

DRAFT PAPER

VISION OF A TIER 2/3 (CLINIC) CAFMHS : CONSENSUS STATEMENT

Distillate of Presentations and Discussion at the Wessex Child and Adolescent Psychiatrists Meeting Wednesday, 11 February 2004

This is an attempt to summarise areas of agreement at this meeting. It had been thought a good idea to try to develop, as far as we can, a shared vision of what Tier 2/3 CAFMHS should look like. The opinion of a reasonable peer group could then be presented as evidence in our efforts to develop CAFMHS locally. Taking the law into our own hands has been prompted by lack of guidance so far from the College.

We shared a vision of a comprehensive CAFMHS composed of the various Tiers (or Concentric Circles depending on how one wishes to visualise it). It is clear that for any one tier to function effectively the other Tiers need also to be adequately resourced and functioning well.

We made a distinction between Core (Specialist) CAFMHS and General (Comprehensive) CAFMHS. Although concentrating the discussion on Specialist Tier 2/3 CAFMHS, we recognised the large amount of overlap with other Tiers in everyday practice.

We did not go into the philosophy of what we aspire to do and kept the discussion pragmatic. Our attempt to summarise it follows.

What should Specialist (Tier 2/3) CAFMHS do:

- (i)** Assessment/treatment/management of more severe/complex mental health problems in youngsters. The key component of specialist CAFMHS is a highly skilled multidisciplinary team approach.
- (ii)** Providing consultation, supervision, liaison, and training to professionals in comprehensive CAFMHS (particularly Tier 1).
- (iii)** Provide crisis response / on call.
- (iv)** Act as a repository of up-to-date knowledge re CAMH issues including availability of services in other tiers, (e.g. Relate, Connexions etc.)

It is recognised that the consultation/liason/training role of CAFMHS is increasing and will go on doing so as comprehensive CAFMHS is developed in line with Government policy.

How should Specialist CAFMHS Operate:

- The expectation is CAFMHS will cover the 0–18 age range. Services currently catering for 0-16 will need extra resources. However, an expansion of infant psychiatry will also need adequate provision.
- A system is needed to prioritise referrals and sign post inappropriate referrals to other services and provide advice to referrers.
- The service takes referrals from a wide range of referrers in the other tiers. A single point of entry has advantages such as a standard referral form and discussion of all referrals in a multi-disciplinary team meeting. Other systems though for prioritising and allocating referrals are in operation but we had little time to discuss and compare the merits of these.
- For referrals taken on, a useful way of categorising them is
 - (a) Referrals needing consultant (medical) input
 - (b) Generic team referrals, i.e. those cases that can be held by any team member
 - (c) Referrals requiring specialist therapeutic approaches, such as family therapy, cognitive therapy, individual psychodynamic psychotherapy etc.
- A Tier 2/3 CAFMHS should be able to offer specialised approaches to eating disorders, other psychosomatic problems (e.g. somatisation, chronic fatigue), ADHD, early onset psychosis, Autistic Spectrum disorders and difficult to engage families. All these areas will involve joint working with other professionals/agencies and joint clinics (e.g. with paediatrics) may usefully be set up. There needs to be appropriate backup from Tier 4/5 Services but, in the main, it is expected that these specialist areas will be covered at Tier 2/3 level. The drawbacks of setting up separate services to cater for these areas (as has happened with the creation of early on-set psychosis teams in Adult Psychiatry) were mentioned, including the de-skilling of existing CAMH teams.

Better links with Adult Mental Health Services will need to be created as the impact of adult mental illness on children and its relationship to family dysfunction is at last coming to be recognised in adult services. Improved liaison will also facilitate sensitive handover from CAMHS to AMH.

- Therapists need time to employ creative ways to engage difficult to reach families.
- The operation of a Self-harm Assessment/Intervention Rota provided by therapists with back-up from consultant psychiatrists.

- We reached no clear conclusions about the optimal population size for a given clinic resource. However, the current Royal College guidelines are that for a total population of 100,000 there should be as a minimum 1.5 full-time Child and Adolescent Psychiatrists. We did acknowledge work being attempted in a number of ways to ascertain the reasonable level of resources a clinic should have to service a particular population.
- The catchment area for the Clinic should, as far as possible, coincide with Local Authority/Education boundaries so effective networking can occur.
- The emphasis is on joined up working with other agencies. Thus clinics need to put a lot of effort into developing links with all the agencies in comprehensive CAFMHS and time needs to be allocated for this.
- The idea of forming individualised helping networks around particular cases was described. Also therapists in the team could be responsible for taking on a particular patch and building up a network of local people to provide intervention. Thus the therapist might act as a care coordinator.
- The interface between Tier 2/3 CAFMHS and Learning Disabilities and Addiction Services need clarifying and protocols for joint working developed.

Size and Composition of the Team:

- The emphasis should be on skills rather than professional background.
- The evidence is that child and adolescent mental health problems often require tackling by a range of approaches in concert, catering for biological, psychological and social factors. Also treatments are not given “pure”, e.g. a lot of cognitive therapy goes on under the umbrella of Family/Systematic Therapy and medication may be prescribed systemically. Therapy often needs to be provided in a creative way rather than according to a cookbook. Thus a clinic needs to provide a range of approaches and requires enough of:

Networking Skills.

Family/Systemic Therapy.

Individual Brief Therapy (including cognitive and solution focused approaches).

Longer-term Psychodynamic Individual Therapy.

Group Therapies.

Creative Approaches (art/drama/play/therapy).

Medication.

In addition, paediatric liaison nurses as part of CAMHS are needed to provide input to eating disorders and other psychosomatic situations.

It is difficult to be prescriptive re the precise number of therapists required for a given catchment area as this would depend on local circumstances, including referral patterns and what is provided in other agencies, (e.g. Relate). However, each clinic needs to provide the full range of the above therapies plus time for all the non-direct clinical contact activities, such as consultation, liaison, supervision, training etc. Staff need time to manage cases well and the issue of capacity still needs to be more precisely addressed.

- There is an optimal size for a team and we briefly entertained the idea that “small is beautiful”. One way of achieving this is to have as many full-time workers as possible to achieve the critical mass size.
- The value of nurse therapists was emphasised in terms of their flexibility, versatility and willingness to help with crises.
- The Tier 2/3 clinic needs an appropriate physical base. We did not have time for discussion as to where this should be sited. A hub and spoke model, i.e. a central base with various satellite clinics radiating out from it, is a useful concept. It is important to emphasise the need for an adequate base in the face of the pressure to be out working in the “community” (wherever this is!). The more therapists do home visits and work on their own, the greater is the need for a secure team to support them. The base provides the setting in which a robust team can develop and provide the multi-disciplinary input which is the hallmark of Specialist CAFMHS.

Areas worthy of further discussion :

- ❖ Role and responsibilities of consultants.
- ❖ The vexed area of conduct disorder.
- ❖ Interface of CAFMHS with addictions and learning disabilities services.
- ❖ Developing better links and joint working with adult services.
- ❖ Role of CAMHS containing anxiety within the professional network.

PH/JL

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