EAST OF ENGLAND
MENTAL HEALTH CRISIS CARE TOOLKIT
- CHILDREN AND YOUNG PEOPLE

Summary Document

CONTENTS

1 INTRODUCTION

1.1 INTRODUCTION AND BACKGROUND

The East of England Clinical Network is pleased to present this toolkit for those developing and providing Urgent and Emergency care and support for Children and Young People who may be experiencing a mental health crisis in the East of England. The intention is that this a useful resource in the development and transformation of services for children and young people in the region and offers a guide to help ensure vulnerable children and young people receive the best possible care at the right time. This document is a summary of more in-depth chapters, which can be found by following the relevant hyperlinks.

Improving the quality of care and access to mental health services for children and young people is a priority for NHS England to deliver the vision set out in *Future in Mind*. The Five Year Forward View for mental health sets out the intention and commitment of NHS England to the aspirations of Future in Mind, which provides a major service transformation programme, aiming to significantly reshape the way services for children and young people with mental health needs are commissioned and delivered across all agencies over the next 5 years.

Clinical Networks (CN) (formally known as Strategic Clinical Networks) have been actively supporting CCG and Local Authority commissioners to work across the local system to develop Local Transformation Plans. The goal is for partners to work together to agree a shared vision and commit to a joint plan of what needs to happen locally to improve children's mental health services. One of the key products of the work of the East of England CN is the development of this toolkit to support providers and commissioners in the development of transformed crisis services for children and young people across the region.

The development of this toolkit has been informed and shaped by a series of consultations and multi-agency events across the region with key partners and stakeholders working together. A list of all participants can be found at the end of this summary document.

1.2   WHO IS THE TOOLKIT FOR?

The aim of this toolkit is to offer a range of resources, information and guidance that can be used in transforming local crisis services for children and young people. The anticipated outcome is that the needs of an extremely vulnerable group of young people is met in a compassionate and informed way to improve the lived experience at such a key time for all involved. The toolkit can be used by:

Commissioners: to ensure the services developed represent best practice and evidence, mapped against service need, and to help ensure that the development of new services fully reflects the views of local service users.

Service providers: to guide service managers and organisational leaders to ensure the work of teams and services is compliant and aligned with the latest national and regional standards.

Practitioners: to provide information, resources to enhance the skills, knowledge and competences of individuals and teams working directly with young people and their families.

Additionally, this resource may be of use to young people and their parents/ carers where they want to understand what should be expected from a service and the standard of care teams and services should be working towards.

1.3   HOW TO USE THE TOOLKIT

The toolkit has been produced in a brief and accessible format to enable users to find the information relevant to them as easily as possible. Throughout the toolkit there are links to a range of documents, some of which were developed specifically for this. This approach has been developed in partnership with a number of key stakeholders in the region to ensure that it is accessible to a range of users.

2 DEFINITIONS OF CRISIS

2.1 SAFEGUARDING AND SYSTEMIC APPROACHES

For children and young people there is often a very significant cross over and interplay between 'social care' crises and 'mental health' crises. Young people are inevitably affected by a number of different systems. A crisis for young people is rarely due to a mental health problem alone: the breakdown in significant relationships; the impact of past or current trauma and abuse or problems with money or housing are likely to present as well.

Emotional wellbeing and mental health affects all aspects of the lives of children and young people, and significantly impacts on their current outcomes and their outcomes later in life. It is therefore vital that they receive the right support as quickly as possible. The interplay between mental health and safeguarding needs can be complex but is vital to ensure that the risk of significant harm is assessed thoroughly on each and every occasion, that local safeguarding children procedures are followed, and that young people receive the right care at the right time. This toolkit adheres to the principles outlined in Working Together to Safeguard Children 2015[1] which emphasises the collective responsibility of agencies in safeguarding children and the need to provide a child centred approach to meet the needs of children and young people as effectively as possible.

The most vulnerable young people often present with complex issues and their behaviour is frequently challenging and dangerous with root causes stemming from traumatic and damaging life experiences. In a crisis, no one agency can meet needs and there is growing recognition of the value of good multi-agency, professional responses offering a child or young person centred positive outcomes.

2.2 DEFINING TERMS: WHAT IS A CRISIS?

The NHS Choices website[2] describes a mental health crisis occurring when someone no longer feels able to cope or be in control of their situation.

A child or young person may feel great emotional distress or anxiety and feel they cannot cope with day-to-day life, school or work. They may have thoughts about suicide; they may deliberately harm themselves; or seek to harm others. They may experience hallucinations or hear voices. A crisis may not be related to a specific mental disorder, it can come about as the result of an underlying medical condition, such as confusion or delusions caused by an infection, overdose, illicit drugs or intoxication with alcohol.

Anyone can experience a crisis. Crises can be experienced by people of all ages, cultures and socio-economic circumstances.

Mind[3] describes a mental health crisis as occurring when someone feels their mental health is at 'breaking point'. For example, reacting to setbacks in an extreme way with feelings becoming so overwhelming that young people run away, hurt themselves or others, feeling they no longer want to go on living. They may:

- Feel paranoid

- Hear voices

- Display other behaviour that feels out of control, and is likely to endanger themselves or others

A crisis is an acute, time-limited episode experienced as overwhelming emotional reactions to an event. What is a crisis for one person may not be so for another. What becomes a crisis may not have been a crisis before or would not be a crisis in a different setting. Crisis has been described as a system out of balance. Crises occur when balance cannot be regained, even though a person is trying very hard to correct the imbalance.

1 https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
2 http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained/Pages/mental-health-emergencies.aspx
3 http://www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/#.WBN5reTrvx8

The Healthy London Partnership Mental Health and Wellbeing Implementation Group[4] uses the following definition of a mental health crisis:

"A mental health crisis occurs when the level of distress and risk presented by a young person is not supported or contained by the care system that is in place for them. It may be the view of the young person themselves and/or the view of those involved in their care, that their current condition and situation represents a crisis. The crisis might be triggered by a worsening of the young person's condition, a weakening of the support system, or both. In reality, these are not independent factors and the young person's experience of weakened support frequently triggers a worsening of their condition".

However, currently, it must be acknowledged that the support for children and young people with emotional and psychological problems or disorders can be fragmented across a network and confusing to navigate for young people and their families.

Despite the statutory duty of cooperation placed on services to work together to the benefit of children and young people, nationally the evidence of improved cross-over and real collaborative partnership is slow to build.

Usefully, the Interim Learning Report from the Department of Education Social Care Innovation Programme[5] has a number of examples of how social care, education and the voluntary sector are working innovatively and more systemically to address mental health issues more effectively.

Different perspectives are important in the definition of crisis. The Joint Commissioning Panel for mental health says that defining crisis involves these different perspectives:

- **Self-definition:** defined by the person or carer as a fundamental part of that person owning the experience and their recovery. Identifying potential crises is a skill that can be developed as part of self-management.

- **Negotiated or flexible definition:** defined as outside the manageable range for the individual, carer or society; to use the crisis service, a decision is reached between the user and the worker.

- **Pragmatic, service orientated definition:** defined by the service as a personal or social situation that has broken down where mental distress is a significant contributing factor. Crisis is a behavioural change that brings the user to the attention of crisis services and this, for example, might result from relapse of an existing mental illness. For the team, however, the crisis is the impact of the change on the user and the disruption it causes to their life and social networks.

- **Risk-focused definitions:** viewed as a relatively sudden situation in which there is an imminent risk of harm to the self or others and judgement is impaired – a psychiatric emergency – the beginning, deterioration or relapse of a mental illness.

- **Theoretical definitions:** where crisis is viewed as a turning point towards health or illness, a self-limiting period of a few days to six weeks in which environmental stress leads to a state of psychological disequilibrium. Crisis is defined on the basis of the severity, not the type of problem facing the individual, and whether any acknowledged trigger factors for a crisis are present.

4 https://www.myhealth.london.nhs.uk/system/files/Improving%20the%20care%20of%20CYP%20with%20mental%20health%20crisis%20in%20London%20-%20 Emerging%20findings%20November%202015.pdf
5 http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained/Pages/mental-health-emergencies.aspx

2.3 WHAT IS A CRISIS SERVICE?

A crisis service is any service that is available at short notice to help resolve a crisis, or provide support while it is happening. The majority of these services are provided by the public sector (NHS or social services) – more information about these services can be found in *Chapter 4* of this toolkit. Broadly these services can be grouped as follows:

- **Paediatric Liaison teams**

- **24/7 Crisis Care Home Treatment Teams**

- **'Tier 3.5' or 'Tier 3+' teams**

- **'Assertive outreach' or 'intensive community' CAMHS services**

However, recently, there is evidence of some examples of crisis support services also being commissioned in the voluntary sector (charities or not-for-profit organisations). For example, Turning Point delivers a service called Crisis Point in Manchester. The service won a national award in 2015 for its innovative work in providing community based short stay crisis accommodation as an alternative to hospital provision.

www.turning-point.co.uk

2.4 DESIGN PRINCIPLES:

Within the national policy direction outlined in the next chapter of this document there is a focus on ensuring the development of locally developed, responsive crisis services. In terms of the context of service design, overall, there is broad agreement that crisis support services should aim to be:

- **Person centred:** ensuring that the perspective of the service user and their family or carers is central.

- **Asset (strength) based:** where support is planned around the strengths and assets available individually and within the family unit and wider support network.

- **Least restrictive:** options are available that help support the service user and their family with minimum restriction where possible.

- **Proportionate:** service options are available that allow for thorough assessment, immediate and short term support and intervention, but also more intensive crisis resolution support [2&3]. Crucially for children and young people safeguarding must be prioritised and central to all assessments to ensure young people are safe.

- **Learning from experience:** post crisis debriefing will allow service users, their carers and multi-agency professionals to identify what works and what doesn't for individuals

- **Self-management focused:** the crisis is viewed as a turning point where an intervention has the potential to help the service user make changes that will resolve the crisis but also provides a change and learning opportunity supporting future self-management. It also enables people to identify their own triggers and spot early indicators of potential crisis or relapse. This is likely to be more challenging when young people remain living in challenging circumstances and remain vulnerable to environmental or family risk factors.

- **Effective multi-agency working:** is pivotal given the range of services and systems that children exist and most particularly in relation to safeguarding. Past serious case reviews have repeatedly referenced the very significant risks for children and young people when agencies fail to work effectively together.

3 LITERATURE REVIEW

3.1 INTRODUCTION & PURPOSE

This review brings together some key literature around the development and provision of mental health crisis services for children and young people. In order to support the alignment of service development with national policy direction and drivers, it summarises the most recent changes at a national level applicable to crisis support. It also sets out the different types of children's mental health crisis services that are being developed across the country to provide a point of comparison and potentially provide inspiration for local developments.

There is growing evidence[6&7] of the effectiveness of early intervention in mental health problems – both for the health of the population and in terms of economics. Early intervention for children and young people reduces the chances of them going on to develop more serious and enduring mental health problems in adulthood, which impact very significantly on outcomes in later life.

In the document 'No Health without Mental Health'[8] the costs of mental ill health during childhood and adolescence are described as ranging from £11,030 to £59,130 annually per child. This figure is said to include costs to the NHS, the costs of reduced educational outcomes, increased crime, as well the wider impact on later quality of life. Crisis teams or Paediatric Liaison teams located within acute hospitals could reduce this spend by reducing out of area placements[9], with even 1% improvement could lead to £5m savings each year.[10&11]

6   NHS Confederation, Mental Health Network. Early intervention in psychosis services. Briefing 219. NHS Confederation, May 2011
    http://www.nhsconfed.org/Publications/Documents/early_interventionbriefing180511.pdf
7   Knapp, Martin, McDaid, David and Parsonage, Michael. Mental health promotion and mental illness prevention: the economic case. Department of Health, 2011
    http://eprints.lse.ac.uk/32311/
8   Department of Health No health without mental health: A Cross-Government mental health outcomes strategy for people of all age. 2011
9   Darwish et al (2006) The community intensive therapy team: development and philosophy of a new service. Clin Child Psychol Psychiatry.(4):591-605
10 Parliamentary Select Health Committee Children's and adolescents' mental health and CAMHS 2015
    http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34210.htm
11 Department of Health No health without mental health: A Cross-Government mental health outcomes strategy for people of all age. 2011

3.2 THE NATIONAL POLICY CONTEXT

CAMHS crisis and intensive service models have developed in response to an ideological move away from inpatient psychiatric care, and a need to offer alternative options of intensive care, to respond appropriately to young people's mental health crises. Policy and practice has recognised the chronicity of mental health conditions, and that long-term pathways are followed by only a few young people with severe, persistent and complex high level needs.

Services and commissioners have both recognised the potential to reduce the severity and length of mental health problems through better early intervention and prevention, right at the beginning of the pathway, ideally perinatally and in early childhood, for children with identified vulnerabilities. Some CAMHS provision report that at least half of the young people they see have never been seen by a service before, giving weight to the drive to retain early intervention services in the system.

Over the last decade there has been a growing awareness of both the need to involve a young person's family and wider community, and the ambition to provide mental health services closer to a young person's home[12].

In 2003, The National Service Framework for Children, Young People and Maternity Services[13] as well as the recently amended **Mental Health Act 2007** set out the expectation that young people should receive care and treatment in an environment that is suited to their age and development.

In 2011, **'**No Health without Mental Health[14] and **Future in Mind** in 2015 raised the issues of parity between physical and mental health and parity between adults and children. The Mandate from the Government to NHS England[15] included a specific objective for the NHS, to "put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole".

The Mandate for 2014-15 also establishes specific objectives for the NHS to improve the care for mental health crises. The immediate commitments made by NHS England are contained in the Crisis Care Concordat. The task and finish group working on the development of the Prevention and Access report[16], (a guiding document for Future in Mind) points to the need to for young people to receive appropriate support and intervention as outlined in the Mental Health Crisis Care Concordat . The *Crisis Care Concordat*[17] says that the local offer for those in crisis should include a swift and comprehensive assessment of the nature of the crisis. This should include an out-of-hours mental health provision that can respond effectively to the needs of children and young people.

Future in Mind[18] also advocated for clear, evidence-based pathways for community-based care, including intensive home treatment where appropriate, in order to avoid unnecessary admissions to psychiatric inpatient care. In line with this, NHS England recently published 'Implementing the 5 year forward view for mental health'[19] which invites CCGs to commission improved access to 24/7 crisis resolution and liaison mental health services, which are more appropriate for children and young people. The expectation of this implementation plan is that, through the increase in community services, there will be a subsequent reduction in the use of in-patient beds for children and young people, with savings to reinvest in community mental health services.

In 2016/17, £5.5 million funding was profiled to aid in the development of crisis and paediatric mental health liaison services, to test and evaluate service models, as currently there is a limited evidence base about what works well.

To support crisis services there is clear guidance from both NICE and the Royal College of Psychiatrists. These acknowledge, for example, that there can be a clinical need for overnight stays in acute hospital following A&E presentation for self-harm in children and young people, to ensure that the crisis can be managed safely.

12 Royal College of Psychiatrists (2014). Managing Self-Harm in Young People. London, RCPSYCH
    http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr192.aspx
13 Department of Health (2003) The mental health and psychological wellbeing of children and young people (standard 9). London, DH.
14 Department of Health (2011) No health without mental health: A Cross-Government mental health outcomes strategy for people of all age. London, DH.
15 Department of Health. The Mandate; a mandate from the Government to NHS England: April 2014 to March 2015. Department of Health, November 2013.
    https://www.gov.uk/government/publications/nhsmandate-2014-to-2015
16 Department of Health (2015). Prevention and Access Task and Finish Group Report. London, DH.
    https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413405/Preventionandaccess.pdf
17 Department of Health and Concordat Signatories (2014). Mental Health Crisis Care Concordat. London, DH.
18 Department of Health (2015) Future in Mind- Promoting, protecting and improving our children and young people's mental health and wellbeing. London,
    DH https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf
19 NHS England (2016). Implementing the 5 year forward view for mental health. London, NHS E.
    https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

4 MODELS OF CRISIS WITHIN NHS CAMHS

4.1 MODELS OF CRISIS IN CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH PROVISION

As referenced earlier, the Mental Health Crisis Care Concordat describes the actions required of commissioners and providers to ensure that those experiencing a mental health crisis are properly supported. It emphasises that crisis is a very serious issue, wherein people who have reached crisis point have been injured or have died when responses have been wrong.

The expectation of the Concordat is that in every locality of England, local partnerships of health, local authority and criminal justice, and other key stakeholders, commit to the local mental health crisis declarations. The 4 key areas of the Concordat are arranged around (click to follow to the weblink):

Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.

Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.

Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.

Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

There are many well established paediatric liaison service models across the country, which are currently being more reliably mapped and compared. Most of these services seek to address the needs of young people as they present to acute hospitals in crisis. There has also been a move,

in recent years, toward providing young people's crisis support services within the community, as an alternative to the use of inpatient psychiatric services, in order to better meet the needs of young people and to improve their experience of services [20].

Note: These two service models of paediatric liaison and community crisis support could be complementary or even integrated, rather than being considered as competing models.

A NHS Benchmarking exercise undertaken in 2013[21], across a network of 65 CAMHS providers, revealed that currently there few areas offering community based crisis response services, with less than 40% of networks providing rapid access to crisis support and intervention through crisis pathways. They described the emergence of 'niche' services that were delivered on an infrequent basis, comprising of services and projects such as: day units, community based crisis support, family preservation schemes, and home treatment services.

'Implementing the 5 year forward view' suggests the introduction of community crisis services and liaison models. However for children and young people, the evidence base regarding such models of crisis response is less well developed than in adult services. Evaluation of new models of crisis care beginning to emerge across the country for children and young people will help to build the evidence base over the next five years.

Note: Given the limited evidence base it is crucial that the development of any crisis or liaison based services for children and young people are based on sound clinical practice, robust clinical and safeguarding protocols and on the use of intelligently selected outcome measures to ensure rigorous and effective evaluation of what works.

20 McDougal, T Cotgrove, A. (eds.) (2014). Specialist Mental Healthcare for Children and Adolescents: Hospital, Intensive Community and Home Based Services. UK Routledge.
21 NHS Benchmarking Network (2013) CAMHS Benchmarking Report. http://www.rcpsych.ac.uk/pdf/CAMHS%20Report%20Dec%202013%20v1(1).pdf

Service standards exist around community CAMHS, which recommend that the specialist and intensive support is provided through a same day response, for those with presenting with a mental health crisis or severe mental health symptoms, with an option to access in-patient provision where a risk to self or others cannot be managed in a community setting[22]. There are also the Core24 standards for liaison psychiatry[23] which are all-age but have an adult emphasis. 'Implementing the 5 Year Forward View' sets out that by 2020/21, all acute hospitals will have mental health liaison teams in place to meet the needs of every age, and at least 50% of these will meet the 'Core 24' service standards as a minimum.

Note: It is important to consider how all-age teams would effectively address the specific developmental needs and the safeguarding needs of children and young people. The risk within an integrated all-age service is that the approach may be overly generic and adult orientated.

The logistical challenge of an all-age service in ensuring that that all clinicians have the right range and depth of skill to assess and treat across the age span is challenging. There is a danger that the dilution of the knowledge, skills and expertise needed in the assessment of children and young people could potentially put young people at increased risk of significant harm. The range of issues impacting on vulnerable children and young people is complex and where the causes of crisis are poorly identified or badly managed, children will be at increased risk of harm.

The Mental Health Taskforce Strategy – 5 year Forward View for Mental Health[24] states that *'by 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission.'*

It is important to acknowledge that there are still a number of barriers to successfully implementing crisis teams across the country including lack of experience in hospital settings, a lack of early support provision, paucity of environment, poor join-up across the system, fragmented commissioning arrangements as examples.[25]

Notwithstanding these challenges, a key theme has emerged from the literature, national guidance and recent policy which will be key in any transformative work. The drive for greater **multi-agency** approaches when developing and providing services that respond to mental health crisis is clear. It is argued that as children and young people exist in a range of systems, a systemic response is considered a necessity to achieve a truly transformative improvement in the delivery of services. Some examples of multi-agency approaches in the management of crisis care are summarised in *4.2*. Where outcomes and evaluation of these services are available these are also briefly presented. Some other innovative approaches to the development of crisis care are also included to promote reflection.

4.2 APPROACHES TO DEVELOPING MENTAL HEALTH CRISIS SERVICES

Crisis interventions, broadly speaking, should aim to understand the cause, nature and severity of a crisis. Children and young people may have different presentations to adults. For example, a suicide attempt by an adult may be categorised as a "mental health crisis". However, for a child or young person, this sort of presentation is more likely to be a psychosocial crisis, requiring assessment and intervention related to physical health, mental health and safeguarding. The approach also needs to be systemic, i.e. involving family and the wider network of existing services, including in joint meetings and planning.

Note: To focus purely on mental health in service design would be likely to miss key clinical areas and therefore be ineffective.

22 CCQI/RC Psychiatrists (2012). Service Standards: 3rd Edition. Quality Network for Community CAMHS. Royal College of Psychiatrists. Retrieved from:
http://www.rcpsych.ac.uk/pdf/QNCC%20Service%20Standards%203rd%20Edition.pdf
23 Mental Health Partnerships (2014) Developing Models for Liaison Psychiatry Services – Guidance.
http://mentalhealthpartnerships.com/wp-content/uploads/sites/3/3-developing-models-for-liaison-psychiatry-services.pdf
24 Mental Health Taskforce (2016) The Five Year Forward View for Mental Health
https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
25 Jennings, S. (2015) Young People in Crisis: Case for Change and Model of Care. Presentation given at Children and Young People Local SCN meeting
http://www.londonscn.nhs.uk/wp-content/uploads/2015/06/cyp-camhs-event-160615-jennings.pdf

A range of adult crisis models have been proposed in literature over the past decade[26,27,28,29] some of which have been adapted for use with children and young people. A number of these emerging models are currently being further developed and some have been evaluated to demonstrate clinical effectiveness. A combined model of crisis care, which integrates specialist community CAMH services and in-patient services, is often cited as best practice[30 & 31]. New crisis services currently being developed can be categorised as follows:

- Paediatric Liaison teams

- 24/7 Crisis Care Home Treatment Teams

- 'Tier 3.5' or 'Tier 3+' teams

- 'Assertive outreach' or 'intensive community' CAMHS services

- **Paediatric liaison** teams provide assessments of emergency situations including overdose or self-harm. They also offer support on the management of psychological sequelae of chronic physical health conditions like diabetes, asthma and support the management of medically unexplained symptoms. Crisis assessments by paediatric liaison teams are embedded within acute hospital settings. Short paediatric stays with skilled multi-disciplinary liaison and interventions are offered to can avoid the need for inpatient psychiatric care.

- **24/7 Crisis Care Home Treatment Teams** support young people on discharge from inpatient units, aim to reduce length of stay and prevent readmission. Home Treatment Teams specifically seek to prevent admission to inpatient care. Services provide a 'step down' function aiming to facilitate early discharge from inpatient care. Both of these sorts of services are catering to a vulnerable and high risk population, managing complexity and risk. Clinical input should involve Consultant Child and Adolescent Psychiatrists. It has been found that some Home Treatment teams may also be successful in engaging with groups who would not typically take up outpatient or inpatient services.

- **Tier 3.5 or Tier 3+ Teams** a crisis and home care team that offers assessment, intervention and support to young people experiencing significant mental health difficulties. The assessment can be offered initially in hospital if the young person has presented there and the care and support offered when the young person goes home to ensure their safety and care needs are met.

- **Assertive Outreach Teams** Intensive Community CAMHS services aim to prevent inpatient psychiatric care. Teams work from within the community to enable young people to stay at home while ensuring that admission, if needed, is made to the appropriate service. They will work to support young people access education, employment and meaningful daily activities, support families in coping and managing young people with mental illness/health issues, support young people and families through education and identification of relapse and crisis signature work, provide opportunities to increase physical as well as mental wellbeing of young people

4.3 CASE STUDIES/SERVICE EXAMPLES

Five areas from the East of England provided information on their current crisis service and their responses to mental health crises for children and young people. The service provision available in these areas is summarised in a separate document. This is presented alongside the findings from recent consultations with local stakeholders.

The full report is also available here.

Additionally, number of innovative services from across the UK have been highlighted for review. A link to a summary report outlining these in more detail can be found by clicking the following hyperlink:

Examples of crisis services in England.

26 Darwish et al (2006) The community intensive therapy team: development and philosophy of a new service. Clin Child Psychol Psychiatry.(4):591-605

27 Lamb, C.E. (2009). Alternatives to admission for children and adolescents: providing intensive mental healthcare services at home and in communities: what works? Current Opinion in Psychiatry, 22, 345-350.

28 McDougall, T., et al . (2008), Tier 4 Child and Adolescent Mental Health Services (CAMHS) - Inpatient Care, Day Services and Alternatives: An Overview of Tier 4 CAMHS Provision in the UK. Child and Adolescent Mental Health, 13: 173–180

29 Worall-Davies, A and Kiernan, K (2005) Using a Virtual Team: An evaluation of the Bradford CAMHS Intensive Home Treatment Approach. Research Report. University of Leeds.

30 McDougall, T., Worrall-Davies, A., Hewson, L., Richardson, G., & Cotgrove A. (2008). Tier 4 Child and Adolescent Mental Health Services (CAMHS) – Inpatient Care, Day Services and Alternatives: A Overview of Tier 4 CAMHS Provision in the UK. Child and Adolescent Mental Health, 13(4), 173-180.

31 Thornicroft, G. & Tansella, M. (2004). Components of a Modern Mental Health Service: A Pragmatic Balance of Community and Hospital Care. Overview of Systematic Evidence. The British Journal of Psychiatry, 185, 283-

5 CO-PRODUCTION AND THE STAKEHOLDER VOICE

5.1 INTRODUCTION

In order to develop the best services and ideal range of provision, providers need to work in partnership with service users and their families. Co-production is defined by the New Economics Foundation as follows:

"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change" (NEF 2009)

Co-production is not a new word for public engagement, service user involvement or consultation. It also goes beyond 'allowing' people to have a say in decision making. Research is showing that public services work best when designed and run by a combination of professional expertise and community insight. Co-production takes place at both the individual and collective levels – when people link up with others either with similar issues or values. The short animation film included here gives a very accessible overview of this issue within public sector services – *The Parable of the Blobs and Squares*

The link to *NESTA Co-production Practitioners' Network* and *Governance International's resources* provide some useful reading and tools to develop practice in this area.

Co-production is an integral part of ensuring that a truly transformative approach has been undertaken across the East of England Region.

To steer and influence service development, there is already available a wealth of information and feedback from a children and young person's and carers' perspective. Some of this is summarised below.

5.2 NATIONAL PERSPECTIVE

There has been a significant amount of work conducted nationally to elicit the views and feelings of young people and their parents and carers in relation to mental health services. There are several useful sites and blogs which articulate views and experiences of young people accessing services and their experience of being engaged in service design (for example *Patient and Public views on 7 day NHS*).

A useful short film made by young people on what they experienced from services in a crisis and what would make things better: *Chilypep video: Young People's experiences of MH Crisis support.*

The toolkit produced by Young Minds reflects the experience of parents and carers: *Parents Say*

Consistently feedback states that services should be delivered as close to home as possible, and that there is a need to help to prevent crisis, as well as respond to it. Children, young people and families have also said that they want to be directly involved in creating plans for their care. They need to get help quickly and do not want to have to navigate through a complex system.

Within consultation exercises, young people generally report that they access a lot of information about mental health online[27]. They would therefore like better use of and more reliable web-based information. They suggest that professionals need to use spaces such as discussion boards and other web-based media as well. The significance of young people's naturally occurring networks of support are hugely significant in thinking about how services are delivered, with young people highlighting that friends are a key source of support (but not always best equipped to help). Similarly, schools are seen as good places to access information and school nurses key professionals.

5.3 LOCAL PERSPECTIVES

The views of a broad range of stakeholders across the region were captured. A report on information reviewed from a consultation with Acute Paediatric Hospital staff can be *found here*.

The themes from this work are summarised below and should help to inform future development work around services to support children and young people in crisis:

- Stakeholders recognised the need for a multi-agency response to mental health crisis, given children and young people exist in a range of systems, a whole system approach would be more likely to achieve success for the young person.

- The inclusion of a broader skill set in the development of services was seen as necessary to achieve a truly transformative improvement in the delivery of local services.

- The need to have a shared value base across the system.

- The need for a clear pathway to enable staff to navigate the system and deliver an appropriate, proportionate and timely response to each crisis situation.

- A clear access point and easy telephone access.

- A parity of crisis service provision to that of adult services.

- The voice of the young person and their parents/ carers being heard and taken seriously and made visible in service development is vital.

- Effective support and containment for both the young person and those working with the young person in the supporting system.

Given the cross-over between different aspects of service provision and crisis intervention, it is worth reflecting on any recent local consultations that have taken place in the region that have relevance. For example, *a recent consultation with a group of young people in Suffolk*[32] about the development of a single point of access and assessment (SPAA) has significant cross-over for consideration in the development of a crisis service. The young people involved urged the need for greater transparency and stressed that they wanted to understand decision making processes around service provision to better appreciate how decisions had been reached. Again this is an important message to commissioners and providers alike. In a national consultation, young people reflected that in the development of any service the following principles should be included:

- **Responsive Services** - Provide the right service at the right time. This means staff who can talk to you who are available at key times, not just 9-5 Monday to Friday.

- **Transparency:** to be open and honest

- **Listening well** to what young people say

- Staff who can **navigate the system** and be clear on next steps

- **Containment:** Provide some support, so the young person feels 'held' by the service

- **Creative questioning:** Ask different sorts of questions to give young people the best chance of communicating

- **Respect:** Treat the young person as a real person

The link to the report can be found here

32 NHS Confederation, Mental Health Network. Early intervention in psychosis services. Briefing 219. NHS Confederation, May 2011
  http://www.nhsconfed.org/Publications/Documents/early_interventionbriefing180511.pdf
Link to Report http://www.childrenscommissioner.gov.uk/sites/default/files/publications/amplify-mental-health-report.pdf

6 **STANDARDS**

6.1   MENTAL HEALTH CRISIS CONCORDAT

The document 'Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis[33]' provides clarity on what people who use services should expect. Specific standards for crisis services for children and young people are shortly to be published by NHS England.

The comments made by young people and other key stakeholders in this report, also provide indicators of potential standards of care, which could be considered and included.

The thematic review[34] undertaken by the Care Quality Commission 'Right Here Right Now' (June 2015) describes people's experiences of help, care and support during a mental health crisis. The summary document usefully pulls together the findings from this review which would support any work on developing service standards.

6.2   CHARACTERISTICS OF CRISIS PROVISION

There some are key characteristics of crisis provision, which may be helpful to note. These are set out below[35]:

● Immediate response: access a crisis response from a CAMHS professional within a few hours of initial request.

● 'Out-of-hours' cover: able to respond within 24 hours 7 days a week, with cover provided by a professional who can undertake a Mental Health Act (MHA) assessment at any hour.

● Assertive approach to engagement: persistent and creative approach with repeated attempts to make contact, including immediate follow-up of those who do not attend appointments (DNAs)

● Flexible approach: safe meeting locations agreed with young person and or carer, at a time that suits them (incl. phone, face-to-face contact at home or school).

● Planned intensive intervention: frequent clinical input and high staff to service user ratio until the need for intensive input is resolved.

● Support the stepped care approach: provide continuity of managed care to standard community, day- or in-patient CAMHS care as required.

● Collaborative relationships: able to access other CAMHS professionals, and agencies as required in order to meet the needs of the young person and their parent or carer

An example of an action plan format is contained in the 10.1 'useful resources' section for use to benchmark against standards.

33 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
34 https://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf
35 RC Psych (2016) QNCC Standards for a Crisis and Intensive Response in CAMHS
http://www.rcpsych.ac.uk/pdf/Quality%20Network%20for%20Community%20CAMHS%20Sample%20Standards%202012.pdf

7 PERFORMANCE

In order to assist services in their transformation journey some tools and resources have been described below, linked to performance and evaluation of services. These can be useful in strategic planning, monitoring performance and evaluating the service transformation.

7.1 CONTINUOUS IMPROVEMENT

The recent strategy developed by the King's Fund states:

'Improvements in the quality of care do not occur by chance. They come from the intentional actions of staff equipped with the skills needed to bring about changes in care, directly and constantly supported by leaders at all levels'.[36]

Continuous improvement is a method for identifying opportunities for streamlining work and reducing waste. Continuous Improvement is about continually improving the quality of a service and is based upon the principle that most things can be improved through small, incremental changes. The continuous improvement cycle is well known in the NHS and is shown below:

Analyse, Plan, Review, Do:

The NHS IQ site has a number of tools which may be of use to both commissioners and service managers on the following link:
NHS Improvement tools

7.2 THE BALANCED SCORE CARD APPROACH

A Balanced Scorecard approach (Kaplan and Norton, 1990) uses 4 quadrants which are underpinned by a clear vision and strategy. The different quadrants focus on a broad spectrum of key areas and move beyond the outputs or narrow performance indicators. Organisation or service vision is delivered when all 4 quadrants are addressed. All sections of the service will be involved to demonstrate progress.

The quadrants are set out below with some prompt questions to illustrate the thinking and reflection that is needed:

Finance
- Does each team/service know its true cost?
- How does the organisation/service demonstrate value for money?
- How can we better ensure services are cost effective?

Internal process
- What processes do services need to excel at in order to deliver high quality service?

Learning & growth
- What do services need to do to improve and sustain improvements?
- How do services need to adapt to better meet demands?
- How do services learn and innovate to respond to changing demands?
- What aptitudes, attitudes, resources and skills are needed in the workforce to deliver high quality services?

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[36] Kings Fund: Improving Quality in the English NHS (2016)
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Improving-quality-Kings-Fund-February-2016.pdf

Stakeholders (service users, government, NHS England, commissioners, CCGs, partners, communities)

- What do services need to do to satisfy key stakeholders?
- To what extent are their expectations/needs met?
- What results do stakeholders need to see?
- What does good look like?

The diagram below shows how these 4 quadrants work together and can be used as a template for future use in services:

INTERNAL PROCESSES

STRATEGIC OBJECTIVE	METRIC	TARGET	INITIATIVE

FINANCIAL

STRATEGIC OBJECTIVE	METRIC	TARGET	INITIATIVE

VISION AND STRATEGY

EMPLOYEE

STRATEGIC OBJECTIVE	METRIC	TARGET	INITIATIVE

CUSTOMER

STRATEGIC OBJECTIVE	METRIC	TARGET	INITIATIVE
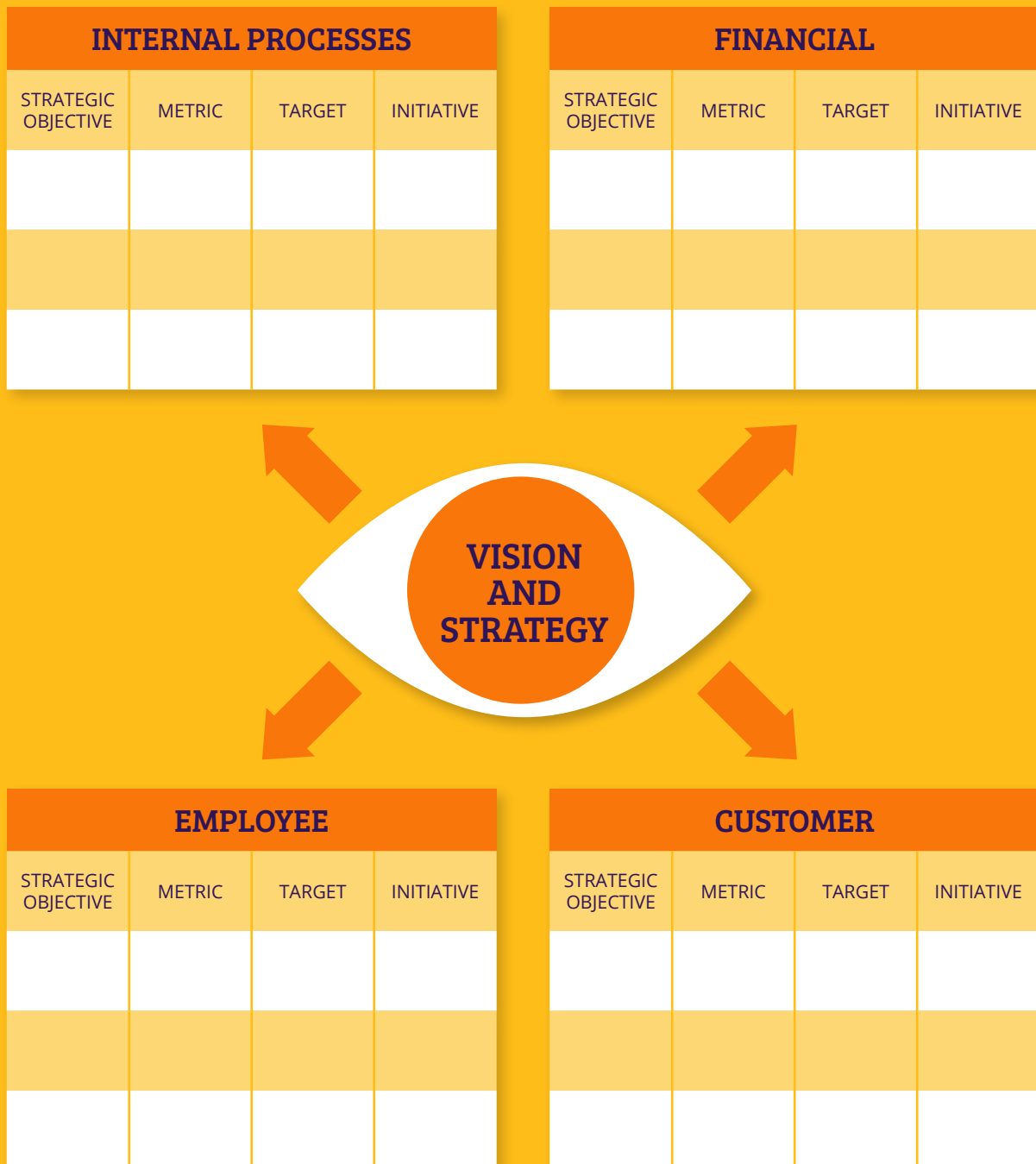
8 EVALUATION

8.1 CLINICAL MEASURES: ROUTINE OUTCOME MEASURES

In order to develop effective and safe services for young people experiencing crisis, commissioners and service providers are required to monitor and evaluate service outcomes. Getting clarity on the longer term goals of intervention and ensuring these are clearly defined is not easy. Agreeing the best outcome measures that helps to track progress towards these goals is challenging but necessary. Good progress has been made recently to ensure measures contribute to the clinical work, rather than being used as a 'tick box' approach.

Whilst this may be a difficult task when a young person and their family are experiencing crisis, stakeholder feedback has shown that this is an important issue to address. It should go without saying that the timing of undertaking any monitoring or evaluation tools needs to be managed in a sensitive and timely way and clinical judgement should be considered in the efficacy of the task.

An outcomes-based approach to evaluation explores the extent to which a service meets the needs of the people who use it. In order to develop a more in-depth understanding of what works, in what circumstances, services need to be able to articulate what is going well and provide evidence of impact. Services need to consider the users' views on meaningful outcomes and how best to judge the extent to which the service can support an individual to achieve these.

The use of routine outcome measures to measure the effectiveness of clinical input, quality of interaction and service provision is recommended in national guidance. A link to a documents and guides outlining the routine outcome measures used across CAMHS CYP IAPT services can be found by accessing the following weblinks:

- *Guide to Using Outcomes and Feedback Tools with Children, Young People and Families*

- *Routine Outcome Measures Table*

9 BECOMING A LEARNING ORGANISATION

To become a learning organisation, both commissioner and provider organisations must develop a culture of reflection and have tools and processes in place to create and sustain shared learning. If we are committed to improving services we must be ready to hear what service users tell us. This section points to some of the available tools which commissioners and providers could adopt to strengthen their existing approach.

There is now a range of available literature that is clear about the gaps and deficits that are all too frequently experienced by children, young people and their families when seeking support on mental health. These are well summarised in the CQC report; *Right Here, Right Now*[37]:

9.1   RIGHT HERE, RIGHT NOW

The 2015 report from the Care Quality Commission, which looks at people's experiences of care during a mental health crisis makes for sobering reading:

- In relation to crisis care, the CQC found that only 14 per cent of people who experienced a crisis felt that the care they received provided the right response and helped to resolve their crisis.

- A substantial number of people who attend A&E multiple times, are already known to mental health services, suggesting that if they struggle to get support elsewhere, many people seek help through A&E.

- Over the last two years there has been no 'notable improvement' in the experience of patients:
  In 2015, 28 per cent of people responding to the community mental health team survey rated their experience of community mental health care as 5 or lower (on a scale of 0 to 10). This is compared with 25 per cent in 2014.

  In addition compared with the previous year, people reported higher proportions in relation to:

  - not feeling listened to by staff,

  - not feeling they were given enough time to discuss their needs and treatments

  - not feeling that they were treated with dignity and respect.

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[37] https://www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf

9.1 TOOLS

i) Reflective Practice

The link below powerfully illustrates the frequent gap between what we would hope to deliver and what is actually received.

5 stories from users who feel like the system has let them down:
https://www.theguardian.com/commentisfree/2016/feb/17/readers-failed-mental-health-services

This type of material could be used in team or service meetings as part of a self-evaluation exercise and as part of identifying small changes which may make a significant difference. This helps in clinicians and practitioners developing their own 'litmus test' such as:

'Would this service have been good enough for my child/grandchild?'

The questions below are more strategic but still offer an example of how commissioners, teams and services could begin to reflect on the impact of services, plans and the extent to which they are making a positive difference and applying learning from service users:

As an organisation how do we learn from the experience of patients? What did they tell us and what have we done about it. What difference did it make? How do we know?

- Mental health work is part of a broad system of care; how does learning in one part of the system influence other parts of the system? What are we doing to share our learning?

- What is our model/method for understanding good practice /success and failure and how is this learning shared?

- To what extent does our local plan allow room for testing and evaluation? How has it been changed to reflect our learning?

- What are the risks that the plan itself may not deliver?

- What is the potential for unforeseen consequences which could have a negative impact on the desired outcomes?

ii) Root Cause Analysis

Root Cause Analysis is included here as a tool for learning and organisational and self-reflection. Root cause analysis (RCA) has been adopted across a range of organisations, both in commercial industry and social and healthcare as an organisational learning technique. RCA recognises that there is rarely a single cause for failure after an event has occurred. It offers a systemic, investigative approach to explore underlying issues, contributory factors and takes a whole system outlook towards learning and future development across an organisation. To be thorough RCA must involve a complete review of all possible antecedent events and actions in relation to what went wrong:

- Look at human behaviour

- Look at processes and systems

- Consider all the key players

- How could things have been done differently

The National Patient Safety Agency (NPSA) has recommended adopting a RCA process to event investigation. It has produced a range of report guidance and templates for use which can be accessed on the following **link**.

In addition, a range of resources have been adapted from the NPSA resources for use. The documents can be used to examine specific incidents, understand and reflect on a particular event and enable learning to take place. A copy of the Concise RCA Template is contained in the appendix of this document by clicking this **link.**

10 USEFUL RESOURCES

This section brings together a number of resources which commissioner and provider teams may find useful

10.1 ACTION PLAN

This is a template for an action plan which uses a red, amber, green rating approach to monitoring progress. The plan can be adapted to suit the purpose. For example sometimes it is useful to have:

● a column on expected outcomes to articulate what success will look like (to help keep the focus)

● a column to summarise progress (where plans are used for reporting purposes)

● a column to show where the evidence for outcomes delivered will be found (to assist in inspection preparation).

CRISIS SERVICE DEVELOPMENT MEETING							
...COUNTY							
Date of initial Meeting		Date of Meeting		Attendees at meeting and role			
		Version no.		Date of Next review		Rag rating - action completed	Rag rating - work commenced	Rag rating - work not commenced

No.	National Driver	Detail	Action required	Lead person	Rag rating	Planned Finish Date	Actual Finish Date

10.2 THE LITTLE BOOK OF LARGE SCALE CHANGE

http://webarchive.nationalarchives.gov.uk/20150317175454/http://www.nhsiq.nhs.uk/media/2596905/large-scale-change-epub.pdf

10.3 STRESSED OUT AND STRUGGLING: DEVELOPING SERVICES FOR 16-25YR OLDS

http://www.youngminds.org.uk/assets/0000/1321/SOS_YM_ServiceMapping.pdf

10.4 FIRST STEPS TOWARDS QUALITY IMPROVEMENT: A SIMPLE GUIDE TO IMPROVING SERVICES

http://webarchive.nationalarchives.gov.uk/20160805124748/http://www.nhsiq.nhs.uk/media/2591385/siguide.pdf

10.5 A TO Z OF MEASUREMENT

http://webarchive.nationalarchives.gov.uk/20160506182103/http://www.nhsiq.nhs.uk/media/2581374/a-z_measurement_glossary_q9.pdf

10.6 ON THE EDGE:

Film made by young people on what they experienced from services in a crisis and what would make things better:
http://www.chilypep.org.uk/current-campaigns/crisis-support-for-mental-health/

10.7 A TOOLKIT PRODUCED BY YOUNG MINDS REFLECTS THE EXPERIENCE OF PARENTS AND CARERS:

http://www.youngminds.org.uk/for_parents/parents_improving_services

10.8 CONCISE ROOT CAUSE ANALYSIS TEMPLATE

This template has been adapted from the National Patient Safety Agency RCA information

1 INCIDENT DESCRIPTION AND CONSEQUENCES
Incident description:
Incident date:
Incident type:
Specialty:
Actual effect on patient:
Actual severity of the incident:
2 LEVEL OF INVESTIGATION
LEVEL 1 – CONCISE INVESTIGATION
3 INVOLVEMENT AND SUPPORT OF PATIENT AND RELATIVES
Add text here
4 FINDINGS:
Add text here
5 DETECTION OF INCIDENT
Add text here
6 CARE AND SERVICE DELIVERY PROBLEMS
Add text here
7 CONTRIBUTORY FACTORS
Add text here
8 ROOT CAUSES
Add text here
9 LESSONS LEARNED
Add text here
10 CONCLUSIONS:
Add text here
11 RECOMMENDATIONS
Add text here
12 ARRANGEMENTS FOR SHARED LEARNING
Add text here
13 AUTHOR AND JOB TITLE
Add text here
14 REPORT DATE
Add text here

A range of Root Cause Analysis tools can be found *here*.

CHRONOLOGY (TIMELINE) OF EVENTS	
DATE & TIME	EVENT

ACTION PLAN	ACTION 1	ACTION 2	ACTION 3
Root CAUSE			
EFFECT on Patient			
Recommendation			
Action to Address Root Cause			
Level for Action (Org, Direct, Team)			
Implementation by:			
Target Date for Implementation			
Additional Resources Required (Time, money, other)			
Evidence of Progress and Completion			
Monitoring & Evaluation Arrangements			
Sign off - action completed date:			
Sign off by:			

11 CONTRIBUTORS, PARTNERS AND STAKEHOLDERS:

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- Sallie Mills Lewis, CAMHS Strategic Lead, Essex

- Luton and Dunstable Hospital

- Norfolk and Norwich Hospital

- Peterborough Hospital

- Suffolk CYP participation group

- Anima Thawait, CAMHS Transformation lead, Cambridge and Peterborough

11.1 PRESENTERS AT THE EAST OF ENGLAND CRISIS EVENT ON THE 22ND SEPTEMBER 2016" .

- Clare Anderson, Clinical Nurse Specialist, CAMHS Crisis and Liaison Team Durham and Darlington.

- Steve Jones, Special Advisor, Children & Young People's Mental Health Clinical Policy & Strategy Team, Medical Directorate, NHS England

- Dr Esther Sabel Consultant Child and Adolescent Psychiatrist, CAMHS Crisis Assessment and Treatment Team (CCATT), Hertfordshire

- Dr Tracey Urquhart, Clinical Psychologist, North East Lincolnshire Crisis and Intensive Home Treatment Team

A report of the event on the 22nd September 2016 can be found *here*.

12 APPENDIX

All these reports were authored by Associate Development Solutions on behalf of the East of England Clinical Network, and have been included here for your convenience.

Report: Children and Young People's Mental Health Crisis Services across East of England Region

1. Introduction

Five areas from the East of England provided information on their current crisis service and its response to mental health crises for children and young people, as part of the stakeholder consultation undertaken to develop the crisis toolkit. This report was completed in August 2016, so services may have changed since then, and can only be a snapshot of that time.

This report summarises the feedback from each area of the region that participated in the consultation, and descried the form and function of their crisis services and the approach they use.

2. Regions

2.1   Bedfordshire (updated January 2017)

The local transformation funds, working in partnership with LCCG, has developed a countywide CAMHS A&E liaison / crisis response service covering Bedfordshire and Luton.

The service is staffed with Registered Mental Health Nurses who are skilled to provide rapid face to face mental health crisis assessment for any young person presenting in mental health crisis in the community or at either of the local acute hospitals (Luton & Dunstable or Bedford General Hospital) between 09.00hrs and 20.00hrs during weekdays and 10 – 16.00hrs at weekends.

Once assessment has been completed the outcome will determine appropriate signposting to relevant services based on presenting clinical needs and risks; which may consider a range of options including: admission into tier 4, therapeutic interventions from any of the local CAMHS teams for further treatment options, other mental health services if appropriate (ie; tier 2), local support services (ie: CAN, local authority) or discharge to tier 1.

The staff are also able to offer telephone advice to potential referrers on the management of cases presenting with potential risks which may trigger a possible referral into the service.

The A&E Liaison staff are attached to the local adolescent mental health teams (AMHTs) and will based themselves in the adult crisis team when out of hours to support lone working and promote interagency pathways.

The service will also have direct access to the CAMHs on call Psychiatrist via 24 hours telephone support. Young people are involved in the planning and reviewing of the CAMHS service, through input into website design, implementation of new care plans, weekly service user groups, feedback questionnaires and stakeholder meetings.

2.2   Cambridgeshire and Peterborough

The crisis team for this area operate on a CAMHS emergency rota until 5pm throughout the week, with 24-hour access to a psychiatrist outside of those times and a rota arrangement for both adult and child mental health crisis practitioners to be available 24/7 for onsite intervention and   assessment, where necessary. The specific crisis provision for children and young people is integrated with the adult service, with a specific crisis pathway dedicated to CYP is currently under   development (as at August 2016). Within the service children and young people are initially assessed by a paediatrician,   who, if the CYP are presenting with a mental health crisis, will then will coordinate with CAMHS, who commence a telephone triage and escalate accordingly.

The service notes proposals to extend the current service, as well as providing additional points of contact to be utilised instead of A&E in the event of a mental health crisis. Utilising Transformation Funding will allow for an extension of the rota until 11pm, as well as having a first response team who can be contacted via 111; whilst a 'Discovery College' will be opened in Peterborough to provide drop-in services from the hours 4-9pm (weekdays) and 12-9pm (weekends) – key times that young people have mentioned previously to be important to them. Additional consideration of CYP views is evident in the planning of the service, as consultations have been undertaken regularly via Healthwatch (a national consumer champion http://www.healthwatch.co.uk/about-us) with regards to the allocation of the Transformation Fund money and all of hospital services.

2.3 East and West Suffolk

The Suffolk Crisis Concordat outlines priorities that include children and young people, though there is not a specific crisis pathway. They have highlighted that significant improvements are required for dealing with mental health crises. Within service hours, crisis referrals are triaged and assessed within national waiting time targets and where necessary CYP will be admitted to an acute or tier 4 bed. The out of hours' crisis responses are undertaken by a member of the adult team and not by a dedicated CYP professional, nor is there a dedicated intensive outreach service to support CYP within their home setting. However, since October 2015 to the present (August 2016) the development of a more tailored service for CYP – a residential unit offering beds in Ipswich – has been underway as part of Innovation funding from DfE. The pilot encompasses a remit of admission for CYP who have been presenting with crises at one of the acute trusts within the area. Despite this there is a concern that some CYP may be admitted to beds unnecessarily, resulting in a delay in therapeutic input.

A mental health liaison service exists within Ipswich hospital and West Suffolk Foundation Trust. However, it no longer covers ages 13 and above though discussions are currently taking place which could alter this. The priorities for this service with regards to crisis care for CYP are the development of an intensive outreach support service, which can allow young people to remain within their homes and communities. Additionally, the development of a robust pathway of response between acute paediatric beds and discharge to a residential unit in Suffolk is utilised, where clinically appropriate. Feedback highlighted that the crisis response needs to both identify and offer a greater focus on the mental health needs of young offenders to ensure appropriate support for them, instead of being held in police cells or secure settings.

Currently children and young people have no involvement in reviewing and planning the service delivered, though the Trusts' transformation plan aims to focus attention onto the need for CYP's inclusion in evaluating services. In particular, it has been noted that a reference group of carers will also work to support this focus.

2.4 Essex

The crisis response within Essex currently operates a single point of access (SPA) via a telephone line to the crisis team and with a new service model being utilised across the county. Crisis staffing capacity has increased from 2 to 3 teams; notably this was able to happen through Local Transformation Plan funds. This funding has also enabled an extension in the hours of service, which now operate in the hours of 9am-9pm, Monday to Sunday, with an out of hours' on-call CAMHS consultant rota. Response times differ depending on where the presentation occurs; within A&E this is within 4 hours, or the next working day following admission for medical stabilisation. Within the community the response is within 24 hours or the next working day.

Currently North and South Essex are utilising slightly different models with regards to the specific crisis pathways. Between the hours of 9-5pm CYP, once deemed medically fit, are referred to the South crisis team via the SPA by A&E staff or paediatrics. At which point a joint assessment will be undertaken by an on-call psychiatrist and the crisis team to establish treatment options and next steps. These can include being discharged, admission to CAMHS Tier 4 or a paediatric ward. The protocol for hours 5-9pm are similar, except assessment will be carried out only by the on-call psychiatrist, and next steps also include discharge home with CAMHS Crisis assessment team within

24 hours or a face to face CAMHS Crisis Assessment follow up within 3 days. The referral care pathway for North Essex encompasses CYP aged 5-17 years, with 18 year olds being referred to the adult mental health service.

A mental health liaison service exists, but is variable across the 5 acute hospitals within Essex and is provided by the AMHS commissioners; this service covers only adults and not CYP. This may change through further discussions between the AMHS and CAMHS commissioners. The local acute paediatric services within the county have the expectation that the local CAMHS teams will provide liaison to them, with the current service leads and area managers meeting regularly with the emergency and paediatric teams.

Currently children and young people are not involved in reviewing and planning the service offered within Essex though the CAMHS Strategic Lead would like them to be in the future.

2.5   Hertfordshire

The crisis service within Hertfordshire operates at Tier 3.5 and is delivered by their mental health trust, Hertfordshire Partnership NHS Foundation Trust (HPFT). The CAMHS Crisis, Assessment & Treatment Team (CCATT) is a multi-disciplinary, community team which provides short term, intensive and flexible assessment and treatment packages of care to children and young people. The C-CATT aims to be a flexible service which provides:

- Assessments for children and adolescents with possible acute mental health needs presenting at Watford General and The Lister Hospital Emergency Departments (A&E) or who are on paediatric wards (including those presenting at Watford General and The Lister Hospitals from outside of Hertfordshire)

- A range of short-term community based assessment and treatment options for this group of children and adolescents and advice and support to parents/carers

The CAMHS Crisis Assessment and Treatment Team (CCATT) is a rapidly responsive (within 4 hours) CAMHS crisis service that responds either in the community prior to and/or at A&E across two hospitals in the county of Hertfordshire, Watford General Hospital and the Lister Hospital. They take referrals of CYP aged 0-18 where there are indications of possible mental health needs involving high risk that would otherwise or do result in hospital attendance. A CAMHS clinician from CCATT is available at the hospitals between 9am and 9pm seven days per week. The team also offers a service from 9am-5pm Monday to Friday in the community. After the initial response, they clinically assess and intervene to effect a change that manages risk and collaboratively helps the young person onto a healthier trajectory. All assessments are led by a CCATT CAMHS clinician and have input from a CCATT Consultant Child and Adolescent Psychiatrist. Children and young people who arrive in crisis after 9pm receive care from both A&E, paediatrics and the psychiatry on call doctors with the aim being to stay in the acute hospital overnight as per NICE guidance.

After acute hospital attendance or Tier 4 admission, young people are followed up in the community by CCATT, usually the same CCATT clinician who led the crisis assessment. The team therefore also undertake ongoing crisis interventions, providing urgent mental health support in the community, wrapping care around the young person and their family, for as long as the crisis remains high risk, until care is safely taken over by other agencies. They conduct follow up care in a seamless manner, bridging the care from the hospital into the community, flexibly across diverse settings including schools and homes, with the aim to reduce the re-escalation of crisis. The clinical and therapeutic engagement from the CCATT team is a unique way to offer less fragmented care, enhance engagement, effect change and manage risk, providing consistency at a time of extremely high risk and distress and where risk of "loss to follow up" is high. This is very much welcomed by young people in the midst of crisis who may have experienced trauma, abuse, and or changes in their care placement. The team provide an exemplary beacon of safety for these young people with high levels of positive feedback.

They also in this way significantly reduce the possibility of young people falling into 'gaps between services.' This

seamless community crisis intervention intuitively prevents re-escalation of risk, through engagement and multi-agency liaison and reduces likelihood of re-attendance in A&E, thus reducing pressures on A&E.

The priority outcomes for the service are:

- Providing an urgent and emergency response to crisis presentations for children and young people

- Avoiding unnecessary Tier 4 inpatient admissions

- Treating children and young people in their home/local community

- Ensuring children and young people and their parents/carers are involved in transforming services

The crisis service has observed good outcomes in terms of ensuring that the response to crisis is rapid and efficient, though they are exploring how this can be enhanced, most notably in relation to presentations within A&E.

There is also a collaboration between the hospitals' paediatric teams and the CCATT, whereby the CCATT aim to support them through consultation on admitted cases, as well as increasing staff awareness and knowledge of mental health. This is achieved by delivering training to staff in acute and paediatric teams.

Within HPFT there is also an adult mental health liaison service – RAID (Rapid assessment, interface and discharge) - which provides support for ages 16 and above, with no plans for this age range to change, although the CCATT in practice sees young people aged 16-17 offering them this more specialised expertise.

The inclusion of children and young people in the development of services remains to be an area that requires further development, though HPFT does have a CYP youth council it engages with. It is possible that CYP's involvement would, in the future, be harnessed from this group to allow engagement relating to work that is being developed around CAMHS Transformation programme and that future provisions can be shaped by CYP.

2.5.1 Evaluation of the Hertfordshire service

A snapshot audit over a one-month period in November 2015 showed that CCATT had received 70 referrals. 99% of these were seen within 4 hours of referral. Discharge was able to be facilitated in 79% from the acute hospital following CCATT intervention, which meant that 55 paediatric beds in that month were freed up. Safeguarding concerns were detected de novo in 8 out of 70 referrals which may not have otherwise been addressed.

10% of cases that received CCATT input resulted in inpatient care, meaning that CCATT supported community follow up for 90% of cases seen. CCATT offered further community crisis intervention to about half of patients seen. Both of the above findings would point to CCATT offering a meaningful alternative to tier 4 inpatient care. This would indicate that up to 35 tier 4 admissions are likely to have been prevented.

Completed: August 2016

Examples of Children and Young People's Mental Health Crisis Services in other parts of England

1. Solihull Intensive Community Outreach Service (ICOS)

The Intensive Community Outreach Service (ICOS) manages all children and young people, aged 11- 17, including those presenting in a crisis (for more information, visit https://solihullccg.nhs.uk/publications/the-services-we-offer-1/1673-solihulls-local-transformation-plan-for-children-and-young-peoples-mental-health-and-wellbeing/file). The ICOS team have four main functions:

- Rapid response for urgent and crisis referrals
- Crisis interventions
- Long-term intensive community outreach service
- Stepped Transition

Children and young people referred to the service from the Single Point of Access (SPOA) who require same day assessment or urgent assessments (needing assessment within 1-7 working days) are offered an appointment within the same day and/or 7 working days by staff from ICOS, guided by mental health needs, risk and complexity. The ICOS team is responsible for managing children and young people already known to the EWBMH service or are presenting for the first time in crisis, both in community and hospital settings. The team will provide a Rapid Response in assessing and planning the treatment of these children and young people. The criteria for Rapid Response are:

1) Evidence of signs and symptoms of a major mental illness such as major mood disorders, disabling anxiety or florid psychosis that is affecting daily functioning;

2) Evidence of severe suicidal thoughts and suicidal behaviour;

3) Evidence of an eating disorder which is seriously impacting on a young person's everyday living

After a Rapid Response Assessment, subsequent interventions for the Child or Young Person will be agreed; this could include one of the following options: brief crisis interventions through ICOS; referral to a specialist part of the service for extended follow up in condition specific pathways; long term intensive outreach follow up within ICOS; referral to highly specialised (Tier 4) services if inpatient admission is required; or, redirected to primary mental health and other voluntary agencies in primary care and/or discharge from services.

The ICOS team has a small cohort of CYP with severe and/or enduring and/or complex and/ or resistant mental illness and/ or hard to engage patients where difficulties with engagement are assessed to be due to treatable mental health problems. These individuals will be offered intensive support in the community and the ICOS team will monitor their mental and physical wellbeing in liaison with GPs, Paediatricians, and other agencies. The team has robust links with police, social services, Place of Safety, Street Triage, A&E and the Rapid Assessment Interface & Discharge (RAID) service.

The ICOS team also offers a "virtual ward" experience, where care offered by a team if mental health professional is provided in the home environment, with the aim of managing crisis and preventing inappropriate admissions where needed and facilitating admissions into the inpatient unit where necessary through close links with the Highly Specialised (Tier 4) service.

Solihull currently has a nationally acclaimed out-of-hours (OOH) service known as the Rapid, Assessment, Interface and Discharge (RAID) service. The RAID service currently is a specialist multidisciplinary mental health service for people aged over 16. The plans are to integrate the staff from ICOS team on a rota basis with the RAID team so that the two services become complementary and become an all-age 24/7 service for the

population of Solihull. Clinicians on the OOH rota will offer a first line response while on call. This will involve assessing the initial situation over the phone and, where indicated, attending A&E, paediatric wards or other community settings in conjunction with police and/or social work services to undertake a fuller assessment. Although, as discussed earlier, care must be taken with this approach to ensure that there are skilled children's mental health professionals, who are able to respond appropriately and effectively to the needs of the children and young people.

1.1   Evaluation of the service

The ICOS service has been in existence for over a decade now, but has undergone some important changes as a result of the findings by the Children and Young People's Mental Health and Well-Being Taskforce report *Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing'*[1]. This means that the newest model has not been evaluated as yet, but the highlights from the 2006 evaluation are presented below. The evaluation focused on both clinical and financial aspects.

Of the 24 young people treated by the service, including those on the current caseload at the time, 22 were female and 2 male. This reflects the fact that many of the young people served by ICOS had eating disorders, which are significantly more common in females. The CGAS scores of the two discharged patients clearly showed a marked improvement in overall functioning. As well as improving the young person's clinical symptoms, the team was able to develop the young person's understanding of, and ability to cope with, both their illness and the social and educational aspects of their lives, thus reducing the likelihood of re-admission and giving them preventative strategies for the future.

There are strong indications that ICOS has been successful in reducing the average length of inpatient admissions. As well as the clear advantages to the young person of reducing time spent   away from home, this helps to free up inpatient beds and reduces the need for out-of-area admissions. The available data suggests a net saving, once the costs of the team have been taken into account. Data from 2008 (the most recent data available for ICOS) suggests that the total cost of the services was just under £170,000. Their caseload was 24 young people, 12 of whom were out of school/work due to a mental health crisis. Out of these 12, 10 were back to school/work very promptly as a result of not being sent to an out-of-area placement and receiving focused care[2].In addition, inpatient activity between 2003 and 2006 decreased by 77%, which is in part attributed to ICOS service[3].

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1   Department of Health /NHSE (2015). Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing https://www.gov.uk/government/publications/improving-mental-   health-services-for-young-people

2. Designated Place of Safety for under 16s in Birmingham and Solihull

Birmingham NHS South and Central CCG has commissioned a designated under 16s Place of Safety (PoS), which is attached to their CAMHS Tier 4 in-patient unit. This approach ensures that children and young people are offered immediate assessment of their mental health needs, and receive appropriate care accordingly. The service provides a safe environment to hold, assess and support children held under Section 135 or 136. Staff in this facility are trained in enhanced procedures to support NICE guidance on the management of short term disturbed/violent behaviour in children and young people's psychiatric settings and have specific training to work with children and young people to deliver age appropriate interventions within an age appropriate environment. However, it is important to ensure that such a model is well integrated with other agencies where a child may have a multiplicity of needs related to their crisis.

The PoS staff work closely with Solihull's Out of Hours, RAID and ICOS to gather information on past psychiatric history, utilising information on the RiO patient information system, and will commence face to face assessment within 2 hours of notification that the child or young person will be arriving at the PoS. The PoS works closely with a defined Out of Hours child and adolescent psychiatric on call rota to undertake all relevant Mental Health Act (MHA) and Children Act assessments. The PoS was originally funded from CAMHS grant monies, and has now become part of the ongoing CAMHS budget for the area. This has resulted in a dramatic reduction of under 18s being held in police cells or placed inappropriately. The Place of Safety has been designed to be age appropriate, with young person friendly seating and facilities, in line with NICE guidelines on the short term management of disturbed or violent behaviour in children and young people. The specification includes collaboration with the Police where young people fall outside of the scope of the service to ensure that a multi- agency protocol is followed.

2.1 Birmingham Home Treatment Team

In 2011/12 Birmingham spent £6.6m on inpatient provision for CYP under 18 years old (48% of total CAMHS spend). During 2012/13 Birmingham CAMHS were commissioned to provide a tier 3.5 Home Treatment service that works 24/7 to prevent admissions into inpatient services. It covers ages 12- 18 who are known to generic CAMHS. The Service was developed with the aim of enabling patients to stay closer to home, as well as to reduce the costs of inpatient admissions. The aims of the s e r v i c e are:

- Safely and appropriately meet the mental health and psychological needs of children and young people in the home who would otherwise be admitted to Tier 4

- Promote early discharge from inpatient mental health provision by effective care planning and appropriate delivery of community based mental health provision and supported by other statutory and voluntary providers

- Reduce use of Tier 4 beds with no linked increase in receptions into care, where this is not indicated

- Support children and young people with severe and complex mental health needs to remain safely with their families

- Provide a responsive and flexible approach to CYP and Families - contribute to the improvement in quality and effectiveness of CAMHS services

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2 Pourgourides, C. and Munro, H. (2008) Intensive Community Outreach Service
file:///D:/Stuff/Downloads/IntensiveCommunityOutreachService.pdf
3 Douglas, H. (2008) Solihull CAMHS Annual Report.

2.2   Evaluation of the service

In 2014/15, the spend on in-patient admissions had reduced to £5.6m from £6.6m in 2011/12 (Birmingham spent £924,550 on Home Treatment and Place of Safety), however, the previous spend (2013/14 is not available at the time of report). This decrease in expenditure was contrary to the national picture which showed an increase in demand for in-patient beds. An evaluation of the introduction of home treatment for Birmingham conducted in 2012 found that implementing home treatment reduced the demand for inpatient provision irrespective of the national increase in demand for Tier 4 beds. Bed days decreased by 23 days per month over the preceding period (652 to 629), a reduction of 3.5%. There was a 13% reduction in inpatient bed use on 3 year average. It was also found that there was increased patient satisfaction as well as improved outcomes and increased access to provision. In 2014/15, a total of 154 patients were admitted into Tier 4, which in comparison to the predicted levels of admissions was significantly below the 275 (adjusted to 225 taking away Sandwell patients) suggested level of need. This 30% reduction in predicted bed use is believed to reflect the improvements brought about by the introduction of a dedicated Home Treatment Service in Birmingham.

The Home treatment service was developed collaboratively with NHSE and the Local Authority and continues to perform well reducing inpatient activity.

3. CAMHS Crisis and Liaison team, Durham and Darlington

The multi-award winning Crisis and Liaison team in Durham and Darlington is provided by TEWV NHS Foundation Trust (for more information, visit http://www.durham.gov.uk/media/8456/Emotional- Wellbeing-for-Children-and-Young-People---Durham-and-Darlington-CAMHS-Crisis-and-Liaison-Team/pdf/BigTentEmotionalWellbeingCYPDDCAMHSCrisisLiasion.pdf). It includes all young people up to the age of 18, who have an acute mental health need that requires urgent health assessment and a plan of care. It offers a flexible and responsive service and reduces the waiting time for a   psychiatric assessment when young people are in crisis. The model is also praised for its contribution to the reduction in use of acute paediatric beds.

The service is nurse-led, with an open access policy. They aim to commence assessment within 1 hour and will provide intensive support at home or in an appropriate setting for up to 72 hours. They also offer telephone support, and liaison with and training to other professionals and members of the children's workforce. They also support A&E and are currently working with NHS 111 to enhance the CAMHS response to young people with mental health needs.

3.1   Evaluation of the service

The service has undertaken joint training with police trainers to deliver training around young people's mental health to police officers. All care plans are developed with young people and include   routine outcome measures. The service has seen a significant reduction in episodes of crisis and unplanned admission. Between 21.5.14 and 30.09.15 (16 months) the crisis team were able to free up 225 paediatric overnight beds that would otherwise have been used whilst young people awaited a duty mental health assessment the following day. For the 365 presentations assessed outside of acute hospital settings, 266 individuals presented with suicidal ideation, panic attacks or threats of self-harm. Traditionally, presentations such as these would be directed to A&E, so the presence of the crisis team has alleviated pressure on A&E departments within the county by an additional 266 presentations (72%).

4. Thames Valley Street triage service

In the Street Triage schemes, mental health professionals provide on the spot advice to police officers who are dealing with people with possible mental health problems. This advice can include an opinion on a person's condition, or appropriate information sharing about a person's health history. It can also include on-the-spot triage, in partnership with the attending police officers. The aim is, where possible, to help police officers make appropriate decisions, based on a clear understanding of the background to these situations. This should lead to people receiving appropriate care more quickly, leading to better outcomes and a reduction in the use of Section 136.

The Thames Valley services operates seven days a week from 6pm to 2am with a mental health practitioner working alongside a police officer (for more information, visit http://www.thamesvalley.police.uk/aboutus/aboutus-street-triage.htm). They will deploy to incidents, offer face-to-face advice and make risk assessments in order to ensure the right care is given to the patient. They also provide advice by phone to any officer in other areas of Oxfordshire, through work in the police enquire centres, and by talking to the person on the phone. Outside of the core hours there is a single telephone point of contact at Oxford Health available which provides an advice lin3 for county-wide police.

4.1 Evaluation of the service

Over a 12 month period, they reported a 78% reduction in the use of police cells. Thames Valley Police have also reported a reduction in time and cost reduction in calls for mental health act assessments, resulting in less demand on AMHPs and section 12 doctors. A higher proportion of patients have been referred to community health services, therefore relieving pressure on acute beds.

5. Interact (Adolescent Outreach Team) in Barking and Dagenham

INTERACT is a mental health community support service that works with young people aged between 12 and 18, following a crisis situation by providing a series of home visits in addition to any support already being received. Working collaboratively with local child and family consultation services, they provide additional community support for young people between the ages of 12 to 18 years. In addition, INTERACT provide the Accident and Emergency/paediatric wards liaison service Monday to Friday 9am to 5pm for King George and Queens Hospitals. They also provide assessment and follow up support and or facilitating admission to the local Brookside adolescent unit, or another unit in a different part of the country, if required.

Interact work alongside any organisations that are already helping young people to give extra support at times of increased difficulties. There are four main situations in which their services would get involved:

1) After a young person's admission on to a general hospital ward or a visit to A&E. Following an assessment the young person may receive support at home following discharge from the ward/A&E.

2) When a decision has been made by the community CAMHS team for a planned admission as either day patient or inpatient, INTERACT may provide short term support to bridge the gap between assessment and admission, or whilst waiting for a decision on funding from NHSE.

3) Following discharge from Brookside, or another in-patient unit, it may be necessary for a young person to receive additional support, for a set period of time, from INTERACT.

4) When the limitations of child and family consultation service mean that a young person would require extra support or be referred for admission to an inpatient unit. The INTERACT team may provide additional support for a period of time and admission may be avoided.

Referrals are accepted from the child and family consultation services (CFCS), eating disorders service (EDS), early intervention in psychosis (EIP) and staff in A&E wards of general hospitals. INTERACT does not accept referrals from GPs, social services, schools, or self-referrals.

Report: Children and Young People's Mental Health Crisis Project: Summary of Paediatric Staff Interviews

1. Scope of the interviews

For the children's and young people's crisis project part of the work was to undertake telephone interviews across the East of England Clinical Network region with acute paediatric service staff. The aim was to capture the current position of children and young people's mental health crisis service provision across the region to inform future pathway development, and to gather their understanding about the current crisis pathways available to them, and the impact on paediatric services.

Recruitment to interview process was problematic, given the busy nature of accident and emergency departments and availability of staff. All of the hospitals outlined below were contacted in order to undertake the interviews. A range of staff were interviewed, including Named Nurses, Named Midwives, A&E Paediatric Lead Nurses, and Consultant Paediatricians. For the interview process the following hospitals were contacted:

Area	Hospital contacted	Interview undertaken
Essex	Basildon and Thurrock	No
	Middlesex	Yes
	Colchester General	Yes
Norfolk	Norfolk and Norwich Hospital	Yes
East and West Suffolk	Ipswich Hospital	Yes
	West Suffolk	No
Luton and Bedfordshire	Luton and Dunstable Hospital	Yes
Herts	West Herts Hospital	Yes
Camb +P	Peterborough Hospital	Yes
	Addenbrookes	Yes

2. Key Emerging Themes

2.1 Parity of service provision and age range of provision

Staff outlined the impact of the lack of parity of service provision to that of adult services. Although all areas had access to a crisis service, the provision of cover and skills set in working with young people was variable. Most of the areas only had specific CAMHS crisis access within weekdays and office hours. It was cited that a number of areas' crisis service would not assess young people. The impact of this was reported as young people being admitted to child or adult wards until they could be assessed by CAMHS staff. The admission was not cited as part of an ongoing assessment of a potential safeguarding need or mitigate further crisis but predominantly due to the CAMH service lack of response. Young people were also described as being admitted to avoid Accident and Emergency waiting times breech as the crisis service could not see them before this target was missed.

There was also a variation in terms of the age that young people would be seen by the adult service. Some areas used sixteen as a cut-off point, another if a young person had undertaken their GCSEs.

2.2 Safeguarding

All staff discussed effective safeguarding arrangements to ensure that young people with safeguarding issues are highlighted, referred to the correct service and health professionals are communicated with. There were different processes across the region with some areas employing liaison nurses to check every attendance and all of the children's notes, however the infrastructure described to report the safeguarding issues was established within and by the acute service. A collaborative approach to safeguarding young people across county borders was also described.

2.3 Liaison

Staff interviewed felt that they undertook effective liaison with other services, including ensuring the needs of children who attended from out of area were addressed appropriately. Liaison regarding physical health needs and continuity of care for young people from out of county were both felt to be well managed.

2.4 Training

A number of areas highlighted a difficulty in working with young people with a mental health needs overall, citing that paediatric nurses would benefit from more training in mental health to enhance their confidence. One area outlined that they employ agency mental health nurses to look after young people who have been admitted to the ward. This would also indicate a masked training issue for ward staff. Another area discussed difficulty in assessing the difference in a mental health or behavioural need which determined the subsequent care pathway.

2.5 Environment and Service Provision

The lack of suitability of an Accident and Emergency environment for young people in crisis was discussed (noisy, bright and numbers of people). In addition to the lack of a CAMHS specific crisis service across the majority of areas, the lack of community provision for young people was highlighted, although a pilot crisis service was discussed in one area. In addition, the lack of information for parents/carers was highlighted as a factor which potentially had an impact on the increased use of Accident and Emergency department.

4. Summary

In summary, the need for a timely CAMHS specific crisis service appears to be the most significant issue affecting the responsiveness of acute services. This appeared to be a consistent theme across all hospitals interviewed. Although young people were not interviewed in the scope of this piece of work, potentially the quality of experience for young people would also be affected with potential unnecessary admissions to acute wards for a range of reasons. It is also not clear how much the lack of staff training, cited by a number of areas, impacts on young people's experiences. It must also be noted that only one area reported to follow a written care pathway.

Suffolk Consultation with young people

Context: A piece of consultation work was undertaken with young people in Suffolk as part of a wider scheme of work. The group decided that they wish to focus on the Single Point of Access in regards to the transformation plan and crisis support, as they believed this was the important element to them.

Young People's Views on Crisis care

In relation to the development of Crisis Service the young people highlighted the following:

- "Don't be afraid to seek help" is the current mental health message, but when you seek help for crisis care, you have to go to A&E. There needs to be mental health nurses, or professionals trained in mental health manned at A&E 24/7. If you go to A&E when you have overdosed or self-harmed you are meant to see a psychiatrist, by law, but this doesn't always happen. There is also no privacy in A&E- you have to sit in the main waiting room, and then are put onto a corridor with the curtain open when you are being seen.

- "It's like you have to time your crises". Mental health crisis care is open 9-5 Monday-Friday. Young people have said that if you have a crisis on a Saturday evening, or during out of hours, you have to wait a long time to be seen.

- There needs to be a replica of A&E specifically for mental health. A&E doesn't know how to respond to mental health problems, and young people tend to find the triage process takes around 4 hours. Some young people have been told by professionals that it is 'just their hormones', 'here we go again', 'oh I guess you've broken up with your partner or whatever', 'were you bored?' etc.

- Crisis support needs to be stronger - especially for under 14's as there currently isn't crisis care for them.

- CYP to rethink crisis services. The group also mentioned crisis care in relation to the transformation plan, as they all have experienced crisis services. The commissioner has agreed to explore further options for the group to be involved in rethinking crisis services.

Concise Root Cause Analysis Template - GUIDANCE

This template has been adapted from the National Patient Safety Agency RCA information, which can be found at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59901

Incident description and consequences
Incident description: Offer a concise description of the event here: For example: *A young person who was referred to the service waited for over six months for an initial appointment. In this time she took an overdose of paracetamol.*
Incident date:
Incident type:
Specialty:
Actual effect on patient:
Actual severity of the incident:
Level of investigation
Level 1 – Concise investigation
Involvement and support of patient and relatives
For example: The service manager met with the young person and their family to hear their recollection of events and offer support. Appointment offered to the family.
FINDINGS:
Detection of incident
For example: The service received information from acute liaison staff after attendance at accident and emergency department
Care and service delivery problems
For example: Key issues such as administration staff vacancies and use of agency admin staff
Contributory factors
List or describe significant contributory factors. See the Classification Framework' tool for list of options (The Contributory Factors Grid could be used in the report or appendix as an alternative to 'Fishbone diagrams', as appropriate to the case.) Include narrative on deliberation as appropriate. For example: delay in access onto electronic system for agency admin staff
Root causes
These are the most fundamental underlying Contributory Factors that led to the incident. They should be addressed or escalated. Root causes should be meaningful, (not sound bites such as a communication

For example: the administrative staff vacancy for over six months in the service meant that there was a significant delay in responding to referrals. In addition, the use of a number of agency staff during this time resulted in the patient's referral letter being lost in the system. A lack of audit of referrals also did not occur.

Lessons learned

Key safety and practice issues identified which may not have directly contributed to this incident but are significant and will be useful learning for others. For example:

CONCLUSIONS:

Recommendations Recommendations should be numbered and referenced and be directly linked to root causes and lessons learned. They should be clear but not detailed (detail belongs in the action plan). To focus effective action it is generally agreed that recommendations should be kept to a minimum where ever possible.

For example: 1. Ensure there is a monthly audit of actions of referrals to the service. 2. Ensure that all administrative (including agency) staff have clear induction to recording systems

Add text here

Arrangements for Shared Learning

Describe how learning has been or will be shared within the organisational governance structure and with other organisations (bulletins, professional networks, etc.)

 Add text here

Author and Job Title

Add text here

Report Date

Add text here

Chronology (timeline) of events	
Date & Time	**Event**

Action Plan	Action 1	Action 2	Action 3
Root CAUSE			
EFFECT on Patient			
Recommendation			
Action to Address Root Cause			
Level for Action (Org, Direct, Team)			
Implementation by:			
Target Date for Implementation			
Additional Resources Required (Time, money, other)			
Evidence of Progress and Completion			
Monitoring & Evaluation Arrangements			
Sign off - action completed date:			
Sign off by:			

Summary Report: A Focus on Mental Health Crisis Support for Children and Young People: Stakeholder Event 22nd September 2016

1. Stakeholder Event 22nd September 2016

1.1   Context to the event

An event was facilitated on the 22nd September 2016 to bring together key stakeholders and services across the East of England. The aims of the event were:

- To focus on developing Mental Health Crisis support for Children and Young People

- To bring together a National and Regional perspective on the transformation agenda for CYP mental health Crisis support services

- Share examples of best practice and innovative service developments from around the country and within the region

- To present an update of regional work being undertaken around the development of a Regional CYP Mental Health Crisis toolkit

- To consider the next steps for transformation services across the region

- Details of the presentations are contained in the toolkit developed from this piece of work and are available on Basecamp.

1.2   Parental Contribution

It is worth noting that a parent of a young person who had experienced a crisis in the region made a valuable impromptu contribution following a presentation. She highlighted the vital need to develop services in the region that are able to respond to children and young people in a timely and appropriate manner. This contribution served as a valuable reminder of the importance to ensure services are developed appropriately and is greatly appreciated.

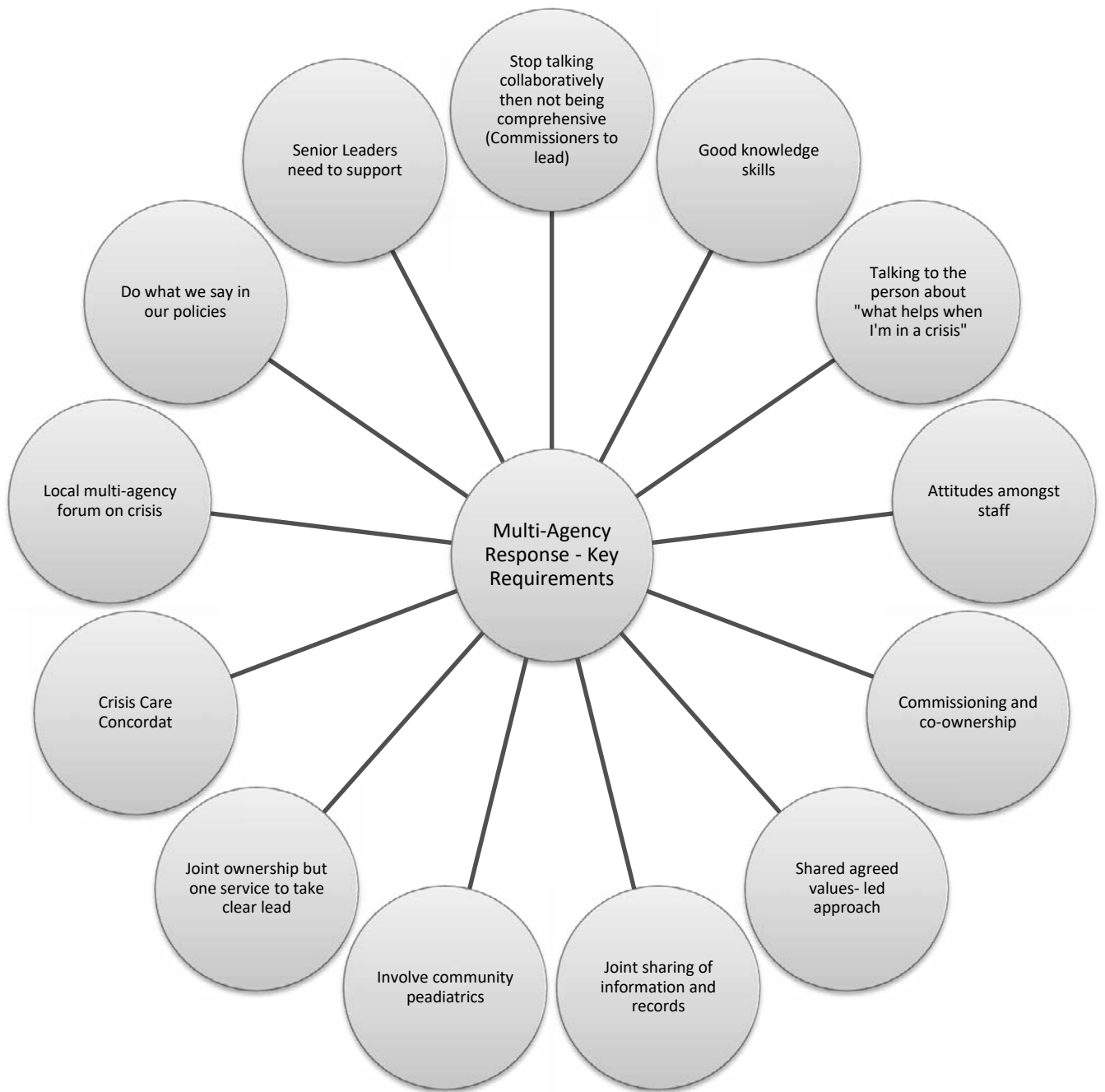## 2. What Is Needed for a Multi-Agency Crisis Response?

A key theme both within the literature, national guidance and policy is that of multi-agency working when developing and providing services that respond to mental health crisis. As children and young people exist in a range of systems, a systemic response is considered a necessity to achieve a transformative improvement in the delivery of services. This was echoed in the presentations at the event preceding this group work activity. In this activity stakeholders were asked to work together and consider, *"In an ideal world, what is needed for a crisis response to be multi agency?"*

The large group feedback outlined the following themes:
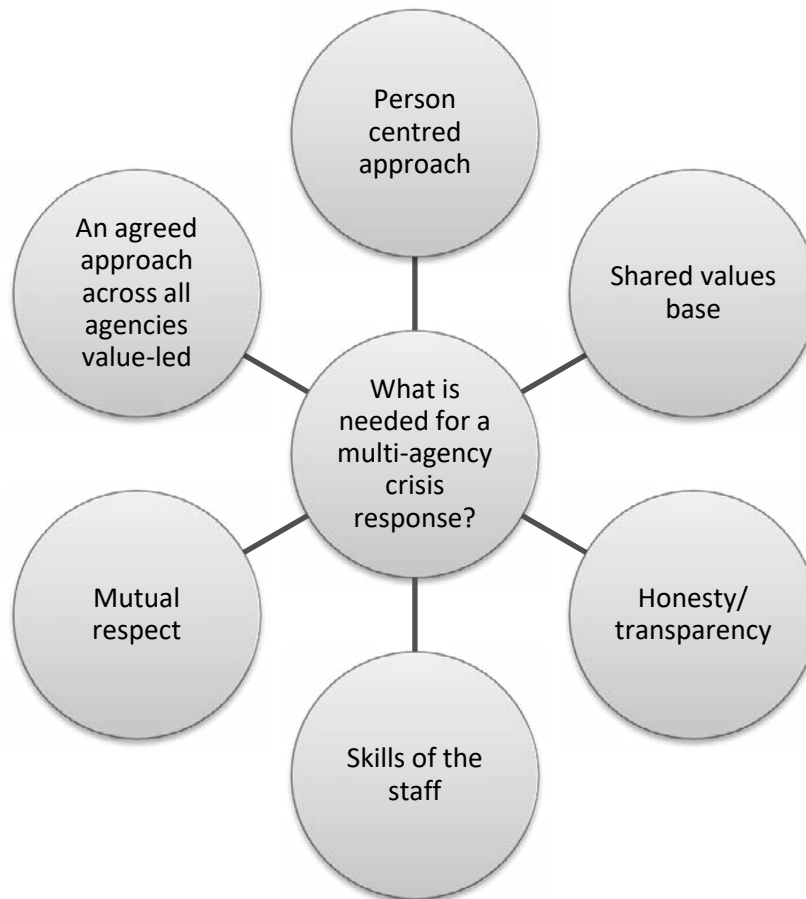
2.1 The round-table groups -"What Is Needed for a Multi-Agency Crisis Response?"

- It depends on the assessment
- Respect for each other's roles
- The response needs a leader
- Needs senior leaders to support multiagency work
- Bureaucracy needs to be at a minimum
- Information sharing amongst the agencies
- Involve the private and independent sector
- 3rd sector/VCS involvement
- Community paediatrics + child health
- 24 hour responsive social workers
- Paediatric/A&E and the hospital
- Real police engagement and training
- AMHP accountability
- Regular multi-agency forum/ meetings locally
- Joint records/ information sharing

Multi-Agency Response - Key Requirements

- Stop talking collaboratively then not being comprehensive (Commissioners to lead)
- Senior Leaders need to support
- Do what we say in our policies
- Local multi-agency forum on crisis
- Crisis Care Concordat
- Joint ownership but one service to take clear lead
- Involve community peadiatrics
- Joint sharing of information and records
- Shared agreed values- led approach
- Commissioning and co-ownership
- Attitudes amongst staff
- Talking to the person about "what helps when I'm in a crisis"
- Good knowledge skills

- "Making friends"- relationship building- bottom up

- Top down- structure in place to manage system

- Community system to model response to providers- anti competitive behaviours

- Attitude and culture

- Joint ownership, but someone taking a clear lead

- Good contingency plans

- A clear escalation process

- Taking responsibility/ delegated authority

- Take the time to reflect and learn

- Co-community & co-ownership

- Ensure all partners/ people are listened to- all views respected

3. What different people need when there is a crisis?
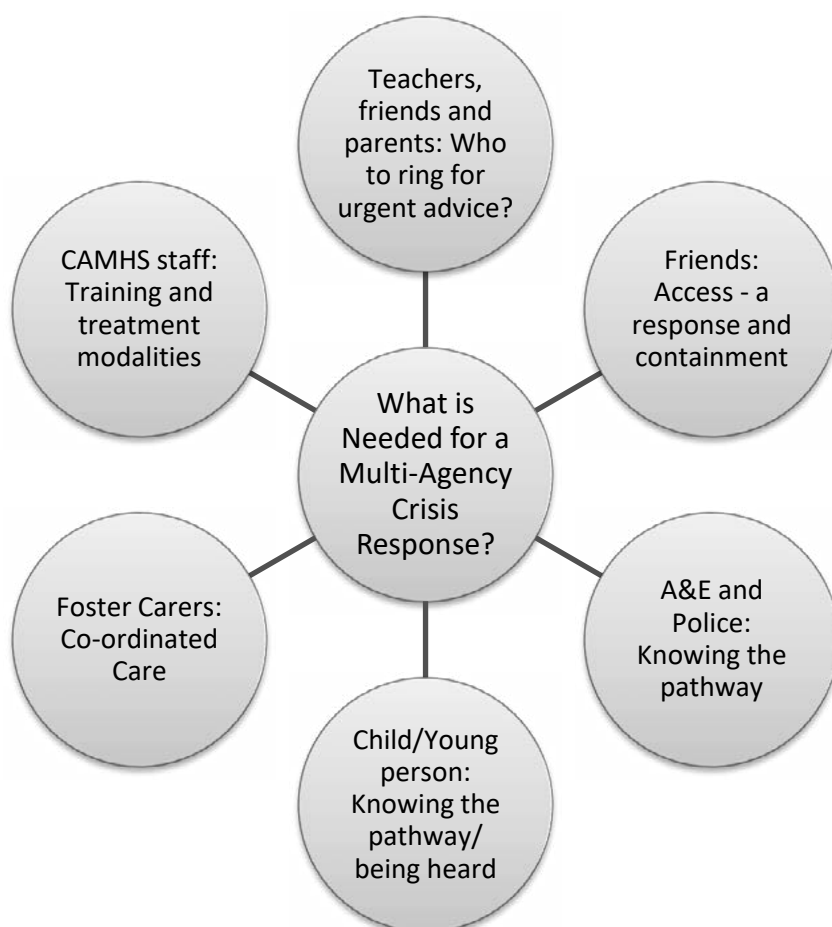
3.1 The round table groups- 'what do different people need when there is a crisis?'

3.1.1 A& E Health Worker

- Training in engagement, community skills- enhancing mental health capacity within physical health
- How can I be empathetic when I'm busy and this child/adolescent has been in A& E with overdose four times before?
- Knowing the pathway to follow
- Training in mental health assessment skills

3.1.2 Teacher

How do I feel?

- De-skilled
- Anxious
- Angry
- "Not my training/problem"
- Unsupported
- Can't get any help from CAMHS

What do I need?

- Who can I ring in a hurry?
- Information from other agencies with personalised written plans (agreed and shared)
- Access to prompt individualised support for each child
- Clear support from school hierarchy
- Lead in my school for Mental Health (a teacher or a counsellor?) for me to go to/ child to see urgently
- Specifically- trained CAMHS staff
- A quiet space to support children
- A way to stop difficult behaviour

3.1.3 Parent's Perspective

- Someone on the end of the phone- someone to care 24/7
- One front door/ one phone number- not many!
- Professionals understanding that it's a crisis for mum and dad too
- That every professional involved has access to my records/ care plan so I don't have to tell my/ our story again and again
- A concrete plan to refer to at home

3.1.4 Foster Carer

- Consent to be involved- depends on age/ order

- Their views are listened to

- Foster carers don't feel that professionals always understand trauma

- Background of child is not always known

- Wider impact (on other children)

- Depth of issues

- Knowing who to contact

- How to still involve the parent (if they want to/ appropriate)

- Range of people involved- wide network- balancing range of views

- Support for foster carers- not that they are carrying the risk alone?

- What happens next? How do they cope?

3.1.5 CAMHS Worker in Crisis Service
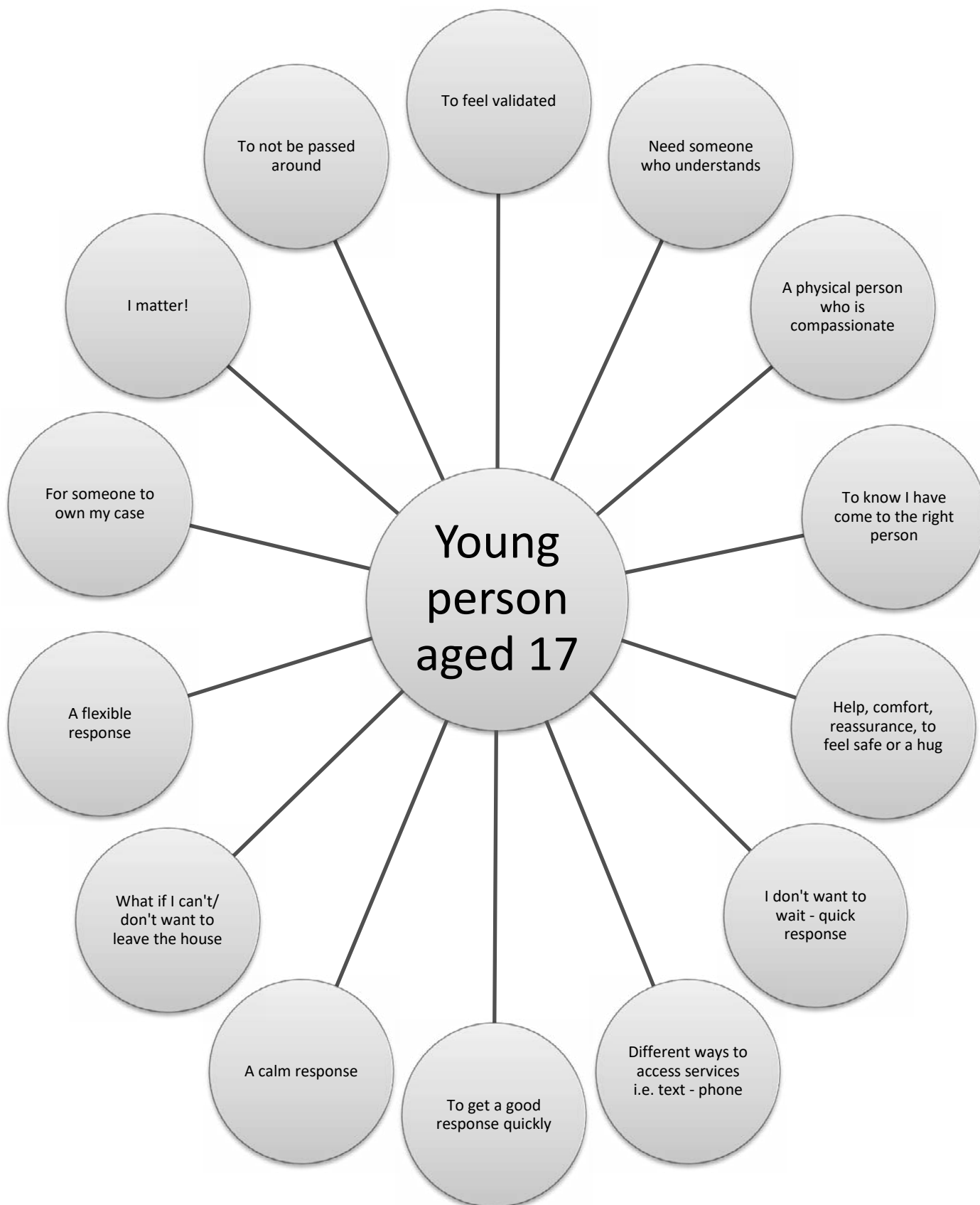
- Training in several treatment modalities in assessment of holistic needs, as well as

  -Mental Health

  -Safeguarding

  -Social issues

  -Substance misuse

- Being well supported by:

  -Own team/ service

  -A&E- understanding & application of NICE guidelines

  -Local authority

  -Police

- Alternatives to A&E and S136 suites for some case 4 assessment & early intervention

- Safety is paramount

3.1.6 Friend of the young person

- Knowing where to go/ access help

- Looking for adult certainty & planning

- "They've just said the thing to make friend tip over."

- Quick response/ containment

- Take into account friends may not physically be in some place i.e. social media

- Managing the burden that friend has been carrying, possibly for a long period of time

- Need to send key messages to schools generically as preventative advice

3.1.7 A Young Person's Needs when they are in Crisis

To feel validated

To not be passed around

Need someone who understands

I matter!

A physical person who is compassionate

For someone to own my case

Young person aged 17

To know I have come to the right person

A flexible response

Help, comfort, reassurance, to feel safe or a hug

What if I can't/ don't want to leave the house

I don't want to wait - quick response

A calm response

To get a good response quickly

Different ways to access services i.e. text - phone

Conclusion: Key Themes

A number of consistent themes evolved throughout the course of the event from both the presentations delivered and group work undertaken. These were:

- The systemic nature of a crisis presentation and subsequent requirement for a multi-agency response

- A shared value base across the system

- The need for a clear pathway to enable staff to navigate an appropriate, proportionate and most importantly, timely response to each crisis situation

- A clear access point and telephone access

- A parity of crisis service provision to that of adult service

- The voice of the young person and their parents/ carers being heard and taken seriously

- Support and containment for both the young person and the supporting system

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