TO: HEALTH AND WELLBEING BOARD
DATE: 10 APRIL 2014

UPDATE ON CHILD AND ADOLESCENT MENTAL HEALTH (CAMHS) SERVICES TIERS 1-4

Joint report of the
Director of Children, Young People & Learning, Bracknell Forest Council
Public Health for Bracknell Forest
Bracknell & Ascot Clinical Commissioning Group
Berkshire Healthcare Foundation Trust and
NHS England

1 PURPOSE OF REPORT

1.1 The purpose of this report is to describe what a good modern Child and Adolescent Mental Health Service (CAMHS) would be like; to set out the current tiers of support and who is responsible for commissioning that provision; and identify the plans and re-commissioning arrangements for CAMHS across each tier of support.

1.2 The successful delivery of CAMHS requires a partnership approach between providers at each service tier, and between commissioners and providers. This report highlights work in progress.

2 RECOMMENDATIONS

That the Health and Wellbeing Board (HWBB):

2.1 Endorse what good looks like and support the ambition to improve Bracknell Forest's emotional health and well being support for children and young people and CAMHS services to achieve at this level

2.2 Note the arrangements in place for commissioning and the plans for re-commissioning services for children with emotional and mental health issues.

2.3 Endorse the determination for early intervention and prevention of escalation where possible to higher tiers of service.

2.4 Request that a lead is identified for each of the Tiers 1-4.

3 REASONS FOR RECOMMENDATIONS

3.1 The HWBB is concerned that children and young people are able to access the emotional and mental health services that they require in a timely manner.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

Why are child and adolescent mental health services important?

5.1 The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) brings together leading organisations with an interest in commissioning for mental health and learning disabilities. They published a guide in October 2013 on child and adolescent mental health services and are considered an important source of information on current and best practice.

They have identified four main reasons why CAMHS is important:

1. Prevalence

5.2 One in ten children aged five to sixteen has a clinically significant mental health problem. Problems most relevant to children and young people are: emotional disorders (eg phobias, anxiety, depression), conduct disorders (eg severe defiance, and physical and verbal aggression, and persistent vandalism), obsessive compulsive disorder, attention deficit hyperactivity disorder, other behavioural problems, tics disorders and Tourettes syndrome, autism spectrum disorders (ASD), substance misuse problems, eating disorders (eg pre-school eating problems, anorexia nervosa and bulimia nervosa), post traumatic stress disorder, the psychological effects of abuse and neglect, attachment disorders (eg children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major carer givers), the psychological effects of living with a chronic illness, somatisation disorders, psychosis, emerging borderline personality disorder.

5.3 Some children experience more than one mental health problem (comorbidity). This can make assessment, diagnosis and treatment more complex.

5.4 Mental health problems and disorders in childhood can have high levels of persistence 25% of children with a diagnosable emotional disorder, and 43% with a diagnosable conduct disorder, still had the problem three years later according to a national study. Persistence rates in both cases were higher for children whose mothers had poor mental health (37% and 60% respectively). Young people experiencing anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety disorders in adulthood. A number of disorders are persistent and will continue into adult life unless properly treated – it is known 50% of life time mental illness (except dementia) begins by age 14.

2. Risk Factors

5.5 Mental health problems in children and young people are the result of complex interactions between constitutional factors (including genetic factors) and environmental factors with the relative contributions varying to disorder and by individual. Although any child or young person can develop a mental health problem there are individual and family/social factors and experiences which can increase vulnerability to developing mental health problems.

5.6 Risk factors include: living with a long-term physical illness or disability, children and young people with intellectual disabilities are at increased risk of developing additional mental health problems, children and young people who are looked after by a local authority (often because of family breakdown) have much higher rates of mental health problems, children and young people who have experienced abuse and neglect, children and young people in contact with the criminal justice system, having a parent with a mental health problem, having a parent with a substance misuse or alcohol problem, having a parent in prison, being from low income households, families where parents are unemployed or where parents have low educational attainment, young people who are lesbian, gay, bisexual or transsexual (LGBT). A range of protective factors in the individual, in the family, and in the community influence whether a child or young person will experience problems. In particular, receiving consistent support from a trusted adult is a strong protective factor.

3. Evidence of Effectiveness

5.7 As noted above, mental health problems which begin in childhood and adolescence are not only common but can have wide ranging effects causing distress, affecting

educational attainment and employment prospects, social relationships and longer term physical and mental health. The National Institute for Health and Clinical Excellence (NICE) has produced a number of detailed clinical guidelines to guide intervention in mental health problems occurring in children and young people.

4. The Economic Case

5.8 There is compelling evidence of the cost benefits of using evidence based interventions. Using conduct disorder as an example, by the time a person is 28 years old, individuals with persistent antisocial behaviour (evident at age ten) will have cost society ten times as much as those without the condition. Parent education and training programmes can have good medium to long term effects at a relatively low cost, by a cost factor of £8 saved to every £1 spent if the costs of crime are included.

What does a good child and adolescent mental health service good look like?

5.9 There is no prescribed 'best practice' model but most would agree that a good service would provide timely support without the need for long waits for interventions. It would be effective and meet the needs of children and young people and be efficient in terms of delivery. Access should be via clear care pathways which are well signposted and understood. The JCP-MH guidance is very comprehensive and proposes a clear model of good service delivery which has been reproduced for information in appendix 1.

5.10 It is recommended that this framework in appendix 1 of what is good practice is endorsed by the HWBB as helping to set out the ambition for Bracknell Forest services.

National perspective and concerns

5.11 The Government's mandate sets the ambition to give children the best start in life. It also sets an objective for NHS England to put mental health on a par with physical health, and to close the health gap between people with mental health problems and the population as a whole.

5.12 In January 2014 the Department for Health published its priorities for transforming support for people with mental health problems over the next two to three years. This is called 'Closing the Gaps'. It sets out 25 priorities for action for children and young people and adults. An LGIU briefing summarises the full report and is attached for further information as appendix 2.

5.13 Nationally there are concerns about the provision of services to support emotional health and well being. In February 2014, in the light of concerns expressed by the Chief Medical Officer and others about both the extent to which children and adolescents are affected by mental health problems and difficulties with gaining access to appropriate treatment, the Health Committee has decided to undertake an inquiry into children and adolescent mental health and Children and Adolescent Mental Health Services (CAMHS). The inquiry will consider the current state of CAMHS, including service provision across all four tiers:

i) Access and availability; funding and commissioning; and quality.
ii) Data and information on children and adolescent mental health and CAMHS.
iii) Preventative action and public mental health, including multi agency working.

iv) Concerns relating to specific areas of CAMHS provision, including perinatal and infant mental health, urgent and out of hours care, the use of S136 detention for under 18s, suicide prevention strategies and the transition to adult mental health services.
The inquiry will report in March 2014.

Local provision

5.14 Current provision for young people with anxiety and depression, psychosis, attention deficit hyperactivity disorder, conduct disorders, autistic spectrum disorder, deliberate self harm, eating disorder or other mental health needs is currently delivered through a network of services in four tiers, depending on the severity or complexity of needs.

5.15 **Tier 1** is provided by universal services such as schools and GPs, along with youth services and support provided by charities and voluntary groups. Tier 1 services provide initial support and are delivered by non-specialist mental health workers.

5.16 For example, Schools provide pastoral care and can sign post to additional information. The Council commission Youthline which provides young people with telephone counselling support. The Public Health team is commissioning new, innovative programmes at a preventative level, often in collaboration with other council teams. This includes projects aimed at promoting well-being via physical activity among children. For example, the Family Health & Learning Project for 4 – 5 year olds, currently being piloted in two primary schools, seeks to increase children's and family's physical activity levels along with providing the child with an opportunity to develop self-esteem, confidence and improve their ability to co-operate and work well with others.

5.17 **Tier 2**: These are targeted services usually provided once a referral is made by schools - some targeted services are commissioned by the Council on behalf of schools such as behaviour support, family and parenting support, educational psychological services, anti bullying work, and Family Focus. Other examples include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services. Youth counselling services provided by the voluntary sector and some more specialist health practitioners such as Looked After Children's nurses, Family Nurse Partnership practitioners and Youth Offending teams also provide Tier 2 support.

5.18 **Tier 3 – CAMHS**: These are specialist community CAMHS which are commissioned pan Berkshire. Tier 3 services are commissioned locally by the Bracknell & Ascot Clinical Commissioning Group (CCG) from Berkshire Healthcare Foundation Trust (BHFT), and is accessed through a GP referral through the common point of entry (CPE), which also sign posts to other services if required. The service accepts referrals from professionals including schools, but predominantly referrals are from GPs and other medical professionals. The report to the HWBB (12/12/2013) by Clare Bright explained the services and quality improvement targets.

5.19 Tier 3 services are usually multidisciplinary teams or services working in a community mental health setting or a child and adolescent psychiatry outpatient service, providing a service for children and young people with more severe, complex and persistent disorders. Team members are likely to include:

- child and adolescent psychiatrists
- clinical psychologists
- community psychiatric nurses
- child psychotherapists
- occupational therapists, and
- art, music and drama therapists.

5.20 Local Tier 3 services are organised into a number of evidence based “pathways”, which include urgent care and Monday – Friday inpatient resources, along with longer term specialist interventions. The Berkshire Adolescent Unit provides some in patient beds 4 nights a week at Tier 3. Children and young people return home at weekends. This model of care is an outlier to other areas of the UK where an enhanced community based provision which is available out of hours and over weekends, particularly for those in crisis or with more acute difficulties is often commissioned. The evidence base for the various models of care at Tier 3 is being reviewed.

5.21 Both numbers of referrals to Tier 3 services, and numbers of children who require support at tier 3 have increased significantly in the last two years, with year to date referral numbers already reaching or exceeding year end totals for 2011/12 in many areas.

5.22 From 1 April 2013 Child and Adolescent Mental Health Services (CAMHS) Tier 4 (inpatients) became the responsibility of NHS England, having previously been commissioned by primary care trusts. Nationally, to date, there have been some significant challenges, the key ones being:-

- Available capacity to meet demand
- Children and young people having to travel long distances to access a bed
- Inequity in provision
- Quality concerns about services resulting in temporary closures to admissions
- Closure to admissions impacting upon capacity.

5.23 NHS England has undertaken the following actions to address and mitigate these issues:-

5.23.1 Commissioned a 3 month national review of CAMHS Tier 4 which is due to report in early April. The terms of reference are:

a. Undertake a factual assessment of current provision and commissioning issues
b. Identify commissioning proposals for CAMHS Tier 4 that include
    i. quality standards
    ii. access standards
    iii. environmental standards
    iv. contract levers
c. Recommend a preferred procurement route with rationale to support the recommendation along with how new market entrants or developments should be managed.
d. Identify any further work required that may include education provision, workforce development or mapping other Tiers of provision.

The proposed review work includes:

- Map current Tier 4 provision split by service type (e.g. secure, Eating Disorders etc.), number of beds, age range, and geographic location
- Collate and compare for each service (type) admission criteria
- Conduct a census and identify by age, Mental Health Act classification, gender, length of stay, out of area placements (defined by out of the originating area specialised service geographic patch)
- Identify number of beds temporarily closed to admissions from 1 September 2012, type, length of time beds closed and reason for closure – source providers triangulating response with commissioners

- Identify any 'best practice' where local services, agencies and commissioning organisations are working together to improve the pathway.
- Requesting Area Teams (Specialised) to provide information about the level and type of tier 3 services commissioned and in place locally along with any evidence of decommissioning or intended decommissioning since 1 September 2012.
- Working with the Clinical Reference Group:
    - Determine access assessment standards (generic and by service)
    - Identify 'best practice' for trial or home leave
    - Identify 'best practice' for discharge thresholds and discharge planning Produce guidance on managing suicidal ideation
    - Identify environmental standards for inpatient units
    - Consider and comment on the potential impact on demand and capacity by introducing these standards.

5.23.2 Dedicated Case Management - The Area Team has appointed a CAMHS case manager to ensure robust pathway management. This includes supporting the effective management of local capacity; timely admission to safe, quality services, which is often very challenging given the current capacity restraints; timely discharge and supporting transition arrangements; close liaison with other agencies eg. LA regarding residential placements and ensuring regular contact is maintained with young people placed off patch, via the CPA and care coordination process.

5.23.3 The Wessex Area Team is undertaking quality visits to provide assurance regarding the quality and safety of CAMHS Tier 4 units on the patch is satisfactory.

5.23.4 There is a weekly national UNIFY process that is undertaken by all Tier 4 CAMHS providers and commissioners each Friday whereby Providers are required to input vacant capacity to a national database. This is followed by a national telecon involving all 10 commissioning teams to review identified capacity, inappropriate admissions to adult or paediatric wards and any concerns in the system preventing access such as delayed discharges, quality and safety concerns, closure of units etc. This information is used to support teams, particularly on a Friday when there is often the greatest pressure on beds. It is also informing the National Tier 4 CAMHS Review.

5.23.5 The Area Team is undertaking a review of the Berkshire Adolescent Unit and commissioning arrangements. There is ongoing work to scope and define the clinical work of the service and to what extent this meets the specification of Tier 4 and to understand any gaps. The unit is engaged in the QNIC peer review process and was included in the provider survey element of the National Tier 4 CAMHS Review.

Current Waiting Times for Treatment

5.24 In 2012/13 Berkshire CAMHS waiting times were slightly below the national average (reference NHS Benchmarking December 2013). However Berkshire CAMHS has seen a 25% increase in referrals over the past year. Comparing Quarter 3 in 2012-13 with 2013-14 the numbers have increased by 1,221 (3462 to 4,683), more than a third. Waiting times in Berkshire have risen as a result. This picture has been mirrored in other parts of the country. In Berkshire all referrals are triaged prior to children and young people being seen face to face, with the exception of urgent care referrals. The waiting targets are as follows: urgent (to be seen within 24 hours) – no breaches year to date; soon (to be seen within 4 weeks) – currently this target is not always being met. Children and young people with attention deficit hyperactivity disorder (ADHD) or autistic spectrum disorder (ASD) should be seen within seven weeks of return of forms by parents and school. There has been a very significant

increase in referrals from these groups and the majority of children are waiting longer than 7 weeks for treatment.

5.25 All children and young people, including non- urgent cases are to be offered a face to face appointment within 12 weeks. Over Q1 and Q2 87% of children and young people from Bracknell were seen within 12 weeks.

Re-commissioning Services

5.26 Commissioners of all tiers of service are reviewing provision. However, the timetable for any potential re-commissioning process has not yet been confirmed. BHFT is working closely with commissioners to further understand the nature of local challenges (which includes engagement with children and their families) and to agree required action in partnership.

5.27 NHS England is currently reviewing Tier 4 provision nationally. A report is expected in April. Nationally demand for Tier 4 beds outstrips supply and there are no dedicated beds in Berkshire at Tier 4.

5.28 Public Health are in the process of preparing for the council's new responsibility to commission health visiting services for 0 to 5 years and the Family Nurse Partnership for first time young mums from pregnancy until the baby is 2 years old. This responsibility will commence in 2015. A programme for a whole-system review of children's universal public health services has been set out (as reported to the Health and Well-Being Board on December 12th 2013). A joint Public Health/Children & Young People 'Task & Finish Group' is reviewing services for 0 – 5 years, whilst being mindful of the links to public health provision for 5 – 19 year olds, including the school nursing service. The review will have at its core a specific focus on promoting the emotional health and wellbeing of children and young people and ensure that there is effective link up with more specialist tiers of service such as CAMHS.

5.29 CCGs in Berkshire are reviewing CAMHS services with support from Thames Valley Strategic Clinical Network. The review will consider "does CAMHS provide timely, effective and efficient services to the population of Berkshire?" and include findings from the national Tier 4 review as well as results from stakeholder and service user engagement. The review will report to CCGs in mid May 2014. Commissioning intentions for the future will then become clearer.

5.30 The review of the Berkshire CAMHS service is going to involve an engagement exercise with those that use the service, have used the service and those who are involved in providing the services. The comprehensive plan includes:

- a survey for children and young people (designed by young people)
- a survey for parents and guardians
- a survey for clinicians and others involved in providing services.
- a survey for GPs
- interviews and focus groups

5.31 There will be a consistency across the surveys so that some areas can be directly compared and other sections specific to the group being surveyed.

5.32 In addition, interviews and focus groups will be organised with families who either identify themselves as willing via the surveys and others identified by CAMHS clinicians.

5.33 We are also seeking other opportunities to engage with groups and individuals eg Community Partnership Forum meetings.

5.34 There will also be awareness raising of this work through the local media.

What do we want to achieve?

5.35 Each service wants to deliver a timely service which meets the needs of young people. At the same time, as far as possible, we all want to prevent young people's needs escalating leading to referral to higher tiers. However, it is recognised that some young people will need to receive higher levels of support and will need to be able to access that provision in some cases immediately and for others within a reasonable timescale.

Examples of re-commissioning emotional health and wellbeing services

Early Intervention – Tier 1

5.36 The Public Health team has already started a process for enhancing the system of support aimed at improving mental well-being among young people. The overarching aim is two-fold. First, the intention is to increase the range of options for young people when they need to seek confidential advice or counselling. Second, the aim is to facilitate the development of positive mental well-being and self esteem via programmes aimed at promoting physical health and social participation. In both cases, new initiatives will build on and enhance any programmes that are already in place.

5.37 For example, a service specification is currently being prepared for the delivery of on-line, confidential counselling that will provide a readily accessible alternative or supplement to existing, face to face counselling provision. Research suggests that young people readily use the internet when seeking help with mental health issues (Burns et al 2010) and review-level evidence indicates that web-based counselling is effective in improving outcomes (Hanley & Reynolds, 2009). A service for Bracknell Forest will utilise fully accredited counsellors and be linked up with local systems for education, support and safeguarding. The programme will be evaluated using standardised measures of well-being as well as feedback from those using the service.

5.38 In addition, new initiatives are being put in place to prevent the uptake of smoking among children, which evidence suggests has an adverse effect on mental as well as physical well-being (via its effects on neurotransmitters such as serotonin). The smoking prevention programmes will have poor self esteem as a key consideration and focus on harnessing social influences in a way that addresses the place of smoking (and other health related behaviour) within youth culture.

Family and Parenting Support – Tier 2

5.39 This has been reviewed and is being re-commissioned providing greater clarity of outcomes and better targeting of parenting programmes to need. This will be fully implemented by September 2014.

Early Intervention Proposal and possible external funding bid for a Social Impact Bond Bid

5.40 We are at a very early stage of exploring the possibility of preparing a bid for external funding for early intervention around preventing cases escalating to Tier 3 CAMHS. It is too early to state if this will be successful and there would be costs associated with payment for achieving the agreed outcomes should the SIB go forward.

Greater Understanding of Transition

5.41 The current system at Tiers 2+-4 requires certain trigger points to be met before a service can be accessed. Seeing service provision as part of a continuum could help resources to be better deployed. A Council/CAMHS Partnership working group is in place, meeting on a quarterly basis. This group brings together agencies in Bracknell Forest to work in partnership to deliver a range of mental health services and link to

Borough wide initiatives as appropriate. Based on a needs analyses the group monitors the priorities and actions within its strategy. The work of this group will be revisited and a paper will be presented at the Children and Young people Partnership meeting in May looking at the way forward. It is envisaged that this group will focus more on the Tier 1 and 2 provision. There is also a Pan Berkshire Strategic commissioning and development group chaired by the CCG commissioner with LA representatives. The focus of this group is moving towards a more strategic view of how the system works across the tiers in Berkshire.

Future Outcomes

The challenge and ambition is:

5.42 To ensure that a "pathway" model of service commissioning enables each tier to deliver the required response times, avoiding unnecessary escalation to higher tiers. However to achieve this ambition the implication for service delivery needs to be considered- if all children and young people were treated within 4-6 weeks there would need to be a massive growth in capacity .

5.43 To confirm an evidence-based trajectory at each tier, which informs levels of investment in services. For example, young people's needs being met in a timely manner at the least restrictive level, and them making a sustained recovery and/or reducing days missed from school due to ill health. This would also require further investment.

5.44 CAMHS will continue to see urgent cases e.g. those who are suicidal or in crisis within 24 hours.

5.45 At a national level the outcomes from the Health Select Committee Inquiry into children and adolescent mental health and CAMHS will further inform and direct service provision.

Conclusion

5.46 There is clearly a great deal of work that is currently taking place both on a national level and local, but it is too early yet to understand the full implications of that work. In preparing this report a number of those strands of work have been brought together and further meetings of commissioners held to confirm the stages reached in developing those arrangements. The new Children and Young People's Plan will continue to co-ordinate the emotional health and wellbeing strands at Tiers 1 and 2.

5.47 It is recommended that once the national reports are concluded, the outcome of the local consultation by the CCG is known in May that a follow-up paper is presented to the HWBB later this year which focuses on next steps and timescales. This needs to include a specific strand of work and investment plans to prevent cases escalating to Tiers 3 and 4 which are high cost for the CCG and NHS England.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The relevant legal provisions are contained within the main body of the report.

Borough Treasurer

6.2 The financial impact of any recommissioned services will need to be established and implications agreed with the responsible funding body prior to effecting any changes.

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