Healthy London Partnership – Children and Young People Programme:

Improving care for children and young people in mental health crisis in London: Recommendations for transformation of services.

Purpose of document

The purpose of this guide is to support the development of accessible, consistent and effective care for Children and Young People (CYP) in mental health crisis across London.

This document is presented as emerging findings so that Commissioners and their partners and clinicians could consider them as CAMHS transformation plans were developed. This document was subsequently refined to take into account feedback from commissioners and clinicians.

Action requested: Commissioners are asked to take note of these recommendations as they finalise and submit their transformation plans.
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Foreword

As commissioners develop and set out with partners and children and young people, to develop transformation plans, there is an opportunity to ensure that transformation in crisis care is a key part of those plans. These should be built on a strong case-for-change, supported where possible with evidence and prioritising the needs of children and young people. This guide aims to support commissioners in making the case, bearing in mind the needs of every service user. A mental health emergency can be as devastating and even life-threatening as a physical health emergency - let this be an area where we can fully demonstrate parity of esteem.

Purpose of this guide

The purpose of this guide is to support the development of accessible, consistent and effective care for Children and Young People (CYP) in mental health crisis across London. This document is presented in its current format as "emerging findings" so that Commissioners and their partners may consider them as they develop their CAMHS transformation plans. The document will subsequently continue to be refined through the transformation planning process supported by the London CYP Mental Health Clinical Leadership Group.

It should be of value to both Children and Adolescent Mental Health Services (CAMHS) commissioners and healthcare providers in describing what best practice should look like. The guidance and recommendations have been divided into the following chapters:

1. Executive Summary.
2. Background information and challenges facing CYP mental health crisis services and recommendations.
3. Recommendations.
4. Recommended generic care pathway for CYP in mental health crisis.
5. Directory of best practice examples from across the UK.

Appendix 1: Recommended Safety and Coping plan.

Chapter 1: Executive Summary

Much of the burden of mental illness in adulthood begins in childhood and adolescence. Mental health problems in children and young people (CYP) may present with or be accompanied by “crisis”. The rates of admission for self-harm, although lower than the average seen across England vary greatly across London, the reasons for this only being partly understood. Crisis care is provided with different models across the city and the difference in distribution of health-based places of safety is a testament of that. Problems with the crisis pathway are recognised and providers are responding by trying to work more upstream with prevention and diversion strategies. It is important to see any crisis from the point of view of the CYP. It may be that failing to do so is an important reason that underpins non-adherence to follow-up. Given that there is accumulating evidence that non-adherence to follow up is a predictor of poor outcomes not only in terms of repeated self-harm and suicide but also in a variety of other psychosocial outcomes, this opportunity to listen to the voice of CYP must be taken, facilitating-design with CYP so that services can truly respond to their needs and preferences. The need to consider safeguarding and child protection and the very close involvement of family are important considerations.

Crisis can occur at any time but often occurs out of hours, when daytime support is not available and at weekends and bank holidays. We should aim for the standard of care 7 days every week of the year, based around clearly written and updated pathways for access to mental health crisis care for all agencies including police, London Ambulance Service, schools, NHS 111 and A&E. Simple access methods (including single point) and waiting standards will aid navigation and timeliness of care. We feel that more collaborative commissioning and provision arrangements will support this and it strikes us that the Strategic Planning Group (cluster of Clinical Commissioning Groups) is a good place to start and build on the collaborative working commissioners have engaged in on their transformation planning. London Specialised Commissioning needs to be integral to these collaborations so that whole pathways can be transformed.

We recognise the importance of multiagency working and giving colleagues in all providers (e.g. health, education, social care, emergency services) the right knowledge, skills and confidence to work effectively and collaboratively across organisational boundaries. We note that many of the young people in the Justice System and those who have been subject to criminal assault (including sexual assault) are living with mental health problems, and may not access the help they need, which compounds their extreme vulnerability. For all CYP known to be at risk of crisis, prediction, early help and good multiagency escalation plans that are well communicated are essential. We recommend the universal use of safety and coping plans as alternatives to admission. There is growing evidence that admission to mental health inpatient units for CYP with complex trauma and abuse and longstanding aggression, oppositional and self-harming behaviour is detrimental to their emotional health. For these reasons we recommend that for any CYP needing admission in London, their care should remain in London except for explicit clinical reasons.

The Learning Collaboratives of the CYP “Improving Access to Psychological Therapies” programme (IAPT) has shown how multi-agency, collaborative and multi-disciplinary education can support transformation and this is a route we should follow. For crisis care this is particularly so and we see further developments in simulation training could bring benefit.

For CYP, transition into adult services can add to the complexity and difficulties of their situation considerably. Early wins can be achieved by proper use of the Mental Health Act which does allow care provision to reflect the maturity and circumstances of CYP, as well as available commissioning enablers/levers. There are also opportunities for commissioners to look at models of 0-25 year care and consider implementation. We see that primary care teams and GPs in particular could play a key role in transition planning.

Collecting and using information to measure and support continuous improvement as well as redesign are key characteristics of high performing health organisations and we welcome the emphasis on this in Future in Mind.

Chapter 2: Background information, challenges facing CYP mental health crisis services and recommendations

What do we mean by crisis?

There have been many attempts to define what is meant by "mental health crisis". Mind defines "mental health crisis" as when a person is in a mental or emotional state where they need urgent help. A mental health crisis can also be described as a change in mental wellbeing that is likely to lead to an unstable or dangerous situation for the individual concerned. A key challenge when designing mental health crisis services which incorporate a service user and carer perspective is that each person's perception of what constitutes a mental crisis is individual, reflecting their history and social support network. People respond differently to clinical situations which objectively appear similar, some finding the situation to be manageable, others finding it overwhelming.[1]

Mental health crisis can be a way of describing the behaviour of a system at a particular point in time rather than a specific type of experience of an individual. One feature of the way a mental health crisis may occur is that it focusses on the predicament of one particular child or young person. The primary helping system for the majority of CYP is the family. Equally they are often supported in a very important way by a school, children's centre or college. In understanding crises we need to examine the functioning of the systems around the child.[2] There are four aspects to this:

- At the point of mental health crisis, the helping system around the young person (YP) is poorly equipped to deal with the problem. There may be a number of reasons for this including the exceptional needs being demonstrated by the YP (suicidality, violence, absconding) and the refusal of the young person to relate to those who are trying to offer help at this point. In such circumstances, it is understandable that there is a search to find others who have the experience to deal with this type of situation.
- The high level of distress or risk, alongside the difficulty in accepting help from usual caregivers leads to high anxiety amongst professionals trying to address the problem.
- There is a view that the situation could get worse unless there is an immediate response.
- The YP appears to be at risk and is showing a high level of either distress/self-harm or anger/violence.

The London CYP Mental Health Strategic Leadership Group recommends 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".*

Differences between Children and Young People and adults in mental health crisis

The main difference between a mental health crisis occurring with CYP, compared to mental health crisis in adults, is the child protection and safeguarding legislation that exists. There may be other relative differences in relation to family, school, etc., but many adults in crisis will need similar consideration of their carers' and / or work environments.

In a child mental health crisis the family is more likely to be involved as the majority of CYP live at home. It may also occur in different environments for CYP, such as at school or college. They may exhibit aggressive behaviour, suicidal behaviour or extreme oppositional behaviour which can be disruptive in these educational environments. Crisis may occur at home and CYP may engage in risky behaviour to themselves as well as to others, including siblings. The involvement of other agencies especially social services and the police force is widespread. CYP in mental health crisis may also have offending behaviour and vulnerability to substance misuse which may result in contact with the youth justice system. CYP in the justice system need to have as equal access to mental health assessment and treatment as those outside it, particularly since many CYP who end up in the Youth Justice System are in mental health crisis.

What do Children and Young People and their families want?

Children and young people and their families want the best help and clinical interventions, as close to home, as possible, when dealing with mental health crisis. They want to help, and to be supported, to prevent crisis from happening and want to work with clinicians to shape their care and plans.

"They want an integrated child, youth and family friendly approach that recognises their particular needs, makes them feel supported, emphasises the positives and helps them to cope".[3]

"Some young people highlighted the need for more information about mental health in general. There was also a need for a clearer roadmap of what to do at different stages – from initial consultation to crisis, including help to identify which stage a young person was in and guidance about where best to get specific information and support".[4]

How national reports support us

What did Future in Mind say about young people in crisis and their families?

If a child or young person has a mental health crisis, they should get extra help straight away, whatever time of day or night. They should be in a safe place where a team will work with them to determine what needs to happen next to help them in the best possible way. If they need to go to hospital, it should be on a ward with people around their age and near to their home. If they need a specialised service, there should be a full explanation of the need to travel further; their local service should stay in touch to get them home as soon as possible. While they are an in-patient, services should ensure they can maintain their education as much as possible. If they need help at home, their care team should visit and work with them and their family at home to reduce the need for them to go into hospital.

Five Year Forward View[5]

This NHS England report sets out a vision for the future and suggests new collaborative models of health care. Most notably, the development of Urgent and Emergency Care Networks – services integrated around A&E departments, GP out-of-hours services, urgent care centres, NHS 111 and ambulance services. Other models of interest to mental health service teams are the Multi-speciality Community Providers – (which enable groups of GPs to combine with nurses, other community health services, hospital specialists and mental health and social care to create integrated out-of-hospital care) and Primary and Acute Care systems (which combines general practice and hospital services).

Future in Mind Taskforce review

The Children and Young People's Mental Health and Wellbeing Taskforce report Future in Mind[6] proposes the development and agreement of Local Transformation Plans for Children

and Young People's Mental Health and Wellbeing. Every CCG with partner agencies will develop a CCG action plan, which will focus in part on the quality of treatment and care for CYP in mental health crisis. CCGs working with partners should be setting out their commitment and local response to improve the care for children and young people in mental health crisis to ensure they are treated in the right place, at the right time and as close to home as possible. Local Transformation Plans will help to ensure that work being planned in the Mental Health Crisis Care Concordat is implemented. This commitment will contribute to the whole offering included in Local Transformation Plans from health promotion and prevention work, to support and interventions for CYP who have existing or emerging mental health problems as well as transitions between services.

This report also recommends having lead commissioning arrangements in every area for CYP's mental health and wellbeing services, with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a Joint Strategic Needs Assessment. It envisages that in most cases the CCG would establish lead commissioning arrangements working in close collaboration with Local Authorities.

Future in Mind recommendations of note:

- Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat is implemented.
- Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.
- Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.
- Promoting implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age.

CCG planning guidance and Mental Health Crisis Care Concordat

The CCG Planning Guidance[7] includes the Mental Health Crisis Care Concordat (CCC) and describes the actions required of commissioners and providers to ensure that those experiencing a mental health crisis are properly supported. This includes the need to ensure that there is enough capacity to prevent CYP (or vulnerable adults), undergoing mental health assessments in police cells.

Achieving Better Access to Mental Health Services by 2020

NHS England and Department of Health recently committed to developing access and waiting time standards in mental and improving access by 2020[8]. The aim is to provide a comprehensive set of access and waiting time standards that bring parity to mental health and physical health services. This applies to CYP who will benefit in the first year with the introduction of the first ever waiting time standards for early intervention in psychosis: specifically, more than 50 per cent of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral. NHS England is embarking on further work with the National Collaborating Centre for Mental health to establish evidence based care pathways across the life-course for those in crisis.

Liaison Psychiatry Services in Accident and Emergency

The national development of all age liaison mental health services in Accident and Emergency (A & E) Departments, with targeted investment over 2015-16, should improve access to appropriate mental health support in A&E for CYP experiencing mental health crisis. It is mandatory that that the views and experience of children and young people are

taken fully into account as urgent and crisis care services are transformed and improved. In particular they should be involved on the co-production of further access and waiting time standards.

Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report

The recent NHS England Tier 4 review[9] has demonstrated there have been gaps in provision regarding mental health in patient care for children and young people, and NHS England is exploring a range of options for future commissioning and more collaborative work. The CAMHS transformation planning framework makes specific reference to this, so that current Tier 4 resource could be directed towards other services such as day care / community care. The review identified "lack of tier 3 provision" as a significant driver for admission. A small national audit within the review showed that some regions "diverted" care away from inpatient care more readily than is routine in London and this was associated with shorter length of stay. This report outlined the need for, and provision of, appropriate inpatient beds for CYP with mental health needs, near where they live and demonstrated a range of areas in need of change / review. It is recognised by commissioners and practitioners that the move to a more centralised commissioning model to reduce inconsistencies in access and delivery was appropriate and necessary, but that this has at times led to fragmentation of pathways and less flexibility in responsiveness and pathway transformation. As community services and inpatient services (Tier 3 and Tier 4) are commissioned by different agencies perverse incentives may arise out of the different funding streams across this pathway. There is an appetite from all involved to take the best of both parts of the system and integrate them.

NICE guidelines

There are NICE guidelines on psychosis and schizophrenia in CYP[10], self-harm[11] and antisocial behaviour and conduct disorders in CYP[12]. There are additional NICE guidelines which may be relevant to a child or young person presenting in mental health crisis, for example assisting in guiding best practice for assessment and treatment of severe depression, eating disorders, obsessive compulsive disorder and other conditions which may occasionally present in crisis.

NHS England is embarking on further work with the National Collaborating Centre for Mental health to establish evidence based care pathways across the life-course for those in crisis.

Healthy London Partnership

Following publication of the London Health Commission report 'Better Health for London'[13], the Health London Partnership (HLP) has been established to improve health services and changes to health in the capital. HLP is focused on 13 transformation programmes, one of which is the CYP programme. The CYP HLP vision is for an integrated system for health and care services which promotes health and well-being and can be easily navigated by CYP, their families and the health professionals to achieve the best outcomes. Care will be provided through high quality facilities, local to families with mental health needs and treated with the same importance as physical health needs. All in-patient care will be delivered in centres of excellence able to provide the highest quality, consultant delivered care, seven days a week.

London response - London CYP Mental Health Strategic Leadership Group

The London Children and Young People's Mental Health Strategic Leadership Group was set up in January 2015 to promote and improve the mental health and emotional wellbeing of CYP in London in every aspect of their life. The group provides a forum for members to share their collective knowledge, deliberate and provide evidence based recommendations and a strategy to improve and promote child and family centred care. This group sits under

the auspices of the Children and Young People's Healthy London Partnership programme and the London Mental Health Strategic Clinical Network. The group has established a co-commissioning forum and organised study days to support CAMHS commissioners with their Local Transformation Plans.

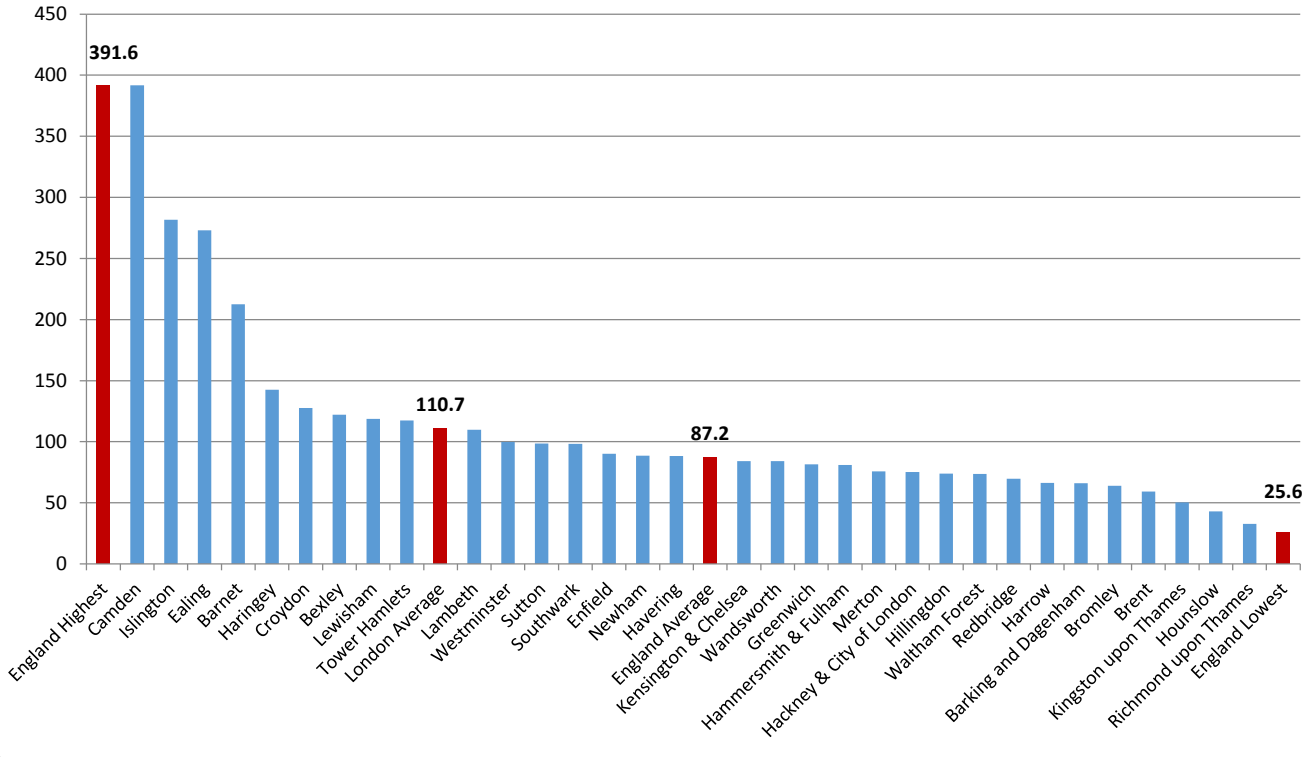
Mental health problems in CYP are common and enduring and crisis commonly arises

Half of all mental illness (excluding dementia) in adults starts before the age of 14, and three quarters of lifetime mental health disorders have their first onset before 18 years of age. One in ten CYP aged 5–16 have a diagnosable mental disorder, equating to three in every school class, or more than 100,000 CYP across the capital. Between 1 in 12 and 1 in 15 deliberately self-harm. Conduct disorders and associated antisocial behaviour are the most common mental health and behavioural problems in CYP which are likely to present in crisis, and nearly always have a significant impact on functioning and quality of life.[14] Although this gives us a glimpse of CYP mental health issues which may result in crisis, unfortunately, there is minimal data on the numbers of CYP who do present in crisis. We do have some indicators though and agencies are developing datasets. It would be useful if agencies could work together to use the information within datasets to create intelligence to improve CYP crisis services.

Figures 1 shows the marked variation in hospital admissions for mental conditions (0-17 years) across London and also that the 'London Average' is considerably higher than the 'England Average'. The reasons for this are currently unclear, though felt to be complex (unmet need, variations in availability of timely outpatient care, patients from outside London accessing its resources, higher numbers of vulnerable/transient families in London, distribution of inpatient settings, different models of care are all considered to be factors) and therefore further analysis of the figures is required to interpret these data. Clarification of baseline activity levels in CAMHS transformation plans may supply more information in this area. Although local CAMHS profiles and practices may be a contributing factor, improvements could be made to reduce the variation.

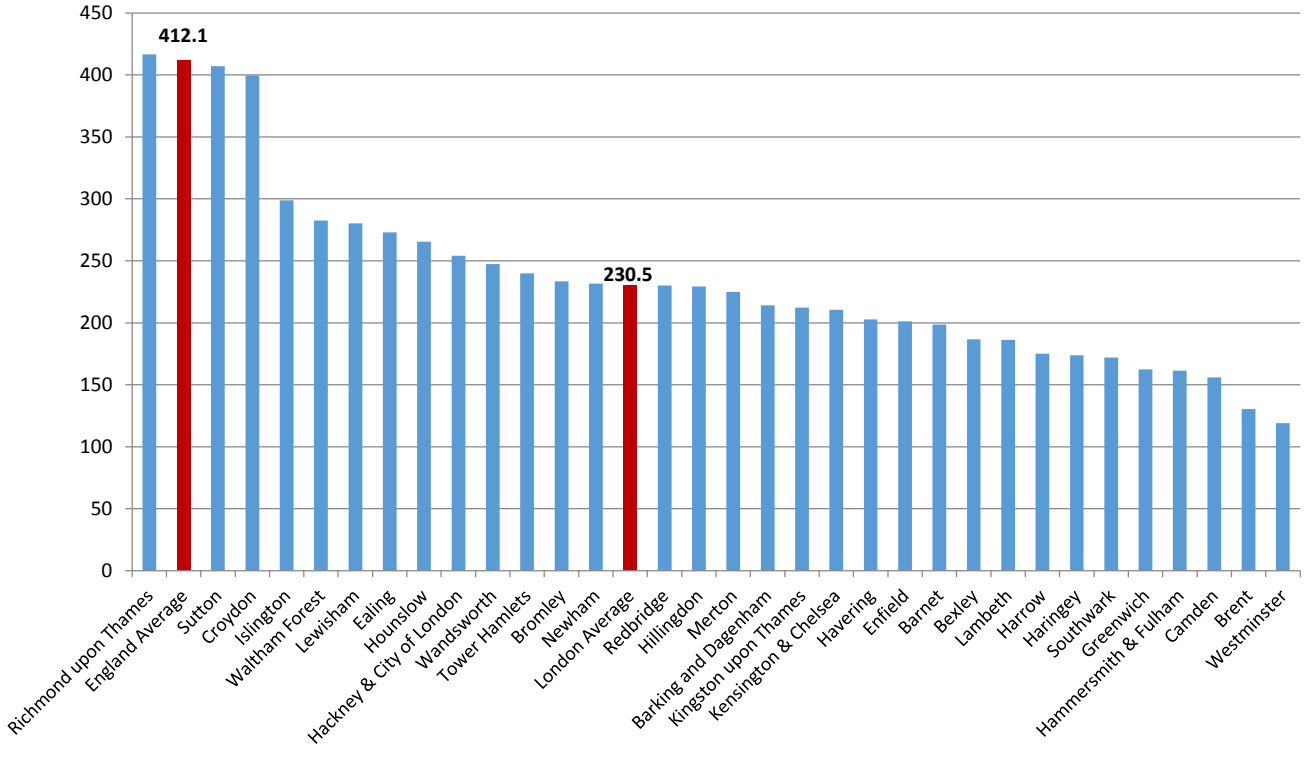
Figure 2 shows that although the 'London Average' for hospital admission as a result of self-harm (10-24 years) is considerably lower than the 'England Average', there is considerable variation observed. Given the variation there is need to understand what drives it, to limit unnecessary admissions whilst maintaining the safest and highest quality care, and where possible keep CYP living in their local community. Some factors which may underpin the high and variable admission rate in London could include planned brief admission as part of an otherwise community oriented eating disorders programme which gets CYP off to a "good and safe start"; recurrent admissions in some CYP; better recording of cases and better coding of them). Activity analysis in CAMHS transformation plans will allow a much better understanding of the drivers of admission rates and explain the variability seen across London, from pretty much the highest to the lowest in England.

Figure 1: Hospital admissions for mental health conditions (crude rate per 100,000 aged 0-17 years) - 2013/14



15

Figure 2: Hospital admissions as a result of self-harm (directly standardised rate per 100,000 aged 10-24 years) - 2013/14



16

Recommendation:

R1. Commissioners should use (and enhance) activity analysis, in their transformation plans, and in reports from the forthcoming national mental health service data set, to understand the reasons for the variability in admission rates and ensure that information systems support regular reporting, high data quality so as to address need and to support quality improvement.

CYP present with a wide variety of issues from emotional distress to severe mental illness, and multi- agency services need to be able to assess and respond to all levels of need. This includes the cross over between behaviour issues, mental health issues, CYP mental health services and children's social care provision.

Access to CAMHS crisis, out of hours and liaison mental health services are variable and use different workforce models. The availability of inpatient care close to home at the right time is very dependent on where the young person lives. One example of this is the distribution and nature of provision of places of safety. The Care Quality Commission website shows the location of designated health-based places of safety in England for people detained under section 136 of the Mental Health Act. (http://www.cqc.org.uk/content/map-health-based-places-safety-0). In some parts of the country, there is no designated health place of safety recorded by the Care Quality Commission for under-18s.[17] In London places of safety may vary from 3 in 1 borough to 1 in 4 boroughs.

Emergency Services are frequently involved in the conveying and care of CYP and adults in crisis with mental health difficulties. The lack of parity of esteem is frequently tangible in these emergency circumstances. It should not matter whether a CYP arrives in a police of ambulance vehicle at their destination, and CYP should be received in the same manner. Medical staff should not assume that because some CYP arrive with police that they are, for example, violent. There are examples where a patient with a mental health disorder has waited in an emergency vehicle for 9 hours whilst a place for care is sought, or taken to Brighton or Manchester as that was the nearest place of safety. Post code variations and barriers to care that are never experienced by those with physical health problems are not infrequent. There are increases in crises involving emergency services around public holidays, when regular care plans are suspended and our most vulnerable patients cannot access support. The conveying of young people over great distances is a challenge for the emergency services and a very poor experience for the young person.

Recommendations:

R2. Collaborative commissioning arrangements across Strategic Planning Groups and across London should ensure that CYP with mental health needs access services at their chosen or ambulance's first point of call.

R3.System service resilience planned around holiday periods should contain a clear focus on mental health care provision for CYP.

London Ambulance Service are responding to the needs of citizens and patients including young people by having one of their two matrons leading on mental health (the other being midwifery) and having four mental health nurses at their clinical hub, able to access crisis teams and divert patients away from accident and emergency departments.

Recommendation:

R4. As part of the review of out of hour's pathway, the role of the clinical hub at London

Ambulance Service should be included.

Service challenges and opportunities in mental health crisis

Below is a list of challenges facing mental health services with linked recommendations, which are detailed in Chapter 3.

1. Prevention / Early support and impact on other parts of mental health services

When a young person presents with a mental health crisis, a major contributing factor is that the services may not be able to deliver consistent and timely intervention as part of early intervention / prevention. Even the most effective prevention services cannot fully eliminate mental health crisis. Most crises are the consequence of a sequence of failures of assessment, detection, and early, effective intervention. There is a large variation in the availability of Tier 1 and Tier 2 interventions nationally, and a lack of consistency about which agencies should commission them. In the education setting, teachers are often the first line of support for CYP who are in mental health crisis. Arguably schools are expected to manage the risk associated with challenging behaviour, but may not be adequately supported and equipped with the skills to deal with this. In exceptional circumstances, this can result in the CYP being sent to A&E and excluded from school until they have been reviewed by the relevant CAMHS team.

Partnership working with youth settings is dependent on the commissioning structure agreement between the Clinical Commissioning Groups (CCGs) and Local Authorities. For example, rapid and easy access to parenting groups provides effective, evidence-based intervention for CYP with disruptive behaviour disorders. These parenting classes have recently been the target of cost-savings and subsequent decommissioning in parts of London. This may result in oppositional behaviour which could have been managed with enhanced parenting, escalating to conduct disorder and potentially in a mental health crisis such as running away from home.

There needs to be a balanced allocation of resources between early support and crisis services. More clarity is needed regarding roles and responsibilities of professionals (and training) and clear local care pathways. This will involve identifying resources, and people able to provide advice, options for support and interventions to reduce need for more specialist support.

Careful consideration should be given to the appropriate response as involvement of multiple services may or may not improve the mental health crisis situation. The response should be proportional with stepped interventions. Ideally Tier 1 and Tier 2 multi-agency services should be supporting schools and CYP in need to prevent the escalation to a mental health crisis.

CYP who are living chaotic, disorganised lives with potential vulnerabilities to child sexual exploitation, involvement in substance abuse, gangs and drug dealing and other delinquent behaviour are also likely to present in mental health crisis. Multi-agency services need to work proactively with these vulnerable groups to enable them to have structure in their lives, thus reducing the likelihood of presentation in crisis; strengthening the systems of support which the CYP requires.

Recommendations:

R5. Education and training for all professionals who are in contact with CYP and families should be a mandatory responsibility for each provider organisation. We would recommend the availability of joint training for all staff, including adult staff. The

training should include risk assessments, review of strengths and weaknesses, child friendships and social support, neighbours, helping young people to manage negative feelings, supporting parents to support their child, creating networks of support and how to work with other professions etc. This is in addition to professionally defined competencies in the assessment, identification, formulation and evidence-based interventions for crisis in mental health disorders. The following professionals should receive mental health first aid training as a minimum:

- *Non-health social workers, residential home workers, secure unit workers.*
- *A&E staff, junior and senior doctors, paediatric nurses, adult mental health professionals especially triage nurses, primary care clinicians.*
- *Schools staff.*
- *Voluntary sector agencies.*
- *Youth Justice Youth Offending Teams (YOT) and Young Offenders institutions.*
- *Crisis line workers.*

We also recognise that a broader range of colleagues across public services could also receive education and training to recognise, support and signpost those with mental health problems and those moving to crisis; for example, those supporting homeless persons and staff of the Department for Work and Pensions. Information about different agency training curriculum should be shared more widely, so different agencies can benefit and understand how staff are trained (e.g. College of Policing curriculum). The same goes for police officers, so often at the front line of mental health crisis.

See best practice example 9 on Simulation Training, best practice example 11 on Education for Health training and best practice example 13 on Camden's Multi agency training (chapter 5).

R6. CCG transformation plans should include the following:

- *Clearly written and updated pathways for access to mental health crisis care for all agencies - including police, London Ambulance Service, schools, NHS 111 and A&E.*
- *Consideration of a multi-agency triage model.*
- *Assessment within 4 hours in line with adult mental health (this may be by adult psychiatry services in the first instance if Out Of Hours).*
- *The Royal College of Psychiatrists, The Crisis Care Concordat, the New Mental Health Codes of Practice maintain that holding CYP in police cells to be a "never event". If this does happen a Serious Incident investigation needs to take place to ensure the appropriate reporting occurs. Learning from these investigations needs to be shared across agencies.*
- *Alternatives to admission to be provided e.g. intensive day support, crisis groups and crisis houses. This could be resourced by local and specialist commissioners working together and using their budgets together to re-commission new care models along these lines. It is important that such models are identified where operating and developed with the participation of CYP and must take a holistic social and healthcare view. Such models should ensure the following aims within 2 years:*
    - *CYP from London should not receive inpatient care outside of London unless it meets a specific clinical need.*
    - *Lengths of stay should meet the best benchmarks in England.*[18]
    - *The number of CYP requiring such inpatient care could be kept to a minimum with optimum use of outpatient services of flexible*

intensities.

- *A system of networked-based benchmarking, continuous quality improvement and peer review, similar in purpose to those in say trauma and stroke care, should be developed, overseen by the London CYP Mental Health Strategic Leadership Group.*
- *Access to appropriate home support where needed e.g. CAMHS home treatment team, CAMHS home visits and voluntary sector support.*
- *Access to other more specialist interventions such as Multi Systemic Therapy (MST) for conduct disorder, Dialectical Behaviour Therapy (DBT), eating disorder and Early Intervention.*

We recommend that at Strategic Planning Group level commissioners develop transformational collaborative models of care that avoid the need for CYP presenting to A&E departments with mental health crisis unless physical needs of care cannot be met reasonably in any other way. They should also aim to even-up discrepancies in care. They should seek the support of local partners, NHS England, the Strategic Clinical Networks, the Police (Metropolitan, British Transport Police and City Police) and London Ambulance Service and it goes without saying the collaboration of CYP and service users.

See best practice example 5 on a Crisis House Model scheme and best practice example 10 for SLAM's DBT therapy (chapter 5).

2. Multi-agency approach

All services providing aspects of care have faced significant budget restraints and reductions that may have increased waiting times. Currently in many areas this is limiting the scope for preventative and therapeutic work, and children and families appear to be more likely to be allocated help if for example there are significant safeguarding concerns. There is an opportunity to develop and support schools with mental health awareness, particularly in Personal, Social, Health and Economic (PSHE) education.

This is particularly relevant when CYP present with uncooperative, aggressive and threatening behaviour. Extended assessment is often required to understand the nature and cause of this behaviour in order to plan interventions from multiple agencies. The containment and management of CYP (of increasingly younger ages) with high levels of aggression is a significant challenge for all agencies. Resources for extended assessment in a residential environment are very limited, in particular for CYP with learning disabilities and comorbid mental illness.

When joint agency working breaks down the likelihood of subsequent mental health crisis increases, because services are not recruited to be part of the support system that is needed. For example, CYP may be discharged from secure units with medication and a diagnosis, and not referred into CAMHS when this should be an essential component of their care package. When this happens, the GP is not always made aware of the diagnosis or need for additional support. In this situation the CYP can be left vulnerable without support from the GP or other support agencies. If this happens, the GP may offer advice which is different to that provided by the secure unit.

There is growing evidence that admission to mental health inpatient units for CYP with complex trauma and abuse and longstanding aggression, oppositional and self-harming behaviour is detrimental to their emotional health.

Recommendations:

See R5 and R6 above.

R7. Improving access to effective support

The following points address wider issues around CYP mental health than access to effective crisis support:

- *Named point of contact in specialist CYP's mental health services, in schools and GP practices.*
- *Single point of access (should include sign posting to specialised crisis support for CYP presenting with mental health crisis).*
- *Access and waiting time standards.*
- *Paediatric mental health liaison services available to CYP.*
- *Planning needs to take place to determine where CYP can be seen i.e. an identified space within A&E or CAMHS service.*
- *Mental health assessments need to be flexible and if needed more community based e.g. at schools and youth hubs. There should be consideration of other community based options for CAMHS assessments.*

All CYP with significant mental health problems should have a safety and coping plan in place to enable rapid support if needed and a consultation with a CAMHS clinician to assess need, provide advice and mobilise relevant support. The CAMHS clinician and the CYP need to work together to jointly agree a safety and coping plan to support the CYP in the future and to revisit this plan on a regular basis. These plans should provide information and sign posting to support organisations, Out of Hours (OOH) services, websites and helplines and about family support available. If CYP suffer a mental health crisis, then analysis of why the plan failed needs to be undertaken as soon as possible. The safety and coping plan should be available to all agencies to access.

See best practice examples 6, 7 and 8 for websites that service users may find helpful and want to include in their safety and coping plans (chapter 5).

See best practice example 12 on Southwark's Signs of Safety scheme on (chapter 5).

See best practice example 14 on St George's, 'What makes a good crisis plan' (chapter 5)

See best practice examples 1 and 2 on Single Point of Access schemes (chapter 5).

See Appendix 1 for our recommended Safety and Coping Plan.

3. Consistency and continuity of care

There needs to be better review systems in place for a young person at risk of a mental health crisis or who has experienced a crisis, including consistent communication across services and agencies. At every step of the care pathway there needs to be robust communication with primary care (GP) and any other relevant individuals/agencies in the young person's network including family, school, and social care.

One major obstacle is poor adherence to follow up and practical help for adolescents who self-harm. Approximately 50% of CYP who attempt suicide fail to receive follow up mental

health treatment. Of those who do receive care, up to 77% are non-compliant with their outpatient treatment. There is accumulating evidence that non-adherence to follow up is a predictor of poor outcomes not only in terms of repeated self-harm and suicide but also in a variety of other psychosocial outcomes. Having clear communication with primary care and schools regarding non-adherence provides a pathway to address this, and by considering innovative ways of management such as step down pathways to primary care, seeing CYP in school settings, compliance with treatment can be improved. This should be a key metric used for monitoring and quality improvement. Multi-Agency Safeguarding Hubs across London also are able to provide information about CYP who are self-harming and are a suicide risk.

Recommendations:

See R5, R6 and R7 above.

R8. Consistency and continuity of care is essential and relies on clear and timely communication which should be a mandatory key performance indicator for each provider with financial penalties if delays occur. Electronic communication between all agencies and to primary care is essential and should occur within 24 hours of discharge in accordance with London acute standards.

The 'London Acute Care Standards for Children and Young People: Driving Consistency in Outcomes across the Capital' identifies the standards for CAMHS in acute settings.[19]

The Model of Care needs to be adapted for local areas with regards to what specialist interventions are required. This will depend on populations and numbers presenting, geography and availability of local in-patient services i.e. Psychiatric Intensive Care Unit, Forensic, and Learning Disability.

Agencies should review costs associated with placements out of area health, social care and education to consider joining together specialist services for a more effective use of resources. This would include specialised commissioners within NHS England.

4. Appropriate settings / times for assessment

Accident and emergency "gateway" model design

Emergency departments are predominantly designed for the treatment of physical health disorders and to provide relevant pathways in adults. They are inherently provided for dealing with all sorts of health-related crises and are seen as a safe haven by professionals, the public alike and for a young person with no "safe haven" at home, at school or in work. . However some CYP who present in mental health crisis will have negative views of emergency departments and acute hospital settings.

The high prevalence of mental health problems presenting as primary or co-morbid presentation means that they are adapted for all age groups to address these issues. Some Emergency departments are identified as designated health-based places of safety under the Mental Health Act where CYP can be detained under section 136; the majority of which are primarily designed for and used for care of adults e.g. A&E. Further thought is required on designing and identifying places of safety outside the designated places of safety.

Waiting times

The constitutional standard of a minimum 4 hours from arrival, through assessment to treatment or admission is seen as unachievable on many occasions. The need to co-ordinate and complete physical and mental health assessment and primary intervention can cause frustration and delay for not only CYP and their carers but also places pressure on professionals caring for other patients. CYP may have particularly long waiting times in A&E whilst awaiting completion of physical assessment for consequences of their self-harm. This adds to the poor experience and this experience may be one reason why, take up of follow-up appointments is poor, with resultant risk of poor outcome. Out of hours presentations in A&E may represent a particular challenge in terms of accessing the range of professionals needed to complete a multidisciplinary assessment and management plan. To enable timely care practitioners providing care and making assessments need appropriate training and support including mental health for CYP liaison advice whenever they need it.

Recommendations:

See R8 above.

R9. 95% of CYP presenting with mental health problems should complete their care in the Emergency Department within 4 hours of arrival or attendance. This standard should apply 7 days a week and through holiday periods. Achievement of the standard should be measured (by activity level, presenting diagnosis and destination) and reported and breach analysis undertaken and reported for performance review and improvement as well as to enable service redesign.

Cross-borough solutions and collaborative provider solutions should be explored to support the meeting of this standard. The Strategic Planning Group areas seem the right size to begin these conversations.

In hospital care settings

In the Emergency Department, there may be a lack of age-appropriate assessment areas for CYP with mental health difficulties. There is also a lack of short stay admission options other than the paediatric ward. Receiving care next to an elderly person or a young infant may not be the preference for CYP. For this and other reasons a paediatric ward may not be an appropriate place for a distressed young person. However when an admission has been agreed, it does represent an opportunity of continuing assessment, “cooling off” and stabilisation, allowing a holistic assessment (social, safeguarding, physical, mental) to emerge supported by staff capable of listening and supporting the young person. It allows for structured and fragmented multidisciplinary assessment with embedded CAMHS input and at least daily supervision. This should be 7-days a week. Time in this setting should be assessment time – not waiting time. Multidisciplinary assessment should be provided in a timely way and for overnight admissions; this should be the following morning.

Recommendations:

R10. Working with CYP including service users, providers should review their arrangements for the provision of inpatient care and co-design care pathways and care-setting that meets the needs of CYP.

New models

Perhaps the default response to the need for an emergency mental health assessment in a young person **should not by default** be a journey through the emergency department. It

may have become so, as the availability of appropriate Out Of Hours (OOH) services to support these CYP and their families within the home environment is very limited at present. Perhaps there is a need for a new model where the physical assessment can be undertaken by multi-skilled practitioners and any appropriate investigations undertaken away from A&E. Here we would be following in the footsteps well-trodden by the ambulance service where ECGS and point-of-care testing for troponin direct patients to the right place of care for a heart attack, ensuring the quickest journey to the heart attack centre for those who need it. Elements of such practice exist in sexual assault referral centres. Given the numbers of CYP likely to need such care, we feel that such solutions should be investigated at the Strategic Planning Group level. Much more detailed analysis is required to understand the likely demand and the need for physical diagnostics and interventions. Whether delivered in an Emergency Department or elsewhere, consideration of age appropriate assessment areas for CYP in mental health crisis including Section 136 suites is needed. The practicalities of how, where and when assessments should take place needs to be considered including an Out of Hours pathway.

Recommendations:

See R6 and R7 above.

R11. There is an opportunity for transformational work for commissioners across their systems working with CYP to look at enhancing crisis care that does not use the emergency hospital pathway. Care following sexual assault is a good example and commissioners should explore the provision of the Child House model for sexual assault (including female genital mutilation), and sexual exploitation and alongside other mental health problems. This is because:

- *Not all CYP will not have a physical problem and need the physical assessment of an acute hospital; some physical assessments can be undertaken outside hospital by paramedics, CAMHS workers and primary care workers.*
- *Many crises are socially-driven and reactive and not health-related - and these CYP are often known to services.*
- *Some CYP choose not to use hospital settings.*
- *Some CYP have a preference for primary care and community settings.*
- *On-going support from professionals will take place in local communities where such services could be set.*
- *Much of what is done in hospital settings could be achieved outside them.*
- *It allows choice by the service user which results in an increase in adherence and effectiveness.*

*R12. CCG transformation plans should include**:***

- *Clear management plan for all CAMHS discharges to adult mental health care and/or to general practice including Local Authority responsibilities, education, and social care.*
- *Joint consultation for handover to adult services to be mandatory where CYP are continuing to need secondary care services.*
- *All CYP being discharged from CAMHS services at 18 years of age to have a safety and coping plan clearly outlining how to get help and this to be sent to all relevant agencies including primary care.*
- *All CYP being discharged from CAMHS services at age 18 years of age to be offered a review appointment in primary care.*
- *Fast track back to services if discharged - either to CAMHS services if contracted to see to age 25, or adult services.*
- *CCGs should consider commissioning 0-25 services or an extended service for*

16-25 years old with relevant resources. There would be much to commend a London-wide approach to such a proposal and we recommend that NHS England (London region) supports CCGs in their on-going transformation planning to learn from established and emergent systems such as Birmingham. Although early in its implementation, it represents a collaborative and visionary approach to service transformation. Commissioners working with adult and CYP providers can in the interim design flexible transition models that address the level of maturity of CYP and their life circumstances rather than "hard and fast" rules. As outlined above the mental health act does not preclude this.

- *CCGs should work with NHS England (London region) to enable better transition from secure units into local CAMHS services.*

Good models exist already in some areas:

- London Ambulance Service mental health signposting and divert.
- INTERACT model in Outer North East London.

5. Managing Transition

If a young person known to children's services near transition age has not been transferred to adult services there is a risk that they may present later with a mental health crisis that could have been avoided. Where transition has not successfully occurred it is likely that communication between CYP and adult services has also been ineffective, and therefore managing the situation will have additional difficulties. The transition from children's services to adult's services needs careful planning to avoid such scenarios.

At present 18 years of age is the typical cut-off for access to CAMHS. Adult services typically will not begin work with a young person before their 18th birthday. New models are emerging to address these issues. In Birmingham for example, a model of integration of care up to the age of 25 has been developed.[20] See best practice example 3 (chapter 5).

Management of a mental health crisis can pose a particular challenge when a young person presents in mental health crisis a few weeks before their 18th birthday. Guidance suggests that it is not good practice to admit a young person within a few weeks of their 18th birthday to an adolescent unit if they will then need to be transferred to an adult ward. However adult wards will not often accept CYP under-18 due to an inaccurate understanding of changes to the Mental Health Act in 2007. It is government policy not to admit a child under the age of 16 to an adult ward, but it possible to admit a young person between 16 and 18 in an emergency if a suitable CAMHS bed is not available or in the circumstances where the adult bed is the most appropriate environment. This could include young people on the verge of transition where an adult ward can provide consistency of care desirable in their recovery. However, when a young person under 18 years old is admitted to an adult ward that ward will need to ensure appropriate safeguards are in place and that the young people can access education if well enough. The Royal College of Psychiatrists Centre for Quality Improvement has produced a set of standards for adult wards admitting under 18 year olds. Clarity is required regarding what other options are available and could be considered. For CYP in transition, it is important to identify the type of support to facilitate safe transition. High quality handover will incorporate safe and effective transfer of documentation and it is important that physical health is properly considered and reviewed in conjunction with primary care. Both the Future in Mind taskforce report and NHS England recognise the need to co-commission community and inpatient services. Commissioning needs to take place across the whole pathway to ensure transparency, effectiveness and efficiency. Access and use of specialised beds is a signal of how the whole system is working and therefore cannot be addressed in isolation.

Recommendations:

See R12 above.

R13. Commissioners should consider relevant contracting enablers to support transition including CQUINs and using the model protocol for transition.

R14. The role of GP in supporting transition chairing a multidisciplinary meeting with the CYP with the MH team at the cross-over should be developed with CYP and piloted.

6. Workforce and Resource

Economic restraint and funding reductions have had a major negative impact on the mental health workforce (in its widest sense) and the emergency services who have often been left to pick up the void. As well as reductions, financial risk management by use of fixed term contracts, for example, can result in a lack of continuity and inconsistency across the service. There is, for example, a lack of specific liaison nurses and liaison services for CYP under 18 years of age. CAMHS services routinely operate outpatient services from 9am to 5pm. However, there is now an expectation to provide extended hours for crisis care with the same or less resource. Crisis care requires multi-agency working, particularly with social care.

The data on admissions to hospital do not distinguish between CYP presenting with a mental health crisis or other crisis. Nor do we have robust data on how many children present in mental health crisis but are not admitted. CYP presenting OOH in mental health crisis is a relatively rare but serious event, and providing age-appropriate, skilled and cost-effective services around the clock is a significant challenge. Although demanding and high impact, the relatively low numbers of presentations in a local area, mean that costs are high for the number of cases seen. This can be ameliorated by the use of social care, paediatrics and adult mental health professionals who are already on site / available 24/7 as the CAMHS work force in any locality is too small to provide access 24/7. Local areas need to assess level of presentations out of hours and develop cost effective solutions, and consider cross boundary solutions.

Support for staff working in such a high intensity area is important. Ensuring good skills and knowledge and effective team working and communication systems is critical. Recognition of their contribution is important for the service and personal resilience.

Recommendation:

See R5 above.

7. Education and Training

There is variable knowledge among frontline staff regarding CYP mental health emergencies. For healthcare staff this includes primary care, secondary care such as accident and emergency staff (nurses and doctors), health visitors, schools nurses and paediatricians. Other key professional groups include school staff such as teachers and other staff as well as youth workers and police) and there is a need for improved training in mental health especially when dealing with CYP in crisis. Any training needs to be at an appropriate level depending on whether it is for other mental health professionals, other clinicians or those with a non-clinical background. There are opportunities with all professions involved to make training and learning recognised as continuing professional development (CPD). For example, children's nurses do not receive any formal training in mental health. Improved practice and confidence in managing mental health needs may be

best achieved by joint practice with mental health professionals alongside front line staff such as liaison services between psychiatry and paediatrics.

The paediatric liaison team (called the Paediatric Mental Health Team, PMHT) in North London is an example of an effective, well-integrated service where the PMHT work very closely within the paediatric department and with local community teams. The PMHT is small (now 3.0 FTE) but it has expanded in the last two years in response to growing demand, following a thorough review by commissioners. The team now consists of three part-time consultant child psychiatrists, a part- time child psychotherapist and a full-time family therapist. The team works closely wherever possible with social workers in the hospital from the local borough. The paediatric department fully recognises that child health requires close attention to physical, psychological and social care needs. Joint working between professionals both within the hospital and with community colleagues is the norm.

Consideration should be given to retraining/updating the mental health knowledge of professionals working with young people who may present in mental health crisis. This should be high-quality, evidence-based education, and/or sign-posting to authoritative online support such as MindEd (aimed at a range of professionals).[21] Multi-disciplinary training aids effective team-working in many care environments. Role play and simulation training is now used in many health care fields where complex and particularly urgent issues are being dealt with or arise (out of hospital emergency care, operative theatre crisis, resuscitation).

Recommendation:

See R5 above.

8. Complex commissioning environment

There are a number of different but often dependent and interacting areas of CYP mental health services commissioned by different agencies i.e. NHSE, CCG, Local Authority, Specialised Commissioning and Public Health. These commissioners, individually, do not commission across the whole pathway which can lead to variability and fragmented services which puts CYP at risk.

Recommendations:

See R5, R12, R13 and R14 above.

R15. NHSE act as commissioners of CYP mental health inpatient services (tier 4). CCG transformation plans should include linking with NHSE to ensure the following:

- *Ensure that providers start discharge planning before/from admission, with a clear definition of the goals and desired outcomes of the admission.*
- *Benchmark length of admission i.e. duty to notify commissioner if over 28 days for each CYP.*
- *Step down to Tier 3 planning before/from admission.*
- *Ensure Local Authority input from beginning to prepare social care package where needed from date of admission so no delayed transfer. Delayed transfers of care should be logged and passed to commissioners at NHSE and relevant Local Authorities.*

9. Principles of interagency working

Joint agency structure

Each CCG needs to establish a joint agency group / network of senior professionals who are tasked to develop joint agency protocols to describe how services should collectively respond to mental health crisis. The group needs to establish local lines of accountability and have methods of monitoring outcomes for CYP mental health crisis in order to refine practice and protocols based on actual outcomes. This will create a learning environment and on-going quality improvement. The group should be tasked to produce local adapted mental health crisis care pathway/guidelines. We have given a recommended core pathway that would be a suitable framework on which to base an optimised local pathway. This should be shared with all agencies and professionals who will be in contact with CYP and who may have to deal with a mental health crisis. This is particularly important for those (not just professionals) who are the first to identify problems and begin to support the young person. Communication and education are important principles of effect pathway working.

The joint agency structure needs to have a process to agree these protocols with all relevant agencies involved in the pathway (including representation from Primary Care, Acute Care, Local Authorities, Social care, Police, Youth justice, Voluntary sector, Youth services and Public Health, as well as local Health and Wellbeing Boards and Safeguarding Boards). This should be referenced in Transformation Plans

Multi-agency services that work in an increasingly integrated fashion

Access to CAMHS for the initial mental health consultation is essential. The mental health needs of the child and family and the role of health services should be clearly defined, and should be just part of a comprehensive assessment which will involve other agencies and identification of a lead professional. Mental health crisis needs to be addressed through multi-agency discussion and collaborative working and support from health care, social care, police and the justice system, schools, youth and voluntary sector working together for the benefit of the CYP.

Any interventions relating to a child or young person in mental health crisis should adhere to local interagency safeguarding policies and procedures.

See best practice example 4 on Hackney and City's Liaison Diversion (Five to Thrive) programme (chapter 5).

10. Engagement with CYP in transforming crisis care:

It is clear that to address the issues identified, CYP need to be involved in service design. To achieve a participatory culture in CYP's mental health, CYP and their families need to:

- be informed about mental health and be able to take an active role in seeking help when they need it and in making decisions about the care and treatment they receive when they access services;
- have access to, and understanding of, the highest quality, evidence-based interventions for mental health disorders;
- share control of resources for local mental health support, including sharing decisions about what is commissioned and how any services are designed and run;
- be enabled to develop supportive peer relationships with other young people and parents and work collectively to initiate solutions to the mental health challenges they perceive in their community;
- understand the local health system and be represented throughout it, including being treated as equals with all other stakeholders in the local system;
- this approach should not be limited to crisis care and could be used generically.

Chapter 3: Recommendations

R1. Commissioners should use (and enhance) activity analysis, in their transformation plans, and in reports from the forthcoming national mental health service data set, to understand the reasons for the variability in admission rates and ensure that information systems support regular reporting, high data quality so as to address need and to support quality improvement.

R2. Collaborative commissioning arrangements across Strategic Planning Groups and across London should ensure that CYP with mental health needs access services at their chosen or ambulance's first point of call so that they are not turned away sequentially from emergency departments or other access points"

R3. System service resilience planned around holiday periods should contain a clear focus on mental health care provision for CYP.

R4. As part of the review of out of hour's pathway, the role of the clinical hub at London Ambulance Service should be included.

R5. Education and training for all professionals who are in contact with CYP and families should be a mandatory responsibility for each provider organisation. We would recommend the availability of joint training for all staff, including adult staff. The training should include risk assessments, review of strengths and weaknesses, child friendships and social support, neighbours, helping young people to manage negative feelings, supporting parents to support their child, creating networks of support and how to work with other professions etc. This is in addition to professionally defined competencies in the assessment, identification, formulation and evidence-based interventions for mental health disorders. The following professionals should receive mental health first aid training as a minimum:

- Non-health social workers, residential home workers, secure unit workers.
- A&E staff, junior and senior doctors, paediatric nurses, adult mental health professionals especially triage nurses, primary care clinicians.
- Schools staff.
- Voluntary sector agencies.
- Youth Justice Youth Offending Teams (YOT) and Young Offenders institutions.
- Crisis line workers.

We also recognise that a broader range of colleagues across public services could also receive education and training to recognise, support and signpost those with mental health problems and those moving to crisis; for example, those supporting homeless persons and staff of the Department for Work and Pensions. Information about different agency training curriculum should be shared more widely, so different agencies can benefit and understand how staff are trained (e.g. College of Policing curriculum). The same goes for police officers, so often at the front line of mental health crisis.

See best practice example 9 on Simulation Training, best practice example 11 on Education for Health training and best practice example 13 on Camden's Multi agency training (chapter 5).

R6. CCG transformation plans should include the following:

- Clearly written and updated pathways for access to mental health crisis care for all agencies - including police, London Ambulance Service, schools, NHS 111 and A&E.
- Consideration of a multi-agency triage model.

- Assessment within 4 hours in line with adult mental health (this may be by adult psychiatry services in the first instance if Out Of Hours).
- The Royal College of Psychiatrists, The Crisis Care Concordat, the New Mental Health Codes of Practice maintain that holding CYP in police cells to be a "never event". If this does happen a Serious Incident investigation needs to take place to ensure the appropriate reporting occurs. Learning from these investigations needs to be shared across agencies.
- Alternatives to admission to be provided e.g. intensive day support, crisis groups and crisis houses. This could be resourced by local and specialist commissioners working together and using their budgets together to re-commission new care models along these lines. It is important that such models are identified where operating and developed with the participation of CYP and must take a holistic social and healthcare view. Such models should ensure the following aims within 2 years:

    - CYP from London should not receive inpatient care outside of London unless it meets a specific clinical need.
    - Lengths of stay should meet the best benchmarks in England.[18]
    - The number of CYP requiring such inpatient care could be reduced with optimum outpatient services of flexible intensities.
    - A system of networked-based benchmarking, continuous quality improvement and peer review, similar in purpose to those in say trauma and stroke care, overseen by the London CYP Mental Health Strategic Leadership Group would be a most welcome example of Parity of Esteem.
    - Access to appropriate home support where needed e.g. CAMHS home treatment team, CAMHS home visits and voluntary sector support.
    - Access to other more specialist interventions such as Multi Systemic Therapy (MST) for conduct disorder, Dialectical Behaviour Therapy (DBT), eating disorder and EI.

We recommend that at Strategic Planning Group level that commissioners develop transformational collaborative models of care that avoid the need for CYP presenting to A&E departments with mental health crisis unless physical needs of care cannot be met reasonably in any other way. They should also aim to even-up discrepancies in care. They should seek the support of local partners, NHS England, the Strategic Clinical Networks, the Police (Metropolitan, British Transport Police and City Police) and London Ambulance Service and it goes without saying the collaboration of CYP and service users.

See best practice example 5 on a Crisis House Model scheme and best practice example 10 for SLAM's DBT therapy (chapter 5).

R7. Improving access to effective support

The following points address wider issues around CYP mental health than access to effective crisis support:

- Named point of contact in specialist CYP's mental health services, in schools and GP practices.
- Single point of access (should include sign posting to specialised crisis support for CYP presenting with mental health crisis).
- Access and waiting time standards.
- Paediatric mental health liaison services available to CYP.

- Planning needs to take place to determine where CYP can be seen i.e. an identified space within A&E or CAMHS service.
- Mental health assessments need to be flexible and if needed more community based e.g. at schools and youth hubs. There should be consideration of other community based options for CAMHS assessments.

All CYP with significant mental health problems should have a safety and coping plan in place to enable rapid support if needed and a consultation with a CAMHS clinician to assess need, provide advice and mobilise relevant support. The CAMHS clinician and the CYP need to work together to jointly agree a safety and coping plan to support the CYP in the future and to revisit this plan on a regular basis. These plans should provide information and sign posting to support organisations, Out of Hours (OOH) services, websites and helplines and about family support available. If CYP suffer a mental health crisis, then analysis of why the plan failed needs to be undertaken as soon as possible. The safety and coping plan should be available to all agencies to access.

See best practice examples 6, 7 and 8 for websites that service users may find helpful and want to include in their safety and coping plans (chapter 5).

See best practice example 12 on Southwark's Signs of Safety scheme on (chapter 5).

See best practice example 14 on St George's, 'What makes a good crisis plan' (chapter 5)

See best practice examples 1 and 2 on Single Point of Access schemes (chapter 5).

See Appendix 1 for our recommended Safety and Coping Plan.

R8. Consistency and continuity of care is essential and relies on clear and timely communication which should be a mandatory key performance indicator for each provider with financial penalties if delays occur. Electronic communication between all agencies and to primary care is essential and should occur within 24 hours of discharge in accordance with London acute standards.

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The Model of Care needs to be adapted for local areas with regards to what specialist interventions are required. This will depend on populations and numbers presenting, geography and availability of local in-patient services i.e. Psychiatric Intensive Care Unit, Forensic, and Learning Disability.

Agencies should review costs associated with placements out of area health, social care and education to consider joining together specialist services for a more effective use of resources. This would include specialised commissioners within NHS England.

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- Some CYP choose not to use hospital settings.
- Some CYP have a preference for primary care and community settings.
- On-going support from professionals will take place in local communities where such services could be set.
- Much of what is done in hospital settings could be achieved outside them.
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- All CYP being discharged from CAMHS services at age 18 years of age to be offered a review appointment in primary care.
- Fast track back to services if discharged - either to CAMHS services if contracted to see to age 25, or adult services.
- CCGs should consider commissioning 0-25 services or an extended service for 16-25 years old with relevant resources. There would be much to commend a London-wide approach to such a proposal and we recommend that NHS England (London region) supports CCGs in their on-going transformation planning to learn from established and emergent systems such as Birmingham. Although early in its implementation, it represents a collaborative and visionary approach to service transformation. Commissioners working with adult and CYP providers can in the interim design flexible transition models that address the level of maturity of CYP and their life circumstances rather than “hard and fast” rules. As outlined above the mental health act does not preclude this.

CCGs should work with NHS England (London region) to enable better transition from secure units into local CAMHS services.

R13. Commissioners should consider relevant contracting enablers to support transition including CQUINs and using the model protocol for transition.

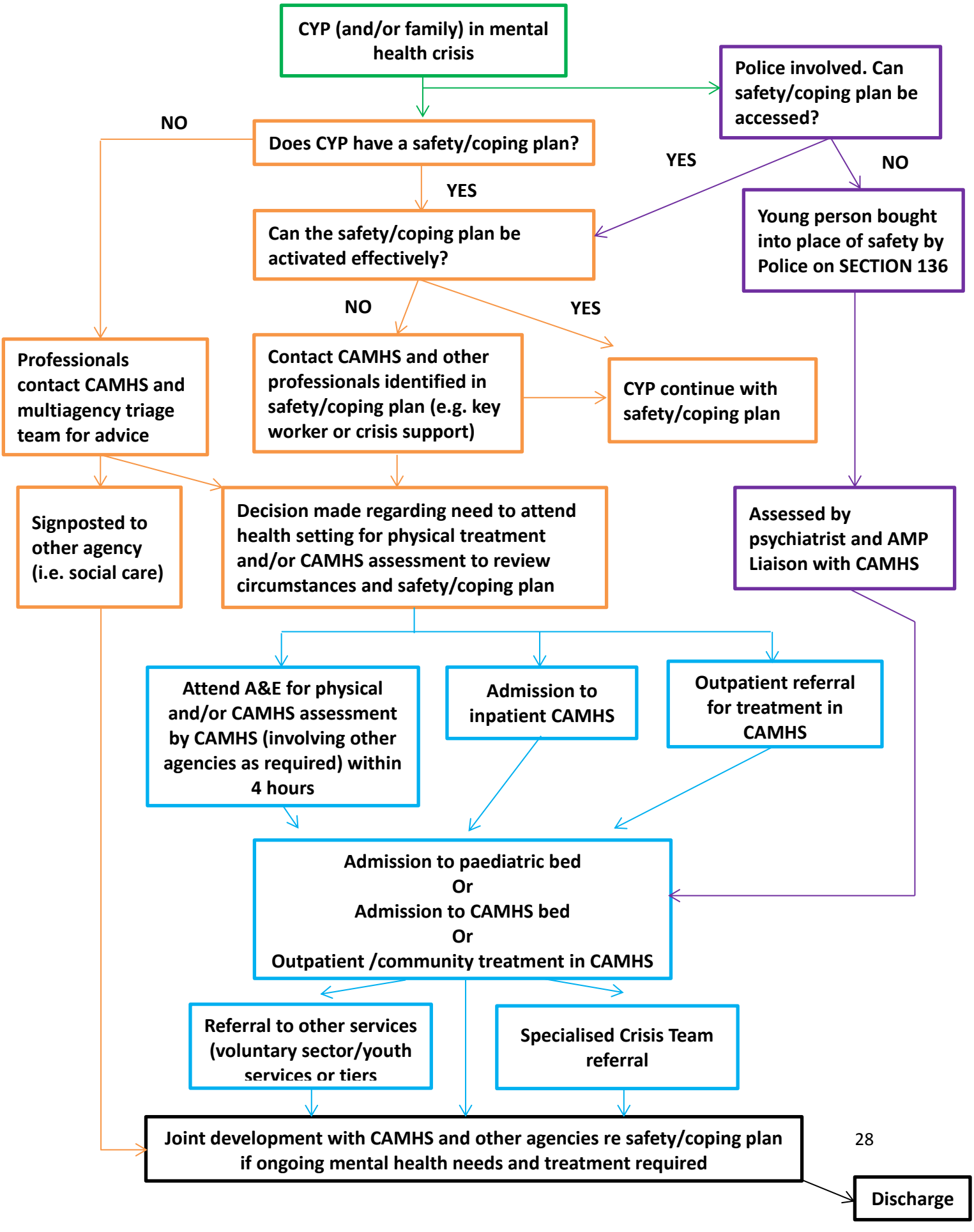
R14. The role of GP in supporting transition chairing a multidisciplinary meeting with the CYP with the MH team at the cross-over should be developed with CYP and piloted.

R15. NHSE act as commissioners of CYP mental health inpatient services (tier 4). CCG transformation plans should include linking with NHSE to ensure the following:

- Ensure that providers start discharge planning before/from admission, with a clear definition of the goals and desired outcomes of the admission.
- Benchmark length of admission i.e. duty to notify commissioner if over 28 days for each CYP.
- Step down to Tier 3 planning before/from admission.

Ensure Local Authority input from beginning to prepare social care package where needed from date of admission so no delayed transfer. Delayed transfers of care should be logged and passed to commissioners at NHSE and relevant Local Authorities.

Chapter 4: Recommended generic in-hours care pathway for CYP in mental health crisis (for adaptation locally)



Out-of-hour's pathway

A pathway for out of hours will be developed by a multi-agency group. Models including street triage will be discussed and the role of the clinical hub at London Ambulance Service for example.

Once this pathway is complete a new version of the document will be circulated.

Chapter 5 - Directory of best practice examples from across the UK

No	Title	Description	Location	Contact name and details
Diagnosis and referral				
1	Integration of CAMHS into a single point of access (SPOA) for Children	The SPOA team offers a range of assessments and treatments. Where appropriate a combination of approaches will be used in line with the CYP's needs and as agreed with the family through care planning.	Richmond CCG, London. 'London mental health crisis commissioning: Case studies'	Website: http://www.swlstg-tr.nhs.uk/our-services/camhs-richmond/ Phone number: 020 8891 7969 Email address: spa@richmond.gov.uk Contact: Dr Brinda Paramothayan , GP Lead for Children's Health and CAMHS, Richmond CCG Email address: brinda.paramothayan@nhs.net
2	Single Point Of Access	Liverpool and Sefton provision is through an array of services that are commissioned across multiple agencies and professional disciplines. CYP can access the most appropriate type of service to meet their presenting difficulties at that particular time.	Liverpool and Sefton	Website: http://www.alderhey.nhs.uk/departments/camhs/information-for-professionals/ Phone number: 0151 293 3662 Email address: camhs.referrals@alderhey.nhs.uk
Models of care				
3	0-25 years service	This service offers a new way of providing mental health services and has solutions to making services accessible to young people.	NHS Birmingham South Central CCG Suggest possibly looking at Norfolk	Website:http://bhamsouthcentralccg.nhs.uk/patient-and-public-engagement/0-25-mental-health-services Email address: cayamhsbham@nhs.net

4	Liaison Diversion (Five to Thrive)	The CAMHS provision for the integrated youth service which is an amalgamation of youth offending, targeted youth support and general youth provision. A mental health focus on early intervention and prevention providing access to all young people across Hackney and additional targeted assessment and treatment for those who need it.	Hackney and City, London	
5	Crisis House Model	Crisis houses provide respite or sanctuary outside of hospital alongside hospital approaches. They have strong support from service user groups.	Royal College of Psychiatrists	Website:http://www.jcpmh.info/commissioning-tools/cases-for-change/crisis/what-works/crisis-houses/
Technology / info services:				
6	Buddy App	Buddy is a digital tool to support therapy services. Clients use text messaging to keep a daily diary of what they are doing and how they are feeling, helping to spot and reinforce positive behaviours.	National	Website: www.buddyapp.org Email address: info@buddyapp.co.uk
7	Well Informed	Well Informed is designed to help non mental health professionals support young people with their mental and emotional wellbeing.	National	Website: http://wellinformed.org.uk/

8	Headscape	A self-help and referral website for CYP struggling to cope with mental health issues. They provide a 'one stop' source of self-help about a range of mental health issues that may be affecting children and young people.	Oxleas NHS Foundation Trust	Website: www.headscapegreenwich.co.uk
Training and education				
9	Simulation Workshop at the Mental and Physical Interface (SWAMPI)	Simulation Training course for mental health professionals	South London and the Maudsley Royal College of Psychiatrists	Course details on website: http://sailcentres.kcl.ac.uk/wp-content/uploads/2013/07/SWAMPI_Flyer_Nov2014.pdf Email address: chris.kowalski@slam.nhs.uk
10	Dialectical behaviour therapy (DBT)	Dialectical behaviour therapy (DBT) is a type of talking therapy which was based on cognitive behavioural therapy (CBT), but has been adapted to meet the particular needs of people who experience emotions very intensely.	South London and the Maudsley	Website:http://www.national.slam.nhs.uk/services/camhs/camhs-dialecticalbehaviour/
11	Education for Health	A charity which provides training for all, supporting the development of the knowledge, values and competencies required to manage Long Term Conditions effectively.	National	Email address: info@educationforhealth.org Phone number: 01926 493313

12	Signs of Safety	A strengths based approach to child protection work with the aim to improve the quality of social work delivered to families and a reduction in the number of children subject to child protection plans. It also aims to improve the risk management of vulnerable children.	Southwark child protection services	Website:http://www.signsofsafety.net/uk-implementation-of-the-signs-of-safety/ Email address: abigail.winter@southwark.gov.uk
13	Camden multi-agency mental health training	A free, specific multidisciplinary training course (including education, social care, police and voluntary sector) on mental health and safeguarding.	Camden Safeguarding Children Board	Website: http://www.cscb-new.co.uk/ Email address: Dameshk.Wijesinha@camden.gov.uk
14	What makes a good crisis plan?	An exemplar crisis plan and good practice standards for the crisis planning process.	St George's, London 'London mental health crisis commissioning: Case studies'	Website:http://sunnetwork.org.uk/wp-content/uploads/2013/08/What-makes-a-good-crisis-plan-V1.0.pdf Contact: Miles Rinaldi, Head of Recovery and Social Inclusion, South West London and St George's Mental Health Trust Email address: Miles.Rinaldi@swlstg-tr.nhs.uk

Appendix 1: Recommended Safety and Coping plan.

If you are struggling with suicidal thoughts or self-harm behaviour, complete the form below. When you are struggling, follow the plan one step at a time until you are safe.

Feeling suicidal / wanting to self-harm is the result of experiencing extreme pain and not having the resources to cope. We therefore need to reduce pain and increase coping resources.

Suicide is a permanent solution to a temporary problem. These feelings will pass. Keep the plan where you can easily find it when you'll need it.

What I need to do to reduce the risk of me acting on the suicidal thoughts / self-harming?
What warning signs or triggers are there that make me feel more out of control?
What have I done in the past that helped? What ways of coping do I have? What will I do to help calm and soothe myself?
What are your main concerns?
What will I tell myself (as alternatives to the dark thoughts)
What would I say to a close friend who was feeling this way?
What could others do that would help?
If I feel like harming myself, I will do one of the following (try to list 6-8 items): 1. 2. 3. 4. 5. 6. 7. 8.
Who can I call: □Friend or relative: □Health professional: □Telephone helpline:

Samaritans: 08457 90 90 90 Childline: 0800 1111 Local Hospital: Trust Urgent Advice Line: Another: Other:
A place of safety I can go to:
If I still feel out of control: I will go to the A&E department If I can't get there safely, I will call 999
Details of any medication (if any) Any physical health needs / conditions / medications:
Any special needs (including religious / cultural needs):

Signed:

Name of service user:

Name of Clinician:

Name and contact details of next of kin:

Who should be contacted when in a crisis:

Who should not be contacted when in a crisis:

Who would you like to advocate for you on your behalf:

Date:

(Form to be sent to relevant agencies, including primary care)

Glossary:

A&E	Accident and Emergency
ASD	Autism Spectrum Disorder
CAMHS	Children and Adolescent Mental Health Services
CCC	Crisis Care Concordat
CCG	Clinical Commissioning Group
CYP	Children and Young People
DBT	Dialectical Behaviour Therapy
EI	Early Intervention
GP	General Practice / General Practitioner
HLP	Healthy London Partnership
HTT	Home Treatment Teams
IAPT	Improving Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
MDT	Multi-Disciplinary Training
MST	Multi Systemic Therapy
NHSE	National Health Service (England)
NICE	National Institute for Health and Care Excellence
OOH	Out of Hours
PICU	Psychiatric Intensive Care Unit
PSHE	Personal, Social, Health and Economic Education
RMN	Registered Mental Health Nurse
s136	Section 136 of Mental Health Act
SPOA	Single Point of Access
YOT	Youth Offending Teams
YP	Young Person

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