

Community Forensic Child and Adolescent Mental Health Services (FCAMHS): a map of current national provision and a proposed service model for the future.

Final Report for the Department of Health

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Executive Summary

This report addresses a series of specific questions in relation to community FCAMHS provision. These include the need for:

- an outline of the needs addressed by such services
- a national overview of existing dedicated FCAMHS community provision and commissioning arrangements
- an outline of proposals for core functions and models of service provision

Part 1 of the report addresses issues of mental health and other need in relation to high risk young people. It also describes the heterogeneity of commissioning arrangements for child and adolescent mental health services and the challenges that this has posed for service development in areas such as community FCAMHS.

Part 2 describes a national mapping exercise of existing provision for ‘any services offering a dedicated service to young people about whom there are mental health concerns who present a high risk of harm to others and/or are in contact with the youth justice system’.

Part 3 describes a validated service model and service standards for community FCAMHS

The appendices contain a variety of documents which relate to the various aspects of this report.

Results

Mental health provision for young people about whom there are mental health concerns who present a high risk of harm to others and/or are in contact with the youth justice system is heterogeneous and patchy in terms of existing national provision. A small number of areas benefit from specialist community FCAMHS provision whilst many others do not. There is now a clear body of evidence relating to validated service models and functions for community FCAMHS.

Recommendations

Action is needed to address gaps in provision and to ensure that children and young people with complex forensic mental health needs have access to appropriate community based services in addition to the existing network of medium secure in-patient units, local tier 3 CAMHS and other therapeutic services. There should be agreed national minimum standards for community FCAMH services and a standard commissioning framework to provide a level of national consistency in provision.

Part 1: Background

Introduction

Forensic child and adolescent mental health (FCAMH) services are concerned with the mental health assessment and treatment of young people aged under 18 who present with high risk of harm to others in a variety of settings or who are in contact with the youth justice system. A network of seven medium secure in-patient services has been nationally commissioned for several years, currently by the National Specialist Commissioning Team (NSCT). However, commissioning arrangements for community-based FCAMH services vary considerably across the country. The development of community-based FCAMH services has been largely ad hoc and different parts of the country have been thought to have varying levels and types of provision.

The Department of Health (DH) recognises that there is no nationally agreed set of core functions specifying the services that community FCAMH should provide, nor any agreed national standards against which such FCAMH services can be assessed.

The precise future commissioning arrangements for community FCAMH services are currently unclear, but as the transition of specialised services commissioning into the NHS Commissioning Board proceeds, the Department of Health wishes to be able to provide a recommended set of functions and service standards to inform the commissioning of comprehensive and high quality community FCAMH services.

Consequently, the Department of Health has engaged Solutions for Public Health (SPH)¹ to provide:

- an outline of the needs addressed by such services
- a national overview of existing dedicated FCAMHS community provision and commissioning arrangements
- an outline of proposals for core functions and models of service provision

This project has been undertaken in collaboration with Thames Valley Regional Community FCAMHS. This service has developed over the last eight years and has been in receipt of DH funding: i) in support of its regional development brief, and ii) in support of a pilot service replication for Hampshire and the Isle of Wight. DH funded external evaluations^{2 3} of these two services have led to recurrent regional specialist commissioning for both.

Clarification about Terminology Used in this Report

This report uses the term ‘high risk young people’ to denote young people about whom there are concerns in terms of risk of harm to others and who may or may not be in contact with the youth justice system (YOTs, courts, custodial settings). The authors acknowledge that the term in other circumstances is used denote young people who also are at risk of self-harm, exploitation or are vulnerable in others ways.

¹ SPH is a not-profit-making organization of public health professionals working within the NHS with wide experience of service evaluations at local, regional and national levels.

² Public health Resource Unit: The Provision of Forensic Child and Adolescent Mental Health Services in the Thames Valley, 2006

³ Solutions in Public Health: Evaluation Of a Pilot community Child and Adolescent Forensic Mental Health Service (FCAMHS) for Hampshire and the Isle of Wight, 2009.

About Community FCAMH Services

A community forensic CAMHS might broadly be defined as a service designed for:

- *young people about whom there are questions regarding mental health or learning disability:*
 - *who present high risk of harm towards others in a variety of settings and about whom there is major family or professional concern*
 - *and/or who are in contact with the youth justice system*

Community FCAMH services typically offer a range of services including clinical consultation and specialist assessment and interventions for young people with very complex needs across a variety of community, residential, secure and custodial settings. In addition to their clinical role, these specialist services are expected to undertake a range of strategic, service development and training functions. Some of these services have emerged as an integral part of CAMH provision where they undertake a range of specialist functions at a regional level and supplement rather than duplicate local CAMHS provision.

A range of other mental health and therapeutic services provide more circumscribed input for high risk young people. This input includes Tier 3 CAMHS liaison input to Youth Offending Teams, (YOTs) and children's social care, services offering intensive family interventions (such as multi-systemic therapy and treatment foster care) as well as a range of therapeutic provision within residential and educational settings for young people. Of course, these young people may also engage with local CAMHS teams within the context of their generic provision.

Epidemiology

It is well documented that a high proportion of young people in contact with the youth justice system (whether in community or custodial settings) have a higher risk of mental health problems, learning disability, learning difficulty, speech, language and communication problems, substance misuse, physical ill-health, and sexual health problems, than their non-offending peers.

A summary of the major health issues for young people in contact with the youth justice system (YJS) in Healthy Children, Safer Communities (2009)⁴, for which the evidence of needs was updated in 2012⁵, is as follows:

- Over three quarters
 - have a history of temporary or permanent school exclusion (custody)
 - have serious difficulties with literacy & numeracy (custody)
- Over half
 - have difficulties with speech, language and communications (custody)
 - have problems with peer and family relationships (community & custody)
 - of young people who commit an offence have been a victim of crime – twice the rate for non-offenders
- Over a third
 - have a diagnosed mental health disorder (custody)
 - of those accessing substance misuse services are from the YJS (community and custody)
 - have been looked after (custody)

⁴ Department of Health. Healthy Children, Safer Communities – A strategy to promote the health and well-being of children and young people in contact with the youth justice system. DH, London, 2009.

⁵ Ryan M, Tunnard J. Evidence about the health and well-being needs of children and young people in contact with the youth justice system. DH, London, 2012.

- have experienced homelessness (custody)
- Over a quarter
 - of young men in custody (and a third of young women) report a long-standing physical complaint
 - have a learning disability (community and custody)
- A high proportion
 - of children from black and minority ethnic (BME) groups, compared with others, have post-traumatic stress disorder (community and custody)
 - have experienced bereavement and loss through death and family breakdown (community and custody)

A number of studies have contributed to this picture. One frequently cited study⁶, conducted in 2005, carried out a comprehensive standardised assessment of the needs of young people who offend in custody and in the community, in six different geographical areas across England and Wales. A total of 301 young people who offend were interviewed, aged between 13 and 18 years, of whom 151 were in secure facilities and 150 in the community. The main findings were that:

- almost a third of young people who offend had a mental health need – around 20% of this group had problems with depression, 10% reported self-harm within the last month, and 5% had psychotic-like symptoms.
- 29% had risky behaviour (e.g. drug or alcohol abuse), 36% had educational or work needs, 35% had needs relating to violence to people and property, and almost half had significant needs relating to peer and family relationships.
- almost a quarter had learning difficulties (IQ<70), a further third had borderline learning difficulties (IQ 70-80), although a lack of educational opportunities may have been a contributory factor.
- there was no significant difference between young people who offend in secure facilities and those in the community in terms of the level of mental health problems experienced. Although young people who offend in the community had significantly more needs than those in secure settings in terms of education, risky behaviours (perhaps due to higher exposure to risks in the community e.g. alcohol, drugs and sexual activity) and social relationships.

The children in secure settings were followed up 9 months later⁷ and were found to have increased needs, particularly around drugs and alcohol. Mental health need was not significantly different at follow up, with 27% showing symptoms of depression, 13% anxiety and 7% self harm.

Another study which examined the mental health needs of boys (age 12-17) in secure settings and how need changed over time also found high rates of psychiatric morbidity.⁸ Prior to admission over 50% misused drugs or alcohol and over 33% were found to be depressed. There were improvements to substance misuse after admission but, for mental health, particularly depression and anxiety, levels remained high and even developed after admission. The most prevalent psychiatric disorders were conduct disorder (91%); major depression (22%) and generalised anxiety disorder (17%), although conduct disorder had completely disappeared after 3 months.

⁶ Chitsabesan P, Kroll L, Bailey S et al. Mental health needs of young offenders in custody and the community. *British Journal of Psychiatry* 2006; 188: 534-540.

⁷ Harrington R, Bailey S, Chitsabesan P et al. Mental health needs and effectiveness of provision for young offenders in custody and the community. Youth Justice Board for England and Wales. London, 2005.

⁸ Kroll L, Rothwell J, Bradley D et al. Mental health needs of boys in secure care for serious or persistent offending: a prospective, longitudinal study. *Lancet* 2002; 359: 1975-9.

Similar results have been found in other studies – one such study⁹ carried out by the Office for National Statistics (ONS) reported on young people in custody aged between 16 and 21. This involved a clinical interview with 632 offenders from all prison establishments, and included male remand, male sentenced and female prisoners. The main findings were:

- the prevalence rates of any functional psychosis in the previous year was 10% for male sentenced, 8% for male remand and 9% for female offenders.
- a high proportion had evidence of several mental disorders – at least 95% of the young people who offend included in the study were assessed as having at least one disorder, and about 80% as having more than one.
- for both boys and girls – 60% used drugs and 25% drank heavily.
- antisocial personality disorder was found in 80%, and paranoid personality disorder in 25%.
- the sample had a lower IQ than the general population.

An American study looked at the prevalence of common mental health disorders in adolescents in the community and of adolescent young people who offend¹⁰. Table 1 illustrates the high prevalence of mental disorders in the latter group compared to the general population.

In addition to the epidemiological evidence cited above, clinical experience of all agencies working with this high risk group of young people is that, not only are they subject to a wide range of psychosocial stressors at any one time, they are also highly mobile both geographically and in terms of their transitions between different groups of professionals. They are subject to frequent moves which may involve placements or custodial settings many miles from home. Furthermore, they are subject either simultaneously or at different times to a range of different welfare (Children Act 1989 and 2004), mental health (Mental Health Act 1983, as amended 2007, Mental Capacity Act 2005) and justice legislation (Crime and Disorder Act 1998).

Table 1. Prevalence of mental disorders in adolescents

Mental disorder	Adolescents in the community (%)	Adolescents who offend, in community and custodial settings (%)
Conduct disorder	2-10	41-90
Attention deficit disorder	2-10	19-46
Substance misuse/dependence	2-5	19-46
Intellectual and developmental disability	1-3	7-15
Other learning difficulties	2-10	17-53
Mood disorders	2-8	19-78
Anxiety disorders	3-13	6-41
PTSD	1-3	32
Psychosis and autism	0.2-2	1-6
Any disorder	18-22	80

A more recent needs assessment exercise based on a review of 100 ASSET documents held by the Surrey Youth Justice Service over the period March to September 2010, showed that this group of

⁹ Lader S, Singleton N, Meltzer H. Psychiatric morbidity among young offenders in England and Wales. Office for National Statistics. London: 2000.

¹⁰ Kazdin AE. Adolescent development, mental disorders and decision making of delinquent youths. In Grisso T, Schwartz RG (eds), Youth on Trial: A Developmental Perspective on Juvenile Justice. Chicago: University of Chicago Press, 2000, vol. 2, pp. 33-64.

young people experience high levels of health needs as well as deprivation and social problems¹¹. Below are some key findings:

- 75% of young people were currently using or had used drugs in the past
- only 14% of young people said they didn't drink alcohol
- 65% of drinkers were binge drinking at least monthly, and 11% were bingeing daily
- up to 84% of young people smoked, and at least half wanted to give up
- 75% of young people's daily functioning was 'significantly affected by emotions or thoughts'
- over half the young people said they had lost someone special
- 31% had suffered from abuse
- 18% had thought about killing themselves
- 80% of young people were not living with both parents, and 35% had lived with two or more different carers in the last 6 months, were currently looked after children or had been in the past
- 89% had at least one family or relationship problem
- 25% were living with known offenders
- 66% were not in mainstream school or college and 57% had no qualifications.

Of the questions specifically related to physical health, 8% of young people were noted as having a health condition which 'significantly affects everyday life functioning', 13% put their health at risk through own behaviour and 26% had 'other problems' related to health. Further investigation of the data, including qualitative comments, indicated that 23% of the sample had a physical health problem of some kind, for example asthma or diabetes. 54% of young people were involved in risky behaviours including drug use, unsafe sex and prostitution. When smoking, binge drinking and living on the streets were included, 81% of young people were engaged in 'risky behaviours'.

A needs assessment project conducted in London in 2010 looked at young people with problems beyond the expertise and resources of borough-based Tier 3 clinicians and Youth Offending Team Health Workers.¹² Key findings from this research were summarised as follows:

- the young people concerned – along with their families and the community in which they live –are vulnerable. They are a risk to themselves, their family and the community.
- the young people concerned have multiple presenting problems. About a third are female. They are likely to be looked after or come from chaotic families and families where the father is absent. Many are not in education, training or employment (NEET), have substance misuse problems and/or belong to a gang.
- the young people concerned have the potential for, or are already exhibiting, extreme violence to themselves and others, with extreme emotional or behaviour disorder.
- from a service point of view, the poor attendance and chaotic lifestyles of these young people and their families require outreach rather than clinic-based work. Currently there are insufficient outreach services capable of managing such a high level of risk in the community.
- a multi-system response is needed to deal with these complex cases, but there is little strategic planning and a lack of clarity about strategic responsibility for this challenging cohort of young people.

¹¹ Daniells E. Surrey Youth Justice Service Health Needs Assessment. Surrey Youth Justice Service and NHS Surrey. March 2011.

¹² Health in Justice LLP. Health needs assessment of young people in London with complex emotional, behavioural and mental health problems who are or may be at risk of committing a serious crime' by Health in Justice .Youth Justice Board and NHS Commissioning Support for London. London, September 2010.

Arrangements for Commissioning Within the NHS

Traditional General Arrangements

At the time that this study was commissioned (Autumn 2011), arrangements for commissioning within the NHS were organised in a hierarchical way depending on the prevalence of the health problem being addressed and the complexity of input required from services. Thus, local commissioning via individual primary care trusts (PCTs) was responsible for generic health services including primary and secondary care at a local level, regional specialised commissioning (i.e. at Strategic Health Authority (SHA level)) was responsible for ensuring that more specialist services were available at regional centres, and national specialist commissioning was responsible for ensuring that highly specialist services were available at national centres or were at least nationally coordinated. An example of services for children commissioned at a local level would include general and community paediatrics, at a regional level paediatric cardiology and neurology and at national level services for craniofacial surgery and some aspects of neurofibromatosis.

In children's mental health, commissioning arrangements have not been as clearly delineated as elsewhere and there has been some lack of clarity in some areas in terms of the commissioning of local and regional services. In general, regional commissioning has not been universally employed for the commissioning of regional specialist CAMH services (such as in-patient units and a range of other 'Tier 4' services throughout England); there are, however, some examples of in-patient services and other services (including regional community FCAMHS in some areas) commissioned in this way. National commissioning has operated in children's mental health to fund highly specialist services such as a national adolescent forensic in-patient service and a national CAMH service for deaf children.

A Note About 'Spot Purchasing'

A number of services operating within or outside the NHS in the UK are either not fully commissioned, or are not commissioned at all by the local/regional/national model outlined above. Such services supplement their commissioned services or are completely funded by 'spot purchasing' arrangements. Spot purchasing is used generally for funding on a case by case basis by local commissioners in areas where there is a lack of specialist opinion and input available. Services operating to fund themselves by spot purchasing are typically specialist and often promote themselves as 'national' services in the sense that they will undertake funded work wherever they are asked to do so; they are not, however, nationally commissioned.

Advantages of spot purchasing arrangements are that specialist opinion can be sought in cases requiring specialist input not otherwise available from a commissioned service. Disadvantages of spot purchasing are as follows:

- it is usually expensive
- it is usually commissioned from practitioners/services not familiar with the child's local area and extent of services available
- it may be provided by services which are geographically remote and which may not be in a position to provide concerted follow-up in highly complex cases
- it creates a potential perverse incentive for the provision of over-detailed assessment reports and recommendations because these are the agreed end points of funding arrangements
- it provides a financial (because it is expensive) and motivational disincentive for the development of local specialist provision in areas where it has traditionally been absent.

Changes in NHS Commissioning Arrangements

At present the commissioning landscape within the NHS is undergoing enormous change. However, the basic principles of local and more specialised commissioning at a regional/national level are being retained.

PART 2: Mapping of Community Provision for High Risk Young People about Whom There are Mental Health Concerns

Introduction

At the time that we undertook this study it was known that there are a range of settings in which young people with high risk behaviours (risk to others) about whom there are mental health concerns might be found. These include:

- community settings (whether living with parents or family, in foster care, in residential placements, special educational settings, in-patient mental health units or elsewhere)
- secure settings (secure children's homes (SCH), Secure Training Centres (STCs), Young Offender Institutions (YOIs), secure mental health units)

Furthermore, placements for high risk young people, whether secure or otherwise, are frequently located away from their home area and beyond the geographical remit of local health services. In addition, such young people are frequently subject to a range of complex legislation (Children Act 1989 and 2004, Mental Health Act 1983, amended 2007, Mental Capacity Act 2005, amended 2007, Crime and Disorder Act 1998, Criminal Justice and Immigration Act 2008, Education Act 2011) often simultaneously, and it is difficult for professionals in any one discipline to maintain an overview and understand such complexity for the benefit of the child concerned.

In this study we sought to ascertain the geographical coverage, service functions and commissioning arrangements for services which considered themselves to be catering for the needs of young people with high risk behaviours (risk to others) about whom there are mental health concerns.

Methodology

SPH developed an initial list of mental health/therapeutic services in the UK known to work in some way, with high risk young people in the community and other settings. This list was based on the published literature and existing knowledge.

This initial list was circulated to the Royal College of Psychiatrists (Adolescent Forensic Special Interest Group), the British Psychological Society and to the members of the Adolescent Forensic Professional Network. Members of these organisations were invited to add contact details for any further services of which they were aware. The remit for inclusion at this juncture was deliberately broad and invited responses from or information about, 'any services offering a dedicated service to young people about whom there are mental health concerns who present a high risk of harm to others and/or are in contact with the youth justice system'.

In total, some 55 services from across the UK were identified by this process. All of these services, regardless of whether they considered themselves to be in-patient, community or some other type of service, were sent a short questionnaire to complete either online or by returning a MS Word questionnaire. If we received no response, the original questionnaire was resent and further non-responders were contacted by phone.

The questionnaire was developed by SPH with the involvement of a consultant child and adolescent forensic psychiatrist working in a community-based FCAMH service. The questionnaire was piloted

with experienced professionals working in the field before being finalised (see Appendix 1 and 2 for introductory letter and questionnaire).

Results

a) Responding Services and Commissioning Arrangements

Responses were received from 48 of the 55 services.

Based on the survey responses, the 48 responding services were assigned to one of five categories:

1. Comprehensive specialist community FCAMH provision (Group 1). These were services with a clear Tier 4 specialist FCAMHS focus including dual-trained staff and functions supplementary to those of generic Tier 3 CAMH services.
2. Specialist FCAMH Tier 4 in-patient service providing some ad hoc community input (Group 2).
3. Local services clearly linked to Tier 3 CAMHS or mental health trusts providing some but not comprehensive forensic function (largely CAMHS input to youth offending teams (YOTs)(n=10) but also includes multi-systemic therapy (MST) pilot sites (n=7)) (Group 3).
4. Other arrangements providing some input to high risk young people with mental health needs (stand-alone therapeutic provision within independent care organisation or specialist education providers (n=4) and national spot-purchased forensic psychology service (n=1) (Group 4).
5. Responders providing no community FCAMH services but involved in in-patient care with high risk young people and/or YOI in-reach/STC mental health in-reach (n=13): not included in analysis.

The number of services in each category is shown in Table 2 together with reported current commissioning arrangements.

Comment

Group 1 services (specialist community Tier 4 FCAMHS), all of which responded to the survey, had heterogeneous commissioning arrangements with equal proportions being locally or regionally commissioned or relying on spot purchasing arrangements. One service was nationally commissioned for Wales. Commissioned provision was clearly distinct from other commissioning arrangements such as those for Tier 3 CAMHS, in-patient FCAMHS provision or mental health in-reach to secure settings.

Group 2 consisted of one service, already a national FCAMH in-patient provider, which offered ad hoc spot-purchased support to nearby areas which do not have currently commissioned community FCAMH provision. This support by its nature was not at the level available from services in Group 1.

Group 3 consisted of the largest group of responders and the survey organisers are aware that there are considerably greater numbers of generic CAMH providers offering generic support to YOTs than those which responded. This group comprises services offering important, but restricted, areas of provision to high risk young people such as routine YOT mental health liaison or intensive, time limited family-based interventions (MST). Commissioning arrangements in this group were usually local or in the case of the MST pilots, via the DH. One Tier 3 CAMH service (because of the expertise of one of its consultants) was trying to establish a service similar to Group 1 services, but could only offer locally spot-purchased assessments.

Table 2: Number of Responses by Category of Service and Current Reported Commissioning Arrangements

	All responses	Local commissioned	Regional commissioned	National/local spot-purchased	Other/unclear
Group 1	13	4	4	4	1*
Group 2	1	0	0	0	1
Group 3	17	9	0	1	7**
Group 4	4	0	0	1	3***
Totals	35	13	4	5	13

* *Welsh FACTS service is nationally commissioned*

***MST pilot sites currently DH commissioned*

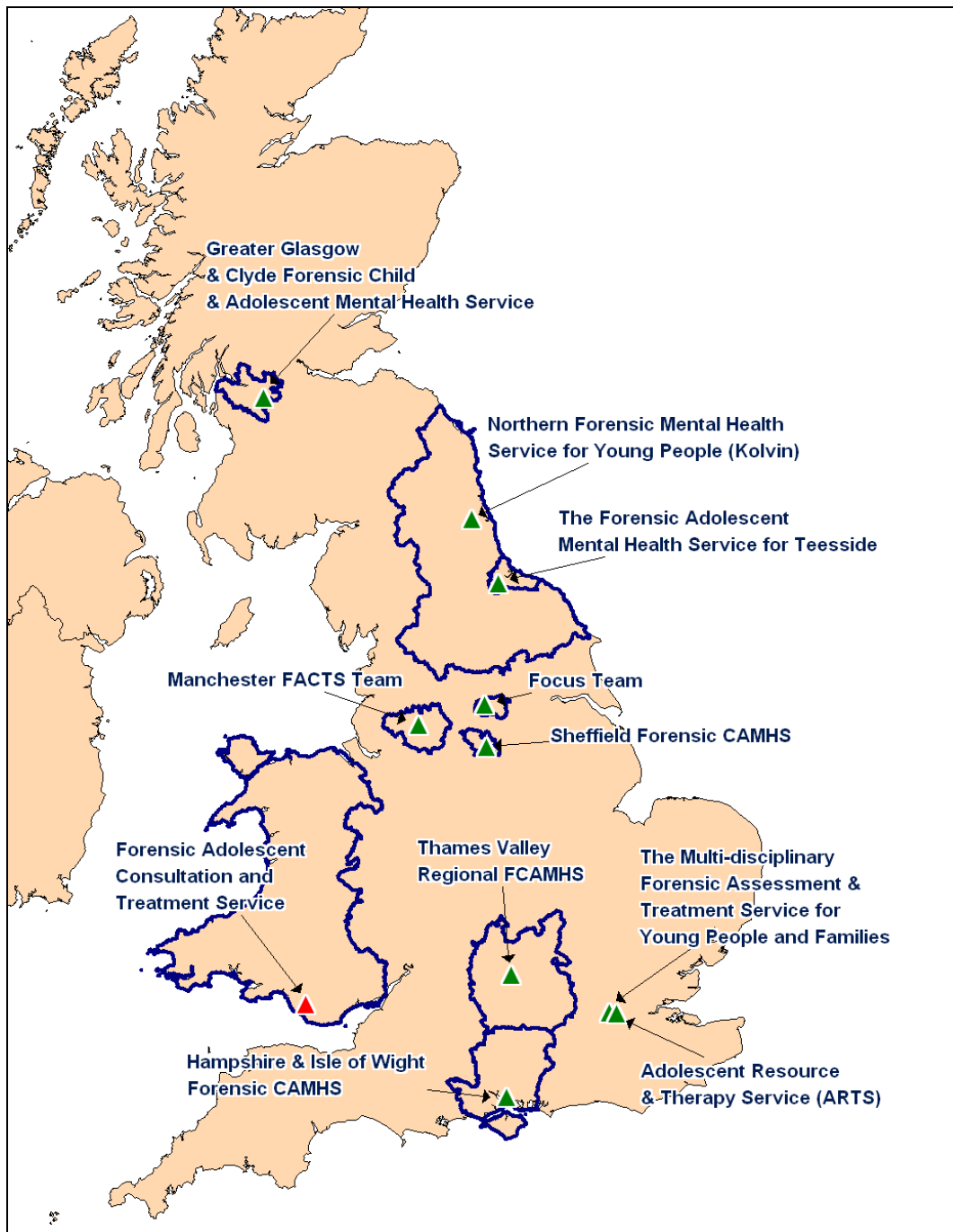
*** *funded within contractual care arrangements for individual child within non-health residential settings*

Group 4 consisted of consisted of a small number of other services providing some input to high risk young people with mental health needs (stand-alone therapeutic provision within independent care organisation or specialist education providers (n=4)) and a national spot-purchased forensic psychology service (n=1).

b) Geographical Coverage Provided by Locally and Regionally Commissioned Services

Figure 1 shows the locations of local/regionally commissioned Group 1 community FCAMH services and their geographical catchment areas.

Figure 1: Map Showing Locations and Approximate Catchments for Group 1 Locally and Regionally Commissioned Community FCAMH Services (excluding spot-purchased provision*)



* spot-purchased provision excluded because not able to deliver full range of FCAMH functions to a given catchment population

Comment

It will be seen that current specialist community FCAMHS services with clearly defined catchments are currently in place. However, the services vary in the extent of their geographical catchments. Some cover local/local authority areas (Lewisham, Lambeth, Wakefield, Sheffield, Teesside); some cover previous Strategic Health Authority or regional catchments, as defined by regional specialist commissioning arrangements (Thames Valley, Hampshire/Isle of Wight, Glasgow and Newcastle); some cover catchments of intermediate magnitude (Western Greater Manchester). The Welsh

FACTS team provides national coverage, but its commissioning arrangements allow for division of the national geography so that regional coverage across Wales is achieved.

It will be noted that large areas of England and Scotland are not covered by clear local or regional commissioning arrangements for specialist Tier 4 community FCAMHS. These areas need to rely on spot-purchased services from services such as The Multi-disciplinary Forensic Assessment and Treatment Service for Young People and Families (South London), Youth First (Birmingham), West London FCAMHS and Manchester FACTS.

c) Linkage with Other Agencies

Table 4 compares specialist FCAMHS (Group 1) with the other services identified as having more restricted involvement with high risk young people (Groups 2, 3, 4).

Table 4: Linkage with Other Agencies: All Responses, Group 1 and Groups 2, 3, 4.

	All responses n=35 (100%)	Group 1 only n=13 (100%)	Groups 2,3,4 n=22 (100%)
Relevant Tiers 2, 3, 4 CAMHS	33 (94)	13 (100)	20 (91)
Nationally commissioned FCAMH in-patient units	19 (54)	12 (92)	7 (32)
Social services	29 (83)	11 (85)	18 (82)
Education	26 (74)	9 (69)	17 (77)
Police	24 (69)	8 (62)	16 (73)
YOS	32 (91)	12 (92)	20 (91)
Other*	13 (37)	9 (69)	4 (18)

* includes services for young people with sexually harmful behaviour, custodial and other secure provision, local Multi Agency Public Protection Arrangements (MAPPA), courts

Comment

All services, whether specialist community FCAMHS or other services with involvement with high risk groups, reported good links with a range of local agencies and statutory providers. This is as expected from services working with young people with complex needs irrespective of their degree of specialist function. Group 1 services, however, reported much closer links with nationally commissioned FCAMH in-patient providers and greater links with other specific provision for high risk young people (e.g. services for young people with sexually harmful behaviour, custodial and other secure provision, local Multi Agency Public Protection Arrangements (MAPPA), courts).

d) Specialist Functions

Table 5 details a range of functions which might be expected of services with specific responsibility for meeting the mental health needs of high risk young people in the youth justice system and elsewhere. The table compares specialist FCAMHS (Group 1) with the other services identified as having more restricted involvement with high risk young people (Groups 2, 3, 4).

Table 5: Forensic Mental Health Functions: All Responses, Group 1 and Groups 2, 3, 4.

	All responses	Group 1 only	Groups 2,3,4
	n=35 (100%)	n=13 (100%)	n=22 (100%)
Support to courts and specialist forensic court assessments	23 (68)	10 (77)	13 (59)
Forensic disposals using Mental Health Act	15 (43)	11 (85)	4 (18)
Detailed risk assessments	26 (74)	13 (100)	13 (59)
Liaison with relevant YOI/STC/SCH to facilitate entry/departure from custody	17 (49)	10 (77)	7 (32)
Liaison with commissioners in complex cases	25 (71)	11 (85)	14 (64)
Liaison with national FCAMH in-patient provision	19 (54)	12 (92)	7 (32)
Service development functions	23 (68)	12 (92)	11 (50)
Training of frontline and specialist practitioners	27 (77)	13 (100)	14 (64)
Youth justice diversion scheme	14 (40)	8 (62)	6 (27)
Other functions	9 (26)	6 (46)	3 (14)
Total n= (%)	570 (57)	816 (82)	459 (46)

Comment

The table shows that specialist community FCAMH teams (Group 1) are more likely to provide the full range of activities listed compared with services in Groups 2, 3 and 4. This is to be expected.

Specialist community FCAMHS teams should be expected to demonstrate clearly that they are fulfilling all functions listed in Table 5. For example, it is crucial that such services all have good links with relevant custodial settings and the court system in their area (reported in 77% of responses). More consistent setting of standards, together with clear geographical catchment responsibilities for such services, would ensure that this is the case.

e) Exclusion Criteria for all Responding Services (Groups 1, 2, 3 and 4) .

Age – most services reported specific age criteria for accepting referrals. Services fell into two groups: those which accept referrals of children and young people up to the age of 18 or 19 and those only accepting referrals for young people between the ages of 10 and 18/19.

Gender –services reported accepting children and young people of both genders.

Geography – the majority of responding services imposed some sort of geographical referral criteria. These included boundaries of PCTs and local authorities and the catchment of various secure units. Some services did not cater for children and young people placed out of area and some would undertake assessment work nationally, but would only follow up and support children and young people more locally.

Behaviour – some services specifically excluded children or young people exhibiting sexually harmful behaviours. A small number of services excluded those who were believed to be actively suicidal or who were in local authority care.

Learning Disability (LD) – some services excluded young people with moderate to severe LD and others accepted referrals for moderate LD but not severe LD. The remainder made no exclusion in relation to LD severity.

Contact with Youth Justice System – most services accepted children in contact with the youth justice system or those considered at high risk of so being. Some services only accepted those in contact with a Youth Offending Service or subject to a community order.

Mental Health Assessment – some services had specific exclusions relating to referrals for mental health assessment. For example, some services accepted referrals only from psychiatrists or other specialist mental health assessment services; other services exclude children and young people with autistic spectrum disorder; some services accepted initial contacts from all agencies and then sought subsequently to work alongside local CAMHS providers.

f) Access to Services

The majority of services operated Monday to Friday from 9am to 5pm. Only 4 of the 13 Group 1 services participated in out of hours cover arrangements for children and young people. It is assumed that all areas will have had an out-of-hours emergency CAMHS service as this is a national requirement.

g) Staffing

Table 6 shows the whole time equivalent (WTE) staffing for each of the Group 1 community FCAMH services and provides an indication of the allocation of staff in different services per million population in their catchment. The staffing figures are again based on figures provided by each service.

Table 6: Whole Time Equivalent (WTE) Staffing per Million Catchment Population for Specialist Tier 4 Community FCAMHS (group1 services)

Service Name	No. WTE Consultant Child & Adolescent Psychiatrist (n=)	No. WTE Clinical Psychologist (n=)	No. WTE Nursing/Social Worker or Therapist	Catchment Area	Approx Pop Size	No. WTE Clinical Staff per million population (excludes admin)
Sheffield Forensic CAMHS	0.5	1	0	City of Sheffield.	556,000	2.7*
Adolescent Resource & Therapy Service (ARTS)	0.2	1	2.6	London Borough of Lewisham,	266,000	14.3‡
Greater Glasgow and Clyde Forensic CAMHS Service	1	3.7	2.0	NHS Greater Glasgow & Clyde	1,200,000	5.6**
The Forensic Adolescent Mental Health Service for Teesside	0.5	1.2	1.6	Teesside	400,000	10.8‡‡
Thames Valley Regional FCAMH (Oxford)	1.0	0.2	0	Oxon, Bucks, Berks and Milton Keynes	2,000,000	0.6
Focus Team, Wakefield	1	2	2.0	Wakefield District	320,000	15.6***
Northern Forensic Mental Health Service for Young People (Newcastle)	0.5	3	2.5	This patch is broadly North Yorkshire to the Scottish Border and across to North Cumbria.	1,100,000	5.4****
Hampshire & Isle of Wight Forensic CAMHS	0.8	0.2	0	Hampshire and Isle of Wight.	2,000,000	0.5
West London Community Adolescent Forensic Service	not stated	not stated	0	'West London'	Possibly 2 000 000 but not specifically defined	Not possible
The Multi-disciplinary Forensic Assessment and Treatment Service for Young People and Families (Maudsley, South London)	1.5	0.8	0	Includes both national spot-purchased provision and arrangement with some south London boroughs but staffing breakdown for each not available	No specific catchment	Not possible
Manchester FACTS Team	1.2	0.2	3.3	Includes both national spot-purchased provision and commissioned case by case service to GMW but staffing breakdown for each not available	National (no specific catchment) and Greater Western Manchester 700,000	Not possible*****
Wales Forensic Adolescent Consultation and Treatment Service	0.6	1.8	1.6	Wales	3,000,000	1.3
Youth First, Birmingham	0.5	0.6	0	National spot-purchased service	No specific catchment	Not possible

*includes in-reach to Aldine House Secure Unit

**includes in-reach to St Mary's and Good Shepherd Secure Units

***includes community FCAMHS role, mental health in-reach to Rivendell Unit at HMYOI/HMP New Hall, input into East Moor Secure Children's Centre, Leeds

****includes mental health in-reach to two Secure Children's Homes (Aycliffe and Kyo House) and a Secure Training Centre (Hassocksfield STC).

*****includes contract for in-reach to Barton Moss Secure Unit (in-reach to HMYOI Hindley is separately commissioned)

‡includes 1 WTE staffing for formal court diversion project (DH pilot site)

‡‡ may include staffing for formal court diversion project (DH pilot site)

Comment

There is significant consistency across all specialist community FCAMH services regarding the need for senior psychiatric and psychological input to the teams. Involvement of nursing staff, social workers and therapeutically trained staff was less consistent with such staff present in 7 out of 13.

There appears to be considerable variation in staffing allocation and distribution across current community FCAMHS provision with a wide variation in whole time equivalents per million of population served. The range is between 0.5/0.6 WTE per million (two regionally commissioned services) and 15.6 WTE per million (a locally commissioned specialist FCAMH service). Staffing ratios for 'spot-purchased' services could not be calculated.

This wide variation could be explained in a number of ways:

- Some services may not have clearly separated their community function and their in-reach functions within existing commissioning arrangements. In-reach provision is labour intensive and this may have contributed in some apparent high staff/population ratios
- Some services may contribute staff time to formal court diversion projects. This again can be time-consuming especially in areas of high population density. Other services may not be involved with such formal projects but should still be ensuring diversion within their overall service remits
- Some services may be providing higher levels of direct therapeutic provision than others which may rely on good relationships with local services/specific local service developments to provide such input
- Some services may include some sex offender intervention work or other specific tasks (when no specific mental health difficulty is present) in their overall FCAMHS remit where others may have sought to cater for such functions by local commissioning developments
- Some services may serve areas of particular deprivation or wide geographical catchment necessitating higher staffing ratios to ensure consistent specialist provision.

In spite of such explanations it would appear that there remains considerable heterogeneity in the composition and remit of specialist community FCAMH services.

Few survey responses included administrative support in their information about staffing. It is for this reason that such roles have not been included in Table 6. This does not mean that the administrator role within a FCAMHS team is not considered important. Good administrative backup to FCAMHS teams is a crucial part of good team functioning.

Conclusions and Recommendations from Mapping of Community provision

Conclusions

Children and young people about whom there are mental health concerns and who present with high risk of harm to others in a variety of settings or are in contact with the youth justice system, have a greater need for mental health services than their non-offending peers. In addition, high risk young people experience high levels of psychosocial adversity, multiple transitions between services, and high levels of geographical displacement. They can also be subject to a complex range of statutory educational, social care (Children Act 1989 and 2004), mental health (Mental Health Act 1983, amended 2007 and Mental Capacity Act 2005) and criminal justice (Crime and Disorder Act 1998) legislation. It is therefore crucial that any attempt to meet the well-documented needs of these young people seeks to address the consistent provision of accepted interventions, but also seeks to offer a coordinated response to complexity.

Key points arising from this study are as follows:

1. Differentiation of Services There is a clear differentiation between specialist community FCAMH services and the functions they fulfil and other mental health and therapeutic services offering more restricted input to high risk young people. The roles of the different types of provision are complementary and supplement each other.
2. Geographical/population coverage. There is patchy geographical provision of dedicated specialist community FCAMH services across the UK. Significant areas of England and Scotland appear to have no provision for this type of service. The size of the population served and how this is defined varies widely with some services covering populations of around two million, whilst others cover a population within a single local authority area.
3. Commissioning arrangements. These vary widely nationally and result in the lack of comprehensive geographical coverage of specialist FCAMH services in England and Scotland. Large areas of England and Scotland do not have access to the specialist skills of a community FCAMH team with a specified catchment. This necessitates the engagement of a 'spot-purchased' intervention from a team which can be remote to the local environment and services. Such input on a case-by-case basis is frequently expensive and may be provided by services who are geographically remote and who cannot participate in local service development. This can result in consequent lack of service development by local clinicians and agencies which might be of greater benefit to young people and their families.
4. Range of services provided. There is considerable consistency between specialist community FCAMH teams (Group 1) in the range of services provided. However, not all were providing all of the core functions which should be expected of them. Services providing some restricted input into high risk young people (Groups 2, 3, 4) showed a far lesser level of provision of specialist function although they clearly have a number of skills and cross-agency relationships which would probably not be present in generic CAMHS provision not involved

with YOTs or high risk cases. The findings of the study suggest that Group 1 services supplemented and enhanced, rather than replicated, existing generic provision irrespective of their current commissioning arrangements (local or regional). Specialist services should thus be defined in terms of whether they are providing a range of specialist functions rather than by the nature of current, demonstrably heterogeneous, commissioning arrangements.

5. Staffing levels and make up. All services have consultant child and adolescent psychiatry and clinical psychology input, but not all have nursing, social worker or dedicated therapist input. Levels of staffing were variable with the Group 1 services receiving input from consultant child and adolescent psychiatrists (range 0.2 to 1.0 WTE) and consultant clinical psychologists (range 0.2 to 3.7 WTE). The total WTE clinical staff per million population served varied between 0.5 WTE and 15.6 WTE. Reasons for this require further elucidation, but nevertheless the heterogeneity of current provision is clear.
6. Inclusion/exclusion criteria. There is some variation in the application of inclusion/exclusion criteria between services particularly in relation to the inclusion or exclusion of children/young people with sexually harmful behaviour or with moderate or severe learning disability.

Recommendations

Action is needed to address gaps in provision and to ensure that children and young people with complex forensic mental health needs have access to appropriate community based services in addition to the existing network of medium secure in-patient units, local tier 3 CAMHS and other therapeutic provision. Even in situations where local Tier 3 CAMHS currently provides liaison to YOTs or where MST pilot sites target families of high risk young people for intensive intervention, there still remains a need for community FCAMHS to supplement such provision. Community FCAMHS should be integrated within comprehensive CAMH provision (see Appendix 7).

There should be agreed national minimum standards for community FCAMH service provision and a standard commissioning framework to provide a level of consistency in how these services are provided across the country.

The current changes in commissioning structures in England offer an opportunity to ensure more equitable commissioning of FCAMH services.

PART 3: Forensic Child and Adolescent Mental Health Services (FCAMHS): Community Services Model

Introduction

Young people under 18 presenting serious risk of harm to others in a variety of settings and those in contact with the youth justice system, have high rates of mental health problems and learning difficulties and have traditionally not accessed core child and adolescent mental health services (CAMHS). Medium secure in-patient FCAMHS provision for children and adolescents has been established with national funding and is commissioned by the National Specialist Commissioning Team (NSCT). In contrast, forensic mental health services for children and young people living in the community have developed in a more piecemeal way without national funding and in the absence of a recognised model of service delivery.

This document sets out a proposed service model for community FCAMH services for use by commissioners and providers in developing services to meet the needs of their local population. The model is based on that developed over several years within the Thames Valley Regional FCAMHS Team and which has been externally evaluated and replicated in Hampshire/Isle of White. Both the Thames Valley and Hampshire/Isle of Wight FCAMHS teams are now recipients of regional specialist commissioning funding. The teams are small and specialist, have strong links across agencies and supplement existing mental health and welfare provision for children and adolescents. They typically cover a regional population of about 2.5 million.

This model is not intended to be exhaustive and is subject to being updated as necessary. The model has informed the recent development of a draft service specification for specialist community FCAMHS within the recent revision of national commissioning arrangements (see Appendix 11).

Eligible Population

The population eligible for forensic CAMH services is as follows:

- children and adolescents up to the age of 18 years
 - with severe disorders of conduct and emotion, neuropsychological deficits or serious mental health problems with/without learning difficulties or where there are legitimate concerns about the existence of such disorders
 - who are engaged in dangerous, high risk behaviours and/or who have become, or are likely to become, involved in criminal proceedings.

This will include young people who present a high risk to others through such behaviours as fire setting, physical assault and sexual offending.

General Functions

The community FCAMHS team will provide specialist child and adolescent mental health expertise at a variety of levels and to a variety of institutions and networks working with young people under 18 years old in contact with the youth justice system. The scope of the team's remit should be broad and is highlighted in Figure 1.

The multidisciplinary team will need to function on several levels in all environments:

- as a resource for information
- as a means of formal consultation
- as a provider of specialist assessments and interventions
- as a training resource for front-line workers
- as a means of informing and developing strategic links between mental health services and the youth justice system
- as a facilitator of smooth transitions for young people both between different services for young people and between children's and adult services.

Specific Functions

Community FCAMHS Tertiary Referral Service (see Appendix 8 and 9)

The service should act as a tertiary referral service for CAMHS teams (including CAMHS/Youth Offending Team (YOT) link workers and learning disability services for young people). In addition, the team should be accessible to all agencies (e.g. social services, YOTs, YOIs, courts, solicitors, education, health commissioners etc.) which may have contact with young people exhibiting risky behaviours or young people in the youth justice system who have mental health difficulties. For this reason, initial contacts about possible referrals should be welcomed from all agencies, although referrals for assessments should be compliant with referral criteria and should usually only be accepted with the knowledge and active support from local CAMHS tier 3 services.

The core functions that should be made available as part of this role include:

i) Liaison with locality CAMHS and Youth Offending Teams (YOTs)

The establishment of good working and training relationships with individual local services (e.g. CAMHS and YOTs) and the promotion of close working arrangements between locality specialist CAMH teams and YOTs for mental health work. The ultimate aim of this area of strategic development is to develop coherent practice models based on local initiatives supported by the specialist FCAMHS team who would take responsibility for cases requiring specialist assessment and input.

ii) Liaison and advice to courts and the legal system

The team should act on various levels in its contact with courts and the wider legal system as both a resource for general advice and more formal consultation, as well as a provider of specialist assessments and management advice (e.g. potential for mental health/learning

disability diversion; fitness to appear/plead; risk assessment in cases with a clear mental health/learning disability component). The emphasis in this area should be to support local services to develop appropriate skills to carry out this function themselves with recognition that in particularly complex cases the team's direct input will be required e.g. in medico-legal assessments and reports for criminal proceedings.

iv) Facilitation of transitions to and from secure and other residential settings

The team should provide support and practical input as required when young people move (usually out of area) to, or return home from, a secure custodial, welfare or mental health placement or other residential settings. For children from the team's catchment placed out of area, there will be an understanding that the team will maintain contact with the case and facilitate any return for the child to his/her home area. In addition, the current regional specialist commissioning arrangement requires that the FCAMHS team be involved in any out-of-county placement decisions on forensic mental health grounds whether via the courts (e.g. following a Hospital Order) or otherwise.

v) Establishing and maintaining good local links with custodial or secure facilities

The existence of a specialist service covering a specified geographical area allows for the possibility of providing input to custodial or secure institutions within that area not previously linked in a coherent way to local CAMH services. This may be on the basis of the establishment of good working relationships between the FCAMHS team and professionals in the secure environment, or it may take the form of separately commissioned mental health in-reach provision.

v) Wider strategic functions

- Linkage with national in-patient services
- Linkage with services elsewhere involved in mental health provision to young people in secure or community settings
- Informing policy and forming strong links with national organisations responsible for strategic development (e.g. DH, YJB, Sainsbury Centre)
- Providing professional training for individuals wishing to obtain the necessary experience to work in this area of expertise.

vi) Identifying gaps in provision and developing allied services

In addition to the functions detailed above, the FCAMHS service may be involved in the development and management of additional specialist services depending on the needs of the local population and the extent to which these are met by existing local services. An example of this is the Child and Adolescent Harmful Behaviour Services (CAHBS) which caters for young people with sexually harmful behaviours in Oxfordshire and Buckinghamshire. This service was developed as a result of a significant gap in provision identified by the FCAMHS team. The Oxfordshire and Buckinghamshire CAHBS teams are managed within the overall FCAMHS team, but operate purely on the basis of referrals where there are concerns regarding sexually harmful behaviour (as opposed to mental health concerns) in young people under 18. They are separately commissioned by local joint commissioning between

local authorities and primary care trusts. Their function is to provide coordination of assessment and intervention across agencies and to provide appropriate training for professionals working with young people.

Referral Process (see Appendix 10)

For those meeting the eligibility criteria for the community FCAMH service the suggested referral process should be:

- The referrer will provide clear reasons for referral and adequate background information including a baseline risk assessment
- The referrer will undertake an initial verbal consultation with a designated member of the FCAMHS team
- Referrers will retain overall clinical responsibility for the young people they refer. They should also identify a CPA case coordinator who will remain in contact with the case throughout the period of FCAMHS team involvement.

Suggested referral outcomes:

There will be three possible outcomes for referrals:

- Referral accepted for brief advice or
- Formal consultation with written feedback to referrer/local network re general management (no direct clinical involvement).
- Referral accepted for specialist assessment and planning re future management. This outcome requires the home team and network to remain involved with the case (e.g. by providing a care coordinator) and to participate in ongoing risk-management. Following the assessment the FCAMHS team will remain involved, as appropriate, to support the local network to manage the case.

Staffing

The specialist community FCAMHS team will be multidisciplinary and will have specialist FCAMHS experience in the assessment and treatment needs of complex high risk young people. The emphasis should be on a small, highly experienced and active team whose members are thus equipped to provide authoritative specialist support to local generic networks.

Specialist Forensic CAMHS Multidisciplinary Team members should include combination of some of the following:

- Consultant psychiatrist (dual trained Forensic and CAMHS)
- Consultant clinical forensic psychologist or consultant clinical psychologist with clear experience of this area of work; other psychology support as considered necessary
- Clinical nurse specialist/senior mental health practitioner (at least Band 7)
- Other relevant specialist professionals with appropriate experience in this area
- Dedicated team administrator

The function of the specialist team combines support for generic child and adolescent services and specialist clinical skills, to provide comprehensive support and prevention. The role of the consultant psychiatrist is essential given the specialist knowledge of the Mental Health Act (1983, as amended 2007), required in this work. Senior (consultant) psychologist input is crucial to address the variety of areas of work within the team and adequate psychology support is necessary given the frequent need for structured psychometric and cognitive assessment. The administrator's role is central and requires a wide-range of skills and coordination of a peripatetic team.

Service Standards

Listed below are a proposed set of service quality standards for FCAMH services, which relate to service structure, processes and outcomes.

Structure

- Coverage of geographically defined population up to 18 years, within eligibility criteria
- Service level agreement (SLA) in place which sets out the geographical boundaries of the service and specifies funding arrangements and services to be provided including provision for children/young people placed out of area
- Multi-disciplinary team (MDT), led by appropriately trained consultant forensic child and adolescent psychiatrist. All practitioner staff should have appropriate experience/qualifications for working with children/adolescents and in forensic mental health
- Referral database which records details relating to individual referrals (see Appendix 12 for example of items to include in database)
- Strong local, regional and national links within CAMHS, YOS and other agencies, and adult forensic mental health services.

Process

- Strong emphasis on liaison work and support for other services working with young people
- Adherence to referral criteria
- Response to referrer within 7 days
- For all cases where advice or formal consultation only is undertaken, clear written feedback regarding agreed outcomes will be provided
- For all young people seen for assessment, prompt, clear written feedback will be given to referrers, associated professionals and families. This will include clinical evaluation, addressing of issues of risk (including appropriate structured assessment) management advice and specialist opinion where requested (e.g. fitness to plead).
- The team will remain active in supporting cases in conjunction with other professionals where this is appropriate. This may involve complex liaison with local, regional and national providers and at times specific direct interventions with the young person. Liaison with adult forensic services.
- Use of Care Programme Approach or identification of lead professional by referring agency.

Service Outcomes

- evidence of identification of young person's needs (diagnosis, risk)
- evidence of meeting young person's needs
 - duration of input from FCAMHS
 - nature of input (advice, consultation, assessment/intervention)
 - outcome in terms of agency involvement/lack of involvement at discharge
 - evidence of needs being met/unmet where clearly identified at consultation/assessment

Service Monitoring and Evaluation

Measurement tools

A range of validated measurement tools is available for monitoring progress and outcomes of children and young people in contact with CAMH services. The following core tools are recommended for this purpose by the CAMHS Outcomes Research Consortium (CORC), a collaboration between CAMH services in the UK with the aim of instituting a common model for routine outcome evaluation and analysing the data derived:

- the Strengths and Difficulties Questionnaire (SDQ) which measures symptom change as reported by parents, teachers and children, and also their report of change in impact on their lives and extent of their difficulties,
- the Commission for Health Improvement (CHI) Experience of Service Questionnaire (ESQ) which measures service experience of children and families,
- the Children's Global Assessment Scale (CGAS), a measure of social and psychiatric functioning for children ages 4–16 years from the practitioner's perspective,
- the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), which measures behaviour, impairment, symptoms and social functioning from the practitioner's perspective, and
- the Goals Based Outcomes Measure (GBO) which measures how far children, young people and families have reached their goals or aims as mutually agreed at the start of treatment.

These generic measures may not all be as useful in measuring outcome in the young people seen by a FCAMHS team and it may be that further appraisal of this aspect of clinical outcome monitoring should be considered in the light of the complex needs of this population. A further challenge for FCAMH services is that, due to the nature of the service, some young people referred to services will not be in direct contact with the FCAMH team (e.g. in advice or consultation only cases), and others may only be in contact with the service on a single occasion (e.g. if referred for assessment/advice on intervention to be given by a different service). In such situations, it will not be possible to obtain baseline and follow up data unless there is an agreed approach to the use of measurement tools across different agencies (a process which is notoriously difficult). For young people who receive input from FCAMH services over a period of time, measurement tools, such as the Children's Global Assessment Scale, can be used at baseline and to monitor progress over time.

Recommended service indicators

The following indicators are recommended for use in monitoring performance of FCAMH services:

- waiting times and numbers: time from referral to assessment, time from referral to first intervention available from hospital data systems
- referral source to measure coverage
- number of young people requiring triage, formal consultation, specialist assessment and intervention
- number of young people who are able to be maintained and cared for within local services, including out of area placement rates and length of stay
- number of young people who are required to be admitted to forensic units or alternative residential placements (e.g. social care or educational)
- extent of multi-agency strategic involvement e.g. delivery of appropriate training, associated service developments
- young person/parent/carer/referrer satisfaction questionnaire survey
- access to support groups and education questionnaire survey plus young person/parent/carer participation
- evidence of programme of joint working with non-specialist centres: to include YOTs, CAMHS, social care, education, custodial settings and others
- evidence of national equivalence of provision and service models
- potential for review of long-term outcomes of young people involved with FCAMHS

Appendix 1: Letter of Invitation to Participate

Dear Colleague

We are contacting you to see whether you would be prepared to complete our survey questionnaire in relation particularly to community Forensic CAMHS provision across the country. The survey is relevant both to services which exist solely as FCAMHS teams and to other CAMHS/children's mental health services which might be providing functions such as YOS liaison or mental health in-reach as part of their more general mental health work with children and young people.

Many of you have already provided your contact details in response to our previous contacts via the RCPsych and BPS Adolescent Forensic Special Interest Groups and the NHS Adolescent Forensic Network.

The purpose of this current work which we have been undertaking with Caroline Twitchett (Senior Policy Lead for Children and Young People at Offender Health, Department of Health) and with Solutions for Public Health (SPH) is as follows:

- to provide a directory of community services working in this field whose contact details could then be made available to relevant services
- to map current levels of provision in community and non-in-patient settings across the country

To our knowledge this kind of exercise has not previously been undertaken. In gathering this information we would wish to use your service's name and contact details for the directory. If you wished we would be willing to anonymise any specific service information provided by you if you felt that this was important.

Initial contact will be made by either one of us or a colleague working with us. We hope that you will be happy to participate.

Many thanks

Yours sincerely

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Appendix 2: Survey Sent to all Respondents

Section 1: Contact Details

1. Please complete the following details for your service:

Name of Service:	
Full Address of Service:	
Tel contact for the Service:	
Name of Service Manager:	
E-mail address:	
Name of Clinical Lead:	
E-mail address:	

Section 2: Current Service Provision:

2. What specific forensic CAMHS services is your service commissioned to provide?

In-patient medium secure	<input type="checkbox"/>	Mental health in-reach to custodial/secure settings	<input type="checkbox"/>
In patient low secure	<input type="checkbox"/>	Other (please describe):	<input type="checkbox"/>
In-patient other	<input type="checkbox"/>		
Dedicated community service	<input type="checkbox"/>		

If Community service/mental health in-reach/other please answer questions 3-12 below. If you only provide in-patient services please go to question 13.

3. Have you strong liaison links with:

Relevant Tiers 2, 3, 4 CAMHS	<input type="checkbox"/>	Education	<input type="checkbox"/>
Nationally commissioned FCAMHS in-patient units	<input type="checkbox"/>	Police	<input type="checkbox"/>
Social services	<input type="checkbox"/>	YOS	<input type="checkbox"/>
Other e.g. MAPP – Please specify	<input type="checkbox"/>		

4. Do you provide any specialist functions such as:

- Support to Courts and Specialist Forensic Court Assessments
- Forensic disposals using Mental Health Act
- Detailed risk assessments
- Liaison with relevant YOI/STC/SCH to facilitate entry/departure from custody
- Liaison with commissioners in complex cases
- Liaison with national FCAMHS in-patient provision
- Service development functions
- Training of frontline and specialist practitioners
- Criminal justice diversion scheme
- Other functions – please specify:

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Section 3: Eligible Population

5. Does your community service have any specific inclusion or exclusion criteria relating to the following factors?

Criteria	Description
Age	
Gender	
Inclusion or exclusion behaviour e.g. service excludes those exhibiting sexually harmful behaviours	
Geographical: Scope of responsibility (e.g. includes/excludes children/young people from population served who are placed out of area/in custody elsewhere)	
Learning Disability e.g. service excludes those with Learning Disability or only accepts those with mild learning disability	
Level of contact with youth justice system e.g. includes both/either those in contact with CJS and/or also those not in contact but at risk of serious harm to others	
Mental Health assessment e.g. service only accepts young people who have had previous CAMHS involvement	
Other – please specify	

Section 4: Service Commissioning and Other Arrangements:

6. Please describe the scope of your community service or community service component in terms of the population served and how your service is commissioned.

Population served by community service (e.g. which PCTs or local authorities)	
<p>Do you provide forensic CAMHS services to any YOIs, Secure Training Centres, or SCHs</p> <p>a) within your catchment area? Yes/No</p> <p>b) Outside your catchment area? Yes/No</p> <p>If Yes, to which institutions? Please name in full</p> <p>If No, who does provide such input?</p>	
Other commissioned community functions	
Name(s) of your commissioning body (bodies) for these functions:	
<p>Please describe the type of commissioning arrangements for your community service in terms of:</p> <p>a) Type of commissioning arrangement e.g. spot-purchased, SLA etc</p> <p>b) Geographical scope e.g. local, national or regional</p> <p>If possible please distinguish between different service components e.g. community FCAMHS, mental health in-reach etc</p>	

Section 5: Access to Services

7. Please describe the arrangements for referrals to the community/mental health in-reach/other elements of your community forensic CAMHS service:

Community

Which organisations do you accept referrals from?	
Are there any organisations from which you cannot accept initial referrals?	
Where do the majority of your referrals come from?	

Mental health in-reach

Which organisations do you accept referrals from?	
Are there any organisations from which you cannot accept initial referrals?	
Where do the majority of your referrals come from?	

Other (please specify:)

Which organisations do you accept referrals from?	
Are there any organisations from which you cannot accept initial referrals?	
Where do the majority of your referrals come from?	

8. Please state the days and hours of operation of the community/in-reach/ elements of your community forensic CAMHS service:

Community

On which days is your service open?	
At what times does your service open?	
Do you offer an out-of-hours service?	

In-reach

On which days is your service open?	
At what times does your service open?	
Do you offer an out-of-hours service?	

Other (please specify:.....)

On which days is your service open?	
At what times does your service open?	
Do you offer an out-of-hours service?	

9. Please list the different types of staff involved in delivery of the community/mental health in-reach/other elements of your forensic CAMHS service

Staff group/discipline (e.g. Consultant Psychiatrist, Clinical/Forensic Psychologist, Nurse etc)	No. of WTE staff in each group	No. of WTE staff with forensic qualifications and/or background	No. of WTE staff with qualification/background in working with children.	No. of WTE staff with qualification/background in working with children and forensic qualification/background	Total sessions offered a week

Section 6: Service Quality

10. To what extent do you consider your existing community service provision enables you to provide a FCAMH service which meets the needs of its catchment population?

11. What, if anything, would enhance the service that you provide?

12. Has your service been evaluated? If so, which bodies have provided such evaluations?

Section 7: Providers of In-patient Services Only

13. Do you provide any non-commissioned FCAMHS type services to community colleagues or settings (as outlined in Section 2 Question 4)?

Section 8: Other Comments

14. Do you have any further comments or information that you think might be important?

Please return your completed questionnaire to michael.griffin@sph.nhs.uk. If you have any queries please send an e-mail or phone 01865 334751.

Appendix 3: Services Contacted to Participate in Study

The table below shows the services that were approached to participate in the survey (n=55) and their response. In total 48 services responded to the survey but 13 of these responses were from services that only provided in-patient services or mental health in-reach.

Name of Service	Response Received
Sheffield Forensic CAMHS	Survey completed
South Essex Partnership Trust	Survey completed – but excluded
Peterborough Family Health and Interventions Service	Survey completed
Hertfordshire Forensic Adolescent Service	Survey completed
Wandsworth YOS	Survey completed
The Hartley Unit – Huntercombe Stafford	Survey completed – but excluded
SCAS - Specialist Child Assessment Service (E Yorks)	Survey completed
Benjamin UK	Survey completed
Positive Pathways Ltd	Survey completed
Hampshire & Isle of Wight FCAMHS	Survey completed
The Multi-disciplinary Forensic Assessment and Treatment Service for Young People and Families (South London & Maudsley)	Survey completed
Forensic Psychology Service (South London & Maudsley)	Survey completed
The Willow Unit, HMYOI Hindley	Survey completed – but excluded
Northern Forensic Mental Health Service for Young People	Survey completed
West London Adolescent Forensic Community Service	Survey completed
Bluebird House	Survey completed
Thames Valley FCAMHS	Survey completed
Focus Team (Wakefield Forensic CAMHS Team)	Survey completed
Head2Head Nottinghamshire (+ Mansfield)	Survey completed
East Lancashire Child & Adolescent Service (ELCAS)	Survey completed
Lambeth CAMHS Team	Survey completed
Lewisham Adolescent Resources Team	Survey completed
Youth First (Forensic CAMHS)	Survey completed
Manchester FACTS Team	Survey completed
The Forensic Adolescent Mental Health Service for Teesside	Survey completed
Greater Glasgow & Clyde Forensic Child & Adolescent Mental Health Service	Survey completed
Wetherby YOI CAMHS	Survey completed – but excluded
Specialist CAMHS, Wrexham (not a specialist forensic team)	Survey completed
Specialist Psychology Service for the East Sussex Youth Offending Team (through CAMHS)	Survey completed
Merton, Surrey and Kingston MST Pilot	Survey completed
Reading MST Programme	Survey completed
Birmingham MST Programme	Survey completed
NELP (North East London Partnership) MST Service	Survey completed
Wirral MST Programme	Survey completed
Youth In Need Greenwich Multi-Systemic Therapy (MST) Team	Survey completed
Brandon Centre for Counselling & Psychotherapy for Young People	Survey completed

The Young People's Service – the Priory Cheadle Royal	Informal response – but excluded
Specialist Care for Young People – Oakview Hospital	Informal response – but excluded
South London & the Maudsley – input to Croydon YOS	Informal response
The Wales FACTS team	Informal response
St Andrews Hospital	Informal response-but excluded
The Wing Centre Bournemouth and Southlands School (Cambrian Group)	Informal response
HMYOI Ashfield , CAMHS team	Informal response-but excluded
Gardener Unit, Manchester	Informal response-but excluded
Roycroft Unit, Newcastle	Informal response-but excluded
Wells Unit, West London	Informal response-but excluded
Bill Yule Unit, South London	Informal response-but excluded
Ardenleigh Unit, Birmingham	Survey completed – but excluded
Kibble Forensic Psychology Service	Did not respond
The National Clinical Assessment and Treatment Service	Did not respond
Engage (Staffordshire)	Did not respond
The Young People's Team – Leicester Partnership NHS Trust	Did not respond
3 further MST pilot teams	Did not respond

Appendix 4: Survey of Community Forensic CAMHS Services

Comments on existing community FCAMH service provision from specialist community FCAMHS teams (Group1 teams)

FCAMH services were asked to describe the extent to which they considered their existing community provision enabled them to meet the needs of their catchment population. The responses of Group 1 community FCAMH services included the following:

- Too many referrals with fewer clinicians
- We provide a comprehensive CAMH service including Diversion work and AIM assessments to young people
- Provides risk assessment, interventions and risk management for outpatient population
- Largely
- It allows us to do this well
- We are well staffed and in a good position to meet the needs of our catchment area
- Reasonably
- We're small and therefore have some limits, but given the restriction in size we meet as much need as we can
- We are unable to provide treatment. Case by case commissioning is very problematic
- A forensic psychology treatment service is being developed to fill the gap in provision for treatment
- Highly
- There are identified areas of gaps in provision which can impact on accessibility of FACTS via current pathways and ability of services to respond to recommendations provided. Areas of particular note include lack of:
 - Multi-systemic therapy, multidimensional treatment foster care, and early intervention for psychosis teams within mental health service provision
 - dedicated service for harmful sexual behaviour
 - medium and low secure in-patient services in Wales
 - secure children's home, STC or YOI in North Wales

The services were also asked to state what would improve the community services they currently provided. The responses of the Group 1 services were:

- More psychiatric input
- Only our consultant psychiatrist is trained in forensic work the rest of the staff are mental health trained and have experience in working with young people who offend. It would be helpful to have pathways to become a qualified forensic clinician which would contribute towards a national standard of service to the client group.
- Access to secure in-patient care in Scotland; senior nursing
- More psychology input - plan to advertise
- Access to providing CAMHS in-reach to Oakhill STC
- A full-time senior social worker
- Increased income
- More money to employ more man-hours to meet the need better. Development of parallel SHB services would also help immensely.
- Secured commissioning
- More staff

- Enhancement might be achieved by addressing the areas of gaps in service provision and coherence in the model of service provision across Wales. Both these areas are being considered and addressed.

Appendix 5: List of Mental Services Providing Community In-put to High Risk Young People

This list is composed of services identified in a national UK mapping exercise undertaken for the Department of Health (Dent et al, 2012). The list is restricted to responding services and will be available on the website of the Adolescent Forensic Special Interest Group website of the Royal College of Psychiatrists. The table is not exhaustive but contains all Tier 4 Community FCAMHS Teams. Other teams wishing to be added to the list should contact Dr Nick Hindley (nick.hindley@oxfordhealth.nhs.uk) as should those wishing to update details of existing services.

Name of Service	Catchment	Type of Service	Lead Clinician/Manager	Commissioning Arrangements	Contact Details
1) Specialist Community FCAMHS Provision					
Sheffield Forensic CAMHS	City of Sheffield	Comprehensive community FCAMH provision	Dr Girish Vaidya	Locally commissioned	0114 2260660
Hampshire & Isle of Wight FCAMHS	Hampshire and Isle of Wight	Comprehensive community FCAMH provision	Dr Jonathan Bigg	Regionally commissioned	01489 587544
The Multidisciplinary Forensic Assessment and Treatment Service for Young People and Families (South London & Maudsley)	National availability; some local arrangements in South London	Comprehensive community FCAMH provision	Dr Peter Misch	Nationally and locally spot purchased	020 3228 3841
Northern Forensic Adolescent Service for Young People	North East Region	Comprehensive community FCAMH provision	Jane Gibson	Regionally commissioned	0191 223 2226
West London Community Adolescent Forensic Service	Western London	Comprehensive community FCAMH provision	Dr Clare Dimond Sharon Davies Dr Tina Irani	Locally spot purchased	0208 4832244
Thames Valley Child & Adolescent Forensic Mental Health Service	Oxfordshire, Buckinghamshire, Milton Keynes and Berkshire	Comprehensive community FCAMH provision	Dr Nick Hindley	Regionally commissioned	0845 219 1459

Focus Team (Wakefield Forensic CAMHS Team)	Wakefield District	Comprehensive community FCAMH provision	Dr Abdullah Kraam Ms Paula Phillips	Locally commissioned	01924 304172
Lewisham Adolescent Resources Team (ARTS)	London Borough of Lewisham	Comprehensive community FCAMH provision	Dr Phil Collins Nick Topliss	Locally commissioned	0208 314 9742
Youth First (Forensic CAMHS)	National	Comprehensive community FCAMH provision	Dr Hilary Grant Fiona McGruer	Nationally spot purchased	0121 678 4602
Manchester FACTS Team	National with some local arrangements for Greater Western Manchester	Comprehensive community FCAMH provision	Dr Kenny Ross Maeve Murphy	Nationally and locally spot purchased	0161 7723811
The Forensic Adolescent Mental Health Service for Teeside	Teeside	Comprehensive community FCAMH provision	Dr Pradeep Rao Richard Deehan Leah Allinson	Locally commissioned	01642 853555
Greater Glasgow and Clyde Forensic Child & Adolescent Mental Health Service	Greater Glasgow and Clyde	Comprehensive community FCAMH provision	Dr Aileen Blower Dr Lorraine Johnstone Dougie Fraser	Regionally commissioned	0141 276 3858
Wales FACTS Team	All Health Boards in Wales	Comprehensive community service CAMH provision	Dr Julie Withecomb Gaynor Kendall	Nationally commissioned	01656 674 954
2) Specialist In-Patient FCAMHS with some Ad Hoc Community Provision					
Bluebird House, Southampton	Some local ad hoc community arrangements with Dorset and Bristol	Specialist Tier 4 FCAMH inpatient service with some community services	Dr Mayura Deshpande Pete Betts	Ad hoc arrangements/unclear	02380 874 600
3) Local mental Health Services with some Forensic Functions					
Peterborough Family Health and Interventions Service	Peterborough City Council	Local services providing some but not comprehensive FCAMH	Dr Rebecca Morland Iain Easton	Locally commissioned	01733 864210

		services			
Hertfordshire Forensic Adolescent Service	Unclear – presumably population of Hertfordshire	Local services providing some but not comprehensive FCAMH services	Lindsey Lovatt	Locally commissioned	01442 388755
Wandsworth YOS Mental Health Team	Wandsworth	Local services providing some but not comprehensive FCAMH services	Candy Fernandez Diane Emmanus	Locally commissioned	0203 5134644
Specialist Child Assessment Service (SCAS) – E Yorks	East Riding of Yorkshire City of Hull	Local services providing some but not comprehensive FCAMH services	Dr Cliff Weston Michelle Watson	Locally commissioned	01482 344625
Head2Head Nottinghamshire	Nottinghamshire	Local services providing some but not comprehensive FCAMH services	Samantha Sykes	Locally commissioned	01623 784831
East Lancashire Child and Adolescent Service (ELCAS)	East Lancashire	Local services providing some but not comprehensive FCAMH services	Dr Tim Morris Jo Weller	Locally commissioned	01254 226334
Lambeth CAMHs Team	Lambeth	Local services providing some but not comprehensive FCAMH services	Dr Richard Church Emma Reynolds	Locally commissioned	0203 228 7370
Specialist CAMHS Wrexham	Wrexham area	Local services providing some but not comprehensive FCAMH services	Dr Peter Gore-Rees/Patrick Howells	Locally commissioned	01978 725242
Specialist Psychology Service for the East Sussex Youth Offending Team	East Sussex	Local services providing some but not comprehensive FCAMH services	Dr. Hugh Milburn	Locally commissioned	YOT East:01424 726520 YOT West:01323 525670

Merton, Surrey and Kingston MST Pilot	Merton, Kingston, Surrey	Local services providing some but not comprehensive FCAMH services	Dr Simone Fox	DH, DfE, local authority - across 3 boroughs and PCT	0208 274 5902
Reading MST Pilot	Reading Unitary Authority	Local services providing some but not comprehensive FCAMH services	Juliette Wait	DH, DfE, LA/PCT	0118 9372076
Birmingham MST Pilot	Birmingham	Local services providing some but not comprehensive FCAMH services	Simon LaLonde (lead clinician) Jai Shree Adhyaru (manager)	DH, DfE, LA/PCT	0121 4640600
NELP (North East London Partnership) MST service	Parts of North East London	Local services providing some but not comprehensive FCAMH services	Dr Jenny Taylor	DH, DfE, LA/PCT	0203 222 5677
Wirral MST Programme	Wirral	Local services providing some but not comprehensive FCAMH services	Tina Goodson	DH, DfE, LA/PCT	0782 7449035
Youth in Need Greenwich MST Team	Croydon/Lewisham and elsewhere	Local services providing some but not comprehensive FCAMH services	Lesley French Linda Devlin	DH, DfE, LA/PCT (but spot purchase available for out of area referrals)	0203 260 5200
Brandon Centre for Counselling & Psychotherapy for Young People	Camden, Haringey, Enfield, Waltham Forest, Hackney, Newham, Lewisham, Islington	Local services providing some but not comprehensive FCAMH services	Charles Wells (lead clinician) Geoffrey Baruch (manager)	Locally commissioned	020 7424 9935
Croydon CAMHS (input to YOS)	Croydon	Local services providing some but not comprehensive FCAMH services	Dr Siobhan Netherwood	Local	020 3228 5826
4) Other Services					

Providing Input to High Risk Young People with Mental health Needs					
Forensic Psychology Service (South London & Maudsley)	National	Other input to high risk young people with MH needs	Dr Troy Tranah	Nationally spot purchased	0203 228 2624 0203 228 3381
The Wing Centre Bournemouth & Southlands School (Cambian Group)	Cambian Group	Other input to high risk young people with MH needs: input to young people in specialist educational settings	Gabrielle Pendlebury	Part of Cambian Group (independent provider)	0800 138 1184
Benjamin UK	Benjamin UK residential establishments nationally	Other input to high risk young people with MH needs: input to clients of independent residential care organisation	Dr Alexandre Gieske Claudette Deysel	Part of Benjamin UK	07792-063264
Positive Pathways Ltd	National residential provider but focus on West Midlands	Other input to high risk young people with MH needs: input to clients of independent residential care organisation	Kevin Epps	Part of Positive Pathways Ltd	0121 270 1066

Appendix 6: Effective Interventions with High Risk Young People and Young people who offend

Background

A comprehensive mental health service for young people who offend needs to include an assessment process using robust and validated assessment tools and, for those identified as having mental health problems, access to evidence-based interventions.

Much of the treatment of mental health need in high risk young people and young people who offend is the same as that clearly evidenced for mental health difficulties in all young people (see major textbooks and NICE guidance). Thus, the main challenge with this group of young people is ensuring consistency of intervention and follow-up and good experience in engaging the young people in question.

This literature review aims to summarise the additional evidence for interventions for young people with mental health problems or learning difficulties who are in contact with the youth justice system or who present a high risk of harm to themselves or others.

Methods

Searches

A literature search was conducted on the 4th of May 2012. Medline, Embase, PsychINFO, Cochrane, TRIP and Campbell Collaboration databases were searched. The search was limited to English language publications from 2002 onwards.

Inclusion criteria

The following broad inclusion criteria were applied:

- Population - children/young people under 18 years who have mental health problems and/or learning disabilities who are in contact with the youth justice system and/or who present a high risk of harm to themselves/others
- Intervention – any
- Comparator - any
- Outcomes - any
- Study design – systematic review/randomised controlled trial (RCT) if no systematic review is available or if RCT is more up-to-date than systematic review

Results

The searches retrieved 124 papers of which four papers (three systematic reviews and one RCT) met the inclusion criteria and hence were included in the review.^{13 14 15 16}

¹³ Townsend E et al. Systematic review and meta-analysis of interventions relevant for young offenders with mood disorders, anxiety disorders, or self-harm. *Journal of Adolescence* 2010; 33(1):9-20

¹⁴ Littell JH et al. Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17. *Cochrane Database of Systematic Reviews* 2005, Issue 4. Art. No.: CD004797. DOI: 10.1002/14651858.CD004797.pub4

The included papers assessed the following interventions: multisystemic therapy, cognitive behavioural therapy and treatment foster care.

Multisystemic therapy

Multisystemic therapy (MST) is an intensive, home-based intervention for families with children and young people with social, emotional, and behavioral problems. Masters-level therapists engage family members in identifying and changing individual, family, and environmental factors thought to contribute to problem behavior. Interventions may include efforts to improve communication, parenting skills, peer relations, school performance, and social networks. The ultimate goals of MST are to empower families to cope with the challenges of raising children with behavioral and emotional problems and to empower children and young people to cope with family, peer, school and neighborhood difficulties.

A recent, well conducted Cochrane review (Littel et al, 2009) assessed the effectiveness of MST for social, emotional and behavioural problems in young people aged 10-17. The review included eight RCTs, mainly conducted in the US, six of which focused on effects of MST for juvenile offenders, including sex offenders, juvenile offenders with substance abuse problems and juvenile offenders in general. The review found no statistically significant differences between MST and usual services in reducing restrictive out of home placements, arrests, convictions, school attendance, self-esteem, delinquency and psychiatric symptoms for young people with social, emotional or behavioural problems.

There have been many RCTs assessing the effectiveness of MST, with the therapy receiving \$20 million in new research grants in January 2004. However, the trials are often of poor quality and the Cochrane authors note that only one of the included trials used intention-to-treat analysis and most outcome assessors were not blinded to the allocation. The Cochrane authors conclude that there is inconclusive evidence of the effectiveness of MST compared with other interventions in young people. However, the systematic review identified 13 possibly randomised studies that were ongoing, which depending on the quality of the trials, should produce more conclusive results in the future.

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) is a structured, time-limited psychological therapy. It is usually offered on an outpatient basis, with between eight and 24 weekly sessions. It involves the patient using behavioural and cognitive tasks to modify their response to thoughts and situations.

One systematic review (Townsend et al, 2009) and one RCT (Mitchell et al 2011) were found that assessed the effectiveness of CBT in young people who offend. The RCT (Mitchell et al 2011) was included in addition to the systematic review (Townsend et al, 2009), because it was conducted after the systematic review was published.

The systematic review (Townsend et al, 2009) assessed the effectiveness of interventions relevant for young people who offend with mood disorders, anxiety disorder or self harm. The systematic review included ten RCTs, half of which used a cognitive behavioural approach. The majority of the included trials were small, of poor quality and old. Only one of the trials was conducted on community based offenders. The systematic review included a meta analysis of three RCTs assessing the effectiveness of group based CBT on depression which showed a statistically significant

¹⁵ Macdonald G, Turner W. Treatment Foster Care for improving outcomes in children and young people. Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD005649. DOI: 10.1002/14651858.CD005649.pub2

¹⁶ Mitchell P et al. Cognitive behaviour therapy for adolescent offenders with mental health problems in custody. Journal of Adolescence 2011; Jun;34(3):433-43

improvement compared to usual care or no treatment (SMD = 0.37 (-0.69, -0.07)). The authors conclude that group-based CBT may be useful for young people who offend with mental health problems, but larger high quality RCTs are needed to bolster the evidence-base.

The included RCT (Mitchell et al 2011) assessed the effectiveness of cognitive behaviour therapy for adolescent offenders with mental health problems in custody in the UK. Forty male offenders (22 from secure settings establishments and 18 from young offender institutions) were randomised to either CBT or treatment as usual. The average age of the participants was 15.6 years, 45% had a history of being in care, 95% had been excluded from school and just under two thirds (62.5%) met the Salford Needs Assessment Scheduled Assessment (SNASA) criteria for an unmet mental health need severe enough to justify an intervention. Participants were assessed at baseline and at a follow up of an average of 11 months, using the Youth Self Report (YSR) tool to assess changes in behavioural and emotional functioning, SNASA tool to assess changes in need and the Difficulties and Coping Profiles questionnaire (DCP). Outcomes at follow-up showed no statistically significant differences between the two groups. However, the trial was too small to detect small differences between the groups so a larger trial is needed to determine whether any small differences exist.

Treatment foster care

Treatment foster care (TFC) is a foster family-based intervention that aims to provide young people (and, where appropriate, their families) with a tailored programme designed to effect positive changes in their lives. TFC was designed specifically to cater for the needs of children whose difficulties or circumstances place them at risk of multiple placements and/or more restrictive placements such as hospital or secure residential or youth justice settings (Macdonald & Turner, 2008).

A Cochrane review (Macdonald & Turner, 2008) was found which assessed the effectiveness of TFC for improving outcomes in children and young people who for reasons of severe medical, social, psychological and behavioural problems were placed in out of home care in restrictive settings or at risk of placement in such settings. Five trials were included, three of which focused on children and young people with emotional and behavioural problems and the remaining two focused on delinquent children at risk of detention or placement in highly restrictive group or residential settings. All of the studies were conducted in the US and almost all the participants were white. The review found statistically significant improvements in antisocial behaviour/delinquency and criminal referrals, but statistically non-significant results were found for self-reported delinquency and psychological functioning. The authors conclude that TFC is a promising social intervention for children and young people at risk of placement in settings that restrict their liberty and who are at a risk of a range of adverse outcomes, but note that the current evidence base is relatively poor.

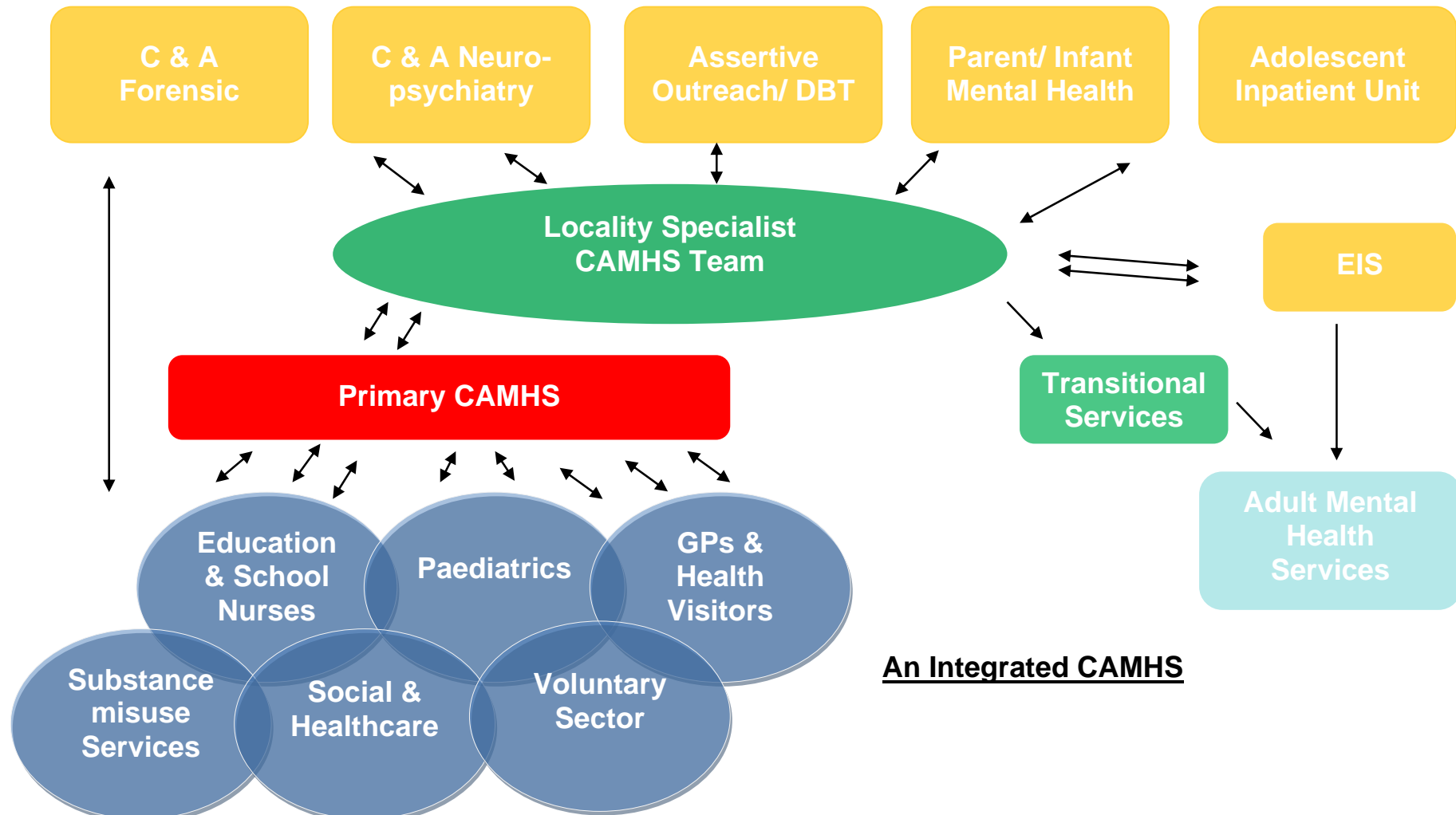
Conclusions

There is a limited evidence base surrounding the effectiveness of interventions aimed at young people with mental health problems or learning difficulties who are in contact with the youth justice system or who present a high risk of harm to themselves or others. This review found three relevant systematic reviews and one RCT, which assessed the effectiveness of cognitive behavioural therapy (CBT), multisystemic therapy (MST) and treatment foster care (TFC). Currently there is inconclusive evidence of the effectiveness of these interventions as the majority of the published trials have small sample sizes or are of poor quality. No evidence was found on the effectiveness of pharmacotherapy on young people who offend with mental health problems. There is a need for large, high quality RCTs assessing the effectiveness of interventions for young people who offend with mental health problems.

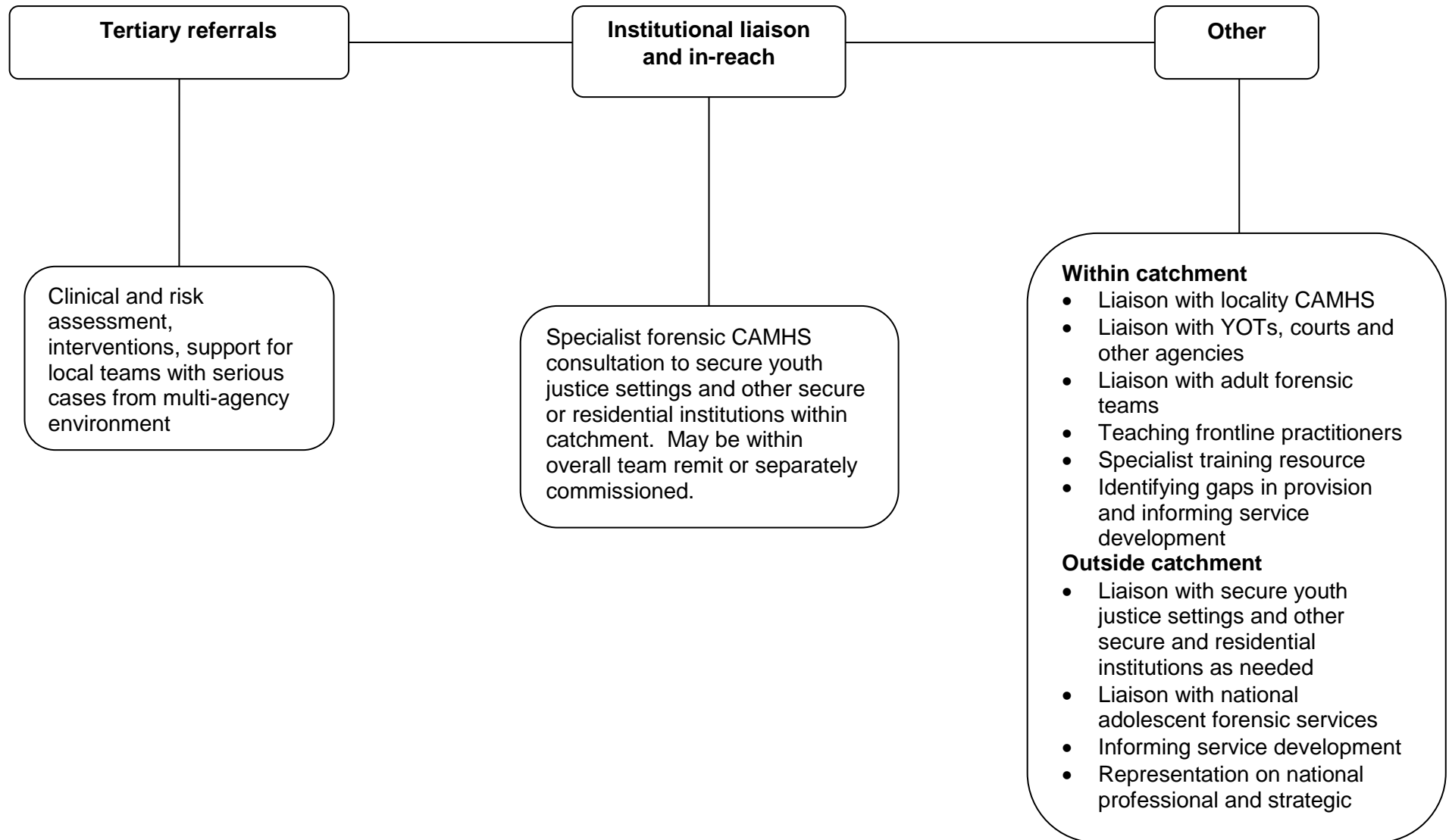
Medline Search Strategy

1. ((juvenile or adolescen* or teen* or young or youth) adj2 (sex offender or paedophile? or pedophile? or rapist? or murderer?)).ti,ab.
2. Juvenile Delinquency/
3. (Child/ or Adolescent/) and (Prison/ or Prisoners/ or Crime/)
4. ((juvenile or adolescen* or teen* or young or youth or child*) adj5 (offender? or criminal? or delinquent? or prisoner?)).ti,ab.
5. ((juvenile or adolescen* or teen* or young or youth or child*) adj5 (prison? or secure setting? or (secure adj3 accommodation) or secure unit? or custody or custodial or court?)).ti,ab.
6. ((juvenile or adolescen* or teen* or young or youth or child*) adj justice).ti,ab.
7. ((juvenile or adolescen* or teen* or young or youth or child*) adj5 justice system?).ti,ab.
8. 2 or 3 or 4 or 5 or 6 or 7
9. self-injurious behavior/ or self mutilation/ or suicide/ or suicidal ideation/ or suicide, attempted/
10. (suicide or suicidal* or self-harm* or selfharm* or self-injur* or selfinjur* or self-mutilat* or selfmutilat*).ti,ab.
11. 9 or 10
12. 8 and 11
13. exp *Mental Disorders/
14. exp mental disorders diagnosed in childhood/
15. (mental health or mental* ill* or mental disorder* or depress* or schizophren* or psychos?s* or psychotic or personality disorder* or disordered personality).ti,ab.
16. (((developmental or learning) adj (disorder? or disabilit* or delay?)) or autism or autistic or asperger* or dyslexia or dyslexic).ti,ab.
17. 13 or 14 or 15 or 16
18. exp homicide/ or exp sex offenses/ or exp violence/
19. Aggression/
20. (aggression or aggressive or violence or attack? or murder or homicide or rape or sexual offense* or paedophil* or pedophil* or sex abuse).ti,ab.
21. 18 or 19 or 20
22. 8 and 17 and 21
23. ((juvenile or adolescen* or teen* or young or youth or child*) adj5 (offender? or criminal? or delinquent? or prisoner?)).ti.
24. ((juvenile or adolescen* or teen* or young or youth or child*) adj5 (prison? or secure setting? or (secure adj3 accommodation) or secure unit? or custody or custodial or court?)).ti.
25. ((juvenile or adolescen* or teen* or young or youth or child*) and justice).ti.
26. 1 or 12 or 22 or 23 or 24 or 25
27. limit 26 to (english language and yr="2002 -Current")
28. limit 27 to "reviews (maximizes specificity)"
29. limit 27 to "therapy (best balance of sensitivity and specificity)"
30. exp Clinical Trials as Topic/
31. Comparative Study/
32. pilot projects/ or program evaluation/
33. intervention studies/
34. intervention*.ti,ab.
35. (best practice or evidence base*).ti,ab.
36. 30 or 31 or 32 or 33 or 34 or 35
37. 27 and 36
38. 28 or 29 or 37
39. (forensic and (adolescen* or child* or youth) and (psychiatr* or mental health)).ti.
40. (forensic adj5 (adolescen* or child* or youth) adj5 (psychiatr* or mental health)).ti.
41. 38 or 39 or 40

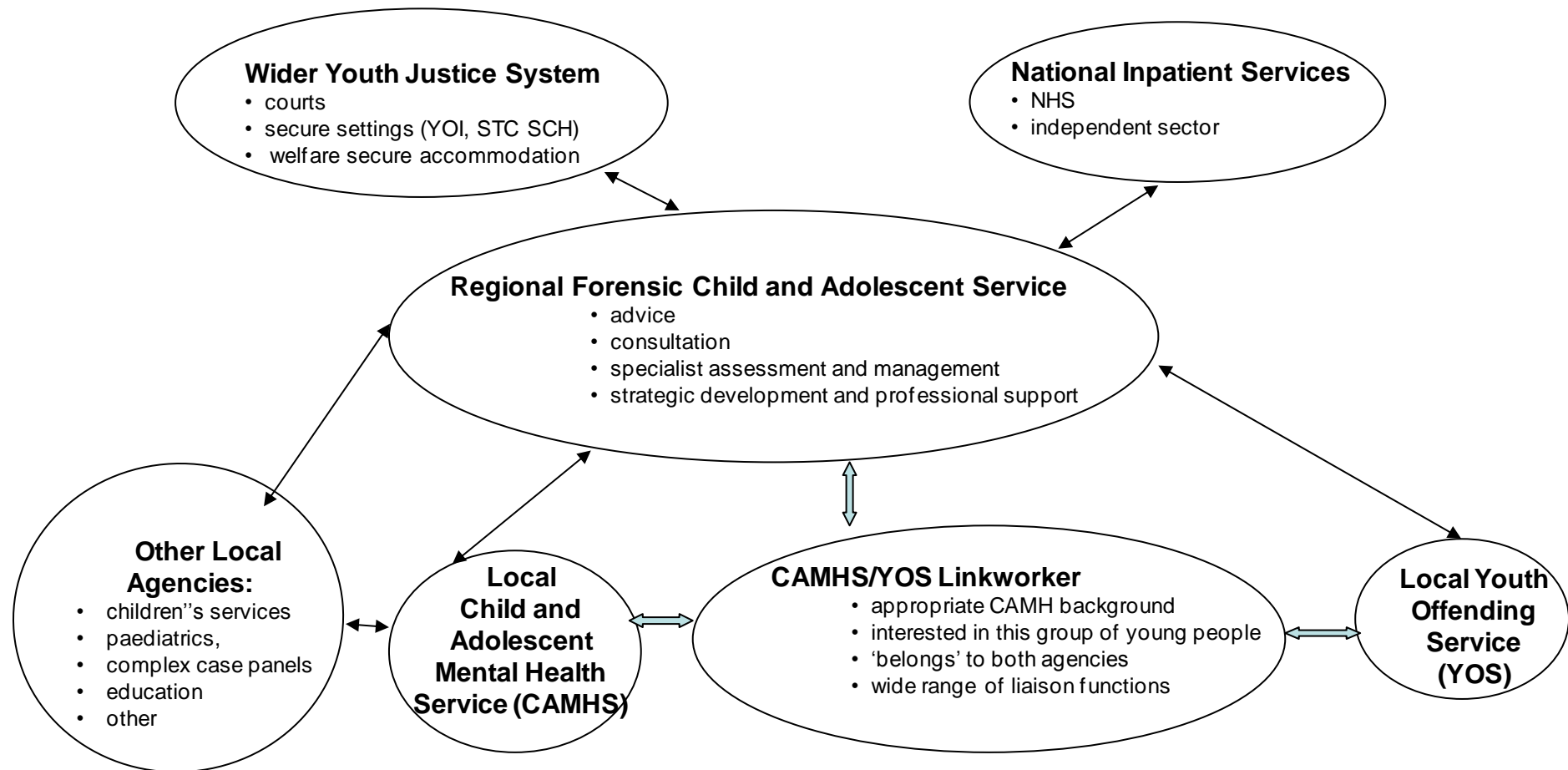
Appendix 7: An Integrated CAMHS Service Including Community FCAMHS



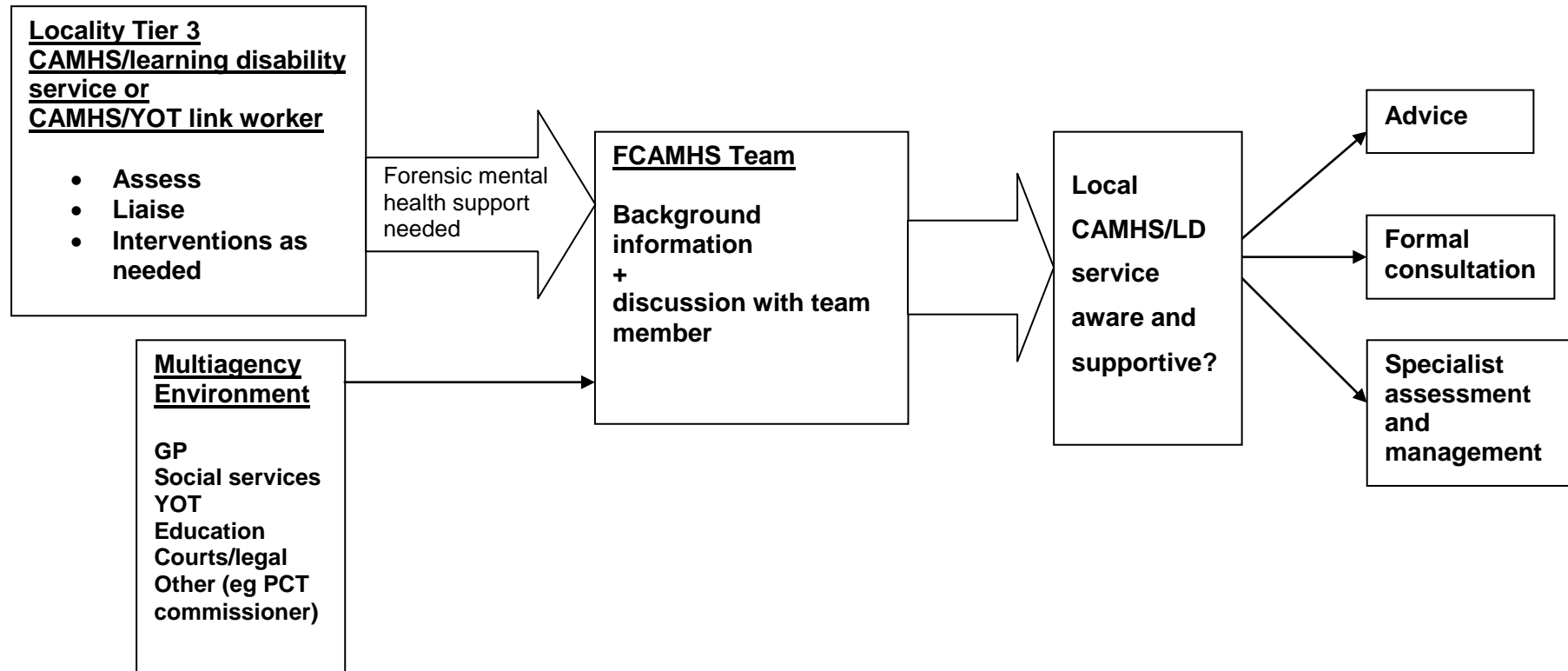
Appendix 8: Schema for a Community Child and Adolescent Forensic Mental Health Service



Appendix 9: Community Forensic CAMHS Network



Appendix 10: Regional Community Forensic Service: Referral Pathway for Young People



Appendix 11: Draft Service Specification for Consideration for National Commissioning

2012/13 NHS STANDARD CONTRACT FOR ACUTE, AMBULANCE, COMMUNITY AND MENTAL HEALTH AND LEARNING DISABILITY SERVICES (MULTILATERAL)

SECTION B PART 1 - SERVICE SPECIFICATIONS

Final Draft – 23.08.2012

Service Specification No.	<i>Enter SSNDS Number and sub section number</i>
Service	Community Forensic Child & Adolescent Mental Health Services (CFCAMHS)
Commissioner Lead	NHS Specialised Services
Provider Lead	
Period	<i>12 months</i>
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National context

A community forensic child and adolescent mental health service (CFCAMHS) can be defined as a highly specialist service designed for young people under 18 about whom there are questions regarding mental health or learning disability who:

- present high risk of harm towards others and about whom there is major family or professional concern;
- and/or are in contact with the youth justice system.

Such services adopt therefore, a broad clinical interpretation of the term 'forensic', but tend to focus for the purpose of service provision on the youth justice arena and on young people's high risk behaviours towards others elsewhere, rather than on work in the civil and family courts.

CFCAMH services typically offer a range of services including clinical consultation and specialist assessment and interventions for young people with very complex needs across a variety of secure, custodial, residential and community settings. In addition to their clinical role, these specialist services are expected to undertake a range of strategic, service development and training functions. Where they exist, these services have emerged in some areas as an integral part of child and adolescent mental health service (CAMHS) provision, where they undertake a range of specialist functions at a regional level. They, therefore, supplement coordinate and support, rather than replicate, local tier 3 CAMHS and provision from other agencies which may be available to high risk young people. The services focus on the maintenance of strong links with Youth Offending Teams (YOTs), custodial and other secure settings, but establish also, good working relationships with a variety of other agencies. They also form a crucial link between local services and nationally commissioned in-patient adolescent forensic inpatient units for young people with mental health and learning difficulties.

Young people under 18 in contact with the youth justice system, or those elsewhere presenting with serious risk of harm to others have high rates of mental health disorders, including learning difficulties (Department of Health (DH): Healthy Children, Safer Communities, 2009; Harrington, Bailey, Chitsabesan, 2005; Grisso and Schwartz, 2000; James and McCann, 1997). They have also

traditionally not accessed core CAMHS provision. This group of young people with complex needs is highlighted in the National Service Framework for Children (NSF, 2004) as requiring special consideration. In recent years, there has been a 20% reduction in young people sentenced to custody with a corresponding increase in numbers of young people with highly complex needs and high risk behaviours being placed instead in community settings and non-youth justice residential settings (frequently subject to care arrangements under the Children Act). These developments have resulted in a growing need for a consistent approach to mental health and risk assessment and intervention in high risk individual cases, in addition to appropriate specialist forensic mental health support for generic local services (CAMHS, Youth Offending Teams (YOTs), children's social care, education or elsewhere) to manage effectively the risk presented by this population and to help meet its needs.

A recent study commissioned by the Department of Health (DH) (Dent, Peto, Griffin and Hindley, 2012) has undertaken a national mapping exercise of current CFCAMH provision. This recent study has built on previous DH development funding which supported external evaluations of regional CFCAMH services operating at a regional (overall population 2-2.5 million) catchment level. The study report also outlines the features of a proposed model for CFCAMHS. The report highlights considerable current inequity in provision (many areas had no dedicated provision) and wide heterogeneity in current commissioning arrangements and populations served by individual CFCAMH teams. It recommends that CFCAMH provision should be available in all areas and that it should be delivered by small highly specialised regional mental health teams who can support existing, more generic provision for young people and provide a core part of a national FCAMHS care-pathway which is currently lacking. A clear service model is now available which has identified the need for specialist direct clinical involvement in 2-5 cases per 100 000 catchment population per year (with a consultative non-direct clinical role in 10-20 cases per 100 000).

This proposed service specification is based on the service model in the above-mentioned DH study.

Evidence base

A representative sample of papers and guidance relating to needs and services is listed below. Further references and more detailed outline of the content of this specification are to be found in Dent et al, (2012) as described in the paragraph above. Broader guidance relating to children and young people can be found in section 3.1 (page 10).

Studies of Mental Health Issues in High Risk Young People

- Prevalence of psychiatric disorders in young people in the care system. (McCann, J.B., James, A., Wilson, S., et al, BMJ, 1996)
- Psychiatric morbidity among young offenders in England and Wales. Office for National Statistics (Lader S, Singleton N, Meltzer H.). London: 2000.
- Adolescent development, mental disorders and decision making of delinquent youths. Kazdin AE. in Grisso T, Schwartz RG (eds), Youth on Trial: A Developmental Perspective on Juvenile Justice. Chicago: University of Chicago Press, 2000, vol. 2, pp. 33-64.
- The Mental Health Needs of Young Offenders, Mental Health Foundation (2002)
- Mental health needs and effectiveness of provision for young offenders in custody and the community. Youth justice Board for England and Wales (Harrington R, Bailey S, Chitsabesan P et al.) London, 2005.
- The National Service Framework for Children and Young People and Maternity services (DH 2004) and Report on the Implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services. Models of Good Practice: p32 Youth justice (DH, 2006)
- Healthy Children, Safer Communities (DH, 2009)
- Health needs assessment of young people in London with complex emotional, behavioural and mental health problems who are at risk of committing a serious offence. (YJB and NHS London, 2010)

Guidance and Studies of Provision for High Risk Young People

- Reaching Out, Reaching In: promoting mental health and emotional well-being in secure settings. (Centre for Mental Health (Khan L.), 2010)

- You Just Get On And Do It: healthcare provision in youth offending teams. (Centre for Mental Health, (Khan and Wilson) 2010)
- The Bradley Report, 2010
- DH Commissioning Guidance for Meeting the Needs of Young People in the Secure Estate;
- CQC transitions report / guidance (2012)
- Community Forensic Child and Adolescent Mental Health Services (CFCAMHS): a map of current national provision and a proposed service model for the future. (Dent, Peto, Griffin and Hindley, Report for DH, 2012); interim draft version available on www.sph.nhs.uk)

This proposed service specification will deal specifically with CFCAMHS provision. After consideration by the Forensic and Secure Clinical Reference Group, it was agreed that existing validated models of specialist community forensic child and adolescent mental health (CFCAMHS) provision should be described in a service specification, separate to adult service specifications, because of significant differences in their remit and function. Close links with the Tier 4 CAMHS Clinical Reference Group have also been established, so that the current specification can be considered alongside other mental health provision for young people.

Stakeholder Feedback

An initial draft of this service specification was circulated to a wide variety of interested parties including senior clinicians and service managers from a number of disciplines (working in a range of inpatient and community FCAMH services), commissioners, senior colleagues at the DH and all members of the Forensic and Secure and Tier 4 CAMHS Clinical Reference Groups. There was an overall positive response to the initial draft and colleagues raised a number of questions, which this final draft has sought to address.

2. Scope

2.1 Aims and objectives of service

The aim of the service is to address the mental health and risk management needs of young people in the youth justice system or presenting with high risk to others elsewhere. The service aims to:

- Improve mental health and well-being by identifying and addressing the mental health needs of high risk young people in a range of secure, residential and community settings
- Minimise risk of harm to self and others when it is linked to mental disorder
- Support access to relevant provision across agencies in line with the young person's identified needs, including transition to secure or adult services
- Supplement local provision with specific specialist input
- Promote social inclusion and ensure parity of provision for young people within the service remit
- Promote and support young people's developmental potential

CFCAMHS will meet these aims through the provision of specialist advice, formal consultation, assessment and intervention for young people presenting with significant risk to others and complex needs beyond that which can be provided by other CAMHS services. The service will be commissioned to work in partnership with wider agencies, to ensure central integrated care provision across health, social care, education and youth justice to optimise the outcomes for young people. This includes teaching and training and promotion of allied service development where there are identified gaps in provision.

The service will assess, deliver and support interventions for young people with mental disorders and high risk whether within or outside the youth justice system and **does not exclude** young people with learning disabilities, or those with neurodevelopmental disorders (although it would seek specialist support as required in such cases).

Underlying Principles

The service will be delivered in line with the following principles:

- Flexibility and accessibility of approach associated with clear and authoritative communication

of opinion

- Enablement of the wider care system: allowing consideration of the needs of high risk young people and ensuring that decisions on placement are based on individual need rather than systemic constraints
- Facilitation of joint working with other professionals and agencies wherever feasible and appropriate
- Provision of safe, timely and effective (evidence based / best practice) assessment and intervention across the different stages of the care pathway. This will include ensuring that all appropriately identified young people from the catchment in question receive the same quality of input and follow-up irrespective of their geographical location or the nature of their current placement.
- Assessments will take place in the child's local area/current residential placement or in a setting appropriate to the child and family's needs (as opposed to a setting most convenient for the CFAMH service)
- The service will be accessible to all young people within the service remit regardless of sex, race, or gender.
- Promotion of attachment, healthy family functioning and continuity of care, wherever possible

2.2 Service description/care pathway

General and Specific Functions

Key roles for CFCAMHS can be summarised in a number of general and specific functions:

General functions include:

- Highly specialist forensic mental health triage, based on needs, urgency and prioritisation to include advice, signposting and formal consultation to a variety of agencies regarding cases of concern
- Support for local services to enhance delivery of responsive child-centred care in high risk cases through multiagency care-planning and promotion of user engagement in care and wider service provision
- Reduction and management of the potential risks posed by the young person to others and self through individualised treatment plans and clinical risk assessment and management processes
- Specialist forensic mental health assessment and intervention in high risk cases where there is a need for specialist opinion to ensure that high risk young people are managed in the most appropriate way
- Where appropriate, ensure evidence-based treatment for complex high risk cases, through a wide range of interventions to address individual's mental health, welfare and educational needs
- Coordination of, and liaison with, mental health services across community and custodial settings, and ensuring that care is provided in line with the welfare principles of the Children Act (1989 and 2004) and Code of Practice to the Mental Health Act (as amended 2007)
- Develop joint working arrangements with CAMHS service, by providing specialist training packages and development and support of CAMHS/YOT mental health link-worker roles on common mental health and risk
- Facilitator of smooth transitions for young people, both between different services for young people and between children's and adult services
- Informing and developing strategic links between mental health services and the youth justice system

Specific Functions

The service should act as a tertiary referral service for CAMHS teams (including CAMHS/Youth Offending Team (YOT) link workers and learning disability services for young people). In addition, the team should be accessible to all agencies (e.g. social services, YOTs, prisons, courts, solicitors, education, health commissioners etc.) that may have contact with young people exhibiting risky behaviours or young people in the youth justice system who have mental health difficulties. For this reason, initial contacts about possible referrals should be welcomed from all agencies, although referrals for assessments should be compliant with referral criteria and should usually only be

accepted with the knowledge and active support from local CAMHS tier 3 services.

Specific functions include:

- Liaison with locality CAMHS and Youth Offending Teams (YOTs) to promote working arrangements and training relationships
- Liaison and advice to courts and the legal system as a resource for general advice, liaison, formal consultation and, on occasions, specialist assessment and management advice to courts and the youth justice process (e.g. potential for diversion, fitness to appear/plead; risk assessment in cases with clear mental health/learning disability component, recommendations for appropriate disposal and follow-up)
- Facilitation of transition to and from, secure settings for young people, providing support and practical input as required, gate keeping of cases where young people move out of area (including, but not exclusively, where a Hospital Order has been made), facilitating, where appropriate, return from secure custodial, welfare or mental health placements
- Forensic CAMHS input into custodial or secure services, where this has not been previously linked in a coherent way to local services
- Strategic role and authority to develop effective strategic partnership relationships that successfully influence and drive appropriate multi-agency developments to cater for other needs of complex, high risk young people (e.g. separately commissioned services for young people with sexually harmful behaviours or mental health in-reach to local secure settings).
- Informing strategic development of mental health services for young people at the mental health/youth justice interface within mental health regions.

Referral Process

- The team will seek to make itself accessible to any professional who wishes to make initial contact or enquiries regarding a young person giving cause for concern and about whom there are questions regarding his/her mental health.
- The essential referral criteria are deliberately broad and allow contact with the team in relation to young people under 18 about whom there are questions regarding mental health or learning disability who:
 - present high risk of harm towards others and about whom there is major family or professional concern
 - and/or are in contact with the youth justice system
- The referrer will undertake an initial short verbal discussion (either face to face or by phone) with a designated member of the CFCAMHS team. The outcome of this initial discussion will result in feedback to the referrer and agreement about further action:
 - a) no further CFCAMH input required (not within referral remit) or signposting to more appropriate service
 - b) referral accepted for further more detailed formal consultation
- Referrers will retain overall clinical responsibility for young people they refer and assume a case coordination role irrespective of level of CFCAMH involvement. In this way, the service local to the child remains linked with the child's progress. They should also identify a case coordinator, who will remain in contact with the case throughout the period of CFCAMHS team involvement.
- If the referrer is not from a local CAMHS team, the CFCAMHS team will always discuss the referral with the young person's local tier 3 CAMH team, so that there is a clear joint approach to the referral from relevant mental health providers.

Possible Referral Outcomes

Once contact has been made with the service there are a number of possible outcomes. These are as follows:

- Referral not accepted
- Referral accepted for either brief advice (including signposting to appropriate services) or more detailed formal CFAMHS consultation with referrer/local network regarding general management
- Formal consultation requires pre-arranged in-depth case discussion and should include prior provision of background documentary information by the referrer to CFCAMH team. There

should be initial agreement that such discussion takes place on the basis that CFCAMH have not had direct clinical input with the young person in question and that advice/recommendations are provided in line with general management principles. At the end of the formal consultation, a course of action will be agreed between referrer and CFCAMH clinician. This may result in:

- a) no further CFCAMH input required
- b) referrer and CFCAMH agree local plan of action and that CFCAMH direct input not currently required; CFCAMH to keep case open and seek progress update before closing or becoming directly involved
- c) CFCAMH team agree to become directly clinically involved usually in conjunction with the referrer. The CFCAMH team will always summarise formal consultation and its agreed outcome in writing to the referrer.
- Following formal consultation, the referral may be accepted for specialist assessment and clinical input as required. This outcome requires the home team and network to remain involved with the case (e.g. by providing a care coordinator) and usually to participate in ongoing risk-management in conjunction with CFCAMH team. Following the assessment, the CFCAMHS team will remain involved, as appropriate, to support the local network to manage the case, even if the young person in question, moves out of catchment into specialist residential, custodial, educational or mental health in-patient provision. Written feedback to the referrer outlining the details of assessment and recommendations will be provided to referrer.

Staffing

The CFCAMHS team will be multidisciplinary and will have specialist FCAMHS experience in the assessment and treatment needs of complex high risk young people. The emphasis should be on a small, highly experienced and active team, whose members are thus equipped to provide authoritative specialist support to local generic networks.

CFCAMH team members should include combination of some of the following:

- Consultant Psychiatrist (dual-trained Forensic and CAMHS)
- Senior grade Clinical Forensic Psychologist
- Clinical Nurse Specialist/Senior Mental Health Practitioner (at least Band 7)
- Other relevant specialist professionals with appropriate experience in this area
- Dedicated Team Administrator

The function of the specialist team combines support for generic child and adolescent services and specialist clinical assessment and intervention skills. The role of the consultant psychiatrist is essential, given the specialist knowledge of the Mental Health Act required in this work. Psychology support is also crucial, given the frequent need for structured psychometric cognitive and other psychological assessments, as well as consideration of appropriate interventions. The administrator's role is central and requires a wide-range of skills and coordination of a peripatetic team.

Specialist Interventions

Treatment of mental health need in high risk young people and young offenders is the same as that clearly evidenced for other young people with mental health difficulties as outlined, for example, in NICE guidance. The team is required to be competent in ensuring that such treatments are delivered when required, in a wide variety of different settings and that professionals in such settings are adequately supported to do this. In addition, it is necessary for the team to have wide experience of interventions or support packages which may be specifically of value in young people with offending behaviours. Whilst the team may not itself deliver such interventions, it will frequently be asked to provide clear opinion with regard to the best course of action in individual cases. Specialist knowledge of different types of residential and educational settings or the applicability of different therapeutic interventions (such as multi-systemic therapy, dialectical behaviour therapy, treatment foster care or treatment of sexually harmful behaviours) in such situations is necessary.

Discharge and Care-Planning

The service will put in place a discharge plan at the point of discharge. It should also consider care-planning from the point of referral and ensure that meeting of need and risk management is clearly

prioritised. This should take into consideration the needs and wishes of child, young person and family, and the involvement of other professionals. A copy of the discharge planning information will be given to the referrer, the general practitioner and, with the permission of the family, to any other involved professionals.

Children and young people may move to other services and other geographical locations. Such transitions will be planned and monitored as appropriate. This may require liaison and ongoing support for the young person from one or more of the following:

- Generic CAMHS
- Other highly specialist CAMHS services such as neuropsychiatry, assertive outreach, services for deaf children, in-patient and adolescent forensic in-patient services (both mental health and learning disability)
- Children's social care and YOTs
- Third sector services
- Adult mental health and adult forensic services
- Adult learning disability and forensic learning disability services
- Specialist educational and other residential provision (including custodial settings)
- Other appropriate services

Service Outcome Measures

There are a range of validated measurement tools available for monitoring progress and outcomes for children and young people in contact with generic CAMH services. These include:

- Strengths and Difficulties Questionnaire (SDQ) which measures symptom change as reported by parents, teachers and children, and also their report of change in impact on their lives and extent of their difficulties,
- Commission for Health Improvement (CHI) Experience of Service Questionnaire (ESQ) which measures service experience of children and families,
- Children's Global Assessment Scale (CGAS), a measure of social and psychiatric functioning for children ages 4–16 years from the practitioner's perspective,
- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), which measures behaviour, impairment, symptoms and social functioning from the practitioner's perspective, and
- Goals Based Outcomes Measure (GBO) which measures how far children, young people and families have reached their goals or aims as mutually agreed at the start of treatment.
- Levels of Service Inventory (LSI)
- Child & Adolescent Service Inventory (CASI) for residential care

These generic measures may not all be as useful in measuring outcome in the young people seen by a CFCAMHS team and it may be that further appraisal of this aspect of clinical outcome monitoring should be reconsidered in the light of the complex needs of this population. One approach that has proved helpful in previous external evaluations of services has been the establishment of a clear quantitative service database. This allows for routine service monitoring and periodic external review which combines service data with qualitative evaluation.

2.3 Population covered

The service outlined in this specification is for young people ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the responsible commissioner and other Department of Health guidance relating to young people entitled to NHS care or exempt from charges).

*Note: for the purposes of commissioning health services, this EXCLUDES young people who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES young people resident in Wales who are registered with a GP Practice in England.

Specifically, the CFCAMH service is commissioned to provide and deliver high quality forensic mental health assessment and intervention for young people living within the catchment (or belonging to that catchment, but placed elsewhere) who meet the following criteria:

Young people eligible for the service will:

- be 18 years old at the time of referral (no lower age threshold for access to the service although most referrals are for 10 to 18 year olds)
- present with severe disorders of conduct and emotion, neuropsychological deficits or serious mental health problems with/without learning difficulties or where there are legitimate concerns about the existence of such disorders
- usually be involved in dangerous, high-risk behaviours whether they are in contact with the youth justice system or not. This will include young people who present a high risk to others through such behaviours as fire setting, physical assault and sexual offending.
- on occasions not be high risk (dangerous to others) but have highly complex needs (including legal complexities) causing major concern within youth justice system (whether in courts, custodial settings or elsewhere).

2.4 Any acceptance and exclusion criteria

CFCAMHS will be commissioned to be receptive to referrers from a wide range of agencies and settings working with young people (for further details see section on referrals, page 58). Experience has shown that reliance on a single referral source (for example local tier 3 CAMHS) can result in unnecessary delay and also in young people with clear mental health needs who have become disengaged from CAMHS, not being referred at all. The CFCAMHS team therefore, needs to arrange its own clear triage function so that all cases requiring specialist input are identified; as elsewhere in the health service, for example A&E departments, where there are serious consequences associated with misidentification of cases at triage, such triage (via the referral process, see pages 58 and 59) should be undertaken by experienced members of the team and not delegated elsewhere.

It is for this reason that the service will have broad and inclusive criteria for initial contact with the team (see section 2.3 above) rather than applying more restrictive and rigidly defined criteria. Furthermore, the team does not necessarily expect that a young person at referral will have a previously diagnosed mental health difficulty. Once again, experience has shown that reliance on previous contact with CAMHS as a referral criterion, can result in young people with current clear mental health problems or learning difficulties, missing out on assessment and input.

Inclusive referral criteria do not mean that the team's specialist skills are not being used efficiently. The clarity of the graded referral process means that:

- specialist assessments and interventions are only undertaken when absolutely necessary
- local services are supported to continue their work with identified young people and encouraged to do this in situations where they might not have felt able to do so
- young people receive input at a level commensurate with their needs and with their potential for risk of harm to others

2.5 Interdependencies with other services

CFCAMH teams necessarily must be expert in liaising and establishing good working relationships with a wide variety of agencies and institutions. This is essential if they are to ensure the best outcomes for the young people with whom they have contact. CFCAMHS must be capable of advising, supporting and challenging such agencies and institutions as appropriate. At times their role in high risk cases will involve the containment of anxiety, whilst at others it will involve the injection of concern where risks were hitherto poorly recognised and addressed.

CFCAMH teams will also provide education within the NHS and beyond to raise and maintain awareness of the needs of young people with high risk presentations.

All CFCAMH providers should be adept at working across agencies and institutions operating not only locally but also at regional and national levels

2.5.1 Co-located Services

No minimum requirement.

2.5.2. Interdependent Services

At National Level:

- Nationally recognised providers of specialist adolescent forensic mental health and learning disability in-patient care
- Multi-disciplinary Forensic CAMHS Network

At Regional Level:

- Department of Health Public Health Team
- NHS Commissioning Board's Regional Centres and Specialised Commissioners
- Regional Improvement and Efficiency Partnerships
- Offender Health Regional Strategy Boards (implementing *Improving Health, Supporting Justice*)
- Multi-Agency Public Protection Arrangements (MAPPA)
- Directors of offender management
- Commissioner and provider representatives for secure establishments
- Youth justice Board heads of region
- Adolescent and Adult Forensic In-patient service providers

At Local level:

- Local Authorities (LAs) in particular children's social care and education
- Health and Well-being Boards
- Local Safeguarding Children Boards
- Public Protection Panels
- Commissioners (LA and mental health)
- Primary Care Trusts (commissioners and their successor GP consortia commissioners)
- Directors of Public Health
- Police and Youth Offending Teams (YOTs)
- Third sector organisations
- Crime and Disorder Reduction Partnerships
- Drug Action Teams (DAAT)
- CAMH directors, managers, senior clinicians and tier 3 locality teams
- General Adult and Adult Forensic Teams

2.5.3. Related Services**At National Level:**

- Department of Health Offender Health Team and CAMHS Teams
- Youth justice Board health leads
- Centre for Mental Health
- Relevant Royal Colleges and Professional Bodies (e.g. Royal College of Psychiatrists (Adolescent Forensic Special Interest Group, Royal College of Paediatrics and Child Health, British Psychological Society)

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

The service is required to comply with the following national standards, guidance, frameworks and legislation as listed below:

- The Children Act 1989 and 2004
- Mental Health Act 1983 as amended in 2007
- Human Rights Act 1998
- Crime and Disorder Act 1998
- Mental Capacity Act 2005
- Crime and Disorder Act
- DH Offender Mental Health Pathway 2005
- NICE mental health guidelines

- Working Together to Safeguard Children (2010) and relevant subsequent legislation
- National Service Framework for Children, Young People and Maternity Services (2004)
- Every Child Matters in the Health Service (DH, 2006)
- New Horizons for Mental Health (DH, 2009)
- DH/YJB Information Sharing Guidance;

3.2 Applicable local standards

None apply

4. Key Service Outcomes

CFCAMH Services will need to demonstrate that they are achieving the core aims of the service (see section 2.1. These core aims are as follows:

- Improve mental health and well-being by identifying and addressing the mental health needs of high risk young people in a range of secure, residential and community settings
- Minimise risk of harm to self and others when it is linked to mental disorder
- Support access to relevant provision across agencies in line with the young person's identified needs, including transition to secure or adult services
- Supplement local provision with specific specialist input
- Promote social inclusion and ensure parity of provision for young people within the service remit
- Promote and support young people's developmental potential

Demonstration of the achievement of these aims will require clear evidence of the following service functions:

- Advice and signposting to referring professionals as appropriate
- In-depth formal clinical consultation with referring professionals
- Specialist CFCAMHS (mental health and risk) assessment and recommendations/provision of intervention
- Multi-agency liaison and active promotion and facilitation of case planning including ensuring of appropriate evidence-based treatments and care
- Longitudinal follow-up of identified cases
- Ensuring of smooth transition for relevant high risk young people to adult services
- Secure setting and court liaison including specialist understanding of and ability to influence care of an identified young person within team's specialist remit
- Close liaison with national adolescent forensic in-patient units
- Ability to deliver psychopharmacological, psychological and family-based interventions as necessary
- Delivery of specialist support and training to identified colleagues within catchment (e.g. CAMHS/YOS link workers, YOTs, individual CAMHS teams, children's social care and residential placements and education)

In addition, there will be a need to collect further service and clinical data, so that demonstration of achievement of aims can be achieved. An example of a suitable comprehensive database is provided in the appendices of the report by Dent et al for the DH (2012). A selection of suitable data is as follows:

- Waiting times and numbers: time from referral to assessment, time from referral to first intervention from hospital data systems
- Referral source to measure coverage
- Number of young people requiring triage, formal consultation, specialist assessment and intervention
- Evidence of identification of young person's needs (diagnosis, risk) and appropriate meeting of young person's needs, including:
 - duration of input from FCAMHS
 - nature of input (advice, consultation, assessment/intervention)
 - outcome in terms of agency involvement/lack of involvement at discharge

- evidence of needs being met/unmet where clearly identified at consultation/assessment
- Number of young people who are able to be maintained and cared for within local services, including out of area placement rates and length of stay
- Number of young people who are required to be admitted to forensic units or alternative residential placements (e.g. social care or educational)
- Extent of multi-agency strategic involvement e.g. delivery of appropriate training, associated service developments
- Patient / parent / carer / referrer satisfaction: questionnaire survey
- Access to support groups and education: questionnaire survey plus patient / parent / carer participation
- Evidence of programme of joint working with non-specialist centres: to include YOTs, CAMHS, social care, education, custodial settings and others
- Evidence of national equivalence of provision and service models
- Potential for review of long-term outcomes of young people involved with FCAMHS

5. Location of Provider Premises

The specialist services are to be:

- Regionally located and provided on a network model to ensure there is consistent and equitable nationwide coverage.
- Provide outreach across each region and ensure that there is appropriate coverage to meet the population needs according to population density, geographical distribution and levels of deprivation

6. Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]

Appendix 12: Sample Database for Community FCAMHS

List of Proposed Fields in Referral Database

Field Name	Description/Potential Responses
Client No.	Internal Id number
Age at referral	Age in years at time of referral
Sex	Male or Female
Ethnic Group	Asian or Asian British: Any other Asian background Asian or Asian British: Bangladeshi Asian or Black British: Pakistani Mixed: Any other mixed background Mixed: Mixed White and Asian Mixed: Mixed White and Black African Mixed: Mixed White and Black Caribbean Not Specified Other Ethnic Groups: Chinese White: Any Other White background White: British White: Irish
Address at time of referral	Not disclosed for analysis
Living arrangements at referral	Birth Family Other family arrangement Foster care Children's home Secure settings Independent living Semi-independent living Criminal Justice (SCH, STC, YOI) Mental health in-patient (PICU) Mental health in-patient (Low/Medium Secure) Adopted family Other specify:
Other agency/agencies involved at referral	Free text
Marital status	Married, Single, Divorced
CPA status	Nil or on CPA
Social Care Status (refer to advice sheet)	Looked After (S30/S31) Leaving Care Child in Need Subject to CP plan Living with birth family Adopted Other specify Not applicable
Education Status	SEN Special schooling Home tuition Out of school CFE Mainstream Other

Other Status at/prior to referral	Mental Health Act Secure Accommodation Order (CA) On remand Community sentence Custodial sentence On bail Other Not applicable
Referrer name and contact details	Free text
Referrer agency	CAMHS Other health Education Children's Services YOT Health YOT Other
Referrer area	Free text
Diagnosis at referral (if any)	Free text
Reason for referral	Free text
Date of referral	Date field
Date of first input	Date field
FCAMHS diagnosis	Free text
Other Status since referral	Mental Health Act Secure Accommodation Order (CA) On remand Community sentence Custodial sentence On bail Other Not applicable
Outcome	Initial Consultation only, case closed immediately Initial consultation only, case closed after 3 months Initial consultation, plus further input, no assessment Initial consultation, assessment, plus further input
Specify further input if Outcome 3) or 4) apply	Professional Liaison Family Liaison Therapeutic input Court
No of Contacts	Attended/ DNA/Cancelled
Date of discharge	Date field
Agency/Key professionals involved at discharge	Free text
Status at discharge (refer to advice sheet)	Mental Health Act Children Act (S20,S31) Leaving care Child in Need Subject to CP plan Secure accommodation order On remand Sentenced Other specify
Living arrangements at discharge	Adoptive family Birth family Children's home Criminal Justice Criminal Justice (YOI) Foster Care

	Independent Living MH In-patient (low/medium secure) MH in-patient (open unit) Semi-independent living Not known Other family arrangement Other (residential school)
Any other comments	