APPENDIX 1

UPDATE ON CHILD AND ADOLESCENT MENTAL HEALTH (CAMHS) SERVICES TIERS 1-4

Extract from Guidance for Commissioners of Child and Adolescent Mental Health Services (JCP-MH) October 2013

What would a good child and adolescent mental health service look like?

Model of Service Delivery
While there is no prescribed 'best practice' model, and services need to relate to local need and circumstances, a good CAMHS should be able to provide care that is:

- Timely – delivered without long (internal or external) waits for interventions appropriate to the age and needs of the child or young person.
- Effective – have sufficient numbers of staff with the right skills to be able to offer evidence based interventions that meet the needs and goals/wishes of children, young people and families.
- Efficient – with a delivery model that best focuses the capacity of the service to the demands of the population.

Access

- There should be clear care pathways with agreed referral processes and signposting.
- Staff within universal and targeted services should be able to discuss potential referrals and receive advice and support through supervision/consultation.
- There should be close working links between targeted and specialist services (including education and local authority children's services, as well as voluntary sector services) to facilitate easy, smooth transfer between the different service tiers, as well as joint working.
- There should be strategies to reach out to groups historically less likely to access CAMHS which are tailored to the particular needs of local populations
- There should be 24 hour services/on-call provision.
- There should be agreement on emergency provision including assessment facilities in Accident and Emergency, place of safety during assessment and access to emergency inpatient beds.

Strategic direction

- Good clinical and managerial leadership should be in place to provide the operational and strategic direction for the team.
- At a multi-agency level there must be commitment to delivering integrated services both in terms of strategic direction and appropriate resourcing (this will require not only effort on the part of CAMHS, but also by multi-agency partners, and commissioners should play a central role in ensuring this occurs).
- Involving young people in planning services is key.

Provision

- There should be an appropriate range of services. These include 'sub-specialist' services for children with learning disabilities, acute hospital liaison services for children with serious and chronic physical illness, services for children and young people with Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD) (which may be provided jointly with community child health/community paediatrics), infant mental health services (which may be provided as part of multi-agency early years provision), eating disorder services,

substance misuse services, and community adolescent forensic services (this is not an exhaustive list and there may be additional needs).

- There should be services which are able to offer more intensive interventions than standard care to children and young people who may otherwise require admission to hospital – these include acute crisis care, but could include services for young people requiring more intensive treatment over a longer period of time (eg young people who are housebound, young people with severe eating disorders, or young people who repeatedly self-harm).
- The commissioning footprint for the sub-specialist services may be larger than the population the CCG is responsible for – in such situations individual CCGs will need to jointly collaborate and doing this can reduce the need for more expensive packages of care by preventing escalation up the care pathway.
- A critical mass of staffing is essential – standard 9 of the National Service Framework recommended that a generic specialist multi-disciplinary CAMHS at Tier 3 with teaching responsibilities and providing evidence-based interventions for 0-17 year olds would need a minimum of twenty whole time equivalent clinical staff (WTEs) per 100,000 total population, while a non-teaching service required a minimum of 15 WTE clinical staff.
- It is unlikely that a fully comprehensive, flexible service (in terms of both offering routine appointments outside traditional hours and at a location other than the clinic) which can offer timely access can be achieved with fewer resources.
- Local geography should be taken into account – where teams cover dispersed populations over a large geographical area, travelling time needs to be factored in when calculating staffing profiles.
- Teams should include a range of skills in both assessment and treatment, including child and adolescent psychiatrists, clinical psychologists, CAMHS nurses, CBT therapists, child psychotherapists, family therapists, creative therapists (depending upon the local team remit/need for access to occupational therapists and speech and language therapists who may be embedded in the team).
- A variety of therapeutic skills are needed, including behavioural, cognitive, interpersonal, psychodynamic, pharmacological and systemic approaches – there is a growing evidence base of interventions that have a positive effect on mental health outcomes for children and young people.
- Services should be provided in appropriate, safe, child/young person centred surroundings.
- There should be good support and development for all staff through supervision, appraisal, continuing professional development (CPD) and mentoring.
- Services should be part of a peer network such as the Quality Network for Community CAMHS (QNCC) and the CAMHS Outcomes Research Consortium (CORC).
- The services need to be sustainable in terms of recruitment and retention.
- Many services have a role in relation to training and workforce development, and this is vital in meeting the needs of future generations.
- Adequate administrative support should be available to the team to maximise the clinical time available for children, young people and their families.

Discharge/transition

- Discharge planning should receive equal attention to referral processes, including where appropriate services/agencies can offer on-going support.
- Clear processes should be in place for young people who will require intervention and support in adult life, and the young person should be involved in the decision making.

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Outcomes, evaluation and feedback

- All services should have a system of routinely collected patient outcomes as recommended by the Children and Young People's Health Outcomes Forum further supported by the Government response 'Improving Children and Young People's Health Outcomes; a system-wide response to the Report of the Children and Young People's Health Outcomes Forum'.
- Such outcomes are one aspect of quality which should also include measures of patient, user and carer experience.
- The information from these outcome measures should be used by clinicians to guide on-going interventions, and used by service managers to improve service provision.
- Many services are already implementing some system of outcomes monitoring.
- The Children and Young People's Improving Access to Psychological Therapies (IAPT) project is:
    - Mandating the collection of a national agreed outcome framework for participating services (these are used on a high frequency, or a session-by-session basis).
    - Using outcome data in the direct supervision of the therapist, to determine the overall effectiveness of the service (and produce service 'benchmark' data).
    - Making these outcome tools, data-sets and guidance available at www.iapt.nhs.uk.
- The CAMHS Outcome Research Consortium (CORC) is a collaboration between CAMHS which use an agreed common set of measures to routinely evaluate outcomes from at least three key perspectives (the child, the parent/carer and the practitioner).
- Effective outcomes monitoring requires administrative and clinical time, commitments, as well as IT resource which must be accounted for in commissioning.

Outcome measurement is one aspect of service evaluation. Others include patient/carer experience, audit, monitoring of adverse events and serious incidents.