Aim
To develop and implement a template for the assessment of young people referred to camhs with primarily challenging behaviours.

Background
There is a nationally recognised gap in provision to meet the needs of young people who have symptoms of conduct disorder. Parenting programmes such as Incredible Years are a well validated treatment for children under 12 at risk of conduct disorder. NICE provides guidance re recommended treatments for over 11years but they acknowledge there are well recognised negative outcomes (e.g. young people learning antisocial behaviours from each other). Klahr in a review paper talks about targeting interventions for specific subgroups within the conduct disorder diagnosis. This gives an opportunity to refine the assessment process and discriminate treatment recommendations, give advice to referrers or contribute to multiagency management of risk.

Design and Methods
The QI methods included the formation of a small group who were willing to support the work. Stakeholder views from families and professionals had been gathered over the previous two years via challenging behaviour workshops. Meetings were held with various camhs managers, clinical governance meetings and camhs consultants to gather their views. Most concern was expressed by consultant colleagues re the validity of the diagnosis and whether it was work we should be doing. We completed a run diagram reviewing a 6 month period looking at all the young people referred into Weymouth camhs 11 years and above. The young people who met the criteria were divided into sets consecutive 5 compliant referrals and the same person assessed whether a full assessment had been made and whether the correct treatment had been recommended.

Actions to achieve improvement
We met with the team and the wider camhs transformation group to develop a pathway and template for assessment. We carried out a one off training session in August 2016 and I continue to provide informal supervision re these cases.

We completed a further run diagram for 6 months of referrals which was a similar time of the year as the first set. Less referrals were received that met the criteria but the run diagrams

Summary of improvement
The camhs staff were overall very positive about the ideas and training. Their experience had been that they often felt very alone with dealing with very risky behaviour without a clear way of working. The idea of contributing to a multiagency forum to manage risk they found very helpful.

July—Dec 2015 141 patients were referred for whom 55 (39%) presented primarily with externalising disorders, 60/40 male female. After the template development and training: Aug 16—Jan 17 127 patients were referred for whom 24 presented with primarily externalising disorders. There was the same ratio of 60/40 of males to females.

On a wider trust basis I have also collected initial figures for two other camhs patches on request, having presented the initial run diagram. Over a six month period one team had 16% externalising disorders and the other 14%. This has highlighted the different referral practices or acceptance through screening. The trust is now more actively looking at the numbers of young people who present risks to others as well as the those who are at high risk to themselves. It has opened the debate about whether camhs should be involved with assessing and treating these young people rather than seeing it as a social care problem. Currently camhs is developing a number of pathways regarding their services and conduct disorder has its own pathway. Therefore this work has fed into a wider agenda.

Run diagrams

Conclusions and Learning
Conduct disorder remains under diagnosed due to practitioners concern over the usefulness of the diagnosis and confidence in bringing about change. The process of drawing up a pathway and template for the assessment of these young people has opened up a wider debate about camhs’ role in providing assessment treatment and advice. Run diagrams have shown that the team has developed increasing confidence in assessing these young people over the last year. Despite trying to build the team involved it continues to need an advocate for these children within the trust. My consultant colleagues raised more concern re the change in practice and it is clear that there is very variable practice across the county. This may reflect catchment areas and availability of other services. As with neurodevelopmental disorders the clarification of ideal services and who might provide them will be part of an education, social care and health agenda. The QI approach helped with focusing areas of change.

Embedding change has been challenging due to change of all senior personnel both medical leads and managers and I have continued to have an advocate role to continue to highlight the needs of these children and families.

The run diagrams have been very helpful in presenting complex data visually and will be a technique I will use going forward.

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References
