Oxfordshire CAMHS Model

2015
## Contents

1 Introduction .................................................................................................................. 4  
2 Our Vision for a transformed CAMHS ............................................................................. 4  
3 A Tier Less Service ......................................................................................................... 5  
4 Approach and general principles .................................................................................... 6  
  4.1 Resilience, capacity building and early support ......................................................... 6  
  4.2 Clinical Leadership ...................................................................................................... 6  
  4.3 Evidence Based Practice .............................................................................................. 6  
  4.4 Single point of access .................................................................................................. 6  
    4.4.1 Quality of referrals ................................................................................................. 7  
  4.5 Self-referrals ................................................................................................................ 7  
  4.6 Support available whilst waiting for first appointment ................................................. 7  
  4.7 Children, young people and their families to be seen in their place of choice ......... 7  
  4.8 Assessment, care planning, discharge and contingency plans .................................... 8  
  4.9 Young People Friendly Service .................................................................................. 8  
  4.10 Working with the whole family .................................................................................. 8  
  4.11 Engagement with children, young people and their families ................................... 9  
5 Outcomes ........................................................................................................................ 9  
  5.1 Outcomes that will be measured .................................................................................. 9  
  5.2 Children and young people’s specific outcomes ......................................................... 9  
  5.1 Waiting times ............................................................................................................... 10  
6 Data collection ................................................................................................................. 10  
7 Delivery partnerships ....................................................................................................... 10  
8 Communication ................................................................................................................ 11  
  8.1 Communication to partners to promote awareness of how to access the service ... 11  
  8.2 Communication to GPs ............................................................................................... 11  
  8.3 Communication with children and young people and their families ..................... 11  
  8.4 Communication with children services ...................................................................... 12  
  8.5 Communication with paediatricians ......................................................................... 12  
  8.6 Communication with schools, colleges ..................................................................... 12  
  8.7 Publication of pathways .............................................................................................. 12  
  8.8 Service offer ................................................................................................................ 13  
9 Collaboration and consultation ....................................................................................... 13
9.1 General principles ........................................................................................................13
9.2 Offer to the Council’s children’s services .................................................................13
9.3 Offer to schools ........................................................................................................13
9.4 Offer to Primary Care and Paediatricians ..................................................................13
9.5 Training offer ...........................................................................................................14

10 Early mental health support .....................................................................................14
10.1 What is it? ..................................................................................................................14
10.2 How will it be delivered ...........................................................................................15
10.2.1 Community based outreach to deliver additional information, advice and consultation ..................................................................................................................15
10.2.2 Through the Single Point of Access (Coping) .....................................................15
10.2.3 Targeted Service (Getting Help) ........................................................................15
10.3 Who is eligible for the targeted Service (Getting Help) .........................................15
10.4 What we expect of universal services before a referral ...........................................16

11 Specialist mental health support (Getting More Help) ..........................................16
11.1 Who is eligible .........................................................................................................16
11.2 Specialisms within CAMHS ..................................................................................17
11.2.1 Eating Disorder Service .....................................................................................17
11.2.2 OSCA and Out of Hours Crisis Team ..................................................................18
11.2.3 Child and Adolescent Harmful Behaviours Service (CAHBS) .........................18
11.2.4 Service for those who have experienced sexual abuse .......................................19
11.2.5 Neuropsychiatry ................................................................................................19
11.2.6 ASD Diagnostic Service and post diagnostic support .......................................19
11.2.7 Specialist Community Mental Health Learning Disability Service (LD/CAMHS) .........................................................................................................................19
11.2.8 Integrated social work service ..........................................................................20
11.2.9 Infant Parent Perinatal Service (IPPS) ...............................................................21
11.2.10 Family Assessment & Safeguarding Service (FASS) .......................................21

12 Vulnerable Groups and tackling health inequalities .................................................21
13 Transitioning to adult services ................................................................................22
14 Workforce skills .......................................................................................................22
14.1 CYP IAPT ..............................................................................................................22
14.2 Treatment/interventions that will be available .....................................................22
15 Integration .................................................................................................................23
| 16 | Role of the Third sector | ................................................................. | 23 |
| 17 | Use of technology | ........................................................................ | 24 |
| 18 | Mental Health Crisis Concordat | ....................................................................... | 24 |
| 19 | SEND Reforms | ........................................................................ | 24 |
| 20 | Evaluation | .......................................................................... | 25 |
| 21 | Appendices | ........................................................................ | 26 |
1 Introduction

The recent review of CAMHS in Oxfordshire and the publication of the national CAMHS Taskforce report “Future in Mind” give us a clear blueprint for the future model of service required. The review concluded that radical change is essential if changing profile of needs are to be met in a way children, young people and families want over the next five years and it was clear that ‘no change is not an option’. Increased capacity is important, but so too is a cultural change to move from a service with thresholds and tiers to a tier less service that addresses needs as they present. The announcement in August of new recurrent investment in CAMHS now provides us with an opportunity to implement the new CAMHS model early and accelerate the implementation and also develop innovative approaches to service delivery over the next few years.

2 Our Vision for a transformed CAMHS

Oxfordshire is a place where every child and young person can achieve their full potential. This commitment is the ‘golden thread’ that binds together our citizens and our services. It is about giving every child the best start in life, keeping them safe through childhood and enabling them to develop into secure and resilient adults and a commitment to promote equality and addressing health inequalities.

We all recognise and value the importance of promoting good mental health and building resilience in children, young people and families. A child’s mental health and wellbeing is everybody’s business so that collective resilience in our communities is seen as our counties strength and is something of which our leaders are proud.

Schools, colleges and early years’ settings (including those in the independent sector) are enabled to develop ‘whole setting’ approach to mental wellbeing. We all recognise the pivotal role universal services play in promoting mental health, building resilience and spotting problems early but we acknowledge that they can’t do this all on their own. We invest time and resources in supporting our universal communities.

Everyone knows where to get help when they need it and is clear about what’s on offer. There is a published offer that is updated annually so that everyone can see what is provided and how taxpayers’ money is spent. The latest developments in digital technology are used to support self-help, self-referral, recovery and independence.
No child or young person should be left without help when they are experiencing mental distress or trauma. Services for children in crisis will be available 24/7. Any child or young person who is in distress will be considered in need of assessment and support quickly. For many this will be same day but we aspire to ensuring that no child is left waiting more than two weeks. Every child will have access to a named ‘supporter’ to help them navigate their way around the system.

Children and young people should keep getting help until they are confident that they are well enough not to need it any more. And if they then feel they need help again within a year, they will be able to refer themselves back into the services using simple online requests.

Every child and young person is treated as an individual, setting their own targets and goals and being able to influence how services develop in the future. There is easy access to information about mental health and mental health problems – if and when people want it. Children and young people are able to develop their own plan with professionals they trust and who take time to get to know them as individuals. Parents are recognised as experts in care of their children and can be offered the tools and resources to promote their own child's recovery and independence.

Everyone who works with children will have the skills, capacity and time to deliver the best care for every child and young person. We have a skill mixed workforce integrated across Oxfordshire with processes and structures in place to encourage joint working, risk management and service development. Our local Voluntary and Community Sector are equal partners in service delivery.

3 A Tier Less Service

A new national model is emerging, named the Thrive Model, which is considered a tier less model. This has been endorsed by the ‘Future in Mind’ report and was also well received by stakeholders during the CAMHs review. It is therefore the intention to replicate the Thrive model in delivering the new CAMHS service (for details of the model see appendix A).

The new CAMHS model will be a departure from the traditional tiered service and will have one single point of access for all the CAMH Services. No family or young person will be turned away and they will be able to access information and advice at a minimum. For those who do not require a CAMHS intervention there will be sign posting to other universal services for support. CAMHS will assist families to access universal services where this is required and CAMHS will develop an active partnership with universal services including third sector to ensure that individuals can access the right services at the right time. For those that require support from
CAMHS they will receive a prompt assessment of their needs and access to appropriate treatment within CAMHS within agreed timescales. Please see Appendix B for a diagram of the model.

4 Approach and general principles

4.1 Resilience, capacity building and early support
The service will use an outward facing and use a collaborative approach, which emphasises capacity and capability building of partner organisations. This is to ensure that children and young people can get support at an early stage before problems become severe and will need the intervention of more specialist services such as CAMHS. The approach will be to offer help early and build on children and young people’s own resilience and encourage self-help techniques where possible and to help give them the skills they need for moving into adulthood. CAMHS will need to undertake a cultural shift from being a diagnostic service to being a service, which can support and offer advice to those who have concerns about children and young people’s emotional and mental health and offer evidenced based interventions.

4.2 Clinical Leadership
The model will be underpinned by clinical leadership. The pathways that are developed and publicised will be clinically led and there will be clinical oversight of the quality of the service. The model will emphasise an approach that encourages continuous improvement and innovation. This will be realised in part by having an annual review of the whole service with clinicians and commissioners to explore areas for improvement and opportunities for innovation.

4.3 Evidence Based Practice
The model will use evidence based interventions supported by National Institute for Health and Care Excellence (NICE), Children and Young People Improving Access to Psychological therapies (CYP IAPT), Social Care Institute for Excellence (SCIE) and emerging research, which has been evaluated as effective. Pathways will be developed which will be evidence based and supported by best practice.

4.4 Single point of access
All referrals for CAMHS services will be triaged at one single point of access (SPA). The referrals will be screened by experienced staff that have the skills and expertise to determine the best service within CAMHS (Early mental health support or more specialist) to deliver an intervention. The SPA will have decision making powers which will mean that once triaged there is an obligation to offer treatment from the teams who have been allocated the referral. Families and young people will be informed that a referral has been received and an appointment time allocated within 10 working days of the service receiving the referral. If an individual is receiving a service from CAMHS and needs to access another service within CAMHS (such as
the Outreach Team), then this will be treated as a transfer and there will not be a need to generate a new internal referral. This is to ensure that the child, young person and their family experience a seamless service and to avoid additional waits in the system that are not accounted for or monitored and to continue to improve access.

4.4.1 Quality of referrals
A minimum standard will be set for information necessary to process a referral. This is to ensure that once a referral is received it can be processed immediately and will not need further information and therefore reducing delays in the child or young person being seen. In primary care referral will be online directly from GP clinical systems. The Single Point of Access will identify where lack of information may be a problem from key referrers and will provide feedback and or training to relevant parties to ensure the quality is sufficient to process the referrals first time. At the launch of the new model the service provider will communicate with key referring agencies on the standard and what information is needed to process referrals swiftly. A referral will however not be turned down on that basis of insufficient information, but work will continue to build capacity in referring agencies to ensure they know what a ‘good’ referral looks like.

4.5 Self-referrals
16 – 17 yr. olds can refer themselves to the service. Families can also self-refer, but this is often best done in collaboration with school/college. It is not necessary to go through a GP to be referred and this message will be proactively communicated to schools through the new strategic partnership with schools.

4.6 Support available whilst waiting for first appointment
Families and individuals will be offered support whilst waiting for the first appointment. A named CAMHS member of staff will make contact with the family or young person and offer support before the first appointment. This support will include information and signposting to local organisations who can provide additional support whilst waiting to be seen and answering questions about CAMHS such as what to expect and when they will be seen. It is expected that the named CAMHS staff will deliver low level interventions as part of care plans and in between appointments with therapist where this is deemed appropriate.

4.7 Children, young people and their families to be seen in their place of choice
Children, young people and their families will be offered a choice of where to be seen, for example at team base, at home, at school, GP surgery or any community based facility where it is deemed safe and age appropriate.

There will be routine options for children, young people and parents/carers to be seen separately or together where requested. This is to enable parents, children and
young people to speak freely and confidentially, which in some instances may be difficult if seen together.

4.8 Assessment, care planning, discharge and contingency plans
The service will adhere to the Care Programme Approach (CPA) and allocate care co-ordinators who will co-ordinate the assessment, care planning, reviews and discharge planning. The CPA co-ordinator will be the main responsible professional who coordinates the delivery of the care plan. The co-ordinator will in conjunction with the named CAMHS staff proactively liaise with families and other agencies to ensure effective delivery of care across agencies.

In line with the Mental Health Crisis Concordat action plan, the service will work with the locally agreed Multi-Agency Risk Assessment Tool and have information sharing protocols in place. There will be a specific contingency plan for each individual as part of their discharge planning which will highlight coping strategies and where to get help. Young people and families can re refer themselves up to one year after discharge and this will not be considered as a new referral, but ongoing work.

4.9 Young People Friendly Service
The service will have an up to date accreditation of the “You are Welcome” criteria to ensure the service is young people friendly. This is the national quality marker for Health Services.

As well as this criterion the service will use an approach of building relationships and getting to know individuals (the therapeutic relationship) in particularly with young people who may find it difficult to engage. Young people tell us that they want to feel listened to and that adults should proactively ask them how they are as they may not offer that information otherwise. Young people tell us that sometimes they are misunderstood and it is important that adults check with them what they mean. Young people would like the CAMHs staff to introduce a ‘get to know me’ session at the beginning of their time with CAMHS so they can better understand the young person and the context of their lives. Young people have told us that they are put off by going straight into therapy sessions that start off focussing on the problems/difficulties the young person is experiencing. Young people value being thought of as whole people and not just a young person with a mental health problem that needs treatment.

4.10 Working with the whole family
The service will work in collaboration with families during assessment, care and discharge planning. This approach is recognising that children and young people do not live in isolation, but within families and that parents in the main have their children’s best interest at heart. The service will ensure that care is effectively co-ordinated between agencies and parents are not left in a position where they have to take this on. This is particularly important in relation to education, training and employment to ensure services are working together effectively to support children
and young people and that care planning is done in conjunction with schools and colleges so children and young people do not lose out on their education, training or employment.

4.11 Engagement with children, young people and their families
The service will ensure that children, young people and their families’ desired outcomes are at the heart of delivering the service. They will be involved in giving feedback and develop the service in conjunction with clinicians. The service will organise regular opportunities for involvement as well as satisfaction surveys.

5 Outcomes
The new CAMHS model will have an emphasis on delivering outcomes rather than a focus on activity. In discussion with young people and parents during the review it was clear that in order to engage young people and families the emphasis has to shift from a ‘one size fits’ all approach to more individualised care planning where individual outcomes are clearly stated and where there is shared ownership of the care plan. Outcomes for children and young people are likely to be different from clinicians’ outcomes and may be framed differently such as: “I want to feel better so I can go to school and see my friends” rather than “I want to feel less depressed”. Outcomes will be used to measure the effectiveness of the service and how well it is responding to individual’s needs.

5.1 Outcomes that will be measured
- More children and young people will recover from mental illness
- More children and young people will access mental health support in a timely manner
- More children and young people will be treated in the community and less will require in-patient treatment
- Less children and young people with mental health problems will lose out on education

Further work is needed on how to measure these outcomes but building on national evidence base they will be comprised of a combination of qualitative and quantitative information.

5.2 Children and young people’s specific outcomes
As part of the Children and Young People’s IAPT approach, clinicians measure ‘treatment room’ outcomes at an individual level. Work is required to standardise measurement so that outcomes can be compared and used to identify where outcomes are being met.
In addition specific outcomes could include:

- Children and young people report that they are part of their own care planning and feel listened to.
- Care Planning and interventions will be outcomes focussed and planned with the young person using CYP IAPT

5.1 Waiting times
The waiting time target that the service will be monitored on, will be the referral to treatment (first appointment) time for those children and young people who require a referral to CAMHS. For a target less than 100% the commissioner would want to know the maximum wait at any one month. This will also be reported. The waiting time targets will monitor:

- % emergency referrals seen in 4hours (and current longest wait)
- % urgent referrals seen in 7 days (and current longest wait)
- % routine referrals seen in 8 weeks (and current longest wait)
- % ASD referrals seen in 8 weeks (and current longest wait)

6 Data collection
The service will implement the CAMHS national minimum data set. The service will as part of the annual review use available data to ensure that the service is reaching out to the entire population including more traditionally excluded groups. It will make use of Locality needs assessments to make the best use of resources and will make links with the school nurse service to identify specific areas of need. The data will be analysed to establish who is accessing the service and action plans will be formulated where gaps are identified.

The service will implement children’s IAPT in the treatment rooms and will use the individual progress measures to evidence the impact the service has on the mental health of the children and young people who receive treatment from CAMHS. This data will when fully implemented be used as an outcomes measure and KPI’s will be set against it.

7 Delivery partnerships
The intention is that the delivery partners such as schools, will be skilled up to support children and young people at the early stage when problems arise and will know when to refer to specialist services (CAMHS) for individual who present with emerging mental health and more severe mental health difficulties.

Where a child or young person is a Looked After Child, the care reviews should as far as possible, incorporate the CPA review and CAMHS review of those not subject to CPA. Where a child or young person has an Education Health and Care Plan then
the care reviews should inform the EHCP annual review. This is to ensure duplication does not take place and care planning across agencies is coordinated for the benefit of the child and young person.

The service will work in close partnerships with the following services:

- Children services
- Education
- GPs
- Paediatricians
- Acute hospitals (incl. A&E)
- Adult MH (including Early Psychosis, IAPT, Complex Needs Service)
- Adult LD
- School Nurses & Health Visitors
- Drug and Alcohol Services
- Youth Offending Service
- Police
- Third sector

**8 Communication**

8.1 **Communication to partners to promote awareness of how to access the service**

The service will develop a strategic communication plan which will include how the service will promote awareness of the service and how to access it. This is to promote on-going communication with partners to ensure they are kept up to date on developments and future plans as necessary. This plan will be shared with commissioners.

8.2 **Communication to GPs**

GPs will receive information when a child or young person is referred into CAMHS including outcome of assessments and treatment plans. GPs will be made aware of who is involved in the care package and receive updates from reviews. They will be made aware of discharge plans and be actively involved in the discharge planning when relevant. This is to ensure that there is a smooth transition back into primary care and that the child or young person is supported as necessary following discharge.

8.3 **Communication with children and young people and their families**

Families and young people will get a letter notifying them that a referral has been received and that an appointment letter will be sent within maximum 10 working days of receiving the referral for routine appointments. Notification of referral will be sent within two working days of receipt. For urgent and emergency referrals telephone
contact will be made on the day of receiving the referral. Families and young people will receive regular communication and copies of assessments, care and discharge plans.

**8.4 Communication with children services**
Where children and young people are known to the Council’s Children’s Services regular communication will take place regarding individual for care planning purposes. Where appropriate and subject to consent, assessments, care and discharge plans will be shared.

**8.5 Communication with paediatricians**
Where children and young people are known to Community Paediatricians regular communication will take place regarding individual for care planning purposes. Where appropriate and subject to consent, assessments, care and discharge plans will be shared.

**8.6 Communication with schools, colleges**
Schools and colleges are an important part in children and young people’s lives and subject to consent, plans will be shared with school staff. School staff will be part of CPA or CAMHS reviews where possible and there will be proactive communication to ensure care plan reflect outcomes around education and attendance at school or college.

**8.7 Publication of pathways**
The service will publicise key pathways and information about how to access the service both routine and in an emergency. The pathways will include how to access:

- Diagnosis of Autism and post diagnostic support
- Self-Harm
- Depression and anxiety
- Eating Disorders
- Psychosis
- Conduct Disorders
- Attachment
- Traumatised children
- Anger management
- LAC and vulnerable children (YOS, fostered/adopted, Edge of Care )
- Support for individuals traumatised by sexual abuse
- Early mental health support for emerging mental health problems
- Children with learning disability and mental health problems

The pathways will be developed with families and delivery partners and will use language which is accessible to families and non-mental health professionals. The pathways will be published and made available to the public and other professionals.
working with children and young people. CAMHS will take an active role in ensuring that delivery partners are aware of the key pathways and how to access them.

8.8 Service offer
The Provider will publicise the service offer. This will include full disclosure of waiting times, referral routes and alternative options for advice and support. The service offer will be proactively marketed to key stakeholders such as GP’s, education, social care and the voluntary sector. The service will develop this in collaboration with young people and families to ensure that the information is accessible and jargon free.

9 Collaboration and consultation

9.1 General principles
The Service will take a strategic lead in supporting universal services to build capacity so they are enabled and confident in supporting children and young people when they first experience mental health difficulties. The aim is for problems to get dealt with early before they become more serious and require a CAMHS intervention. This strategic support will include information, advice, consultation and bespoke training for staff.

9.2 Offer to the Council’s children’s services
In addition to the above, CAMHS will have joint meetings with the Council’s Children’s Services to discuss complex cases, offer advice and supervision of individuals. The two services will have regular contact to discuss who will be best placed to offer an intervention and joint assessment and treatment where appropriate. Discussion will include step up and step down support for individual children/young people where this is deemed appropriate.

9.3 Offer to schools
Schools and colleges will have designated CAMHS link worker that they can contact for information, advice, and consultation and to discuss need for bespoke training for staff. The CAMHS link worker will be the main point of contact where there are issues around communication with CAMHS for individuals. The link workers will ensure good communication is maintained between CAMHS and the schools and colleges. The link worker will deliver services directly into schools where appropriate and will also provide support and consultation to the named school nurse in secondary schools.

9.4 Offer to Primary Care and Paediatricians
GPs and Paediatricians will have a named Psychiatrist who can be contacted either by telephone or email. The Psychiatrist will provide information, advice and consultation on individual cases (risk share). The named Psychiatrist will ensure good communication is maintained between CAMHSs and GPs and Paediatricians. As
well as the named Psychiatrist, GPs and Paediatricians can also use the SPA for a no names consultation.

GPs and Paediatricians will receive notification when a child or young person is referred into CAMHS (when by other agency and subject to consent) as well as outcomes of assessments, treatment and discharge plans and who is involved including new link worker for families.

CAMHS will send a prompt letter if medication has been issued and will provide prescription for the 14 days post discharge. If further prescribing is required the Psychiatrist will inform the GP within 7 days of discharge.

Finally, urgent and emergency referrals will not be reprioritised without discussion with the referring GP or Paediatrician.

9.5 Training offer.
CAMHS will develop a strategic training programme in consultation with their key delivery partners. An analysis of training needs will be developed with key stakeholders and the programme will be refreshed annually. As a minimum this will include

- Young People and mental Health
- Self-harm and anxiety
- Bespoke training as needs develop
- PPEP Care
- Risky behaviours training

10 Early mental health support

10.1 What is it?
The Early mental health support will provide information, advice and consultation to the wider children’s workforce, parents and young people as part of the early mental health support offer.

For those who need a targeted intervention, a range of evidenced based interventions will be offered. These will include, but not limited to:

- Cognitive Behavioural Therapy (CBT)
- CYP IAPT
- Brief Solution focussed Therapy
- Problem solving techniques
- Family work
The length and number of the interventions will be based on an evidenced approach and best practice and will not be limited to a set number of sessions where the clinical indication is that an individual would benefit from further input.

10.2 How will it be delivered
The information, advice and consultation element will in the main be delivered through the SPA. There will be a dedicated telephone line that will be operated by experienced clinicians who have the skills to determine the most appropriate support needed. Responses to enquiries will be dealt with within one working day and emergency enquiries will be dealt with within 4 hours. The use of technology will be employed where possible to enable ease of access. Use of email, Live Chat, and Video conferencing (Face Time, Skype etc.) will be developed in consultation with parents and young people.

For those who require a CAMHS assessment the initial support prior to treatment will include information, advice and support for families and young people whilst they wait for their first appointment via a CAMHS link worker who will work proactively to support the family or young person.

10.2.1 Community based outreach to deliver additional information, advice and consultation
A pilot will be undertaken to evaluate the effectiveness of community based outreach. The Early Mental Health outreach service will offer information, advice and sign posting to third sector providers where appropriate. Individuals accessing an outreach service who are identified as needing more mental health support either through the targeted or specialist service will then not require a new referral, but will be referred by the outreach worker.

The pilot will explore the possibility of using a no names basis and create ID’s which can then be used for ongoing transfer into CAMHS.

10.2.2 Through the Single Point of Access (Coping)
The single point of access will offer information, advice, telephone and email consultation.

10.2.3 Targeted Service (Getting Help)
This service will offer face to face interventions as listed above and the use of technology such as FaceTime and Skyping to make the service more accessible will be explored.

10.3 Who is eligible for the targeted Service (Getting Help)
For children and young people (5-18 year olds) who are experiencing the first signs of mental health, behavioural or emotional concerns and where interventions from schools and Childrens’ Services have not been effective.
- 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 for (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.
- Simple phobias and self-harm – where this is mild to moderate.
- Anger management issues.
- Persistent difficulties in making and maintaining relationships with family and peers, including insecure attachments.
- Parents/carers who would benefit from time limited parenting support to help understand their child’s challenging behaviour including help with routines and boundary setting (this may be delivered in conjunction with Children’s Services).
- Children and young people whose impaired mental wellbeing interferes with their ability to achieve well at school.
- Children and young people reacting to issues of bereavement, trauma and loss.
- Children and young people affected by parental mental ill health.

10.4 What we expect of universal services before a referral
It is expected that evidence based interventions for universal services have been used to support children and young people before a formal referral is made to CAMHS for assessment. There is likely to be a case for some children and young people where CAMHS will need to offer supervision to other professionals to support their needs being addressed by universal services.

It is anticipated that as the offer to schools is implemented there will be very few referrals that CAMHS will not already be aware of or are supporting.

11 Specialist mental health support (Getting More Help)
11.1 Who is eligible
The service will see, assess and treat as appropriate children and young people where there are concerns around the following mental health problems. (0-18):

- Emotional and behavioural disorders (moderate to severe).
- Conduct disorder and oppositional defiant disorder.
- Eating disorders.
- Self-harm.
Suicidal ideation.
Dual diagnosis – including comorbid drug and alcohol use.
Neuropsychiatric conditions.
Attachment disorders.
Post-traumatic stress disorders and trauma.
Significant mental health problems where there is comorbidity with mild/moderate learning disabilities or comorbid physical and mental health problems.
Mood disorders.
Anxiety disorders.
Co-morbid Autistic Spectrum Disorders (aged five and above).
Chronic Fatigue/Somatisation Syndrome.
Obsessive Compulsive Disorder & Tourette’s.
Psychotic illness (Young people with first symptoms of psychosis will be referred to the Early Intervention in Psychosis Service).

11.2 Specialisms within CAMHS
There are some areas in CAMHS where ‘getting more help’ means seeing a more specialist team. In this model this will include:

11.2.1 Eating Disorder Service
Young people with eating disorders currently make up a large proportion of those who are in-patients and they have a disproportionately long length of stay in hospital. It is currently estimated that young people with an Eating Disorder make up about 5% of a CAMHS team caseload but take up around 15-20% of the CAMHS team time. Early intervention in eating disorders has proven effective in terms of health outcomes in the longer term, but young people where intervention is delayed, often experience poorer outcomes and sometimes life-long disorders requiring the support of adult mental health services. Therefore in line with a new emphasis on early intervention and support nationally and in the new CAMHS model the Eating Disorder Service will also be redesigned.

The existing ‘mini’ Eating Disorder Team in CAMHS will expand and a new service model, which will be compliant with NCCM/NHSE Guidelines and national waiting time’s standard, will be implemented.

The key aims of the service will be:

- To provide a comprehensive and accessible eating disorder service offering NICE-concordant assessment and treatment for children, adolescents and their families
- To reduce barriers to early intervention by introducing self-referral alongside training and consultation to primary care services
➢ To reduce the number of admissions/length of inpatient stay and improve clinical outcomes
➢ Improve health outcomes of those with an eating disorder
➢ To aim for more efficient use of outpatient resources (achieved by protected time, adequate resources and training of staff)
➢ To improve links and shared protocols with paediatrics
➢ To develop teaching, research and audit
➢ To work closely with the adult eating disorder service forming a comprehensive service across the age span
➢ To work closely with parents and young people in developing the service

11.2.2 OSCA and Out of Hours Crisis Team
Sometimes a young person needs a different response to their presenting needs. The Assertive and crisis team will operate 24/7, 365 days a week. It will deliver:

➢ Assertive outreach
➢ 24-hour/7-day emergency/crisis assessment and intensive intervention to reduce hospital admissions
➢ In-reach to designated schools and support to LAC and Edge of Care through the Oxfordshire County Council Children’s homes.
➢ Consultation, support and advice to Youth Offending Service and the Kingfisher Team (victims of CSE)
➢ Extended transition support to young people aged 18-24 years.

11.2.3 Child and Adolescent Harmful Behaviours Service (CAHBS)
The CAHB Service is for children and young people who display harmful sexual behaviours. The service will carry out the following tasks:

➢ Specialist assessment, decision & support on appropriate case management
➢ Quality assurance of assessments undertaken in other agencies
➢ Specialist interventions, whole system approach for high risk cases
➢ Supervision/consultation for tier 2 (Getting Help) tier 3 (Getting More Help) case management
➢ Gatekeeper appropriate specialist services
➢ Liaise with other statutory services
11.2.4 Service for those who have experienced sexual abuse
The service will act as a single point of access for all children and young people who have experienced current or historic sexual abuse. The service will carry out the following tasks:

- Specialist assessment
- Decision & support on appropriate case management where cases are held in other agencies
- Quality assurance of assessments undertaken in other agencies
- Specialist interventions, whole system approach for the most complex cases
- Supervision/consultation for tier 2 (Getting Help) tier 3 (Getting More Help) case management
- Training to other agencies to build capacity
- Liaise with other delivery partners to ensure individuals and families get support from the most appropriate agency.
- Support effective transition into adult support services where appropriate

11.2.5 Neuropsychiatry
The Neuropsychiatry service offers a service to children and families providing comprehensive care packages to those children and families with complex Neuropsychiatric difficulties. This is for cases where there is an anticipated primary diagnosis of Autistic Spectrum disorder, Attention Deficit Hyperactivity Disorder or Tourette syndrome associated with secondary mental health or co-morbid psychological difficulties. The service also provides additional expert review through Tier 3 (Getting More Help).

The team will also provide particular expertise in comprehensive assessment and advice on treatment for children with complex epilepsy and psychological difficulties, including non-epileptic psychogenic seizures.

11.2.6 ASD Diagnostic Service and post diagnostic support
This service will coordinate and offer a NICE compliant diagnostic service to both comorbid and non-comorbid 5-18 year olds. The assessment of non-comorbid children will take place in partnership with the community paediatric service. Families will be offered post diagnostic support after the assessment process has been completed to enable them to understand the impact of the condition and to give them tools to equip them to support their child or young person.

11.2.7 Specialist Community Mental Health Learning Disability Service (LD/CAMHS)
The Specialist Mental Health and Learning Disability Service aims to improve early access and mental health interventions/treatment to children and young people with moderate to severe learning disabilities and mental health difficulties:
To provide direct assessments, clinical expertise and evidence based interventions for children and young people with moderate to severe learning disabilities, including those exhibiting sexualised behaviours, conduct disorders and forensic presentations.

To be a specialist resource for consultation and care planning for other health/social care and educational professionals, particularly regarding transition planning to support learning disabled children, young people with a mental health difficulty to remain living in the community.

24 hour cover 7 days per week and crisis intervention to avoid hospital admission where possible.

To provide access to emergency mental health assessments both in and out of hours by an appropriately trained professional.

To facilitate and support designated places of safety for young people with learning disabilities detained for assessment under Sections 135 and 136 of the Mental Health Act 1983.

To provide effective and sustainable transition support from young people to adult services, and a clear viable pathway through services. To contribute to, lead and provide evidence of attendance at Transition Action health action planning meetings, and care planning.

The service will be a specialist service within CAMHS and will be responsible for coordinating the care of all children and young people with a moderate to severe learning disability and mental health problem. Children and young people who access this service should still have full access to other services in CAMHS as appropriate such as family therapy for example and the early mental health support.

11.2.8 Integrated social work service
The integrated social care service will provide social care assessment, interventions and take a lead in managing cases where safeguarding is of concern. Staff members will work to their professional background and deliver a social work service that:

- Works with family members and professional colleagues to alleviate the need for children and young people to become subjects of a child protection plan, or to be looked after by the local authority.

- Participation in Child Protection Conferences, Family Support Conferences and Family Group Conferences and involvement in court proceedings where appropriate. Some of these children will be subjects of a child protection plan, in the initial stages of care proceedings, or accommodated short-term.

- Consultation to CAMHS colleagues regarding safeguarding and parenting (corporate and otherwise) based on up-to-date knowledge of relevant social care policy and research.
11.2.9 Infant Parent Perinatal Service (IPPS)
The multi-disciplinary service will provide specialist assessment and evidenced based treatment to women in the ante and postnatal period who are experiencing mental health difficulties. They will provide training to the universal workforce, will provide consultation to other professional and will provide evidence based interventions for women with mild to moderate perinatal mental health problems.

The IPPS service will also be responsible to liaison with adult mental health and maternity services.

11.2.10 Family Assessment & Safeguarding Service (FASS)
FASS provides a specialist service to families where children are identified as most vulnerable to abuse and neglect.

This is a multi-disciplinary service that provides specialist assessments, and evidence based treatments including parent-infant psychotherapy, family work, consultation and training to Tiers 1 (Coping), 2 (Getting Help) and 3 (Getting More Help), including midwifery, health visiting and specialist CAMHS. It is flexible in its response, assessment and treatment services are adapted to meet the specific needs of the families referred.

12 Vulnerable Groups and tackling health inequalities
The new CAMHS model will have particular emphasis on improving access to our most vulnerable groups of children and young people and to reduce health inequalities. The key groups, (but not limited) to are:

- Black and Minority Ethnic Groups
- Children who are Looked After (LAC) or on the Edge of Care
- Children who have been fostered or adopted
- Children with a learning disability and or ASD
- Young people in the Youth Justice System
- Children who have suffered sexual abuse or sexual exploitation
- Children and young people who Self harm
- Children and young people who have suffered from neglect or trauma

Children who are LAC or on the Edge of care will receive dedicated support through the children’s homes via the virtual therapeutic team consisting of the following multi-disciplinary team:

- Psychiatrist (CAMHS)
- Psychologists (OCC, ATTACH Team)
- Social Workers (OCC)
- CAMHS Mental Health Worker (Assertive Outreach Team)
- LAC and Edge of Care Health Nurses (OH)
Young people who are known to the YOS Team will have mental health support through the assertive outreach team as will the young people known to the Kingfisher Team. They will work in close partnership with the new sexual abuse pathway service and the sexually harmful behaviours service.

For children and young people who self-harm or have suffered neglect or experienced trauma they will be supported through the CAMHS community teams (Getting More Help). This will be evidenced through publication of care pathways.

13 Transitioning to adult services
A good transition into adulthood is considered of key importance within the new model. All young people within the service will have a clear plan for their pending discharge from services back to independence or for their transfer to adult mental health services. This will start at least six months before their 18th birthday (or the end of Year 13 at school). Young people will be assessed to establish who might be suitable for the extended service in the OSCA Service for 18-25 year olds. CAMHS will implement the mental health service transitions for young people SCIE Guide 44 and work with adult service in particular adult mental health, learning disability and social care services to ensure young people have a good experience of transitioning. The service will ensure they are compliant with the requirements set out in the Care Act 2014 and the Children and Family Act 2014

14 Workforce skills
CAMHS will review gaps in their workforce skills required to implement the new CAMHS model and eating disorder service. A training plan will be produced with annual targets and will be reviewed annually to identify any new training needs as they arise. This will be developed alongside the ‘Workforce Tracker’.

14.1 CYP IAPT
IAPT outcomes measures will be implemented across all the services and for those staff who have yet to receive training this will be offered and will be included in the overall CAMHS training plan. As development in CYPIAPT come on stream this will be implemented as appropriate. Outcomes gathered from individual sessions will in time be used for outcomes measures to evidence the effectiveness of the service overall.

14.2 Treatment/interventions that will be available
The following treatment/interventions will be available, but not limited to:

- CYPIAPT
- Family work
- CBT
- Trauma focussed interventions
- Parenting interventions (Conduct Disorders)
- Evidence based Eating Disorder Interventions
- Psychosis and schizophrenia
- Play therapy
- Family therapy
- Problem solving techniques
- Interventions for somatic disorders
- Anger management

15 Integration
In Oxfordshire the proposal is to reshape the Council’s children’s services so that integrated early intervention and social care teams provide support and consultation to universal services through Locality Support Teams. There will also be Family Support Teams providing Family Support and statutory services for children and families requiring intervention.

The new services will be delivered through Children and Family Centres and a network of ‘outreach’ locations. There are clearly opportunities for the new CAMHS model to integrate with Council services. This will happen at three levels:

- Locality and Community Support teams (for single point of access and early help)
- Family Support Teams (for targeted interventions by CAMHS Teams and work around specific vulnerable groups)
- Intensive and Specialist Support for specific groups including Looked After Children and the LD/CAMHS service.

16 Role of the Third sector
There are a number of functions within CAMHS which could be undertaken by third sector organisations such as improving support to families and young people, support following diagnosis, low level interventions for some mental health problems such as anxiety and mild depression and parenting interventions. Families often rate the third sector highly and in particular the fact that families often find them less stigmatising to access. The third sector is often innovative and is quick at adapting service models as needs arise, which can be more difficult for statutory services. The third sector is also well placed to support some of those who will not require a CAMHS intervention and in order for the new CAMHS model to work effectively it will be necessary for CAMHS to develop robust relationships with the third sector for community support (Coping) and to deliver the new CAMHS model in partnership. It is envisaged that a number of third sector organisations will be delivering the new model with the existing provider as the lead contractor to make it flexible, innovative and capitalising on expertise in niche areas that exist within the sector.
17 Use of technology
Throughout the CAMHS review it became clear that to make CAMHS more accessible, responsive and able to cope with some of the new requirements it will be necessary to harness technology. Therefore in the short term it will be necessary to develop web based information portal that can be accessed by families, young people and professionals. This should have jargon free information about how to get support, information about mental health conditions and self-help tools.

In the medium to longer term developments around on-line appointment system for routine appointments, accounts for families where their ‘homework’ is posted and online communication such as Live Chat, Skyping and FaceTime will need to be considered.

New delivery models are emerging known as ‘blended services’ where there is access to face to face support, but also online support if that is what the family or young person wants. Young people and families were very supportive of those new models during the review and felt that it would give them more flexibility and a more personalised service. These new models of delivery will need to be considered and any developments will be co-produced with young people and families.

18 Mental Health Crisis Concordat
The Mental Health Crisis Concordat is a new strategically important direction of travel. The new CAMHS model will deliver support to children and young people in a mental health crisis and be committed to deliver against the local plan. This includes an awareness of the Crisis Concordat throughout the services irrespective of whether access is through the ‘Getting Help’ offer or ‘Getting More Help’ offer. Key emphases is on delivering care in the right place at the right time and thereby avoid unnecessary hospital admissions and reduce the number of young people who may become subject to s.136.

In order to deliver this the Crisis Team will work in close partnership with the Street Triage Service and the new Liaison and Diversion Team. All children and young people who are getting support from the specialist CAMHS (Getting More Help) will have a contingency plan which will state how to access support in a crisis and individualised self-help techniques to cope if a crisis occurs.

19 SEND Reforms
The Children and Families Act 2014 requires health providers to work with a new framework of assessment based on the single plan (Education, Health and Care Plan). The new CAMHs model will take into account the requirements under this legislation and will develop robust processes for delivering those requirements in partnership with the Local Authority. It will ensure that assessments and reports are produced in a timely manner in order that the EHC plan can be developed with
families and young people and speedy access to services is provided. Where young people are transitioning joint planning will take place with adult services to ensure a seamless transitioning to adult support where relevant.

20 Evaluation
It is expected that the service will build in evaluation of the key elements of the new model. The service will also use evaluation from other areas to inform the delivery of the new service.
Appendices

Appendix A

Coping

Context: There is an increased interest in the promotion of resilience, to build the ability of a community (school/family) to prevent, support and intervene successfully in mental health issues. Initiatives such as Headstart (£75 million funded by Big Lottery), the Penn Resilience programme and others seek to help young people and families to help themselves. A proliferation of digitally based support (e.g. via email, phone and web) is becoming increasingly available and being used to support young people in their communities. There is increasing academic interest (e.g. community psychology) on how we can more effectively draw on strengths in families, schools and wider communities. School-based interventions have been shown to support mental health(15) peer support can promote effective parenting(16) and integration of mental health in paediatric primary care can support community resilience(17). The wider government policy can impact positively or negatively on the emotional well-being of the child within the family – the government initiative to have a Family Impact Assessment of all government policy is welcomed if it proves effective.

Data: Analysis of CAMHS data as part of the development of payment systems clusters suggests that many (indeed the modal number) of young people and parents attending CAMHS attend only once, with many being seen for less than three contacts. Data would indicate that the majority of these leave the service through mutual agreement between the provider and young person or family members. Whilst it is not possible to determine from existing data whether the majority of these leave satisfied, nor how many are referred elsewhere, practitioner reports at least a proportion of this group find relatively few contacts, even one single
contact, enough to normalise their behaviour, reassure families that they are doing the right things to resolve the problem without the need for extra help and to signpost sources of support.

Resource: The payment systems project group are currently suggesting this group might be the first (likely cheapest) of three clusters for payment system (see below for other clusters)(18).

Need: Within this grouping would be children, young people and families adjusting to life circumstances, with mild or temporary difficulties, where the best intervention is within the community with the possible addition of self-support. This group may also include those with chronic, fluctuating or ongoing severe difficulties, for which they are choosing to manage their own health and/or are on the road to recovery.

Provision: The THRIVE model of provision would suggest that wherever possible, this provision should be provided within education or community settings, with education often (though not always) the lead provider and educational language (a language of wellness) as the key language used. It is our contention that health input in this group should involve some of our most experienced workforce, to provide experience and decision making about how best to help people in this group and to help determine whose needs can be met by this approach.

Getting Help

Context: There is increasingly sophisticated evidence for what works with whom in what circumstances(11) and increasing agreement on how service providers can implement such approaches(19) alongside embedding shared decision making to support patient preference(20) and the use of rigorous monitoring of outcomes to guide treatment choices(21). The latest evidence suggests that only 33% of young people will be “recovered” at the end of even the best evidence-based treatments.

Data: Analysis of CAMHS data for payment systems has found that the majority of children and young people seen in CAMHS are seen for less than twelve face-to-face meetings, whether in schools, clinics or the community.

Resource: The payment systems project group are currently suggesting this group might be the second (middle costing) of three clusters for payment system (see below and above for other clusters).

Need: This grouping comprises those children, young people and families who would benefit from focussed, evidence-based treatment, with clear aims, and criteria for assessing whether aims have been achieved. This grouping would include children and young people with difficulties that fell within the remit of National Institute for Health and Care Excellence (NICE) guidance and where there are interventions that might help. 9
**Provision:** The THRIVE model of provision would suggest that, wherever possible, provision for this group should be provided with health as the lead provider and using a health language (a language of treatment and health outcomes). It is our contention that health input in this group might draw on specialised technicians in different treatments. The most radical element of what we are suggesting is that treatment would involve explicit agreement at the outset as to what a successful outcome would look like, how likely this was to occur by a specific date, and what would happen if this was not achieved in a reasonable timeframe.

**Getting more help**

**Context:** There is emerging consensus that some conditions are likely to require extensive or intensive treatment for young people to benefit. In particular, young people with psychosis, eating disorders and emerging personality disorders are likely to require significant input. Data: Analysis of CAMHS data for payment systems found that only a very small percentage of children seen in CAMHS receive more than 12 contacts with a large variation in amount of resource use within this group. Resource: The payment systems group are currently suggesting this group might be the final (most expensive) of three clusters for payment system (see above for other clusters). It is recognised that, for some of these young people, individual agreements with commissioners will be needed to arrange payment as the range of costs within this group are so wide.

**Need:** This grouping comprises those young people and families who would benefit from extensive long-term treatment which may include inpatient care, but may also include extensive outpatient provision.

**Provision:** The THRIVE model of provision would suggest that wherever possible, provision for this group should be provided with health as the lead provider and using a health language (that is a language of treatment and health outcomes). It is our contention that health input in this group should involve specialised health workers in different treatment.

**Getting risk support**

**Context:** This is perhaps the most contentious aspect of the THRIVE model and has certainly been the need/choice group we have found it hardest to agree a simple heading for. We posit that even the best interventions are limited in effectiveness. As noted above, a substantial minority of children and young people do not improve, even with the best practice currently available in the world(22). There has, perhaps, in the past been a belief (strongly held by service providers themselves) that everyone must be helped by a service and if they are not then that is an unacceptable failure. The THRIVE model suggests that there be an explicit recognition of the needs of children, young people and families where there is no current health treatment available, but they remain at risk to themselves or others.
Data: On current data sources available it is not possible to disaggregate this group from the three other groups within the THRIVE model, which are proposed to be used for future payment systems. It is likely that many, though not all, of this group will be subsumed within the getting more help group above (the most costly grouping for payment). Resource: Practitioner report suggests this group may require significant input; they certainly take up a lot of energy in terms of discussions within and between services. Some services report currently distinguishing members of this group as a group of children, young people and families who may be termed “not ready” for treatment, or in need of ongoing monitoring. It may be that many are currently being offered intensive treatment for which they are failing to attend appointments or making no progress in terms of agreed outcomes. It is suggested that over time this group may be disaggregated as a distinct grouping for payment systems.

Need: This grouping comprises those children, young people and families who are currently unable to benefit from evidence-based treatment but remain a significant concern and risk. This group might include children, young people who routinely go into crisis but are not able to make use of help offered, or where help offered has not been able to make a difference, who self-harm or who have emerging personality disorders or ongoing issues that have not yet responded to treatment.

Provision: The THRIVE model of provision would suggest that, for this group, there needs to be close interagency collaboration (using approaches such as those recommended by AMBIT to allow common language and approaches between agencies) and clarity as to who is leading. Social care may often be the lead agency and the language of social care (risk and support) is likely to be dominant. Health input should be from staff trained to work with this group and skilled in shared thinking with colleagues in social care, but with explicit understanding that it is not a health treatment that is being offered.

Thriving

This is the state we are all seeking to achieve! Services are and should be helping with prevention, promotion, awareness raising work in the community to support this and may involve consultation and training that is not focussed on particular children or families. It is likely that such work will need to be funded separately from any payment system based on per-head payments as these are community-focussed and public health-focussed interventions.

For full description of model see
Appendix B

New Oxfordshire CAMHS Model