

**NHS STANDARD CONTRACT  
FOR TIER 4 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS):  
CHILDREN'S SERVICES**

**SCHEDULE 2 – THE SERVICES – A. SERVICE SPECIFICATIONS**

<b>Service Specification No.</b>	C07/S/b
<b>Service</b>	Tier 4 Child and Adolescent Mental Health Services (CAMHS): Children's Services
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	2013/14
<b>Date of Review</b>	

This specification provides an overarching core specification for all Tier 4 CAMHS Children's Services. There are additional appendix specifications for Tier 4 CAMHS Eating Disorder Services and Tier 4 CAMHS Learning Disability Units.

There is a separate service specification for Tier 4 CAMHS Adolescent In-patient Units and Specialist Autism Spectrum Disorders Services.

## **1. Population Needs**

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

#### **National Context**

Child and Adolescent Mental Health (CAMH) Tier 4 Children's Services deliver specialist in-patient and day-patient care to children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMH services.

Current estimates of the total number of patients in England using the Services are 140-150 per year (based on data gathered between 2008 and 2010).

There are currently eight dedicated Tier 4 CAMHS Children's Units in England these are located in Manchester, Liverpool, Sheffield, Birmingham, Cambridge and London. All units offer care to children aged under 12 and under; occasionally younger adolescents 13 and over are admitted if their profile and needs are better met in a children's unit. , One unit offers family admissions allowing admissions of very young children and parents with mental health disorders.

## **Evidence Base**

The best UK research evidence regarding Tier 4 CAMHS In-patient treatment for children is derived from the Children's and Young Person's Inpatient Evaluation (CHYPIE) Department of Health study (Green, Jacobs et al 2007) which examined care pathways, outcomes and health economics for children and adolescents using a selected group of Tier 4 services. For the children aged 12 and under in this large UK study, clinical outcome scores (The Children's Global Assessment Scale (CGAS) and Health of the Nation Outcome Scale Children and Adolescents (HoNOSCA)) showed clinically and statistically significant improvement in scores between admission and discharge. After discharge the clinical scores for children returned to levels commonly recorded in children attending outpatient clinics. Clinical gains made were maintained a year after discharge.

The service is commissioned within the context of National CAMHS policy e.g.: Children and Young People's Health Outcomes Forum Report (2012); No Health Without Mental health; An all age strategy (2011); Achieving Equity and Excellence for Children (2010); The National Service Framework for Children, Young People and Maternity; The mental health and psychological wellbeing of children and young people (2004).

The service also operates in compliance with the legislative frameworks of the Children Act 2004 and the Mental Health Act 1983, as amended by the Mental Health Act 2007.

Care should be informed by evidence based practice including National Institute for Health and Care Excellence (NICE) and other best practice guidelines. The service will provide care within the framework provided by membership of the Quality Network for Inpatient CAMHS (QNIC) and will develop the service and maintain / improve quality through a system of review against QNIC service standards.

## **2. Scope**

### **2.1 Aims and objectives of service**

The aim of the service is to deliver family centred specialist inpatient, day patient and outpatient/outreach mental health care and treatment to children (and their families) who are suffering from severe and /or complex mental health conditions that cannot be adequately treated by community based services.

The service will achieve this aim by:

- Providing a holistic comprehensive assessment of the child's needs and those of their family.

- Providing appropriate, multi-disciplinary, intensive mental health treatment appropriate to the child's age and developmental stage, using agreed best practice protocols (e.g. NICE guidelines) where available.
- Providing treatment that will result in improved function and safe and sustainable recovery and improved resilience as shown by improved mental well-being, increased social inclusion, increased access to education and improved peer/family relationships
- Providing treatment in a safe, age appropriate, child friendly environment where risks are managed proactively and in the least restrictive way ensuring the safety of the child and others.
- Working collaboratively with parents/carers to provide family centred care
- Providing care in a unit as close as possible to home unless specific circumstances suggest that more effective care could be delivered in a unit at a greater distance.
- Providing timely assessment and treatment including urgent admissions when needed and ensuring that children spend the least possible time in inpatient care consistent with safe and sustainable discharge
- Ensuring effective communication between service users (including families), health providers and other involved agencies using the Care Planning Approach so that families and professionals are fully involved in the treatment and discharge process and that timely and appropriate community services are available upon discharge.
- Preventing inappropriate admissions of children with mental health disorders to adolescent mental health wards, paediatric wards or other residential settings.
- Collecting Service User and Carer feedback systematically to monitor and improve the quality of service provided.

## **2.2 Service description/care pathway**

Please note appendix specifications to be read in addition to the below (if provided):

Appendix 1: Specialist Eating Disorder Services

Appendix 2: CAMHS Inpatient Learning Disability Services

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

Tier 4 CAMHS Children's Units provide highly specialist care and treatment across an integrated care pathway. The community element of the pathway includes Tier 3 CAMHS services, which will be commissioned by CCGs and may also involve services commissioned and provided by local authority children's services.

Referral to a Tier 4 CAMHS Children's Unit should be via Tier 3 CAMHS service.

Acceptance by a Tier 4 CAMHS Children's Unit will be through a gate-keeping assessment to determine whether in-patient admission is appropriate.

Where the Tier 4 CAMHS Children's Unit offers different service elements (day / in-patient and Intensive Outreach) assessment will determine which element of the service is most appropriate in meeting the young person's needs. Day patient attendance may be provided for young people who would otherwise require in-patient care but because of proximity to the unit, the level of risk and the level of family support are able to be cared for within this level of service. Intensive Outreach may be provided for some young people who would otherwise require day/in-patient care but where both the level of risk and treatment needs can be managed within this level of service. Children will move through levels of service as clinically appropriate, aiming for discharge back to community Tier 3 CAMHS services as soon as it is safe to do so.

The service will provide care and treatment for children aged 12 and under who are experiencing severe mental disorders leading to significant impairment and/or risk. The types of disorders include the following:

- Psychosis
- Eating Disorders
- Affective Disorders
- Developmental Disorders including Autism, Attention Deficit Hyperactivity Disorder (ADHD), Tic disorders
- Obsessive Compulsive Disorders
- Anxiety and Emotional Disorders
- Self Harm, Attachment and Emotional Regulation Disorders
- Primary diagnosis of Mental Illness with co-morbid Learning Difficulties

Frequently children present with very severe levels of challenging behaviour i.e. aggression/violence to others. Often children also have multiple risk factors including exposure to parental mental illness, parental offending behaviour, abuse, or parental substance misuse. Some children will be in the care of the local authority or live in families who are refugees or asylum seekers.

Admissions occur for four main reasons:

- The child is experiencing significant impairment and their condition is deteriorating or failing to improve significantly despite appropriate outpatient management;
- There is a need for intensive assessment which could not be provided by Tier 3 CAMHS;
- There is a need for intensive treatment which could not be provided within Tier 3 CAMHS
- There is a need to reduce the risk to the child, family or others whilst offering intensive treatment.

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

- Referral
- Assessment

- Admission
- Treatment/ Care Programme Approach (CPA) process
- Discharge planning and discharge
- Transition to appropriate after care (usually Tier 3 CAMHS services)

The services will also comprise the following elements:

- In/day patient education provision
- Outpatient second opinion assessments, advice and consultation to Tier 3 CAMHS
- Outpatient attendance as part of discharge transition
- In addition services may provide:
  - Outreach to facilitate transition from day/in-patient care
  - Access to accommodation for parents/carers to facilitate assessment/treatment.

### **Referral**

Referral Routes:

- Referrals will be accepted from or supported by tier 3 CAMH services.

Response Times:

- Emergency referrals will be reviewed and responded to by a senior clinician within 12 hours ; emergency assessment will be offered within 24 hours
- Urgent referrals will be reviewed and responded to within 48 hours
- Routine referrals will be reviewed and responded to within 1 week and assessment offered within 4 weeks

### **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**

A gate keeping assessment for acceptance by Tier 4 CAMHS Children's Unit will be

undertaken. The assessment will explicitly address the following issues:

- Major treatment/care needs
- Comments on the best environment/ level of service in which the care should be provided
- Risks identified
- Comments on the ability of the holding/referring organisation to safely care for the patient until admission can be arranged
- Where the assessment is to determine whether in/day-patient care is appropriate the service shall ordinarily undertake an assessment of the child's suitability for care and treatment at the service premises to allow the parents/carers to make an informed decision about admission. The wishes and feelings of the child and parents/ carers should always be sought as part of the assessment.

Following such assessment:

- If it is agreed the child requires day/in-patient admission and the service is able to meet their needs and a bed is available within an agreed timeframe, the service will complete a full assessment report and initial care plan.
- Where after assessment it is determined the child requires care from a more specialist Tier 4 service (such as a Tier 4 Learning Disability Service, Tier 4 Eating Disorders Service) or another unit Tier 4 Children's Unit with different expertise the service will provide advice on the type of unit required
- Where after assessment it is agreed the child does not require a Tier 4 CAMHS service or the or parents decline a service (subject to their being no indication to over-ride this decision Children's Act 2004) a full assessment report should be provided including where appropriate advice to the Tier 3 service on future care.

## **Admission**

Admission could be to any of the following service elements:

- In-patient admission
- Day patient attendances at the facility

All patients will be under the care of a named consultant Child and Adolescent Psychiatrist.

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

All children 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 child's parents/carers as appropriate.

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, developmental history etc.).
- Psychological (e.g. neuropsychological, use of diagnostic tools and questionnaires to elicit psychopathology and monitor change, family functioning etc.).
- Social work (e.g. any safeguarding issues, benefits, parents/carers needs, family functioning etc.).
- Educational.

Speech and language assessments may be required and accessed as needed although not provided as routine; occupational therapy (e.g. Activities of Daily Living (ADL), sensory and coordination, social skills, etc) assessments may be required although not provided as a routine.

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 young child's needs change.

The care and treatment plan will be reviewed on a weekly basis by the service in collaboration with parents/carers.

The service will organise a Care Programme Approach (CPA) meeting involving the child's parents/carers, Tier 3 CAMHS and any other agencies involved in the young persons in the first 4– 6 weeks of day/in-patient admission, depending on the needs child's and the complexity of the system/network surrounding them.

### **Treatment and Care Programme Approach**

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

The care plan shall reflect the young person's needs in the following domains:

- Mental health;
- Developmental needs
- Physical Health
- Risk;
- Family;
- Social functioning;
- Spiritual and cultural;
- Education, training and meaningful activity;
- Where relevant includes a Carers Assessment;
- Where relevant includes accommodation / financial needs;

The treatment / care plan should 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 should incorporate routine outcomes monitoring used to monitor progress and treatment on a week to week basis, as a minimum this should incorporate clinician rated outcomes such as the Children's Assessment Global Scale (CGAS) but wherever possible should also include parent/carer rated outcomes and where possible patient rated outcomes such as those in Quality Network for Inpatient CAMHS, Routine Outcome Monitoring (QNIC ROM) and Children and Young People Improving Access to Psychological Therapy (CYP IAPT) datasets). For children admitted for treatment of low weight eating disorder this should 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 (RCPsych) 2012)

The service should incorporate outcomes monitoring its CPA review process using the standardised outcome measures published by QNIC /CAMHS Outcomes Research Consortium QNIC –ROM- as a minimum the CGAS and HoNOSCA

Following the initial assessment of need and CPA meeting, the service shall undertake the regular CPA reviews at a frequency determined by the child's needs but generally at a frequency of between 4-6 weekly.

Outside of the educational timetable, units will provide a programme of structured group activities. Units should provide a programme of therapeutic groups / activities.

All children should be offered regular key worker time at a frequency determined by their needs. In addition where specific individual therapies are indicated these should be offered without delay. Such therapies include Cognitive Behaviour Therapy, counselling, play therapy. Services may also offer creative therapies and psychodynamic psychotherapies.

All families will be offered Family meetings which will start within one week of admission and should continue at a frequency determined by the child's needs

In addition there parent and family work may include:

- Behaviour modification with parents as co-therapists
- Parenting skills training o Parents support group
- Social work support
- Systemic family therapies
- Other therapies as appropriate to support positive family relationships

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

The range and nature of risk behaviour in a Tier 4 CAMHS Children's Unit is broad

and can include self-harm, suicide, physical consequences of low weight, absconding, aggression, sexualised behaviour, fire-setting, safeguarding concerns.

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

Tier 4 CAMHS General Children's Unit 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 children.

The service should have a dynamic risk assessment model in place to support clinicians in making day- to -day decisions about individual children's care.

The service shall meet the risk assessment requirements appropriate for the care and security of all children, 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 a service for children.
- in 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 children, 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 standards developed Quality Network Eating Disorders CAMHS and Junior MARISPAN in relation to managing the physical health risks occurring in the context of low weight.
- the service shall ensure that risk is assessed and evidenced throughout the treatment process and collaborative care plans are developed with the child's parents/ carers ( and where possible the child) to manage it.
- 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.

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

Enhanced observations are a level of supervision by staff beyond the level of routine observations within a children's unit where children are a significant risk to themselves or others All Tier 4 CAMHS Children's Units shall:

- Develop and implement a policy for enhanced observations;
- 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). Engagement, collaboration and negotiation with the child are the core values underpinning this requirement, alongside maintenance of a safe environment, respect and care that reflects the needs of the young person. If a child is subject to Enhanced Observations, the continuing need for the observations should be reviewed at daily and reduced to the minimum at the earliest opportunity. Wherever possible it is expected that Enhanced Observations will be undertaken by staff members who have an on-going relationship with the child.

- 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 service's premises (or any part thereof), employing an appropriate risk management strategy to minimise potential hazards

## **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 the transfer of patients to a provider of other health services is in accordance with the policy previously agreed between the service and the coordinating commissioner and is in accordance with national guidelines and protocols and with good clinical and industry practice. Arranging appropriate transport to other health services shall be the responsibility of the service;
- 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 without limitation, immediate treatment, stabilisation and arranging for the transfer of the patient to an appropriate NHS Trust which can provide the level of care required. This will include any other steps that could reasonably be required to minimise the adverse consequences of the medical emergency, including using, where appropriate, locally agreed transfer protocols where these exist and complying with the latest UK Resuscitation Council guidance on basic life support for children and all future updates/revisions.

## **Psychiatric Emergencies**

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).

## **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 The Office for Standards in Education (OFSTED) registered. The Provider educational provision will be funded by re-charge of the patient's home-base Local Authority.

## **Discharge planning and discharge**

The service will ensure that all children will have a discharge meeting prior to discharge to hand the case back to the local community services and to feedback the work that the service has done and whether the treatment goals have been met (CPA discharge meeting). This review will involve the family and all community agencies involved with the child including the referring CAMHS team. The service will ensure that community services are aware of the interventions that have been delivered and that they are involved in planning any on-going work that is required.

It is not intended that the Tier 4 CAMHS Children's Unit will complete all required treatments for a child but only those elements which cannot be delivered in a community setting and requires an in-patient or day patient stay.

Most children will need on-going community care for a period of time after discharge.

All children will have a planned end to treatment if at all possible, with a structured ending that is consistent for each child. This may include a formal recognition of the end of their stay such as a party, or a presentation.

A discharge summary will be sent to the family, referrer and the General Practitioner (GP) at the end of each child and family's placement. 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 ensure high levels of liaison with schools to ensure educational re-integration is successful

## **Follow-Up Care**

Services will provide appropriate follow-up care following discharge – this can include outreach sessions, liaison with local services, and outpatient therapy sessions. Follow-up care should be agreed with the family and other agencies at the discharge planning meeting and it should be agreed which team will take lead responsibility for the family following discharge. It is particularly important that it is agreed whether Tier 3 or Tier 4 CAMH teams are taking the lead responsibility for health care after discharge as both teams may be working with the family for a period of time.

### **Delayed Discharges**

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

### **Discharges Against Medical Advice**

Unplanned discharge – the service has agreed protocols for occasions when a child or family discharge themselves against medical advice. This includes immediate notification of the GP, community mental health team and all other relevant agencies. It also includes notification of the commissioning body. The service will co-ordinate the network to ensure that the child and family continue to be offered appropriate health and other services.

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

Where a child requires transfer to an alternate mental health provider service, the current service will take lead responsibility in effecting the transfer. The services shall:

- Discuss the reasons for transfer and options for care, fully with the child and family
- Collaborate with the alternate provider to facilitate transfer;
- Take all necessary steps to prepare the child for transfer;
- On transfer, facilitate an appropriate clinical handover including, but not limited to:
  - Sharing current care and treatment programme;
  - Providing copies of the last review;
  - Sharing the most recent risk assessment;
  - Providing a comprehensive record of all current medication;
  - Formal medical and nursing handover to include all relevant aspects of physical health care;
  - Formal handover information of all therapeutic and MDT interventions;
  - Arrange and pay for appropriate transport consistent with the Patient's risk assessment;

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

Tier 4 CAMHS Adolescent Units will have multidisciplinary teams which have specialist experience in treating complex mental health problems in young people. The staffing of the unit should be compliant with Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC) essential standards 2011. The staff team will include:

- Consultant Child and Adolescent Psychiatrist
- Psychiatrists in training
- Clinical Psychologists
- Clinical Nurse Specialists
- Registered mental nurses (experienced in CAMHS)
- Registered general nurses /paediatric nurses where units provide care for young people with eating disorders
- Healthcare assistants (experienced in CAMHS)
- Occupational therapists
- Teachers and learning support assistants
- Social work
- Family Therapist
- Staff skilled in creative therapies
- Staff skilled in group work
- Dietetic advice where services provide care for young people with eating disorders
- Access to psychotherapy as appropriate
- Administrative staff

Where services admit young people requiring physiotherapy for example, young people with severe psychosomatic disorders because of a co-morbid physical condition, appropriate arrangements should be made.

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

Services are open 24 hours a day, 365 days a year. Services will be able to offer admission 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 children'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 children with mental health problems.

The advocacy service can also have a role in supporting the development of group advocacy within the unit so that children 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)

### **2.3 Population covered**

The service outlined in this specification is for patients 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 purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

Specifically, this service will generally treat children aged 12 and under, with complex and or severe mental health disorders, with young people over this age using Tier 4 CAMHS Adolescent Services.

In some circumstances (e.g. a child/young person with developmental delay or social disability), it may be clinically appropriate for children aged 13 or over to be treated in a Tier 4 Children's service rather than an adolescent service. Services will consider this on a case- by- case basis and will liaise between the referring community service, the Tier 4 adolescent service and the Tier 4 children's service to agree which service will best meet the child/young person's needs. A joint assessment may assist in establishing where treatment is best delivered.

Very rarely there may be circumstances when a child of 12 or under may be more appropriately treated in an adolescent service rather than a children's service. In this exceptional circumstance the relevant community CAMH service, Tier 4 CAMHS Children's Units and Tier 4 CAMHS Adolescent services should liaise closely to ensure that the child's need are met in the most appropriate service. A joint assessment may assist in establishing where treatment is best delivered.

### **2.4 Any acceptance and exclusion criteria**

#### **Acceptance criteria**

The service will provide care and treatment for children aged 12 and under who are experiencing severe and complex mental disorders leading to significant impairment and/or risk and which cannot be adequately treated within Tier 3 CAMHS.

The service will also provide care and treatment for children aged 12 and under with severe and complex needs where more intensive assessment is required than can be offered within Tier 3 CAMHS.

### **Exclusions**

The service will assess whether they can provide safe and appropriate assessment and treatment for each child referred to the service. The service will not be able to accept:

- Children who 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.
- Children with developmental disorders whose needs cannot be met by the service (e.g. severe or profound learning disabilities) – these children should be treated in specialised Tier 4 services for children with learning disability.
- Children with a primary diagnosis of Substance Misuse
- Children who are in need of Secure Care in Forensic Services
- Children whose principal referral criteria is the breakdown of family or care placement
- Children who are currently in Secure Placements provided by Local Authorities, who in the first instance should be referred to the National Forensic service.

In the very rare event that a service proposes to withdraw treatment from any child or family, the service shall discuss this with the relevant commissioner and inform the commissioner of the steps it has taken or proposes to take. The service will also liaise with, and inform the referrer of the circumstances leading to withdrawal of treatment and to provide the referrer with advice and support in on-going case management as far as they are able.

### **2.5 Interdependencies with other services**

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

#### **Co-located services**

The Tier 4 CAMHS Children's Unit should be co-located with either other Tier 4 CAMHS services or other children's in-patient services or be supported by a network of mental health/ paediatric services within the vicinity or have robust adequate response plans in place to deal with any emergency requiring additional staff.

**Interdependent Services:**

- Education
- Tier 3 CAMHS
- Acute hospital services
- Laboratory services

**Related Services:**

- Primary Care
- CAMHS Deaf Service
- Other Tier 4 CAMHS services
- Local Authority Children's Services
- Education

**3. Applicable Service Standards****3.1 Applicable national standards e.g. NICE, Royal College**

Services will:

- Meet and maintain national quality standards and any other national quality requirements that may from time to time be specified amended or updated,
- Agree local quality improvements in health and wellbeing and reduction of health inequalities in line with local priorities and the expressed preferences of local communities, including without limitation, and as may be amended or updated from time to time:
  - National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08 and any subsequent related guidance
  - The Mental Health Act 2007 and Code of Practice
  - Mental Capacity Act 2005
  - Care Quality Commission Registration Regulations 2009
  - National Services Framework for Children, Children and Maternity Services
  - The Essence of Care – Patient focussed benchmarking for health care practitioners (February 2001) Updated 2010
  - Peer Review Service Standards including but not limited to the Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC) Service Essential Standards
  - For services providing care for young people with eating disorders the Quality Network for Eating Disorder Standards QEDS CAMHS and Junior MARISPAN Guidelines
  - Achieving Equity and Excellence for Children 2010
  - Children and Young People's Health Outcomes Forum Report 2012
  - The Munro Review of Child Protection 2010
  - The Children Act 2004

- Working Together to Safeguard Children 2010
- National Minimum Standards (NMS) under the Care Standards Act (CSA) 2000;
- NHS Litigation Authority (NHSLA) Standards
- NICE Guidelines.

### **Service Environment**

The service will meet the following standards:

The premises and the facilities generally are child 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 HCAI code of practice
- The service ensures that the nutritional needs of all children are adequately met and that comments about food and nutrition are incorporated in menu design
- An environment that ensures that no child, visitor or staff member is allowed to smoke on the premises
- Facilities which include a room which is suitable for contact between children and their families and is available at weekends and evenings.
- 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 child protection 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 child protection issues;
- There is a robust mechanism in place for the reporting of child protection concerns (in accordance with the Children Act 1989 and 2004); and
- All clinical staff receive training in child protection 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 children are appropriately detained under the Mental Health Act (2007) and that there is proper administration of the Act.

### 4. Key Service Outcomes

Treatment of mental health problems for children is intended to improve the mental health and general wellbeing of the child and should be 'patient centred' and achieved by effective and evidence -based interventions leading to improved outcomes.

Tier 4 CAMHS units should be compliant with QNIC quality standards and value for money principles. Outcomes include:

- Appropriate assessment and diagnosis
- Stabilisation and/or resolution of mental health crisis
- Readiness for reintegration into education or plans for alternative training and development
- Readiness to resume outpatient psychiatric care
- Relapse prevention strategies
- Improved well being
- Comprehensive admission, CPA documentation and discharge summaries

The service will use outcome measures recommended by Child Health Outcomes Forum 2012. Tools such as those included in the QNIC ROM outcomes dataset - HoNOSCA, C-GAS, Strengths and Difficulties Questionnaire (SDQ), and others will be used to measure change and assess progress. The service will also routinely use questionnaires to monitor specific psychopathology such as those included in CYP IAPT datasets (for example psychosis; anxiety; depression; OCD). Feedback on children's and their parents/carers experience of the service will be routinely sought.

Education will be delivered in line with QNIC and OFSTED essential standards as a minimum.

## APPENDIX 1

<b>Service Specification</b>	C07/S/b
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<b>No.</b>	
<b>Service</b>	Tier 4 CAMHS Specialist Eating Disorder Services
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	2013/14
<b>Date of Review</b>	To be reviewed by the T4 CAMHS Clinical Reference Group during 2013/14

Please note this is an appendix to the Tier 4 CAMHS General Adolescent Services specification and Tier 4 CAMHS Children's Unit Specifications and should be considered as additional requirements of the standards outlined in the core specification.

## 1. Population Needs

### 1.1 National/local context and evidence base

#### National context

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 primary reason for referral to such services is the presence of a severe eating disorder although units are able to treat the psychiatric co-morbidities which commonly accompany severe eating disorders.

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.

Tier 4 CAMHS specialist eating disorder services will admit children and young people aged between 12th and 18th 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.

There are approximately 11 specialist units in England (Source QNIC database 2012) 4 within the NHS ;1 in the East of England; 1 in London; 1 in West Midlands

and 1 in the North East of England and 7 Independent Sector Units mostly in the South-East and Midlands. The NHS Units and some Independent sector units are co-located with other Tier 4 CAMHS.

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.

The current NHS Tier 4 CAMHS Eating Disorders Units function as an integral part of the regional/sub-regional Tier 4 CAMHS provision with referrals of children and young people with eating disorders from their current catchment areas being directed to the Tier 4 CAMHS Eating Disorders Unit rather than the Tier 4 CAMHS General Adolescent Units. In addition the NHS Tier 4 CAMHS Eating Disorder Units accept referrals from other Tier 4 CAMHS General Adolescent or Children's Units where the severity / complexity of the child/ young person's needs means their needs cannot be met within another Tier 4 CAMHS setting (including lack of response to treatment, more severe physical health risks).

The independent sector units also accept referrals directly from Tier 3 CAMHS and from other Tier 4 CAMHS.

### **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, 2006). 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).

Anorexia Nervosa is noted to be most prevalent in adolescents although increasingly younger children are noted as presenting. In addition, the numbers of male patients is also increasing (Royal College of Psychiatrists, 2012). As a result, the lower estimates are likely to be conservative.

Anorexia nervosa is a chronic condition with an average duration of 5-6 years (Strober et al 1997) 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 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 NHS Information Centre data 2009-10 reported 882 admissions eating disorders under 18s, most admissions 14-16 year olds and 90% girls; 75% admissions due to anorexia. There were small number of boys admitted and a small number of under-12s.

NICE Guidelines C69- recommends in-patient admission where there is a moderate

– high physical risk OR where there is a high risk of suicide or serious self-harm and day/ in-patient treatment for patients whose condition has not improved despite appropriate outpatient treatment.

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.

Children and young people admitted to inpatient units have more severe problems than those treated by existing community services, and whilst they improve substantially during their inpatient stay and are generally satisfied with their care, there is some evidence that long-term admission may have a negative impact on outcome (Gowers, Weetman, Shore, Hossain, Elvins, 2000).

Reports suggest that admission rates are lower in areas where Tier 3 CAMHS has developed expertise in treating eating disorders (House et al 2012, in press) and it is possible that some of the young people admitted to Tier 4 CAMHS Units could be cared for as well by intensive community services or where admission has occurred, the duration of the hospital stay could be shortened. However, currently development of community services is patchy and there is thus a continuing role for day /in-patient care.

Most children and young people with eating disorders are admitted to Tier 4 CAMHS General Adolescent Services and Tier 4 CAMHS Children's Units and in terms of relative effectiveness few studies have examined this – COSI-CAPS study 2008 found both types of unit achieved similar outcomes although the specialist eating disorder units tended to admit more severely ill patients.

## **2. Scope**

### **2.1 Aims and objectives of service**

The aim of the service is to deliver specialist inpatient, day patient, outreach and outpatient mental health 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 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:

- Restoration of weight and growth and physical health as well as improved outcomes and safe sustainable recovery such that the child or young person is able to return home to the care of community services.

## **2.2 Service description/care pathway**

### **2.21 Service Model /Care Pathway**

Children and young people are referred to Tier 4 CAMHS Eating Disorder Services from either Tier 3 CAMHS 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 4 CAMHS Specialist Eating Disorder Service will provide Intensive Outreach to support children and young people at home as an alternative to admission where the level of risk allows; this may also include supporting children and young people who are waiting for admission as well as post-discharge support.

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

- Outreach to support discharge

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 services may offer as additional elements of service;

- Intensive Outreach as an alternative to admission or to support children/young people who are waiting for admission

## **Referrals**

Referral routes:

- Referrals will be accepted from Tier 3 CAMHS, 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 24 hours
- Response to urgent referrals will be within 48 hours
- Response to non urgent referrals will be within 5 working days

## **Assessment**

A pre-admission assessment will usually be carried out to determine suitability for admission and where day-patient attendance or Intensive Outreach is available, whether this should be offered. The assessment will usually be on the service premises so that children, young people and parents can provide informed consent, there should however be flexibility according to need.

Where following pre-admission assessment admission as a day/inpatient is recommended and a place is available within an appropriate timescale an initial care plan should be drawn up.

Where admission is recommended but there is likely to be a delay the service should discuss options with the child/young person and parents and referrers – referral and admission to an alternative unit may be required OR admission to a paediatric ward with support from the Tier 4 Eating Disorders Unit or Tier 3 CAMHS OR Outreach to support the child/ young person at home pending admission. The options being influenced by the child/ young person's level of risk and child/young person's and parent's choice.

Where following pre-admission assessment it is not thought Tier 4 CAMHS Eating Disorder Unit or the young person and/or parents decline admission (and there are

no indications for use of the Mental Health Act 2007/1983 or Mental Capacity Act 2005 or Children's Act 2004 to override this ) advice will be given to the referring Tier 3 or Tier 4 CAMHS on future management.

### **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 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, 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**

Provide robust discharge planning which will include relapse prevention planning and liaison with other agencies/ services.

### **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 2011 and Quality Network for Eating Disorders 2012.

## **2.3 Population covered**

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

## **2.4 Any acceptance and exclusion criteria**

### **Acceptance Criteria**

Primary diagnosis of a severe and complex eating disorder which cannot be treated within Tier 3 CAMHS 3 or other Tier 4 inpatient CAMHS service

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

Tier 4 CAMHS specialist eating disorder units may admit children and young people with lesser degrees of severity of eating disorder but who are experiencing psychiatric co-morbidity leading to severely impaired functioning or significant risk which cannot be safely managed in a community setting by a Tier CAMHS team.

Tier 4 CAMHS specialist eating disorder teams may admit children and young people with less severe eating disorders but where because of co-morbid physical illness the risk to their health is greater.

Rapid weight loss with evidence of high risk behaviour or medical compromise

### **Exclusions**

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

## **2.5 Interdependencies with other services**

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

Tier 4 CAMHS and/or paediatric hospital services

## **3. Applicable Service Standards**

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

In addition to those in the CAMHS tier 4 specification:

- NICE 2004 Clinical Guideline CG9 - Eating Disorders, Core interventions in the treatment and management of Anorexia Nervosa, Bulimia Nervosa and related eating disorders.
- Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa (2012)
- Quality Network for Eating Disorder standards (QED) in addition to QNIC standards.

### **4. Key Service Outcomes**

Services should routinely measure outcomes using indicators such as those in the QNIC ROM data. Successful treatment is expected to lead to improved outcomes as measured by Outcomes indicators in the QNIC ROM alongside indicators of weight and growth.

Services should also routinely measure young people's parents/ carers' experience of the service using an appropriate measure such as those included in the QNIC ROM.

The assessment of the quality of Tier 4 CAMHS specialist eating disorder units should use measures of outcomes / effectiveness, safety and patient experience.

## APPENDIX 2

<b>Service Specification No.</b>	C07/S/b
<b>Service</b>	Tier 4 CAMHS In-patient Learning Disability Service.
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	2013/14
<b>Date of Review</b>	To be reviewed by the T4 CAMHS Clinical Reference Group during 2013/14

Please note this is an appendix to the Tier 4 CAMHS General Adolescent Services specification and Tier 4 CAMHS Children's Unit Specifications and should be considered as additional requirements of the standards outlined in the core specification. The below requirements would also be considered additional for a low secure CAMHS learning disability unit.

<b>1. Population Needs</b>
<b>1.1 National/local context and evidence base</b>
<b>National context</b>
<p>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:</p> <ul style="list-style-type: none"><li>• Mild Learning disability IQ 50-70</li><li>• Moderate Learning Disability IQ 35-49</li><li>• Severe Learning Disability IQ 20-34</li><li>• Profound Learning Disability IQ below 20</li></ul> <p>The Tier 4 CAMHS Specialist Learning Disability Unit provides day/ in-patient care and treatment for children and young people with:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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</li><li>• children and young people with moderate to severe learning disabilities and with</li></ul>

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 chronically 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.

There are currently three NHS Tier 4 CAMHS Learning Disability units - in Newcastle upon Tyne which has 26 beds (6 for younger children, 12 open adolescent units beds and 8 low secure adolescent beds); in Solihull which has 12 adolescent beds on two units and Sheffield 6 beds. These units offer care across the range mild-severe learning disability.

There are also a small number of independent sector providers; The largest in Northampton has 40 beds ( 20 in the male Forensic Learning Disability pathway and 20 in the mixed gender neuro-developmental service) and offers care to young people with mild-moderate learning disabilities. There is a 10 bedded low secure learning disability unit in Attleborough Norfolk for adolescent males offering care across the range; mild-profound . There are a number of other independent sector units who will admit children and young people with learning disabilities although these units are not specialist units.

There is currently no nationally collected data on the numbers of children and young people with learning disability including the numbers requiring specialist services and local areas vary in the extent to which they collect specific data on rates of learning and other neuro-disability. Thus estimates of need are informed by the limited research available and demand for services is the only proxy for need.

There is patchy 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. There is also a shortage of specialist in-patient provision

(Regional Reviews of Tier 4 Child and Adolescent Mental Health Services, Kurtz 2007. Care Services Improvement Partnership).

[Note - For these reasons the CRG recommend a review to establish level of need, care pathways and models of provision in order to advise longer term commissioning of such services.]

The age of transition from mental health services for children and young people with learning disabilities to mental health services for adults with learning disabilities varies across the country being 18 in some areas and 19 in others.

### **Evidence Base**

Children with a learning disability form 2.5% of the child population. In a population of a typical borough of 250,000 were 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.

At any one time in a typical borough more than 500 children with a learning disability will require mental health assessment and treatment – only a minority are likely to require day/in-patient care.

The Royal College of Psychiatrists Report on Psychiatric Services for Children and Young People with Intellectual Disabilities (2010) recommends 3-4 beds per million total population for young people with a severe learning disability, 2-3 beds for those with a mild learning disability and 1 bed for those requiring low secure provision.

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

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. Scope**

### **2.1 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

### **2.2 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. Within the provider network there may be sub-specialisation in relation to degrees of disability / needs.

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 a Gate-keeping Assessment to assess their needs and whether a Tier 4 CAMHS Learning Disability Unit is required. The Gate-keeping Assessment may take place at the Unit premises allowing the child/young person and parents/carers to visit the service premises 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. An assessment will be transferable across the provider network rather than an individual unit where a sub speciality is required.

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.

### **Treatment 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

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.

## **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.

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 to 1 and occasionally 2 to 1 staffing are required.

All staff have to be trained and kept regularly up to date with de-escalation techniques and nationally recognised methods of physical restraint.

## **Advocacy**

The 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 / carers appropriate.

## 2.3 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, many of whom also have autism

## 2.4 Any acceptance and exclusion criteria

### Acceptance Criteria:

Referrals are accepted from Tier 3 CAMHS/ community learning disabilities or other Tier 4 CAMHS. Once a referral is received it will be reviewed by a senior clinician within the service.

The services will accept referrals for children and young people; 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.

## 2.5 Interdependencies with other services

## Co located Services

The service should be co-located either with other Tier 4 CAMHS units or within a Learning Disability Psychiatric Hospital as staff need support from other units, at times. It is not safe for units to be developed in isolation from either other CAMHS Tier 4 units or other learning disability hospital units.

Where the unit is co-located with services for adults the Children's and young people's service should have separate facilities including outdoor recreational facilities

### Additional Interdependent Services:

- Community Learning Disability Services
- Social Care
- Community paediatric services

## 3. Applicable Service Standards

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

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

## 4. Key Service Outcomes

Children and young people will experience improvements in their mental health and well-being and reductions in risk behavior. Parents and carers will feel more able to support their child and manage their child's behavior.

Outcomes will be monitored using standardised measures suitable for use with the child/young person including those in QNIC –ROM and CYP IAPT datasets.

## **ANNEX 1 TO SERVICE SPECIFICATION:**

### **PROVISION OF SERVICES TO CHILDREN**

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

This specification annex applies to all children's services and outlines generic standards and outcomes that would be fundamental to all services.

The generic aspects of care:

The Care of Children in Hospital (Health Service Circular (HSC) 1998/238) requires that:

- Children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis in hospital.
- Children requiring admission to hospital are provided with a high standard of medical, nursing and therapeutic care to facilitate speedy recovery and minimize complications and mortality.
- Families with children have easy access to hospital facilities for children without needing to travel significantly further than to other similar amenities.
- Children are discharged from hospital as soon as socially and clinically appropriate and full support provided for subsequent home or day care.
- Good child health care is shared with parents/carers and they are closely involved in the care of their children at all times unless, exceptionally, this is not in the best interest of the child; Accommodation is provided for them to remain with their children overnight if they so wish.

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

All paediatric specialised services have a component of primary, secondary, tertiary and even quaternary elements.

The efficient and effective delivery of services requires children to receive their care as close to home as possible dependent on the phase of their disease.

Services should therefore be organised and delivered through "integrated pathways of care" (National Service Framework for children, young people and maternity services (Department of Health (DOH) & Department for Education and Skills, London 2004)

#### **Interdependencies with other services**

All services will comply with Commissioning Safe and Sustainable Specialised Paediatric Services: A Framework of Critical Inter-Dependencies – DH

## **Imaging**

All services will be supported by a 3 tier imaging network ('Delivering quality imaging services for children' DOH 13732 March2010). Within the network;

It will be clearly defined which imaging test or interventional procedure can be performed and reported at each site

Robust procedures will be in place for image transfer for review by a specialist radiologist, these will be supported by appropriate contractual and information governance arrangements

Robust arrangements will be in place for patient transfer if more complex imaging or intervention is required

Common standards, protocols and governance procedures will exist throughout the network.

All radiologists, and radiographers will have appropriate training, supervision and access to Continuing Professional Development (CPD)

All equipment will be optimised for paediatric use and use specific paediatric software

## **Specialist Paediatric Anaesthesia**

Wherever and whenever children undergo anaesthesia and surgery, their particular needs must be recognised and they should be managed in separate facilities, and looked after by staff with appropriate experience and training.<sup>1</sup> All UK anaesthetists undergo training which provides them with the competencies to care for older babies and children with relatively straightforward surgical conditions and without major co-morbidity. However those working in specialist centres must have undergone additional (specialist) training<sup>2</sup> and should maintain the competencies so acquired<sup>3</sup> \*. These competencies include the care of very young/premature babies, the care of babies and children undergoing complex surgery and/or those with major/complex co-morbidity (including those already requiring intensive care support).

As well as providing an essential co-dependent service for surgery, specialist anaesthesia and sedation services may be required to facilitate radiological procedures and interventions (for example MRI scans and percutaneous nephrostomy) and medical interventions (for example joint injection and intrathecal chemotherapy), and for assistance with vascular access in babies and children with complex needs such as intravenous feeding.

Specialist acute pain services for babies and children are organised within existing departments of paediatric anaesthesia and include the provision of agreed (hospital

wide) guidance for acute pain, the safe administration of complex analgesia regimes including epidural analgesia, and the daily input of specialist anaesthetists and acute pain nurses with expertise in paediatrics.

\*The Safe and Sustainable reviews of paediatric cardiac and neuro- sciences in England have noted the need for additional training and maintenance of competencies by specialist anaesthetists in both fields of practice.

## References

- Guidelines on the Provision of Anaesthetic Services (GPAS) Paediatric anaesthetic services. Royal College of Anaesthetists (RCoA) 2010  
[www.rcoa.ac.uk](http://www.rcoa.ac.uk)
- Certificate of Completion of Training (CCT) in Anaesthesia 2010
- CPD matrix level 3

## Specialised Child and Adolescent Mental Health Services (CAMHS)

The age profile of children and young people admitted to specialised CAMHS day/in-patient settings is different to the age profile for paediatric units in that it is predominantly adolescents who are admitted to specialised CAMHS in-patient settings, including over-16s. The average length of stay is longer for admissions to mental health units. Children and young people in specialised CAMHS day/in-patient settings generally participate in a structured programme of education and therapeutic activities during their admission.

Taking account of the differences in patient profiles the principles and standards set out in this specification apply with modifications to the recommendations regarding the following

- Facilities and environment – essential Quality Network for In-patient CAMHS (QNIC) standards should apply  
(<http://www.rcpsych.ac.uk/quality/quality accreditation/audit/qnic1.aspx>)
- Staffing profiles and training - essential QNIC standards should apply.
- The child/ young person's family are allowed to visit at any time of day taking account of the child / young persons need to participate in therapeutic activities and education as well as any safeguarding concerns.
- Children and young people are offered appropriate education from the point of admission.
- Parents/carers are involved in the child/young persons care except where this is not in the best interests of the child / young person and in the case of young people who have the capacity to make their own decisions is subject to their consent.
- Parents/carers who wish to stay overnight are provided with accessible accommodation unless there are safeguarding concerns or this is not in the best interests of the child/ young person.

### **Applicable national standards e.g. NICE, Royal College**

Children and young people must receive care, treatment and support by staff registered by the Nursing and Midwifery Council on the parts of their register that permit a nurse to work with children (Outcome 14h *Essential Standards of Quality and*

*Safety*, Care Quality Commission, London 2010)

- There must be at least two Registered Children's Nurses (RCNs) on duty 24 hours a day in all hospital children's departments and wards.
- There must be an Registered Children's Nurse available 24 hours a day to advise on the nursing of children in other departments (this post is included in the staff establishment of 2RCNs in total).

Accommodation, facilities and staffing must be appropriate to the needs of children and separate from those provided for adults. All facilities for children and young people must comply with the Hospital Build Notes *HBN 23 Hospital Accommodation for Children and Young People* NHS Estates, The Stationary Office 2004.

All staff who work with children and young people must be appropriately trained to provide care, treatment and support for children, including Children's Workforce Development Council Induction standards (Outcome 14b *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010).

Each hospital who admits inpatients must have appropriate medical cover at all times taking account of guidance from relevant expert or professional bodies (National Minimum Standards for Providers of Independent Healthcare, Department of Health, London 2002). "Facing the Future" Standards, Royal College of Paediatrics and Child Health.

Staff must carry out sufficient levels of activity to maintain their competence in caring for children and young people, including in relation to specific anaesthetic and surgical procedures for children, taking account of guidance from relevant expert or professional bodies (Outcome 14g *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010).

Providers must have systems in place to gain and review consent from people who use services, and act on them (Outcome 2a *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010). These must include specific arrangements for seeking valid consent from children while respecting their human rights and confidentiality and ensure that where the person using the service lacks capacity, best interest meetings are held with people who know and understand the person using the service. Staff should be able to show that they know how to take appropriate consent from children, young people and those with learning disabilities (Outcome 2b) (*Seeking Consent: working with children* Department of Health, London 2001).

Children and young people must only receive a service from a provider who takes steps to prevent abuse and does not tolerate any abusive practice should it occur

(Outcome 7 *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010 defines the standards and evidence required from providers in this regard). Providers minimise the risk and likelihood of abuse occurring by:

- Ensuring that staff and people who use services understand the aspects of the safeguarding processes that are relevant to them
- Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed.
- Ensuring that people who use services are aware of how to raise concerns of abuse.
- Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern.
- Having effective means of receiving and acting upon feedback from people who use services and any other person.
- Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:
  - having clear procedures followed in practice, monitored and reviewed that take account of relevant legislation and guidance for the management of alleged abuse
  - separating the alleged abuser from the person who uses services and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the provider
  - reporting the alleged abuse to the appropriate authority
  - reviewing the person's plan of care to ensure that they are properly supported following the alleged abuse incident.
- Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance.
- Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local authority policies.
- Participates in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.
- Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.
- Taking into account relevant guidance set out in the Care Quality Commission's Schedule of Applicable Publications
- Ensuring that those working with children must wait for a full CRB disclosure before starting work.
- Training and supervising staff in safeguarding to ensure they can demonstrate the competences listed in Outcome 7E of the *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010
- All children and young people who use services must be:
  - Fully informed of their care, treatment and support.
  - Able to take part in decision making to the fullest extent that is possible.
  - Asked if they agree for their parents or guardians to be involved in decisions

they need to make.

(Outcome 4I *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010)

### Key Service Outcomes

Evidence is increasing that implementation of the national Quality Criteria for Young People Friendly Services (Department of Health, London 2011) have the potential to greatly improve patient experience, leading to better health outcomes for young people and increasing socially responsible life-long use of the NHS.

Implementation is also expected to contribute to improvements in health inequalities and public health outcomes e.g. reduced teenage pregnancy and STIs, and increased smoking cessation. All providers delivering services to young people should be implementing the good practice guidance which delivers compliance with the quality criteria.

Poorly planned transition from young people's to adult-oriented health services can be associated with increased risk of non adherence to treatment and loss to follow-up, which can have serious consequences. There are measurable adverse consequences in terms of morbidity and mortality as well as in social and educational outcomes. When children and young people who use paediatric services are moving to access adult services (for example, during transition for those with long term conditions), these should be organised so that:

- All those involved in the care, treatment and support cooperate with the planning and provision to ensure that the services provided continue to be appropriate to the age and needs of the person who uses services.
- The National Minimum Standards for Providers of Independent Healthcare, (Department of Health, London 2002) require the following standards:
  - **A16.1** Children are seen in a separate out-patient area, or where the hospital does not have a separate outpatient area for children, they are seen promptly.
  - **A16.3** Toys and/or books suitable to the child's age are provided.
  - **A16.8** There are segregated areas for the reception of children and adolescents into theatre and for recovery, to screen the children and adolescents from adult Patients; the segregated areas contain all necessary equipment for the care of children.
  - **A16.9** A parent is to be actively encouraged to stay at all times, with accommodation made available for the adult in the child's room or close by.
  - **A16.10** The child's family is allowed to visit him/her at any time of the day except where safeguarding procedures do not allow this
  - **A16.13** When a child is in hospital for more than five days, play is managed and supervised by a qualified Hospital Play Specialist.
  - **A16.14** Children are required to receive education when in hospital for more than five days; the Local Education Authority has an obligation to meet this need and are contacted if necessary.

- **A18.10** There are written procedures for the assessment of pain in children and the provision of appropriate control.

All hospital settings should meet the Standards for the Care of Critically Ill Children (Paediatric Intensive Care Society, London 2010).

There should be age specific arrangements for meeting Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These require:

- A choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs;
- Food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background
- Support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.
- For the purposes of this regulation, "food and hydration" includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed.
- Providers must have access to facilities for infant feeding, including facilities to support breastfeeding (Outcome 5E, of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

All paediatric patients should have access to appropriately trained paediatric trained dieticians, physiotherapists, occupational therapists, speech and language therapy, psychology, social work and CAMHS services within nationally defined access standards.

All children and young people should have access to a professional who can undertake an assessment using the Common Assessment Framework and access support from social care, housing, education and other agencies as appropriate.

All registered providers must ensure safe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines (Outcome 9 Essential Standards of Quality and Safety, Care Quality Commission, London 2010). For children, these should include specific arrangements that:

- Ensures the medicines given are appropriate and person-centred by taking account of their age, weight and any learning disability
- Ensuring that staff handling medicines have the competency and skills needed for children and young people's medicines management
- Ensures that wherever possible, age specific information is available for people about the medicines they are taking, including the risks, including information about the use of unlicensed medicine in paediatrics.

Many children with long term illnesses have a learning or physical disability. Providers should ensure that:

- They are supported to have a health action plan
- Facilities meet the appropriate requirements of the Disability Discrimination Act 1995

They meet the standards set out in Transition: getting it right for young people. Improving the transition of young people with long-term conditions from children's to adult health services. Department of Health Publications, 2006, London.

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