

C04/S(HSS)/a

**2013/14 NHS STANDARD CONTRACT
FOR MENTAL HEALTH SERVICE FOR DEAF CHILDREN AND ADOLESCENTS**

PARTICULARS, SCHEDULE 2- THE SERVICES, A - SERVICE SPECIFICATIONS

Service Specification No.	C04/S(HSS)/a
Service	Mental health service for Deaf children and adolescents
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Deaf children's access to generic child and adolescent mental health services (CAMHS) is recognised as poor (Social Policy Research Unit research, 2009). There are currently an estimated 8500 severely to profoundly deaf children (aged 0-18) in England. The total number of all deaf children in England is reported to be 20,160 aged 0 – 18, of whom 42% are severely or profoundly deaf (8,470). 'Forging New Channels' reports that whilst 50.3% of such children will have some mental health problems, 3.4% will require highly specialist services at any one time (Hindley et al, 1994) giving an expected total of 290 for 0 – 18 year olds. The national caseload is expected to be slightly larger numbers to accommodate variation.

The service is expected to see a total of 364 referrals (per year) broken down into the following regions:

Area	Approximate No. of Referrals	Referrals broken into regions
Northern Arm (York, Manchester, Newcastle)	104	North East (22), North West (44), Yorkshire & Humber (38)
Central Arm (Dudley, Nottingham, Oxford)	99	East Midlands (31), West Midlands (39), South Central (29),

South East Arm (London, Cambridge, Maidstone)	125	London (56), South East Coast (29), East of England (40)
South West (Taunton)	36	South West (36)
Total	364	

The above referral levels are modelled based on experience of referrals to date, research and knowledge from the deaf and mainstream school populations and geographical populations of local deaf communities.

These approximate figures may vary and may be revised in consultation and discussion with the commissioners.

The national service is required to provide a service to deaf children or hearing children of deaf parents living anywhere in England and is responsible to activity promote the service and reduce any barriers for access.

Evidence base

Deaf children with mental health problems are known to have difficulties in accessing mainstream services (Towards Equity and Access, 2005). They often have complex mental health problems and physical, psychological, neurological or developmental co-morbidities. Communication problems with resultant socio-emotional and cognitive developmental delay, central nervous system damage, delays in accessing services, problems with peer and family relationships are all thought to contribute to higher levels of mental health problems (Hindley et al, 1994; du Feu and Fergusson, 2003). Deaf children are also more likely than hearing children to experience emotional, physical and sexual abuse and these experiences also increase risk of mental health problems (ADSS and others, 2002).

The specialist skills required to meet deaf children's needs, mean that generic services are often not able to provide an adequate service (Bailly and Lauwerier, 2003; NDCS, 2005); this mirrors the wider picture of the health care experiences of deaf people (Harmer, 1999).

The mental health service for deaf children and adolescents (MHSDCA) completed a 3 year pilot in a limited geographical area (3 strategic health authorities) between 2004 and 2009 which was independently evaluated by the Social Policy Research Unit. "Forty eight families referred to the services over the course of a year were interviewed at referral and 6-8 months into treatment. Qualitative accounts (parents (n=41) and children (n=20)) and scores on a parent completed standardised mental health measure (Strengths and Difficulties Questionnaire, SDQ) showed positive outcomes had been achieved for the majority of children, with changes in SDQ scores being statistically significant at follow up. In addition, parents and children both completed the CHI Experience of Service Questionnaire (ESQ). 80% of children

believed that the specialist service had helped them and over 80% parents agreed”.

Over three quarters of referrers reported being satisfied with the outcomes for the children they had referred. Referrers identified key skills which distinguished the specialist services from generic CAMHS and which, they believed, were critical to the quality and efficacy of the service. These were:

- meeting the child’s communication needs
- expertise in mental health and deafness
- the ability to accept referrals quickly
- liaison with schools
- provision of a range of therapeutic approaches
- provision of outreach clinics which reduces the child/family travelling to the clinics
- parents additionally reported the presence of deaf staff on the team as being important.

2. Scope

2.1 Aims and objectives of service

The National Deaf Child and Adolescent Mental Health Services (MHSDCA) is commissioned to provide a highly specialised mental health to deaf children and young people (aged 0 to 18 years) and hearing children of Deaf adults, in both the community and in-patient setting, on behalf of the NHS England for the population of England. MHSDCA is a Highly Specialised Service for Deaf Children Young People and Families. For the purposes of this specification document it will be referred to henceforth as MHSDCA.

The MHSDCA philosophy of care is to operate as a bilingual and bicultural MHSDCA where:

- the nature of clients as D/deaf and hearing individuals (and their families) is acknowledged and fully understood
- their linguistic and cultural preferences are respected and met, and
- their mental health needs are effectively catered for.

The aim of the service is to improve their mental health by delivering highly specialised assessment and treatment packages in a safe environment; at home, community, clinic or inpatient setting, with the aim of:

- improving mental health and well being
- providing services that are linguistically accessible
- minimising the risk to themselves or to others
- promoting social inclusion and reducing isolation
- improving their quality of life
- promoting systemic changes that impact positively on their mental health including safe inclusive education where communication needs are met and children and young people have access to healthy learning and peer

relationships

- enabling them to function in daily life to the best of their ability
- providing an in-depth understanding/assessment of the child's language
- providing awareness to generic CAMHS to promote joined up provision of CAMHS for deaf children and young people
- promoting an equitable and accessible mental health service at highly specialist levels for deaf children and young people and their families.

The service is commissioned to work in partnership with wider agencies ensuring the young person's needs are central to integrated care provision across health, social care, education and the third sector to ensure timely transfer for specialised assessment and treatment.

Key roles for the national service are to provide:

- specialist mental health assessment of deaf children and young people being referred from generic CAMHS or educational establishments
- specialist language/communication assessment provided by deaf and hearing clinicians working together, to enable access to all levels of CAMHS
- treatment through a wide range of deaf appropriate interventions to address individual's mental health needs
- reduction and management of the potential risks posed to both self and others by the individual, through individualised treatment plans; dynamic clinical risk assessment and management processes
- delivery of responsive individualised care through multi-disciplinary care planning involving both deaf and hearing staff (where appropriate using the CPA framework)
- promotion of user engagement in their care and wider service through active service user involvement
- specialist advice to generic CAMHS to ensure young people are treated in the most appropriate place
- partnerships with local deaf and mainstream schools and with other health, social care, non-statutory and education agencies to develop comprehensive and integrated care pathways, and to promote better services for the client group through teaching, research and service development
- support for professionals working with deaf people to access specialist training and resources to promote the wellbeing of deaf children and their families.

Strategic objectives

To raise awareness of the issues for deaf children and young people, and the issues facing children of deaf adults, in order to promote a more effective response in terms of speed and appropriateness. MHSDCA is also committed reducing the risk of misdiagnosis and inadequate or delayed treatment. Ultimately, a successful MHSDCA service will lead to a reduction in deaf adults needing to access mental health services, entering the criminal justice system and an increase in skilled Deaf and hearing bilingual practitioners working together to provide a highly specialised service for deaf families. The service aims to develop an experienced and credible workforce that can meet the needs of service users and this would include professionals with a range of skills, knowledge and expertise who are both D/deaf

and hearing.

Objectives:

to provide a comprehensive service for all eligible referred deaf young people;

- expert diagnosis of severe mental illness utilising the most up-to-date validated assessment/diagnostic tools and knowledge
- expert management of deaf young people with confirmed diagnosis of severe mental illness through the use of the most up-to-date clinical protocols for prescribing, therapeutic interventions and symptom management
- to support young people in being able to effectively communicate and advocate on their behalf
- effective monitoring of deaf young people to ensure optimal daily function and social inclusion with regards to their mental health
- to operate a rolling programme of accessible clinical audit to test current practice and inform the evolution of care and therapeutic intervention for the range of mental health conditions in deaf children and young people
- to provide therapeutic support and care with a patient and deaf family centred focus to maximise the child and family experience of care within the nationally designated providers
- to be seen as the leading clinical services and a source of expert advice for the diagnosis and management of deaf children and adolescent mental health within the NHS, social care and educational system
- to support local deaf and mainstream schools, CAMHS, health and social care providers to manage deaf young people with severe mental health where ever it is clinically appropriate and safe to do so. Provide high quality information for patients, families and carers in appropriate and accessible formats and media
- to develop the experience, knowledge and skills of the MDT to ensure high quality sustainable provision to include the development of specific skills such as fluency in British Sign Language (working towards BSL level 3 or higher in order to communicate effectively with colleagues and families)
- to include and support the training of Deaf/deaf professionals within the team
- to support the development of career pathways and training opportunities for deaf professionals within the service.

2.2 Service description/care pathway

The national service provides evidence-based treatment for young people either at home, in the community or in an inpatient unit and ensures that there is an effective, safe, and timely discharge to local services, giving specialist professional advice to referrers and other agencies where needed.

Management

The service will have dedicated management time funded by the NHS England.

Managers in each of the four sites will have local management responsibilities for

their teams and for the outreach teams based in other CAMHS departments. Managers will also have national management responsibilities to ensure equity of access across the country and consistency of care pathways, national protocols about communication, interpreting, training and workforce development. The four main service managers will meet regularly.

Each of the four community outreach services and the in-patient provision will have a clinical lead who will work closely with the dedicated manager.

The four managers and the five clinical leads as well as deaf service consultants will meet six monthly at an MHSDCA Service Review to ensure consistent national development and standards. The NHS England will organise national away days annually for staff and a national audit meeting annually as well as a national stakeholder meeting to promote PPI every one to two years. The NHS England will also disseminate decisions about service provision down to the local arms of the service. The NHS England will also discuss national aspects of quality improvement schemes and cost improvement schemes and support decision making about their impact upon local services. The NHS England will also discuss national issues about training and workforce development.

Workforce

In line with the well-researched finding that deaf children have received a poor service for many years in generic CAMHS, there will be an understanding that where MHSDCA local services are managed alongside other CAMHS, the dedicated funds for this service will be protected for the benefit of deaf children and their families.

The service will be delivered by a multi-disciplinary team with up to date skills and knowledge. For a highly specialised deaf mental health service to be effective it needs to be well represented by deaf and hearing staff with a good understanding of the full range of cultural and linguistic differences present in the client group. All teams will work towards the development of improved career pathways and training opportunities for deaf staff, and work towards deaf staff being represented in a range of posts across the service. All hearing staff will continue to work on the improvement of their BSL skills and deaf awareness, and this along with the improvement of mental health skills and knowledge will be central to service training planning.

Each outreach locality will always include time from:

- consultant child and adolescent psychiatry
- consultant child clinical psychology
- child mental health nurse practitioners or equivalent therapist practitioner time
- deaf family support worker or specialist deaf outreach worker.

Each main centre may in addition have time from other disciplines as determined by need that may include:

- language therapy

- occupational therapy
- family therapy
- social work practitioner time.

Inpatient Service Provision

- specialist assessment and inpatient psychiatric service for deaf children resident in England and Scotland
- six inpatient beds for the diagnosis and assessment of deaf/deaf children and adolescents with known or suspected mental health problems that require inpatient assessment and/or treatment
- appropriate, individualised, evidence-based psychiatric treatment (including drugs costs) and mental health care during the period each young person is an in-patient
- family support for the period of the inpatient stay
- support to other professionals to enable timely transfer to community or specialist services
- co-ordinated follow-up care and, if necessary, initial support and advice for the agencies providing it.

However, long-term follow-up care is not included in the specification.

Community Outreach Provision

- specialised assessments and person centred interventions, based upon assessment of need and risk to those deaf children and families meeting the referral criteria and who reside in England;
- support, advice and treatment in partnership with local generic CAMHS, improving the quality and accessibility to tier 2 services for these children and young people;
- specialist consultation and advice to generic CAMHS as well as other key professionals working with deaf children and adults including existing networks of teachers of the deaf and deaf social workers, residential school staff and other professional groups;
- develop joint working arrangements with CAMHS through providing specialist training packages and development of CAMHS working links offering the opportunity for consultation;
- network of trained interpreters experienced in working with deaf children in mental health settings.

Staff in outreach services will initially provide assessment, school liaison and family work. They will work closely with existing professionals in their locality providing services from CAMHS, education, social services and third sector agencies. They will develop multi-disciplinary working to extend the range and quality of services available to deaf young people. Good communication underpins services and the team of D/deaf and hearing mental health professionals need a sound collective knowledge and fluency in the range of communication modes used by deaf children,

including British Sign Language (BSL).

Expertise of clinicians will be required in:

- working with deaf staff, interpreters and language therapists in understanding language and communication;
- British Sign Language up to Level 2/3 (as appropriate) and have a good understanding of alternative communication systems;
- language development and disorders;
- an understanding of deaf culture and to recognise the importance of working with deaf staff and interpreters for their extensive knowledge and experience of Deaf culture as well as their links to the deaf community;
- knowledge of deaf education, networks and professionals;
- knowledge and skills in mental health problems in deaf children.

Professionals also need to be able to work effectively with qualified BSL interpreters and relay interpreters, and understand the challenges of interpreting in other minority community languages. BSL/English interpreters need specialist training to work with mental health professionals and with deaf children who have child mental health problems.

The service will provide clinics in all residential or special schools for the deaf, namely:

- Northern Counties School, Newcastle
- RSD Derby
- Mary Hare, Newbury
- RSD Exeter
- RSD Margate
- Hamilton Lodge, Brighton
- Frank Barnes School
- Heathlands, St Albans
- Oak Lodge, Wandsworth
- (RSD Manchester) Seashell Trust
- Doncaster School for the Deaf
- St John's School for the Deaf, Wetherby
- Elmfield Primary and Secondary School
- Longwill School for the deaf.

NB: The national service will seek to actively support all non-residential deaf schools when required.

Telelink facilities will be used to link different geographic parts of the national service for management meetings, supervision. Where appropriate other technologies (e.g. Skype and Facetime) will be used for example to provide accessibility to both Deaf and hearing professionals seeking consultation. Teleconferencing will also be used to provide consultation with schools and supervision between sites. It will also be used for continuous professional development (CPD) purposes. In situations where it would enhance patient care it will be used clinically (e.g. accessing a BSL therapist or reducing family travelling time).

Care pathways

The national service will provide Tier 3 & 4 care as outlined in the Health Advisory Service (1995) 'Together We Stand' tiered model:

- Tier One - teachers of the deaf, social workers for the deaf, school staff, paediatricians and others will continue supporting families in nurturing the emotional and psychological needs of deaf children and young people;
- Tiers Two and Three - deaf children and young people will access generic CAMHS services. These CAMHS will be able to access consultation and liaison from MHSDCA;
- Tiers Three and Four - MHSDCA will see deaf children and young people with more complex and high level mental health needs. These specialist services will also support generic CAMHS (tier two) and other professionals (tier one) working with deaf children. This will be done through consultation, training, and where appropriate joint assessment and co-working;
- Tier Four inpatient service – there will be strong links between the outreach services and the tier four in-patient service based at Corner House at South West London and St Georges' trust in London. The in-patient service will work closely with outreach centres around pre-admission assessments, good communication with community services during client admissions and in good post-discharge planning.

The service will provide safe and effective clinical care across the different stages of the following care pathway and is detailed in appendix 1:

- Consultation
- Referral
- Pre-assessment
- Decision to admit
- Admission
- Treatment Programmes/CPA
- Discharge.

Days/hours of operation

The national service is to operate at the following times:

- Community Outreach Service - Monday to Friday 0900 – 1700 hours;
- Inpatient Service - 24 hour 7 day residential unit. (the unit will close at the weekend if children/young people are well enough to return to their families).

Discharge planning:

Outreach - The national service is required to put in place a discharge plan at the point of discharge and aim to proactively consider discharge needs from the earliest point in treatment (to include the assessment). This would take into consideration the needs and wishes of child, young person and family, and the involvement of other supportive professionals. A copy of the discharge planning information will be given to the referrer, the general practitioner and with the permission of the family to any other involved professionals.

Children and young people will transition to other services where this is appropriate. This may include care from:

- generic CAMHS
- local authority staff
- third sector services
- adult mental health services
- adult specialist deaf mental health services
- adult learning disability services
- or other appropriate services.

Inpatient provision - Discharge from the inpatient unit will be agreed with the young person and the child's family as appropriate. Discharge planning will be discussed with the young person, the family and the referrer at the earliest opportunity (beginning at admission). The discharge will be agreed based on the general improvement of the child/young person difficulties so that the outreach centres, local CAMHS and other services can continue the therapeutic care plan.

Discharge will also be carefully planned with the outreach centre involved as well as the children and their families. The service will also identify the care co-ordinator in the outreach (and the local CAMHS when involved) who will be taking over the child and family's care so that the child/young person and their families can become familiar with them and find support in the separation from the unit.

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- adult mental health services
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- or other appropriate services.

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2.3 Population covered

This service covers patients registered with an English General Practitioner or those resident in England and eligible for treatment in the NHS under reciprocal arrangements (for example European Union citizens). Patients from Wales and Northern Ireland are not part of this commissioned service and the trust must have separate arrangements in place.

The national service will provide consultation on a discretionary basis to Wales, Scotland and Northern Ireland and will only carry out direct clinical work with children or families in Scotland, Wales or Northern Ireland if the child is either resident or in school in England. We will support the development of new services in other countries.

2.4 Any acceptance and exclusion criteria

Referrals are invited from professionals who work with children. A referral form can be requested by phone/fax. Contact needs to be made with the team for consultation to discuss a potential referral. For further details refer to the care pathways.

The MHSDCA (community) service provides assessments and interventions to those children and families meeting the referral criteria and who reside in England. To be referred, a child should meet both of the following criteria:

- a mental health condition where there are severe or complex child mental health needs equivalent to a Children's Global Assessment Scale Score of 50 or below;

And have either:-

- a severe or profound hearing loss or
- BSL as their preferred/first language or
- a significant language impairment related to hearing loss
- where a hearing child with mental health problems has a parent who is a BSL

user, or has a severe or profound hearing loss, an assessment will be provided.

Referrals to the service will be accepted from a range of professionals including CAMHS teams, teachers of the deaf, social workers, hospital consultants and general practitioners. Self or family referrals are not accepted. The MHSDCA Inpatient service provides assessment and treatment for those children and families meeting the following criteria:

- deaf children/young people of deaf or hearing parents, aged between 8 and 18 years
- children/young people who have mental health difficulties is of a sufficient severity to warrant inpatient assessment and care, mental health difficulties including:
 - anxiety
 - depression
 - psychosis
 - neurodevelopment
 - emotional/behavioural problems
 - substance misuse.

Or:-

- children/young people with mild or moderate learning difficulties when deafness is integral to their presentation. Where the child's learning difficulty is severe or profound, the referrer will be advised to request consultation from the Deaf Child & Family Service
- care is unable to access their local service because of issues relating to their deafness and where deafness is an integral factor in their presentation.

The service accepts referrals for families that local services report finding difficult to engage. In collaboration with the referrer and following a preadmission assessment, the Corner House team will determine if an assessment admission can be progressed.

Acceptance of a child to the unit at any time will depend on the age and gender mix of current inpatients, the primary consideration being that of safety for young people and staff at Corner House.

Exclusion criteria:

- in line with the National Service Framework (NSF) for CAMHS the service will provide assessment for children and young people until their 18th birthday (for admissions to the in-patient provision the child will need to be above aged 8)
- children/young people who require forensic secure settings
- those with a conduct disorder only will not be admitted to the in-patient mental health provision
- not registered with a GP in England.

Response time & detail and prioritisation

Outreach service - The national service is required to make contact with a family within two weeks and begin the assessment process within four weeks of referral.

Inpatient provision - It is good practice to have a preadmission assessment with the aim to offer an assessment within two weeks from referral. Children and young people are assessed and admitted sooner when at greater risk, such as acute psychosis or depression with potential threat to the young person's life.

The deaf service is accessible to deaf children and their families regardless of their choices about modes of communication, language, amplification or education. The service is apolitical in terms of language choices for children. The MHSDCA will provide equitable services for any children or young people from 0-18 from any cultural background, religion, gender and with any illness or disability.

Every reasonable effort is to be made to make services accessible, including consideration of cultural issues as well as choice of venue and use of interpreters and deaf interpreters (relays). Providers require staff to attend mandatory training on equality and diversity and the facilities provided offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information (as well as on DVD) will be available in multiple languages including BSL

The provider has a duty to co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, religion and disability equality legislation.

2.5 Interdependencies with other services

The MHSDCA will hold twice yearly co-ordinating meetings (The National Co-ordinating Group) to include the clinical lead and operational manager from each of the four main centres, PPE representatives, senior clinicians from disciplinary groups and a finance manager representing the four main finance managers. This meeting will afford an opportunity for national service co-ordination and planning. The nationally designated MHSDCA providers are the leaders in the NHS for patient care in this area. They provide a direct source of advice and support when other clinicians refer patients into the nationally designated providers. The providers are also required to provide education within the NHS, Education and Social Care to raise and maintain awareness of deaf child and adolescent mental health and its management.

The national providers will form a relationship with local education, health and social care providers to help optimise any care for Deaf CAMHS provided locally for the patient. This may include liaison with a range of professionals including teachers of the deaf, social workers consultants, GPs and community nurses. Clinicians, working with deaf staff and interpreters, in outreach and inpatient service will initially provide assessment, school liaison and family work. They will work closely with existing professionals in their locality providing services from education, social service and the voluntary agencies. They will develop multi-disciplinary working to

extend the range and quality of services available to young people.

Specialist services will provide support for generic CAMHS services. This support will include:

- direct consultations
- co-working for complex cases
- good liaison and individual child care planning.

The specialist and outreach services will work together to provide a network of telelink mental health services, where possible supporting links to teleconferencing facilities in residential schools for the deaf and provision of a network of ten CAMHS centres (all specialist and outreach services). The teleconferencing facilities will be used for the provision of consultation, liaison, supervision, managerial discussions and delivery of therapy. The national centres will work together with other regional and national organisations to improve and facilitate appropriate high quality training for professionals in both specialist and generic services. This will include having more input to currently developing courses in Newcastle, Birmingham and York and other Higher Education institutions.

The Towards Equity and Access (TEA) report specifically mentions the need to use video conferencing to access services and recommends that mainstream child and adolescent mental health services should work with national services for deaf children.

The national service will undertake:

- a yearly national audit meeting to include mapping of provision and review (involving NHS England)
- a yearly national away day to discuss service development;
- regional tele-conference clinical meetings
- regional governance bi-monthly meetings
- national bimonthly management meetings.

The national service will seek to develop effective partnerships with:

- National Deaf Children's Society
- British Association for Teachers of the Deaf, regional associations and networks of teachers
- locally specific deaf services (e.g. CHISWG, audiology departments);
- British Association for the Deaf
- Association of Sign Language Interpreters
- British Society for Mental Health and Deafness
- Sign Health
- other relevant voluntary sector organisations such as Deaf Parenting UK, Delta and the Elizabeth Foundation
- relevant networks and screening programmes.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

The nationally designated MHSDCA service providers must be fully integrated into their trust's corporate and clinical governance arrangements, ensuring that the process is fully accessible. There is an expectation that practitioners will participate in continuous professional development and networking, which will include deaf aspect training, learning and development. There is also a need to work within trusts to promote equity of access for deaf and hearing staff and patients.

The designated centres will meet on an annual basis to review the clinical governance and outcomes of the service through the National Co-ordinating Group including:

- clinical outcomes
- service issues
- evidence based practice
- audit activities, service evaluation and research.

The national service will develop common evidence base tools and training programmes:

- common risk assessment and management approaches and systems
- training for developing the skills required to work with deaf children and young people with mental health issues
- clinical information systems, reports to commissioners
- patient consultation and advocacy.

Local multiagency child protection policies will be adhered to, the common principles of which are endorsed by the National Deaf CAMHS.

Arms of the service will be looking to work together to improve provision of care for deaf children, within and outside the service. The service will seek to influence NICE guidelines and are developing a national research agenda from national portfolio grant funding. A clinical research group for deaf child mental health sponsored by the Mental Health Research Network has been formed and is active.

The service is to deliver treatment in line with the NICE guidelines specific to the treatment of mental and emotional health and wellbeing:

- NICE guidelines for Psychosis and schizophrenia in children and young people
- NICE guidelines for Attention Deficit Hyperactivity Disorder
- NICE guidelines for autism
- NICE guidelines for self-harm
- NICE guidelines for eating disorders
- NICE guidelines to reduce substance misuse in vulnerable young people
- NICE guidelines for Anxiety and Depression
- NICE guidelines for Post Traumatic Stress Disorder.

Since NICE guidelines have been developed largely using an evidence base from

the hearing population adaptations may be made to make the guidelines relevant to deaf children and their parents. For example, some therapies may need adapting for cultural and linguistic purposes and some may not be appropriate (e.g. have not been validated in the deaf child population). It is important for MHSDCA to support and work in partnership with current researchers around the development of deaf validated tools for assessment and intervention.

4. Key Service Outcomes

Outcomes:

- to maximise the child and adolescent development, mental health, well being and social inclusion of deaf young people with severe mental illness through optimal clinical management and support
- to maximise the young person's ability to effectively communicate in all areas of their lives
- the service is required to monitor improvements in a young person's mental health, before and at the end of a period of treatment (or every 6 months if shorter) using the following outcomes:
 - Children's Global Assessment Scale
 - Strengths and Difficulties Questionnaire
 - Child Health Improvement Experience of Service Questionnaire (at the end of a period of care)
 - Goal Based Outcome Record.

(The service aims to provide all documentation and communication in the stated preferred language of the family.)

5. Location of Provider Premises

The national service will be delivered as a community outreach model across England supported by specialised inpatient care.

Inpatient care (one centre), covering all of England

- South West London & St Georges Mental Health NHS Trust

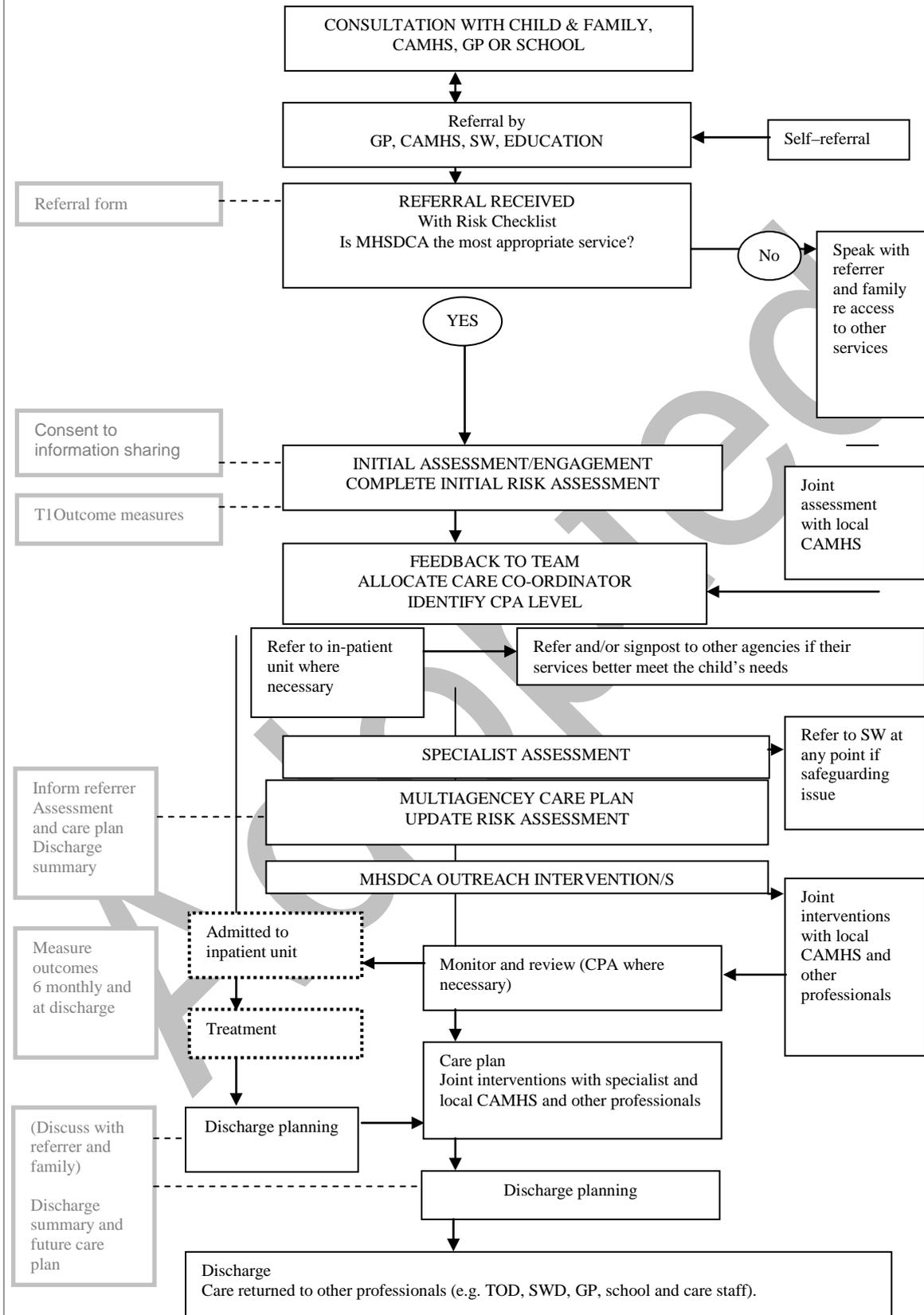
Community care (comprising four main centres)

- London & South East – South West London & St Georges Mental Health NHS Trust (with outreach teams based in Cambridge and Maidstone)
- North of England – Leeds and York NHS Partnership Foundation Trust (with outreach teams based in Manchester and Newcastle)
- South West – Somerset Partnership NHS Foundation Trust

Midlands – Dudley and Walsall Mental Health Partnership NHS Trust (with outreach teams based in Oxford and Nottingham).

Adopted

Appendix 1 – Care Pathway



End.

Adopted