & Self-help in surviving Trauma (Uk Based info for PTSD): www.assisttraumacare.org.uk
Online leaflets on Post traumatic stress disorder, facts & coping:
www.rcpsych.ac.uk/mentalhealthinfo/problems/ptsd/posttraumaticstressdisorder.aspx (facts)
www.rcpsych.ac.uk/mentalhealthinfo/problems/ptsd/posttraumaticstressevent.aspx (coping)

NICE: QS116 (Domestic violence and abuse)

Area of need – Psychosis

This is relatively rare in children and young people.

Characterised by:

- Delusions (false fixed beliefs)
- Hallucinations (sounds, visions, taste, sensory)
- Bizarre and/or unusual ways of thinking e.g. the radio is talking to them, they can read people's mind/insert thoughts
- Disorganised speech
- Disorganised behaviours

See also:

- Depression
- PTSD
- Emerging Personality Disorder
- Bipolar disorder

Guidance for referrer

Refer to specialist C-CAMHS if symptoms present and sustained (4 weeks or more).

Consider referral to the Early Intervention Service (EIS) for those young people with 1st episode psychosis (see section 5 for contact details).

Note the impact of chronic substance use, especially cannabis (skunk in particular) and hallucinogens e.g. ecstasy.

Explore family functioning/impairment. Establish safeguarding principles and assess for exploitation.

Develop appropriate risk plans.

For further info:

www.rcpsych.ac.uk
www.MindEd.org.uk

www.YoungMinds.org.uk

NICE: QS102 (Oct 2015) and CG155 (May 2016)

Area of need – Selective Mutism

- Evidence of limited speech: the child does not speak in at least ONE social setting (after having mastered speech and communication)
- Age 3yrs+
- Can be associated with anxiety and can be a trauma response.

See also:

- Social Anxiety
- PTSD
- Neurodevelopmental difficulties

Guidance for referrer

Initial referral to be sent to Speech and Language Service for assessment. There is additional evidence of an emotional well-being difficulty that is having an impact on social, relational and educational experience. If SM felt to be symptomatic of underlying emotional health need e.g. trauma, social phobia then consider referral to C-CAMHS and/or completing a joint piece of work.

Refer to Educational Psychology if difficulties predominantly present in educational setting.

For further info:

www.YoungMinds.org.uk
www.MindEd.org.uk



Dorset HealthCare University NHS Foundation Trust
Sentinel House
4-6 Nuffeld Road
Poole
BH17 0RB

01202 277000
dorsethealthcare.nhs.uk
 @DorsetHealth