

PLEASE NOTE –

This Report is a redacted version of the final Report. Individual quotations made by parents, children and young people, and those professional comments which referenced specific case examples have been removed. This is to protect identities and because permission was not given for publication.



Child and Adolescent Mental Health

**A Review Beechcroft and the acute child and adolescent
mental health care pathway**

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CONTENTS

Executive Summary	7
Section 1 - Introduction	14
1.1 Children's Rights set out in the UN Convention on the Rights of the Child	15
1.2 Terms of Reference.....	15
1.3 Methodology.....	16
1.4 Policy context	17
1.5 Integrated Delivery	18
Section 2 – Factual Information	21
Section 3 - Findings	26
3.1 Commitment.....	26
3.2 Need.....	26
3.3 Strategy	26
3.4 Culture.....	27
3.5 Geography, its impact on service provision and access to inpatient provision.....	28
3.6 Complexity: its impact on referrals, workload and case-mix.....	29
3.7 Pathways of care.....	31
3.8 Leadership.....	32
Delivery.....	34
3.9 Integrated working.....	34
3.10 Step-up, Step-down and Transition.....	37
3.11 Out-of-hours and on-call	39
3.12 Eating Disorders.....	40
3.13 Self Harm	41
3.14 Specialist Regional Services.....	42
Section 4 - Beechcroft	44
4.1 Beechcroft	45
4.2 Admission pathways	50

4.3	The Treatment Model	51
4.4	Evidence-based practice, Goals and Outcomes Measurement.....	52
4.5	Care Planning.....	53
4.6	Length of stay and discharge planning	54
4.7	Multidisciplinary working	55
4.8	Clinical Supervision.....	56
4.9	Leadership in an in-patient setting	57
4.10	Staffing and workforce development.....	59
	Section 5 - Commissioning	63
	Section 6 – Consultation and Inclusion	66
6.1	What Children and Young People Told Us	66
6.2	What Parents and Carers Told Us	67
6.3	What Other Professionals Told Us.....	70
	Section 7 - Conclusion.....	74
	Section 8 - A dynamic model of provision.....	76
	Section 9 - Recommendations	81
9.1	STRATEGIC.....	81
9.2	DELIVERY.....	82
9.3	COMMISSIONING RECOMMENDATIONS.....	86
9.4	BEECHCROFT RECOMMENDATIONS	87
9.5	RECOMMENDATIONS FOR A DYNAMIC MODEL OF DELIVERY Error! Bookmark not defined.	
	Section 10- Appendices	92
	Appendix 1 - Documents Examined	93
	Appendix 2 - People/Services Consulted	97
	Appendix 3 - Other Relevant Documents.....	98
	Appendix 4 - Northern Ireland Policy and Guidance	100
	Appendix 5 - The Review Team	102
	Appendix 6 - Royal College of Psychiatrists Recommendations on staffing levels	104
	Appendix 7 - NICE Guidelines that apply to Children and Young People.....	109

Executive Summary

This review was commissioned by the Health and Social Care Board, the Public Health Agency and Belfast Health and Social Care Trust.

We were asked to undertake a comprehensive peer review of the Regional CAMHS Inpatient Unit at Beechcroft and the acute CAMHS care pathways; analyse the strategic and operational fit of the inpatient unit with the Stepped Care Model; engage stakeholders including children and young people; review the current interfaces between Beechcroft and other stakeholders; review the current operating model including the step up and step down services and opportunities for a progressive outreach model; to consider options for consolidating and/or improving the service and to make recommendations for the development of an intensive support model for children and young people with acute, complex and challenging mental health and emotional needs. The Review is intended to inform the Health and Social Care Board's strategic direction and decision-making.

The whole CAMHS system in Northern Ireland is on a journey of transformation, where professional groups and teams are still working on how best to work together, and are in the process of building systems and structures that have the potential to provide the highest quality mental health care for children and young people. This is influenced by a clearly stated policy direction toward integration, equity, early intervention and a model of Stepped Care.

We have encountered children's services and mental health providers and their partner services at all points of the compass, where provision and planning is affected by geography, hidden need, historical working models, strategic relationships, difficulties in recruitment, and reported increasing levels of complexity in family lives.

We have visited regional specialist children's services and local CAMHS teams that are striving (and in the main, succeeding) to find common ground and work in partnership.

We spent a lot of time in the Step 5 inpatient service which appears to have become the lightning conductor for all the services provided in the community and is predominantly responding crisis admissions and high levels of disturbance and self-harm in children and young people.

We met a small, and as yet incomplete, young and energetic new crisis assessment and intensive treatment service that is focussing on preventing admissions, and commissioners managing complex levels of information and sensitive relationships in their effort to get the right services to families, in the right place at the right time.

We spent a considerable amount of time with commissioners, understanding how commissioning works and how it links with service improvement.

The level of complexity in families lives, and the challenges of trying to address how best to respond to that complexity in the public sector are immense. In planning and delivering our services, there is always a danger that we inadvertently mirror the difficulties that families are facing.

The critical components for building more efficient systems are present in Northern Ireland, but require commissioning and delivery outputs to be strengthened and then embedded, and demonstrate more evidence of co-production methods that cross the traditional professional and service boundaries and that make best use of the strategic drivers expressed in policy. Government departments, commissioning teams, executive leaders, operational and service managers and stakeholders with an interest in child and adolescent mental health all have a role in this endeavour.

The critical role of Local Implementation Teams and Children and Young People's Strategic Partnerships as infrastructure intermediaries cannot be under-estimated. Integration is a key theme in public policy; LITs and CYPSPs are relatively newly formed groups but are in a position to lever and influence local stakeholders in the drive to deliver integrated delivery and modernise CAMH services in Northern Ireland.

Equally important is the role of local service leaders and managers. We would like to see more leadership functions distributed across teams in order to embed the understanding of the strategic reforms in everyday practice.

Improving communication through regular newsletters or e-briefings to all staff is important, as is encouraging discussion and co-production within and between teams, workstreams, specialisms and services. A clear, well communicated strategy, high quality methods of communicating with the whole system and having the right people in the right places who exhibit strong leadership characteristics, are the golden threads that should be woven through any change process in order to stabilise it.

We make recommendations in relation to the following themes, which we have summarised. The complete set of recommendations can be found in Section 9 of this report:

The consistent involvement of children, young people and their families

We consulted with children, young people and their families and without exception, they said that they wanted to play a bigger part in how services are developed, reviewed and commissioned. In addition they wanted more information about their care, treatment, care and discharge planning

and transition to adult services. They sought genuine involvement and wanted to see the principles of user and carer engagement embedded in everyday practice.

Strategy

A population based needs assessment is necessary for children and young people under the age of 19 in order to inform the workforce development programme. Workforce development is one of the nine key outputs in the DHSSPS CAMHS Guidance Implementation Plan Indicators monitored by the Local Implementation Teams.

Local Implementation Teams are critical strategic intermediaries, positioned to influence and lever change and are therefore a key component in the delivery of good outcomes for children and young people with mental health problems and to sharing the responsibility for steering a shared vision and culture of co-production with commissioners, providers and service users.

A skills audit should be triangulated with the workforce development plan and a population based needs assessment in order to fully inform the strategic and delivery imperatives outlined in CAMHS: A Stepped care model.

Leadership is a key component in driving and embedding change and we recommend a leadership development and coaching module in the CAMHS Continuing Development Programme.

We emphasise the importance of involving all senior clinicians and practitioners, including Child and Adolescent Psychiatrists, in service design and the distributed leadership approach.

Delivery

Delivery should be planned around robust pathways of care which are coherent and sufficiently flexible to take account of the levels of complexity that affect children and young people and are likely to benefit from inpatient care. We make recommendations about the development of the acute mental health care pathway and include specialist regional services, out of hours, specific issues such as self-harm, eating disorders, children who present in an emergency and Step 3, 4 and 5 CAMHS.

We propose the development of managed clinical networks with named co-ordinators, that will ensure services are responsive and consistent and to develop opportunities to develop learning, practice and collaboration across trusts and Step 5 CAMHS.

We make recommendations about investing in technology to ensure that geographically distant trusts can collaborate more meaningfully and regularly with Step 5 CAMHS without the need for long journeys.

We make recommendations intended to strengthen care, discharge and transition planning and delivery.

We found evidence of the important contribution that all services make in the lives of children and young people with acute mental health needs and we recommend the standardisation of delivery, and access to a consistent model of delivery in Crisis Assessment and Intensive Treatment service across all the trusts in Northern Ireland, regional specialist services and children's services and that it benefits from a clinical network to ensure continuity.

We emphasise that in a modern CAMHS, an out of hours CAMHS opinion and mental health assessment should be available 24 hours a day, 7 days a week for all professionals requesting professional consultation with CAMHS clinicians and/or to provide a mental health assessment for those children and young people with acute mental health needs.

We include the regional specialist services in our recommendations and recommend the alignment of commissioning intentions for those units in order that child and adolescent mental health services are consistently available and the delivery of CAMHS consultation and clinical input into the regional specialist services is formalised in Service Specifications.

In particular we recommend that short and long terms needs of children with intellectual disability are reconsidered, that Step 3 community based intellectual difficulties services are significantly strengthened, that day services are commissioned. We also recommend that a small inpatient service for children and young people with intellectual disability is located closer to Beechcroft, for brief stays where young people require stabilisation, assessment and treatment, and to increase opportunities for co-working.

Commissioning

We were impressed with the progress made in commissioning and the investment in service improvement, particularly in relation to Primary Mental Health Workers and the Crisis Assessment and Intensive Treatment Teams.

We recommend that all commissioning functions relating to children and young people should remain distinct but be better aligned across all the commissioning themes so that the proposed care pathways and other recommendations in this report are adequately supported through the commissioning process.

We would like to see commissioners ensure that Service Specifications are renewed, are robust and specify that access to regular consultation, training and support to other professionals is built into CAMHS provider capacity.

Similarly, commissioners should formalise the expectations of Steps 3, 4 and 5 CAMHS delivery in relation to children and young people vulnerable to developing or who are suffering from mental disorder in specialist regional services.

We recommend that commissioners support the development of CAMHS Acute Care Networks in order to support the hub and spoke model of provision and networked support and development proposed in Section 7.

We propose that commissioners work with Steps 3, 4 and 5 CAMHS and other stakeholders to revise the acute threshold criteria so that it takes account of the proposed clinical networks and the proposal regarding Step 5 CAMHS set out in Section 7.

Finally we propose that involving children, young people and families is not the sole responsibility of provider services. Commissioners too, should actively engage them, and involve them in commissioning plans and reviews.

CAMHS inpatient services

We propose that Beechcroft maintains its current capacity but that the Wards are reconfigured into smaller units – two short stay intensive assessment units, two intensive care beds, two treatment units, an eating disorder unit and the provision of day services.

We would like to see the standardisation of Crisis Assessment and Intensive Treatment teams across all the trusts which will be integral to managed clinical networks, and there are already plans to make this happen. The Crisis Assessment and Intensive Treatment Teams are pivotal to the integrated components of the assessment pathway into and out of Beechcroft.

The establishment of routine outcomes measurement and evidence-based practice is as essential to support the fidelity to the treatment model as it is to informing clinical decision making and the clinical supervision of professionals. We therefore recommend that all clinical staff and practitioners receive clinical supervision for at least one hour a month, that clinical outcomes are routinely recorded and outcomes measures are used to inform clinical practice.

The model of treatment undertaken by the inpatient service should include as a minimum, cognitive behaviour therapy, dialectical behaviour therapy, eye movement desensitisation and reprocessing, interpersonal therapy, psychotherapy, solution focussed therapy, systemic family therapy and psychopharmacology. The ability to access training to support the therapeutic model should be included in the workforce development strategy.

The social work, clinical psychology and psychotherapy, systemic family therapy and activities co-ordination roles should be enhanced in

Beechcroft in order to strengthen the multidisciplinary nature of the assessment, formulation, diagnosis and treatment of children and young people and increase the range of therapies available.

Inpatient nursing roles should be modernised and the nursing workforce incentivised through enhanced clinical roles, for example Advanced Practitioner and Nurse Consultant roles, in order to develop the range of skills within the nursing workforce and to create career pathways within Step 5 CAMHS with the aim of improving patient care, support and mentoring to less experienced nurses and to improve recruitment and retention.

We have recommended the development of a distributed leadership model and strengthened clinical roles across the professions (nursing in particular) within the inpatient service, in order to develop opportunities for co-production, and widening the responsibility for embedding changes in practice and service development across the professional disciplines.

We found the CAMHS system would benefit from stronger medical leadership and that improved levels of collaboration across the trusts and the inpatient unit would improve communication, and ensure that medical representation on strategic groups was enhanced.

Improving the involvement of children, young people and their families is critical in terms of care and discharge planning and service development.

A dynamic model of provision

We propose a dynamic model for acute child and adolescent mental health provision that includes children's social services, builds on the current organisational structure and the strengths, talents and experience in the current workforce. We believe this model will mean services are better positioned to support the strategic thrust of the CAMHS service model and recent Northern Ireland policy.

We propose that the current capacity in inpatient CAMHS is maintained, but reconfigured to include two five-bed assessment units, two intensive care beds, two eight-bed treatment units, and a small inpatient eating disorder unit and day services. This is likely to require capital expenditure to reconfigure the current facility. We also propose that day services are developed in local services as part of the overall strategy to prevent acute admissions and maintain children in their community.

We envisage that the Community Assessment and Intensive Treatment Teams, once fully established across all the trusts, will play a critical role with the majority of those young people who require admission.

We recommend that short and long terms needs of children with intellectual disability are reconsidered, that Step 3 community based intellectual difficulties services are significantly strengthened, that day

services are commissioned. We also recommend that a small inpatient service for children and young people with intellectual disability is located closer to Beechcroft, for brief stays where young people require stabilisation, assessment and treatment, and to increase opportunities for co-working.

The role and function of Beechcroft, supported by the Steps 4 and 3 CAMHS functions and regional specialist teams, should be strengthened through new managed clinical networks using a hub-and-spoke model, for eating disorders, self-harm, intellectual disability, looked after children in need of mental health provision, mental health services for children and young people involved in the criminal justice system, those presenting at A&E and forensic CAMHS.

Through the findings of this review of Beechcroft and the acute child and adolescent mental health pathways, and our subsequent recommendations, we have set out the primary areas of activity that require refreshing, strengthening, replacing or commissioning.

Section 1 - Introduction

“Mental health and emotional wellbeing is everyone’s business. It is not just the responsibility of professionals working in the field of child and adolescent mental health. It includes prevention, perinatal care, child development, child protection, physiological and family support, crisis resolution, community support and inpatient care. Delivery of effective services will require multi-disciplinary working involving a wide range of professionals. This regional service model creates an impetus for greater integration and collaboration within and across sectors”.

This introductory paragraph to *CAMHS: A service model*, published by DHSSPSNI in 2012, consolidates the messages in a number of key reports published in Northern Ireland since the publication of The Bamford Review in 2006. Bamford’s message was clear. There was under-investment in mental health services. Child and Adolescent Mental Health services were under-developed and inconsistent. Children and young people and their families could not rely on a wrap-around inter-disciplinary service, where there was good communication between professionals and where the challenges in their lives were responded to by individual agencies and organisations, and services were co-ordinated.

That message remains relevant today. Although some of the historic challenges to the way children, young people and their families live their lives in Northern Ireland have changed, and services have responded to changing levels of need, many of those challenges remain. Indeed, some have been compounded. The impact of low levels of investment in CAMHS, poverty, Unemployment, community unrest, poor mental health outcomes, the prevalence of mental health problems and the legacy of the troubles has a significant and insidious impact and a long reach.

Multi-generational trauma is a consistent context. The solutions do not lie solely in producing policies. Those policies must be translated into action, evidence-based interventions and services that are carefully and systematically commissioned, strategically steered, led with passion and heart, and embedded in the practice of well trained, supported professionals and reinforced by systems governance.

This report is relevant to everyone - providers of Children’s social services, learning disability, child and adolescent mental health, adult mental health and education services, Commissioners of children’s, learning disability and mental health services, the Public Health Agency and Government Departments.

1.1 Children's Rights set out in the UN Convention on the Rights of the Child

All nations that are signatories to the UNCRC should work to ensure that it is made law. Everyone under the age of 18 has rights in the Convention. Of particular interest to this review are:

Article 3. The best interests of children must be a top priority in all things that affect children

Article 4. Governments must do all they can to make sure every child can enjoy their rights.

Article 6. Every child has a right to life

Article 12. Every child has the right to have a say in all matters affecting them and their views must be taken seriously

Article 19. Governments must do all they can to ensure children are protected from all forms of violence, abuse, neglect and bad treatment

Article 23. A child with a disability has the right to live a full and decent life with dignity and independence. Governments must do all they can to provide support to disabled children.

Article 23. Every child has the right to the best possible health

Article 25. If a child lives away from home they have the right to a regular check of their treatment and the way they are cared for

Article 33. Governments must protect children from the use of illegal drugs

Article 34. Governments must protect children from sexual abuse and exploitation

Article 37. Children who are locked up should be in prison only as a last resort and for the shortest time. They must be able to keep in contact with their family.

Article 40. Children accused or guilty of breaking the law must be treated with dignity and respect.

The UNCRC was ratified by the UK on 16 December 1991. It has not been incorporated into domestic law, but it has important consequences for the rights of children, since all domestic legislation should comply with international obligations.

1.2 Terms of Reference

The review team (See Appx 5) was commissioned by the Health and Social Care Board in partnership with the Public Health Agency and Belfast Health and Social Care Trust, to undertake a review of the acute child and adolescent mental health care pathway, and the strategic, operational and clinical functions of the regional CAMHS inpatient service - Beechcroft.

In particular we were asked to engage with stakeholders, children, young people, carers and parents and staff; examine the interfaces with children's health, social care and other agencies; comment on the therapeutic model used at Beechcroft; examine step-up and step-down opportunities and the opportunities to develop a progressive outreach service with other secure services; consider the options for consolidating and/or improving the children's and CAMHS services represented on the pathway and make recommendations for the development of intensive support model for children and young people with acute, complex and challenging mental health and emotional needs.

1.3 Methodology

We used the following methodology and examined the relevant local documents set out in Appendix 1, other seminal reference documents in Appendix 3 and Northern Ireland Policy and guidance in Appendix 4:

- We had an initial meeting with commissioners to further clarify elements of the review outputs.
- Undertook desk-based research using Northern Ireland and English documents as benchmarks. We noted emerging themes and exceptions which informed subsequent structured questions to stakeholders about culture, practice, clinical decision making, governance, joint working, evidence of integration, involvement of children, young people and parents, strategic processes and how they inform delivery, quality and outcomes.
- We noted whether and how strategic and operational and commissioning priorities are set and by whom; evidence of teamwork, multi-disciplinary working, co-production, care pathways, professional development, supervision, appraisal, the views of children, young people, their parents and carers.
- We noted evidence of leadership, good management, professional autonomy, evidence-based practice, whether outcomes were routinely measured and whether and how data was used to inform clinical decisions and service improvements.
- We undertook planned site-visits and meetings with all Health and Social Care Trusts community based CAMHS teams, The Iveagh Centre, Beechcroft, Youth Justice at Woodlands, Eating Disorder Team, Young People's Centre, Crisis Assessment and Intensive Treatment Teams, and we heard about the planned forensic child and adolescent service.

- 66 individual structured face-to-face interviews with staff in a range of settings who deliver child and adolescent mental health services, and from a representative sample of professions and services including commissioners. For those who could not attend we undertook 13 telephone interviews including commissioners, GPs, A&E
- We set up a focus group for children and young people to express their views – 16 attended; a focus group for parents and carers to express their views – 6 attended; we met with the Bamford sub-group
- We set up a confidential online Survey Monkey platform and had responses from 13 young people who were current inpatients and 2 that were former patients; 4 parents and carers; and 56 professionals, 16 of whom worked at Beechcroft
- We kept notes of all our meetings, interviews and focus groups. We analysed the notes and discussed them, summarised our findings, grouped them into themes, noted and interrogated exceptions. All these findings have informed the draft, the final report and recommendations.

1.4 Policy context

A number of policy documents and guidance have been published since the Bamford Review in 2007. We list them in Appendix 4 because they provide a critical context for our work. They exemplify the current Northern Ireland policy framework which directly informs service development and delivery.

In fact they provide a clearly articulated framework which, if no other policy documents were produced in the next three years, provides sufficient overview, strategic direction and leverage to enable the commissioning and delivery of a comprehensive child and adolescent mental health service.

The key to success in this respect is to consistently translate the policies and priorities that will inform and develop complementary delivery models across the Health and Social Care Trusts and which have the potential to provide a seamless service.

The DHSSPS 10-year strategic framework *Our Children and Young People, Our Pledge* (2011) has already set out its aspiration to build outcomes-based approach based on the principles of early intervention and prevention.

The RQIA CAMHS Review 2011 made clear statements on areas that must be improved and the DHSSPS report *Child and Adolescent Mental Health Services: a Service Model* (2012) and

set out the step-care model upon which Trust-wide plans have been built.

The Northern Ireland Guidelines and Audit Implementation Network (GAIN) is responsible for developing regional audit and for publishing best practice guidelines, although there is little evidence of CAMHS work at this stage.

1.5 Integrated Delivery

The Health and Social Care Board commissions five integrated health and social care trusts to deliver health and social care across Northern Ireland.

“The advantage of the structurally integrated system in Ireland seems to be that a single employer with one source of funding, a single set of goals and one organisational vision is likely to avoid many of the problems of fragmentation described elsewhere” (Heenan and Birrell, 2006).¹

The Royal College of Nursing report *Integrated Health and Social Care: a review of the literature and implications for Scotland* observes²

“A range of factors either help or hinder integration and joint working between health and social care staff, but the contribution of professional stereotypes and issues of status is significant. It seems clear that for any form of multi-disciplinary integration to be successful time and energy have to be devoted to helping the different professional groups understand each other’s roles, responsibilities and ways of working. Joint training and education can make an important contribution here as can having different professional groups work together from a shared location”.

Our experience is that the existence of integrated health and social care trusts does not necessarily mean that the planning, delivery and workforce development *is* integrated. Whilst there is ample evidence of policy that promotes integration there are real challenges in making integrated delivery a reality.

A pre-requisite to effective integrated delivery is integrated strategic thinking and commissioning, combined with the ability to track data and outcomes and developing good strategic and operational outcomes. We found that delivering a coherent

¹ Heenan, D. and Birrell, D. (2006), “The integration of health and social care: The lessons from Northern Ireland”, *Social Policy & Administration*, 40 (1), 47-56

² http://www.rcn.org.uk/data/assets/pdf_file/0008/455633/Hilarys_Paper.pdf

approach to all these elements requires further development and leadership.

It is important to balance issues of quality whilst also collecting data and measuring outcomes. It is difficult to quantify one single component which eases the passage of integration but our experience is that integration is more likely to be successful where multi-disciplinary relationships are embedded and where the vision of the future is communicated regularly and where there is a willingness to share information, share costs and share risk.

A well-integrated system will be able to accommodate the outcomes of investment by one part of the system being demonstrated in another. There are perverse incentives in all systems, however a well-integrated system will enhance the ability to manage the perverse incentives that will inevitably arise and to plan services together, to test out new ways of working in partnership – and make it more likely that the opportunities offered by integration are fully realised³.

The strategic thrust of Northern Ireland policy emphasises early intervention and prevention, integration and a responsive range of CAMHS services. Concurrent activity in early intervention and prevention as well as more specialist services is essential, and our understanding is that this will be driven through early intervention plans, parenting programmes, family hubs, the Early Intervention Transformation Programme and mental health support in schools.

Commissioners, the Local Implementation Teams in partnership with the Children and Young People's Strategic Partnerships provide the critical structural cohesion, strategic framework and leverage required to drive and to monitor the integration agenda, and are the dynamic local catalysts that drive the change agenda. The benchmarks of progress will be a genuine partnership with delivery partners and full implementation of the regional outcome indicators that are shared by all trusts.

An integrated approach to strategy and delivery should strengthen strategic relationships, and co-production of priorities plans and outputs should be a primary objective of the LITs and CYPSPs.

In referring to Northern Ireland policies and listing them in *Appx 4*, we urge politicians, commissioners and providers to continue to drive through changes, reiterate the narrative and actively model how working together can positively impact on professional roles and relationships and better outcomes for children and families.

³ Cheminais, R. (2009). Effective multi-agency partnership: Putting every child matters into practice.

We have placed the views of children and families at the centre of our work. Our findings are benchmarked against their experience in the CAMHS system. They indicated very clearly that sometimes services worked well, but our view was that the potential benefits offered by an integrated structure are not yet fully realised in either the patient or the parent/carer experience.

Articulating a consistent message and embedding the principles of good leadership will help to embed the strategic relationships and the practice-based adjustments necessary across the areas of professional activity, and help staff understand why these changes need to take place. The changes must be informed by the realities of the patient/carer experience. We know that putting policy into action and delivering good outcomes is not easy, but it is important, because the end-point will make a difference to the lives of children, young people and their families.

It is important that health, children's social care, schools, the voluntary sector, the youth services (and faith organisations) own and understand the specific contribution they make to the emotional health, psychological wellbeing and mental health of their young people, and to negotiate a path through the barriers of professional identity, and specific service thresholds, supported by cross-cutting workforce development programmes.

All this starts with policy. It is the intelligent and dynamic application of policy into practice that should be the stock-in-trade of all leaders and managers in services, aimed at supporting and developing their staff and improving the outcomes for children and young people with mental health problems and illness.

"There needs to be a much better understanding between inpatient and wider residential and community based services as to what each can provide, and closer liaison between services to ensure a more 'joined up' approach. It seems that assessments and therapeutic approaches differ and we don't know where we stand"

Comment from an interested professional on Survey Monkey July 2014

A key measure of whether the principles of integration and equity set out in national policy is embedded in all sectors is not only through the *activity and outputs* of leaders, their approach and people-skills and the way in which they communicate new ideas, but in the practice of front-line staff. Improving the quality of information sharing and setting change in its proper context will reduce the likelihood that staff will lose sight of the values that are driving new procedures and pathways.

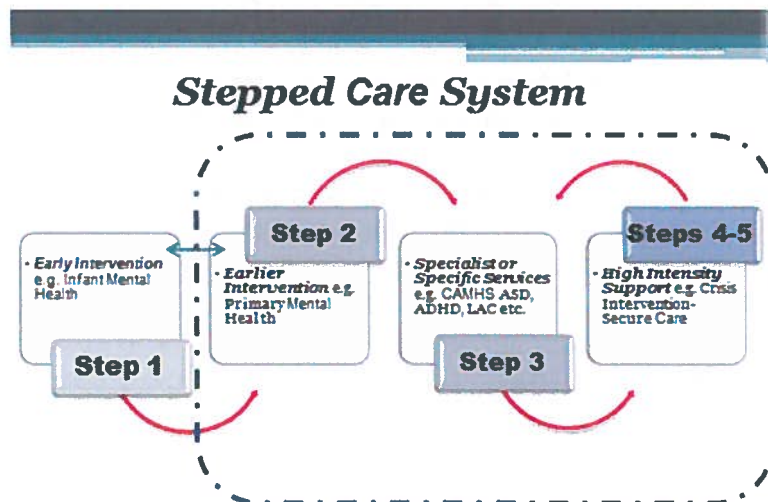
Section 2 – Factual Information

2 Factual information

Northern Ireland's total investment in child and adolescent mental health services is £19,313,207 representing 8% of total health expenditure. The national average is 10%, indicating an under-investment in child and adolescent mental health services. And additional £3,525,229 is spent on Autistic Spectrum Disorder services.

Its core CAMHS service is represented by Primary Mental Health Workers, five community based specialist CAMHS teams (Step 3) in each of the regions; Crisis Assessment and Intensive Treatment Teams (Step 3) at different stages of development across the regional teams, eating disorder services and a 33 bed inpatient CAMHS unit with two intensive care beds (Beechcroft – Step 5). There is a plan for a community based Forensic Adolescent Consultation and Treatment CAMH service, which will be managed by South Eastern Health and Social Care Trust. There are no secure CAMH services in Northern Ireland. Inpatient care for 8 young people with intellectual disability is provided at The Iveagh Centre but is not commissioned by mental health services.

Care Pathways exist and others are in the process of development to ensure a coherent strategic approach across the regional teams in delivering the Stepped care model.



Source: Health and Social Care Board, May 2014

Since the publication of the Stepped Care model, Local Implementation Teams have been set up with multi-agency membership, supported by 9 regional outcomes indicators.

Workforce development plans are in the early stages of development.

Crisis Assessment and Intensive Treatment Teams are currently operational in Belfast and South Eastern Trusts. In the remaining Trusts, the CAT and ITT are in various stages of development with the Western Trust having an established Crisis Resolution and Home Treatment Team and currently focussing on developing out of hours provision. In the Southern Trust the CAT and ITT are in place for a limited number of hours and in the Northern Trust currently in the recruitment stage.

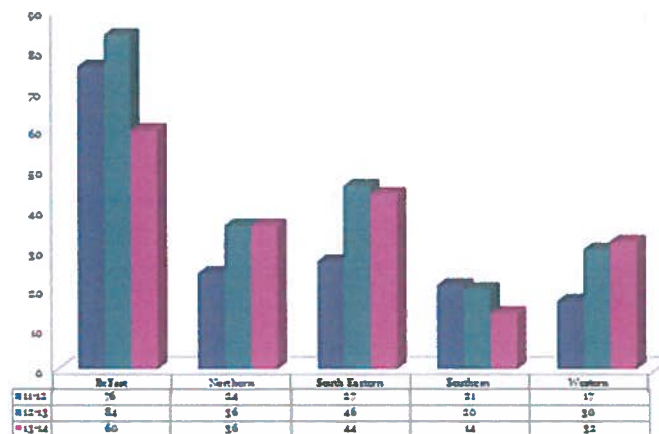
Early intervention, infant mental health and integrated child development, therapy and CAMHS related services are beginning to be developed.

All Trusts are currently scoping the delivery of evidence-based practice and a clearly stated therapeutic model based on NICE guidelines and effective service delivery is enhanced and monitored either by CORE, CORC or the electronic framework.

The number of referrals accepted by Step 3 CAMHS in 2010/11 was 5392 and in 2013/14 it was 4854; however the number of in-year referrals in 2013/14 rose by 45 compared with 2012/13. The numbers of referrals being accepted has increased in the Belfast, Northern and Southern Health and Social Care Trusts. Clinical caseloads have risen significantly in the Western and Southern Trusts, have fallen slightly in the Northern and South Eastern Trusts and fallen significantly in the Belfast Trust.

The profile of CAMHS inpatient admission provided by Belfast Health and Social Care Trust indicates the greatest number of admissions from the Belfast and South Eastern Trusts (although those numbers fell in 2013/14). The only Trust to show a consistent reduction in admissions over three consecutive years is the Southern Trust. The only Trust to show a consistent increase in admissions over three consecutive years is the Western Trust.

CAMHS Profile of Inpatient Admission



Source: Health and Social Care Board, May 2014

Numbers Admitted To Adult Wards	2011-2012	2012-2013	April 13-Mar 14
EHSCT	16	0	0
SEHSCT	8	1	0
NHSCT	16	7	8
WHSCT	11	3	9
SHSCT	22	4	3
Regional	73	15	20
Change	Baseline	-81%	+33%
Bed Days Utilised	2011-2012	2012-2013	April 13-Mar 14
EHSCT	379	0	0
SEHSCT	80	16	0
NHSCT	211	39	19
WHSCT	215	2	61
SHSCT	184	32	8
Regional	1069	89	88
Change	Baseline	-92%	+12%
Average LOS	14.6	5.9	4.4
Change	Baseline	-60%	-25%

Source: Health and Social Care Board, May 2014

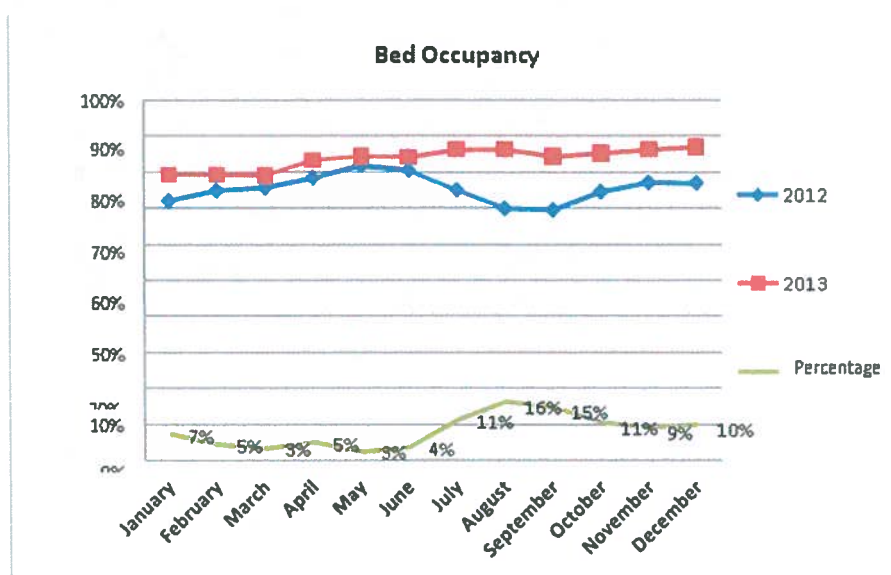
Admission to adult beds appears to be significantly affected by the need for short term crisis management in the absence of an available bed at Beechcroft. The number of young people admitted to adult mental health wards increased by 33% in 2013/14, with significant increase in admissions from the Western Trust – although one admission in the Western Trust included an admission that accounted for more than 50% of the total bed days. Average length of stay is 4.4 days. The majority of those young people were aged over 16 on admission, and three were 15 years old.

Beechcroft CAMHS Inpatient Unit was commissioned as a new-build facility in September 2010 for children and young people up to the age of 18. It has a budget of £5.7m. It has two wards,

Ward 1 has 16 beds and two intensive care beds; Ward 2 has 15 beds. Initially it was set up as an inpatient unit for children and for young people. More recently the number of young people requiring admission in England has meant that the majority of beds are occupied by young people aged 14 and over. This correlates with the findings of the NHS England Step 4 Review published in 2014 which showed that between 1999 and 2006 there was a 30% reduction beds for u14s and a 28% increase in beds for 12-18s. However in England the number of independent sector beds for 12-18s has increased by 66%, an element which is not comparable with Northern Ireland which has no Independent sector Step 4 provision.

Beechcroft has an average length of stay of 11 weeks on Ward 1 (shortest 3 days) and 8.3 weeks on Ward 2 (shortest 2 weeks)⁴.

Our understanding is that at Beechcroft, the bed occupancy is consistently close to 100% whereas the RCPsych recommendation is that bed occupancy should be 85% to allow for acute admissions. However given that the majority of admissions to Beechcroft are already acute admissions, and elective admission appears to be a rarity, it is not surprising that the unit is working at full capacity.



Source: NHSEngland CAMHS Step 4 Report, 2014: England – CAMHS T4 bed occupancy

⁴ Source: CCQI 2014

“There is no absolute standard for bed numbers, based upon evidence for either population needs or the effectiveness of inpatient provision. A proxy measure of 20-40 beds per 1,000,000 total populations is generally used, as suggested by the RCPsych”⁵

Beechcroft has 114.7 wte staff (including administrators and education staff). We found the Beechcroft staffing capacity to be generally in line with RCPsych 2013 recommendations, but suggest that increased capacity is necessary in family therapy, social work and clinical psychology and psychodynamic psychotherapy, based on RCPsych figures. It is important to note that these skills may not be restricted to a professional group – indeed we found that family therapy skills were not just present in family therapists. However capacity is not the only factor to be taken into consideration. As indicated in the NHSE CAMHS Tier 4 report⁶, variation in practice relating to community based provision, the presence and effectiveness of step-up and step-down services, management of delayed discharges and staffing levels all impact on whether the level of bed provision is sufficient to meet need.

⁵ Z Kurtz. 2007 Step 4 Review CSIP quoting Cotgrove et al 2004 RCPsych)

⁶ <http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

Section 3 - Findings

3 Findings

3.1 Commitment

Everyone we interviewed was committed to working collaboratively and wanted services to continue to grow and to improve. People were just as open to describing things that worked well as those that did not work and it was clear that change and greater clarity about the roles and functions of all services is welcomed. This attitude was seen at all levels from commissioners, staff and young people and their families. However, not everyone felt certain about where they fitted in the process of change, nor what was expected of them. Many did not believe their managers and service leaders knew this either.

3.2 Need

We were unable to identify whether an u19 population-based CAMH needs assessment had been undertaken. Until the need is identified, services will continue to be developed piecemeal and in response to immediate pressures but in the absence of evidence of need, thus using precious resources on interventions which are not all evidence-based and which might be prioritised for use elsewhere.

Commissioners or the Public Health Agency should commission a population based needs assessment of children and young people under the age of 19, including eating disorders, and a skills audit of children's services, CAMHS and regional specialist services in order to inform the workforce development plan, a sector training strategy and personal development plans following annual appraisal.

3.3 Strategy

Every major policy and strategy requires a local strategic driver; a mechanism for ensuring a consistent approach to delivering quality services and monitoring outputs and outcomes.

We recognise that the changes required by the RQIA report and the Stepped Care model will take time to embed. There is evidence that the journey has started and that Local Implementation Teams and Children and Young People's Strategic Partnerships are already critical strategic intermediaries

in driving and monitoring the change in local areas, regularly audit the translation of plans into outputs and measure the impact of outputs on improving outcomes for children and families.

We urge those regional strategic partners and organisations to fully realise their potential to gain traction and lever change and to ensure that the importance delivery is not lost in the practicalities of re-configuration.

The rapid activity that accompanies transformational change has a tendency, over time, to obscure the fundamental reason why change is happening. The key to delivering the necessary changes is through leadership, consistency, supporting staff in delivering evidence-based interventions and maintaining fidelity to the key messages which initiated the change.

3.4 Culture

Perceptions of culture - 'the way we do things around here' - sometimes block or divert the processes of change because of received and perceived wisdom and myths about difference. We encountered frequent examples of "That's the way we do things in Northern Ireland", "Things are slow to change in Northern Ireland", and "It's different here in Northern Ireland".

We appreciate the context of Northern Ireland history, the impact of the troubles on families and on service providers, the legacy of multi-generational trauma, the impact of recent austerity measures and cost efficiencies and the practical problems of providing a full range of services to families. However we do not believe that the structural, geographical, delivery and leadership challenges are very different from other services and areas we have reviewed in the UK and it is well documented that the views and experiences of young people and their parents or carers are similar across all inpatient settings.

What will make a difference to the speed and sustainability of change is how quickly local organisations grasp and then drive change, their plans for taking their staff with them, their methods of communicating the key messages and specific support to the leaders who are driving the change. Expecting change to be embedded in a system where staff do not feel well supported and where there is no regular feedback to staff and managers about progress other than delivery targets is unrealistic.

The factor that most positively affects embedding learning and change is a sense of connection to the whole system and where mechanisms exist to address the human consequences and

impact of change on the workforce and leaders. Failure to address this is likely to weaken the desired outcomes.

We note that Finance Minister Simon Hamilton has set out ambitious plans in *Northern Ireland – a strategy for asset management*⁷ to make better use of its £36bn of public assets and developing the role of voluntary and community sectors in providing public services. He has emphasised, however, the critical need for radical change in the mind-set of public service leaders to drive reform and ensure effective implementation of such plans, and with this we concur.

LITs and CYPSPs should take steps to ensure that a shared vision and a culture of co-production between commissioners, providers and service users is embedded in planning and review processes in line with strategic objectives

3.5 Geography, its impact on service provision and access to inpatient provision

Geography appears to be a significant factor in influencing referrals, service usage, the quality, frequency and consistency of communication and relationships with the inpatient service. Service models in the Step 3 teams differ slightly, as do the stages of development of those services commissioned by HSCB.

Regardless of geography, good data collection, good quality communication, ensuring a consistent approach, and understanding the local delivery context are critical considerations when ironing out some of the current local challenges.

Those challenges are not only about geography – although there are perceptions by outlying trusts that the Belfast and South Eastern Trust, being geographically closer to Beechcroft, have better access to beds and a better working relationship. Staff in trusts more geographically distant said they felt it was harder to make and then sustain consistent working relationships with Beechcroft.

We note that the number of admissions to Beechcroft from the Belfast and the South East Trust are consistently higher than those from Southern, Western and Northern Trusts between 2011 and 2014 but the absence of comprehensive data and a population based needs assessment make it difficult to identify the

⁷ http://www.sibni.org/investment_strategy_for_northern_ireland_2011_-_2021.pdf

critical components other than those relating to population density. We note that the greatest population density is in the Belfast and South Eastern Trusts.

There have been no admissions to adult mental health provision by Belfast and South Eastern Trust for the past two years; however the number of admissions to adult mental health beds has risen significantly in the Western Region, and marginally in the Northern region. We were told by local trusts that this is because of a lack of bed availability but it could also be influenced by variation in local capacity, staff-mix and practice. The number of bed days utilised on adult mental health wards by the Western Trust increased from four to 61 between February 2011 and March 2014, however in spite of a slight increase of one admission by the Northern Trust in the same period, the number of bed days decreased from 42 to 26.

The greater the geographical distance from Beechcroft, the less likely it was that Step 3 CAMHS perceived feeling properly acknowledged and connected and a lack of tailored support to more distant trusts was evident. We think this is legitimate and relationships with the more geographically distant trusts should be developed and sustained, and tailored adjustments made to managing and responding to expectations and approach. Our recommendation relating to managed clinical networks in 8.1 will help formalise our recommendations in this section, as is the recommendation about the development of day services in local Step 3 CAMHS.

Regular liaison meetings between Steps 3, 4 and 5 should be facilitated by Step 5, to ensure that opportunities for consultation to prevent admission are embedded in everyday practice

HSCB should assist all trusts to acquire the technology which will enable video conferencing facilities

3.6 Complexity: its impact on referrals, workload and case-mix

Similar to other parts of the UK, pressures on CAMHS and other systems in Northern Ireland are significantly affected by the complexities of family lives and the challenges faced by families, the impact of substance misuse on mental health, multi-generational trauma and family breakdown.

Anecdotally, we were told that pressures on the public sector and on voluntary organisations have seen upward adjustments to

public sector service thresholds. This has certainly been noticed in England also, and the net result is that young people often present later and with greater levels of complexity and risk. However, if this is the case in Northern Ireland, the skills in the workforce have not been sufficiently developed to respond to this complexity. A combination of complexity and higher thresholds of service provision can increase the risk of families not receiving the services they need.

Staff consistently told us that the children and families they work with have a number of needs that sometimes feel beyond the ability of individual services to respond adequately to that need. Some staff told us that they no longer have the opportunity for a mixed caseload. They said that all young people present with more complex needs and families have higher expectations of public services. Sometimes the complexity, demand and expectations required more time than they were able to offer, especially when faster throughput is required by their organisations. We were not commissioned to examine caseloads in detail.

Common disorders are apparent even in the most complex presentations and a clear theoretical model should underpin responses to need, combined with regular clinical supervision and reflection time to maintain a sense of perspective and self-efficacy when caseloads are high.

“Green and Jacobs (1998) contend that the complex needs of one young person can have an immediate and detrimental effect on the dependency needs of the rest of the inpatient group and the therapeutic environment. The Royal College of Psychiatrists (1999) recommends that both admissions and staffing levels should be informed by patient dependency measures”⁸.

We recommend that commissioners and service managers reflect on this and consider whether current services could be delivered in different ways and in non-traditional places. Certainly families told us that delivering a ‘standard service’ in a ‘standard way’ no longer fits the way they live and the challenges they are facing. All CAMHS systems across the UK are dealing with this challenge and must get ahead of the curve in terms of service and delivery models. Delivering the same services we have always done, and in the same way, will not reach the families that need help.

⁸ The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study, 2008
http://www.nets.nihr.ac.uk/_data/assets/pdf_file/0008/64457/FR-08-1304-062.pdf

Commissioners should review the range of referrals accepted by Step 3, 4 and 5 CAMH services, triangulate the findings with the range of services being offered and the skills and capacity of the workforce to deliver evidence-based treatments and interventions

3.7 Pathways of care

We noted the LIT CAMHS Plan Indicators include a target for completing comprehensive pathways of care (Indicator 3). This is good, and is essential to informing workforce development and the inevitable adjustments which must be made over time to service structure.

Our fieldwork found evidence that work is well underway in developing pathways of care. Where it existed, we found the pathway development to be robust.

We urge those responsible for leading change to ensure that the pathways are inter-connected and are sufficiently flexible to ensure that those with the most complex needs have the ability to access services on the pathway. In relation to developing consultation models for complex need and mental health, clinicians should always be involved in the planning.

Children, young people and their families should be routinely engaged in pathway development, as they will already be experts in negotiating existing, *and non-existent*, pathways. However, pathway development alone will not improve service delivery. The manner in which the pathway is made effective, a commitment to continuous improvement and regular feedback and reviews involving stakeholders are essential components in quality delivery. The measure of a good pathway is that it should

- Involve children, young people and families are part of its development
- Be coherent and accurate
- Easily described (ask a child or a parent or a professional to describe it. If they cannot, it is a good measure of i) whether it will work for them and ii) whether it makes sense to them)
- Tangible (children, young people and parents should be able to see and feel that it is working to their benefit)
- Workable (professionals must understand their role in making the pathway work)
- Implemented by staff with the right skills and aptitudes

Pathways must be coherent and sufficiently flexible to take account of those with the most complex need

The following pathways should be strengthened and/or developed

- **From children's services and other services into Step 3 CAMHS accompanied by clear referral criteria**
- **For eating disorders, including a day services, supported by a clinical network**
- **For children and young people with intellectual disability who need access to a CAMH service, supported by a clinical network**
- **For self-harm and suicidal ideation, supported by a clinical network**
- **For looked after children who need to access specialist (Step 3) CAMHS**
- **For out-of-hours CAMHS provision that links to CAT and ITT, the A&E pathway, supported by a co-ordinated clinical network**

3.8 Leadership

We found good leadership in some parts of the system but the concepts, goals and tasks of leadership were interpreted differently by the Step 3 and Step 5 services. As a result there appeared to be an inconsistent approach to the management of change and service and different leadership expectations in the professions represented in those services.

We found examples of leaders working as individuals and who exceeded their capacity within a pressured system; we found some examples of leaders working together and other examples where leaders appeared isolated and demoralised. Effective leaders were recognised within the system but because they were effective, they were expected to do more than was possible.

We found staff who wanted to lead but where their aptitude for leadership went unrecognised, or rigid systems disabled them. We found systems and professions that would benefit from leadership but a reticent approach to the leadership role. Equally we found staff in some leadership roles that did not appear to yet have the leadership qualities that the role required.

Leadership is an essential component of managing change, good governance and leading an effective and dynamic staff group. Good leadership strengthens the level of positive engagement by staff. In essence

*“engagement relates to the degree of discretionary effort employees are willing to apply in their work in the organisation. It recognises that whatever their level or role in the organisation, every employee ultimately chooses whether to contribute the minimum levels of performance required (or to sabotage), or to go beyond the minimum required by the post and to offer outstanding effort in their role”.*⁹

In most places we visited, there was a real sense of urgency to reform and transform and translate policies into real services for real people. We found this was sometimes evidenced in improved practice. However, more often the immediate evidence of change were written procedures, processes, pathways, flow-charts and protocols and emerging evidence of new ways of working being consolidated. If we requested information it was unfailingly provided. What was offered on paper was not always matched by evidence of embedding in practice, the principles that underpinned the process. What made a difference was where leaders communicated effectively with staff, patients and parents about explained how these new processes, protocols and procedures fit into the wider picture.

The exceptions to what we were told about inconsistent communication by managers and senior staff were characterised by the efforts of charismatic individuals who had not only internalised the vision and were able to translate it, but who were good strategic leaders, consistently good communicators and who lead teams and services that were demonstrably more effective in responding to the needs of families and joining up the dots between services.

Distributed leadership - where professional leads have responsibility, accountability and the opportunity to develop their management and leadership skills - should be a defining feature of a well-managed change process. Leadership should not be left to those whose natural inclination is to pick up the leadership baton – leadership characteristics should be identified and encouraged, and then developed through the distributed leadership model.

Trusts should make explicit the key leadership roles in each trust and regional facility and then map the strategic delivery requirements of the stepped care model against leadership roles and functions, to ensure that those activities relating to

- Strategic leadership
- Fidelity to the model

⁹ *Engaging Leadership: Creating organisations that maximise the potential of their people* 2008, CIPD

- Liaison with LITs and CYPSPs
- Pathway development
- The development and sustaining of strategic relationships and local service interfaces
- Supporting and staffing regional facilities
- Meaningful engagement of children, young people and their families
- Service development
- Service delivery, audit and quality
- Evidence-based practice and outcomes measurement and links to supervision and case management
- Workforce development, planning, appraisal

are effectively managed and that the roles and responsibilities of clinical and strategic leaders are clear to them and that they are well supported.

The Continuing Development Programme for CAMHS should contain a module on leadership. The workforce development programme should position itself to identify and encourage latent and emerging talent, bring on new managers and extend the skills and capabilities of experienced managers.

The CAMHS Continuing Development Programme should include a leadership development module involving senior clinicians, managers and commissioners, which includes action learning and coaching for emerging and for experienced leaders and managers and includes action learning and coaching

The Medical Director should meet regularly with the Trust Clinical Directors as a group in order to strengthen strategic oversight, improve the information flow and ensure there is a consensus to support necessary changes in service delivery

Senior clinicians and other senior stakeholders should be actively involved in service design, and be part of a distributed leadership approach

Delivery

3.9 Integrated working

Those with whom we spoke observed that the whole system of provision for children and young people has been subject to efficiency savings – across children’s services, community based

support and CAMHS. Most referred to the pressures of a constant barrage of referrals, more work than they are capable of servicing, being very busy, mostly crisis-driven, with little time for reflection and little time for preventive work.

Integrated health and care trusts should improve the opportunities and ability to resolve these challenges. It is disappointing that trusts have been unable to resolve these in spite of the beneficial and permissive structure of integration and with the benefit of improvement funding.

We heard about many good examples of joint working, collaboration and care of children and young people by CAMHS Step 3, Crisis Assessment and Intensive Treatment Teams and Children's Services most of which were predicated upon the drive and commitment of individuals. We were also told about gaps in provision, poor communication, information not following the patient journey, lack of liaison between community based children's and CAMHS teams, GPs, A&E and paediatrics which indicated a systemic problem. Individual practitioners and clinicians bridge the systemic problems but there is a lack of drive to ensure a systematic and consistent approach. High quality provision should not depend upon Herculean actions by individuals – the system should be configured in such a way that it is possible to deliver to a consistently good standard by everyone.

People consistently told us that they wanted to work closer together and to support one another but that a reliably consistent approach by all services was the most difficult thing to achieve. Staff cited heavy workload, their lack of understanding about what each part of the system does, worries about changing threshold criteria, their ability to be able to access a range of services and lack of time to develop the inter-disciplinary relationships so fundamental to collaborative working. These challenges and apparent inconsistencies need to be urgently addressed by local service leaders and commissioners. Inconsistency and hesitancy at the interfaces will affect the efficiency of the developing care pathways.

Children's social services staff described demand outstripping its ability to respond effectively. We also noted the responses from Acute Medicine, Step 3 CAMHS, GPs and Adult Mental Health professionals as well as Children's social services and the voluntary sector in the Survey Monkey questionnaire and we were struck by the variance in the quality of relationships and the level of collaboration between children's services and Step 3 CAMHS across Northern Ireland. There were a number of examples in the Survey Monkey study, and in our interviews, which appear to indicate a tendency toward 'referring on' rather than

offering/seeking/providing consultation and joint working. There were, of course, notable exceptions. However children and their families told us that they, too, experience a separation between the different services they receive which do not always feel like the 'wrap around' services, they expect.

The culture of 'referring on' potentially weakens the quality of inter-professional relationships and reduces opportunities for collaboration and joint working, unless those referrals are guided and enhanced by the care pathway. We were concerned to hear some community based staff say that when a child is admitted to any of the regional facilities the services that supported that child in the community are often withdrawn due to local delivery pressures, which then makes it more difficult for the regional service to discharge or move a child back into community based services with planned support and engagement. In the process, the child and the family experience a lack of continuity in planning, care and delivery.

Looked after Children's services felt that the children they care for – especially those in fragile placements, and/or in residential care – need specialist mental health support but they do not consistently receive it from Step 3 CAMHS. As professionals they also want professional consultation to be available to help them manage challenging behaviour.

Most of those we spoke to in education, children's social services and residential settings said that they really valued the opportunity for consultation between themselves and community based, crisis assessment, intensive treatment and inpatient CAMH services. However this opportunity for consultation did not appear to be consistently applied across all the trusts and is not specified in the Service Specification or SLA. The provision of consultation and joint working must be a component of the Service Specification for Step 3 and 5 CAMHS.

Children's social services, A&E, GPs and Adult Mental Health Services staff all expressed concern about the absence of consistent out-of-hours CAMHS provision across Northern Ireland and its impact on integrated delivery. This is further explored in section 3.11.

If a child or young person is in an inpatient unit there is an expectation that community based professionals will attend discharge planning meetings. This is not always the case, we found. All sectors must be in a position to contribute to planning the continuing care for young people. 'Out of sight, out of mind' is short-sighted and not in the child's best interests and its impact interrupts the natural flow that should inform a fluid care pathway.

3.10 Step-up, Step-down and Transition

It is not until the full (or at least consistent) establishment of co-ordinated community based activity in children's services, that the pressures on the current Step 5 service can be accurately evaluated.

The role of the voluntary sector, primary care, schools, early intervention, children's social services, Step 3 CAMHS, into CAT and ITT, mental health inpatient care, paediatric inpatient care, forensic, youth justice and secure children's facilities, intellectual disability - supported by workable care pathways and robust alternatives to inpatient care - all have a part to play in preventing admission.

As it stands, commissioning for and referrals to Step 5 services would be enhanced by more coherent alignment of the commissioning themes across the regional specialist services. Currently referrals to Step 5 appear to be influenced by perceptions of risk and how this is managed in the community, the capacity and capability of Step 3 CAMHS, the availability of crisis assessment and intensive treatment and outreach support, and by the different stages of development and the priorities of each trust. The Step 5 service has become a lightning conductor for the rest of the system.

The challenges and opportunities that exist in Step 3, CAT, ITT and Step 5 should be considered and resolved in tandem to reduce the number of crisis admissions to Step 5 and improve the quality of discharge processes and the transition to adult mental health services. Examining the economies of scale that could be achieved in providing highly specialist secure mental health services was not in the scope of this review. We noted there were a small number of highly specialist referrals that were spot-purchased from NHS and Independent providers in England. It could be that the incidence of need is so low that it would not be cost effective to provide those services in Northern Ireland; however the principles of regular reviews in the presence of clinical outcomes measurement is an essential element for monitoring the quality of those placements.

Crisis Assessment Teams & Intensive Treatment Teams were conceived as enhancing the dynamic of the care pathway and its presence will inevitably require adjustments in Step 3 and Step 5. They offer a good model and a good service but are at different stages of development. As a priority HSCB should work with all Trusts to ensure that this consistency is achieved.

Once the CAT & ITT model is consistently applied across the trusts and all staff are in post they have the potential to manage a high level of risk in the community. They are flexible and responsive. The risk, however, is that because of their small size, staff will burn out.

Commissioners and providers could consider the potential of a rotating development programme based on a practice rota to support new delivery models, with the aim of increasing the breadth of experience in the CAMHS workforce. CAMHS staff could be offered, for example, the opportunity to work in primary care settings, support other specialised regional units, work in inpatient care and community based CAMHS teams including CAT and ITT. This could be considered as an essential component of workforce planning, building experience, professional development, professional relationships and an enhanced career pathway.

Step up and step down services should be co-owned by Children's Services, Step 3 CAMHS, Step 5 CAMHS, CAT and ITT. A partnership approach between these services should enable dynamic outreach approach to be drawn down from a combination of offers to provide a wraparound service for the most vulnerable children and young people. Such an approach should aim to provide care and support as close to home as possible, prevent admission, provide additional support following discharge and be clearly commissioned and co-ordinated.

Planning and delivering consistently high quality transition into adult services appears to be affected to some extent by the availability of community based staff but more significantly by whether early planning is embedded into the system. 67% of respondents (n=38) to the Survey Monkey platform said they had been involved in planning discharge and transition, however some said they needed much more notice about meetings and some said they were unable to attend because of pressures in their own service.

The planning and delivery of a seamless transition to adult services appears to vary and be affected by how soon the plans for transition are started, the availability of community based staff and access to a range of adult mental health services. Parents in the focus group also expressed concerns that if their child is approaching 18, they are unlikely to receive the range of therapeutic input in adult mental health services that they receive in CAMHS. This provides an interesting and a challenging paradigm for service planners and commissioners.

Care, Discharge and Transition Planning Meetings should be child-centred, include children and young

3.11 Out-of-hours and on-call

The u19 population of Northern Ireland is 481,100¹⁰.

It is difficult to understand how other professionals who are required to provide 24/7 services such as out-of-hours children's social care service, acute medicine, GPs and all other services provided to children and families can operate well in the absence of a specialist CAMHS consultation and assessment between 17.00 and 09.00, at week-ends and bank holiday periods. We are concerned that although collaborative out of hours arrangements are in place across Northern Ireland - provided by out of hours adult mental health services and CAT and ITT up to 20.00hrs in Belfast and the South Eastern Trusts during the week - the lack of consistent and available specialist child and adolescent mental health expertise is not in the best interests of children and young people; neither does it enhance inter-professional relationships.

The variation across the trusts in providing a consistent on-call system can contribute to increasing the levels of risk being managed by General Practice, community based and acute services. Increased levels of mental health risk in the absence of specialist child mental health consultation, assessment and treatment are likely to contribute to increased numbers of emergency (unplanned) admissions to Step 5 CAMHS and to acute health and social care services.

Out-of-hours provision is an essential component of the acute care pathway. It is in fact preventative in nature, contributes to the safe management of risk, increases the likelihood that children will be treated in the least restrictive setting, and supports other professionals and services that are dealing with the most vulnerable children and young people. It is not necessarily an inevitable stepping stone to inpatient care.

The CAT in Belfast and South Eastern Trusts operate a 24/7 system with on-call provided through the multi-disciplinary team and with a Specialist Registrar and Consultant Child and Adolescent Psychiatrist offering on-call support. However, at present a similar level of service is not available in other trusts, although they are being developed.

¹⁰ ONS 2012

We predict that once there are region-wide CATs and ITTs and a consistent approach to managing those children most at risk of admission, it is possible that the number of CAMHS inpatient admissions will reduce. However Beechcroft staff noted that admissions from Belfast and South Eastern Trusts served by CAT and ITT are in fact more likely to be more complex. Commissioners should monitor changes in the admission profile to Beechcroft once the CATs and ITTs are embedded in local trusts as this might require changes in staffing configuration.

An out-of-hours CAMHS opinion and access to urgent mental health assessment should be commissioned uniformly across all Health and Social Care Trusts and available 24 hours a day, 7 days a week, supported by agreed joint protocols.

3.12 Eating Disorders

The inpatient eating disorder service is small and its capacity does not enhance the necessary connections with community based services. Levels of community eating disorder provision vary across Step 3.

There is a paucity of medical input commissioned into eating disorder services in general, and the disappointingly poor take-up of training offered by the inpatient eating disorders team staff to community and inpatient teams (due, we were told, to capacity and pressures on caseloads). We found a significant increase in the number of admissions for eating disorders over the past 12 months. It would be important to further explore the reasons for this and expand the range and scope of Eating Disorder provision in the community.

We believe there is scope to develop a Northern Ireland-wide centrally managed eating disorder service which would bind the separate trust managed services, achieve economies of scale and build a community of eating disorder clinicians that are currently widely dispersed.

Commissioners should develop a Northern Ireland-wide centrally managed eating disorder service as part of a hub-and-spoke provision, with a service manager a full time dietician and dedicated medical input, along with other specialist areas of provision, with a service manager, a full time dietician and dedicated medical input, and a clinical network and a small number of inpatient beds.

3.13 Self Harm

We found regular references to self-harm and the threat of self-harm and suicide in our fieldwork. The increased prevalence of suicide in u25s in Northern Ireland, and adverse publicity about it, has increased professional concerns about how to respond to it effectively.

We recognise of course that clinicians deal with the sequelae of self-harm on a daily basis but we are concerned that some staff appear find the management of self-harm very challenging.

We are also concerned that children and young people in community based and inpatient settings use the threat of self-harm and suicide as a lever to either get access to an inpatient bed or to delay discharge from it.

We did not find evidence of a robust clinical analysis of this apparent trend or hear mention of a clinical model/framework to manage it, and certainly we found a lack of consistency in how those threats are dealt with. The NHS England CAMHS Tier 4 report observes that although for many young people admission can be life-saving, admission to hospital can also have an iatrogenic effect especially for those suffering from chronic suicidality and self harm. The report also notes that

“in such cases discharge becomes increasingly problematic and inpatient and outpatient teams and families become increasingly concerned about risk and reluctant to pursue discharge even in the face of worsening presentation. This can lead to prolonged stays in hospital and in some cases and escalation to increasing levels of security¹¹”

We remained unclear whether there was a clear clinical model for understanding and managing threats of suicide – particularly in relation to discharge planning. Although it is not uncommon, we were also concerned to hear staff perceptions that it is ‘safer’ for the young person to be an inpatient than to return home.

The NHSEngland 2014 report recommends that, in the absence of specific evidence for treatment of adolescents, that a similar approach to that used to manage chronic suicidal thinking and actions in adults with Borderline Personality Disorder, and that the NICE Guidelines on the Treatment and Management of Borderline Personality Disorder (2009) should be used. Admission under these circumstances should be time-limited, short and focussed

¹¹ NHSEngland Step 4 Review 2014

around reducing risk and structured multi-domain approaches (including *brief hospitalisation*) is recommended.

The response and the clinical management by staff and services to threats of further self-harm is often dependent upon the skill-mix and experience of the staff engaged with the young person, the professional's access to consultation and the time and support to reflect on incidents of self harm and suicide and to learn from them.

NICE guidelines should be consistently used to inform clinical practice in the management of self-harm and the threats of self-harm and to strengthen the skills of all staff working with children and young people who self-harm

3.14 Specialist Regional Services

3.14.1 Iveagh Centre

We made one site visit to the Iveagh Centre. The Consultant was not present due to a pressing clinical issue and parents/carers were not spoken to. There was evidence that changes had been made since the RQIA report, such as the regular reflective practice group and there was planned staff recruitment. We understand that soon after our visit RQIA made an unannounced visit and imposed some performance measures.

We found Iveagh had significant challenges. The most pressing is limited access to specialist, multidisciplinary, community based CAMHS. This absence contributes to the ability to quickly discharge young people from the unit with appropriate levels of community based support. There is no local specialist residential provision for those young people who are not able to live at home and only fragile integration with CAMHS. The staff we spoke with were very keen to be integrated with CAMHS.

Iveagh is not commissioned by mental health commissioners and is managed by disability services for children that are mainly concerned with physical disability and so have limited understanding of mental health. Families have usually been struggling for a considerable amount of time in the absence of a robust community based provision before their child ends up on the ward. The relief and respite that results means that they often no longer feel they can continue to have their child at home. They request residential services, which are difficult to access and after admission, discharge is frequently delayed because of the lack of

community based services. Currently there are 2 children on the ward who have been there over one year.

The lack of community based services raises issues about whether children and young people with intellectual disability have equal rights and equal access to a full range of services that should help them flourish. The short term and long term needs of children and young people with intellectual disability and the services that support them need to be re-assessed.

3.14.2 **Woodlands**

This provision is commissioned through the Department of Justice.

We were told that the young people in Woodlands had significant levels of mental health problems and disorder, frequently compounded by co-morbidity. Although there are good relationships with Step 5 CAMHS, these are not formalised and strengthened by the current commissioning process. We found the mental health nursing and mental health medical provision is significantly under-resourced, that nursing staff in particular do not receive regular clinical supervision and do not have access to appropriate continuing professional development.

It is our understanding that the mental health nursing provision will in future be led by the South Eastern Health and Social Care Trust as part of the Forensic Adolescent Consultation and Treatment Service *FACTS* which will be provided as an in reach service to Woodlands.

3.14.3 **Lakewood**

We did not visit Lakewood, however the principles that should inform high quality and consistent access to Step 3 and Step 5 CAMHS is reiterated in other sections of this report.

3.14.4 **LAC Therapy Team**

We did not visit the LAC therapy team, however the principles that should inform high quality and consistent access to CAMHS is reiterated in other sections of this report.

3.14.5 **Planned Forensic provision *FACTS***

We were heartened by the plans for CAMHS forensic provision.

We understand that the forensic provision will be commissioned to be managed within children's services.

The short and long term provision for the needs of children with intellectual disability should be re-assessed, Step 3 community based intellectual difficulties services should be significantly strengthened, and day services commissioned.

A small inpatient service for children and young people with intellectual disability would ideally be located closer to Beechcroft, for brief stays and where young people require stabilisation, assessment and treatment, and to increase opportunities for co-working.

The Department of Health, Social Services and Public Safety and the Department of Justice should work together to ensure that the provision of mental health assessment, care and treatment meets the acute and ongoing mental health need of young people in Woodlands, that nursing staff receive regular clinical supervision and have access to the CAMHS continuing professional development framework.

Medical input to Woodlands should be increased by one day a week

Service Specifications should formalise the relationship and expectations of Step 3, 4 and 5 CAMHS clinical and the professional support offer to all the regional specialist services and require that evidence-based interventions and routine outcomes monitoring are undertaken by them.

Section 4 - Beechcroft

4 Beechcroft

4.1 Beechcroft

We spent time on Ward 1 and Ward 2 and PICU and are very grateful for their support to this process, for the information they shared, for their time and for their commitment to the children and young people and parents with whom they work.

In-patient provision is a highly specialised service for children and young people with severe and/or complex problems that need a combination or intensity of interventions that cannot be provided by community based Step 3 CAMHS. Its function is to provide a safe and containing therapeutic environment where intensive assessments can take place, where the child and young person can be stabilised and where intensive treatment is necessary.

Admission criteria in the UK vary but in the main they encompass three main categories:

“High risk – admission may be indicated when there are high levels of risk to the child or young person, secondary to suicidal thoughts or behaviours or self neglect, and beyond the capacity of the family and community-based services to manage. Admission is expected to reduce this risk.

Intensive treatment – when a disorder is associated with other psychosocial difficulties, and/or co-morbid disorder resulting in difficulties pervading all aspects of the child/young person’s life.

Intensive assessment - 24-hour assessment and supervision by a multidisciplinary team to gather information to guide further management”¹².

We would expect a modern Step 5 CAMH service to provide for the following groups of children and young people aged under 18 who are experiencing severe mental disorders leading to significant impairment and/or risk.

These children will be in need of admission because:

- They are suffering significant impairment and their condition is deteriorating or failing to improve with outpatient care
- There is a need to provide intensive assessment which cannot be provided by Step 3 CAMHS

¹² Adapted from McDougall, T; Cotgrove, A *Specialist Mental Healthcare for Children and Adolescents*, 2014

- There is a need for intensive treatment which cannot be provided by Step 3 CAMHS
- The risks to the child, family or others are significant whilst treatment is being provided

The treatment model and care plan must demonstrate:

- Evidence-based interventions and treatments based on NICE Guidelines
- Routinely recorded outcome measures which are used to monitor clinical progress and treatment
- Offer regular reviews of the treatment and involve the child or young person and parents/ carers
- Structured education programmes should be offered and a full programme of recreation and therapy.
- Specific therapies offered should include Cognitive Behaviour Therapy, Cognitive Analytic Therapy, Dialectical Behaviour Therapy, Eye Movement De-sensitisation Re-processing, and Interpersonal Therapy and also include creative therapies and psychodynamic psychotherapies.
- Systemic Family Therapy should also be available, especially to those with Eating Disorders¹³

Acute in-patient admission should always be considered as part of the whole pathway of acute and community provision. Admission should be for as brief a time as is therapeutically necessary and links sustained between in-patient clinicians, community based clinicians and education providers.

“Research evidence which is mostly qualitative and comprises descriptions of practice, suggests a need for a combination of a variety of complementary models of Tier 4 CAMHS intensive mental healthcare provision, including intensive outreach/home treatment services, crisis intervention teams and specialist out-patient services (e.g. for eating disorders, dialectical behaviour therapy), and age-appropriate day-patient and in-patient care – acute and planned treatment provision (Cotgrove et al 2007; Shepperd et al, 2008; Lamb, 2009; McDougall et al , 2010)”¹⁴

Children and young people and their parents/carers should understand why they have been admitted, their rights during admission, what options they have in terms of treatments and interventions and should understand how treatment, planning for discharge home or to other facilities, or transition to adult services

¹³ Building and Sustaining a Comprehensive CAMHS, RCPsych, 2013

¹⁴ The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study, 2008 http://www.nets.nihr.ac.uk/data/assets/pdf_file/0008/64457/FR-08-1304-062.pdf

will be planned and managed. They should understand how they can contribute to their care management and treatment plans; the name of their Advocate and how to contact them, and how to complain.

We interviewed staff and managers on the Beechcroft inpatient unit. Both wards have more beds than is recommended by the Royal College of Psychiatrists as best practice, however with the current high level of demand and with the CAT and ITT service improvements in Step 3 at varying stages of development, we do not recommend reducing the number of inpatient beds. We do recommend reducing the number of children and young people in each ward reducing the size of the wards and their configuration whilst maintaining the current capacity.

The Royal College of Psychiatrists report (2013¹⁵) says

“The recognised optimal maximum number of beds for an adolescent inpatient unit is 10–12. This should ensure that the unit is conducive to treatment and is clinically and financially viable”.

Beechcroft felt like the end point of the CAMHS continuum rather than an essential delivery point as part of a range of services on the acute care pathway. It experiences the backwash of pressures from all other parts of the system, it has its own pressures and it has become the lightning conductor for crisis admissions and acute assessments. In light of our recommendations in Section 8 the pathway will need further development.

We recognise that a significant amount of very detailed work has already been undertaken to develop the acute care pathway and this is exemplified in a full range of written protocols and processes. Having spoken with Beechcroft staff and a range of providers, the intention behind these protocols and processes appears to be neither consistently understood nor applied so that what appears on paper is not always that which is experienced by those who would benefit from access to consultation, joint work, outreach from Beechcroft or those who contribute to case management, case planning and discharge planning.

Staff at all levels articulated this and observed that although the processes and protocols are developing fast, the culture and flexibility that supports change in local services is not moving as swiftly. This needs to be managed imaginatively by commissioners and providers so that the intention that is evidenced on paper and

¹⁵ Building and Sustaining a Comprehensive CAMHS, RCPsych, 2013

in procedures is translated into embedding a qualitative difference in the way staff delivery services to children, young people and their families.

The two wards at Beechcroft have very different cultures. The legacy of one ward, originally intended as a children's ward, persists. We found little evidence of the two wards working collaboratively. Staff described different practices across the wards and young people commented that they only met peers from the other ward when they were at school- but they wished to do more together.

In contrast, the admission process means that a young person may be assessed as requiring admission by a consultant from one ward but then admitted to the other ward if that is where there is an available bed. These different clinical approaches can lead to a lack of continuity for young people and they commented on it.

Two beds are reserved for the intensive care unit (ICU). Some staff told us they were concerned that young people spend too long in the ICU – sometimes, we were told, for months. This is despite use of daily review forms and care planning being in place. Others felt the location of the ICU is problematic and some staff reported feeling isolated.

The recent RQIA reports and inspections make important recommendations. These are very helpful and they have inevitably led to rapid attention to filling gaps and responding to those recommendations. This is positive, and demonstrates the ability of the system to respond to the need for change. However, at times the ensuing processes appear to have overridden the purpose and principles underpinning them. This has resulted in the system looking sound on paper, but we found new ways of working are not embedded as standard practice by staff, nor reflected in the experience of consistent quality of care by the young people and families.

We heard reports of lengthy care planning meetings, preceded by time spent on pre-populating the pro-forma and lengthy discussion about the most appropriate CGAS score. This contrasted with the experience of the young person being a passive one, only asked to give a paper update on how they saw things which the care planning team considered and developed the care plan which was then fed back to the young person when they were called in to the meetings. Unsurprisingly this led to young people and parents not feeling involved, consenting or sometimes even committed to their care plan.

We recognise that care planning has become more structured only recently and as result of the RQIA Inspection. This is likely to mean a focus on process to embed the new practice. The important quality issues also need to remain in focus.

Staff at Beechcroft emphasised to us how busy they were and that they felt under a lot of pressure but felt that this was not really appreciated by their managers. They described working with a very complex, traumatised population and it is now rare to have a planned admission; exclusively crisis admissions have become the norm especially for suicidal and risky behaviour in adolescents with a background of severe trauma.

We found that inevitably, in an inpatient setting staff are dealing with an extremely challenging client group who are not always mentally ill in the classic sense but who are volatile, emotionally distressed and who put themselves and others at risk. Both these groups of young people clearly need mental health interventions but in different ways, linked to the evidence base.

The ward based staff view often contrasted with the management view that the wards are well staffed. There has been a recent period of high staff turnover and locum posts have not been re-funded. A consultant psychiatrist has left and not yet been replaced. This rapid change in staffing continuity has not been managed by adjustments to job plans. This is not uncommon in inpatient services and so perhaps supervisors and line managers need to be more active in ensuring the job plans are manageable.

The staff are clearly working very hard, and often over their hours, but it is not clear how much of this is contributed to increased administration tasks (the introduction of a new electronic care plan combined with an administrator being on long term sick leave) and the lack of time to stop and think about how best to allocate tasks.

The new CAT AND ITT and ITT teams in the South East and Belfast Trusts were considered by some as actually contributing to the change in the profile of admissions, and this is probably inevitable. These new intensive community teams are capable of supporting high levels of mental illness in the community and high levels of risk. As a consequence, when the need for admission arises, the disturbance and needs of the adolescent are very high. This pressure in the system is only likely to increase as more CATs and ITTs come into play. In contrast, there was a view that admissions from the Northern and Western Trusts were more about difficulty containing lower risks in the community in the absence of CAT AND ITT and ITT to support this.

4.2 Admission pathways

The criteria and pathway to admission for Beechcroft should be reviewed in order to properly reflect our recommendations for strengthened Service Specifications for all Acute and Specialist CAMH Services and incorporate the recommendations for a dynamic model of provision in Section 8 of this report.

In spite of the admission criteria and pathway, we found that the purpose of admission in relation to individual staff was often unclear – to us, to other professionals and sometimes to staff in Beechcroft itself.

Staff and young people could not clearly describe to us the goals of admission, other than the need to contain risk in the community or provide a therapeutic milieu experience. The position of Beechcroft as a component of rather than the end-point to the care pathway needs to be emphasised and, at an individual level, the purpose of admission needs to be clarified and communicated in assessment and care planning processes.

“The purpose of admissions is unclear. We have many emergency admissions but difficult to discharge when a lot become dependent on the safety in the ward and do not want to go and risk of discharge is viewed as high if discharged but not when on the ward”

Beechcroft staff member. Survey Monkey platform

More use of information from community teams is needed to inform the quality of inpatient assessments - Step 3 staff reported that their knowledge of the young person was frequently not requested nor used. However, Beechcroft staff described to us instances when key information had not been passed on by Step 3 such as child protection status. There is a lack of clarity about who is responsible for ensuring adequate information sharing on admission. This illustrated that the progression through the pathway is sometimes fragmented nature of pathways.

A case manager should be appointed to children and young people with complex needs where admission is being discussed. The case manager would be responsible for co-ordinating the range of services available to the young person and appropriately diverting admissions to Beechcroft where the overwhelming presentation relates to welfare needs as opposed to mental disorder.

The acute care pathways should be revised, taking into account the recommendation for a dynamic model of provision set out in Section 8 in this report

A case manager should be appointed to children and young people with complex needs where a potential admission is being discussed

4.3 The Treatment Model

We were unable to achieve a high level of clarity about the range of available treatments and whether there was consistent fidelity to the treatment modalities that are offered, subsequently supported by regular clinical supervision and routine outcomes measurement. This should be specified in the Service Specification.

We would expect the full range of treatments outlined in Section 4.1 of this report to be available.

We were surprised at the infrequent reference to evidence-based practice and that many staff were unable to name the treatment model that informed their practice with individual children and young people. Most young people were also unable to tell us what their treatment was called. Young people told us that they could not remember being given choices about the type of interventions, nor told the evidence for the approach that was chosen and why it might help them, nor did they appear to be given written information about the treatment model being used.

We heard no reference to Northern Ireland Quality Standards for Mental Health or about evidence-based practice guidelines. We remained uncertain about how interventions were decided upon, based on what evidence of effectiveness, in spite of lengthy formulation meetings.

Although there were exceptions – particularly the more experienced staff and/or those trained in specific treatments - many staff tended to describe what they were doing as ‘engaging patients’, ‘working individually’, using ‘adapted models’ or ‘working with parents/families’. We are not saying that there is no treatment model, rather that if there is an agreed model, the staff with whom we spoke were unable to articulate it clearly when we asked. We wondered what impact this might have on children and young people, on parents and carers and on the staff themselves and how high quality clinical supervision can take place in the absence of a stated model of treatment.

All clinical interventions must be evidence-based and follow NICE guidelines

All treatment interventions should be evidence-based and outcomes focussed, supported by routine application of NICE/Evidence-based guidance and supported by a robust learning and development framework

4.4 Evidence-based practice, Goals and Outcomes Measurement

We found limited evidence of all services being outcomes focussed, or that they consistently use evidence-based interventions and routinely monitor outcomes.

NICE (National Institute for Health and Care Excellence) publishes evidence-based clinical guidelines for England and Wales and we are aware that the HSCB CAMHS Guidance Implementation Plan Indicators emphasise the importance of benchmarking existing intervention against NICE guidelines. This is helpful. The development of consistent evidence-based practice across the sectors is critical in terms of reducing inequalities, improving the quality of provision and informing the broader workforce development framework as well as providing a critical baseline for individual practice monitored through clinical supervision, appraisal and personal development plans.

We encountered a number of examples where practitioners told us they did a 'version of CBT' or an 'adaptation' of other therapeutic models. This reinforced our strong sense of a lack of fidelity to evidence-based models of intervention and which, if practiced, will provide an evidence base against which to measure outcomes. Outcome measurement is not valid if there is no fidelity to the model and outcomes themselves are likely to be sub-optimal.

In Beechcroft we were told outcomes are measured – most commonly by HoNOSCA, CGAS, Beck's Depression Inventory and SDQ. We found that the data has only recently been routinely collected but we saw no evidence of what use is made of the outcomes measurements to inform clinical practice. This needs to be specifically reinforced by Commissioners in the Service Specifications. Routine outcomes measurement should always inform clinical practice, be monitored in clinical supervision and used as evidence to inform care planning meetings and professional development. It is difficult to see how care plans can be monitored effectively if goals are not made explicit at the outset and if routine outcomes measurement is not undertaken.

Routine Outcomes Measurement that informs clinical decision making is a fundamental component of Children and Young People's Increasing Access to Psychological Therapies programme in England. However, it has also been an incremental process in England, starting with supporting people to just collect outcome measures. This should be the starting point in Northern Ireland but should be quickly accelerated across to clinical supervision and inform continuing professional development in annual appraisal.

Young people and parents told us they were unaware that outcome measures were being completed and said they did not receive feedback or measures of their own progress. Young people were unable to describe to us the goals of their admission other than their problems were so serious that they needed admission and most could not name the treatment model being used. Engaging children, young people and parents in these basic elements of practice and treatment is essential. If they are not, then practice will be defined by a cautious and paternalistic approach and will not feed into the requirements of the stepped-care model that actively engages children and young people in care planning.

Clinicians might wish to become familiar with some resources produced by the CAMHS Evidence-based Practice Unit, which were produced for children and young people, explaining common mental health problems and disorders http://www.ucl.ac.uk/ebpu/docs/publication_files/choosing_july and a Guide to using Outcomes and Feedback Tools with Children and Young people http://www.ucl.ac.uk/ebpu/docs/publication_files/Guide_COOP_Book010414.pdf

Goals based outcomes and routine outcomes measurement should be standard practice and used to improve clinical outcomes, and to inform clinical supervision

4.5 Care Planning

As is common to most organisations undergoing scrutiny whilst managing fundamental changes, we found significant emphasis on paperwork, recording and form filling, as previously mentioned.

The fundamental purpose of care planning sometimes appeared to have become lost in the practicalities of serving the processes. We noted that the most recent RQIA report had led to two significant changes being made in the last 6 months: involving young people in their care planning and discharge planning meetings, and introducing an electronic care planning pro-forma

alongside paper held records. Whilst this had improved recording (although introduced double recording and thus contributed to increased time spent on administration) the focus on why these things were being done was lost on some staff members.

We were told about the amount of time being spent by the whole team on weekly care plan reviews (sometimes a whole day), with the detailed pro-forma being pre-populated with updates and the meeting focussed on completing the fields. Descriptions of care plans often appeared to be about approval or not of a weekend pass, and the need to stay in or be discharged, rather than clear description of progress towards goals based on evidence and using outcomes measures to inform the process.

Young people have recently been invited to provide a written view of how they feel they are doing, which is considered by the clinical staff that then make the plan. The young person then joins the meeting to be told the plan. Young people told us that in spite of this initial inclusion they did not feel fully active in their involvement throughout their stay or in how they actually agreed to their care plans, particularly if they choose not to be involved in the care planning meetings.

We recognise that implementing the principle of inclusion of young people in care planning is in the early stages of development and that there is a vision for more sophisticated care planning. We also recognise that some of the feedback from QNIC participation report (June 2014) indicated that young people said they *are* included in care planning. In our opinion this not simply about being included in a meeting, it is more a matter of the quality of that inclusion.

Care planning should be person-centred and be clear to all staff, young people, their parents and carers, who should be actively involved through the whole process

4.6 Length of stay and discharge planning

Many staff told us that in their opinion children and young people's stay as inpatients is too long and is often hampered by extended and unfocussed discharge planning meetings and processes.

In general staff (on the inpatient unit and others) told us that admission is mostly helpful to young people but that the length of stay can often be counter-productive; young people sometimes find it hard to move on and then use strategies to prevent discharge.

Our task was not to investigate individual cases, and we observed that the levels of disturbance on admission that cannot be managed in the community are often played out again in inpatient settings. The culture of the inpatient wards is not always sufficiently robust to manage the additional elements of the impact of case mix on individual patients. Parents told us that they notice their children learning to 'copy' the symptoms of other patients – as they describe it - and mirror their behaviour. They expressed a view that staff are not always adept at managing these dynamics. However they expect them to be. This affects parent's confidence and they ask themselves whether their children are in the best place.

Discharge also appears to be affected by perceptions about the ability and capacity of the Step 3 CAMHS service and the availability of other community based service to safely contain and manage the young person following discharge.

Although the Beechcroft paperwork describes discharge being planned from admission, this was not always reported in our interviews with staff or young people. Discharge often appears to be delayed due to young people threatening suicide, with staff making risk-averse decisions, sometimes not in consultation with the multidisciplinary team and with inconsistent approaches to risk sharing with young people, their families and community teams. Therefore not only are admissions characterised by emergencies and crisis, it also appears to have become harder to discharge them. This is clearly unsustainable in terms of patient flow, the prevention of bed blocking and accessible care pathways.

Our observations on transition are set out in Section 3.10.

Discharge planning should be focussed on the evidence of outcomes data, clinical observation and the young person's view.

Every effort must be made by Step 3 and Step 5 staff to jointly own the discharge planning process.

4.7 Multidisciplinary working

Staff spoke about enjoying and the benefits of working with colleagues in a multidisciplinary setting, but there were also tensions described in the perceptions of the balance of power between the nursing and medical staff, which were often described to us as being played out in clinical decision making and care. An example is a young person who was not granted a weekend pass

at the care plan review due to risk who later that week was granted a pass by the ward staff. Care planning meetings only rarely had a full representation of relevant staff.

There are clear benefits in multi-disciplinary working and we think that a better articulation of the roles of each profession and the skills and perspectives they bring to assessment, formulations and treatment should be strengthened in the Beechcroft staff group.

Clinical leaders should further develop and promote to staff the benefits of a multidisciplinary staff approach to working with children and young people

4.8 Clinical Supervision

Most trained medical staff at Beechcroft described inconsistent access regular clinical supervision and a loss of time for reflective practice. However, doctors felt able to speak with a colleague or senior person if they needed to on an ad hoc basis. There was limited peer supervision between the consultant psychiatrists who described working to their own models. In general, we found many staff at Beechcroft who said there is no time to reflect on what they do and how they work. In contrast Iveagh has prioritised this and has an externally facilitated Reflective Practice meeting monthly.

When we spoke with doctors, they said their experience of medical supervision ranged from 'I haven't had supervision for years', to 'once or twice a year', to 'monthly'.

There was sufficient variation in how frequently other clinical staff had clinical supervision for us to make a clear recommendation about the frequency of supervision and the inclusion of routine outcomes measurement as a regular component of clinical supervision and to inform continuing professional development.

We understand the Trust standard is for two supervision sessions annually. We consider this to be insufficient, particularly in light of the complexity and vulnerability of the children and young people on the unit and the challenges on the ward. We understand that the QNIC accreditation return indicated that staff receive as a minimum, one hour of clinical supervision a month. This does not reflect what was told to us by staff as to what they actually receive.

A robust model of supervision should be developed and clinical supervision should be made available for all staff for at least one hour per month as a standard

4.9 Leadership in an in-patient setting

We mention leadership a number of times in this report. It is our view that clarifying the roles of key leaders, and supporting them, is critical to achieving the change.

Some senior clinical staff think they have a limited leadership role, and do they put themselves forward to lead. There is a risk that this contributes to them feeling uninvolved and unwilling to take responsibility for decisions outside their immediate, individual control. Senior clinical leadership is also critical to the success of a robust CAMHS system.

Nursing leadership and the development of nursing roles within Beechcroft needs to be strengthened, as mentioned in 3.8.

We would welcome greater visibility of clinical leaders on the ward who should be supporting, teaching and developing the practice and confidence in less experienced staff. This would counter-balance an impression that leadership is simply about ensuring compliance with operational procedures.

We encountered some Beechcroft staff in existing leadership roles who were simply excellent – however because they are approachable and efficient they attracted more work and responsibilities simply because they were good at what they do. The system should be driving the development of a distributed leadership model, which will, in time, strengthen the system. The risk at the moment is that too many tasks are concentrated on too few people; this has a tendency to become self-perpetuating and reduce opportunities for sharing responsibilities and distributed leadership.

We found too, that medical leadership was inconsistent in its quality and its delivery. There was an apparent lack of desire and confidence to lead in a system that was described to us as 'crisis driven'. We were told that medical leadership roles in CAMHS are unpopular and no-one really wants to do it. We are concerned about this.

We heard opinions expressed that managers make the decisions about service design, and doctors said they often do not feel included. However, contrary to this, we were also made aware that all LITs have child psychiatry representation. There is clearly a role here for improved and shared decision making and better communication within and between the professional disciplines.

A more comprehensive approach to involving all clinicians in service planning is essential as it will enhance outcomes relating to the development of pathways of care that manage risk, admissions, discharge and transition. However the responsibility on individuals involved in service and pathway planning and review is that they fully liaise with their peers, act as a conduit for information about proposals and to feed those views back into the strategic/planning meetings. Often, we found, individuals were involved in planning but their peers were not aware, or did not feel included. It is incumbent on those people who chair service planning and pathway review groups to reinforce the importance of individual agency in the group membership and for the representatives to sustain a close liaison with the professional groups and/or teams those individuals are representing.

We are as concerned about the morale of junior and senior doctors as we are concerned about morale in other staff. This should be urgently addressed through high quality medical leadership. That doctors feel at arms-length to the systems in which (to the outsider, at least) they have a senior and influential role, is concerning.

The Regional RCPSYCH group offered its perspective in a written submission and emphasised its limited involvement to date in discussions about changes to the inpatient units in particular, and would like to experience "*more robust engagement of clinicians in the planning of acute/inpatient services*" and a greater recognition of the importance of the contribution of clinical leadership to strategic decision making. This should be addressed. We found that as a group, the Consultant Child and Adolescent Psychiatrists are supportive of change but we observed that individually, and in their own settings, they feel much more isolated and this makes it harder to work together clinically across the region.

The absence of clear medical leadership was also reflected in Consultant job plans, and the apparent lack of monitoring of workload and appraisal for more junior staff. There was a lack of differentiation in the type of work done by consultants and more junior staff. This may be in response to the high workload and loss of capacity due to posts not being refunded.

The clinical roles and leadership functions should be reviewed and strengthened and a culture of co-production should be further developed and strengthened

The leadership model should be one of distributed leadership in order to strengthen inclusion, promote good communication between disciplines and to further

promote the delivery framework within the acute care pathway

4.10 Staffing and workforce development

We did not see a current workforce development plan but we noted the CAMHS Guidance Implementation Plan Indicators include reference to workforce development. A workforce development plan in the absence of a population based needs assessment and skills audit, is unlikely to be effective.

The children's workforce plan should be developed concurrently across all sectors and be informed by commissioning, planning and delivery perspectives. In addition, it should be triangulated with a children's sector skills audit, a population based needs assessment and the requirements of evidence-based treatment and interventions for children and young people with mental health problems.

We feel there is probably sufficient experienced staff across the piece, but we are not certain that there is an equitable distribution of experienced and less experienced nursing staff, particularly in Beechcroft. We are heartened that the proposal to transfer the responsibility for clinical provision into Woodlands to the South Eastern Trust once the *FACTS* service is established will ensure that nursing staff receive regular clinical supervision and ongoing professional development. Commissioners need to consider the level of Psychiatry input required to support Lakewood, in spite of the high levels of disruption and the vulnerability of the young people.

In Beechcroft, the unit appears to have the required number of consultant psychiatrists, junior grade doctors and other staff but we were told that junior doctors sometimes feel unable to take annual leave because of workload and that there is, for some, a lack of clarity about what they are expected to do¹⁶.

Refreshing the nursing structure by increasing the range of roles and responsibilities undertaken by nurses, should inform a clear career pathway for specialist nurses, especially if it is enhanced by an extended CAMHS continuing development programme.

Offering more opportunity for specialist management and enhanced leadership responsibilities would also help with staff retention, increase the capacity to deliver the range of necessary therapeutic interventions in partnership with other professions, and

¹⁶ *Building and sustaining specialist CAMHS to improve outcomes for children and young people. 2013; RCPsych*

provide more support and development opportunities for less experienced nurses.

Beechcroft would benefit from more clinical leaders being visible on the wards. The presence of clinical leaders and senior staff is encouraging to and supportive of less experienced staff.

We were concerned that not all the nursing staff in the regional Step 5 units had access to frequent clinical supervision and support to enable them to build their skills, expertise and confidence. Some recently qualified nurses said they felt out of their depth in the Step 5 environment and said they felt they had insufficient experience and insufficient support in their roles.

Greater use should be made of the skills and experience that children's and learning disability trained nurses offer in the CAMHS environment and the contribution they could make to holistic care on the wards. They bring experience, skills and knowledge that complement those of mental health nurses and in particular may help improve the quality of day-to-day physical care and the management of challenging behaviour. If nurses with these qualifications are not represented on the wards, consideration should be given as to how their inclusion could enhance the skill-mix in the staff group.

The Health Care Assistants in Beechcroft told us they felt undervalued and under-used even though they had a lot of experience. This left most of them feeling demoralised. Health Care Assistants make up nearly 25% of the Step 5 workforce and in our view, their skills and aptitudes should be optimised to the full, including enhanced roles for experienced Health Care Assistants.

Activities Co-ordination was consistently praised by staff, patients and parents – however we were told that too often, activities are cancelled at the last minute due to disruptions on the wards. Activities did not appear to be equally available on both wards. Children and young people told us that the activities vastly improved the quality of their time spent at Beechcroft. The Activities Co-ordinator capacity role should be enhanced so that there is one Activities Co-ordinator per Ward.

The role and function of social workers in Beechcroft and Step 3 CAMHS is under-used; indeed those with social work qualifications were more likely to describe themselves as therapists than social workers. A social work perspective in assessments and formulations is an essential bio-psycho-social component of a multidisciplinary assessment and we would like to see the role and function of social work strengthened in Step 3 and 5 CAMHS and its capacity increased in Beechcroft. In our

view this will also benefit co-ordination of children's social care in discharge planning.

The level of trauma described by practitioners and clinicians and the slightly reduced number of clinical psychologists compared with RCPsych recommendations, would indicate that more clinical psychology and the development and provision of psychodynamic psychotherapy would be beneficial using evidence-based interventions, that family therapy provision should be strengthened within the Step 3 and Step 5 service and that IPT and DBT is made available in the therapeutic resource, particularly for those with emerging personality disorders.

The Education facility was consistently praised by the young people, parents and clinical staff. It appears to offer highly flexible individual education plans, and high quality liaison with the young person's local school. Young people said they were grateful for the continuity that the education offer enabled them to have. Most of them were anxious not to lose ground academically whilst they were inpatients.

We were heartened to find professions allied to medicine in CAMHS, such as Occupational Therapy and Art Therapy and Music Therapy were in the multidisciplinary team, albeit not growing at the same rate as nursing. Again, we consider the full range of professional input into a well-rounded assessments and formulation prior to a treatment plan is critical, as is the range of therapeutic models offered by them.

Beechcroft wards should be reconfigures but the number of beds should not be reduced. This will require capital investment.

Wards should be smaller – no more than 5 beds per ward in assessment, and 8 beds per ward in Treatment. Ward blocks should be allocated to assessment (2x5 beds), ICU (1 bed per assessment ward), Treatment (2x8 beds), Eating Disorder (a small unit) and Day services supported by clear referral criteria.

The alliance and co-dependency between Steps 4 and 5 should be strengthened by enhancing local CAT and ITT activity and capacity and channelling all referrals for inpatient admission through CAT and ITT which will have a primary liaison relationship with the admissions units.

Step 5, Step 3, CAT, ITT and other community based services should be commissioned to provide and

enhanced collaborative outreach service with the aim of providing wraparound services to children and young people at risk of admission but requiring services additional to CAT and ITT.

A case manager should be appointed to children and young people with complex needs where a potential admission is being discussed and the clinical roles and leadership functions should be reviewed and strengthened and a culture of co-production further developed and strengthened.

A distributed leadership model should be developed in order to strengthen inclusion, promote good communication between disciplines and to further promote the delivery framework within an acute care pathway

Skill-mix should be strengthened to include Senior Practitioner and Advanced Practitioner roles in nursing, and increased capacity for social work, psychodynamic psychotherapy, clinical psychology, systemic family therapy and Activities Co-ordinator; a rotating practice-based development programme across Step 3, 4 and 5 CAMHS should be considered in order to increase the breadth of experience in the CAMH workforce.

Clinical supervision should be available for all staff for at least one hour per month as a standard; goals based outcomes and routine outcomes measurement should be standard practice and used to improve clinical outcomes and to inform clinical supervision.

All treatment interventions should be evidence-based and outcomes focussed, supported by routine use of NICE/Evidence-based guidance and supported by a robust learning and development framework.

All treatment interventions should be evidence-based and outcomes focussed, supported by routine use of NICE/Evidence-based guidance and supported by a robust learning and development framework. The model of care for Step 5 should be built around these evidence-based interventions and supported by routine outcomes measurement that informs clinical practice and supervision. Treatment options should include as a minimum CBT, DBT, EMDR, IPT, Psychodynamic Psychotherapy, Solution Focussed Therapy, Psychopharmacology, and Systemic Family Therapy.

Section 5 - Commissioning

5 Commissioning

Nearly all the service leaders we spoke to said that the most helpful thing that could emerge from this review was for commissioners to state with absolute clarity what it is that they are commissioning, from whom, and what the expectations are in relation to delivery and how delivery and quality will be monitored and inform service improvement. In particular they sought clear Service Specifications from commissioners.

It was helpful to be provided with a very clear outline of the 9 Regional Outcomes Indicators which set out the priorities for development and delivery and which are added to the Local Implementation Teams quarterly progress reports. The level of detail in these indicators and the granularity of the LIT reports make it evident that strategic planning, and structural frameworks have been well thought through by commissioners; which is why it was surprising to note the lack of certainty in some clinicians and providers.

In our opinion improvements in the alignment of the main commissioning themes, roles and tasks would be helpful in helping commissioning communicate their priorities to providers and to explain how the co-dependencies in some specialist regional facilities have been accommodated within the commissioning process and service specifications. We can see why the separation of commissioning tasks might have emerged because of the structural changes over the past few years but it is necessary now to revisit the commissioning model in the context of the stepped care model.

Commissioners should formalise the relationships and expectations within and between the community based and regional delivery arms, and specify the level of expected specialist mental health provision within and between the specialist regional facilities.

At present some services appear to overlap and there are others (for example the nursing service within Woodlands), where support and supervision to mental health nurses is lacking; where there is no commissioned psychiatric service available to staff in the secure children's home, and where the forensic CAMHS service is being planned to be managed in residential children's services (although our understanding is that it will eventually be managed within CAMHS).

We noted that where improvement funds had been injected into local services – for example for primary mental health workers and for crisis assessment and intensive treatment interventions – it had sometimes proved difficult to disaggregate the CAMHS funding from the block mental health contract. Where local efficiency savings have also been imposed this makes it more difficult for commissioners to identify the reasons for delayed delivery, especially where improvement funds have been injected and where the funded improvements appear not to have been delivered in full.

Commissioners must require that trusts provide them with sufficient information to enable outcomes and value for money to be measured against their investment. Trust finance directors and chief executives must work collaboratively with HSCB to ensure that the full value of service improvement funding is utilised to the benefit of children and young people. If this integrated and collaborative approach is not mirrored at executive level, it will not be delivered in an integrated way to families. The Public Health Agency message and health economics are clear – early intervention and a full spectrum of planned interventions and services available to families will improve health and social care outcomes.

Finally, we commend Commissioners for their strategic vision in relation to commissioning, their role in driving forward the stepped care model, and their commitment to investing in service improvements for CAMHS. We think Commissioners should now identify new methods of communicating regularly with the whole workforce and its strategic stakeholders, to emphasise not only the ‘*what*’ (the role of commissioning and service improvement, and commissioning priorities), but also to the ‘*how*’ (what needs to happen next and how do commissioners anticipate those priorities will be put into practice). Commissioners should exemplify the model of an integrated approach to partnership working with other commissioners responsible for other commissioning themes, as well as strategic partners and providers to drive the change agenda.

Commissioning roles that relate to all children and young people should be aligned across all commissioning themes and ensure that commissioning activity incorporates the full range of mental health provision required by children and young people, and supports the delivery of care pathways.

Commissioners should produce clear Service Specifications that inform all acute and specialist

services and that specify the range of evidence-based treatments necessary in an inpatient unit (see Beechcroft recommendations).

The Specification should require evidence-based practice, outcomes-focussed interventions, and routine outcomes measurement that inform clinical practice and clinical supervision. It should include a requirement for CAMH consultation, training and support to other professionals is built into delivery capacity.

HSCB executive team should work with the executive teams in each Health and Social Care Trust to ensure that the commissioner's strategic intentions and priorities for children and young people are clear and that resources are fully utilised.

Commissioners should review the existing number of inpatient beds and remodel the environment to create smaller functional wards including dedicated Eating Disorder provision

Commissioners should include clinicians in the revision of the CAMHS acute threshold criteria

The TOPS programme should be evaluated to inform a future decision about whether a day services should be part of the Beechcroft offer and/or whether other day services should be provided by Step 3 CAMHS.

Commissioners should engage regularly with children, young people and their families in order that their views inform commissioning intentions and reviews, and should also develop and distribute a regular e-newsletter to all stakeholders to share good news and inform all staff about progress and new plans.

Commissioners should assist all trusts to acquire the technology which will enable video conferencing facilities.

Section 6 – Consultation and Inclusion

6 Consultation and Inclusion

6.1 What Children and Young People Told Us

We sought the views of children and young people who were currently inpatients, those that had previously been inpatients and those who attended the Belfast Young People's Centre. Their views were mixed. We recognise that those who responded were a self-selecting group.

We met with 16 young people in a focus group. 13 young people from all three groups have responded to the online survey. Six responded on paper to the online survey questions. 99% of respondents were female aged between 14 and 17. (n=35)

Three young people told us they were certain that if they had not been admitted to Beechcroft they would have seriously harmed themselves and they appreciate the care they have received.

The majority said that they could contribute to their care plans and to discharge plans, but this was limited to discussing with the Advocate and being called into the meeting. They appreciated their Advocate and said that the advocacy service was good. Most of them said that they felt staff were under pressure and this had a negative effect on being able to take part in activities and sometimes therapy. It also stopped them requesting support when they needed it. They described several instances when staff were busy dealing with an incident leaving the young people to assume care for their peer who was distressed.

The young people told us they were able to carry on with their education because of the education unit at Beechcroft and they appreciated it. Many told us the structure the education unit provided and the support from education staff was the best thing about being an inpatient.

We asked young people what they would like to improve. They told us that in spite of being involved in the paperwork relating to care planning they did not always feel their true views were heard and sometimes attending the care planning meeting meant they didn't really say what they wanted to say in spite of having an advocate. They wanted better food, more food and for the wards to not run out of milk. They wanted the showers to work properly. They wanted people to take them seriously when they said they didn't want to leave.

When we met with the young people at Beechcroft the overarching impression was of young people who felt that the staff were under a lot of pressure. They told us that some staff are very good and some are not much older than them and that although young people are not allowed mobile phones, staff use their mobile phones on the ward. They feel that the boundaries sometimes get blurred and this is particularly disconcerting when they are blanket sanctions on the ward. Young people said they sometimes just don't know where they stand. They expect staff to be professional at all times – they don't expect them to be their friends.

Young people told us that some staff are brilliant and really helpful but that they do not see doctors very often. Few could name the type of therapy they were receiving; most said they were involved in care planning and discharge planning (although also reported not always agreeing to comply with them) and some find them helpful but others said that they do not always like the group meetings.

Most young people told us that the mix of 12 to 17 year olds is not helpful to them, and they felt protective of the younger children. They thought the wards were too big and too noisy and that particularly when there were incidents on the ward (which they describe as frequent), they feel isolated and frightened. We were concerned to hear some young people tell us that if they have been involved in a restraint procedure that they have not received neither a medical review after restraint nor a reflective review with the nurses. We were not commissioned to look at case notes and this finding should be followed up by clinical staff and commissioners.

6.2 What Parents and Carers Told Us

Six parents/carers chose to attend the focus group and three parents responded online to the survey. We were disappointed with the number of responses from parents and asked staff to redistribute the survey link to parents but received no further responses. We recognise that those who responded are a self-selecting group.

Those who responded online were generally more positive about their experience as parents and carers involved in CAMHS than those who attended the focus group. They expressed appreciation of staff, and relief that their child was safe. However they felt that there should be more activities, that the children and young people get bored, especially in the evenings and at weekends.

The parents in the focus group came with particular issues they wished to discuss. Their main concerns related to their role as parents and as 'experts' in their own children; their relationship with ward staff; their views about planning, treatment and discharge; patient safety and communication with health and social care staff.

All parents attending the focus group expressed in the strongest terms their desire for their children to recover, return home with improved mental health, for the care of their child to be co-ordinated, transitions managed well and for better dialogue between themselves and hospital staff.

They noted different personal experiences of their children being on Ward 1 and Ward 2 and wondered why the two wards felt so different because as parents, they view Beechcroft as one unit. Their view was that it should be consistent, run in the same way.

The parents who attended were concerned that their children were not always safe, they regularly absconded from the wards. They were also concerned at how difficult it is to enter the ward, sometimes waiting for 15 minutes for someone to answer the door – and yet they reflected on how easy it is for their children to run away from the unit. Understandably they could not reconcile this in their own minds.

They have noticed that their children are subject to the influence of other young people with conditions that are the same and different to their own child. They expressed concern that with a medium to long term admission they have noticed their children absorb and replicate behaviours demonstrated by other young people and that sometimes they develop new symptoms. Their view is that young people spend too much time together in an unstructured environment, develop worries about one another and form unhealthy alliances because they are bored; they think young people stay too long on the unit and that they (parents) expect to experience an impetus for discharge so that their children do not become what they called 'totally dependent on the care and treatment offered in an impatient unit, because it is not the real world'. They worry and offered examples of behaviour and disturbance that quickly develops between the young people which sometimes rapidly escalates out of the control of staff managing the ward.

They noted that sometimes the way in which young people formed into groups and identified with one another appeared to be stronger than that the ability of the ward staff to manage. This perplexed them as parents. They described it as a paradox because although they felt powerless as parents, their children

and young people appeared, at times, to have a very powerful influence on what happens on the ward.

The parents looked to the staff to control this dynamic but they observed that frequently this did not happen – a young person said they did not want to go home, or that they would kill themselves if they were discharged and so they stayed until the next discharge planning meeting, and the next, but sometimes in the absence of a clear treatment plan. Parents felt strongly that threats of suicide were a powerful lever which they looked to ward staff to modify and actively manage, but which frequently they failed to do.

They expressed concern about the staffing levels and said their children told them there are insufficient staff to deal with emergencies whilst simultaneously being unable to support younger and/or more vulnerable young people on the ward. They also expressed concern about the length of time it takes to assess need and to formulate a diagnosis and then a treatment plan. One parent said that therapy for her child did not start until 9 weeks after admission.

Other parents expressed worries about the management of physical illness whilst their children were in-patients and also were worried about the management of their child's transition to adult services and when and how transition is planned. They were concerned that adult services do not deliver the same level or type of services that young people receive in a CAMHS environment and whether their child's progress would be maintained.

The parents who attended said they felt they had to fight for information about their own child and for written copies of the care plan. Two parents expressed strongly held concerns about the lack of attention to physical illness in their children, and poor response to insulin-dependent diabetes requirements.

Some parents said they had complained, but that they did not want to make a fuss as they felt it might affect the care their children received.

We have highlighted the views of children, young people, parents and carers in this report because their experience offers a critical benchmark for whether the policies and the procedures are working for them. In reading the sections relating to our findings, we invite your reflection on the patient and the parent/carer experience and how their views might inform strengthened and improved elements of development in each of the sections. If we fail to take those views into account and act upon them then we fail to adhere to the principles of including those voices - the most

important of which is to be heard and to influence what happens next.

6.3 What Other Professionals Told Us

We met with a range of professionals, practitioners, managers and clinicians, engaged them in telephone conferences and through Survey Monkey. We had 56 responses to the Survey Monkey platform, from social workers, nurses, psychiatrists, service managers, psychologists, advocates and residential social workers.

They made the point that all services were under pressure, with referral rates characterised by high levels of complexity and co-morbidity. Those who responded wanted more face to face contact with Step 3 and Step 5 CAMHS clinicians and practitioners, shorter stays in inpatient care, better communication and sharing of information, inclusion in care planning and stronger evidence of integration and joint-working.

Most respondents were realistic about what could be provided by CAMHS and expressed views that making the system more transparent, with greater clarity about referral, admission and discharge criteria and a better understanding of what they should expect from CAMHS would be a good starting point, as would be coherent pathways of care as an essential tool for all professions to ensure that children, young people and their families get the right service at the right time.

There were particular sticking points; A&E found it difficult getting a response for children and young people in A&E with mental health problems, self-harm and suicidal ideation. This was compounded by lack of out-of-hours emergency provision and often resulted in an admission to a general ward because a mental health assessment was not available. GPs wanted absolute clarity about what to do when presented with a child in the surgery who clearly has mental health needs, desire earlier access to a full range of services that would help their families, and a comprehensive approach to the assessment and treatment of children and young people with ADHD.

This is a representative sample of responses from professionals who responded on the Survey Monkey platform, and which reflected some of our findings:

“Access to beds has improved immeasurably. There is also a significant shift in that crisis admissions can be dealt with in an appropriate time frame. The addition of CAT AND ITT and IIT have been positive. Elective admissions regarding a

second opinion/diagnostics are a thing of the past and a great loss for our population. I wonder if a day hospital might be a beneficial addition to manage this type of request avoiding the dynamics of an in-patient cohort. Clinical presentations in CAMHS have changed radically, the complexity has multiplied exponentially (please consider we are a community not even one generation away from conflict, so many of our parents are traumatised and secondary trauma to their children is a real issue). It is my impression that clinicians have little control over the direction of travel for the unit as senior management dictate this. Consultants have felt very undermined and undervalued by operational and medical management in recent years. I worry, as do the team I work in, that we are becoming a service that can only pay attention to crisis. I worry for colleagues (all disciplines) in the unit re the level of violence they face, the burn out working with the demand. I worry re the staff mix, often very in-experienced and the employment of lower grades..... (8 words omitted which would identify respondent) patients I would have considered admitting before, I sometimes prefer to manage in the community as I feel they would be exposed to great disturbance and the aims of admission may not be met due to the extreme demands on the unit. Unfortunately, many young people and their parents have told us informally after admission that they found the experience very difficult, they have sometimes expressed fear from other children and they had very little individual time for staff”.

“I have attended several Discharge Planning Meetings and would find it helpful if there was more of a discussion in advance of these meetings between Beechcroft and CAMHS, to ensure there is joined up thinking in terms of potential discharge, planning for the young person’s gradual discharge and ensuring all are in agreement with the package of support available for the young person on their discharge”.

“Staff very friendly and informative. Good surroundings and ambience. My client said she was well cared for and listened to”.

“I’d like to see greater utilisation of option of consultation prior to admission. Professional meetings with outpatient Step 3 to ensure opportunity to explore dilemmas re presentation of young person prior to admission and discharge”.

“I wonder about the increased development of psychological formulations to influence daily interactions with young

people, which could be considered therapeutic. Often a significant amount of assessment has been completed prior to admission and at times this information is lost and a risk assessment model predominates. I am also concerned about the perceived deterioration of young people when they are admitted, although this is common to many residential facilities too”.

“Generally positive feelings about Beechcroft. I do wonder that maybe we are a bit low on beds, going by the RCPsych guidance. I think it would be very positive indeed to have more face to face discussions with CAMHS staff, at a planning level, where the role of Step 3 and indeed Step 3 could be discussed - a sort of away day every so often, where there could be constructive debate and discussion. I don't know that we often look at the evidence base around admission and risk management. There is room for improvement there I wonder”.

“I think there needs to be more differentiation between short term crisis admissions and longer term therapeutic admissions. In my opinion they are too inclined to hold on to young people with drug and alcohol problems, emerging personality disorders etc. who have been admitted in a crisis and who really should be moved out as soon as possible otherwise they rapidly become dependent and institutionalised and in my experience become far worse with more acting out than previously - partly because they team up with other similar young people on the ward to create a very unhealthy atmosphere. As a consequence, young people with serious mental illness eg psychosis often can't tolerate the ward because of all the acting out”.

“Previously the ward had seemed to be a bit unorganised; however this has greatly improved in recent months. For those young people who are not attending the school during the day, more activities could be organised”.

“I welcome the development of the Intensive Home Treatment team”.

“Given the unconscious dynamics on an inpatient unit that affect both patients and staff, I feel concerned that there are not child and adolescent psychotherapists amongst the staff group, which I think would help make sense of some of the anxieties that are stirred up and could be a containing and helpful presence”.

We had six responses from adult mental health services:

“What could prevent admission? In my opinion is a CAMHS service that focuses on prevention (rather than gold plated acute treatment) infant mental health and intervention at an earlier stage in a committed and well-resourced way, (not just paying lip service) in response to the overwhelming evidence for its need NOW to prevent the major crisis for young people in our society that we are facing”.....” crisis or home treatment option alternative source of safe accommodation with 24 h our crisis or assessment input or more beds for young people”.

Regarding placement of young people on adult mental health wards:

“Crisis or home treatment option alternative source of safe accommodation with 24 hour crisis or assessment input or more beds for young people” “young person is at risk from physical and psychological dangers and the environment is inappropriate and non-therapeutic” “For some it offers asylum in the sense of being able to be away from some troubling aspects of the world and perhaps a chance to think. To counter this others find the disturbance of other patients distressing.”

Section 7 - Conclusion

7 Conclusion

The findings of this review reflect the lived experience of those using, referring to, associated with, commissioning, monitoring and regulating, co-dependent upon and/or providing the service and those receiving or waiting for a CAMHS service.

The whole CAMHS system in Northern Ireland is on a journey of transformation, where professional groups and teams are still working on how best to work together, and are in the process of building systems and structures that have the potential to provide the highest quality mental health care for children and young people. The direction of travel is clearly influenced by policy and guidance which promotes integration, equity, early intervention and a model of Stepped Care for CAMHS.

We have encountered children's services and mental health providers and their partner services where planning and provision is affected by geography, hidden need, historical working models, strategic relationships, difficulties in recruitment, and reported increasing levels of complexity in family lives.

We have visited regional services and local teams that are striving (and in the main, succeeding) to find common ground and work in partnership.

We spent a lot of time in the Step 5 inpatient service which appears to have become the lightning conductor for all the services provided in the community and is predominantly responding to crisis admissions and high levels of disturbance and self-harm.

We met a small, as yet incomplete, young and energetic new crisis assessment and intensive treatment service that is focussing on preventing admissions and commissioners managing complex levels of information and sensitive relationships in their effort to get the right services to families, in the right place at the right time. We spent considerable time with commissioners, understanding how commissioning works and how it links with service improvement.

The level of complexity in families lives, and the challenges of trying to address how best to respond to that complexity in the public sector are immense. In planning and delivering our services, there is always a danger that we inadvertently mirror the difficulties that families are facing.

The components for making the system more efficient are present, but require more consistency in commissioning and delivery, greater levels of co-production that breach traditional boundaries and make best use of the strategic drivers expressed in policy. Government departments, commissioning teams, executive leaders, service managers and all stakeholders with an interest in child and adolescent mental health have their part to play.

The critical role of Local Implementation Teams and Children and Young People's Strategic Partnerships as infrastructure intermediaries cannot be under-estimated. Integration is a key theme in public policy; although LITS and CYPSPs are relatively newly formed groups they are in a position to lever and influence local stakeholders in the drive to deliver integrated delivery and influence the modernisation of CAMH services in Northern Ireland.

We make recommendations in relation to strategy, delivery, commissioning, Beechcroft and a dynamic model of provision. The complete set of recommendations can be found in Section 9 of this report.

Section 8 - A dynamic model of provision

8 The model

In this section we have set out our proposal for a new delivery model which

- incorporates the principles of collaborative planning and provision across a full range of services so that community based children's services and CAMHS are supported to deliver optimal outcomes for children and young people
- reconfigures the delivery of Steps 4 and 5 and incorporates an acute care pathway that significantly influences the admission process
- proposes a dynamic outreach model based on principles of joint working, drawing in a range of social care, support and treatment services, including CAT and ITT
- if resources allow, or different priorities are made, we see the full outreach model playing an essential part in supporting children and young people at home, providing alternatives to admission.

We propose that Beechcroft capacity remains as it is but that it is split into smaller functional and co-dependent units. Our proposal is that there should be two admission wards and two treatment wards, a small eating disorder inpatient unit and a day treatment facility.

The Royal College of Psychiatrists recommend 10-12 beds are the most viable. We are proposing two x 5-bed admission wards which could be co-located but where the functional clinical delivery unit is more domestic in size and the dynamics potentially more manageable.

The clinical model we propose is inextricably linked to the role and function of CAT and ITT, Step 3 and other services providing a comprehensive approach to supporting the young person at home with the addition of local day services. If admission is necessary, the inpatient assessment process is rapid and rapid discharge back down the clinical pathway is a priority, if clinically appropriate. If not, the young person transfers to the treatment unit. The acute admission wards should be enhanced by a two Intensive Care beds.

The rationale is similar for the proposed two x eight bed treatment wards. The model should be outcomes focussed evidence-based treatment informed by NICE guidelines and delivered in smaller clinical units, aiming to reduce lengths of stay to a minimum and to manage some of the more challenging unintended consequences of admission to an 18 bed unit.

The pathway into and out of inpatient care is enhanced by managed clinical networks for the most challenging disorders, provided by a multi-agency staff group familiar to the young person and as part of a consistent pathway.

We propose that a small eating disorder unit is also commissioned concentrating on treating the most vulnerable and most ill young people in need of acute medical care, re-feeding and therapy. The Eating Disorder Appendix to the NHS Step 4 standard contract¹⁷ notes that

“Step 4 CAMHS Eating Disorder Units function as an integral part of regional/sub-regional Step 4 CAMHS provision with referrals..... being directed to the Step 4 CAMHS Eating Disorders Unit rather than the Step 4 CAMHS General Adolescent Units”.

Already mentioned in this report, is the absence of population based needs assessment. We therefore do not posit the number of beds required for eating disorder inpatient care.

Children, young people and their parents/carers should be consulted and included and placed at the heart of the delivery model.

We recommend consideration of this model. It represents an inter-agency partnership between the current Step 3 Step 4 and Step 5 services and includes within the CAMHS family, the proposed forensic CAMHS provision, the mental health components offered to Woodlands, Lakewood, Looked After Children’s Therapy and Intellectual (Learning) Disability. Children’s social services are a critical delivery partner.

8.1 Managed clinical networks and a hub-and-spoke model in specialist Step 3 CAMHS should be commissioned for

- Eating disorders
- Self-harm and suicidal ideation
- Intellectual disability
- Looked after children in need of mental health provision

¹⁷ NHSE Standardised Step 4 contract

- Mental health services for children and young people involved in the criminal justice system
- Forensic CAMHS
- Children and young people presenting in an emergency at A&E

These should be developed to support the most vulnerable children and young people in those areas of provision that feed into acute admission and/or other regional services. This has the potential to make best use of the skills and staff already working in those areas, through collaboration and joint learning. The networks should be managed by a named co-ordinator.

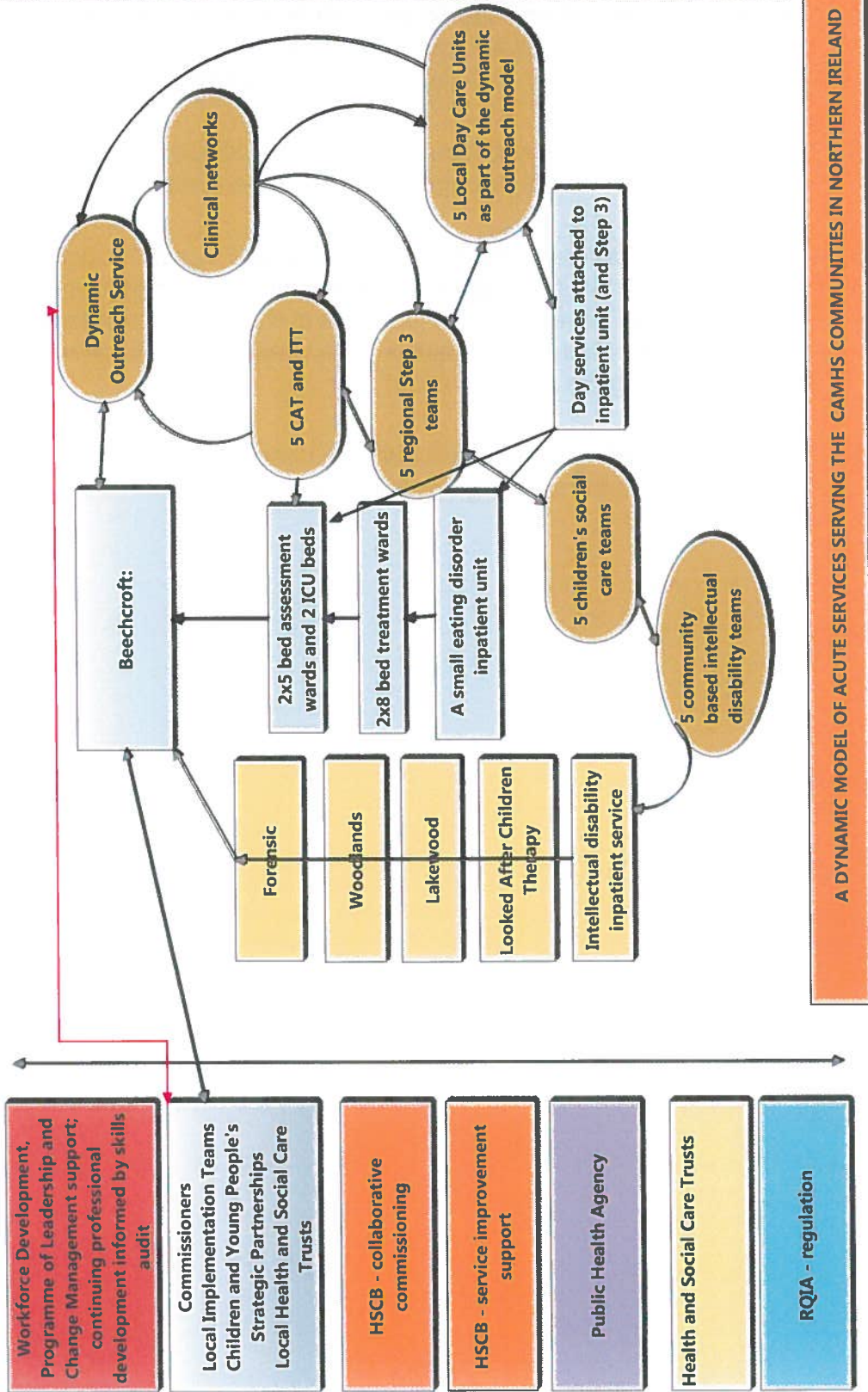
- 8.2** The current number of beds in Beechcroft should be maintained but ward size should be reduced. This will require capital investment.
- 2x5 bed assessment wards and 2 ICU beds
 - 2x8 bed treatment wards
 - A small inpatient eating disorder unit
 - Day services unit.
- 8.3** Admission for assessment should, wherever possible be via CAT/ITT intervention and CAT and admitting clinicians at Beechcroft Service Manager should work together to act as the gatekeepers for admission. CAT/ITT outputs should be enhanced to provide a formal liaison service with the assessment wards, undertaking assessments that inform admission. The transition to treatment wards should be via assessment wards, or with clinical agreement, direct to treatment wards
- 8.4** Commission CAT/ITT, along with Children's Services, the voluntary sector, Step 3 and Step 5 CAMHS to jointly plan and deliver the dynamic outreach model which should increase the reach to prevent admission to Step 5 wherever possible, but also serves as a step-down service in the community, including local day services to enable earlier discharge from inpatient care.
- 8.5** Commission a specialist community based intellectual disability service, provided jointly by children's services and health services. This should include intensive home support, community based respite services, short-stay periods of inpatient care for stabilisation and intensive assessment. The primary investment to support this delivery model should be based in community services.
- 8.6** All specialist services should be commissioned collaboratively, supported by clear Service Specifications which formalise the expectations and delivery of professional consultation, joint

working and clinical delivery by Step 3, Step 4 and Step 5 CAMHS to specialist regional services.

- 8.7** All clinical interventions should be evidence-based, outcomes focussed and utilise routine outcome measurements which should inform clinical practice and regular clinical supervision.
- 8.8** The delivery of these services should be supported by well-trained managers and leaders through a distributed leadership model.
- 8.9** Developing a defined model of distributed leadership throughout the Step 3 and Step 5 CAMH system has the benefit of formally identifying and developing new leaders in the system and to feed into a CAMHS leadership network, with greater opportunities for communicating the shared vision.
- 8.10** All change leaders should be able to access a leadership development and coaching programme.

Managed Clinical Networks led by a network co-ordinator

Pathway development, some of which are enhanced by the outputs of managed clinical networks



Section 9 - Recommendations

9 Recommendations

The recommendations are set out in five sections.

- Strategic recommendations
- Delivery recommendations
- Commissioning recommendations
- Beechcroft
- A dynamic model of provision

9.1 STRATEGIC

- 9.1.1 Commissioners or the Public Health Agency should undertake a population based needs assessment of children and young people under the age of 19 including eating disorders, a skills audit of children's services and CAMHS and regional specialist services in order to inform the workforce development plan, a sector training strategy and personal development plans following annual appraisal
- 9.1.2 LITs and CYPSPs should take steps to ensure that a shared vision and a culture of co-production between commissioners, providers and service users is embedded in planning and review processes, in line with strategic objectives

- 9.1.3 The CAMHS Continuing Development Programme should include a leadership development module, which includes action learning and coaching for emerging and for experienced leaders and managers across all Steps of provision
- 9.1.4 The Medical Director should meet regularly with the Trust Clinical Directors as a group in order to strengthen strategic oversight, improve the information flow and ensure there is a consensus to support necessary changes in service delivery
- 9.1.5 Consultant Child and Adolescent Psychiatrists and clinicians should be actively involved in service design, and be part of the distributed leadership approach
- 9.1.6 Meaningful, regular and active engagement of children, young people, parents and carers and involvement in service development should be evidenced throughout the commissioning, planning, practice, treatment, and discharge processes

9.2 DELIVERY

9.2.1 Pathways of Care

- 9.2.1.1 Pathways must be coherent and sufficiently flexible to incorporate those with the most complex need.
- 9.2.1.2 The following pathways should be strengthened and/or developed:
- A pathway from children's services and other services into Step 3 CAMHS accompanied by clear referral criteria
 - A pathway for eating disorders that includes a day services, supported by a co-ordinated clinical network
 - A pathway for children and young people with intellectual/learning disability who need to access a CAMHS service, supported by a co-ordinated clinical network

- A pathway for children and young people in the youth justice system who need to access a CAMHS service, supported by a co-ordinated clinical network
- A pathway for self-harm and suicidal ideation, supported by a co-ordinated clinical network
- A pathway for looked-after children who need to access specialist (Step 3) CAMHS
- A pathway for out-of-hours CAMHS provision that links to the A&E pathway, supported by a co-ordinated clinical network
- A pathway for accessing CAT and ITT, admission to Beechcroft or The Iveagh Centre and to include step-up and step-down services supported by a co-ordinated clinical network

9.2.2 Leadership

9.2.2.1 The CAMHS Continuing Development Programme should include a leadership development module involving senior clinicians, managers, regional specialists and commissioners, which offers a learning pathway for emerging and experienced leaders and managers and includes action learning and coaching

9.2.2.2 Senior clinicians and other senior stakeholders should be integral to a distributed leadership approach

9.2.3 Clinical Networks

9.2.3.1 Priority should be given to setting up managed clinical networks, with named clinical co-ordinators to ensure that services are responsive and consistent to provide better co-ordination and the opportunity to develop learning and practice

9.2.3.2 Clinical networks should be strategically aligned with the main care pathways

9.2.4 Geography

- 9.2.4.1 There should be regular liaison meetings between Steps 3, 4 and 5, and regular opportunities for consultation to prevent admission are embedded in everyday practice
- 9.2.4.2 Commissioners should consider assisting all trusts to acquire the technology to enable video conferencing
- 9.2.5 **Care Planning, Step up, Step down and Transition**
- 9.2.5.1 Care Planning, Discharge Planning and Transition meetings should be child-centred, include children, young people and their families and information appropriately shared with them
- 9.2.5.2 Discharge Planning Meeting dates should be set in advance and should be prioritised. Referrers should prioritise attending those meetings
- 9.2.6 **CAT & ITT**
- 9.2.6.1 The availability of CAT & ITT should be standardised across the trusts and should form a critical component of a dynamic outreach model which should draw from CAT, ITT, other specialist services, Step 3 and 5 CAMHS and co-ordinated centrally and have its own managed clinical network to ensure continuity
- 9.2.7 **Out-of-hours service**
- 9.2.7.1 An out-of-hours CAMH opinion and access to a mental health assessment should be commissioned uniformly across all Health and Social Care Trusts and available 24 hours a day, 7 days a week, supported by agreed joint protocols
- 9.2.8 **The Specialist Regional Services**

- 9.2.9 The short and long terms needs of children with intellectual disability and services should be reconsidered and Step 3 community based intellectual difficulties services significantly strengthened; that day services should be commissioned. A small inpatient service for children and young people with intellectual disability would ideally be located closer to Beechcroft, for brief stays where young people require stabilisation, assessment and treatment, and to increase opportunities for co-working.
- 9.2.9.1 The Department of Health, Social Services and Public Safety and the Department of Justice should work together to ensure that the provision mental health assessment, care and treatment meets the acute and ongoing mental health needs of young people in **Woodlands**, that Nursing staff receive regular clinical supervision and have access to the CAMHS continuing professional development framework
- 9.2.9.2 Medical input to Woodlands should be increased by one day a week
- 9.2.9.3 Service Specifications should formalise the relationship and expectations of Step 3,4 and 5 CAMHS clinical and the professional support offer to **all the specialist regional services** and require that evidence-based interventions and routine outcomes monitoring are undertaken by them
- 9.2.10 **Eating Disorders**
- 9.2.10.1 Commissioners should develop a Northern Ireland-wide centrally managed eating disorder service as part of a hub-and-spoke provision, with a service manager a full time dietician and dedicated medical input, a managed clinical network and a small number of inpatient beds in Beechcroft
- 9.2.11 **Self-harm and suicidal ideation**

- 9.2.11.1 NICE guidelines should be consistently used to inform clinical practice in the management of self-harm and the threats of self-harm, and to strengthen the skills of all staff working with children and young people who self-harm.
- 9.2.12 **Evidence-based practice and routine outcomes measurement**
- 9.2.12.1 Step 2, 3, 4 and Step 5 CAMH services should use goal based approaches and routinely use outcome measurement tools - CGAS, HoNOSCA, Becks Depression Inventory and SDQ and the measures used to inform evidence based treatment and clinical supervision; Commissioners should continue to monitor the use of evidence-based practice and NICE guidelines through Service Specification reviews and the LIT Outcomes Indicators

9.3 COMMISSIONING RECOMMENDATIONS

- 9.3.1 Commissioning roles that relate to all children and young people should be aligned across all commissioning themes and ensure that the full range of mental health services required by children and young people and supports the delivery of care pathways
- 9.3.2 A workforce skills audit should be commissioned to inform the workforce development programme.
- 9.3.3 Commissioners should produce clear Service Specifications that specify the range of evidence-based treatments necessary in an inpatient unit (see 9.4.9). The Specification should require evidence-based practice, outcomes-focussed interventions, and routine outcomes measurement that inform clinical practice and clinical supervision. It should include a requirement for CAMH consultation, training and support to other professionals is built into delivery capacity

- 9.3.4 HSCB executive team should work with the executive teams in each Health and Social Care Trust to ensure that the commissioner's strategic intentions and priorities for children and young people are clear and that resources are fully utilised
- 9.3.5 Commissioners should review the range of referrals accepted by Step 3, 4 and 5 CAMH services, triangulate the findings with the range of services being offered and the skills and capacity of the workforce to deliver evidence-based treatments and interventions
- 9.3.6 Commissioners should maintain the existing number of inpatient beds and remodel the environment to create smaller functional wards including dedicated Eating Disorder Inpatient Provision
- 9.3.7 Commissioners should include clinicians in the revision of the CAMHS acute threshold criteria and develop a robust commissioning specification for all acute and specialist services including specifying the range of evidence-based therapeutic interventions necessary in an inpatient unit
- 9.3.8 The TOPS programme should be evaluated to inform a future decision about whether a day services should be part of the Beechcroft offer and/or whether other day services units should be provided by Step 3 CAMHS
- 9.3.9 Commissioners should engage regularly with children, young people and their families in order that their views inform commissioning intentions and reviews and develop and distribute a regular e-newsletter to all stakeholders to share good news, and inform all staff about progress and new plans
- 9.3.10 Commissioners should assist all trusts to acquire the technology which will enable video conferencing facilities

9.4 BEECHCROFT RECOMMENDATIONS

- 9.4.1 Beechcroft wards should be reconfigured but the number of beds should not be reduced. This will require capital investment
- 9.4.2 Wards should be smaller – no more than 5 beds per ward in assessment and 8 beds per ward in Treatment. Wards should be allocated to assessment (2x5 beds), ICU (1 bed per assessment ward), Treatment (2x8 beds) a small Eating Disorder inpatient unit and day services, supported by clear referral criteria
- 9.4.3 The alliance and co-dependency between Steps 4 and 5 should be strengthened by enhancing local CAT and ITT activity and capacity and channelling all referrals for inpatient admission through CAT and ITT which will have a primary liaison relationship with the admissions units
- 9.4.4 Step 5, Step 3, CAT, ITT and other community based services should be commissioned to provide an enhanced collaborative outreach service with the aim of providing wraparound services to children and young people at risk of admission but requiring services additional to CAT and ITT
- 9.4.5 A case manager should be appointed to children and young people with complex needs where a potential admission is being discussed and the clinical roles and leadership functions should be reviewed and strengthened and a culture of co-production should be further developed and strengthened
- 9.4.6 The leadership model should be one of distributed leadership in order to strengthen inclusion, promote good communication between disciplines and to further promote the delivery framework within the acute care pathway
- 9.4.7 Skill mix should be strengthened to include Senior Practitioner and Advanced Practitioner roles in nursing, and increased capacity for social work, psychodynamic psychotherapy, clinical psychology, systemic family therapy and Activities Co-ordinator; a rotating practice-based development programme across Step 3, 4 and 5 CAMHS, should be considered in order to increase the breadth of experience in the CAMHS workforce

- 9.4.8 Clinical supervision should be available for all staff for at least one hour per month as a standard; goals based outcomes and routine outcomes measurement should be standard practice and used to improve clinical outcomes, and to inform clinical supervision
- 9.4.9 All treatment interventions should be evidence-based and outcomes focussed, supported by routine use of NICE/Evidence-based guidance and supported by a robust learning and development framework. The model of care for Step 5 should be built around these evidence-based interventions and supported by routine outcomes measurement that informs clinical practice and supervision. Treatment options should include as a minimum CBT, DBT, EMDR, IPT, Psychodynamic Psychotherapy, Solution Focussed Therapy, Psychopharmacology, and Systemic Family Therapy.

9.5 RECOMMENDATIONS FOR A DYNAMIC MODEL OF PROVISION

- 9.5.1 Managed clinical networks and a hub-and-spoke model in specialist Step 3 CAMHS should be commissioned for
- Eating disorders
 - Self-harm and suicidal ideation
 - Intellectual disability
 - Looked after children in need of mental health provision
 - Mental health services for children and young people involved in the criminal justice system
 - Forensic CAMHS
 - Children and young people presenting in A&E
 - CAT and ITT

These should be developed to support the most vulnerable children and young people in those areas of provision that feed into acute admission and/or other regional services. This has the potential to make best use of the skills and staff already working in those areas, through collaboration and joint learning. The networks should be managed by a named co-ordinator

- 9.5.2 The current number of beds in Beechcroft should be maintained but ward size should be reduced. This will require capital investment.
- 2x5 bed assessment wards and 2 PICU beds
 - 2x8 bed treatment wards
 - A small inpatient eating disorder unit
 - Day services
- 9.5.3 Admission for assessment should, wherever possible be via CAT/ITT intervention and CAT and admitting clinicians at Beechcroft Service Manager should work together to act as the gatekeepers for admission. CAT/ITT outputs should be enhanced to provide a formal liaison service with the assessment wards, undertaking assessments that inform admission. The transition to treatment wards should be via assessment wards, or with clinical agreement, direct to treatment wards
- 9.5.4 Commission CAT/ITT, along with Children's Services, the voluntary sector, Step 3 and Step 5 CAMHS to jointly plan and deliver the dynamic outreach model which should increase the reach to prevent admission to Step 5 wherever possible, but also serves as a step-down service in the community, including a local day service to enable earlier discharge from inpatient care
- 9.5.5 Commission a specialist community based intellectual disability service, provided jointly by children's services and health services. This should include intensive home support, community based respite services, and short-stay periods of inpatient care following assessment. The primary investment and delivery model should be based in community services. This will require further investment

9.5.6 All specialist services should be commissioned collaboratively, supported by clear Service Specifications which formalise the expectations and delivery of professional consultation, joint working and clinical delivery by Step 3, Step 4 and Step 5 CAMHS to specialist regional services

Section 10- Appendices

Appendix 1

Documents Examined

1. Delivering the Bamford vision - The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan 2012-2015 –*DHSSPS Integrated Projects Unit – November 2012*
2. A Report on the Inspection of the Care Pathways of a Select Group of Young People Who Met the Criteria for Secure Accommodation in Northern Ireland - *RQIA March 2011*
3. Belfast and South Eastern CAMHS Crisis Assessment Intervention & Intensive Treatment Team (CAIITT) ED/GP pathway for Acute presentation of under 18s who require same day assessment
4. RQIA Independent Review of Child and Adolescent - Mental Health Services (CAMHS) in Northern Ireland – 22 February 2011
5. RQIA Independent Review of Child and Adolescent Summary - Mental Health Services (CAMHS) in Northern Ireland – 22 February 2011
6. Improving Mental Health Pathways and care for adolescents in transition to adult services in Northern Ireland (IMPACT) - *Gerry Leavey, Sheena McGrellis - 20.02.14*
7. Child and adolescent mental health Services A service model - July 2012 final– *Department of Health, Social Services and Public Safety.*
8. PowerPoint Presentation – Acute CAMHS - 2014 current profile of inpatients
9. Last 10 Discharges from Beechcroft (Ward 1) in Each Trust Area to ascertain 7 day follow up appointment by community CAMHS
10. Last 10 Discharges from Beechcroft (Ward 2) in Each Trust Area to ascertain 7 day follow up appointment by community CAMHS
11. Admissions of Children & Young People to Beechcroft by Age
12. Admission Flowchart

13. Admission Flowchart Part 2
14. Amended Regional Emergency Mental Health and Deliberate Self Harm Care Pathway Young People 0-18
15. Beechcroft Children and Adolescent Mental Health Service Step 3 Patient Leaflet.
16. Beechcroft Child and Adolescent Inpatient Service *Welcome Pack for Children and Families – Edition 4*
17. Voice of Young People in Care – Advocacy Service Leaflet V 5
18. Beechcroft Staff List
19. Patient based policy - Beechcroft admission pathway – *Belfast Health and Social Care Trust – 2010*
20. CAMHS Pathway - Voice of Young People in Care
21. Copy of Accreditation Self Review Workbook – Cycle 13
22. Central Point of Referral Chart
23. Child Protection Policy for Beechcroft v1 03 – 19.02.2014
24. Consent Form to Advocacy Service in Beechcroft
25. Card Before You Leave Leaflet Draft 4 - *Belfast Health and Social Care Trust*
26. Discharge/Pass Medication Request – Letter for GP - *Belfast Health and Social Care Trust*
27. Beechcroft ICU record - activity plan – 9.11.10
28. Beechcroft ICU record – Admission – 9.11.10
29. Beechcroft ICU restricted & banned item list – 20.10.10
30. Beechcroft ICU record – Daily MDT Discussion Record – 9.11.10

31. Beechcroft ICU guidelines - discharge from ICU – 9.11.10
32. Beechcroft ICU guidelines - draft 3 - 20.10.10
33. Beechcroft Monitoring use of ICU - 20.10.10
34. Beechcroft ICU – Nursing Record – 9.11.10
35. About ICU in Beechcroft – Leaflet
36. Beechcroft – Unit Information
37. LAC Pathway
38. Parents/Carers' Letter - Planned Admissions - *Belfast Health and Social Care Trust Jacquie Wilson, Assistant Clinical Services Manager*
39. Parents/Carers' Letter - Crisis Admissions - *Belfast Health and Social Care Trust Jacquie Wilson, Assistant Clinical Services Manager*
40. Belfast Trust Stepped Care Services for Children – Services Scope – Billie Hughes 2014
41. Specification for Review of Beechcroft Regional In patient Unit for Child & Adolescent Mental Health Services (CAMHS)
42. Staffing Numbers – Royal College of Psychiatrists
43. Implementation of stepped care model in CAMHS – Revised PowerPoint Presentation
44. Structured Therapeutic Programme - Ward 1
45. Referral Guidelines For Child And Adolescent Mental Health Services Regional Threshold Criteria (Step 2 and Step 3 service provision)
46. VOYPIC Parents Letter - *Ann McGuigan*
Beechcroft Independent Advocacy Service – 21 January 2014

47. Admissions of Children & Young People to Beechcroft by Age – 2011-2014
48. CAMHS – Age Gender Profile – April 2011
49. CAMHS IPT Mapping – January 2014
50. Review of Iveagh Centre, Children's Learning Disability Inpatient Service. B.H.S.C.T. – September 2013
51. Copy of April 2014 Admissions to Iveagh Centre
52. Beechcroft Children's Unit Final Report Royal College of Psychiatrists *Editors: Jane Solomon-* April 2011
53. My Transition Plan - Belfast Health & Social Care Trust
54. Social Care and Children's Directorate Organisational Structure – Updated 16.4.14
55. Families Matter: Supporting Families in Northern Ireland, Regional Family and Parenting Strategy - *Department of Health, Social Services and Public Safety, Belfast - March 2009*
56. Families' and Children's Services Guide 30 - Think child, think parent, think family: a guide to parental mental health and child welfare - *The Social Care Institute for Excellence (SCIE) – Published December 2011 Review December 2014*
57. Transforming Your Care: Review of Health and Social Care in Northern Ireland (2011): DHSSPS
58. "Learning Together Working Together" Regional Mental Health & CAMHS Continuing Professional Development Framework
"Evidenced based CPD involves planned learning and development activity that develops, maintains or extends knowledge, skills, understanding and/or performance". Rodney Morton HSCB Briege Quinn PHA
59. NI CNO 2007 Standards Review of the Quality of Supervision CPD Framework

Appendix 2 People/Services Consulted

Clinical Services Manager (1)
Ward Managers (2)
Social Worker (2)
Ward Sisters (7)
Health Care Assistants (9)
Crisis Assessment and Intensive Treatment Team Leader (1)
Crisis Assessment and Intensive Treatment Team (1)
Consultant Child and Adolescent Psychiatrist (5)
Specialist Registrar (2)
Senior House Officer (1)
Clinical Psychologist (2)
Nurse Therapist (2)
Staff Nurses (3 groups)
Service Improvement Manager (1)
Activities Co-ordinator (1)
Teachers (2)
RQIA (1)
Eating Disorders Team (3)
Nurse Director, Public Health Agency (1)
Community GP (2)
Assistant Clinical Director (1)
Assistant Director, Nursing (Eating Disorders) RVH (1)
Iveagh Centre (3)
Medical Director (1)
CAMHS Clinical Director (1)
Director Woodlands Centre (1)
Health and Social Care Board (5)
Director Mental Health, Learning Disability and Social Work (1)
Western Health and Social Care Trust CAMHS
South Eastern Health and Social Care Trust CAMHS
Southern Health and Social Care Trust CAMHS
Northern Health and Social Care Trust CAMHS
Belfast Health and Social Care Trust CAMHS
Focus Group, Children and Young People (16)
Focus Group, Parents and Carers (6)
Survey Monkey responses:
 Children and Young People (13)
 Parents and Carers (3)
 Interested Professionals (56)
 Beechcroft Staff (16)
 Former patients of Beechcroft (2)
The Bamford sub-group (19)
Health and Social Care Board (4)

TOTAL 204

Appendix 3 Other Relevant Documents

1. DHSSPSNI Child and Adolescent Mental Health Services: A service model 2012
2. The Bamford Review of Mental Health and Learning Disability
3. "The integration of health and social care: The lessons from Northern Ireland", *Social Policy & Administration*, 40 (1), 47-56
Heenan, D. and Birrell, D. (2006),
4. Integration of health and social care. A review of literature and models Implications for Scotland. Prepared for the RCN in Scotland by Hilary Robertson January 2011
http://www.rcn.org.uk/data/assets/pdf_file/0008/455633/Hilarys_Paper.pdf
5. Effective multi-agency partnership: Putting every child matters into practice. *Cheminais, R. (2009)*.
6. Z Kurtz. 2007 Step 4 Review CSIP quoting Cotgrove et al 2004 (RCPsych)
7. Engaging Leadership: Creating organisations that maximise the potential of their people 2008, CIPD
8. Building and sustaining specialist CAMHS to improve outcomes for children and young people. CR182. 2013. *Royal College of Psychiatrists*
9. NHEngland Step 4 Review 2014
10. Northern Ireland Statistics and Research Agency
<http://www.nisra.gov.uk/demography/default.asp3.htm>
11. Child and Mental Health Intelligence Workforce – Public Health Agency England <http://www.chimat.org.uk/camhs/workforce>
12. Child and Adolescent Mental Health Services (CAMHS) Raising Standards Through Sharing Excellence - *NHS Benchmarking Network – December 2013*
13. The Evidence Base to Guide Development of Step 3 CAMHS, Children and Young People Families Programme, National CAMHS Support Services, Department of Health - *Zarrina Kurtz - April 2009*

14. Children and Young People in Mind: the final report of the National CAMHS Review – *Department of Health – 18th November 2008*
15. CAMHS Standard, National Service Framework for Children, Young People and Maternity Services – *Department of Health - 04 Oct 2004*
16. Specialist Mental Healthcare for Children and Adolescents: Hospital, intensive community and home based services – Ed. Tim McDougall, Andy Cotgrove
17. The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study, 2008
http://www.nets.nihr.ac.uk/_data/assets/pdf_file/0008/64457/FR-08-1304-062.pdf
18. Heenan, D. and Birrell, D. (2006), "The integration of health and social care: The lessons
19. from Northern Ireland", *Social Policy & Administration*, 40 (1), 47-56
20. [http://www.rcn.org.uk/_data/assets/pdf_file/0008/455633/Hilarys Paper.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0008/455633/Hilarys_Paper.pdf)

Appendix 4

Northern Ireland Policy and Guidance

1. Northern Ireland Executive Programme for Government 2012 Set out the programme to be delivered through the Delivering Social Change Programme and focussing on early intervention and prevention
2. Children and Young People Early Action Document 2012 Builds on the pledges made in 2006 in the 10 year Strategy for children and Young People. Key components are early years and early intervention, transformation, integrated delivery and to facilitate joined-up planning and commissioning across Departments
3. Improving Children's Life Chances: The Child Poverty Strategy 2011 – a shift toward early intervention and joint working. Family Support Hubs, preventative programmes and joined-up commissioning
4. Health and social Care Board Transforming your Care 2013 – key principles are the roll-out of Family Nurse Partnerships, support for parents, improvements in services for children with mental health problems and cross-department working.
5. DHSSPS The Bamford Review 2006 – the first CAMHS review in Northern Ireland
6. Families Matter, 2009 – the regional family support strategy for children and young people
7. Healthy Child, Healthy Future 2010 – the framework for universal child health promotion, emphasising the importance of early years
8. Children and Young People's Strategic Plan 2011-14 – the responsibilities for strategic relationship building, planning and partnership arrangements and regional mechanisms for putting strategy into action
9. CAMHS – A service model – sets out the importance of pathways and the stepped care model

10. Transforming your Care 2011 – the strategic implementation plan for health and social care, promoting integration
11. Public Health Agency Regional Framework on Infant Mental Health – emphasising the importance of perinatal and infant mental health, parenting and specialist early intervention for children with special needs and mental health problems
12. Department of Education Learning to Learn 2012 – setting out frameworks for Sure Start, delivering high quality information to parents, carers, children and young people and the extended schools programme
13. Department of Employment and Learning Pathways to Success 2012 – preventing exclusion, promoting participation and prevention of NEETS; early intervention programmes for children at risk.
14. Department of Justice Reducing Reoffending – Towards a Safer Society 2012 – prevention and diversion strategies; building safer and confident communities
15. A Community Safety Strategy for Northern Ireland 2012-17 – identifies the social determinants of offending; emphasises prevention and early intervention
16. RQIA CAMHS – A service model 2011 - the preferred model for the organisation and delivery of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland

Appendix 5

The Review Team

Lead Reviewer: Dawn Rees

Level 7 Executive Coach; 2007 Institute of Leadership and Management Fellow, Institute of Leadership and Management since 2009 Kings Fund 2006; Top Manager Programme graduate Diploma in Management; 1995 Institute of Management Advanced Diploma in Children and Families (Distinction); 1993 University of East Anglia Master of Arts; 1990 University of East Anglia Certificate of Qualification in Social Work; 1990 University of East Anglia State Registered Nurse; 1974

From 2005-11 Dawn Rees was accountable to the Department of Health and Department for Education in England, leading the development and management of national CAMHS improvement programmes: the National CAMHS Support Service, National Targeted Mental Health in Schools Programme and the National CAMHS Workforce Programme. She has held senior management roles in health and local authorities since 1995 and was an advisor to the National Service Framework (Standard 9) development team 2003, a member of the DH CAMHS Review and National Advisory Council and the DH CAMHS delivery board 2006-11. She has a national reputation for her understanding of policy, operational and strategic management, commissioning, and analysis of complex systems. As an independent consultant she had significant input in Northern Ireland as advisor to the Bamford Review process after its publication; the McCartan Review, and quality assurance to the NI Mental Health Standards Framework.

Nurse Consultant: Tim McDougall

*ENB Specialist Practitioner: Child & Adolescent Mental Health; 1998-2000 University of Salford
ENB 603: Child & Adolescent Mental Health Nursing; 1998-9 University of Salford
BSc (Hons) Psychotherapeutic Interventions; 1998-9 University of Salford
Diploma in Professional Studies in Nursing (Mental Health); 1993-6 University of Manchester*

Tim McDougall is a Nurse Consultant, Clinical Director of Step 3 CAMHS and Trust-wide Clinical Director for CAMHS in Cheshire and Wirral Partnership NHS Trust. He is experienced in CAMHS clinical leadership and governance, strategic partnership development, service planning,

delivery and research. Tim is a member of the QINMAC Intensive Community Standards Development Group and of a number of NICE CAMHS specific appraisal panels and groups. He has worked in community based CAMHS, Adolescent Forensic CAMHS teams, Youth offending Teams and Inpatient units. He is a former Nursing Policy Advisor to the DH (England).

Consultant Child and Adolescent Psychiatrist: Dr Ann York

CCST Child & Adolescent Psychiatry; 1988

MRCPsych; 1987

MBBS; 1982 University of London

Mental Health Act: Section 12 Approved Clinician

Dr Ann York was a Consultant Child and Adolescent Psychiatrist with South West London and St George's Mental Health NHS Trust until 2014. Since 1996 she has worked clinically with young people experiencing the full range of mental health problems. Her clinical specialisms are neurodevelopmental disorders and depression. Ann sits on the Project Board and chairs the Expert Advisory group for NHS England CAMHS Currency development (formerly Payment by Results); Chairs the CYP IAPT service transformation group, is co-founder of the Choice and Partnership Approach (CAPA), is a CORC committee member, sits on the QNCC advisory group and is a Cochrane peer-reviewer. She has undertaken specialist CAMHS reviews for HASCAS and QNCC and brings a wealth of clinical and service development methodology to the consultancy team. She was formerly DH Medical Advisor 2007-09.

Appendix 6
Royal College of Psychiatrists
Recommendations on staffing levels

1 RCPSYCH 2013¹⁸:

RCPSYCH 2013:

Staffing levels for 12-bedded CAMHS Step 3 in-patient unit

The exact nature of staffing required for a given in-patient unit will depend on the patient group and clinical context (e.g. children's unit, generic adolescent admission ward, acute admission ward, adolescent psychiatric intensive care unit). It is influenced by skill mix, task demands of a particular shift, case dependency/acuity and case-mix.

Ward nursing staff/patient shift ratios

- High-dependency/high-acuity case: 1:1 to 3:1 for the most highly disturbed

- Medium dependency case (10-minute checks, intensive support at meal-times):1:2

- General observation/maintenance of safety/therapeutic programme times: 1:3

- Minimum of two registered mental health nurses with relevant child and adolescent experience (Grade 5–8a) per day shift; one at night – this will need to increase depending on numbers of in-patients and acuity of case mix on shift; some children's (<12 years) services might have a general trained nurse with relevant experience as one of the registered nurses
Ward manager: 1.0 WTE Band 7+ (or equivalent) registered mental health nurse

Consultant psychiatrist: 1.0 WTE (which may be provided by two clinicians in a split post). The number of consultant psychiatrist sessions needed will be influenced by the patient group and clinical context, for example a children's (<12 years) unit may require less, an adolescent psychiatric intensive care unit more consultant psychiatrist time.

Non-consultant psychiatrist (staff grade/trainee): 1.0 WTE (4 h per patient/week)

¹⁸ <http://www.chimat.org.uk/camhs/workforce>

Clinical psychologist: 1.0 WTE

Social work: 0.5–1.0 WTE

Family therapy: 0.5 WTE as a minimum. However, the task demands with respect to delivery of evidence-based interventions to different groups (e.g. younger children, children and young people with eating disorders) will increase the staffing requirement.

Therapists trained in psychological interventions with children and young people: access to regular designated sessions of cognitive–behavioural therapy, dialectical behaviour therapy, psychodynamic psychotherapy, interpersonal therapy, eye movement desensitisation and reprocessing, etc.

Occupational therapy: 0.5 WTE

Dietician: Formal arrangements to ensure access to regular designated sessions

Physiotherapy, speech and language therapy: Formal arrangements to ensure access when required

Creative therapies (art/drama/music therapy): Arrangements to ensure access

Teachers (including for specialist subjects): 1 WTE to 4 students/lesson.

Ratio of 1:1 frequently necessary

Pharmacist: Regular input to staff

Duty doctor: Identified duty doctor to attend unit, including out-of-hours

NUMBER OF BEDS

24–40 CAMHS beds are required per 1 million total population up to the age of 18. The Royal College of Psychiatrists recommends 3–4 beds per 1 million total population for young people with severe intellectual disability and 2–3 for those with moderate intellectual disability (Royal College of Psychiatrists, 2010), and 1 low secure bed per 1 million total population (Kurtz, 2009).

The number of beds also needs to take into account the availability of intensive non-bed-based services designed to provide an alternative to admission.

The recognised optimal maximum number of beds for an adolescent inpatient unit is 10–12 (Box 1). This should ensure that the unit is conducive to treatment and is clinically and financially viable. There is no minimum number of beds, but it is difficult for a stand-alone unit to be financially viable below 6–7 beds owing to the irreducible minimum

2 College Report CR182, RCPsych 2013]

Out-of-hours CAMHS provision

All children and young people with mental health disorders must have access to care out of the normal working daytime hours. There is currently little evidence on the demand or effectiveness of out-of-hours specialist CAMHS provision. Availability of out-of-hours advice is far from universal due to either lack of adequate resources and workforce (Royal College of Psychiatrists, 2002) or reluctance by staff to provide this. Child and adolescent psychiatrists, child mental health nurses, general psychiatrists, paediatricians and other professionals share concern about the availability of on-call services for children and adolescents with mental health disorders.

In many areas the CAMHS out-of-hours service is provided by the consultant child and adolescent psychiatrist. In services with trainee child and adolescent psychiatrists, trainees may provide the first on-call cover, with supervision from CAMHS consultant psychiatrists. However, in most areas of the UK, trainees are not available and owing to the low number of CAMHS psychiatrists, it is neither possible nor appropriate for CAMHS to provide a first on-call child psychiatrist service. In some areas, telephone consultation is made available to paediatric and adult mental health clinicians, and the first on-call is provided by an adult psychiatry trainee with supervision from the CAMHS consultant psychiatrist. In these cases, joint protocols are agreed between the relevant professionals to ensure that children and adolescents receive the best possible care. In some areas where there are no psychiatric trainees and a paucity of consultant psychiatrists, other senior members of the multidisciplinary team (e.g. psychologists, nurses, social workers) contribute to out-of-hours cover. In other areas, the service may be provided by adult mental health crisis resolution and home treatment teams, with access to telephone advice from CAMHS professionals.

In areas where the capacity of CAMHS psychiatrists to provide comprehensive out-of-hours cover is limited, it is vital that planning takes place between commissioners, CAMHS, adult mental health services and paediatrics in order to explore creative solutions, allowing for the possibility of assessment and consideration for admission in a crisis. In England and Wales, this will include young people taken to a place of safety under Section 136 of the Mental Health Act 1983.

Recommendation

A CAMHS opinion should be available 24 h a day, 7 days a week. Joint protocols must be agreed between the relevant professionals including adult mental health services – particularly in areas where there are no

trainee child psychiatrists – to ensure that children and adolescents receive the best possible care at all times. Mental health professionals should not be on call out-of-hours more than 1 in 4 days, unless such work is part of their weekly shift work.

3 RCPSYCH 2013:

Recommendations

- Specialist Step 2/3 CAMHS for children up to their 17th birthday require 20.0 WTE clinicians per 100 000 total population (including 2.4 WTE psychiatrists and 5.0 WTE primary mental health workers/Step 2 CAMHS workers) for a service that provides teaching and 16.0 WTE clinicians per 100 000 total population (2.0 WTE psychiatrists) for a non-teaching centre.

- Specialist Step 2/3 CAMHS for 16- and 17-year-olds only requires 6.6 WTE clinicians (1.45 WTE psychiatrists) per 100 000 total population for a non-teaching service and 8.4 WTE (1.8 WTE psychiatrists) for a service that provides teaching. This equates to 19.3 WTE clinicians per 100 000 total population for a non-teaching CAMHS and 24.2 WTE for a teaching CAMHS up to the 18th birthday. This does not include capacity for severe intellectual disability, youth offending and substance misuse work.

- Liaison to youth offending teams and substance misuse services should nevertheless be regarded as a core function of comprehensive CAMHS provision in all areas, but require additional and significant workforce capacity.

- Skill mix in teams must ensure a range of clinical professionals who are able to deliver recommended evidence-based interventions – cognitive, behavioural, psychodynamic and systemic skills, complemented by psychiatric medical skills.

- It is recommended that commissioners and planners of specialist CAMHS link with partner agencies in a given locality, to ensure the appropriate planning and provision of mental health services for the 0- to 4-year-old population.

- Each profession must have access to uni-professional supervision

Step 2/3: treatment, liaison and consultation to other agencies for: psychosis affective disorder, including bipolar disorder, ADHD, autism spectrum disorder, Tourette syndrome and complex tic disorders self-harm

and suicide attempts eating disorders obsessive–compulsive disorder, borderline personality disorder, phobias and anxiety disorders mental health problems secondary to abusive experiences, mental health problems associated with physical health problems and somatoform disorders.

Royal College of Psychiatrists 29

Guidance for provision of specialist CAMHS

The following mental health problems can also be provided for exclusively by specialist CAMHS, but in some areas may be provided for by other agencies and specialists such as paediatricians, health visitors and multi-agency teams, with input by specialist CAMHS workers: services for under-5-year-olds with milder behaviour or sleep problems (e.g. health visitor-led sleep and behaviour clinics) mental health problems associated with intellectual disability (e.g. provided by multi-agency teams) autism spectrum disorder, ADHD, Tourette syndrome and tic disorders conduct disorder (e.g. youth offending teams and local authority services) adjustment disorder (e.g. voluntary sector services dealing with parental separation) elective mutism (e.g. speech and language therapy services) elimination problems (e.g. paediatric and health visitor services).
Paediatric mental health liaison services.

A significant proportion of paediatric patients have mental disorders (Meltzer et al, 2000; Hysing et al, 2007) and paediatricians play a significant role.

APPENDIX 7

NICE GUIDELINES THAT APPLY TO CHILDREN AND YOUNG PEOPLE

NICE has produced evidence-based clinical guidance for England and Wales on a number of topics with relevance to CAMHS practice. The following list is correct as of September 2013.

- Eating disorders (CG9)
- Self-harm (CG16)
- Anxiety (CG22)
- Violence (CG25)
- Post-traumatic stress disorder (PTSD) (CG26)
- Depression in children and young people (CG28)
- Obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD) (CG38)
- Antenatal and postnatal mental health (CG45)
- Bipolar disorder (CG38)
- Drug misuse: psychosocial interventions (CG51)
- Chronic fatigue syndrome/myalgic encephalomyelitis (CG53)
- Attention-deficit hyperactivity disorder (ADHD) (CG72)
- Antisocial personality disorder (CG77)
- Borderline personality disorder (BPD) (CG78)
- Schizophrenia (update) (CG82)
- When to suspect child maltreatment (CG89)
- Depression with a chronic physical health problem (acg91)
- Nocturnal enuresis – the management of bedwetting in children and young people (CG111)
- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (CG113)
- Alcohol dependence and harmful alcohol use (CG115)
- Psychosis with coexisting substance misuse (CG120)
- Autism in children and young people (Acg128)
- Self-harm (longer-term management) (CG133)
- Conduct disorders in children and young people (CG158)
- Social anxiety disorder (CG159)
- Four commonly used methods to increase physical activity (PH2)
- Interventions to reduce substance misuse among vulnerable young people (PH4)

- School-based interventions on alcohol (PH7)
- Physical activity and the environment (PH8)
- Maternal and child nutrition (PH11)
- Social and emotional well-being in primary education (PH12)
- Social and emotional well-being in secondary education (PH20)
- School-based interventions to prevent smoking (PH23)
- Alcohol-use disorders: preventing harmful drinking (PH24)
- Health and well-being of looked after children and young people (QS31)
- Insomnia – newer hypnotic drugs (TA77)
- Attention-deficit hyperactivity disorder (ADHD) – methylphenidate, atomoxetine and dexamfetamine (review) (TA98)
- Structural neuroimaging in first-episode psychosis (TA136)
- Domestic violence and abuse – identification and prevention (in progress)

These guidelines have an impact on interventions to be delivered by CAMHS. Currently in many areas, specialist CAMHS do not have the capacity or skills to deliver the guideline recommendations. For example, there are not enough trained therapists in some areas to carry out cognitive-behavioural therapy recommended by NICE for the treatment of depression. In England, the CYP-IAPT is expected to go some way to address this particular issue.