

Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)



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Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)

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Guidance to Commissioners:

The aim of this sample specification is to support Child and Adolescent Mental Health Service (CAMHS) commissioners (NHS, Social Care, Local Authority and Education). Each provider working to deliver services within the local care pathway will need an individual service specification that sets out what is covered by their contract with the commissioning agency. The specification is intended to support the commissioning of targeted and specialist services (Tiers 2 and 3). It can be adapted to cover just targeted (Tier 2) or just specialist (Tier 3) services. This sample service specification is non-mandatory.

Although the specification has been developed using an NHS template, its content can be used by other commissioners as appropriate and it aims at all times to acknowledge the multi-agency nature of commissioning and delivery of CAMHS in its widest sense. The specification should be appended to the NHS Contract.

All service specifications for CAMHS should sit within an agreed, integrated, strategic plan developed by multi-agency partnerships that takes account of the breadth of services for children and young people. Children, young people and families should be involved in the development of the strategy. Local agency partners should include as a minimum Health, Social Care, Education and, where present, voluntary/third sector and/or independent sector providers. Commissioners should be mindful of the needs of inclusion [health groups](#). The strategic plan should be agreed by the Health and Wellbeing Board or other appropriate governance structures, e.g. children's trusts or 'adult services' commissioners working to extend provision to the upper age limit. The strategic plan should take account of commissioning by NHS England for highly specialist services. The overall strategy should include consideration of how commissioning services might improve the economic, social and environmental well-being of the area in line with the Public Services (Social Value) Act 2012.

The strategy should be built on the Joint Service Needs Assessments (JSNAs) as the foundation for the commissioning of functional, integrated care pathways that takes into account the needs of all children and young people in their local population including those with specific, complex and multiple needs.



Children, young people and, their parents /carers and providers should be involved in the development of individual specifications for services to suit local circumstances and need.

The specification and guidance have been developed iteratively by a team of joint commissioners, providers and young people with extensive consultation with CCG and Local Authority commissioners. It is based on a wide range of best practice, policy documents and NICE Clinical Guidelines concerned with services that should be available in local communities to support emotional wellbeing, the development of resilience, and the treatment of mental health problems and disorders in children and young people. It has been developed to support the delivery of a service that is compliant with the service values and standards set out in "[Delivering With and Delivering Well](#)"¹, a document developed by accrediting bodies, organisations involved in demonstrating quality CAMHS, commissioners, providers and young people as part of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) CAMHS transformation programme.

The resulting specification should be clear about what each provider is commissioned to provide and also what the provider will *not* provide, including the responsibilities with respect to inappropriate referrals. These should sit where possible within an integrated approach to delivery focussed on meeting user needs. The commissioned service should work with other services to improve accurate identification of need and swift and flexible access to services to the services an individual needs. This might include specific protocols for vulnerable groups with the most complex need.

It is critical that commissioners ensure that they work with each provider to agree the level of activity that is included in the final contract and that this level is appropriate to the capacity of the service to deliver the specification as detailed. Information given to children, young people, parents/carers and referrers about the services should reflect clearly what has and has not been commissioned.

The specification will need to be reviewed regularly (at least annually) and updated to reflect national and local strategic decisions and changes of resource by:

- Commissioners and providers, with active engagement from children, young people and parents/carers locally
- The CAMHS partnership and local governance structures such as Health and Wellbeing Boards.

Commissioners will need to be aware of the potential impact of cost-improvement programmes implemented by providers on how they meet the specification, and agree any changes to the scope as a result. An agreed change request procedure should be aligned to appropriate governance arrangements within the provider and commissioning organisations.

¹ CYP IAPT Values and Standards Subgroup - CYP IAPT National Service Development Group, CAMHS Press (2014)

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.”

This specification is being piloted with Clinical Commissioning Groups (CCGs) that volunteer to be part of the pilot. An evaluation will take place to find out how useful CCGs have found the sample specification.

Colour coding in this document:

1. **Pink headings** indicate mandatory sections.
2. **Black text** is suitable for inclusion in the NHS Standard Contract but may be varied locally by commissioners.
3. **Blue text** is guidance or where local detail must be added. Commissioners may find it helpful to include some of the guidance within the text or may wish to delete it from the final service specification before the specification is included in the NHS Standard Contract.
4. The service specification documents should be read in conjunction with the [NHS Standard Contract](#) and the [NHS Standard Contract 2014/15 Technical Guidance](#).

The specification contains hyperlinks (underlined sections) to guidance developed by a group of NHS and Local Authority commissioners, providers and young people who worked on this specification together. For this reason, commissioners may find it helpful to work with this document on a computer rather than with a printed copy.

The PDF version of this model specification is the original full version published by NHS England. A Word version of the model specification is also available for commissioners to use when developing their own specification for their local area – commissioners may amend and insert detail where appropriate. Once changes have been made, that specification should be attributed to the specific commissioner/local area, not NHS England overall.

SCHEDULE 2 OF NHS STANDARD CONTRACT – THE SERVICES

A. Service Specifications

Service	
Specification No.	
Service	Targeted and Specialist (Tiers 2 and 3) Child and Adolescent Mental Health Services. Commissioners wishing to commission targeted services separately from specialist services may wish to use this specification and delete sections that are not relevant.
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 Purpose, introduction and context

The purpose of this document is to specify the provision of Targeted (Tier 2) and Specialist (Tier 3) Child and Adolescent Mental Health Services (CAMHS) from the provider. It will describe the role, function and responsibilities of these services.

Specification aims and evidence base

Services for children and young people should place them and their parents/carers at the heart of everything they do.

1.2 National/local context and evidence base

There has been universal acknowledgment in policy over the past ten years of the challenges faced by children and young people in developing resilience and psychological wellbeing. For those children and young people with diagnosable mental health problems and their parents/carers and the agencies that support them, the challenges are greater. A number of disorders are persistent and will continue into adult life unless properly treated. It is known that 50% of lifetime mental illness (except dementia) begins by the age of 14 and 75% by age 18. Young people who are not in education, employment or training report particularly

low levels of happiness and self-esteem. The Macquarie Youth Index 2014 reported that 40% of jobless young people have faced symptoms of mental illness as a result of being out of work, and one-third of long-term unemployed young people have contemplated suicide. At the same time, effective treatments have been identified to improve the life chances of children and young people, and to minimise the impact on the long-term health of the population and economic cost to the public purse.²

Comprehensive support for children and young people with emotional and psychological problems or disorders is provided through a network of services, which include:

- Universal services such as early years services and primary care (Tier 1 CAMHS)
- Targeted services such as youth offending teams, primary mental health workers, educational psychologists and school and voluntary/third sector providers counselling (including social care and education) (Tier 2 CAMHS)
- Specialist community multidisciplinary CAMHS teams (Tier 3 CAMHS)
- Highly specialist services such as inpatient services and much specialised outpatient services (Tier 4 CAMHS).

These services are not provided exclusively by the NHS.

As children and young people's emotional wellbeing and mental health affect all aspects of their lives, no one service alone will be able to meet their needs. There is a duty of cooperation placed on commissioners and services to work together to the benefit of children and young people. The multiagency nature of CAMHS will require a multi-agency approach to commissioning is required. Changes in one agency or one part of the system can affect demand and delivery in another. This interdependency can create risks if not properly considered but also brings with it the possibility of agencies working together to meet the needs of the populations they serve and to achieve wider system efficiencies. Services should work together in integrated ways to ensure appropriate communication and transitions.

This specification should therefore be linked to other specifications within the local area. For example (this is not an exhaustive list):

- Public Health
- Health Education
- CAMHS highly specialist services (Tier 4 CAMHS)

² Department of Health, HM Government, ['No Health without Mental Health. A cross governmental strategy for people of all ages'](#), Crown Copyright (2011)

Green et al, ['Mental Health of children and young people in Great Britain'](#), Office of National Statistics (2004)

Kim-Cohen, J. et al, ['MAOA, maltreatment, and gene-environment interaction predicting children's mental health: new evidence and a meta-analysis'](#), *Molecular Psychiatry* (2006) v.11, 903-913

The Prince's Trust Macquarie, ['Youth Index 2014'](#), Prince's Trust (2013)

- Health Visiting
- School Nursing
- Community Child Health
- Acute Paediatrics
- Accident and Emergency Services
- Perinatal Mental Health Services
- Adult Mental Health services
- Workforce planning and education of staff.

Also consider:

- [Local guidance which may impact on CAMHS, for example, *Looked After Children Guidance*.](#)
- [Linking with children's partnership arrangements, the duty of cooperation and joint commissioning arrangements for wider children's services](#)

It is important that children and young people, however they first present with difficulties, are supported by professionals to receive appropriate help and support as soon as possible. This specification details local integrated, multi-agency care pathways that enable the delivery of effective, accessible, holistic evidence-based care.

What children, young people and parents/carers tell us they want from CAMHS and other stakeholders

- [Delivering With and Delivering Well³](#) sets out standards created using previous consultations with children, young people and families
- [Insert results of local views and surveys of the views of children, young people and parents/carers.](#)

Financial cost of child and adolescent mental health problems

The costs incurred to the public purse of not treating children and young people early in their lives are considerable. For example:

- Mental health problems in children and young people are associated with excess costs estimated at between £11,030 and £59,130 annually per child. These costs fall to a variety of agencies (e.g. education, social services and

³ CYP IAPT Values and Standards Subgroup - CYP IAPT National Service Development Group, CAMHS Press (2014)

youth justice) and also include the direct costs to the family of the child's illness.⁴

- There are clinically proven and cost-effective interventions. Taking conduct disorder as an example, potential life-long savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems.⁵
- The costs of providing safe and effective interventions associated with supporting children and young people in the community with crisis support or outreach can be considerably less than those associated with inpatient care.

Insert local information to include population of children and young people according to age range of the specification

The figures should be adjusted for deprivation or other locally agreed benchmarking formats, for example:

- Estimated number of children/young people with mental health problems and conditions
- Estimated need for CAMHS
- Vulnerable groups – see Section 3.2, *Continuing Care and Assessment*, for example groups,

1.3 Sources of information and support

- Include Joint Strategic Needs Assessment information.
- The [CHIMAT website](#) contains a range of tools and advice to support commissioners to plan and review CAMHS. In addition, there is a CHIMAT newsletter and specific tools to assist – for example, the [CAMHS prevalence-based Service Snapshot](#).
- [CYP IAPT website](#) contains a range of resources and guidance for commissioners.
- [Youth Access](#) are providers of young people's advice and counselling services across the UK
- Joint Commissioning Panel for Mental Health [Guidance for Commissioners of Mental Health Services for Children and Adolescent to Adult Services](#).

⁴ Department of Health, HM Government, [No health without mental health: A cross-Government mental health outcomes strategy or people of all ages. Supporting document - The economic case for improving efficiency and quality in mental health](#). Crown Copyright (2011)

⁵ Friedli, L. & Parsonage, M. [Mental Health Promotion: Building an Economic Case Northern Ireland Association for Mental Health](#), NIAMH (2007)

- The [Mental Health Intelligence Network](#) analyses information and data and turns it into timely meaningful health intelligence for commissioners, policy makers, clinicians and health professionals to improve services and outcomes.
- [Child Outcomes Research Consortium \(CORC\)](#) contains a wide range of resources to help commissioners and services develop mechanisms to collect and use outcomes meaningfully
- [Choice and Partnership Approach \(CAPA\)](#) website offers a helpful demand management system for CAMHS
- [YoungMinds](#) contains a wide range of resources for children young people, parents, services and commissioners about child mental health

2. Outcomes

CAMHS contributes to a number of strategic outcomes that have been pre-defined both nationally and locally.

2.1 NHS Outcomes Framework Domains and Indicators

The provision of good CAMHS will support improved outcomes across all five domains.

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

2.2 Public Health Outcomes Framework

Domain 2	Health Improvement	X
Domain 4	Healthcare, public health and preventing premature mortality	X

2.3 Local Area strategic outcomes

Commissioners should ensure that the Local Area strategic outcomes link to National policy and make best use of underpinning evidence.

Local Authorities may wish to consider guidance and support material from the [Local Government Association](#).

NHS England has produced [a range of information for CCGs and Local Authorities](#). Each pack sets out key data to inform the local position on outcomes. Please note that these are focused on high-level comparative information on the NHS, Adult Social Care and Public Health frameworks.

2.4 Locally defined outcomes

Commissioners should agree local outcomes or indicators based on the specific needs of their population and the quality and accessibility of current service provision. Locally defined outcomes can help drive up quality improvements and help achieve the desired outcomes for patients. Local outcomes are more likely to be relevant if they are developed with children, young people and parents/carers. Outcomes are more likely to be achieved if they are agreed by partners and receive support from partnership bodies (e.g., Health and Wellbeing Board, Children's Partnership arrangements).

Consider the following when defining specific outcomes:

- Joint Strategic Needs Assessment
- Joint Health and Wellbeing Strategy
- Local Children and Young People's plan
- Identifying local expertise (e.g., [Public Health England](#)) to summarise population needs and priorities
- Where local services have already joined the [CYP IAPT programme](#), or are a member of the [Child Outcomes Research Consortium \(CORC\)](#), or are part of the CAMHS Currencies Programme, commissioners may want to include some of the agreed outcome measures with a timetable for delivery.
- See [example outcomes](#)⁶

3. Scope

3.1 Aims and objectives of service

⁶ Clark, D. (lead) with CYP IAPT National Service Development Group - Commissioning Subgroup (2014), adapted from outcomes delivered by Oxford Health NHS Foundation Trust

The provider shall:

- Work with children and young people and parents/carers in co-designing and reviewing care pathways.
- Work with all relevant agencies to ensure that services for children and young people with mental health problems are coordinated and address their individual needs, providing a holistic approach.
- Ensure that children, young people and their parents/carers are treated with compassion, respect and dignity, without stigma or judgment.
- Ensure that children and young people's physical health and social needs are considered alongside their mental health needs.
- Ensure that children and young people who access the service are seen in a timely manner.
- If appropriate to the provider, ensure that services are provided in an emergency or crisis, including out of hours 24/7 [The specification should be clear about whether this provision is a CAMHS-led and staffed service or a service that can draw on CAMHS expertise. Arrangements should clearly state how other professionals working out of hours in other services \(i.e. Emergency Duty teams and paediatrics\) are supported.](#)
- If the provider does not provide emergency/crisis care, ensure that protocols are in place between the provider and the provider(s) of emergency or out-of-hours care, should support or consultation be required urgently.
- Provide initial and follow-up assessments that are written and shared with the child, young person and/or parent/carer.
- Seek and use feedback in a range of settings, including the use of routine outcome monitoring in therapy, positive feedback regarding service delivery, and complaints.
- Ensure that children, young people and their parents/carers are offered a choice of interventions appropriate to their needs.
- Ensure the impact of trauma, abuse or neglect in the lives of children and young people is properly considered when identifying appropriate interventions
- Ensure that any additional vulnerability or inequality suffered by children and young people (e.g. learning disability, victim of child sexual exploitation) is properly considered when identifying appropriate interventions
- Agree the aim and goal of interventions with the child/young person or parent/carer, monitor the changes to agreed and shared goals as well as symptoms, and amend therapeutic interactions as a result of these changes, to deliver the best possible outcome.

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- Provide information at all stages of the pathway about interventions or treatment options to enable children, young people and parents/carers to make informed decisions about their care appropriate to their competence and capacity; this information needs to be clear, easy to understand and jargon free.
- Provide written information to the child/young person and parent/carer about the care plan and how to access services (both routinely and in a crisis); this information needs to be clear, easy to understand and jargon free.
- Provide written assessments, care plans, etc. that are easy to understand and jargon free; any technical terms in these assessments/care plans should be defined.
- Provide information about how the services commissioned will increase opportunities for social value and social capital in line with the Social Value Act 2012
- Ensure that children and young people leaving the service have an agreed and documented discharge plan that supports self-management where possible and explains how to access help if this becomes necessary. Where a young person is moving to another service, whether to adult mental health services or to a different service, the provider will ensure that the agreed transition protocol is followed. As a minimum this will involve: a joint meeting between the provider and the new service that includes the child/young person and/or parent/carer, and a written discharge summary, followed up after 6 months to check that the transition has proceeded smoothly.
- Ensure that the service is accessible and provided in an appropriate setting that creates a safe physical environment. This will take into account issues such as stigma and, where appropriate, gang violence.
- Ensure that the service provides relevant Continuing Professional Development (CPD), appropriate supervision and regular appraisal to staff, and has a clear workforce plan that takes account of the changing needs of the local population.
- Maintain an accurate data set and provide accurate and timely reporting to commissioners (local, regional and national) and national organisations (e.g. Health and Social Care Information Centre, CORC) when requested.
- Have clear reporting processes and standards, for example, the [Youth Wellbeing Directory](#) and [CORC](#).
- Work collaboratively with other agencies in the health and social care system to ensure regular case reviews to ensure effective progress through the care pathway.
- Ensure that the technology in place includes effective integrated embedded technology to support and underpin practice in a clinically meaningful way.
- Ensure that management information is readily accessible and regularly used

for service improvement.

- Ensure that there is a formal route for referring children/young people to highly specialist mental health services (e.g. inpatient services, specialist outpatient services).
- Ensure that clear communication pathways and information sharing mechanisms are in place so that children, young people and, where appropriate, their parents/carers experience a smooth journey through the care pathway.
- Work together with relevant agencies in health, social services and education to ensure that children and young people have appropriate advice and support throughout their care. This includes using whatever locally agreed systems there are to support joint agency working (e.g., Early Help Assessment (EHA) Team Around the Family), meeting safeguarding standards and providing clear protocols on information sharing, with children and young people being asked for consent regarding information sharing with other agencies (rather than a blanket decision not to share health information with such agencies). This should include information about non-attendance, to mitigate against the risks inherent in the fact that children and young people are often dependent on others to access care.

3.2 Legal and regulatory framework

Consider the following and insert as appropriate:

The service will operate according to relevant legislation and guidance, with particular reference to:

- [Mental Health Act 1983 \(amended 2007\)](#) and Code of Practice, including protocols for emergency assessment under Section 136
- [Mental Capacity Act 2005](#)
- [Children's and Families Act 2014](#) including specific duties in relation to children and young people with SEND. Further detail can be found at [here](#)
- [Equality Act 2010](#)
- [National Service Framework, 2004](#)
- [Care Act 2014](#)
- [The Human Medicines Regulations 2012](#)
- [Public Services \(Social Value\) Act 2012](#)
- Safeguarding procedures (e.g. [Working Together to Safeguard Children](#))

2013)

- The findings from serious case reviews in particular the requirements to share information in a timely manner. See [Working Together to Safeguard Children](#) for further guidance
- [Promoting the health of looked after children](#)
- [NHS Choice of Provider initiative](#)
- [Personal Health Budgets](#) may be a good way of arranging services for some patients.

If appropriate, the provider will be registered with the [Care Quality Commission](#).

The provider will ensure that all professionals will remain compliant with their relevant professional standards and bodies and be revalidated as required.

The provider will have an indemnity scheme.

The provider will have a governance system to manage and learn from complaints and incidents and to meet the training and supervision needs of its staff. [A service that does not have any \(formal or informal\) complaints should be of as much interest as one with a high level of complaints. If children, young people, parents/carers or referrers do not have a mechanism to raise concerns, this could suggest a service is not working in partnership with its clients and referrers.](#)

[Providers and commissioners may wish to consider the use of Independent Advocacy Services to support children and young people to gain access to information, to fully explore and understand their options, and to make their views and wishes known.](#)

3.3 Service description/care pathway

For all children and young people who meet the criteria for targeted or specialist services CAMHS (Tier 2 or Tier 3) the following principles apply:

Providers will:

- Ensure services are available to all children and young people without regard to gender, sexuality, religion, ethnicity, social, or cultural determinants. However, where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such services will enhance rather than detract from the existing provision.
- Offer children, young people and parents/carers age-appropriate information about their condition and care.
- Ensure that services have age-appropriate physical settings.

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- Conduct a full initial assessment which includes a comprehensive psychosocial assessment, for example, using the [Choice and Partnership Approach \(CAPA\)](#).
- Ensure that the rationale for diagnosis, evidence considered and decisions made will be fully documented. This will be shared with the child/young person and parent/carer in writing as appropriate.
- Ensure that initial and continuous care planning involves all members of the team providing care, the child/young person and their parents/carers.
- Develop a risk management plan, if required, in collaboration with the child/young person and their parents/carers.
- Ensure that informed consent issues around both sharing of information within the family and with other agencies and around treatment are clearly explained and documented.
- Provide care/interventions that will prevent unnecessary admission to an inpatient bed and promote safe discharge and recovery.
- Ensure that all service developments and/or redesigns are undertaken using co-production.
- Ensure any cross-charging arrangements for cross-boundary children/young people are included.
- Ensure that legal rights for patients with regard to choice of mental health provider are implemented. See www.england.nhs.uk/ourwork/qual-clin-lead/pe/bp/guidance/ for guidance.
- Contribute to other parts of agreed multi-agency care pathways.
- Provide a liaison service to all appropriate acute units, including a robust clinical emergency service with out of hours, weekend and bank holiday capability.

The locally agreed care pathway(s) is/are: [What is inserted here will depend on the local definition of a care pathway. Some areas have high-level comprehensive integrated CAMHS pathways that include self-care, mental health promotion and training, early intervention, access to treatment/interventions and transition/discharge. Other care pathways will focus on referral into services only. If this specification is for one service then how that service fits into the wider CAMHS pathway needs to be considered and a flow chart/diagram showing how to access that particular service needs to be provided – this, of course, needs to be user friendly.](#)

This care pathway should include consultation and liaison.

For sample care pathways please see:

- [Liverpool locally developed pathway](#)⁷
- [Care Pathways in CAMHS](#)⁸

3.4 Acceptance criteria

The service has clear acceptance criteria that are available to referrers, children/young people, their parents/carers and other agencies/services. It is particularly important to have clarity about what is and is not included. The commissioner and provider will need to be explicit should thresholds change for any reason.

The aims of CAMHS [insert relevant description, e.g. targeted or specialist] is to provide support to colleagues working in universal and targeted [amend as relevant] services with children and young people, assessment and treatment in the context of emotional, developmental, environmental and social factors to children/young people experiencing mental health problems.

Targeted/Tier 2 CAMHS

Mild to moderate emotional wellbeing and mental health problems of children/young people alongside their parents/carers either in clinics and/or community settings such as GP practices, schools or, where appropriate, the home environment.

The service will network with a range of services and other agencies as appropriate, including community paediatric providers.

Commissioners should consider how they will commission a range of services for children and young people who will typically present with one or more of the following:

- Family issues – where this is having an adverse effect and the child or young person is showing signs of developing a mental health problem or disorder
- Mild to moderate emotional and behavioural disorders
- Child behaviour problems (sleep, feeding, tantrums) once physical causes have been considered and the behaviour falls outside what might be considered to be within the range of normal behaviour
- Conduct disorders
- Anxiety, depression, stress and or other mood disorders, e.g. low self-esteem

⁷ Local example from Liverpool CAMHS

⁸ Worton, K. (lead) with CYP IAPT National Service Development Group - Commissioning Subgroup (2014)

- Adjustment reactions
- Simple phobias Self-harm – where this is mild to moderate
- Bereavement
- Bullying
- Anger management issues
- Relationship problems.

Specialist/Tier 3 CAMHS

Most young people will present with moderate and severe mental health problems that are causing significant impairments in their day-to-day lives. These may be acute presentations.

There should be a pathway for challenging behaviour of mild to moderate severity in place.

Commissioners should consider how they will commission a range of services for children and young people who will typically present with one or more of the following :

- Emotional and behavioural disorders (moderate to severe)
- Conduct disorder and oppositional defiant disorder
- Hyperkinetic disorders
- Psychosis
- Obsessive-compulsive disorder
- Eating disorders
- Self-harm
- Suicidal ideation
- Dual diagnosis – including comorbid drug and alcohol use
- Neuropsychiatric conditions
- Attachment disorders
- Post-traumatic stress disorders
- Development disorders
- Significant mental health problems where there is comorbidity with mild/moderate learning disabilities or comorbid physical and mental health

problems

- Mood disorders
- Somatising disorders
- NB: Presentations that could be described as emerging personality disorder will probably be accepted under mood disorder, suicidal ideation and self-harm.

Commissioners should also take account of other specialist services, e.g. for children with Learning Difficulties

Providers will:

- Accept referrals for children and young people aged [\[insert age group here\]](#) where there is a reasonable description that suggests that the child/young person may have an emotional wellbeing or mental health problem from [\[insert geographical area or other description e.g. CCG name here\]](#). Ensure that this reflects the scope of services and local variations, e.g. if ADHD services are provided by community child health this would not be included in this specification, but the link to the community child health specification should be included.

[The age range for this specification is determined by local decision, but should be explicitly stated.](#)

[Any agreements regarding flexibility around transition of care from the provider to other providers should be made clear. For example, if the age range is 0–18, the specification should include information about how the needs of relevant young people up to the age of 25 \(in accordance with the Children and Families Act 2014\) will be met with a link to the relevant specification in another contract.](#)

[When looking at service upper age limits consider:](#)

- [Age limits of other services – are there any gaps?](#)
- [What happens to cases that are not eligible?](#)
- [Collection of data re: cases declined.](#)
- Accept referrals from [Insert all locally agreed referral pathways including self-referral, and single point of access.](#)
- In cases where referrals are found to be inappropriate, with consent, refer or signpost the child/young person and their family/carers to other services.
- Provide locally available, age- and developmentally appropriate, co-produced information for children/young people, parents/carers and referrers about the services provided and how they are accessed.

- Support the Early Help Assessment/Common Assessment Framework and local protocols.
- Support and ensure inter-agency working.
- Support and ensure discharge or transition planning.
- If the service concludes that the needs of child/young people or parents are better met by other agencies. It will [\[Insert protocol here.\]](#)
- Ensure that the referrer is clear as to whether the service has accepted the referral and, if not, in line with agreed information-sharing protocols, provide the rationale for this and written suggestions to what the services will do: [for example, whether the service will refer on or signpost or expect the referrer to do so.](#)
- [Consider providing a referral and advice line so that those thinking about referring can have a discussion prior to the referral.](#)
- Gather the agreed range of information at the point of referral [\[Insert protocol\]](#)

3.5 Exclusion criteria

[It is very important that children, young people, parents/carers and referrers are equally clear about presentations the service is *not* commissioned to accept. This information should be publicly available and a system put in place should this be disputed.](#)

Children and young people may *not* be eligible for the service provided by [\[insert provider name\]](#) on the basis of:

- Age [insert local threshold](#)
- The referred problem may be best treated in an alternative service (and the protocol by which the service will refer to the alternative must be explicit)
- Where a more clinically appropriate service has been commissioned from an alternative provider (Tier 4, children with severe disabilities)
- Children in court proceedings where intervention is not advised under Home Office guidelines
- Court assessments, unless specifically contracted
- Where the service is not commissioned to include the clinical presentation [\(specify, and provider to record specific instances\)](#)

Insert locally agreed protocols for specific services here. Examples of other services that are commissioned to work with specific children and young people that might otherwise be considered within the specification due to their likely presentation with might include looked after children, adopted children, Early Intervention Psychosis

Consider the needs of children and young people with multiple problems (e.g. substance misuse and mental health, eating disorder and depression) and clarify lead agencies.

3.6 Initial assessment

Insert here local protocol for how referrals are assessed, e.g. if there is a single point of access. The outcome of the assessment should be recorded in the service user's note and be passed on to any other service involved in the care of the service user with the informed consent of the young person and/or parent/carer. Include information sharing protocols with schools and other agencies e.g. Social Care.

Providers will:

- See crisis/emergency referrals (define) within [insert number] hours. Insert out-of-hours protocols for referrals, covering 24/7 access.
- See urgent referrals (define) within [insert number] days.
- For routine referrals (define), carry out initial assessment within [insert number] weeks of receipt of accepted referral.
- Offer to provide the agreed intervention within [insert number] weeks of the initial assessment.
- Assure that the member of staff undertaking the initial assessment is appropriately trained and experienced to undertake assessment, to identify strengths and difficulties including identification of mental health disorders, supported by formulation or diagnosis where appropriate.
- Work in collaboration with the child/young person and, where possible, the parents/carers on the decision to refer for further assessment and/or treatment or to discharge and/or signpost, based on the combined assessment of their needs and risk.

3.7 Continuing care and assessment

Providers will:

- Ensure that care plans (following the [Care Programme Approach](#) [CPA], where applicable) are in place for all people receiving support for mental health problems. These plans should be coordinated across agencies, teams

and or disciplines, be clearly written, identify the key coordinator and be developed in collaboration with children/young people and parents/carers where possible. A copy should be given to the service user, parent/carer (if appropriate) and other agencies such as the GP.

- Ensure that the care plan includes appropriate risk management and crisis planning.
- Review the care plan with the service user and parent/carer (if appropriate), including the goals of treatment, and revise the care plan at agreed intervals. **The dates for review should be set out in writing and depend on the nature of the problem – many problems should be reviewed every three months but others may require a less frequent review. Where a significant change has taken place, or when there is a change in the care management plan, review should be carried out as soon as is practical.**
- Select treatment options in consideration of:
 - Age-appropriate best practice/evidence-based psychological intervention
 - Pharmacological and psychosocial interventions
 - Environmental and occupational/educational interventions or provision
 - The availability of a multimedia prevention package whilst on waiting list
 - Engagement, flexibility and choice.

Any planning for children and young people with severe educational needs should take account of and be part of the child or young person's statement/Education Health and Care plan.

3.8 Does Not Attend (DNA) /Re-engagement policy

When a service user does not attend, a risk assessment should be made and acted upon. A service should not close a case without informing the referrer that the service user has not attended. The service should make explicit re-engagement policies available to referrers, children/young people and parents/carers.

3.9 Care transition protocols

The service will have protocols in place to ensure that transitions between services are robust and that, wherever possible, services work together with the service user and parents/carers to plan in advance for transition (this is especially critical in the transfer from CAMHS to adult mental health services and primary care or other services, e.g. voluntary/third sector). As a minimum, children/young people leaving

CAMHS should have:

- A written and agreed care plan detailing what service they will receive post-CAMHS
- At least one face-to-face meeting with their CAMHS key worker and the key worker from the service to which they will move for further care
- Follow up after the transition, within six months, to ensure appropriate interventions are in place
- A written and agreed plan, if no further interventions or treatment are planned, so that the young person and, where appropriate, parents/carer knows what to do if they become unwell
- A specific protocol for those going to primary care.

Service Transition Protocols should ensure that:

- Children and young people will have continuity of care
- Any risks or safeguarding concerns are clearly considered and documented
- Arrangements for transition planning take place.

Groups needing particularly robust transition processes include:

- Looked after children
- Care leavers moving to independent living
- Young people entering or leaving inpatient care
- Young people entering or leaving prison
- Young offenders
- Children and young people with learning disabilities
- Unaccompanied asylum-seeking minors
- Children and young people with caring responsibilities
- Those not in education, employment or training (NEET).

For further information and tools to assist with the commissioning of transition, see [CHIMAT CAMHS transitions resources](#).

Insert local transition protocol(s) to adult mental health or other services

3.10 Staffing arrangements, recruitment and training, supervision/appraisal requirements

Providers will:

- Ensure the workforce has the necessary compassion, values and behaviours to provide person-centred, integrated care and enhance the quality of experience through education, training and regular continuing personal and professional development (CPPD) that instils respect for children/young people and parents/carers.
- Anticipate the numbers and capabilities of the workforce needed currently and for the future, ensuring an appropriate skill mix in teams able to deliver a range of recommended evidence-based interventions with a delivery model that best focuses the capacity of the service to the demands of the population.
- Ensure the workforce is informed about other CAMHS providers, and has the knowledge and ability to communicate effectively with other relevant services.
- Ensure the workforce is educated to be responsive to changing service models, innovation and new technologies, with knowledge about effective practice and research that promotes adoption and dissemination of better quality service delivery.
- Ensure there are sufficient staff educated and trained with the required knowledge and skills within teams. The skill set required in the team may be subject to change according to changes in local needs.
- Ensure that there is compliance with the recommendations of the [Francis Report \(2013\)](#) and in particular the [Code of Candour](#).
- Monitor caseloads for staff to ensure safe and effective delivery of services.

Further guidance can be found at the links below:

- [CHIMAT](#)
- [CAMHS Workforce Guidance](#)⁹
- [CYP IAPT Principles in CAMHS Services: Values and Standards: “Delivering With and Delivering Well”](#)¹⁰

⁹ Nixon, B. (lead) with CYP IAPT National Service Development Group - Commissioning Subgroup (2014), adapted from ‘*Delivering workforce capacity, capability and sustainability in Child and Adolescent Mental Health Services*’ National CAMHS Workforce Programme, CSIP, (2006)

¹⁰ CYP IAPT Values and Standards Subgroup - CYP IAPT National Service Development Group, CAMHS Press (2014)

3.11 Activity

The activity level within the NHS contract sets out the numbers of new cases and levels of activity funded by this contract. Commissioners will need to have in-depth discussions with providers regarding the number of assessments, cases and consultation levels commissioned. Commissioners may find the [Choice and Partnership Approach \(CAPA\)](#), [LEAN Improvement Approach](#) and advice from the [Royal College of Psychiatrists](#) regarding staffing levels useful as an aid to agreeing the levels of activity covered by this specification. Commissioners will need to keep this under review, particularly if resource levels to CAMHS change.

See [capacity/activity modelling](#)¹¹ for further guidance.

3.12 Information governance and accountability

The provider will comply with all relevant legislation and guidance to record information, in particular to comply with Data Protection acts, and comply with requirements to keep records for an appropriate period

3.13 Interdependence with other services/providers

Providers should ensure they have excellent links with services regularly used by young people:

- General Practice
- Schools and academies FE colleges and other education providers
- Children centres and early years settings (nurseries)
- Early Help provider
- Health visitors
- Other mental health services (adult, specialist, forensic)
- Voluntary sector providers
- Independent providers
- Inpatient or other highly specialist services
- Youth services
- Safe guarding – children and adults (Local Safeguarding Children’s Board) ([Append policy](#))
- Local authorities
- Acute sector hospitals

¹¹ Nixon, B. (lead) with CYP IAPT National Service Development Group - Commissioning Subgroup (2014)

- Emergency departments
- Community child health
- Criminal justice system – including young offenders services
- Addiction services
- Job centres and careers advice
- Local independent providers.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

This specification links to the following NICE Quality Standards and will be reviewed upon the publication of further guidance.

Please note that the list below is not exhaustive.

NICE quality standards relating to mental health and emotional wellbeing of children and young people

NICE Quality Standard/ Guidelines number	Title and link	Published	Review	Age range
QS31	Health and wellbeing of looked-after children and young people	April 2013	Apr 2018	0–18
QS34	Self-harm	June 2013	June 2018	Children and young people from 8 and adult
QS39	Attention deficit hyperactivity disorder	July 2013	July 2018	Children and young people from 3 and adult
CG28	Depression in children and young people	Sept 2005	Dec 2015	<18
QS48	Depression in children and young people	Sept 2013	Sept 2018	5–18
QS51	Autism	Jan 2014	Jan 2019	Lifespan
CG 128	Autism diagnosis in children and young people	Sept 2011	Nov 2014	<18

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QS53	Anxiety disorders	Feb 2014	Feb 2019	Lifespan
PH 4	Interventions to reduce substance misuse among vulnerable young people	March 2007		< 25
QS59	Antisocial behaviour and conduct disorders in children and young people: pathway	April 2014	April 2019	< 18
CG 158	Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management	March 2013		<18
CG9	Eating disorders	January 2004	TBC	Children and young people from 8 and adult
CG78	Borderline personality disorder	January 2009	January 2015	Adults and young people (<18)
CG 155	Psychosis and schizophrenia in children and young people	January 2013		< 18

4.2 Standards for children and young people's and parents' participation

All services must include their clients when designing and monitoring services. The list below is not exhaustive

- Department of Health (2011) [Quality Criteria for young people friendly health services](#) ('You're Welcome') sets out principles to help commissioners and service providers to improve the suitability of NHS and non-NHS health services for young people.
- National Youth Agency (2006) [Hear by Right](#). Standards for young people's participation (not specifically mental health) (purchase price).
- Health and Social Care Advisory Service (2008) [Turning what young people say into what services do. Quality Standards for children and young people's participation in CAMHS](#) is based on the Hear by Right standards above and adapted specifically for CAMHS.

- "[Delivering With and Delivering Well](#)"¹² was developed by young people, commissioners and providers to integrate the principles of the CYP IAPT programme into existing quality assurance and accreditation frameworks.

4.3 Applicable standards set out in guidance and/or issued by a competent body

For example

- [Quality Network for Community CAMHS Standards](#)
- [Quality Network for Inpatient CAMHS Standards](#)
- [Youth Wellbeing Directory and ACE-V Quality Standards](#)
- [Child Outcome Research Consortium](#) (CORC)
- [Choice and Partnership Approach](#) (CAPA)

Associated policy documents:

- [No Health without Mental Health. Department of Health \(2011\)](#)
- [Talking Therapies, a 4-year plan. Department of Health \(2011\)](#)
- [Closing the Gap. Department of Health \(2014\)](#)
- [NHS and Social Care Act \(2011\)](#)
- [Children and Families Bill \(2013\)](#)
- [Mandate to Health Education England](#)
- [Chief Medical Officer's Annual Report on State of Public Health \(2014\)](#)
- [Behaviour and Discipline in Schools, Department of Education \(2014\)](#)
- [Public Services \(Social Value\) Act 2012](#)
- [Achieving Better Access to Mental health Services by 2020](#)
- [Five Year Forward View](#)
- [Forward View into action: Planning for 2015/16 guidance](#)

4.4 Applicable local standards

¹² CYP IAPT Values and Standards Subgroup - CYP IAPT National Service Development Group, CAMHS Press (2014)

Commissioners will need to determine the local standards. [Consider standards agreed by local Health and Wellbeing Boards, CAMHS and Mental Health strategies and CCG priorities.](#)

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See National Contract Schedule 4 Parts A-D)

CAMHS are not included in the National Operational Requirements or the National Quality Requirements. Quality will therefore be regulated through local quality requirements.

These should be reported by the end of the first working week following each quarter.

The most effective quality requirements will be those developed through frank and realistic dialogues between commissioners, providers and the children/young people and parents/carers in the local population.

Quality requirements should work from existing quality levels and function as a mechanism for driving continuous improvement in achievable and sustainable ways, and towards quality standards set out in Section 4, and according to Health and Social Care Outcomes Frameworks. Where possible, quality requirements should be aligned with specific measurable outcomes (see 5.3).

Quality requirements should be operationalised so that progress can be tracked on a quarterly basis and measured in steps that are agreed through dialogue with stakeholders.

5.2 Data recording must include:

All services providing NHS-funded CAMHS must be locally collecting and using [CAMHS Minimum Dataset](#) which has been approved by the Information Standards Board for Health and Social Care (ISB) as an information standard for the NHS in England.

Data recording should include:

- Agreed assessment measures
- Whether the individual is currently being seen by any other local services, including in schools or academies.

Note that the CAMHS Minimum Dataset will merge with the following imminently:

- CYP IAPT dataset
- Child Outcome Research Consortium (CORC+) dataset
- CAMHS Currency (PbR) datasets.

Commissioners may wish to include these datasets within the specification to prepare for merger.

5.3 Health and Social Care Outcomes Frameworks

The [Department of Health and Social Care Outcome Frameworks](#) are an interrelated architecture of indicators to guide the setting of quality requirements. These are mapped to suggested key performance indicators (KPIs) in [this guidance document](#)¹³

Insert local CAMHS guidance, strategies and local commissioning support framework here

5.4 Feedback and Outcomes Tools

Providers should use the tools that best facilitate continuous quality improvement in their clinical practice to ensure quality requirements are meaningful both in tracking progress and for day-to-day clinical work and collaborative practice.

The [CYP IAPT Programme](#), [CORC](#) and the [Evidence Based Practice Unit](#) have brought together a set of validated tools for measuring outcomes of clinical treatment and gathering experiential information about treatment. These are described in the [Guide to Using Outcomes and Feedback Tools with Children, Young People and Families](#).

5.5 Applicable CQUIN goals (See Standard Contract Schedule 4 Part E)

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. [Commissioning for Quality and Innovation Guidance \(14/15\)](#) explains the aims, objectives and financial framework.

Whilst a proportion (0.5%) of the overall proportion (2.5%) of the CQUIN aligned income should be linked with national CQUIN goals where applicable, it is suggested that commissioners may consider creating local CQUINs using

¹³ CYP IAPT National Service Development Group - Commissioning Subgroup (2014)

qualitative and quantitative measures

See example local CQUINs below

- [Transition CQUIN Requirements](#)¹⁴
- [Recovery CQUIN](#)¹⁵
- [North West London CQUIN](#)¹⁶
- [Liverpool CQUIN](#)¹⁷

Further guidance is available in CORC's [Position on CQUIN targets](#).

6. Location of Provider Premises

The provider's premises are located at:

Commissioners may wish to specify the range of locations that meet the needs of children/young people and their parents/carers and provide a choice of venue, for example, children's centres, clinics, drop-in sessions in other services (e.g. specialist CAMHS in YIACS, if outreach is included).

7. Individual Service User Placement

Commissioning should be framed by the following principles:

- Children and young people should be treated, as far as possible, within their own community/close to home and in a timely manner.
- Commissioners will need to ensure that appropriate plans are in place for children and young people in crisis, and that services that provide these have CAMHS staff at the point of entry, such as A&E.
- It is essential that children, young people and parents/carers are involved in commissioning and service design (as well as providing feedback to services). Children, young people and their parents/carers, as well as those who have yet to access services, can help commissioners prioritise and identify any gaps and blocks to access, and assist providers in improving services and evaluating change.
- Commissioners should consider the diversity of the populations they are responsible for – in terms of not only cultural and ethnic diversity, but all of the factors that may influence the risk of developing mental health problems

¹⁴ Local example for Rotherham, Doncaster and South Humber NHS Foundation Trust

¹⁵ Strachan, C. Example Recovery CQUIN 14-15 document for National Service Leads Meeting (2014)

¹⁶ Local example from North West London Commissioning Support Unit

¹⁷ Local example from Liverpool (Alder Hey & Mersey Care)

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as well as those that need to be taken into account in the design and delivery of services.

- Transition arrangements into adult services must be in place, including transition arrangements to primary care if children/young people are not going to meet adult mental health services thresholds but still require some level of support.