Joint Commissioning Panel for Mental Health

www.jcpmh.info

Guidance for commissioners of child and adolescent mental health services

Practical mental health commissioning
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Ten key messages for commissioners

1. The moral and economic case for interventions to improve children and young people’s mental health and wellbeing has been known for some time. However, despite increased investment in recent years, shortfalls in service capacity remain and there is evidence of disinvestment.

2. Commissioners will need to use the levers of legislation to maintain investment and develop services to meet the mental health needs of children and young people. The first Mandate from the Government set NHS England the objectives of:
   - putting mental health on a par with physical health
   - closing the health gap between people with mental health problems and the population as a whole
   - extending and ensuring more open access to the Improving Access to Psychological Therapies (IAPT) programme, in particular for children and young people.

3. Mental health problems which begin in childhood and adolescence are not only common but can have wide-ranging and long-lasting effects. These can lead to significant distress, poorer educational attainment and employment prospects, social relationships, and longer-term physical and mental health problems. A number of disorders are persistent and will continue into adult life unless properly treated. It is known that 50% of lifetime mental illness (except dementia) begins by age 14. Fortunately there is a growing evidence-base for a range of interventions which are both clinically and cost effective.

4. Child and adolescent mental health services (CAMHS) are provided through a network of services which includes:
   - universal services such as early years services and primary care (Tier 1 CAMHS)
   - targeted services such as youth offending teams, primary mental health workers, and school and youth counselling (including social care and education) (Tier 2 CAMHS)
   - through to specialist community CAMHS (Tier 3 CAMHS)
   - and highly specialist services such as inpatient services and very specialised outpatient services (Tier 4 CAMHS).

5. Referral rates to Tier 3 CAMHS have increased greatly in recent years, with the number of cases rising by more than 40% between 2003 and 2009/10.

6. As CAMHS is a multi-agency service, a multi-agency approach to commissioning is required. Changes in one agency or one part of the system can affect demand and delivery in another. This interdependency can create risks if not properly considered but also brings with it the possibility of agencies working together to better meet the needs of the populations they serve, and achieve wider system efficiencies.

7. CAMHS can only provide the services that they are commissioned to provide. Therefore CAMHS should be planned and commissioned as integrated, multi-agency services with care pathways that enable the delivery of effective, accessible, holistic evidence-based care.

8. Commissioners will need to liaise with colleagues responsible for other children’s health services, as well as schools and local authorities. In many areas, voluntary sector organisations provide services for children, young people and families often at the targeted service level (Tier 2 CAMHS). Such services may have complex funding arrangements and it is important this aspect of provision is not overlooked.

9. There will be considerable information available from the local CAMHS strategy and needs assessment, service specifications, and contracts to orientate new commissioners.

10. Involving children and young people and parents/carers in commissioning and service design (as well as providing feedback to services) can help commissioners prioritise and identify any gaps and blocks to access, and assist providers in improving services and evaluating change. Commissioners should consider the diversity of the populations they are responsible for – not simply cultural and ethnic diversity, but all of the factors which may both influence the risk of developing mental health problems as well as those which need to be taken into account in the design and delivery of services.
Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. The JCP-MH brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- people with experience of mental health problems and carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- Afiya Trust
- British Psychological Society
- Representatives of the English Strategic Health Authorities (prior to April 2013)
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning

The JCP-MH is part of the implementation arm of the government mental health strategy No Health without Mental Health. The JCP-MH has two primary aims:

- to bring together people with experience of mental health problems, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, the experience and viewpoints of people with mental health problems and carers, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published Practical Mental Health Commissioning, a briefing on the key values and principles for effective mental health commissioning
- has published twelve other guides on the commissioning of primary mental health care services, dementia services, liaison mental health services to acute hospitals, transition services, perinatal mental health services, public mental health services, rehabilitation services, forensic services, drug and alcohol services, community specialist mental health services, acute care (inpatient and crisis home treatment), and older people’s mental health services
- provides practical guidance and a developing framework for mental health commissioning.

WHO IS THIS GUIDE FOR?

This guide describes what ‘good looks like’ for a modern child and adolescent mental health service (CAMHS).

It should be of value to Clinical Commissioning Groups (CCGs) and NHS England.

HOW WILL THIS GUIDE HELP YOU?

This guide has been written by a group of CAMHS experts. The guide primarily covers commissioning of specialist CAMHS by CCGs, but it also partly refers to other elements of the CAMHS system.

Much of the guide is evidence-based and includes reference to the expert documentation completed by the National CAMHS Support Service. Ideas that are felt to be best practice by expert consensus are included.

By the end of this guide, readers should be more familiar with the concept of CAMHS and better equipped to understand:

- what a good quality, modern, service looks like
- why a good CAMHS delivers the mental health strategy and the Quality Innovation Productivity and Prevention initiative – not only in itself but also by enabling changes in other parts of the system
- the benefits of CAMHS to children, young people, their families and carers
- why CAMHS are important for commissioners.
What are child and adolescent mental health services?

Comprehensive mental health services for children and young people should:
- cover all ages (pre-birth to 18)
- address all emotional, behavioural and mental health disorders
- provide for children and young people with intellectual disabilities
- work across all interfaces – education, social care, youth justice, paediatrics and child health (including acute care, community child health, primary care, substance misuse, and adult mental health)
- address all levels of severity from prevention and early intervention through to intervention for children and young people with severe and complex problems
- support other agencies/professionals working with children and young people
- be prepared to focus on the relationships and systems surrounding the child or young person (rather than simply taking an individual-based approach)
- work through networks, collaboration and pathways with other agencies.

STRUCTURED TIERS

The structure and operation of CAMHS can appear complex at first. This is often because its organisation differs from both: (a) traditional secondary care mental health services for adults and (b) physical health services for children and young people (specifically in regard to multi-agency relationships and interdependencies).

The structure of CAMHS is therefore often best explained in terms of how a child or young person accesses the service, with four ‘tiers’ of service provision:
- universal services (Tier 1) – these include general practitioners, primary care services, health visitors, schools and early years provision. Such professionals should be able to:
  - promote mental well-being
  - recognise when a child or young person may have developmental or mental health problems that a universal service cannot meet
  - and know what to do when this is the case.

Universal services are commissioned by health and local authority children’s services and may be provided by a range of agencies.

- targeted services (Tier 2) – these services include mental health professionals working singularly rather than as part of a multi-disciplinary team (such as CAMHS professionals based in schools, or paediatric psychologists in acute care settings). In addition, Tier 2 services include school counsellors and voluntary sector youth counselling services.

Targeted services also include services provided for children and young people with milder problems. These are often provided by primary mental health workers (as outreach from Tier 3 CAMHS) who may work with the child or young person directly or indirectly by supporting professionals working in universal services.

Targeted services also include those provided to specific groups of children and young people who are at increased risk of developing mental health problems (e.g. youth offending teams and looked after children’s teams).

It should be noted, that although community paediatrics and child health services represent secondary care provision, they may also be defined as Tier 2 CAMHS. This is because they often take the lead for children with developmental disorders and attention deficit hyperactivity disorder (ADHD), with children and young people with more complex problems being referred into Tier 3 services.
Targeted services are commissioned and provided by a range of agencies, although arrangements will vary across the country and according to the nature of the service.

- **specialist CAMHS (Tier 3)** – these are multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions. Access to the specialist team is often via referral from a GP, but referrals may also be accepted from schools and other agencies, and in some cases self-referral. Specialist CAMHS can include teams with specific remits to provide for particular groups of children and young people including:
  - CAMHS learning disability teams
  - community forensic CAMHS
  - adolescent substance misuse teams
  - crisis/home treatment teams working intensively to prevent admission to hospital
  - paediatric liaison teams providing CAMHS input to children and young people in acute care settings.

Specialist services are usually commissioned and provided by the health sector, although there is generally a contribution from other agencies.

- **highly specialist services (Tier 4)** – these include day and inpatient services, some highly specialist outpatient services, and increasingly services such as crisis/home treatment services which provide an alternative to admission. Such services are often provided on a regional or supra-regional basis.

In addition there are a small number of very highly specialised services including medium secure adolescent units; services for children/young people with gender dysphoria; CAMHS services for children and young people who are deaf; and highly specialist obsessive compulsive disorder services. Each of these services will have been commissioned on a national basis to date.

**COMMISSIONING FOOTPRINT**

The ‘commissioning footprint’ is the size of the population over which a service is most effectively and efficiently provided. For CAMHS, the size of this footprint will not only vary, but will also reduce with progression through the tiers.

From 1 April 2013, CCGs were expected to commission Tier 1-3 services where appropriate in tandem with other agencies. Tier 4 CAMHS and the other highly specialised services are directly commissioned by the NHS England. Specialist substance misuse services for young people will be commissioned by local authorities.

The focus of this guide is primarily on Tier 2 and 3 CAMHS services which CCGs are expected to provide.

**Similar presentations, different interventions**

Similar presenting problems in children may have very different underlying causes. This can require different interventions (see box 1). For those unfamiliar with commissioning CAMHS, this can cause confusion. However, it is vital that all agencies work together, and that (a) where children and young people require intervention from more than one agency or (b) where children and young people require referral from one agency to another, that this is (c) experienced as a smooth transition.

**Everybody’s business**

All professionals working with children and young people have a responsibility to help them be emotionally and mentally healthy – whether it is a teacher in a primary school helping a child who is being bullied, a youth counsellor helping a young man who is depressed and without a job, a GP considering if a young woman is experiencing early signs of psychosis, a paediatrician caring for a child with diabetes whose treatment adherence is poor, or a social worker working with a child who has just been received into care.

Anxiety, for example, may be the result of environmental factors – such as bullying in school, parental disharmony, or even abuse (physical, sexual or emotional) – or the result of internal psychological states (such as negative thinking styles).

In most cases, a mix of individual and environmental factors are likely to be at play. It is vital to develop an understanding of the different factors underlying the psychological distress for the particular child (the formulation) in order to judge the most appropriate intervention.

So for the child with a negative thinking style, individual cognitive behavioural therapy (CBT) provided by a mental health professional would be an appropriate intervention.

But for the child presenting with anxiety due to abuse, the most appropriate first line intervention would be by social care to ensure the child is protected.

In other cases where school or family stressors are leading to anxiety in the child, the most appropriate first-line intervention may be the family or school, although in both instances direct work with the child may be required as a second-line intervention.

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**BOX 1: SIMILAR PRESENTATIONS, DIFFERENT INTERVENTIONS**

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Why are child and adolescent mental health services important to commissioners?

There are four main reasons why CAMHS are important to commissioners:
1. Prevalence
2. Risk factors
3. Evidence of effectiveness

1. PREVALENCE

One in ten children aged five to 16 has a clinically significant mental health problem. Problems most relevant to children and young people are:
- Emotional disorders (e.g. phobias, anxiety, depression)
- Conduct disorders (e.g. severe defiance, and physical and verbal aggression, and persistent vandalism)
- Obsessive compulsive disorder
- Attention deficit hyperactivity disorder
- Other behavioural problems
- Tic disorders and Tourette's syndrome
- Autism spectrum disorders (ASD)
- Substance misuse problems
- Eating disorders (e.g. pre-school eating problems, anorexia nervosa and bulimia nervosa)
- Post-traumatic stress disorder
- The psychological effects of living with a chronic illness
- Somatisation disorders
- Psychosis
- Emerging borderline personality disorder.

Comorbidity
Some children experience more than one mental health problem (comorbidity). This can make assessment, diagnosis and treatment more complex.

The 2004 ONS survey found that one in five children with a mental disorder were diagnosed with more than one of the main categories of mental disorder. The most common combinations were conduct and emotional disorder and conduct and hyperkinetic disorder.

Persistence
Mental health problems and disorders in childhood can have high levels of persistence: 25% of children with a diagnosable emotional disorder, and 43% with a diagnosable conduct disorder, still had the problem three years later according to a national study. Persistence rates in both cases were higher for children whose mothers had poor mental health (37% and 60% respectively). In particular, receiving consistent support from a trusted adult is a strong protective factor.

2. RISK FACTORS

Mental health problems in children and young people are the result of complex interactions between constitutional factors (including genetic factors) and environmental factors with the relative contributions varying by disorder and by individual.

Although any child or young person can develop a mental health problem there are individual and family/social factors and experiences which can increase vulnerability to developing mental health problems (see box 2).

Although children and young people in these groups may be at higher risk, this does not mean that as individuals they are all equally vulnerable to mental health problems.

A range of protective factors in the individual, in the family, and in the community influence whether a child or young person will experience problems. In particular, receiving consistent support from a trusted adult is a strong protective factor.
3 EVIDENCE OF EFFECTIVENESS

As noted above, mental health problems which begin in childhood and adolescence are not only common but can have wide-ranging effects causing distress, affecting educational attainment and employment prospects, social relationships and longer-term physical and mental health.

Fortunately there is a growing evidence-base and a range of interventions which are both clinically and cost effective.

The National Institute for Health and Clinical Excellence (NICE) has produced a number of detailed clinical guidelines to guide intervention in mental health problems occurring in children and young people. However, although there is a growing evidence-base for interventions with children and young people, there are still areas where the evidence-base is scant.

Importantly, both the model of interventions used (e.g. CBT, medication, family therapy) and the way the clinician works in collaboration with a family or young person (the therapeutic or working alliance) can have a significant effect on clinical outcomes. Thus services need to be commissioned and designed in such a way that allows full provision of evidence-based interventions as well as facilitating the development of good therapeutic relationships.

BOX 2: RISK FACTORS FOR DEVELOPING A MENTAL HEALTH PROBLEM: CHILDREN AND YOUNG PEOPLE

Risk factors include:

- living with a long-term physical illness or disability:
  - approximately 11% of children experience significant chronic illness, including chronic mental health disorders\(^{26}\), while 10-13% of adolescents report living with a chronic condition that substantially limits their daily life\(^{26}\)
  - living with a severe physical illness impacts on young people themselves, their emotional and social development, and their families
  - children living with a long-term physical illness are twice as likely to suffer from emotional or conduct disorders\(^{24}\)

- children and young people with intellectual disabilities are at increased risk of developing additional mental health problems

- children and young people with autism spectrum disorders are also more likely to develop a co-morbid mental health problem

- children and young people who are looked after by a local authority (often because of family breakdown) have much higher rates of mental health problems

- children and young people who have experienced abuse and neglect

- children and young people in contact with the criminal justice system

- having a parent with a mental health problem

- having a parent with a substance misuse or alcohol problem

- having a parent in prison

- being from low-income households, families where parents are unemployed, or where parents have low educational attainment

- being a refugee or asylum seeker

- being from traveller communities

- young people who are lesbian, gay, bisexual or transexual (LGBT).

4 THE ECONOMIC CASE

There is compelling evidence of the cost benefits of using evidence-based interventions. Using conduct disorder as an example:

- by the time a person is 28 years old, individuals with persistent antisocial behaviour (evident at age ten) will have cost society ten times as much as those without the condition\(^{27}\)

- parent education and training programmes can have good medium to long-term effects at a relatively low cost, by a cost factor of £8 saved to every £1 spent if the costs of crime are included\(^{27}\)

- if services had intervened early for just one in ten of the young people sentenced to prison each year, public services could save over £100 million annually\(^{28}\).
What do we know about current child and adolescent mental health services?

The moral and economic case for early intervention to improve children and young people’s mental health and wellbeing has been known for some time. However in a difficult financial climate there is a danger of disinvestment in services.

Commissioners will need to use the levers of legislation, statutory guidance and policy to help maintain investment and develop services to meet the mental health needs of children and young people.

**LEGISLATIVE LEVERS**

The legislation which relates to children and young people is complex. Different laws apply, depending on the age, competence and capacity of the child or young person. Commissioners of mental health services for under-18 year olds need to have a working knowledge of the following:

- the Children Act 2004
- the Mental Capacity Act 2005
- the Mental Health Act 1983 (as amended in 2007)
- the Health and Social Care Act 2012

**STATUTORY GUIDANCE**

Commissioners must take account of statutory guidance when planning and commissioning services.

CAMHS health commissioners and providers work very closely with colleagues in local authority children’s services. There is considerable guidance in place which sets out the expectations for CAMHS health providers working with colleagues.

The following are important documents for health commissioners:

- *Working Together to Safeguard Children*[^29]
- *Statutory Guidance on Promoting the Health and Well-being of Looked After Children*[^30]
- *Statutory guidance on securing sufficient accommodation for looked after children*[^31]
- *Support and aspiration: A new approach to special educational needs and disability*[^31].

The legislation and statutory guidance sit within a policy framework which reinforces the importance the government places on the provision of good mental health services across the lifespan of an individual.

**POLICY FRAMEWORKS**

The policies of the current government have built on those of the previous administration, but with some important differences. The National Service Frameworks[^32] and targets which drove interest and improvement have been replaced by an emphasis on delivering better outcomes that are meaningful to patients and users, rather than simply the measurement of activity and process. The following therefore need to be read carefully:

- *No Health Without Mental Health: a cross government mental health strategy for all ages*[^4]
- *Support and Aspiration: a new approach to special educational needs and disability– Progress and next steps*[^31]
- *Improving Children and Young People’s Health Outcomes : a system wide response to the Report of the Children and Young People’s Outcomes Forum*[^33]
- *Healthy Lives Health People – our strategy for public health in England*[^34]
- *Foundation Years Policy Statement*[^29]
- *The Munro Review*[^35]
- *Review of commercialisation and sexualisation of childhood*[^36]
- *Positive for Youth – a new approach to cross governmental policy for 13–19 year olds*[^37]
- *Drug Strategy Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*[^38]
- *Improving Health Services for Children in the Criminal Justice System*[^39].

As CAMHS sits within a complex multi-agency network, commissioners need to monitor both health policy and policy in others areas (which may not be directly health-related but will nevertheless impact on CAMHS).

More directly, the performance of NHS commissioners will be monitored against the following policy documents:

- the Government’s Mandate to NHS England [www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf](www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf) which sets the ambition to give children the best start in life. It also sets an objective for NHS England to put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole. As part of pursuing this objective, it asks NHS England to extend and ensure more open access to the Improving Access to Psychological Therapies (IAPT) programme, in particular for children and young people, and for those out-of-work
- the NHS Operating Framework which contains a commitment to early intervention to improve mental health services[^40].

[^29]: Working Together to Safeguard Children
[^30]: Statutory Guidance on Promoting the Health and Well-being of Looked After Children
[^31]: Statutory guidance on securing sufficient accommodation for looked after children
[^32]: National Service Frameworks
[^33]: Improving Children and Young People’s Health Outcomes
[^34]: Healthy Lives Health People – our strategy for public health in England
[^29]: Foundation Years Policy Statement
[^35]: The Munro Review
[^36]: Review of commercialisation and sexualisation of childhood
[^37]: Positive for Youth – a new approach to cross governmental policy for 13–19 year olds
[^38]: Drug Strategy Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life
[^39]: Improving Health Services for Children in the Criminal Justice System
[^4]: No Health Without Mental Health: a cross government mental health strategy for all ages
[^31]: Support and Aspiration: a new approach to special educational needs and disability– Progress and next steps
[^33]: Improving Children and Young People’s Health Outcomes
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[^38]: Drug Strategy Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life
[^39]: Improving Health Services for Children in the Criminal Justice System
[^4]: No Health Without Mental Health: a cross government mental health strategy for all ages
What do we know about current child and adolescent mental health services? (continued)

Much of the revenue for CAMHS sits within existing budgets held by CCGs and local authorities. There are additional resources within health, social services and education which can be used to fund CAMHS at universal, targeted and specialist levels including:

- the Early Intervention Grant which focuses on early intervention and prevention services
- the CAMHS grant now within the Local Revenue Support Grant
- the Pupil Premium to fund services in schools to support children with mental health or behavioural difficulties
- Health Visiting increases to support parents to bond well with their children and identify families at risk who require extra support
- Children and Young People’s IAPT project – unlike adult IAPT programmes, this project does not create separate new services but seeks to transform existing CAMHS through a package of support for service transformation, training in evidence-based therapies and to introduce regular sessional monitoring
- the Complex Families project – aimed at the 120,000 most complex families, encouraging pooled budgets and work to effect change in chaotic families.

**CQUINs**

The Commissioning for Quality and Innovation (CQUIN) scheme aims to ensure that quality improvement and innovation form part of commissioning discussions and delivery.

CQUIN works alongside other financial levers which, when used together, reinforce an overall approach to improving quality and encouraging innovation. CQUIN is intended to encourage ambition and continuous improvement beyond the minimum.

For an example of CQUIN for transition by young people from CAMHS, see Planning Mental Health Services for young adults improving transitions: [www.nmhdu.org.uk/silo/files/planning-mental-health-services-for-young-adults--improving-transition.pdf](http://www.nmhdu.org.uk/silo/files/planning-mental-health-services-for-young-adults--improving-transition.pdf)

**HORIZON SCANNING**

Commissioners operate in an environment where initiatives and policy come thick and fast. Commissioners are often the bridge between the commissioning organisation and the providers, and need to keep themselves up-to-date to fulfill their responsibility to commission within a statutory framework in line with the requirements of NHS operating guidance.

To keep abreast of developments, commissioners may benefit from subscribing to newsletters created by CHIMAT who send out regular updates divided into policy, research and news. These include Children and Young People’s Policy, for CAMHS, for Learning Difficulty and CAMHS and Perinatal and Infant Mental Health. [www.chimat.org.uk/default.aspx?QN=CHMK9](http://www.chimat.org.uk/default.aspx?QN=CHMK9)

CAMHS commissioners may also find the following areas of particular interest over 2013–14:

- CAMHS currencies. Payment by Results (or tariff-based care) is already in place in the acute sector, and is moving into adult mental health services. There is a project underway to define currencies for CAMHS to ensure that the particular complexity of CAMHS is reflected in the clusters and pathways which underpin currency development for the future.
- Children and Young People’s IAPT Project. The project will continue till March 2015, and information about outcomes will begin to flow from the first CYP IAPT sites, allowing the methodology to be refined further.
- NHS England will further develop scopes and specifications for Tier 4 CAMHS, Tier 4 CAMHS Autistic Spectrum Disorders services and CAMHS secure services.
- Raising Participation Age – from 2013 all young people will be required to participate in education until the end of the academic year in which they turn 17, and from 2015, from their 18th birthday. Areas which have yet to make the changes required by the National Service Framework for Children and Maternity for CAMHS to cover children up to their 18th birthday will need to consider how such services adapt to ensure they link appropriately with colleagues in education.

**QUALITY AND PRODUCTIVITY CHALLENGE**

The QIPP programme presents an opportunity to make improvements in the quality of transitions and the outcomes for young people and their families, as well as achieving cost savings. There is also guidance from the Department of Health – *The economic case for improving efficiency and quality in mental health* – which highlights the economic savings that can follow from effective intervention in the early years.41,42
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.

Knowing what to provide is key (see page 16), but the following areas and principles will be of assistance to all CAMHS commissioners.

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 hr services/on-call provision

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 ADHD and 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 local needs)
- 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.

There are numerous sources of information and support that commissioners can draw on to ensure they have accurate and up-to-date information – see ‘assessing the level of need’ section in www.chimat.org.uk/camhs/commissioning

**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 (see box 3).

**BOX 3: HOW CAN YOU INVOLVE CHILDREN AND YOUNG PEOPLE IN COMMISSIONING?**
CAMHS Commissioners will find a wide range of tools and partners who can help in developing participation of children and young people and their parents in commissioning at www.chimat.org.uk/camhs/commissioning and www.myapt.org.uk Local authorities, voluntary sector organisations and increasingly NHS services have established user and carer groups who can help commissioners understand services and identify gaps and priorities.

Guidance for commissioners of child and adolescent mental health services 11
What would a good child and adolescent mental health service look like? (continued)

- a critical mass of staffing is essential – standard 9 of the National Service Framework\(^{32}\) 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 20 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 locations other than the clinic) which can offer timely access can be achieved with less 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): [www.rcpsych.ac.uk/quality/quality.accreditationaudit/communitycamhs.aspx](http://www.rcpsych.ac.uk/quality/quality.accreditationaudit/communitycamhs.aspx) and the CAMHS Outcomes Research Consortium (CORC): [www.corc.uk.net/](http://www.corc.uk.net/)
- 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.

**Outcomes, evaluation, and feedback**

- all services should have a system of routinely collecting patient outcomes as recommended by the Children and Young Peoples 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’s and Young People’s Health Outcomes Forum\(^{33}\).
- 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 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](http://www.iapt.nhs.uk)
- the CAMHS 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 – find out more at [www.corc.uk.net](http://www.corc.uk.net))
- effective outcomes monitoring requires administrative and clinical time, commitment, as well as IT resource which must be accounted for in commissioning.

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

- all NHS services will soon have to adopt measures of patient experience; in CAMHS the CHI-ESQ is already used in the CORC and CYP-IAPT datasets, and CYP-IAPT includes an on-going measure of therapeutic alliance.
It is vital that there is intelligent use of outcomes measurement and evaluation so that there are not negative unintended consequences such as ‘cherry-picking’ of referrals.

All evaluation must be used to maintain and promote a culture of compassion and thoughtful reflection as well as the ability to contain anxiety.

The measurement and interpretation of patient/carer experience in CAMHS can be complex. In most cases there is alignment between the interests of the child/young person and their patients/carers, but this may not always be the case. The goals of the young person may be incompatible with health and this may be reflected in measures of experience. Services need to be able to use evaluation data in a developmental manner and there are a number of peer networks across CAMHS to facilitate this including the QNCC and CORC, and the Quality Network for Inpatient CAMHS (QNIC) and CORC, as well as the collaborative networks of the CYP-IAPT pilots.

Service specifications should detail the Key Performance Indicators for the service. KPIs should be measurable, unambiguous and collected from routine data capture. For example:

- outcome measures
- process measures such as waiting times, sources of referral, number of referrals accepted, numbers not accepted
- length of treatment.

The London CAMHS Programme has put together a set of commissioning indicators: (www.chimat.org.uk/resource/item.aspx?RID=100467). Box 4 is an example of a CAMHS metric, while box 6 provides an example of a list of indicators.

**BOX 4: SAMPLE CAMHS METRIC**

**Out of hours – crisis intervention:**
Provider shall provide a monthly activity report to the commissioner by 15th operational day. Report to be split by local authority district. Report to commence for April 2010 activity.

**CAMHS waiting list:**
The service provider will provide a monthly report on the number of patients on the waiting list for CAMHS (Tier three) as at month end census date. Information to be reported by local authority district and waiting time band. Provider to submit report to the commissioner by the 15th operational day.

**Datasets:**
The service provider will return the following grids to the CAMHS Strategic Manager by 15th operational day after each quarter end. Dependent on contract renewal, targets will be revised and agreed towards each year-end for implementation for the following year. Information to be available by service:

- Tier 3 specialist CAMHS – excluding engage service
- counselling service
- early intervention/primary care service
- learning disabilities and CAMHS
- out-of-hours when developed – by end of Q3, any variation to this to be advised.

**BOX 5: USEFUL RESOURCES**

**Centre for Quality Improvement**
The Quality Network for Community CAMHS (QNCC) is a network that works with community-based child and adolescent mental health services, improving services for young people through a supportive, standards-based review process. A key focus of the network is the interface between CAMHS and other agencies involved in delivering care such as social services, education and the voluntary sector.

The Quality Network for Inpatient CAMHS (QNIC) is a network for in-patient child and adolescent mental health services. Approximately 85-90% of units in the UK and Ireland are members. QNIC demonstrates and improves the quality of child and adolescent psychiatric in-patient care through a system of review against service standards. The process is supportive and enables information sharing between services that can sometimes be isolated.

www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/childandadolescent.aspx

**Youth Wellbeing Directory and ACE-V Standards**
The Youth Wellbeing Directory with ACE-V Quality Standards is an online tool for commissioners, service providers and service users. The overarching aims of this directory and quality assessment tool are to guide and facilitate funders’ decision-making and to provide templates to enable providers to self-report good service provision.

The website enables commissioners to search and compare service providers across the UK – whether voluntary, private, NHS or other – in one place. Commissioners are able to easily contact all those UK service providers that aim to improve the emotional wellbeing and/or mental health of children and young people up to the age of 25 and their families.

Through the website, commissioners have the chance to take a more in-depth look into the practice and qualities of service providers that complete the full ACE-V Quality Standards self-assessment form. It will allow commissioners to learn more about these providers in the following areas: (1) Accountability and responsible practising; (2) Compliance with safe practising; (3) Empowerment of children, young people and their families; and (4) Value.

www.ace-value.co.uk  www.youthaccess.org.uk/publications/counselling-publications
What would a good child and adolescent mental health service look like? (continued)

## BOX 6

### CAMHS BY SERVICE

<table>
<thead>
<tr>
<th>A</th>
<th>Number of referrals</th>
<th>Data development</th>
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<tbody>
<tr>
<td>1</td>
<td>Number of referrals by source</td>
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<tr>
<td>2</td>
<td>Number of re-referrals (6 months after discharge)</td>
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<tr>
<td>3</td>
<td>Number of referrals refused</td>
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<td>4</td>
<td>Number and percentage of urgent referrals seen within 24 hours/next working day</td>
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<table>
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<tr>
<th>B</th>
<th>Number of assessments</th>
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<td>Number of assessments carried out</td>
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<tr>
<th>C</th>
<th>Number of young people on caseload</th>
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<th>Direct work (type of intervention at start of treatment)</th>
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<td>Type of intervention as per CORC data set (at beginning of intervention)</td>
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<td>0&lt;=5 weeks</td>
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<td>11</td>
<td>14&lt;=18 weeks</td>
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<td>12</td>
<td>&gt;18 weeks</td>
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<table>
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<td>25</td>
<td>&gt;26 weeks</td>
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<td>Outcomes</td>
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<td>26</td>
<td>Breakdown of discharge reasons as per CORC dataset</td>
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<td>27</td>
<td>How many were transferred to adult mental health services</td>
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<td>28</td>
<td>Outcome – SDQ</td>
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<td>J</td>
<td>Consultation</td>
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**DEMOGRAPHICS**

Young people who commenced contact with CAMHS

<table>
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<tr>
<th></th>
<th>Breakdown by gender</th>
<th>Breakdown by ethnic group</th>
<th>Breakdown by Local Authority district</th>
<th>How many had a learning disability?</th>
<th>How many had a physical disability?</th>
<th>How many were looked after?</th>
<th>How many were in contact with youth offending service?</th>
<th>How many had a Child Protection Plan?</th>
<th>How many were in need of housing support?</th>
<th>How many were excluded from education establishment at the time of assessment?</th>
<th>How many were NEET (Not in Education, Employment or Training)?</th>
<th>How many were placed on standard or enhanced care programme co-ordination (CPA)?</th>
<th>How many were 0–4?</th>
<th>How many were 5–9?</th>
<th>How many were 10–14?</th>
<th>How many were 16–18?</th>
</tr>
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| 1 |                     |                          |                                      |                                    |                                     |                           |                                                 | Item 9-11, agreed to be included in aims – data quality improvement

**CAMHS**

<table>
<thead>
<tr>
<th>Numbers and narrative of training events</th>
<th>Annual</th>
<th>End of Q4</th>
<th>Contract Monitoring Group and PCT Head of Children Services</th>
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<tbody>
<tr>
<td>Pre and Post SDQ report</td>
<td>Annual</td>
<td>End of Q4</td>
<td>Contract Monitoring Group and PCT Head of Children Services</td>
</tr>
</tbody>
</table>
What would a good child and adolescent mental health service look like? (continued)

**HOW DO YOU KNOW WHAT YOU NEED TO PROVIDE LOCALLY?**

For each tier of service, commissioners will need to ask:

1 what are referral criteria and pathways? Are these clear? Do they fit with the services above and below? Are there any gaps?
2 are the services accessible? Are any groups left out and why?
3 what are the waiting times?
4 what are the outcomes?
5 what do children and young people and their families say about their experience of using the service?

**Universal (Tier 1): services such as GPs, teachers, health visitors**
- how can targeted and specialist staff (from Tier 2 and 3) support Tier 1 staff to understand basic mental health issues, manage what they can, and refer when they need to?

**Targeted services (Tier 2):**
- do children and young people have access to school and youth counselling? Although it may not be the commissioners responsibility to commission such services entirely or directly, there is a role in supporting those who do commission them (and who may lack mental health expertise)
- do clear pathways from universal to targeted services exist? And from targeted to specialist services? Targeted workers may also need access to consultation, training and support from specialist colleagues.

**Specialist services (Tier 3): multi-disciplinary CAMHS teams**
- do targeted services exist for young adults and vulnerable young people who don’t meet the threshold for secondary care adult mental health services but who still need support?

**Specialist services (Tier 3):**
- does the service offer a comprehensive range of services and the full range of evidence-based treatments, and if not, what is missing and why?
- are pathways clear, and are waiting times appropriate?
- are there ‘internal waiting lists’? If so, what are the waiting times?
- do the services offer outreach/work in settings other than the clinic when needed?
- does the service work well with other agencies such as youth justice and local authority children’s services?
- how many children and young people were admitted as inpatients in mental health units? Were they admitted to age appropriate environments and how long did they stay?
- do your services have sufficient, appropriately skilled staff?
- do you have services for young adults, and what is the transition on from specialist services whether to adult services or elsewhere like?

**Specialist services (Tier 4):**
- although you may not commission inpatient or highly specialist services directly, your community will use them – in order to commission for a full pathway, you will need to understand why your children and young people are referred away from local community services Tier 3 CAMHS (work with your partners, providers, local authorities, to audit this).
- for many children and young people, home-based packages of care can support them to stay in their community, but some will require admission either for clinical or safety reasons.
- children and young people who need a highly specialist service also need one that is appropriate for their age, and one which is a close to home as possible.
- are young people under-18 being admitted inappropriately to adult mental health wards (occasionally this may be appropriate where a young person by virtue of their age, needs and preference would be better admitted to an adult unit)?
- are there delayed discharges because of an absence of appropriate community provision (this can include an absence of a home placement to return to)?
- are there appropriate liaison protocols with local authorities to ensure that where multi-agency intervention is required to enable and support discharge this can be arranged without delay?
- how does the pattern and frequency of referral for inpatient care compare to other similar areas? (higher local use may reflect robust Tier 3 arrangements/other agency provision)
- how good are working relationships between Tier 3 and Tier 4 and other highly specialised services? Is there liaison with the local area teams commissioning on behalf of NHS England?
Supporting the delivery of the mental health strategy

The Joint Commissioning Panel for Mental Health believes that commissioning which leads to the effective planning and management of CAMHS, including the involvement of patients and their carers in the development of these services, will support the delivery of the mental health strategy by contributing to the following shared objectives:

Shared objective 1: More people will have good mental health.
Commissioning high quality CAMHS will result in more children and young people of all ages and backgrounds having better wellbeing and good mental health. It will also help fewer children and young people develop mental health problems, by starting well, developing well, learning well, working and living well.

Shared objective 2: More people with mental health problems will recover.
Commissioning high quality CAMHS will help more children and young people who develop mental health problems to have a good quality life. This includes a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live as they reach adulthood.

Shared objective 3: More people with mental health problems will have good physical health.
Interventions addressing the comorbidity of physical and mental illness will help ensure that fewer children and young people with mental health problems will be at risk of premature morbidity and mortality in adult life. There will be improvements in the mental health and wellbeing of children and young people with serious physical illness and long-term conditions.

Shared objective 4: More people will have a positive experience of care and support.
Good quality CAMHS commissioning, wherever it takes place, should aim to offer access to timely, evidence-based interventions and approaches that give children and young people and their families the greatest choice and control over their own lives and a positive experience of care. Where inpatient care is required this should be in an age appropriate setting and in the least restrictive environment.

Shared objective 5: Fewer people will suffer avoidable harm.
Children and young people and their families should have confidence that care is safe and of the highest quality. This can be achieved through standards of high quality CAMHS care and the use of quality outcome measures to achieve this.

Shared objective 6: Fewer people will experience stigma and discrimination.
A high quality CAMHS that is valued and effective is likely to contribute to improved public understanding, and as a result, negative attitudes and behaviours to children and young people with mental health problems will decrease.
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Development process

This guide has been written by a group of CAMHS experts. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts.
References


