You pays your money and you takes your choice

Helping purchasers to commission an appropriate child and adolescent mental health service

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Health services are now commissioned at a local rather than a regional level. It is essential for local consultants to have an input to the planning and commissioning process. For the child and adolescent psychiatrist this task is complicated by an absence of nationally agreed guidelines on the level of resourcing required for a district child and adolescent mental health service. This paper describes an approach to advising purchasers which offers them a choice of service models that differ in their levels of resourcing. Each of the service models is described briefly. The advantages and flexibility of this approach are discussed.

The National Health Service (NHS) is currently in the throes of important changes in the planning of health services: the responsibility is shifting from the regional health authorities to local purchasing consortia consisting of one or more health authorities, the associated Family Health Services Authorities, advised by the Director of Public Health, and fundholding general practitioners (GPs). In the case of child and adolescent mental health, there is also a move towards the multi-agency planning of services (Department of Health and Department for Education, 1995).

Child and adolescent mental health services (CAMHS) are particularly vulnerable to these changes. The new purchasers often have a poor understanding of the role of child and adolescent psychiatrist, the epidemiology of child and adolescent psychiatric disorder and the remit, staffing and structure of CAMHS. It falls to the local consultant child and adolescent psychiatrist to attempt to educate them. They have at their disposal a number of helpful documents which address the planning of child and adolescent mental health services (e.g. Harris Hendricks & Black, 1990; Kurtz, 1992; Kurtz *et al*, 1994; Department of Health and Department for Education, 1995; Health Advisory Service, 1995), although none contains explicit recommendations on the basic level of resourcing required for a district service. Without these to support their case, clinicians in a chronically under-resourced service are handicapped in negotiations with purchasers. Although they will wish to press for the best possible level of service for their district, if they are too zealous they will run the risk of being viewed as unrealistic and their suggestions dismissed. The commissioning authority may then go on to design their own, possibly less clinically appropriate, service.

We have developed an approach to advising purchasers which capitalises on the lack of authoritative recommendations on the level of resourcing required for a district service: *Commissioning Child and Adolescent Mental Health Services: Choices for Purchasers* adopts the style of a hotel guide. It contains blueprints for a range of services, from 'one star' to 'five star', together with details of the facilities on offer (staffing levels, premises required, services available). We have used three service models, based on a typical catchment population of 100 000 with no marked socioeconomic skew. Each is described clearly, so that the advantages of the better service models and the shortcomings of the lesser are obvious. The purchasers are thereby furnished with the information necessary to make an informed choice on the level of service to commission. Table 1 shows the headings that were used to draw up the three models.

The optimal or 'five-star' service model, which we called the 'Comprehensive Service', was based on the size and scope of service that we considered ideal for a typical district. It consists of a multidisciplinary out-patient team with ten clinical staff and two multidisciplinary day patient services (which would be shared with another district) with six clinical staff each, one for adolescents and for children. In addition, one to three beds would be available on regional in-patient unit(s). The Comprehensive Service has an open referrals' system and provides a wide range of out-patient and day-patient assessments

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Table 1. Useful headings to consider when producing child and adolescent mental health service specifications

Population: the size of the population served, the age range (e.g. 0–18, 5–16, etc) and the number of new referrals to be processed by the service per year
Source of referrals: GP referrals only, medical professionals' referrals only, open access service
Assessments provided: urgent psychiatric assessments, behavioural assessments, neuropsychiatric assessments, neuropsychological assessments, forensic psychiatric assessments, education assessment, assessment of pervasive developmental disorders, etc.
Therapeutic approaches offered: family therapy, play therapy, pharmacotherapy, social skills groups, therapeutic programmes for sexually abused children and their families, group therapy for parents of young children, etc.
Consultation: to paediatric/medical services, to social services, to schools, etc.
Teaching: medical students, psychiatric trainees, social services, student nurses, etc.
Research
  Audit: clinical and medical.
  Premises and equipment: size of premises, word processors, budget for toys, books and journals, staff training budget, etc.
Staffing levels
  Management structure: is the manager a member of the multidisciplinary team, does the manager control the budget, etc.
  Secretarial support

for children and adolescents up to the age of 18 and young adults with children. Assessments are also conducted in schools and social services settings. A wide range of therapeutic approaches are available for out-patients and day-patients. Extensive consultation to other professionals and services is offered with an emphasis on the prevention and early detection of psychiatric disorder. Teaching is provided to a variety of professionals in different settings. There is ample scope for research and audit. This service would be able to process and treat up to 400 new referrals per year.

The minimal or 'one-star' model is based upon the nightmare scenario (which at times seems increasingly likely to be realised) of a consultant working single-handedly with secretarial support: the 'Consultant Only Service'. This would take referrals from medical professionals only of children and adolescents below the age of 16. Urgent psychiatric assessments only would be offered and there would be very limited scope for therapeutic approaches. One to three beds would need to be purchased on regional in-patient unit(s). This service would be able to assess and treat 50 new referrals per year.

An intermediate service model, the 'Basic Service', approximates to the minimum acceptable level of service for a district. It comprises a multidisciplinary out-patient service with six clinical staff. In addition, one to three beds are purchased on regional unit(s). Referrals are taken from professionals only of children and teenagers up to the age of 16 years. A more limited range of assessments and therapeutic approaches is offered than for the comprehensive service. There is far less scope for preventive and early treatment work and more limited consultation, teaching, research and audit. This service would be able to assess and treat up to 250 referrals per year.

The document also contains an introduction with the aims of a child mental health service, a brief review of the epidemiology, a description of the types of clinical cases needing out-patient, day-patient and in-patient services respectively and a brief description of preventive work. The 'tiers' of child and adolescent mental health service described by the Royal College of Psychiatrists (Hill, 1994), the Department of Health (1995) and the Health Advisory Service (1995) are acknowledged in the service model descriptions. There is a glossary listing the professionals who may be a part of the multidisciplinary team, together with their training and professional remit.

These principles can also be applied to negotiations with fundholding GPs. Fundholders are becoming an increasingly significant purchasing mechanism for out-patient CAMHS and total fundholders will also purchase day- and in-patient services. Clinicians can offer fundholders a choice of different levels of service, e.g. assessment and treatment, psychiatric assessment only, consultation with primary care professionals. A prerequisite of this approach is a realistic tariff that takes account of the overall cost of providing the services specified. It is essential for clinicians to maintain control over the treatment provided to individual cases so that fundholders cannot purchase therapeutic approaches that are clinically inappropriate.

The advantage of providing a choice of service models is that the purchasers are educated about CAMHS and, whichever model is chosen, the clinician's input to the planning process is maintained. A key element is that the number of

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referrals which can be processed per year is defined for each service model. It is important that this figure is incorporated into the purchaser–provider contract so that any discrepancy between the level of service commissioned and the level of need will be self-evident. If this situation arises, the purchaser should be encouraged to choose the way in which the service should respond, for example, by establishing a prioritised waiting list or by returning less serious referrals to the referrer. Resources in the NHS are limited and purchasers want the maximum clinical return for their investment. However, it needs to be made clear that it is counterproductive for clinical staff to struggle to offer adequate services with inadequate resources.

Describing the consultant-only service does not imply that the clinician believes that this is an acceptable level of service. By listing in detail the shortcomings and dangers of such a service, the purchasers are steered away from it and towards the Basic or Comprehensive Services.

Comments

The 'purchaser–provider' model has increased the accountability of clinicians, managers and purchasers for the clinical services provided. Inadequacies in services that are the result of underfunding rather than clinical inefficiency are clearly the responsibility of the purchasers. It is the responsibility of clinicians to provide the purchasers with the information that will enable them to commission a service appropriate to local needs. If the consultant describes several services models with differing levels of resourcing, together with the facilities offered and the shortcomings in each case, the purchasers are enabled to make an informed choice in the commissioning process. Describing a clearly inadequate level of service does not imply the clinician's approval of under-resourcing: this option is available to purchasers with or without the clinician's input. If the clinician describes carefully the clinical consequences of such a choice, then it is less likely to be made. This approach is flexible and can be tailored to suit the preferences of different clinicians and the requirements of different districts.

Copies of *Commissioning Child and Adolescent Mental Health Services: Choices for Purchasers* and of *The Child and Adolescent Psychiatrist's Stall in the Health Market*, the companion document which describes for purchasers the training, areas of expertise and skills of a child and adolescent psychiatrist, are available from the authors.

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