

# Support for Change

## Approaches and models for the development of provision for children and young people's mental health 2008

### Chapter 9

#### Models and approaches for development: Emergency and out of hours arrangements



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## 9. Models and Approaches for Development: Emergency and Out of Hours Arrangements

**Table 9.1: The Mental Health of Children and Young People: a Framework for Promotion, Prevention and Care: summary of core sections that relate to emergency and out of hours mental health arrangements**

Service Elements	Selected examples of activities required	Relevant outcomes
Emergency and out of hours mental health arrangements	<p>Multi-agency development of arrangements for the assessment and management of children and young people presenting with mental health emergencies on a 24-hour basis</p> <p>Integration of emergency mental health arrangements with standard NHS arrangements and implemented in the same way</p> <p>Development of locally agreed evidence-based multi-agency protocols for managing common mental health emergencies</p> <p>Establishment of clear and agreed arrangements to ensure appropriate environments for children and young people requiring psychiatric in-patient care (Sec 23 of the MHA)</p> <p>Designation of one place within each psychiatric inpatient facility for children or young people for emergency admissions</p>	<p>Children and young people are able to access appropriate assessment, support and treatment quickly when they need it</p> <p>Streamlined continuing care arrangements for children and young people presenting with common mental health emergencies</p> <p>Children and young people requiring psychiatric inpatient care are admitted to appropriate environments</p>

## **9.1 Key themes affecting development and implementation**

### **9.1.1 Unpacking the terms emergency, out of hours and crisis support**

The framework includes among the service elements for specialist services the need for emergency and out of hours arrangements (Table 9.1 above). Part of this is the need to ensure services and supports are in place for children and young people in 'crisis'. Although clearly linked, as a preliminary there is a need to unpack these terms. One way to think of this might be in terms of three overlapping elements:

- 'Crisis' as the severity and intensity of the child or young person's experience (from whatever cause/whatever effect/and by whoever defined)
- 'Emergency' indicating the rapidity of response required to the issue presented
- Out of hours, indicating that the presentation, however severe, occurs outwith normal working hours e.g. weekends or evenings/at night

As a first step there is a need at local levels to develop:

- A shared understanding of what defines a 'crisis' and what 'crises' require an 'emergency' response
- How 'emergency' is defined
- Arrangements for supporting children and young people who present with a need for specialist responses because of a mental health problem (including self-harm or attempted suicide), outwith 'normal' working hours - which may or may not otherwise be regarded as a crisis or emergency.

### **9.1.2 What do we know about the level and nature of the need?**

As well as the apparent muddiness of terms such as 'crisis' and 'emergency', there is a lack of systematic quantitative data to indicate the level of need and demand for support by children and young people experiencing mental health crises and/or need support as a matter of urgency (including as a result of self-harm or attempted suicide): whether accessed through NHS 24, A & E, paediatric units, Young People's Units or adult mental health or via community based resources. Available proxy indicators might include the data reproduced by the Child Health Support Group on psychiatric in-patient services for children and young people, which suggest that (prior to the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003) up to 80% of admissions to specialist units for children and young people were emergency admissions (Child Health Support Group, 2004). Mental Welfare Commission data also indicate that over the financial year 2006 - 2007, 186 cases, or 156 young people, were admitted to non-specialist settings (predominantly adult wards) (MWC, 2007). But these data may not be robust indicators either of need or of demand for specialist services, including for community-based services.

Data on hospital admissions for self-harm and for attempted suicide, may also be a poor indicator of the need for support - as work by Hawton et al (2002) indicates, among young people who self-harm, few actually present to hospital services for care and treatment.

Notwithstanding this vacuum in quantitative data, available qualitative data, collected from young people, and from professionals, suggest that obtaining help in a crisis and/or in an emergency was a 'crunch point' in terms of the capacity and capabilities of specialist services.

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A consultation undertaken on behalf of the Mental Welfare Commission by SDC revealed the variable experiences of young people at times of crisis, which could involve contact with the police, A&E staff and ward staff (SDC,2005). A number were admitted to paediatric acute care wards and one was admitted to a neonatal care. As a result young people felt out of place, either because of their age or on account of their reason for admission. The young people also reported encountering practical problems, for example with access to clothes and money, phone and friends. An earlier study in England found that over half the sample of 45 young people felt that they did not get the support they needed at times of crisis. Some of the difficulties they identified were systemic - long delays in getting help, waiting lists, being transferred between services and professionals, but some were perceived to be attitudinal - a feeling that they were not understood by professionals, that they were not taken seriously or that people were not interested in them (Smith and Leon, 2001).

The same study also sought the views of organisations and professionals providing crisis services, including CAMHS. Factors perceived to contribute to the sense that services did not always work well for young people aged 16 - 25 years in crisis included lack of staff and funding resources, lack of communication between services, lack of specialist knowledge, lack of services in relation to some groups of young people, such as those with a dual diagnosis, power imbalances between statutory and voluntary agencies, and the complexities of the problems faced by young people, as well as the difficulties of engaging with young people who do not want help (Smith and Leon, 2001).

Some of these concerns, particularly those relating to systemic, capacity and capability issues, are reflected in the survey of professionals carried out in Scotland as part of the second phase of the SNAP Assessment of Child and Adolescent mental health needs in Scotland (Health Scotland, 2006). Although not specific to crisis services, a number of the "frustrations" identified included both those relating to their own self-perceived lack of expertise, but also those relating to the wider service system including the perceived difficulties in achieving positive collaborative work because of slow response times, gaps in services and the different perspectives and priorities of professionals.

Those outwith specialist services, including primary care practitioners and teachers, highlighted the difficulties of getting rapid support, either to enable them to provide support, or for direct input to a child or young person.

In terms of "innovations" for making the service better, the most frequent suggestion made for improving specialist services for children and young people was for "some form of rapid assessment that can be simply and reliably accessed" (p.112): a one-stop shop or system of triage for ensuring children and young people were routed to an appropriate service were suggested. Helplines or email support providing 24-hour advice and guidance for professionals and parents were also proposed by survey respondents.

### 9.1.3 Policy drivers

The policy drivers reflect the complexity of the terrain of mental health crisis and emergencies. Initiatives of relevance include, for example:

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- Policies supporting integrated children's and young people's services (e.g. GIRFEC)
- Those relating specifically to children's health and wellbeing, including their mental health, (Scottish Executive 2005b; Scottish Executive 2007a; Scottish Government, 2008 )
- Policies for improving population mental health and wellbeing, including children and young people (Scottish Executive, 2007b)
- Policies which have specific implications for emergency and out of hours services including the *Unscheduled Care Collaborative Programme* (Scottish Executive, 2005 a), and, specifically in relation to children and young people, the *Emergency Care Framework* (2006c)
- Policies and legislation relating to mental health, including the *Mental Health (Care and Treatment) (Scotland) Act 2003*, *Delivering for Mental Health* (Scottish Executive, 2006 a) and *Delivering for Mental Health Crisis Standards* (Scottish Executive, 2006b)

An overview of key policy initiatives is given in Section 3 earlier.

### Mental health policy and legislation

One of the key principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 is that provision under the Act should secure the welfare of the child. Further, under Section 23, the Act places a duty on NHS boards to ensure that, on those occasions when a child or young person under the age of 18 years requires psychiatric in-patient treatment this is provided in a way that is appropriate to the particular needs of the child or young person. While admission of a 16 or 17 year old to adult wards may, on rare occasions, be appropriate, guidance issued by the Mental Welfare Commission (MWC) is that on the whole this is "deeply undesirable and may be detrimental to the young person" (MWC, 2006). As noted above, data produced by the MWC reveal that children and young people continue to be admitted to 'non-specialist' settings. Further, for around one-fifth of these admissions access to specialist clinical input was not available.

To address this one of the three priorities identified in relation to children and young people within *Delivering for Mental Health* (Scottish Executive, 2006x), is to reduce the number of admissions of children and young people to adult beds by 50% by 2009.

Volume 2 of the Mental Health Act Code of Practice (Scottish Executive 2005b) also recommends that relevant local agencies and service providers who might potentially be involved in psychiatric emergencies work together to develop and agree a Psychiatric Emergency Plan to agree procedures to manage the transfer and detention process of a patient with minimum distress and risk. The Remote and Rural Areas Resource Initiative (RARARI) also funded a project to develop guidelines on the holding and transfer of patients who cannot be managed safely in the community in rural and remote areas. Both recommendations cover but do not relate specifically to children and young people.

Data collected as part of the Mental Health Act implementation process revealed that in June 2005 five NHS boards had crisis services in place for children and adolescents, 2 NHS Board areas were planning separate services to be in place by October 2005, one Board area was proposing to use their CAMHS service on an advisory basis for their out of hours service, and seven areas had yet to timetable this action. The current pattern of provision across Scotland is not known.

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Launched in 2005, the three-year *National Unscheduled Care Collaborative Programme* aims to improve access and reduce waiting and delays for unscheduled care, with the aim of a maximum four-hour emergency waiting time target by December 2007. It describes four patient flows through the system as well as a fifth 'flow' of out of hospital care. Both paediatrics and mental health are identified as requiring specific consideration (Scottish Executive, 2005a).

Although coming from different directions, the *Emergency Care Framework for Children and Young People* (Scottish Executive, 2006c), and *Delivering for Mental Health Crisis Standards* (Scottish Executive, 2006b), both provide standards and criteria for consideration if a child or young person presents with a mental health problem at a time of crisis or in an emergency.

Relating to children and young people but not specifically those presenting with mental health emergencies or crises (other than self-harm - see below), the Emergency Care Framework sets out a four tiered model of emergency care from community hospital/primary care through to specialist children's hospital.

The Framework also recommends that all emergency care sites should provide a safe non-threatening environment for the treatment of children and young people.

Further, staff should have a core set of skills and competencies to provide care to children and young people, with access to support and advice from a registered children's practitioner. The report also recommends implementation of a standard assessment method.

The *Delivering for Mental Health Crisis Standards* (Scottish Executive, 2006b), for responses aimed at "prevention, intervention and recovery through the management of individuals during periods of acute illness, relapse or mental distress", are not specifically about, but do encompass children and young people. The standards include, for example, the need for protocols and supported transitions to children's and adolescent services.

As discussed below, the eight standards may offer a structure for considering responses to the needs of children and young people who present with mental health emergencies or require out of hours support.

### Self-harm

The Emergency Care Framework (Scottish Executive, 2006c) includes among those who it regards as being at particular risk children and young people presenting with possible/actual self-harm. In relation to this group of children and young people the report recommends that "staff must be empathetic to their needs and have the competencies to recognise their vulnerability" (para 62). On the basis that the treatment needs of children and young people are more complex than with adults, the report recommends that there must be appropriate referral mechanisms to CAMHS.

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NICE clinical guidelines on Self-harm (NICE, 2004) also include specific issues relating to young people who present in primary or secondary care. This includes training of children's and young people's triage nurses in the assessment and early management of mental health problems and in particular the assessment and early management of children and young people who have self-harmed, overnight admission to a paediatric ward, and assessment and consultation, in the course of admission, by CAMHS. The guidance also recommends that CAMHS staff involved in the assessment and treatment of self-harm of children and young people, should be trained in this area, skilled in risk assessment, receive regular supervision and have access to consultation with senior colleagues.

### 9.1.4 Developing a framework: key issues that service systems need to address

*"It is fundamental to recognise that children are not small adults. They are physiologically different, experience specific illnesses linked to their physical maturity, and have different emotional and environmental needs depending on their developmental stage" (Unscheduled Care Collaborative Programme, Scottish Executive, 2005a, p. 7)*

Within the current system and policy context there are five key issues for national and local systems to consider in developing a framework of support for children and young people in crises and/or who need support within a short time frame, or outwith normal working hours.

These are:

- Being clear about and reaching a shared agreement about who/what is covered by 'crisis' or 'emergency' mental health provision, and the arrangements for those who, on the basis of need identified, and/or age, fall outwith those criteria
- Agreeing standards and principles
- Defining pathways
- Developing protocols
- Building staff capacity and capability

### 9.1.5 Reaching shared agreement about who and what is covered by 'crisis' and 'emergency' support

"It is not easy to define crisis. A crisis for one person is not necessarily a crisis for another person. Who defines crisis, whose crisis is it?" (Smith and Leon, 2001).

As the *Only Connect* report suggests (Health Scotland, 2006), one of the key frustrations or obstacles to positive joint working, were different conceptualisations of what constituted an appropriate referral to specialist CAMHS. What constitutes, or is defined as a 'crisis' may be another grey area. Participants in the Support for Change workshop, for example, referred to the 'looseness' of the term 'crisis': contingent on who and how a 'crisis' is defined: between, for example, mental health crises and social crises, including self-harm, which may arise as a consequence of child protection and/or social factors.

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In addition is the perceived difference between what a child, young person or their family and other non-specialist professionals (e.g. residential care staff, teaching staff, youth and community workers, primary care staff, A & E or paediatric health care staff) view as a 'crisis' and what specialist providers of mental health services might see as a 'crisis'.

There may even be differences in perspective between CAMHS and adult mental health services. Relatedly, are the differences between agencies and between professionals in the criteria for (and perceived expertise in) assessing and determining levels of risk.

Factors that may influence what comes to be considered a 'crisis' may therefore include:

- Situations which comprise a 'crisis' at any time: because of the nature and assessed level of risk/severity of problem to which a child or young person is exposed
- Situations which are a 'crisis' because of the rapidity of the response required to prevent or mitigate (further) risk
- Situations which may be perceived as a 'crisis' because they occur out of 'normal' working hours
- A problem that is a 'crisis' because of the context in which it happens. In rural and remote areas, for example, providing an unscheduled response may have more impact on the total service system than in more urban areas. A problem may also take on the quality of a 'crisis' if those working with the child or young person do not feel able to provide support, this might apply to families, but also different professional groups, for example teaching staff or residential care staff

Locally (and perhaps nationally) there may be a value in developing intra and inter agency/professional understanding of:

- What constitutes a 'crisis' requiring specialist mental health input
- The assessed level of risk requiring a rapid response: who assesses the risk and the rapidity of response required for different types and levels of risk
- Who and how appropriate, support, treatment and care is provided in response to 'crisis'
- Protocols and processes for referral to other agencies/professionals/services and anticipated rapidity of response of other agencies and professionals

Referral/transition issues to consider include the following:

- From health to social work: for example, if an initial presentation for self-harm proves to be a social care/child protection need, how is transition to social work services/placements managed, including the speed of response?
- From children and young people's mental health services to adult mental health services for young people who fall outwith the remit of CAMHS due to their age

### **9.1.6 Standards and principles**

In addition to the principles outlined in the Framework for children and young people's mental health, the Mental Health Foundation report (Smith and Leon, 2001), suggests nine principles for developing community-based crisis services. These principles were developed from the research (box 7.1), and although intended to specifically address services for young people aged 16 - 25 years, have applicability for crisis services for those who are younger.

**Figure 9.1: Principles for developing community-based crisis services**

1. Service specifically for young people (aged 16 - 25 years)
2. Young people with mental health problems are young people first
3. Incorporating young people's definition of crisis
4. Accessibility, including informing people about the service, physical accessibility for people with physical disabilities, location, opening hours, addressing equal opportunities (including child care arrangements), confidentiality, welcoming
5. Professionals and young people working together
6. Rapid response
7. A range of support (both within a service and across services)
8. Involving young people in the design and delivery of services
9. Effective monitoring and evaluation of services

Source: Smith and Leon, 2001

A number of these principles overlap with the *Delivering for Mental Health Crisis Standards* (Scottish Executive, 2006b) (see Box below), which include but are not specifically designed for children and young people's crisis services.

**Figure 9.2: Delivering for Mental Health: mental health crisis services**

1. Crisis services should provide community based accessible, appropriate and immediate interventions which aim to prevent or reduce the impact of a crisis. Prompt and timely support should be offered to those in crisis at hours when they are most needed
2. Assessment and planning processes promote recovery and take account of service users' own resources and support structures
3. Service responds to diverse needs and carries out its functions in a manner which encourages equal opportunities

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4. Crisis services negotiate and develop discharge and follow up plans collaboratively with service users, incorporating the views of their carers and relevant services (where reasonable and applicable) providing opportunities for reflection
5. Service users are supported to actively and positively participate in decision-making within individual support plans, and have opportunities to contribute to the planning and development of the service
6. Carers views are incorporated in support plans (where reasonable and practicable) and carers have opportunities to contribute to the planning and development of the service
7. A local training framework is in place ensuring crisis services are provided by staff trained and skilled in managing risk, delivering strengths based mental health interventions that complement and value existing support mechanisms
8. Crisis services work in partnership with other mental health services and wider community organisations, to ensure that service developments are accessible and responsive to community needs and complement existing services

Source: Scottish Executive, 2006b

Potentially there is scope at both national and local levels to develop standards relating to the range of community and hospital based responses to children and young people in crisis, across the age range that embody the ethos' underlying both these sets of service principles (and the ethos' of the different partners to these standards, including those of children, young people and their families or carers).

### 9.1.7 Defining pathways

Notwithstanding the definitional issues referred to above, research cited in the Mental Health Foundation report (Smith and Leon, 2001) suggests that there are three main groups of young people who present as emergencies, i.e. require a response within 24-hours, to community based professionals:

- Young people with an identified mental health difficulty e.g. psychosis, serious self-harm or eating disorder
- Young people who may take an overdose or self-harm and who are admitted to hospital via A & E
- Children and young people who present with conduct disorders/out of control or challenging behaviours

Points of entry to services and the levels of response received or needed may, however, vary between and within these groups and between individuals. Different sources of guidance draw on the concept of the 'tier' to relate response to need. The different 'tiers' used in current guidance in Scotland are summarised in table 7.2

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**Table 9.2: Tiers of response by source of guidance**

Tier (lowest to highest)	Source of guidance			
	Emergency Framework for children and young people	Framework for children and young people's mental health	Mental Health Delivery Plan Crisis Standards	Unscheduled care collaborative programme - Mental health patient flows
0			Preventative (population mental health)	Out-of-Hospital Care:  Primary care and psychiatric emergency services will see many people who do not need and never get assessment in the acute setting e.g. acute psychotic breakdowns, depressive episodes, and the abrupt loss of ability to cope in dementing illness
1	Community hospital, minor injury facility, Primary care medical centre, out of hours centre, NHS 24	Primary level of services - universal services	'mainstream':  mild to severe;  within normal hours  Response within normal mainstream services timescale e.g. primary care/CMHT	Minor injury and illness e.g. a patient in a minor injury unit after minor self-inflicted cutting, without suicidal intent

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2	General Hospital with A & E department without Inpatient paediatric unit	CAMHS Consultation and advice to colleagues in tier 1 and also some direct work with young people and their families	'Crisis' moderate to severe;  Out of hours;  Immediate response necessary	Acute Assessment e.g. A patient in A & E after an overdose or other self-harm, with or without suicidal intent or a patient in A & E declaring suicidal intent not yet acted upon
3	General hospital with Inpatient paediatric unit	Specialist service for more severe, complex or persistent disorders	e.g. Intensive Home Treatment Team	Medical admissions e.g. frequent medical admissions in a patient with chronic physical illness and co-morbid depression
4	Specialist Children's Unit	Tertiary level such as day units, specialist outpatient teams and inpatient units		Surgical admissions e.g. a patient requiring plastic surgery following serious self-cutting or a patient requiring orthopaedic surgery after trauma sustained in a deliberate jump

The table points up the complexity of the potential 'pathways' and the criss-crossing between 'generic' crisis, emergency and out of hours services (including social work out of hours services) providing across the age range, children and young people's services, children and young people's specialist mental health services and adult mental health services. To ensure appropriate responses according to the child and young person's age, the nature and severity of the risk to which they are exposed there is a need to grasp this complexity locally to develop clear pathways and responses within and across agencies and services. A simplified approach might be to think less in terms of different 'tiers', and to think in terms of functions:

- Early intervention: preventing crises or crisis escalation where practicable
- Responding to 'crisis':
  - Self-help (where appropriate)
  - Non-specialist community responses
  - Specialist community responses
  - Hospital based responses
- Beyond the crisis

Clearly in any area the particular configuration will be contingent on the composition of the service system. This may be particularly the case in rural and remote areas where the distinctions between these functions may be particularly blurred. Further, there is a need for permeability between services and levels, to reflect the complexity and changing nature of the needs presented by a child or young person and also their family or carers.

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### Early intervention: prevention

Early intervention to prevent 'crisis', as far as practicable underpins both current policy, across areas (Scottish Government, 2008), as well as underpinning the policies specific to the mental health and wellbeing of children and young people articulated in the framework for children and young people's mental health (Scottish Executive, 2005x), but also in *Health for all Children* (HALL 4). The Integrated Assessment, Planning and Recording Framework (IAF), being introduced under *Getting it Right for Every Child*, (Scottish Executive, 2005d) provides an avenue for early intervention in relation to children known to be at risk. Primary Mental Health Workers - discussed in Section 7.2 - also have a key role in identifying those children who may be at risk of experiencing difficulties that could escalate or become a 'crisis'. Pathways to care for children and young people who are LAAC (Section 7.3), will also need to include consideration of responses to children who may experience mental health crises.

Although not 'early intervention', in order for children and young people who have experience of mental health problems to be able to have a say in the treatment they receive if they do experience a mental health crisis, young people including those aged under 16 years can make an Advance Statement as long as they can understand the nature and consequences of the procedures or treatment. Data is not available to indicate the patterns of usage of Advance Statements in total, though this is believed to be small, nor specifically among young people.

### Responding to 'crises'

As noted above, in terms of responding to 'crisis', there are a number of points of entry.

#### *Self help*

Helplines such as Samaritans, Breathing Space, Childline and Parentline, clearly have a role in responding to the needs of children and young people who may telephone seeking assistance. In terms of strategic planning key issues are: that children and young people are aware of these resources and that these resources are informed about local sources of further help [as far as practicable]. Breathing Space also provides a 'self-help' toolkit on sources of help. Childline in Scotland offers training on a consultancy basis to organisations and agencies.

In recognition of the specific problems in accessing support in rural and remote areas, Breathing Space is currently embarking on a series of awareness raising initiatives specifically targeted at rural and remote areas, with a particular focus on Orkney, Shetland and the Western Isles.

#### *Non-specialist community responses*

Within the community there are a number of non specialist agencies/professionals who may come into contact with a child or young person who appears to be experiencing mental health difficulties (including self-harm or suicidal thoughts/intentions). Here 'non-specialist' encompasses not just agencies/professionals who are not mental health specialists, but also includes those not specific to children and young people. These include:

- Primary Health care
- NHS 24
- Social Work/Local Authority teams: e.g. children and families, criminal justice, housing/homelessness teams, Out of Hours/Emergency Duty Teams

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- Drugs and Alcohol teams
- Teaching/education professionals
- Residential care staff/through care staff
- Foster carers
- Youth workers
- Criminal justice agencies
- Children's Hearing system

The strategic need is to ensure that professionals and workers in contact with children and young people across the spectrum have resources to enable them to identify and provide an initial appropriate response (see below for examples of training guides) and are aware of the routes to specialist advice and consultancy and resources, through CAMHS, for example, and can feel confident that these resources are available.

### ***Examples: training resources***

Scottish Mental Health First Aid Training  
<http://www.healthscotland.org.uk/smhfa/>

Asist (Applied Suicide Interventions Skills Training)  
<http://www.chooselife.net/Resources/ResourceDatabase/AppliedSuicideInterventionSkillsTraining.asp>

Hands on Scotland: a web-based toolkit for anybody working with children and young people. It includes sections on self-harm as well as on supporting children and young people who have experienced a range of life events. <http://www.handsonscotland.co.uk>

East Renfrewshire Council Department of Education: Staff Guide for responding to suicidal/self-harming young people in a school setting  
<http://www.chooselife.net/Resources/ResourceDatabase/staffguidetosuicide.asp>

Given the complexity in some cases, of determining whether the 'crisis' is primarily social/child protection and/or related to mental health problems, participants in the workshop undertaken in the course of the Support for Change project, considered there was a value in multi-agency working to ensure a 'place of safety', to which a child or young person can be admitted out of hours which would enable an assessment of a child's mental state.

### *Specialist community based response*

In terms of specialist community based models for tackling or preventing the escalation of crises with a mental health component among children and young people, there are a range of different approaches. The Mental Health Foundation research in England, for example, identified nine different models (Smith and Leon, 2001):

- Crisis intervention team
- Crisis house
- Respite service
- Respite centre

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- Mental health focused resource for young people
- Mental health workers working within existing advice and information centre for young people
- Floating support project
- Service designed by young people
- Virtual crisis service

There has been no systematic analysis of different models being used in Scotland, and only one area responding to the *Where are We Now* survey as part of the Support for Change project identified crisis services as an area where they felt they had made most progress. This, however, was largely focused on providing support in relation to children and young people admitted to hospital via A & E and paediatrics.

Clearly CAMHS have a role in supporting or providing advice to primary care clinicians on managing a crisis or self-harm episode. More research and evaluation however, needs to be undertaken to obtain a better sense of how this is working in practice across Scotland including in rural and remote areas.

In addition to the work of CAMHS examples of community based support projects include:

- Penumbra Youth Project in Fife. Recently evaluated by SDC (Woodhouse et al, 2008), this provides support, advice and early/crisis intervention for vulnerable young people aged 12 - 21 years
- Cascade Young People's Project, which, funded through Choose Life, provides a support worker to offer support to young people aged 11 - 18, including crisis work, one-to-one support and self-help

However, while it is possible to find example of evaluations of models for adults such as Forth Valley Intermediate Home Treatment Team (McLean et al, 2006) it has not been possible to find evaluations of similar community based intensive treatment models for children and young people in crisis in Scotland.

### *Hospital based responses*

Hospital based responses include services to children or young people who present with a mental health crisis or emergency to A & E, for example children and young people who may have self-harmed. It also includes paediatric in-patient services, as well as process and procedures for admitting a child or young person to a specialist in-patient unit, or where appropriate in-patient facilities are not available, to adult mental health services.

For 'generic' A & E and paediatric services, there is a need to ensure that staff are able to access specialist advice and consultancy for a child or young person who presents or is admitted, including outwith hours. In one area a Tier 3 CAMHS service has been developed to provide a service to A & E and paediatrics for children who present with self-harm or overdosing (box 7.4)

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### **Example: Tier 3 CAMHS support for children and young people who present to A & E or Paediatrics who have self-harmed or overdosed**

#### Aims and objectives:

To offer a specialist CAMHS assessment within 24-hours for all children who present with self-harm or overdose

To undertake a risk assessment

Identify need for further input/intervention (minimum offered would be a follow on consultation with a psychiatrist after three weeks)

#### How provided:

Every member of Tier 3 service (including psychology, OT and nursing staff) are on the rota.

If someone is admitted and the CAMHS service is called before 12.00 the child or young person would be seen that afternoon. If referral is made after that time they would be seen the next day. All would be seen within 24-hours and assessed. In A & E the assessment would be joint with the SHO/psychiatrist

#### Referral criteria:

Children aged 0 - 18 years in full time education

Team wants to see all cases of self-harm (irrespective of assumed intention)

Possible for senior clinical nurse (on paediatrics) to refer i.e. not just consultant

#### Local drivers/facilitators:

- Setting up of local clinical forum (following a Critical Incident Review) with representatives from CAHMS, A & E and Paediatrics (co-chaired by paediatrician and CAMHS psychiatrist). Previously no clear links between A & E, paediatrics and CAMHS.
- Sense of increasing numbers of children and young people with self-harm problems being referred to A & E, but not being systematically referred for CAMHS assessment/follow up.
- Paediatric link worker attached to CAMHS
- Openness and willingness on part of CAMHS, A & E and paediatrics to help make it happen

Evaluation: In process

#### Beyond crises

Beyond the emergency or crisis there is a need for pathways to map out who has continued responsibility, as appropriate to need, and the transitions to appropriate services.

### **9.1.8 Developing protocols: defining roles and responsibilities**

The complexity and criss-crossing nature of 'crisis' and 'emergency'/out of hours responses suggests the need for clear pathways and protocols defining roles and responsibilities **between** key agencies as well as **within** agencies. A recent draft report from the Royal College of Psychiatrists, for example, recommends that pathways of care and treatment protocols are agreed between local CAMHS and adult mental health services with respect to self-harm and emergency presentations to A & E departments.

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In relation to the interface between CAMHS and adult mental health services this needs to include ensuring the appropriate assessment, treatment and care for children and young people who are admitted to adult beds (when this is not appropriate to their needs), and for adolescents who fall outwith the age limit for local CAMHS, but are at the lower age limit of adult mental health services.

Planning of services therefore needs to take into account the range of different stakeholders, as noted in the Unscheduled Care Collaborative Programme:

*"There is a risk that the psychiatric needs of patients in acute hospital settings will be overlooked by services developed for physical problems, but also acute settings will be excluded from the development of community psychiatric emergency services. Redesign of mental health services therefore needs to take a whole systems approach and the needs of patients with mental health problems addressed in the improvement work in each patient flow"*

*(Unscheduled Care Collaborative Programme, Scottish Executive, 2005a, p. 8)*

### **Example: clinical forum**

In one area a clinical forum has been set up to support discussion and joint working between CAMHS, A & E and Paediatric services.

Co-chaired by a Paediatrician and CAMHS psychiatrist, the forum includes representatives from A & E in-patient and community paediatrics, CAMHS clinical leads, adult mental health services and social work. In addition to developing a self-harm algorithm, the forum was in the process of developing pathways for ASD, eating disorders and ADHD.

Within health systems this needs to include primary care, including primary care Out of Hours provision and NHS 24, as well as, for example, the Scottish Ambulance Service.

Other stakeholders outwith health include not just the local authority (including social work out of hours services), but also, for example, education, secure care providers, the police and other criminal justice agencies, etc.

The particular configuration will vary and an initial task may be to map out the key stakeholders in each local area preparatory to developing protocols outlining roles and responsibilities.

Given the cross-cutting roles and responsibilities there may be a key role for Community Health Partnerships in developing what the Framework for Children and Young People's Mental Health (Scottish Executive, 2005c) describes as 'horizontal' integration with children's services partners, 'horizontal' integration with health service partners, as well as 'vertical' integration with specialist mental health services.

### **9.1.9 Building staff capacity and capability**

Staff capacities and capabilities need to encompass skills in working with children and young people as well as skills in working with children and young people who may be experiencing a mental health 'crisis'.

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The *Emergency Care Framework for Children and Young People* (Scottish Executive, 2006c), for example, recommended the development by NES of a multi-professional emergency care competency system for practitioners who provide emergency care for children and young people. Once developed competencies should be maintained and updated (NES, 2006).

Consideration of staff capacities and capabilities therefore needs to include:

- Capacities of all professionals working with children and young people to respond to the immediate needs of a child or young person who presents with a mental health 'crisis', (including the capacity to access CAMHS for consultation and advice)
- The capacities of staff working in 'generic' emergency and out of hours health and social work services to respond to the immediate needs of child or young person who may present with a mental health crisis. NICE guidelines on self-harm (NICE, 2004), for example recommend that:
  - Children and young people under 16 years of age who have self-harmed should be triaged, assessed and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department (para: 1.9.1.1)
  - Children and young people's triage nurses should be trained in the assessment and early management of mental health problems and, in particular, the assessment and early management of children and young people who have self-harmed (para 1.9.1.2)
- Staff working in adult mental health services to respond appropriately to the immediate needs of young people who may present to services. MWC guidance on the admission of children to adult mental health wards, includes, for example, that nursing staff with experience of working with young people should be available to provide direct input to care, and support and guidance to ward staff (MWC, 2006)

At each stage there is a potential role for CAMHS in providing advice, consultation and training.

- In addition, consideration could also be given to the capacities and capabilities of staff working in CAMHS to support cross-disciplinary capacity to assess risk (see example below)

### ***Example: CAMHS inter-disciplinary out-of-hours service***

In one case example all members of a Tier 3 CAMHS out of hours service undertake risk assessment, including psychology, nursing and OT. The inclusion of OT was made possible following discussions with the College of Occupational Therapy and with the provision of additional training and supervision.

## 9.2 Key learning points for implementation / model development

For children and young people experiencing mental health 'crises' and/or requiring emergency or out of hours responses the number of different points of entry, and the criss-crossing of professions and agencies underlines the necessity for joint working/partnership working within and between agencies in order to 'get it right' for every child and young person in terms of minimising harm and preventing future crises. Table 9.3 provides a representation of levels and intensity of intervention and the roles of services in delivery of care, support and treatment.

At present there appears to be little systematic mapping, research or evaluation being undertaken to get a sense of the systems currently in operation Scotland-wide, and as a consequence, little opportunity for shared learning. Nonetheless there are a number of key issues to be considered at both national and local level:

- The need to develop shared understandings of what constitutes a mental health 'crisis' or 'emergency' with a view to determining roles and responsibilities
- The need to develop care pathways for children and young people experiencing mental health problems, in ways which recognise the different potential points of entry
- Ensuring staff at the different points of entry are (a) able to respond (or bring in expertise) in working with children and young people and (b) have, or are able to draw in expertise on children and young people's mental health in a timely and appropriate fashion
- Ensuring clear protocols for access to relevant skills and appropriate and smooth transitions for the child or young person through the system

CAMHS clearly have a role in terms of training, advice, consultancy and direct work at the interfaces between:

- 'generic' services aimed at dealing with people in crises/emergencies (including, but not exclusively tailored for children and young people)
- non mental health specific children and young people's services
- adult mental health services

But what is also important is the need to ensure clarity of roles, responsibilities within and across and permeability between different points on the pathway to ensure that children and young people are able to receive appropriate support, care and treatment from appropriately trained staff able to respond to their specific needs as individuals and as children and young people.

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**Table 9.3: Emergency and out of hours arrangements**

Level of service	Activity / intervention	Delivered by
<p><b>Universal services (Tier 0-1)</b></p>	<p>Mental health promotion activities</p> <p>Early intervention to prevent crisis developing / escalating</p> <p>Advice, information and support for children, young people and families/carers</p> <p>Drop in services for young people</p> <p>Phone lines</p>	<p>Youth work, children's services, schools, primary health care, supported by mental health promotion services and PCMHW</p> <p>Youth services</p> <p>Out of hours health care and social work services NHS 24 Childline, Breathing Space etc</p>
<p><b>Additional support (Tier2)</b></p>	<p>Short term interventions with capacity for immediate response to crisis</p> <p>Community based crisis responses</p> <p>Assessment and referral /signposting</p> <p>Training, advice and consultation for universal services</p> <p>Liaison with other services including adult mental health services, drug and alcohol services</p>	<p>A&amp; E services, primary care, social work services, schools, paediatric services</p> <p>Advice services, support services</p> <p>CAMH services</p>
<p><b>Intensive support (Tier 3- 4)</b></p>	<p>Assessment of more complex situations and acute / persisting needs</p> <p>Intensive treatment and support</p>	<p>CAMH services Specialist paediatric services</p>

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