Improving care for children and young people with mental health crisis in London

Recommendations for transformation in delivering high-quality, accessible care

October 2016

Healthy London Partnership – Transforming London's health and care together

Contents

Foreword

A mental health emergency can be as devastating and as life-threatening as a physical health emergency, and the long-term effects of failing to provide effective mental health care in childhood are well recognised. Unfortunately the care provided to children and young people in London presenting in mental health crisis is often fragmented, delayed, does not address their needs, adds to their feeling of stigma and all of which can lead to a worse outcome.

The purpose of this guide is to support the development of accessible, consistent and effective care for children and young people in mental health crisis across London. It is part of a body of work that aims to provide guidance on all aspects of crisis care. However we have begun with a specific focus on emergency health and typically “NHS” care. We acknowledge that many crises have a social basis and a social response. We signpost the work of partner agencies including local authorities and local child and adolescent mental health services (CAMHS) transformation governance groups should use this guidance to consider the wider multi-agency response to crisis, supporting the provision of high quality accessible care without stigma. It is our view that interagency cooperation and joint working is essential to ensure that children and young people receive the best possible service when they present in crisis.

This guidance follows and is built on emerging findings that were shared with commissioners as they developed CAMHS local transformation plans in autumn 2015.

The guidance also references and aligns its recommendations with Healthy London Partnership’s work on mental health crisis care, in providing guidance on the care of people detained under section 136 of the Mental Health Act in emergency departments and Health-Based Place of Safety.

In developing this guidance, we particularly considered the commissioning standards for mental health crisis care in London published in November 2014 that are now reflected in the London Quality Standards.

Action requested

Commissioners should ensure that these recommendations are fully enacted within CAMHS local transformation plans (refreshed by October 2016) and as they develop the urgent and emergency care component of their sustainability and transformation plan (STP). This is to ensure that children and young people’s mental health and wellbeing is being fully supported as set out in *Future in Mind*, the *Five Year Forward View for Mental Health* and in subsequent implementation guidance.

Urgent and emergency care networks and providers, using the voice of children and young people (and those that care for them), need to support the design, delivery and assurance of improved crisis care.

Document authors

Healthy London Partnership’s Children and Young People’s Programme

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Executive summary

The Healthy London Partnership Children and Young People Mental Health and Wellbeing Implementation Group use 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".

Crisis can show itself as self-harm, overdose, an abnormal mental state – a 'psychiatric emergency' or in many other ways. Children and young people getting into crisis is common. It is part of a burden of mental health difficulties that will ultimately lead to three quarters of adult mental health problems. Being in crisis is frequently the first presentation for a child or young person to mental health services. Where services are delivered in partnership, with clear plans and good communication, children and young people's needs are well served but unfortunately this is not always what they experience.

Children and young people want an integrated child, youth and family friendly approach that recognises their needs, as they see them, and that makes them feel supported, emphasises the positives and helps them to cope. Children and young people's and their families' views are essential to designing the right care for mental health crisis. Those with learning difficulties frequently experience particular difficulties in accessing the right care, at the right time and in the right place.

It is important to note that for children and young people presenting in crisis, this is rarely due to a mental health problem alone. Difficulties in relationships with peers, parents or carers, stress about housing, money, education as well as difficulty accessing appropriate care where they live are some of the possible factors. As a result, a pure health or NHS response is not likely to resolve the crisis and its causes. Therefore all contact with children and young people in crisis must explore these wider areas of their lives.

A range of national strategies and policies mandate action. These include *Future in Mind*, the *Five Year Forward View for Mental Health* and the *Mental Health Crisis Concordat*. For London, the Commissioning Standards for Crisis Care and Healthy London Partnership's *Acute Care Standards for Children and Young People* clearly set out expectations of quality and access that should be met. The delivery of the national and London standards are underpinned by the establishment of urgent and emergency care networks who are tasked with transforming care.

Transition age to adult services presents additional difficulty for children and young people in crisis, both in acute hospital and mental health settings. This may be made more so by the confusion caused by services using different ages when transition is enacted. Hence children and young people often feel that they have fallen through the gap between youth and adult services. Some health care systems are moving to a 0-25 provision to address this. Where children and young people are of transition age, consideration of the use of adult health facilities will be necessary and it is important to understand that adult health facilities can be used by exception but with very clear safeguards in place.

Providing a 24/7 children and young people mental health specific workforce (including both professionals from NHS CAMHS and partner agencies) for dealing with crisis is challenging and

is only in place in parts of London. Given the relatively low numbers of children and young people presenting in crisis compared to adults, in order for at least equivalent access to care in such a crisis, models of service resourcing are likely to need to be designed over a bigger footprint. This is so that resources are used effectively and no service feels too small to be safe and sustainable. Due to the current models of service delivery, some children and young people admitted on a Friday may remain inappropriately on an inpatient paediatric ward until the following Monday waiting for the mental health assessment they require. This is not acceptable and local models of service delivery must address this.

The entire workforce caring for children and young people requires the knowledge, skills and competencies to play their part in delivering developmentally-appropriate care.

Recommendations

Recommendation 1: Meeting previously defined standards

Timescale: Audit autumn 2016; commissioning intentions and service planning winter 2016/2017; delivery 2017/2018

In implementing the following recommendations the London Mental Health Crisis Care Standards must be implemented in a way that gives specific focus to the needs of children and young people and should be adapted and implemented in line with *London Acute Care Standards for Children and Young People* to ensure consistent outcomes across the capital (Appendix 1). As a start we recommend during 2016/17 that baseline audits are undertaken against the standards to support service planning.

Recommendation 2: A Safety and Coping Plan for all CYP

Timescale: Developing an agreed local approach by December 2016; piloting by March 2017; fully implemented April 2017; audit report October 2017

All children and young people with known mental health problems already in contact with services, whether by reason of a mental health disorder or circumstances, should have a patient and family acceptable, relevant, and realistic safety and coping plan that aims to reduce the risk of crisis but able to address a crisis should it occur. This is a written plan which has been co-produced with the child or young person and their parent/carers and shared with them in writing, to create a child, young person or family-held record.

See Appendix 2 for an example safety and coping plan. For a child or young person with a learning disability and those with an autistic spectrum disorder, who is at risk of crisis, their care and treatment review should underpin their safety and coping plan. This should ensure that the plan addresses their communication needs at the time it is drawn up and at the time of crisis. The safety and coping plan should be readily accessible when needed and local digital interoperability roadmaps should support electronic availability backed up with sharing of the clinical and safeguarding records.

Recommendation 3: A 24/7 service

Timescale: Audit autumn 2016; commissioning intentions and service planning winter 2016/2017; delivery 2017/2018

Crisis care systems should operate 24 hours a day, seven days a week and be co-designed with children and young people, their parents/carers, acute health and mental health providers to best meet the needs of the local area. Pathways for children and young people requiring further inpatient physical or mental health care should be jointly developed and include protocols for managing delays in admission/transfer to specialist beds. Pathways should be consistent with the all-hours pathway described in figure 10.1 (page 23); for those where a Tier 4 pathway is considered they should be consistent with figure 10.2 (page 24). Consideration should be made of the use of incentives such as CQUIN payments to support rapid transformation.

Recommendation 4: Effective governance

Timescale: Autumn 2016

There should be visible and prominent clinical audit and governance processes established to ensure that crisis care issues are reported, understood and addressed through effective feedback and quality improvement. These processes should include:

- Reports to Health and Wellbeing Boards and clinical commissioning groups (CCGs).
- Local assurance through CAMHS transformation planning oversight groups.
- Activity analysis including reports from the forthcoming national Mental Health Services Data Set.
- Collecting data on waiting times and delays for assessment, treatment and transfer.
- Monitoring of non-adherence to follow-up appointments following an episode of crisis care.
- Defining the role of the Multiagency Safeguarding Hub.
- Exception reporting and serious incidents.
- The experience and voice of children and young people and their families/carers via friends and family and participation groups or by other methods.
- Assessment of the effectiveness of safety and coping plans through clinical audit including a measure of the breakdown of residential placements.
- Incorporation into local Mental Health Crisis Care Concordat structures.

Recommendation 5: Sign-off and publish clear local guidelines

Timescale: 1 January 2017

Each local area should develop clear, accessible guidelines for each interaction between an acute hospital, mental health provider trust and local authority that are providing care for a child or young person who presents in crisis up until their 18th birthday. Each set of guidelines should outline the collective and individual organisational responsibility for provision, for on-site care and off-site support. These plans should be signed off by the local CAMHS transformation group and urgent and emergency care networks. Where appropriate the plan should be collaborative across CCGs and Boroughs.

Collaborative commissioning and provision arrangements should be enacted and agreed with commissioners and local authorities. These plans should include clear arrangements for the transfer of care onwards from the emergency department to colleagues who will be providing continuing care as outlined in the figure 10.1. These guidelines should ensure that children and young people are screened, assessed and managed jointly with social care. The exact balance

and who leads on a multiagency care package needs to be agreed with the child or young person and their family or carers. These plans must be accessible at the point of need.

The plans must be designed and resourced to address the situation where a child or young person is considered for Tier 4 care (pending the changes from the review in specialised commissioned services Tier 4, see 4.12, page 16) and must support local care if an inpatient bed is not available. Plans should ensure that the correct processes and documentation are used (see 4.12 Specialised commissioned services Tier 4) and should define roles and responsibilities (including social care) and escalation arrangements. This will involve development of further co-commissioning between NHS England Specialised Commissioning and CCGs which is expected to be set out in collaborative commissioning plans by the end of December 2016. A template for these plans is provided in Appendix 3. Local areas will need to liaise with NHS England Specialised Commissioning to agree these arrangements. The guidelines should specifically reference arrangements for children and young people in care (looked-after children), those with learning disabilities and should incorporate the specific roles and responsibilities for emergency department staff in relation to crisis care. Further guidance will be provided by Healthy London Partnership's Urgent and Emergency Care Programme.

Recommendation 6: Education and training

Timescale: Training needs analysis by December 2016; planning by March 2017; delivery by March 2018

All staff who engage with children and young people should receive the necessary education and training to provide safe and effective clinical and emotional care, including training for mental health staff in increasing physical health skills and for physical health staff in responding to mental health need. Training should include how to support vulnerable children and young people, such as those with learning difficulties, as well as those who are looked after children. Relevant statutory and mandatory training as well as professional competencies should be built into current educational provision and personal development.

Joint and interagency training brings significant additional benefits around breaking down silos and increasing mutual respect and understanding which can be further promoted by sharing information about different agency training curricula (e.g. College of Policing curriculum).

Local training needs analysis should be undertaken by providers and relevant syllabuses with content developed and modified to meet that need, working with relevant agencies such as Health Education England.

Recommendation 7: Health Based Place of Safety (specifically for children and young people on a section 136 pathway, brought to NHS premises by the police)

Timescale: All-ages guidance October 2016; analysis for implementation planning autumn 2016; refreshed sustainability and transformation plans autumn/winter 2016/2017

An adequate and accessible health-based place of safety should be identified for children and young people who present in crisis to the police and are brought to a healthcare facility on a section 136. The role of the health-based place of safety in managing mental health crisis should be recognised by both acute and mental health trusts and joint pathways should be developed between providers. These arrangements should be signposted within sustainability and transformation plans. Arrangements should include using networking and mitigation plans for exceptional circumstances. These should be signed off by urgent and emergency care networks.

Where possible, a designated hub health-based place of safety for children and young people should be collocated with CAMHS inpatient care and have strong links with a local emergency department and paediatric departments for management of co-existent medical problems. It must be remembered that the large majority of children and young people presenting in crisis to emergency departments are not on a section 136 and they will require mental health care and frequently concomitant physical health care.

Healthy London Partnership's urgent and emergency care and mental health programmes are developing all-ages guidance for the section 136 pathway and facilities and resources required at designated health-based places of safety. It is important that planning for children and young people is integral to implementation of this guidance and consistent with these recommendations.

1 Background

1.1 The challenge facing children and young people and the burden of mental health crisis

Half of all mental illness (excluding dementia) in adults starts before the age of 14. Three quarters of lifetime mental health disorders have their first onset before 18 years of age. Based on the last national survey in 2004, at least one in 10 children and young people (aged 5 to 16 years) are thought to have a diagnosable mental disorder, equating to three in every school class, or more than 100,000 children and young people across the capital. Most professionals believe that prevalence rates have increased since that time. Between one in 12 and one in 15 children and young people will deliberately self-harm. Conduct disorders and associated antisocial behaviour are the most common mental health and behavioural problems for children and young people that are likely to present in crisis. Children and young people can be intoxicated with alcohol, other agents, and drugs at the same time as being in mental health crisis and may have taken these intending to cause self-harm.

Failure to prevent crisis and deal with it effectively represents a lost opportunity for children and young people, at the point of crisis and for their future mental health. Approximately 50 per cent of children and young people who attempt suicide fail to receive follow-up mental health treatment. Of those who do receive care, up to 77 per cent are non-compliant with their outpatient treatment. There is accumulating evidence that non-adherence to follow-up is a predictor of poor outcomes, in terms of repeated self-harm and suicide but also in a variety of other psychosocial outcomes. The national confidential enquiry into suicide by young people reinforces the need not to let such opportunities be lost. Of the 145 suicides of children and young people in England between January 2014 and April 2015, 54 per cent had previously self-harmed.[1] Multi-Agency Safeguarding Hubs across London represent a key platform at which information about children and young people who are self-harming and are a suicide risk can be shared, including links to primary care and education, and can ensure a multiagency response and monitoring.

There appears to be marked variation in acute hospital admissions for mental health conditions (0-17 years) across London and the London average is considerably higher than the England average. The reasons for this are currently unclear, though felt to be complex. On the other hand the London average for hospital admission as a result of self-harm (10-24 years) is considerably lower than the England average, although again with considerable variation. We need to understand the reasons for the variation – what part is service related and what to circumstances children and young people find themselves in.

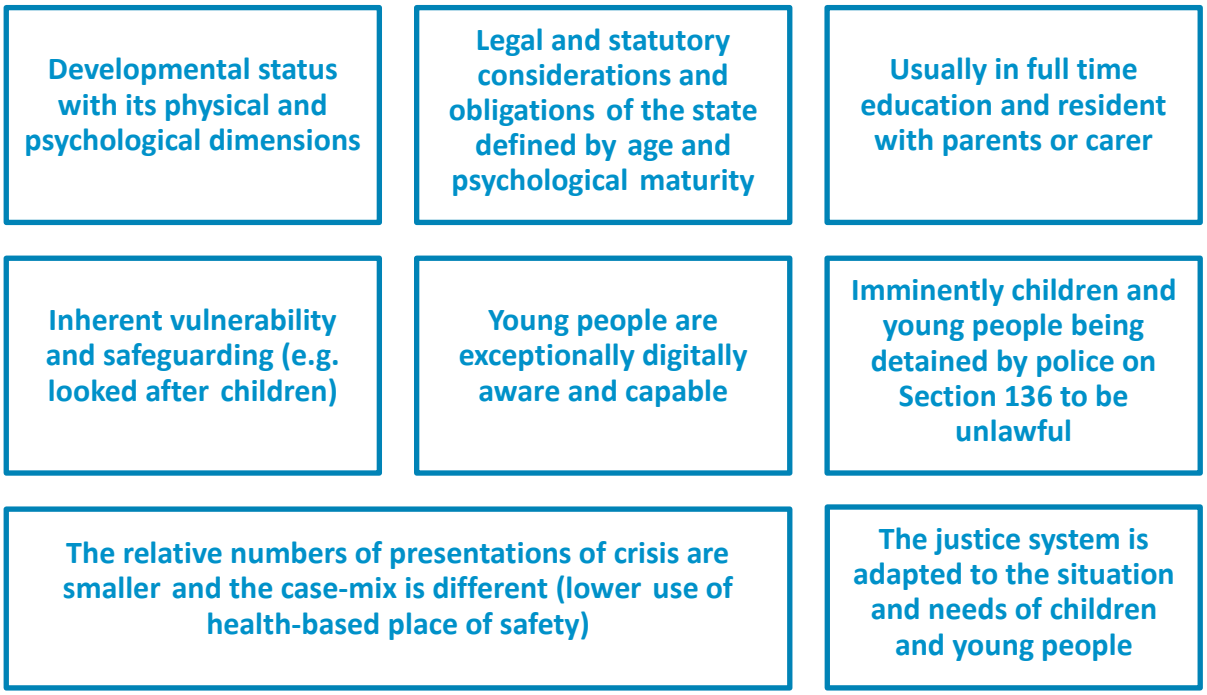
Access to CAMHS crisis, out-of-hours and liaison mental health services across London is variable, and there are different workforce models. If admission is required, the availability of inpatient care close to home at the right time is very dependent on where the young person lives. Difficulty in accessing on-going local care outside the emergency department can result in further delays and the need for transfers outside the area, often considerable distances outside London and the Southeast. These problems may be exacerbated at weekends.

For those children and young people, and their families, who are living with a learning disability, the burden at the point of mental health crisis can be even more profound. The combination of complex commissioning and provision arrangements; the likelihood of behaviour that challenges; clinical teams not having the necessary skills, knowledge and information; as well as the alarming change in environment for the child or young person can lead to a profoundly disturbing

situation. The system response may then be tilted towards accessing a specialist inpatient bed that may be located in a completely different part of the country, adding greatly to the burden.

2 Differences between children and young people and adults in mental health crisis

These can be summarised as:



In a child or young person mental health crisis the family is likely to be involved, as most children and young people live at home with their parents or carers. Crisis may also occur in different environments for children and young people, such as at school or college. They may exhibit aggressive behaviour, suicidal behaviour or extreme oppositional behaviour that can be disruptive in these educational environments. Crisis may occur at home and children and young people may engage in behaviour that is risky to themselves and others, including siblings. Mental health issues are highly prevalent in children and young people in the youth justice system, hence the frequent involvement of other agencies especially social services and the police. Children and young people in mental health crisis may show offending behaviour at the time and they are also vulnerable to substance misuse at these times. The life experiences of looked-after children make them especially vulnerable to mental health problems and risk of crisis.

3 What do children and young people and their families want when they are in crisis?

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 be supported to prevent crisis from happening and to work with clinicians to shape their care and plans. They need to be able to get help quickly and simply and not need to navigate a complex system. A single point of access would greatly help meet that need.

“Children and young people 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”.[2]

“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”.[3]

Children and young people have also told us:

“Communicating through parents makes young people feel like we are incapable of managing our own health. This can make it harder to beat mental illness, as nobody knows how the young person is feeling and you can’t deal with things collaboratively”

Children and young people wish to be cared for in comfortable environments. They need a record of what is going on and to be no-longer surprised by the use of such antiquated technology as the fax machine. They also reminded us that failing to get access to services by not meeting a clinical threshold could leave things to spiral and result in a higher demand for crisis and emergency services.

4 Strategy

A number of elements of national and regional policy are relevant.

4.1 Future in Mind[4]

Future in Mind states that:

“If you have a crisis, you should get extra help straightaway, whatever time of day or night it is. You should be in a safe place where a team will work with you to figure out what needs to happen next to help you in the best possible way. If you need to go to hospital, it should be on a ward with people around your age and near to your home. If you need something very specialised, then you and your family should be told why you need to travel further, and the service should stay in touch to get you home as soon as possible. And while you are in hospital, we should ensure you can keep up with your education as much as you can……If you need help at home, your care team will visit and work with you and your family at home to reduce the need for you to go into hospital.”

Future in Mind also recommends:

- Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are 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.

4.2 Five Year Forward View[5]

The *Five Year Forward View* promotes the development of urgent and emergency care networks – integrated systems of care built around patients' need delivered through emergency departments, GP out-of-hours services, urgent care centres, urgent mental health care setting, NHS 111 and ambulance services. During 2016, a major development in the design and delivery of the *Five Year Forward View* was the establishment of sustainability and transformation plans with the question: "How will you put your Children and Young People Mental Health Plan into practice?" This is underpinned by the CCG Improvement and Assessment Framework having a focus on transformation in children and young people's mental health services, crisis care, liaison mental health services transformation and out of area placements for acute mental health inpatient care. The *Five Year Forward View* is supported by specific implementation guidance which states: "In delivering this expansion within community based services, CCGs should commission improved access to 24/7 crisis resolution and liaison mental health services which are appropriate for children and young people."

4.3 Mental Health Crisis Care Concordat[6]

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

4.4 Transforming care for people with learning disabilities

This national programme is completely revolutionising the way we think about and provide care for all people with learning disabilities, so people with learning disabilities can remain in their communities, and live with what we heard movingly advocated at our recent Healthy London Partnership children and young people's learning disabilities workshop – 'An ordinary life'. A cornerstone of the programme is the use of care and treatment reviews to plan care out of hospitals and similar institutions, as care and treatment reviews have been demonstrated to divert people away from hospital admission when they are at the point of crisis.[7]

4.5 Achieving better access to mental health services 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 children and young peopl 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. For those with eating disorders, waiting time standards have been defined and the standard will be measured and monitored in 2016/17; a maximum of four weeks from first contact with a designated healthcare professional for routine cases, within 1 week for urgent

cases. In cases of emergency, the eating disorder service should be contacted to provide support within 24 hours[9].

4.6 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report[10]

Has shown there have been gaps in provision with NHS England exploring a range of options for future commissioning and more collaborative work. This is expected to report in early 2016. 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 or 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 much more readily than is seen in London and this was associated with shorter length of stay. This report outlined the need for, and provision of, appropriate inpatient beds for children and young people with mental health needs, near where they live and demonstrated a range of areas in need of change or review.

4.7 NICE guidelines

These have been published on psychosis and schizophrenia[11], self-harm[12] and antisocial behaviour and conduct disorders.[13] 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 together with guidelines about dealing with maltreatment. These guidelines and others relating to them give advice about the management of intoxication. Significant intoxication will need to be managed in the emergency department initially with close collaboration and communication between the medical treating team and the mental health team. NICE has also issued guidance on important components of a SCP which include:

- Possible early warning signs of a crisis and coping strategies.
- Support available to help prevent hospitalisation.
- Where the person would like to be admitted in the event of hospitalisation.
- The practical needs of the person if they are admitted to hospital (e.g. childcare, care of other dependents, including pets).
- Details of advance statements and advance decisions.
- Whether and the degree to which families or carers are involved.
- Information about 24-hour access to services.
- Named contacts.

4.8 London Commissioning Standards for Crisis Care[14] and the 'London Acute Care Standards for Children and Young People[15]

The London Commissioning Standards for Crisis Care standards were published in October 2014 and made brief reference to children and young people. These standards should be now be used for the care of children and young people with suitable amendments. Healthy London Partnership's *London Acute Care Standards for Children and Young People* identifies the standards for CAMHS in acute settings and makes reference to the care of children and young people in mental health crisis. The focus of these standards is providing clear and robust flexible and responsive pathways of care which well trained staff deliver. The standards are summarised in Appendix 1.

Healthy London Partnership's Children and Young People's Programme produced emerging crisis care findings guidance in 2015. These were shared with commissioners leading the development of CAMHS local transformation plans in response to *Future in Mind*. This guidance included a core CAMHS pathway that was at that time described as 'in hours'. This earlier guidance can retrospectively be considered as an excerpt of the subsequent 24/7 pathway. It shows how having available CAMHS practitioners to see or give advice about patients can direct them more quickly to the care that will best suit their needs (Figure 10.3). These standards mirror those above but also the need for interagency collaboration, including with the police around section 136 care and emphasise the need for documented crisis plans.

4.9 Use of adult mental health inpatient facilities

Young people aged 16 and 17 may, in exceptional circumstances, be admitted to an adult mental health ward if this is in their best interests and the ward environment is suitable. There are two categories of exceptional circumstances:

(i) Emergency Admissions: the admission to an adult ward is the most appropriate means of meeting the young person's needs at that time. While such admissions may be justified when responding to a crisis situation, this will only be acceptable in the short term.

(ii) Atypical Admissions: given the young person's particular circumstances the best place for the young person is an adult ward (for example, a young person is nearly 18, has left school and is being treated by the Early Intervention Psychosis team which has beds on the ward to which the young person will be admitted.

Young people under 16 must never be admitted to an adult ward.

The Code of Practice to the Mental Health Act 1983 for England 2008 describes factors to be considered when deciding whether the ward environment is suitable. They should have:

- appropriate physical facilities
- staff with the right training, skills and knowledge to understand and address their specific needs as children and young people
- a hospital routine that will allow their personal, social and educational development to continue as normally as possible
- equal access to educational opportunities as their peers, in so far as they are able to make use of them, considering their mental state.

Registered persons who provide psychiatric units for adults must notify CQC if they admit a child or young person aged under 18, if that placement has lasted for a continuous period longer than 48 hours. The CQC provided an updated note on this aspect of care in May 2012.[16] Their guidance states care can be provided in such a setting, but only in exceptional circumstances and if:

- liaison protocols with CAMHS with appropriate risk assessments are in place
- there are relevant safeguarding (including CRB) procedures.

Further practical suggestions are given in the guidance. The Royal College of Psychiatrists Centre for Quality Improvement has produced a set of standards for adult wards admitting under 18 year olds.[17]

4.10 Health-based place of safety and section 136 pathway

Healthy London Partnership's Urgent and Emergency Care Programme is developing all-ages standards to be consulted on in Spring/Summer 2016. The needs of children and young people will be incorporated and commissioners should work to these standards when published. In London, police custody is never used for a child in crisis and detained under section 136 of the Mental Health Act. The Policing and Crime Bill 2015-2016 that is currently progressing through Parliament has a provision that child may not be removed, kept or taken to a place of safety that is a police station under section 136 of the Mental health Act. The duration of detention in other settings is now limited to 24 hours rather than 72 hours previously.

4.11 Urgent and emergency care networks

These have been established across England and represent a fundamental shift in the way urgent and emergency care services are provided; different parts of the system working together to create a completely new approach to delivering care. The aim is for a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families. For those with more serious or life threatening emergency care needs, make sure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

To implement these networks change is required across the urgent and emergency care system by:

- providing better support for people to self-care
- helping people with urgent care needs to get the right advice in the right place, first time
- providing highly responsive urgent care services outside of hospital
- ensuring that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
- connecting all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

4.12 Specialised commissioned services: Tier 4

NHS England commissions these highly specialist inpatient and outpatient units for children and young people with severe mental health problems. This includes the 262 inpatients beds in London (40 per cent of which are occupied by children and young people transferred in from outside London); as well as for the 107 children and young people of London accommodated in beds outside London in January 2016. Despite increases in beds commissioned nationally, increasing referral rates and increasing length of stay mean that frequently, when the crisis is such that an inpatient specialised placement is sought, no local or even distant bed is available. This leads to those children and young people often brought to emergency departments by the police under the Mental Health Act (section 136) being held in that department by police and NHS staff until a placement can be found. These incidents are frequently escalated to NHS England on-call managers.

Some areas in London have addressed this with services that aim to provide the requisite care locally – 'Tier 3.5' in Bexley and 'INTERACT' in North East London being examples. NHS England Specialised Commissioning has begun to develop a case for change to build on and diffuse these models, to reduce the need for beds and to keep care local. In addition, a live searchable bed-state review system was due to be operational from the beginning of May 2016, to identify capacity that is available at the point of need.

The Transforming Care Programme aims to return people with learning disabilities from hospitals and institutions, back into their own communities, and also aims to prevent them being readmitted or admitted there in the first place. (Care and treatment reviews can be seen as a very sophisticated safety and care plan when it comes to planning for and dealing with crisis in these children and young people).

Specific documentation is provided by NHS England for referral to Tier 4 services and includes:

- Referral for Access Assessment into Inpatient Services for Children & Young People (Form 1)
- Access Assessment for Inpatient Services for Children & Young People (Form 2)
- Specialised Mental Health Services Operating Handbook Protocol

Copies of these forms and the protocol are available from NHS England Specialised Commissioning (London Region).

4.13 Social care and looked-after children

It is also important to note that for children and young people presenting in crisis, it is rarely only due to a mental health disorder. The difficulties in a child or young person's social life in their family, community and school are almost universal. Some children and young people are exceptionally vulnerable with complex needs and presentations. One such group is looked-after children who may present with behavioural and conduct difficulties as well as risk–taking behaviour affecting themselves and others. As a result a pure health or NHS response is not likely to resolve the crisis and its causes.

For example, children and young people presenting with deliberate self-harm (which often requires physical/ medical treatment) may be doing so because they cannot cope with an unsafe home. If an alternative placement is needed, there may be delays whilst emergency social care (e.g. foster care) is organised. It is reported that the number of foster carers with a spare bedroom has decreased significantly in central London following recent changes in housing benefits arrangements. The risk behaviours of some children and young people may be of much concern, such that a residential placement may break down and return there may be denied.

Therefore all contact with children and young people in crisis must explore these wider areas of their lives and ensure that necessary social care can be accessed in a timely way. Substance misuse is also common place in children and young people with mental health issues and those presenting in crisis and it is important that easily accessible assessment and intervention is coordinated between health and social care.

Mental health crises need to be screened, assessed and managed jointly with social care. The exact balance and who leads on a multiagency care package needs to be negotiated with the children and young people and their families. These may include short stay/intensive outreach day hospital and residential placements. The crisis house model that is becoming commonplace in adult mental health crisis care may offer new pathways of care for such vulnerable children and young people and merits consideration for piloting. Care pathways need to ensure that social and educational information is considered early as well as considering the needs of adults in the child or young person's life. This is a wider consideration than just safeguarding.

5 Engagement with children and young people in transforming crisis care[3]

It is clear that to address the issues in access and quality of care, the views of children and young people need to be involved in service design. Children and young people and their families have told us that to better gain their participation they should:

- Help shape resources for local mental health support, including sharing decisions about what is commissioned and how any services are designed and run.
- Understand the local health system and be represented throughout it, including being treated as equals with all other stakeholders in the local system.
- Understand the evidence base for interventions used or proposed.

For example they have told us they would like to see care that allows them 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.
- 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.

I-statements are powerful statements in which children and young people have set out their expectations of care and experience of care:

- Those caring for me involve me in discussions about my care and listen to what I think works well.
- Staff believes what I am saying and take my opinion seriously. My voice is not ignored just because I have an adult with me and I am not spoken over or about just because I am young.
- Wherever possible I am given options in my care that recognise that I am an individual and that every situation is different.
- I am never left waiting on my own without knowing what is going on and I am always involved in making plans for what happens next.
- Those involved in my care make the effort to get to know me. They understand that although I may be an adult legally, I may not always feel like one.
- Those involved in my care are always honest with me. They support me to gain confidence in them when I am feeling vulnerable.
- As far as possible my confidentiality is respected and only the friends, family and carers that I choose are involved in my care.
- I am supported to achieve my aspirations for other areas of my life such as education, hobbies and relationships.
- Those caring for me take the time to find out about my fears. They take them seriously and reassure me.
- I am prepared for the changes which are coming up and not left feeling I am going into the unknown.

6 Accessing crisis care through the hospital emergency department

Although not required or sought for every crisis, emergency departments are there to deal with all health emergencies that present there. Because of their visibility, anonymity, non-stigmatising connotations and 24 hour access they are a safe haven for professionals and the public alike. Their aim emphasised through the Crisis Care Concordat is to provide care that represents parity of esteem between physical and mental health care.

There is a need to co-ordinate and complete both physical and mental health assessment and treatment efficiently and failure to do so can cause frustration and delay for children and young people and their carers. Sometimes this is because mental health assessment is not started until the physical health situation is resolved or cleared. This can result in a poor experience and may be one reason why take up of follow-up appointments is poor. Out of hours presentation in the emergency department may represent a particular challenge in children and young people being able to access the right professionals to complete a multi-agency assessment and management plan.

Following assessment and initial treatment a child or young person's continuing care may be transferred to an inpatient paediatric or medical ward. As well as continuing medical treatment and observation it does represent an opportunity for: 'cooling off, stabilisation and holistic assessment (social, safeguarding, physical and mental) with staff able to listen to and support the young person. It allows for a structured multidisciplinary assessment with embedded CAMHS input, the latter providing at least daily supervision.'

7 Transition

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.[17] Ineffective or delayed transition (or loss to follow-up) may lead to lack of continuity of care which could lead to avoidable crisis as the safety and coping plan cannot be affected. This may 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 children and young people under 18 years of age, due to an inaccurate understanding of changes to the Mental Health Act in 2007 (2.4.8). It is permissible to admit a young person between 16 and 18 years 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.

Children and young people at transition ages do face additional problems if they require admission into a medical inpatient setting with the choice of an adult medical ward or children's (paediatric) ward. They should be able to express a preference and have that preference taken into account. The lack of an agreed protocol to guide staff and the necessary arrangements being in place, especially out-of-hours, in these situations can lead to very significant delays and exacerbate crisis.

Differences in thresholds between CAMHS and adult services may also mean that young people presenting in crisis shortly after their 18th birthday, having been discharged from CAMHS, may

fail to meet the threshold for acceptance into an adult service and left without any outpatient provision, a situation they are likely to find bewildering.

8 Workforce

Compared to adult services there is a lack of specific liaison nurses, experienced with children and young people, Approved Mental Health Professionals (AMHPs) and liaison services for children and young people. It is the norm for CAMHS services to routinely operate crisis response services from 9am to 5pm, Monday to Friday, because there is an insufficient workforce to operate for longer hours than this. Meeting the London Commissioning Standards for Crisis Care sets an expectation to provide extended hours for crisis care remembering that it requires multiagency working, particularly with social care.

Compared to adult crisis care, the relatively low numbers of presentations in children and young people in a local area, means that costs for 24/7 CAMHS-delivered care would be very high for the number of children and young people receiving care. The lack of a round-the-clock CAMHS workforce is to an extent ameliorated by the use of social care, paediatrics and adult mental health professionals who are available. However this does mean that some children and young people must wait long periods to receive definitive care planning – around weekends and bank holidays this may mean waits of up to five days, which is clearly unacceptable.

This situation suggests we consider a larger scale or footprint of a team / service should that crosses CCG and local authority boundaries.

9 Education and training

It is essential that professionals who will be involved in the care of children and young people, who present in crisis or have comorbid physical and mental health difficulties, have skills and the knowledge to allow them to work with children and young people and provide safe and effective care.

However, there is variable knowledge among frontline staff regarding children and young people's 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. There are opportunities with all professions involved to make training and learning recognised as continuing professional development. 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.

Appropriate resources should be allocated to ensure relevant retraining and updating of these. 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) multidisciplinary training aids effective team-working in many care environments.[18] 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).

It is important to note the breadth of professionals (both specialist and wider groups) who may provide care and support for children and young people in crisis:

- Non-health social workers, residential home workers, secure unit workers.

- Emergency department staff, junior (including foundation) and senior doctors, paediatric nurses, adult mental health professionals especially triage nurses, primary care clinicians.
- Schools staff.
- Play staff.
- Voluntary sector agencies.
- Youth Justice Youth Offending Teams and Young Offenders institutions.
- Crisis line workers.

Important areas of understanding and skills include:

- Relevant professionally defined competencies.
- Learning difficulties and autistic spectrum disorder.
- Mental health first aid.
- Risk assessments.
- Review of strengths and weaknesses.
- Child friendships and social support.
- Neighbours.
- Managing negative feelings.
- Supporting parents to support.
- Creating networks of support.
- Working with other professional in assessment, identification and formulation.
- Understanding of evidence-based interventions.
- Understanding and applying the relevant legal frameworks.

10 Figures and appendices

Figure 10.1 - All-hours pathway

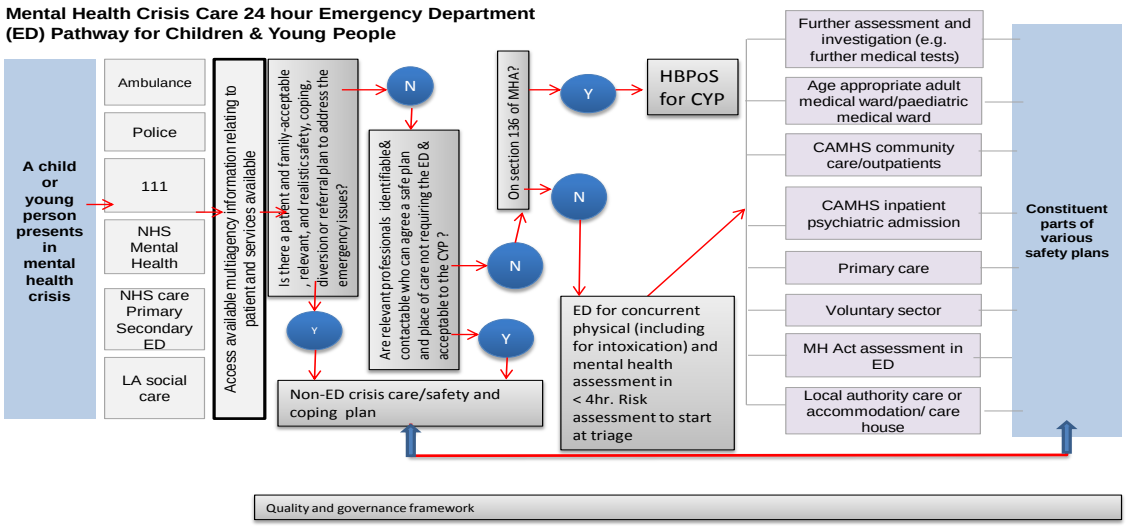


Figure 10.2 Tier 4 Pathway

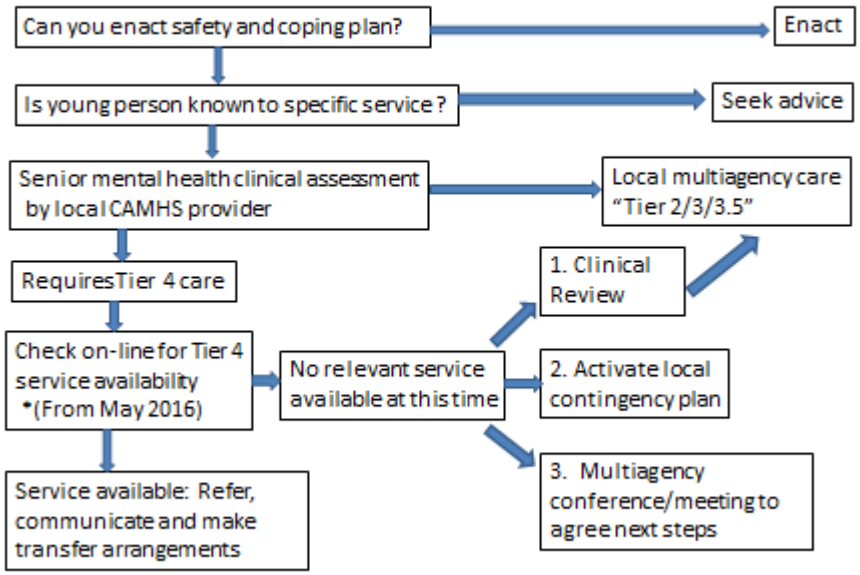
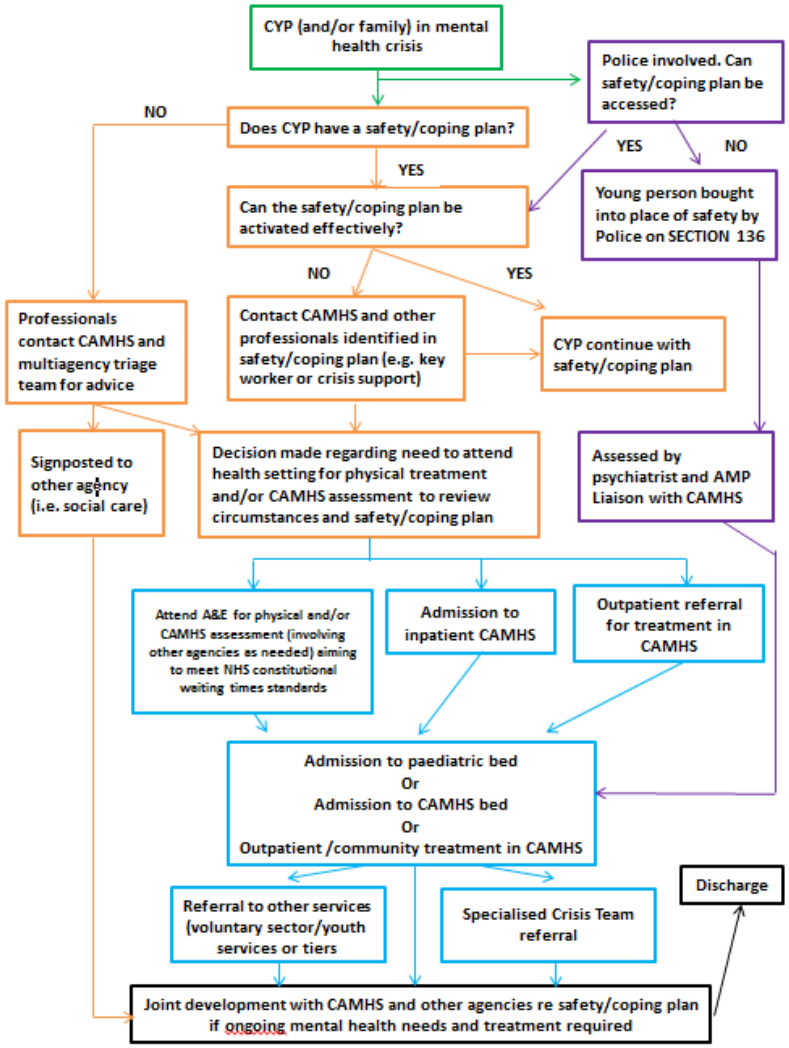


Figure 10.3 - CAMHS 'Core' pathway for children and young people in mental health crisis



Appendix 1

London Commissioning Standards for (Mental Health) Crisis Care[14]

- A local mental health crisis helpline should be available 24 hours a day, seven days a week, 365 days a year with links to out of hour's alternatives and other services including NHS 111.
- People have access to all the information they need to make decisions regarding crisis management including self-referral.
- Commissioners should facilitate and foster strong relationships with local mental health services including local authorities and the third sector.
- Training should be provided for GPs, practice nurses and other community staff regarding mental health crisis assessment and management.
- Emergency departments should have a dedicated area for mental health assessments which reflects the needs of people experiencing a mental health crisis.
- People should expect all emergency departments to have access to on-site liaison psychiatry services 24 hours a day, 7 days a week, 365 days a year.
- Arrangements should be in place to ensure that when Mental Health Act assessments are required they take place promptly and reflect the needs of the individual concerned.
- Police and mental health providers should follow the London Mental Health Partnership Board section 136 Protocol and adhere to the pan London section 136 standards.
- All people under the care of secondary mental health services and subject to the Care Programme Approach (CPA) and people who have required crisis support in the past should have a documented crisis plan.
- People should expect that mental health provider organisations provide crisis and home treatment teams, which are accessible and available 24 hours a day, 7 days a week, 365 days a year.

London acute care standards for children and young people[15]

- Emergency departments have a single point of access for child and adolescent mental health (CAMHS), or adult mental health services with paediatric competencies for children over 12 years old. Referrals are available 24 hours a day, seven days a week, with a maximum response time of 30 minutes.
- There are robust arrangements between fully staffed emergency departments and urgent care centres. This includes protocols covering consultation and transfer of cases.
- All services offer information and advice to help young people and their families make decisions regarding psychological wellbeing and mental health support needs based on informed consent. The service makes attempts to provide flexibility about

involving other people in the assessment and treatment process.

- Appropriate staff receive training and appraisal to ensure they are able to talk to young people about mental health issues; knowledgeable about a range of support and treatment options; clear about who they are able to help; able to recognise and facilitate informed consent; and able to recognise and respond to different therapeutic needs such as those relating to gender, sexual orientation and age

- A clear referral path is identified for young people with emotional and mental health concerns. The pathway may include specialised CAMHS input, including psychiatry, psychology, individual and family psychotherapy, social work, and CAMHS-trained and experienced nurses

Appendix 2: Safety and coping plan example

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 my 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: □ Mental Health Trust Urgent Advice Line: □ My social worker or social services team: □Other:
A place of safety I can go to:
If the plan above is not working for me and I still feel out of control: □I will go to the ED 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)

Appendix 3: Local multiagency contingency plan for Tier 4

Components

- Where will care be provided?
- Who will provide clinical care and how will clinical advice be sought?
- Who will provide security and safety?
- What are escalation arrangements and arrangements for multiagency conference?
- What are agreed resourcing arrangements?
- What are timescales?
- What are arrangements for audit and assurance?
-

Where will care be provided?

- Can you designate and use another local CAMHS bed if one is available?
- It may be easier to resource/staff an adult bed adapted for children and young people
- Not in the emergency department
- Not in a medical or paediatric inpatient bed unless physical health issues require it

Who will provide clinical care and how will clinical advice be sought?

- By the local CAMHS service and using existing on-call arrangements
- Exploit/enhance Tier 3&4 interface services
- Will need a mobilisation plan for staffing
- Tele-support from Tier 4 provider
- Specify arrangements for physical/medical advice and care

Who will provide security and safety?

- This should transfer from the police if they are in attendance
- Provided by the organisation site on which care is being delivered at that time and during transfer to the next site

What are arrangements for escalation and for multiagency conference?

- Senior manager on-call for Mental Health Trust to oversee delivery of plan and set up multiagency conference
- Escalates if needed to Sector on-call who
- Escalates to London on-call
- Specialist commissioner lead for the sector chairs conference

What are agreed resourcing arrangements?

- Based on likely activity across London can a pan London/Sector budget be agreed for say up to 48 hours?
- Clear arrangements for securing any such budget

What are timescales?

- 4 hours
- Clinical assessment of need
- Current security arrangements aim to allow police to leave
- 4-8 hours
- Bolstered security arrangements ensure police can leave
- 12 hours
- Patient in interim setting

- Following morning
- Multi-agency conference

What are arrangements for audit and assurance?

- Continue current NHSE/Specialised Commissioning arrangements and regular monitoring report described by both provider and sector –to report to Quality and Governance Committee NHS England (London Region) and Healthy London Partnership's Urgent & Emergency Care Committee
- Reports to Urgent and Emergency Care Network Board
- Reports to relevant CCG CAMHS Transformation Planning assurance groups

Glossary

AMHP	Approved Mental Health Professional
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CPA	Care Programme Approach
CTR	Care and treatment review
CYP	Children and Young People
ED	Emergency Department (also known as A&E)
GP	General Practice / General Practitioner
NICE	National Institute for Health and Care Excellence
SCP	Safety and Coping Plan

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