

## SCHEDULE 2 – THE SERVICES

### A. Service Specification

<b>Service Specification No.</b>	C07/S/a
<b>Service</b>	Child and Adolescent Mental Health Services Tier 4 (CAMHS T4): General Adolescent Services
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	12 months
<b>Date of Review</b>	

This specification provides an overarching core specification for all Tier 4 CAMHS Adolescent Services. Additional requirements for CAMHS Eating Disorder Services and inpatient learning disability services are contained within as appendices.

There are separate service specifications for Tier 4 CAMHS Low and Medium Secure Services, Tier 4 CAMHS PICU and Tier 4 CAMHS Children's Inpatient Units and Tier 4 CAMHS Specialist Autism Spectrum Disorders Services.

#### 1. Population Needs

##### 1.1 National/local context and evidence base

Tier 4 Child and Adolescent Mental Health Services (CAMHS) General Adolescent Services deliver tertiary level care and treatment to young people with severe and/or complex mental disorders.

Services are provided for young people between 13<sup>th</sup> and 18<sup>th</sup> birthdays with a range of mental disorders (including depression, psychoses, eating disorders, severe anxiety disorders, emerging personality disorder, severe psychosomatic disorders) associated with significant impairment and/or significant risk to themselves or others such that their needs cannot be safely and adequately met by community Tier 3 CAMHS. This includes young people with mild learning disability and Autism Spectrum Disorders who do not require Tier 4 CAMHS Learning Disability Services

Future in Mind (2015) emphasised the need for 'improved care for children and young people in crisis so they are treated in the right place, at the right time and as close to home as possible'. This includes 'implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care 'however, there is recognition that there will always be some children and young people who require more intensive and specialised inpatient care. 'The key to commissioning the right type of care, in the right places is to adopt a whole system commissioning perspective.....this should

address the role of pre-crisis, crisis and 'step-down' services alongside inpatient provision.'

Tier 4 CAMHS General Adolescent Services offer in-patient and day-patient care (the latter for young people who live close to the service and where the level of risk allows, often as a step-down transition to discharge).

### **Evidence Base**

Assessing the incidence and prevalence of severe adolescent mental disorders likely to require Tier 4 CAMHS Adolescent Services is challenging. Prevalence is influenced by a variety of factors (social deprivation, family breakdown, learning difficulties, ethnicity etc.) and estimates of prevalence of specific child and adolescent mental health disorders are often broad and relate to the full range of clinical severity whereas only a minority require Tier 4 care. In addition to epidemiological factors service factors such as gaps in service, capacity of community services or quality of "out-of-hours" support will influence use of Tier 4 services (Child and Adolescent Mental Health Services( CAMHS )Tier 4 Report, 2014 NHS England).

A number of National Institute for Health and Care Excellence (NICE) guidelines include specific recommendations regarding in- patient care:

NICE (2004) - Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders CG9

NICE (2005) - Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder CG31

NICE (2006) - The management of bipolar disorder in adults, children and adolescents, in primary and secondary care CG38

NICE (2009) – Borderline Personality Disorder: recognition and management CG78

NICE (2011)- Psychosis with substance misuse in over 14s: assessment and management CG120

NICE (2013) – Psychosis and schizophrenia in Children and Young People: recognition and management CG155

- NICE (2015) - Depression in children and young people: identification and management in primary, community and secondary care CG28

In addition, the 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder – Commissioning Guide' (July 2015) makes recommendations on when inpatient care should be considered.

There are no randomised controlled trials comparing inpatient care for adolescents (as provided in the UK) with alternative intensive interventions. However, there are a large number of studies using different designs which generally conclude that inpatient care is effective. Summaries of these studies can be found in The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services -COSI-CAPS report (**The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study ; Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO)Tulloch et al HMSO 2008 .**

Whilst outcomes are generally positive, there are a number of factors that can predict better outcome at an individual patient level, for example motivation to change, therapeutic alliance/engagement with the young person and/or their family, planned treatment and planned discharge, use of effective treatments, and use of after care. The benefits of inpatient treatment also need to be balanced against potential detrimental effects, for example loss of family and community support (**An evidence synthesis of risk identification, assessment and management for young people using tier 4 inpatient child and adolescent mental health services Hannigan et al 2015 Health Services and Delivery Research 2015; Vol. 3: No. 22;; The Evidence Base to Guide Development of Tier 4 CAMHS Kurtz 2009, Department of Health, Children , Young People and Families Programme. National CAMHS Support Service).**

The needs of young people in crisis are often different from those with long- standing complex and severe difficulties. For this reason inpatient services for these different groups are sometimes provided separately with young people admitted in crisis being cared for separately from young people requiring longer term treatment and rehabilitation The evidence in support of the benefits of planned admissions comes from a range of studies showing that outcomes are better when treatments and discharge are planned, the young person has motivation to change, and there is a therapeutic alliance/engagement with the young person and/or their family. (**Cotgrove et al, 2007 Cotgrove AJ, McLoughlin R, O’Herlihy A & Lelliott P. (2007). The ability of adolescent units to accept emergency admissions: changes in England and Wales between 2000 and 2005. Psychiatric Bulletin 31: 457-459.)**

Where outreach services have been developed length of stay is approximately halved, there by potentially reducing the number of Tier 4 beds needed for a given population (CAMHS Tier 4 Report, 2014). Other evidence points to the reduction in the need for admission where effective home treatment services have developed (**Clinical effectiveness of treatments for anorexia nervosa in adolescents: randomised controlled trial. Gowers et al 2010 Br J Psychiatry. 2007 Nov 191:427-35 Shepherd S, Doll H, Gowers s, James A, Fazel M, Fitzpatrick R and Pollock J, 2009, Alternatives to inpatient mental health care for children and young people. Cochrane Library.)**

Some Tier 4 CAMHS General Adolescent Services are provided as integrated services including crisis management and intensive outreach services allowing safe, high-quality alternatives to in-patient care for young people who would otherwise require admission. Where such services have developed there has been better use of beds in terms of shorter lengths of stay and a reduced need for admissions (CAMHS Tier 4 Report, 2014).

All Tier 4 CAMHS in England are members of the Quality Network for In-patient CAMHS which develops service standards incorporating Care Quality Commission and other essential standards and assesses compliance with the standards by self-assessment and annual external peer review. (QNIC) (<http://www.rcpsych.ac.uk/quality/qualityandaccreditation/childandadolesc ent/inpatientcamhsqnic.aspx>)

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

<b>Domain 1</b>	<b>Preventing people from dying prematurely</b>	
<b>Domain 2</b>	<b>Enhancing quality of life for people with long-term conditions</b>	
<b>Domain 3</b>	<b>Helping people to recover from episodes of ill-health or following injury</b>	
<b>Domain 4</b>	<b>Ensuring people have a positive experience of care</b>	
<b>Domain 5</b>	<b>Treating and caring for people in safe environment and protecting them from avoidable harm</b>	

The service is required to monitor clinical outcomes. As a minimum the service will use outcome measures as indicated in QNIC ROM, including:

1. Clinical measures

- SDQ (self-report, parent/carer and teacher),
- HoNOS-CA,
- and CGAS.

These measures will be collected on admission, every 3 months and at discharge. These outcome measures will be reported on both a national and individual service basis.

2. Education providers will provide the following data:

- English and Maths attainment level on entry and discharge using points values
- A measure of wider progress and wellbeing in education, in addition to academic progress, to be completed each academic term, such as the Every Child Matters Teacher and Student Assessment.

3. Parent / carer and young person feedback

- On young people and carer's experience of the service will be routinely sought as described in section 3.2.

Services will be required to submit evidence of achievement of outcome measures as defined in the standard contract. This will include the measures as outlined above plus additional measures that will be reviewed annually.

### 3. Scope

#### 3.1 Aims and objectives of service

The aim of the service is to provide a cost-effective, evidence based day/ inpatient and Outreach service to improve the mental health of young people who are suffering from severe and/ or complex mental health conditions.

The service will achieve this aim by:

- Providing a multi-disciplinary approach to care and treatment to meet the mental health, physical, educational/occupational, social and spiritual needs of the young person
- Providing treatment within safe, age appropriate and therapeutic environments
- Involve young people in actively planning and participating in their care

- Ensuring effective communication and involvement of parents/ carers
- Ensuring effective communication and liaison with referring community CAMHS and any other agency involved
- Provide timely and evidence based care and treatment for young people
- Ensure care is provided in the least restrictive environment
- Ensure services are delivered as part of an effective care pathway allowing for stepping up and down the level of intensity of intervention.
- Ensure treatment monitored through the use of established and validated outcome measures as a minimum those measures included in the Quality Network for Inpatient CAMHS, Routine Outcome Monitoring (QNIC ROM) set.
- The service will aim to facilitate early, safe and sustainable discharge planning so as to ensure that young people spend the least possible time in day/inpatient settings.
- The service will develop effective transition arrangements, for example, where young people need to be referred to Adult Mental Health Services
- Services will collect and use feedback from young people using the service and parents/carers in the monitoring of service quality and in service development.
- Services will involve young people and their parents/carers in service development.

### **3.2 Service description/care pathway**

Please note appendix specifications below are to be read in addition, where these services are provided:

- Appendix 1: Specialist Eating Disorder Services
- Appendix 2: CAMHS Inpatient Learning Disability Appendix

#### **Service Model and Care Pathway:**

Tier 4 CAMHS General Adolescent Services will be provided across an integrated care pathway which includes crisis/ home treatment services and outreach services and Tier 3 CAMHS.

Effective community services are important in preventing or reducing need for admission, and identifying those most appropriate for referral to Tier 4 CAMHS inpatient services.

Referral to a Tier 4 CAMHS General Adolescent Service will be via Tier 3 CAMHS or community AMHS service.

Acceptance by a Tier 4 CAMHS General Adolescent Service will be via an Access Assessment which must consider the goals of admission and any potential harms of admission as well as benefits and whether the young persons needs could be better met by alternative services such as crisis-home treatment services.

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Young people will move through levels of service as clinically appropriate, aiming for discharge back to community Tier 3 CAMHS as soon as it is safe to do so.

The service will be accessible so that young people can be cared for as close to home as possible to enable leave, community reintegration and family work. It will provide care 24 hours a day, 7 days a week including a capacity for emergency admission.

The service will provide safe and effective care across the different stages of the following care pathway:

- Referral
- Assessment
- Crisis management in the community
- Admission
- Treatment/ CPA process
- Discharge planning and discharge
- Transition to appropriate after care (usually Tier 3 CAMHS)

The services will also comprise the following elements:

- In/day-patient education provision.
- Outpatient attendance as part of pre-admission assessment and discharge transition
- Outreach

The Tier 4 CAMHS Adolescent Service pathway will include crisis/home treatment services – these may be provided as part of the Tier 4 CAMHS service or as part of the Tier 3 CAMHS in which case there must be close working relationships with the Tier 4 CAMHS Adolescent Service.

There are different models for how the crisis/home treatment services can be delivered or provided. These will not be specified in detail here, but rather general principles will be outlined allowing some flexibility for local implementation. The crisis assessment, crisis management and gatekeeping functions are best provided by a single team, that may or may not offer other functions such as intensive outreach and/or home treatment. The team should be integrated with the Tier 4 CAMHS service and led by CAMHS staff who have high levels of relevant CAMHS experience and training. There should be consultant level input into the team. The size of the team will be determined by a combination of geography, population size and population need.

In addition, it is desirable for Tier 4 CAMHS Adolescent services to provide:

- Outpatient second opinion for patients referred from Tier 3 CAMHS for an admission to tier 4
- Planned, intensive home based treatments (in addition to home based interventions to support young people in crisis).

## **Referral**

Referral Routes:

Referral to a Tier 4 CAMHS General Adolescent Service will be from Tier 3 CAMHS or community adult mental health services.

Response Times:

- Emergency referrals will be reviewed and responded to by a senior clinician within 4 hours; emergency assessment will be offered within 12 hours;
- Urgent transfer referrals will be reviewed and responded to within 48 hours
- Routine referrals will be reviewed and responded to within 1 week

## **Equity of access to services**

The service provided will uphold equality and diversity legislation and should not discriminate on the basis of the following characteristics:

- Ethnicity
- Legal status (e.g. asylum seekers)
- Disability
- Gender

- Sexuality
- Religion

The service will endeavour to provide a service that meets the specific needs linked to a child's culture, religion, gender or sexuality. This will include the provision of interpreters and access to multi faith rooms.

### **Assessment**

An Access Assessment for acceptance by Tier 4 CAMHS Adolescent Service will be undertaken; this should be done in consultation with the Crisis/Home treatment services.

There should be flexibility as to the location of the assessment (e.g provider premises, Tier 3 CAMHS base, patients home or other location) according to need. The assessment will explicitly address the following issues:

- Major treatment/care needs
- The best environment / level of service (day/in-patient or community crisis management/intensive outreach) in which the care should be provided
- Risks identified
- Level of security required
- Comments on the ability of the holding/referring organisation to safely care for the patient until a transfer can be arranged or until crisis assessment team can mobilise.

### **Admission to Tier 4 CAMHS**

Admission can be to any of the following service elements:

- In-patient admission
- Day -patient attendances at the facility
- Crisis management/intensive outreach where the latter is offered by the Tier 4 CAMHS Adolescent Service

All patients will have an identified Consultant Child and Adolescent Psychiatrist, although the Responsible Clinician/Approved Clinician may be from another discipline.

Upon admission all young people will have an initial assessment (including a risk assessment) and care-plan completed within 24 hours. Where admission is for day/in-patient care this will include a physical examination.

For young people receiving Crisis/Home Treatment from the Tier 4 CAMHS Adolescent Service the physical assessment may be provided by the young person's General Practitioner (GP) or by a medic from another team, e.g paediatrician.

All young people will have a full multi-disciplinary team assessment and formulation of their needs and a care/treatment plan, which should as far as possible be drawn up in collaboration with the young person (and their parents/carers as appropriate). The care plan will address the young person's goals and wishes / feelings as far as possible.

Speech and language assessments and occupational therapy (e.g. Activities of Daily Living (ADL), sensory and coordination, social skills, etc) assessments may be required and where these are not provided 'within house' by the Tier 4 CAMHS Children's Service there should be defined agreements to ensure these can be accessed in a timely fashion during the course of the child's admission.

Where admission has occurred as an emergency such that a Tier 4 CAMHS Access Assessment has not been possible there should be a multi-agency review within 5 working

days – this should involve the young person, parents/carers, community team and any other agency involved in the young person’s care. This review should address the same questions as the Access Assessment – the goals of admission,

Where the young person has a learning disability or ASD and a Care and Treatment Review was not carried out prior to admission there must be a CTR within 10 days in line with CTR guidance and policy published in October 2015.

Treatment will take place alongside assessments and if appropriate start at the point of admission. The care and treatment plan will be modified and updated regularly as the young person’s needs change.

The service will organise regular Care Programme Approach (CPA) meetings involving the young person, their parents/carers, Tier 3 CAMHS and any other agencies involved in the young persons care. For planned admissions this will be within the first 3 (three) – 6 (six) weeks of day/in-patient admission, depending on the needs of the young person and the complexity of the system/network surrounding them.

### **Treatment and CPA**

The service will ensure that the CPA shall be implemented by the service and used for all young people and forms the structure of care planning. The CPA format and documentation used must be appropriate for use with young people.

The care plan shall reflect the patient’s needs in the following domains:

- Mental health
- Developmental needs
- Physical Health
- Risk
- Family support / functioning
- Social functioning
- Spiritual and cultural
- Education, training and meaningful activity
- Where relevant includes a Carer’s Assessment
- Where relevant includes accommodation / financial needs
- Where relevant addresses substance/ alcohol misuse
- Where relevant addresses offending behaviour

The treatment / care plan will be evidence based and be based upon current NICE guidelines where these exist or where NICE guidelines do not currently exist for a particular disorder, other established best practice guidance.

The treatment/care plan will incorporate routine outcomes monitoring used to monitor progress and treatment on a week to week basis, as a minimum those in QNIC ROM. For patients admitted for treatment of low weight eating disorder this will include regular monitoring of weight and other physical indices in accordance with Junior Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines (Royal College of Psychiatrists 2012 or the most recent updated version).

Following the initial CPA meeting, the service will organise regular CPA reviews at a frequency determined by the patient’s needs but generally at a frequency of between 4-6 weekly.



Day/In-patients will be offered a structured programme of education enabling them to continue their education. In addition, services will offer a structured programme of recreational as well as therapeutic groups. Patients will have an individualised programme which allows attendance at elements of the group programme appropriate to their need.

Patients receiving Outreach will attend elements of the day/in-patient programme according to need.

All patients will be offered regular key worker time. Where specific individual therapies are indicated these should be offered without delay. Such therapies include Cognitive Behaviour Therapy (CBT), Interpersonal Therapy for Adolescents, Cognitive Analytic Therapy (CAT), Dialectical Behaviour Therapy (DBT), and Eye Movement De-sensitisation Reprocessing (EMDR). Services may also offer creative therapies and psychodynamic psychotherapies.

All families will be offered family meetings to identify family support needs as well as the potential need for formal family interventions/therapy. Where a specific form of family therapy is indicated such as Eating Disorder Focussed Family Therapy (EDFFT) for anorexia nervosa this will be offered.

The referring Tier 3 CAMHS or AMH team will ensure a Care Co-ordinator attends CPA reviews and retains contact with the patient and their parents/carers during the period of Tier 4 care. Where Crisis-Home Treatment is provided as part of the community Tier 3 CAMHS such services should in-reach to the tier 4 CAMHS service to aid the transition to community care.

### **On-going Risk Assessment and Management.**

The range and nature of risk behaviour in a Tier 4 CAMHS General Adolescent Service is broad and can include self-harm, suicidal behaviour, physical consequences of low weight, severe self-neglect, absconding, aggression, sexualised behaviour, fire-setting, exploitation by others. It is also important to assess the risks and potential adverse consequences of admission for the young person.

Risk assessment and management involves a consideration of the individual patient's risk factors and environmental factors which in day/in-patient services include consideration of the group dynamics and impact of other patients.

Tier 4 CAMHS General Adolescent Services thus require a broad understanding of risk assessment and management and a range of risk management strategies which can be tailored to the needs of individual patients.

The provider shall have a dynamic recognised risk assessment model in place to support clinicians in making day- to -day decisions about individual patient's care.

The provider shall meet the risk assessment requirements appropriate for the care and security of all young people, including but not limited to measures whereby the risk assessment and management model incorporates the principles of hazard identification, risk reduction, risk evaluation and a recognised risk communications process.

Hazards within the day/in-patient environment are addressed and the environment meets recognised safety standards for psychiatric in-patient settings compatible with the service being

an 'open' service.

There will be a designated high- dependency' area within the premises where patients requiring a higher level of security can be cared for- this should include bedroom, bathroom and recreational areas.

Day/in-patient services nursing staff levels are adequate to effectively manage risk.

Staff, particularly nursing staff are skilled in managing risk and can employ a range of techniques including engagement of young people, distraction, de- escalation, support and supervision, physical intervention

Where the service cares for young people with low weight eating disorders the service shall comply with the guidance developed by the Royal College of Psychiatrists (2012 or most recent updated version) Junior MARISPAN in relation to managing the physical health risks.

The service monitors the profile of risk incidents at a service level to identify any patterns and themes which should then be addressed

The service undertakes significant event analysis of all serious incidents with evidence of identified learning

The service will ensure that young people who pose a significant and continued risk to others OR whose risk to themselves cannot be safely managed within a general purpose adolescent unit be transferred to an appropriate environment such as a PICU or Low Secure Unit.

### **Enhanced Observations (Specialing)**

All Tier 4 CAMHS General Adolescent Inpatient Services shall:

- Develop and implement a policy for enhanced observations in the day/in- patient element
- Enhanced observations are a level of supervision by staff beyond the level of routine observations and are provided at a frequency of regular 5 minute checks or continuous supervision.
- Deliver such Enhanced Observations as may be required, in line with good clinical practice (for example but not limited to - when a young person exhibits overt physically aggressive behaviour towards others, or is an active risk to themselves). The observations should be reviewed at least twice daily and reduced to the minimum at the earliest opportunity
- Enhanced Observations will be undertaken by staff members who are familiar with the care needs of the young person
- Enhanced Observations will in normal circumstances be considered to be part of the contracted level of general care.

### **Emergencies**

All services shall:

- Ensure that sufficient staff with appropriate skill, training and competence are available to maintain patient safety at all times
- Ensure that appropriate healthcare specialist on call arrangements are in place (these should include senior nursing staff and psychiatrists including access to Consultant Child and Adolescent Psychiatrist advice)
- Ensure that it maintains a safe environment for patients, staff and visitors to the provider's premises (or any part thereof)

## **Physical illness and medical emergencies**

The service shall:

- ensure that there are appropriate processes in place with primary and secondary care providers to allow for the treatment of co-morbid physical illnesses or injuries and emergency transfer of patients to other medical facilities where this is required;
- ensure it has at each of the service's premises (and each of the parts thereof) adequate equipment including resuscitation equipment
- ensure it has procedures to deal with medical emergencies, including, immediate treatment, stabilisation and arranging for the transfer of the patient to an appropriate general hospital which can provide the level of care required and any other steps that could reasonably be required, including using, where appropriate, locally agreed transfer protocols where these exist and complying with the latest UK Resuscitation Council guidance on basic life support and all future updates/revisions.

## **Psychiatric Emergencies**

The service's management of violence and aggression shall be in accordance with NICE Guidance 10 'Violence and aggression; short term management in health, mental health and community settings.

The service shall ensure that all staff involved in administering or prescribing rapid tranquillisation, or monitoring patients to whom parenteral rapid tranquillisation has been administered, receive on-going competency training to a minimum of Intermediate Life Support (ILS) or equivalent standard (e.g. ILS – Resuscitation Council UK covers airway, cardio pulmonary resuscitation (CPR) and use of defibrillators).

## **Home and Weekend Leave**

Home leave is important in helping young people maintain family and community relationships whilst in an in-patient setting and an important element of the transition to out-patient care.

Each planned home leave shall be risk assessed and managed with due regard for the service's duty of care to the patient and the commissioning body's statutory duty of care.

## **Education**

All day/in-patient services will provide educational sessions during normal academic term. Education should be an integral part of the service provision. The Provider educational provision should be subject to inspection by The Office for Standards in Education (OFSTED) and meet necessary curriculum and education standards. The cost of the educational provision will be recharged directly by the provider to the patients home Local Authority. The cost will not be included within the cost charged to the NHS.

The provider will liaise with partners to make sure recommendations of Care and Treatment Reviews are undertaken and must ensure that educational needs continue to be met . Where appropriate (when a child or young person has a Education Health and Care plan, or statement of special educational need (where this has not yet been converted) or is receiving SEN support, the provider will ensure that the child or young person continues to access the education and support specified within their plan. This may sometimes require a review or revision of the plan.

## **Discharge planning and discharge**

Discharge planning should be started at the point of admission agreeing what change is required in order for the young person to be able to safely return to the care of Tier 3 CAMHS. This may include a period of intensive outreach provided by Tier 4 CAMHS.

The decision to discharge or transfer a young person will normally be agreed at formal CPA review and should normally be agreed with the patient, their parents/carers and the Tier 3 CAMHS. Criteria for discharge will be individualised but should be broadly that the patient's level of risk has reduced and there has been a reduction in impairment and their treatment needs can be met within Tier 3 CAMHS.

The Provider shall use all reasonable endeavours to avoid circumstances whereby discharge is likely to lead to emergency re-admission, including agreeing a crisis plan in a CPA review meeting.

Throughout the period of care the Provider will remain in contact with referring Tier 3 CAMHS and other agencies as appropriate in relation to the patient's progress and prospect and timing of discharge. The Provider will also support the patient to retain contact with their home-base community as appropriate.

All Tier 4 CAMHS Adolescent Service pathways will include intensive outreach services to help facilitate the earliest appropriate discharge for those that are admitted. This service can include staff from within the inpatient outreach team liaising with professionals working in the community and offering intensive support to families or carers or services linked to Tier 3 CAMHS in-reaching whilst the young person is in hospital and providing intensive support to facilitate discharge

A discharge summary will be sent to the family, carer or person with parental responsibility, referrer and the General Practitioner (GP) at the end of each young person's stay. This will include recommendations for future work/treatment. This summary should be sent to other involved agencies with the consent of the child and/or family.

The service will offer liaison with schools to support educational re- integration

## **Delayed discharges**

If a patient is delayed from being discharged from the service other than for clinical reasons, the Provider will inform the relevant commissioning body and the referrer as soon as possible to identify how the delay can be overcome. This may involve liaison with other agencies.

## **Discharges Against Medical Advice**

The Provider will have agreed protocols for occasions when a patient discharges themselves against medical advice and use of the Mental Health Act 2007/1983 or Mental Capacity Act 2005 is not indicated. This will include immediate notification to the GP, Tier 3 CAMHS and all other relevant agencies and the commissioning body. The Provider will co-ordinate the network to ensure that the young person and family continue to be offered appropriate health and other services.

## **Transfer to another Tier 4 CAMHS setting**

Where a patient requires transfer to an alternate mental health inpatient service, the current

service will take lead responsibility in effecting the transfer. The provider will:

- Collaborate with the alternate provider to facilitate transfer
- Take all necessary steps to prepare the patient and parents/carers for transfer
- On transfer a full handover including assessment reports, care plan, risk, treatment received and response
- Arrange and appropriate transport and any required escort consistent with the Patient's risk assessment
- The service will ensure high levels of liaison with schools to ensure educational re-integration is successful
- The clinical needs and best interests of the young person should dictate whether they are transferred from one unit to another

### **Physical healthcare**

Providers should ensure that patients routinely undergo a full assessment of physical health needs. Care and treatment plans should reflect both mental health and physical healthcare needs and all patients will:

- have access to a comprehensive range of primary healthcare services
- undergo regular and comprehensive physical health checks (including medication monitoring) as required
- undergo follow-up investigations and treatment for physical conditions as required.

Providers caring for young people with low weight eating disorders should provide monitoring and services which comply with Junior MARSIPAN guidelines (RCPsych 2012 or most recent update)

The provider will:

- Carry out all appropriate age and gender specific screening and vaccinations in line with Department of Health (DH) guidance where these are required.
- Develop referral pathways to secondary healthcare services within timescales according to DH guidelines or good clinical practice.
- Provide general health promotion activities including screening, dietary advice, sexual health, advice on drug/alcohol use and the opportunity to exercise (with appropriate supervision).
- Provide targeted programmes on smoking cessation (as appropriate).

### **Multi-Disciplinary Team (MDT)**

Tier 4 CAMHS Adolescent Services will be multidisciplinary. The staffing of the unit should be compliant with Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC) essential standards. The staff team will include:

- Consultant level as well as non-consultant grade medical staff
- Clinical Psychology
- Nursing staff
- Occupational therapist
- Teaching staff
- Social work
- Family Therapist
- Staff skilled in group work
- Creative therapies
- Dietetic advice where services provide care for young people with eating disorders
- Access to psychotherapy as appropriate
- Administrative support

- Access to physiotherapy

### **Days/ hours of operation**

Services are open 24 hours a day, 365 days a year. Services will be able to offer admission and assessment and crisis responses 24 hours a day 7 days a week.

### **Advocacy**

The service will ensure that there is appropriate access to an Independent Mental Health Advocacy (IMHA) service to ensure young people's rights are safeguarded.

A general advocacy service will be commissioned to work towards the self-advocacy model and will support children as necessary but especially around CPA and care planning. The advocacy service should have experience in working with young people with mental health problems.

The advocacy service can also have a role in supporting the development of group advocacy within the unit so that young people can feedback and participate in the development of the service.

### **General Paediatric care**

When treating children, the service will additionally follow the standards and criteria outlined in the Specification for Children's Services (attached as Annex 1 to this specification)

### **3.3 Population covered**

The service outlined in this specification is for young people ordinarily resident in England\*; or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the responsible commissioner and other

Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

Note: for the purpose of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practices in Wales and INCLUDES patients resident in Wales who are registered with a GP Practice in England.

Specifically, this service is for young people requiring specialised intervention and management, as outlined within the specification.

### **3.4 Any acceptance and exclusion criteria and thresholds**

#### **Acceptance Criteria**

The service will accept referrals of young people who meet the following criteria:

- Primary diagnosis of mental illness and which does not exclude young people with a mild learning disability, drug and alcohol problems or those with social care problems as secondary needs.
- Severe and complex needs that cannot be safely managed within Tier 3 CAMHS.
- From 13yrs up until 18th birthday (there may be rare cases of 12 year olds being more appropriately admitted than to a Tier 4 CAMHS Children's Unit).
- Who may require detention under the Mental Health Act 2007 although the latter is not a pre-requisite.

## **Exclusions**

- Over 18 years of age (unless this is for a short time period to complete an episode of care and appropriate safeguards are in place).
- Young people with a moderate or severe learning disability.
- Young people with a primary diagnosis of substance misuse
- Young people with a primary diagnosis of conduct disorder and no co-morbid mental illness
- Young people whose primary need is for accommodation due the breakdown of family or other placement
- Young people who are in need of Tier 4 CAMHS Low Secure or Tier 4 CAMHS Medium Secure care
- Young people who are currently in secure placements provided by local authorities or Youth Justice, who in the first instance would be referred to the Tier 4 CAMHS Medium Secure or a Low Secure Unit
- Young people who are deaf where care may be more appropriately be provided by the National Deaf CAMHS service.
- Young people with severe autism spectrum disorders where it is clinically assessed that care would be more appropriately provided by a specialist unit

Occasionally children will present with extreme behavioural disturbance that cannot be managed safely by the service and which is likely to have a detrimental effect on the care and treatment of other children in the service. In such cases the provider should advise on what other services could be approached. These may include developing bespoke arrangements for a particular child or consideration of placement in a secure tier 4 CAMHS service or secure children's home.

### **3.5 Interdependencies with other services/providers**

CAMHS operate within a complex system of health, education and Local Authority Children's Services.

#### **Co-located Services:**

Providers will need to be located with other mental health services to ensure a critical mass of staff to ensure adequate response team resource or robust adequate response plans should be in place to deal with any emergency requiring additional staff.

#### **Interdependent Services:**

- Education
- Tier 3 CAMHS
- Acute hospital services including paediatrics, laboratory services and services for special investigations
- Other Tier 4 CAMHS provision including PICU
- Adult Mental Health Services

#### **Related Services:**

Service delivery will demand effective partnerships between agencies for children and young people with complex and high-levels of need and joint protocols should be agreed at senior officer level between the NHS and Local Authority Children's Services, to ensure the needs of young people requiring this level of care, are effectively met:

- GPs and Primary Care

- Local Authority Children's services
- Education
- Third sector organisations

#### **4. Applicable Service Standards**

##### **4.1 Applicable legislation and national standards e.g. NICE**

Services will:

- Meet and maintain national quality standards and any other National standards including but not confined to
  - National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08 and any subsequent related guidance;
  - Care Quality Commission (CQC) Standards
  - The Children Act 1989 and 2004
  - Mental Health Act 1983 (as amended) and the Mental Health Act Code of Practice 2015
  - The Essence of Care – Patient focussed benchmarking for health care practitioners (February 2001) Updated 2010
  - NHS Litigation Authority (NHSLA) Standards.
  - OFSTED Inspection Framework (2015)
  - Working Together to Safeguard Children; A guide to interagency working to safeguard and promote the welfare of children, March 2013
  - NICE Guidelines
  - Accredited training in restraint

##### **Service Environment**

The provider will meet the following standards:

- The premises and the facilities generally are young person and family friendly and meet appropriate statutory requirements, are fit for purpose as determined by the relevant statutory regulator (e.g. the Care Quality Commission), conform to any other legislation or relevant guidance
- A clean, safe and hygienic environment is maintained for patients, staff and visitors
- A care environment in which patients' privacy and dignity is respected and confidentiality is maintained
- There is appropriate, safe and secure, outdoor space for recreation and therapeutic activities
- A care environment is provided where appropriate measures are taken to reduce the potential for infection and meets the requirements of the Healthcare Associated Infections (HCAI) code of practice
- The service ensures that the nutritional needs of all young people are adequately met and that comments about food and nutrition are incorporated in menu design
- An environment that ensures that no young person, visitor or staff member is allowed to smoke on the premises
- Facilities which include a room which is suitable for contact between young people and their families and is available at weekends and evenings
- Bedroom and bathroom areas should be gender-segregated.
- Provide an area that can be used as a multi faith room



## **Safeguarding**

All appropriate measures shall be taken by services in relation to the protection of children and children under their care; in particular, they shall ensure that:

- There is a safeguarding policy in place that reflects the guidance and recommendations of a 'Competent Authority' and that policy is implemented by all staff
- There is a nominated person within the service who fulfils the role of the competent person for safeguarding issues;
- There is a robust mechanism in place for the reporting of safeguarding concerns (in accordance with the Children Act 1989 and 2004); and
- All clinical staff receive training in safeguarding issues to meet their obligations under the Children's Act 1989, the Children's Act 2004 and so as to meet the requirements of this Agreement and in accordance with the Safeguarding Children and Young People: Intercollegiate Document for Healthcare Staff 2009.

## **Mental Health Act**

The service will ensure when appropriate young people are appropriately detained under the Mental Health Act 1983 (amended 2007) and that there is proper administration of the Act.

### **4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

Quality Network for Inpatient CAMHS (QNIC) Standards 2015 or most recent update

Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa Royal College of Psychiatrist 2012 or most recent updated version

## **5. Applicable quality requirements and CQUIN goals**

**5.1 Applicable quality requirements (See Schedule 4 Parts A-C of the contract)**

**5.2 Applicable CQUIN goals (See Schedule 4 Part D of the contract)**

## **6. Location of Provider Premises**

**The Provider's Premises are located at:**

## **APPENDIX 1 of C07/S/ CAMHS T4 General Children & Adolescents Specifications**

### **B. Service Specification Appendix: Eating Disorders**

<b>Service Specification No.</b>	C07/S/a (Appendix 1 ED)
<b>Service</b>	Tier 4 CAMHS Specialist Eating Disorder Services
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	12 months
<b>Date of Review</b>	

## 1. Population Needs

### 1.1 National/local context and evidence base

Tier 4 CAMHS specialist eating disorder units are for children and young people suffering from severe eating disorders resulting in significant weight loss and/or severely impaired growth such that their health, growth and development are at risk and who have not responded to Tier 3 CAMHS outpatient treatment. Children and young people may also be referred for treatment where at the point of referral to Tier 3 CAMHS they are within a high risk low weight range and could not be safely treated within Tier 3 CAMHS.

The 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder – Commissioning Guide' (July 2015) makes recommendations for when inpatient care should be considered. This is primarily for medical stabilization and initiation of re-feeding or because of 'psychiatric' risk – it is recommended in the guidance that most children and young people are treated as outpatients and that where admission occurs there is in-reach from the community eating disorders team to facilitate discharge as soon as possible.

Tier 4 CAMHS specialist eating disorder services admit children and young people with anorexia nervosa, atypical anorexia, eating disorders not otherwise specified (EDNOS), food avoidant emotional disorder, refusal syndromes and phobias leading to severely restricted eating. Services may also admit children and young people where as part of a severe psychosomatic disorder their eating has become significantly restricted.

Tier 4 CAMHS specialist eating disorder services will admit children and young people aged between 12<sup>th</sup> and 18<sup>th</sup> birthday with over 18s being admitted to services for adults and under 12s admitted to Tier 4 CAMHS Children's Units.

Children and young people who have eating and feeding problems in the context of moderate to severe learning disabilities and Autism Spectrum Disorder are usually treated in Tier 4 CAMHS Learning Disability Units if they require admission.

Most children and young people with eating disorders are however treated within Tier 4 CAMHS General Adolescent Units or Tier 4 CAMHS Children's Units.

### **Evidence base**

There is a lack of detailed information on the distribution of eating disorders. An annual incidence of 8 per 100,000 and the average prevalence of 0.1 to 0.3% for adolescents is reported by Hoek (**Hoek HW. Incidence, prevalence and mortality of anorexia nervosa and other eating disorders. *Curr Opin Psychiatry*. 2006;19(4):389–94.**). In more focused surveys of anorexia nervosa the disorder most likely to require in-patient admission, approximately 90% of sufferers are girls and about a third of sufferers are expected to be undiagnosed with many sufferers concealing their condition (Hoek HW, 2006).

A recent UK study based on general practice registers found the age-standardized annual incidence rate of all diagnosed ED for ages 10–49 increased from 32.3 (95% CI 31.7 to 32.9) to 37.2 (95% CI 36.6 to 37.9) per 100, 000 between 2000 and 2009. The incidence of AN and BN was stable; however, the incidence of EDNOS increased. The incidence of the diagnosed ED was highest for girls aged 15–19 and for boys aged 10–1

Anorexia nervosa is a chronic condition with an average duration of 5-6 years (**Strober, M., Freeman, R., & Morrell, W. (1997). The long-term course of severe anorexia nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10–15 years in a prospective study. *International Journal of Eating Disorders*, 22, 339–360.**) and has the highest mortality rate for any mental disorder.

The National In-patient Child and Adolescent Psychiatric Study (NICAPS) surveyed all Tier 4 CAMHS Units in England and Wales in 1999 and found young people with severe eating disorders to be the largest single diagnostic group accounting for approximately 22% of admissions amongst adolescents and approximately 5% of admissions in the under 12 year olds (under-12s). The Child and Adolescent Mental health services (CAMHS) Tier 4 report (2014) found a similar pattern.

Gowers et al in 2010 carried out a randomized controlled multi-centre trial of treatments for adolescent anorexia nervosa including assessment of cost-effectiveness and patient acceptability - the TOuCAN trial and found that inpatient treatment did not confer any benefit over community based treatment.

First-step treatment provided by community services specializing in eating disorders assessment and treatment have been found to be associated with a lower subsequent need for inpatient care than either generic CAMHS or initial inpatient treatment Byford **S, Barrett B, Roberts C, Clark A, Edwards V, Smethurst N, Gowers S. Economic evaluation of a randomised controlled trial for anorexia nervosa in adolescents. *Br J Psychiatry*. 2007;191:436–440.**

**Comparison of specialist and non specialist care pathways for adolescents with anorexia nervosa and related eating disorders. House et al. 2012 *International Journal of Eating Disorders* 45(8)**

- Recent research from Germany (**Day-patient treatment after short inpatient care versus continued inpatient treatment in adolescents with anorexia nervosa (ANDI): a multicentre, randomised, open-label, non-inferiority trial Herpetz-Dalman et al 2014 *The Lancet*, Vol. 383, No. 9924, p1222–1229**) suggests that day-patient treatment may be equally effective to inpatient treatment at lower cost.

Several studies have examined effectiveness, costs, satisfaction and outcomes including the COSI-CAPS study (<http://www.rcpsych.ac.uk/pdf/COSI%20CAPS.pdf>. (RCPsych 2008)) found most young people improved substantially during their inpatient stay and were satisfied with their care. With respect to outcomes Tier 4 CAMHS Eating Disorder Units and Tier 4 CAMHS General Adolescent Units achieved similar outcomes although the specialist eating disorder units tended to admit more severely ill patients.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

<b>Domain 1</b>	<b>Preventing people from dying prematurely</b>	
<b>Domain 2</b>	<b>Enhancing quality of life for people with long-term conditions</b>	
<b>Domain 3</b>	<b>Helping people to recover from episodes of ill-health or following injury</b>	
<b>Domain 4</b>	<b>Ensuring people have a positive experience of care</b>	
<b>Domain 5</b>	<b>Treating and caring for people in safe environment and protecting them from avoidable harm</b>	

The service is required to monitor clinical outcomes. As a minimum the service will use outcome measures as indicated in the Access and Waiting Time Standard for Children and Young People with an Eating Disorder including:

#### 1. Clinical measures

SDQ (self-report, parent/carer and teacher),  
EDE-Q  
%BMI  
Score 15  
SFQ  
GBOs  
HoNOS-CA,  
and CGAS.

Where the young person is experiencing co-morbidity these measures should be supplemented as appropriate. These measures will be collected on admission, every three months and at discharge. These outcome measures will be reported on both a national and individual service basis.

2. Education providers will provide the following data:

- English and Maths attainment level on entry and discharge using points values
- A measure of wider progress and wellbeing in education, in addition to academic progress, to be completed each academic term, such as the Every Child Matters Teacher and Student Assessment. This measure should be agreed and implemented by all units in the CAMHS T4 network.

3. Parent / carer and young person feedback using the CHI-ESQ

- On young people and carer's experience of the service will be routinely sought as described in section 3.2.

Services will be required to submit evidence of achievement of outcome measures as defined in the standard contract. This will include the measures as outlined above plus additional measures that will be reviewed annually.

Services should routinely measure outcomes. Successful treatment is expected to lead to improved outcomes as measured by Outcomes indicators stipulated in the 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder – Commissioning Guide' (July 2015).

### **3. Scope**

#### **3.1 Aims and objectives of service**

The aim of the service is to deliver specialist inpatient, day patient, care to children and adolescent suffering from severe eating disorders such that their health, growth and development are at high risk and where they cannot be adequately treated by Tier 3 CAMHS Eating Disorders Teams or within general Tier 4 inpatient services.

The services objectives will be to:

- Limit the physical and psychiatric morbidity, social disability and mortality levels caused by eating disorders.
- Effectively treat children and young people with very complex eating disorders

Successful treatment is expected to lead to:

- Improved physical and mental health and parental coping such that the child or young person is able to return home to the care of community services.

#### **3.2 Service description/care pathway**

##### **Service Model and Care Pathway:**

Children and young people are referred to Tier 4 CAMHS Eating Disorder Services from either Tier 3 CAMHS Eating Disorders Teams or other Tier 4 CAMHS provision

Tier 4 CAMHS specialist eating disorder services provide in-patient and day- patient care (the latter for young people who may require in-patient care but where they live sufficiently close to the in-patient base and the level of risk allows this).

The Tier 3 CAMHS Eating Disorders teams will retain close working links with the Tier 4 CAMHS eating disorders throughout the young persons admission including in-reach and facilitating step-down care.

The Tier 4 CAMHS specialist eating disorders service should provide a full multi- disciplinary team that is able to offer a full range of interventions as recommended by NICE and other best practice guidance for disorders where NICE guidance does not exist.

The service will provide expertise in treating the psychological and medical complications of eating disorders including re-feeding patients and achieving weight gain (occasionally under the Mental Health Act) and ensuring the appropriate risk management arrangements necessary for such interventions are in place. The service will have the skills and facilities to manage Naso-gastric (NG) feeding and Percutaneous Endoscopic Gastrostomy (PEG feeding), although is not expected to have skills/facilities for PEG insertion.

The service must have good access to general paediatric and general medical facilities given the physical health risk for this patient group. Within the service there must be medical and nursing staff with expertise in managing the physical complications of anorexia nervosa and related disorders.

The service will provide:

- Assessment
- Admission
- Bespoke packages of intensive day treatment for young people who would otherwise be admitted as an inpatient or as part of a discharge pathway

The services will also comprise the following elements:

- Day/In-patient education provision
- Second opinion assessments, advice and consultation to Tier 3 CAMHS and other Tier 4 CAMHS

The pathway should include intensive home-based treatment as an alternative to admission which should be integrated with the Tier 4 service

### **Referrals**

Referral routes:

- Referrals will be accepted from Tier 3 CAMHS eating disorder services, Tier 4 CAMHS General Adolescent Units and Tier 4 CAMHS Children's Units.
- Referrals will be reviewed and responded to by a senior clinician within the service.

Response times:

- Response to emergency referrals will be within 4 hours
- Response to urgent referrals will be within 24 hours
- Response to non-urgent referrals will be within 5 working days

### **Assessment**

An Access Assessment for acceptance by the Tier 4 CAMHS Eating Disorders Service will be undertaken, this should be done in consultation with the Tier 3 Community Eating Disorders team. There should be flexibility as to the location of the assessment according to need. The assessment will explicitly address the following issues:

Goals of admission

Major care and treatment needs

The best environment/level of service (day-inpatient or community tier 3 CAMHS)

Risk identified

Level of security required

Comments on the ability of the holding-referring organization to safely care for the patient until admission can occur.

### **Admission**

The inpatient / day patient service will:

- Provide a comprehensive assessment of physical health (including Body Mass Index (BMI), physical examination, blood tests, electrocardiogram (ECG)) and a comprehensive psychiatric assessment and full risk assessment in accordance with NICE guidance CR69, Junior MARSIPAN Royal College of Psychiatrists 2012 or the most recent update and CPA good practice guidelines.
- Offer carer assessments where appropriate.

## **Treatment / interventions**

The service will;

- Provide a high quality intervention aimed at medical stabilisation, weight restoration and the adoption of healthier eating patterns including reduction of the behaviours linked to the eating disorder. The service will also treat any
- psychiatric co-morbidity. The service will provide:
  - Safe re-feeding, including access to dietetic advice and paediatric / general medical advice
  - Be able to provide NG insertion and feeding, and PEG feeding
  - Be able to provide daily biochemistry, frequent physical observations, management of abnormal weight control behaviours (for example - water loading, excessive exercising, self-induced vomiting and laxative abuse), the ability to conduct daily ECG, treatment of pressure sores and immediate cardiac resuscitation with presence of 'crash' team.
  - Provide high quality psychological interventions including Cognitive Behavioural Therapy--Eating Disorders Cognitive Analytic Therapy, Interpersonal psychotherapy, Psychodynamic psychotherapy, Dialectic Behaviour Therapy
  - Provide appropriate evidence based family therapy and family interventions including supported family meals, parents groups.
  - Provide a multidisciplinary approach in line with current NICE guidance CR69, which includes access to a variety of non -psychological interventions including occupational therapy and dietetics.

## **Discharge planning and discharge**

Work closely with the community eating disorders teams to plan discharge

## **Multi-Disciplinary Team (MDT) Membership**

The staffing of the unit should be compliant with Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC) essential standards and

Quality Network for Eating Disorders standards.

### **3.3 Population covered**

Specifically, this service is for children and adolescents requiring specialised care and treatment for complex eating disorders.

### **3.4 Any acceptance and exclusion criteria and thresholds**

#### **Acceptance Criteria**

Primary diagnosis of a severe and complex eating disorder which cannot be treated within Tier 3 CAMHS Eating Disorders team either because of physical or psychiatric risk

Where there has already been an admission to or assessment by another Tier 4 CAMHS unit and the severity / complexity of the eating disorder is such (includes lack of response to treatment in Tier 4 CAMHS) a specialist eating disorder service is indicated

## Exclusions

Young people who have weight issues in the absence of a recognised eating disorder.

### 3.5 Interdependencies with other services/providers

#### Co-located Services:

Tier 4 CAMHS and/or paediatric hospital services

## 4. Applicable Service Standards

### 4.1 Applicable national standards e.g. NICE

### 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- NICE (2004) - Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders CG9

In addition the 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder – Commissioning Guide' (July 2015) makes recommendations on when inpatient care should be considered.

## 5. Applicable quality requirements and CQUIN goals

5.3 Applicable quality requirements (See Schedule 4 Parts A-C in the contract)

5.4 Applicable CQUIN goals (See Schedule 4 Part D in the contract)

## APPENDIX 2 of C07/S/ CAMHS T4 General Children & Adolescents Specifications

### Service Specification Appendix: Learning Disability Service

<b>Service Specification No.</b>	C07/S/a (Appendix 2 CAMHS LD)
<b>Service</b>	Tier 4 CAMHS In-patient Learning Disability Service.
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	The name of the individual leading on the service for the provider
<b>Period</b>	12 months
<b>Date of Review</b>	



## 1. Population Needs

### 1.1 National/local context and evidence base

For the purposes of this specification the International Classification of Diseases (ICD) 10 categories for learning disability are used as these are commonly used in health services rather than the educational categories. Whilst recognising that Intelligence Quotient (IQ) is only one domain of disability the categories are:

- Mild Learning Disability IQ 50-70
- Moderate Learning Disability IQ 35-49
- Severe Learning Disability IQ 20-34
- Profound Learning Disability IQ below 20

The Tier 4 CAMHS Specialist Learning Disability Unit provides day/ in-patient care and treatment for children and young people with:

- moderate to severe learning disabilities and co-morbid mental health problems which cannot be adequately and safely treated within Tier 3 CAMHS / Learning Disability Services because of the associated risk to self or others
- children and young people with mild learning disability and co-morbid mental health problems which cannot be adequately or safely treated within Tier 3 CAMHS because of risk to self or others and whose needs cannot be met within a Tier 4 CAMHS General Adolescent Unit or Tier 4 CAMHS Children's Unit
- children and young people with moderate to severe learning disabilities and with complex behavioural difficulties who exhibit a lower level of risk but where physical illnesses may be contributing to their problems and this requires in-patient investigation and assessment and who because of their behaviours cannot be adequately or safely treated within a paediatric ward or medical ward.

As the specialist services have highly specialist skills the services also receive referrals for outpatient second opinion assessments on children and young people with learning disabilities and co-morbid mental health problems.

Tier 4 CAMHS General Adolescent Services provide care for the majority of young people with mild learning disabilities requiring a Tier 4 day/in-patient admission and Tier 4 CAMHS Children's Units provide care for children with mild-moderate learning disabilities requiring Tier 4 day/in-patient admission.

Many children and young people with more severe learning disabilities exhibit challenging behaviour and require specialist educational placements or other residential placements. The Tier 4 CAMHS Specialist Learning Disability Units are not an alternative for such placements but instead are aimed at providing a level of assessment and/or treatment which cannot be provided in such a setting in conjunction with a Tier 3 CAMHS or Tier 3 CAMHS Learning Disability team.

Currently there are 5 services in England across 4 providers, 3 of these are NHS services and one is an independent service.

Data is collected via the Assuring Transformation data set which includes children and young people with a learning disability and/or autism. We have also had data collected by DH via the Learning Disability Census.

There is varied development of community learning disability services for children and young people (Getting it right for children and young people; overcoming cultural barriers in the NHS so as to meet their needs: Dept of Health, 2010.). This situation can result in both under-detection and under- treatment of mental health problems in this population as well as referral for in- patient care or for other residential placements which could be avoided by provision of adequate Tier 3 CAMHS and other community learning disability services. Information in relation to local areas and how services are provided should be reflected in their Local Transformation Plans (LTPs) which were developed in 2015.

### Transforming Care

The provider will adhere to/ support all Transforming Care policy including Care and Treatment Reviews.

<https://www.england.nhs.uk/wp-content/uploads/2015/10/ctr-policy-guid.pdf>

The provider will pay particular attention to the following requirements:

1) Work with partners to prevent children and young people with learning disabilities and/ or autism being admitted unnecessarily into inpatient learning disability and mental health hospital beds; and ensure when admission is necessary it will be as close to home as possible, at lowest level of restriction, and for the shortest time possible

The provider will ensure any admission is supported by a clear rationale of planned assessment and treatment together with defined and measurable outcomes.

The provider will work with partners to ensure active discharge planning is undertaken from the point of admission

The provider will work with all partners; and with the child, young person and their family, to support discharge into the community (or less restrictive setting) at the earliest opportunity.

2) The provider will enable/ contribute to Care and Treatment Reviews as set out in the policy

The provider will work with commissioners to ensure post admission and six monthly Care and Treatment Reviews are completed within the prescribed timescales

The provider will ensure all clinical staff, paperwork and other resources are available for Care and Treatment Reviews

The provider will support commissioners in organising care and treatment reviews, including but not limited to involving families and others

The provider will liaise with partners to make sure recommendations of Care and Treatment Reviews are undertaken and must ensure that educational needs continue to be met alongside the creation and the revision of Education health and care plans.

### **Evidence Base**

Children with a learning disability form 2.5% of the child population. In a typical population of

250,000 where approximately 20% of the population will be children (about 50,000) of these about 1500 will have a learning disability and 250 will have an IQ of less than 50( Kiernan C and Qureshi H (1993) in C.Kiernan (ed) Research to Practice: Implications of research on the challenging behaviour of people with learning disability. British Institute of Learning Disability Kidderminster ).

A third to a half of children with a learning disability has a significant mental health problem or a severe behavioural disorder as compared to around 10% of the non- learning disabled population. Approximately 20% have co-morbid autism the proportion increasing with the severity of learning disability and these children/ young people form the bulk of those presenting with severe behavioural disorders especially aggression and self-injurious behaviours.

There is a paucity of high quality empirical research to guide treatment for children and young people with learning disabilities and treatment is often extrapolated from the non-learning disabled population.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

<b>Domain 1</b>	<b>Preventing people from dying prematurely</b>	
<b>Domain 2</b>	<b>Enhancing quality of life for people with long-term conditions</b>	
<b>Domain 3</b>	<b>Helping people to recover from episodes of ill-health or following injury</b>	
<b>Domain 4</b>	<b>Ensuring people have a positive experience of care</b>	
<b>Domain 5</b>	<b>Treating and caring for people in safe environment and protecting them from avoidable harm</b>	

The service is required to monitor clinical outcomes. As a minimum the service will use outcome measures as indicated in QNIC ROM, including:

1. Clinical measures
  - SDQ (self-report, parent/carer and teacher),
  - HoNOS-CA,
  - HoNOS-Sec, and CGAS.

These measures will be collected on admission, every six months and at discharge. These outcome measures will be reported on both a national and individual service basis.

2. Education providers will provide the following data:
  - Educational attainment and targets.
  - Pre-existing statement of special educational needs/EHC plan
  - A measure of wider progress and wellbeing in education, in addition to academic progress, to be completed each academic term, such as the Every Child Matters, Teacher and Student Assessment.

3. Parent / carer and young person feedback

- Young people and carer's experience of the service will be routinely sought as described in section 3.2. The means by which this feedback is collected should be agreed and implemented by all units.

Providers will be required to submit evidence of achievement of outcome measures as defined in the standard contract. This will include the measures as outlined above plus additional measures that will be reviewed annually.

### 3. Scope

#### 3.1 Aims and objectives of service

The aim of the service is to provide effective, evidence based care and treatment to children and young people with learning disabilities who are suffering from severe and/ or complex mental health problems such that there are:

- improvements in mental health and reductions in risk and challenging behaviour;
- support and advice to parents/carers to enable them to better support the child/ young person;
- advice to Tier 3 CAMHS / community learning disabilities teams and other agencies on future management
- advice and support to parents/carers to help them better manage the child/young person's behaviour
- enabling safe and sustainable discharge to a community setting.

The service will also:

- Ensure effective communication and liaison with Tier 3 CAMHS / community learning disability services, primary care and other agencies as appropriate

#### 3.2 Service description/care pathway

##### Service Model and Care Pathway

These are specialist units providing care and treatment to children and young people with a learning disability **and** co-morbid mental health problems.

The presence of a learning disability by itself in the absence of co-morbid mental health problems (including challenging behaviour requiring assessment / treatment in hospital) would not be reason for admission.

The service will provide :

- Assessment
- Day/ In-patient care
- Advice and liaison to referring community teams and other agencies as appropriate
- Information and support to parents/carers
- Second opinion assessments and advice / consultation to Tier 3 CAMHS/ community learning disability teams and other Tier 4 CAMHS

##### Referral

Referral should be from Tier 3 CAMHS/ Community Learning Disability Services or other Tier 4

CAMHS. Response times are as detailed in core specification except:

- Emergency admissions are not usually possible due to the need to assess the young person before admission. However it may be possible in some instances when the young person resides near the Tier 4 CAMHS Specialist Learning Disability Unit. Advice can be given to referrers on management pending assessment.

### **Pre-admission Consultation and Initial Assessment**

Prior to admission children and young people will have an access assessment to assess their needs and whether a Tier 4 CAMHS Learning Disability Unit is required. The access assessment may take place within the Tier 4 service, allowing the child/young person and parents/carers to visit the service premise which is an important aspect of informed consent but where required assessment can be at the child/young person's home base or other location. A community \CTR will be arranged when the young person is known to have a learning disability and or Autism prior to admission being agreed, the only exception being when due to risks and time factors this is not possible.

Where it is thought a Tier 4 CAMHS Learning Disability Unit is not required advice should be given to the referrer on other management and service options.

### **Admission**

Upon admission all children and young people should have an initial assessment (including a risk assessment and physical examination) and a care-plan completed within 24 hours.

All children and young people should have a full multi -disciplinary team assessment and formulation of their needs and a care/treatment plan which should as far as possible be drawn up in collaboration with the child/young person and parents/carers as appropriate . The time frame for this will range from 1 (one) to a maximum of 12 (twelve) weeks for a full and comprehensive assessment.

Examples of assessments:

- physical (e.g. physical examination and special investigations as indicated such as blood tests, Magnetic Resonance Imaging (MRI)/Computerised Tomography (CT) scan, Electroencephalogram (EEG), Electrocardiogram (ECG) etc.);
- nursing (e.g. baseline of general and any specific behaviours, communication, relationships, social skills, physical observations etc.);
- psychiatric (e.g. mental state examination to elicit psychopathology, risk, capacity and consent, the use of the Mental Health Act, developmental history etc.);
- psychological (e.g. neuropsychological, use of diagnostic tools and questionnaires to elicit psychopathology and monitor change, family functioning etc.);
- speech and language therapist (e.g. assessment of communication and language skills)
- occupational therapy (e.g. Activities of Daily Living (ADL), sensory and coordination, social skills, etc.);
- social work (e.g. any safeguarding issues, benefits, parents/carers needs, family functioning etc.);
- teacher (education and learning needs)

Treatment will take place alongside assessments and starts at the point of admission. The care and treatment plan will be modified and updated regularly as the child or young person's needs change.

When a child or young person remains in hospital after 6 months a second CTR will be arranged

and at each 6 months period subsequently.

### **Treatments and Interventions**

The CPA format and documentation used must be appropriate for use with children and young people with learning disabilities and take account of the fact that children and young people with learning disabilities are often subject to multiple planning frameworks, avoiding unnecessary duplication where possible.

CPA and CTR processes are different but have some commonalities and these two processes should compliment each other. Interventions may include:

- Psychological interventions directly with the child/young person or indirectly via nursing staff/parents/carers
- Creative therapies
- Speech and language therapy
- Occupational therapy
- Family based interventions
- Psychotropic and other medication

Whilst day/in-patients the child/young person shall receive education specifically tailored to individual need and provided by teachers skilled in special needs teaching. There should also be a programme of suitable activities.

As many children and young people also have complex physical disabilities/ needs any interventions required including physiotherapy will be provided by the service in collaboration with other providers.

There should be access to dietetic advice within the service.

The treatment/care plan will incorporate routine outcomes monitoring used to monitor progress and treatment. These measures must be appropriate for use with the child/young person and can be selected from the QNIC ROM data set, in addition the Health of the Nation Outcome Scale-Learning Disabilities (HONOS-LD), Nisonger can be used.

Following the initial assessment of need and CPA meeting, the service shall undertake the regular CPA reviews at a frequency determined by the young person's needs but generally at a frequency of between 6 -8 weekly. CTRs occur prior to admission or within 2 weeks following admission and then every 6 months or earlier if requested.

### **Discharge**

Discharge planning should start at the point of admission, agreeing with parents/carers and others in the child's or young person's network what change is required in order for the child or young person to be discharged to community services. The recommendations made from Care and Treatment Reviews should form the basis of discharge plans.

If they do not already have a Social Worker appointed from the local area the service will liaise with referrers and the appropriate local authority to ensure a Social Worker is appointed as multi-agency support is often required to support discharge. If changes are required in community provision including the child/ Young person's placement multi-agency planning must be initiated as soon as possible.

### **Multi-Disciplinary Team (MDT)**

The staffing of the unit should be compliant with Royal College of Psychiatrists Quality Network for In-patient CAMHS (QNIC) essential standards (2011). The addition staff team will include:

- Mental health nurses (including learning disability trained nurses),
- Psychiatrists (child and adolescent psychiatry or learning disability Certificate of Completion of Training (CCT) or dual CCT)
- Clinical psychologists (learning disability or child psychology trained or dual trained) ,
- Social workers
- Speech and language therapist
- Occupational therapist trained in sensory strategies.
- There should be input from a dietician.

There should be access to physiotherapy and general paediatric / medical specialists for children and young people who require this.

The ratio of staff to children and young people is generally much higher than in Tier 4 CAMHS General Adolescent Services or Tier 4 CAMHS Children's Services .The high personal care needs and higher risks of aggression often mean 1:1 and occasionally 2:1 staffing are required.

All staff must be trained and regularly updated in respect of de-escalation techniques and nationally recognised methods of physical restraint.

### **Advocacy**

The advocacy service will be experienced in working with children and young people with learning disabilities.

Services will ensure that information is presented in a format that is understood by individual patients and their parents and carers as appropriate.

### **3.3 Population covered**

Specifically, this service is for children and adolescents who have a learning disability and co-morbid mental health problems associated with risk to self and / others which cannot be safely or adequately cared for in community services or other CAMHS Tier 4 services, some of whom may also have autism.

### **3.4 Any acceptance and exclusion criteria and thresholds**

#### **Acceptance Criteria:**

Referrals for admission are accepted where the child or young person has had a pre admission CTR and access assessment, supporting admission to Tier 4 services. For emergency admissions where there is insufficient time to arrange a CTR before admission a blue light meeting (refer to CTR policy) should be arranged followed by a CTR within 2 weeks of admission. In some cases the CAMHS Tier 4 Learning Disability Service may also be the access assessor. Once a referral is received it will be reviewed by a senior clinician within the service.

The following factors influence whether a specialist Learning Disability unit is required:

- The presence and nature of co-morbidities autism and other neuro-disabilities etc. in addition to co-morbid mental disorders such as psychosis, bi-polar disorder, depression.
- The degree of disability. Children/ young people with a more severe learning disability have

high personal care needs (i.e. need help washing, dressing, may be incontinent). They may demonstrate behaviours that are harder to manage in other Tier 4 CAMHS settings such as stripping, faecal smearing, regurgitation and sexually inappropriate behaviours.

- Aggressive and self- injurious behaviours. The majority of children will have demonstrated aggression and/or self- injury prior to admission which has often precipitated the admission.
- Specialised education is required.
- Referrals will be accepted where the young person meets criteria for detention under the Mental Health Act, 2007 /1983 or under provisions of the Mental Capacity Act 2005 or for under 16s under provisions of the Children's Act 2004 including Parental Consent where appropriate.

## **Exclusions**

IQ above 70 (for young people requiring forensic services the threshold may be higher in borderline IQ range according to need).

Children and young people with a learning disability whose primary need is for accommodation because of family or placement breakdown.

Children and young people with a learning disability who do not require treatment as an in-patient

## **3.5 Interdependencies with other services/providers**

### **Co-located Services**

Generally, a site location shared by other mental health inpatient services is preferable to avoid isolation for staff and patients. **Additional Interdependent Services:**

- Community Learning Disability Services
- Social Care
- Paediatric services

## **4. Applicable Service Standards**

### **4.1 Applicable national standards e.g. NICE**

NICE guidance in mental health may exclude children and young people with a learning disability. The following NICE guidance includes children and young people with a learning disability:

- NICE Guideline 72 Attention Deficit Hyperactivity Disorder
- NICE Guideline CG128 Autism in children and young people

### **4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

Royal College of Psychiatrists Report 163 Psychiatric Services for Children and Adolescents with an Intellectual Disability

4.3 The provider will support the Care and Treatment Reviews as outlined in the national policy.

## **5. Applicable quality requirements and CQUIN goals**



**5.5 Applicable quality requirements (See Schedule 4 Parts A-C in the contract)**

**5.6 Applicable CQUIN goals (See Schedule 4 Part D in the contract)**

**6. Location of Provider Premises**

**The Provider's Premises are located at:**