UPDATE ON PROGRESS IN ACUTE MENTAL HEALTH REDESIGN AND REVIEW OF CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

PURPOSE

At its February meeting the Board requested that the Mental Health and Learning Disability Team bring back a report on Acute Mental Health redesign for the September meeting. At the Annual Review, the Minister for Public Health raised specific data issues around the CAMHS HEAT target and numbers of under 18 admissions to adult wards, and requested a progress report on a review of community CAMHS provision by the end of October 2011.

This paper updates the board on progress with both those issues, recognising there is a degree of co-dependency between them. The Board is asked to note progress to date and work that is currently ongoing, in preparation for more detailed papers on each issue to come to the Board in October.

CAMHS REVIEW

While there has been considerable progress in the development of CAMH services in Lanarkshire in recent years, there has also been a growing level of expectation at national level.

Meeting the HEAT target to “Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013” with the expectation that an 18 week target will be introduced for December 2014 is a priority for the CAMH service. In addition, the service is working to implement (by 2015) The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care, including the provision of Primary Mental Health Teams and Intensive Home Treatment, and to take account of other relevant documents, such as the recently published Framework to Improve the Mental Health of Children and Young People with Learning Disabilities.

As CAMH services have been a priority across Scotland, there has been considerable expansion and investment in all Health Board areas. In 2005 CAMH services across Scotland were reported as having 8.6 wte staff per 100k population against a recommended minimum staffing level of 15 wte per 100k. At that time, Lanarkshire had one of the lowest staffing levels at 3.7 wte per 100k. Since then, investment has led to expansion, and the June 2011 census shows that Lanarkshire staffing has increased to 10.3 wte per 100k. However, the overall staffing across Scotland now sits at 16.3 wte per 100k, and Lanarkshire has the second equal lowest staffing of the mainland Boards.

Despite the low staffing level, the CAMH service in Lanarkshire has made considerable progress in addressing priorities, with longest wait reducing from 53 weeks at April 2010 to 24 weeks in June 2011. This has been done on the basis that the tier 3 Child and Family Clinic Teams accept referrals up to the 16th birthday. Services in most of the rest of Scotland have moved to accept referral, either up to 18th birthday, or to 18th birthday if still in full-time education.

The CAMH service in Lanarkshire therefore faces considerable pressures, and the review is likely to identify ongoing gaps in our ability to fulfil all the policy requirements within current resource. The service has been considering options for meeting the demands that will, of
necessity, include exploring opportunities for joint working across traditional service boundaries, within children’s services and between CAMHS and adult services.

The particular issues raised by the Minister at the Annual Review were as follows:

**Data collection**

The Minister highlighted problems with collection of the correct data for tracking the access to treatment target. CAMH services in Lanarkshire have, in common with many other services, been using referral to first assessment times as a proxy measure. The work to update PIMS to allow measurement of referral to treatment, as required by ISD, had been delayed as IT resources were focused on other priorities, such as the introduction of TrakCare across the Acute Division.

Presently, the PIMS system records the date that a referral is received, and the date of first appointment. Waiting times are recorded based on these two data points only. Compliance with ISD requirements will add the ability to record and code patient unavailability, offers of appointment and also the outcome of appointments, including ‘Did Not Attend’, cancellations, the outcome of assessment and delivery of treatment information. This ability, and the staff training required to make these adaptations to the system, is scheduled to be completed over the next eight weeks.

The CAMH Service has developed a flow chart for the management of referrals, and this is being piloted in the Motherwell/Wishaw team, pending the introduction of the new recording method on PIMS. The pilot is scheduled to complete in December, and with the changes made to PIMS over the next eight weeks, this will allow the new recording system to be rolled out across all CAMH teams in January 2012.

Once a referral is received, a decision is made about whether or not it meets the criteria of the service, or if further information is required. At present, these decisions are taken at a weekly allocation meeting but, depending on the data from the pilot, this could be done more frequently. Where further information is requested, the waiting time clock is paused. If a referral is deemed urgent, an appointment will be arranged within 3 weeks.

A routine referral will be placed on the waiting list and an opt-in letter sent to the family. If they respond within 3 weeks, an appointment will be arranged. If they do not respond, the family is discharged and taken off the waiting list. If the family do not attend despite opting in, a further opt-in letter will be sent, but the waiting time clock will return to zero.

The time allocated for an initial assessment appointment for a family in the CAMH service is normally 90 minutes, allowing a clinician to make an assessment and, usually, to begin to deliver some form of intervention, viz: parental guidance, psycho-education or family intervention, at the first appointment. National definitions are that the decision about whether treatment is started at a first appointment is for the clinician concerned. The clinicians in the service are agreed that in the vast majority (estimate 95%), of cases, there is some form of treatment started at the first appointment.

Where there are particular complexities, or where there is further information required from other agencies to allow a completion of assessment prior to commencing treatment, there are codes (complex assessment or incomplete referral information), that pause the clock while the information is obtained before a decision on appropriate treatment is taken.

The CAMH service does not think that the change in the way data is collected will impact adversely on performance against the HEAT target, and remains of the view that the most difficult aspect of meeting the 26 week and then the 18 week target will be the matching of capacity to demand.
Under 18 admissions

The Minister focused on the number of under 18 admissions to adult mental health wards. In Delivering for Mental Health (2006), the Scottish Government made a commitment (Commitment 11), to reduce the number of admissions of children and young people to adult beds by 50% by 2009. This commitment was not met despite the opening of additional specialist inpatient beds, including those at Skye House in Glasgow.

In Lanarkshire, under 18 admissions to adult mental health wards have increased from 25 in 2008/9 to 38 in 2009/10 and 39 in 2010/11. This is despite an increase in admissions to Skye House, the specialist adolescent unit in Glasgow from 0 in 2008/9 to 4 in 2009/10 and 8 in 2010/11.

A large majority of admissions of children with mental health needs under the age of 16 are to paediatric wards, the exception being where behavioural risks would potentially disrupt the care of other children in the paediatric setting. Young people of 16 or 17 are admitted to adult mental health wards if urgent admission is required. The shared care protocol involving paediatrics, adult wards and CAMH teams is regularly reviewed, and any issues about the operation of the protocol addressed.

The increasing number of admissions of young people is a cause for concern, and a case review is currently underway with partners from North Lanarkshire Council to identify the reasons for the most recent admissions, and to investigate whether any alternative solutions would have been appropriate in those cases. The results of this review will form an action plan for immediate implementation to begin to reduce any hospital admissions identified as inappropriate.

There are also concerns about the use of admission as a means of addressing problems in the out-of-hours-period. Data from 2007/8 shows that 75% of admissions of under-18s where data was reviewed occurred out of hours and only 25% within CAMHS operating hours. Skye House does not accept admissions outside office hours. There is a protocol for the management of children and young people out-of-hours that ensures CAMH services are engaged in management at the earliest possible opportunity. However, it remains the case that the decision about whether to admit a young person out-of-hours is usually taken by relatively inexperienced junior medical staff with non-specialist consultant advice. Given a situation where a young person is brought to hospital, sometimes by the Police or by Social Workers, there is a concern that admission can sometimes appear to be the safest default position. CAMHS teams will continue to work with other teams to ensure the protocol for admissions is applied effectively, and that there is a focus on avoiding inappropriate admissions wherever possible.

The delivery and success of a plan to address the numbers of under-18 admissions will be dependent upon the provision of community alternatives. These include a better understanding within all community teams of the resources available from local authority partners to support children at risk, options for support and treatment at home, and improved training in the assessment and immediate management of children and young people for key staff such as junior doctors and the Mental Health Assessment Team nurses.

This issue, along with the review of community provision, will be addressed in more detail in a paper for the Board meeting in October.

ADULT ACUTE MENTAL HEALTH REDESIGN

Following the Board’s agreement in February 2011 to progress this issue, there has been a programme of stakeholder engagement around the available options for redesign of adult acute mental health beds and community services, resulting in the emergence of a preferred option.
The data on current bed occupancy, use of beds by patients from other Health Board areas, identification of specific groups at high risk of readmission and clinical variance between teams in use of beds, have all suggested that there is considerable scope for further movement of resource from hospital to community in adult mental health services.

A paper has been prepared outlining the process of engagement, the options considered and the preferred option. This paper also outlines the changes to the clinical model that would be required to deliver a substantial reduction in acute adult mental health beds, highlighting the treatment of young people as one of several groups that would require an increased focus to reduce the likelihood of admission.

Following the Minister for Public Health’s request that a progress report on a review of community services for under-18s be provided by the end of October, it was felt more appropriate to bring the acute mental health redesign paper to the Board in October, to allow the two pieces of work to be considered together.

There is potential within the adult mental health redesign to consider options that will support the development of age appropriate services for the under-18 age group, some of whom are currently managed entirely within adult services. Options, such as a designated area within the inpatient unit with staff trained to offer specialist input to a younger age group remain available, and to some extent are already in place through the use of Ward 1 at Wishaw as the site for initial admissions if the paediatric ward is inappropriate, given that Paediatrics only admit children to age 16. There is also potential in exploring how resources in the community could be pooled between CAMHs and adult services to provide a service targeted at the under-18 age group, particularly in the out-of-hours period. All of these options will be considered in the progress report to be produced in October.

RECOMMENDATION

The Board is asked to note the content of this report, and to endorse the action being taken to address immediate issues around data reporting in CAMHS and under 18 admissions. A more detailed report, recommending a preferred option on acute mental health redesign and a way forward for CAMH Services, will be brought to the Board in October.

FURTHER INFORMATION

For further information, or clarification of any issues in this paper, please contact :-

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