

Meeting the target: providing on-call and 24-hour specialist cover in Child and Adolescent Mental Health Services

Final report

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Summary

Background

This report presents the findings from a two-stage study undertaken between April and December 2006 by the Thomas Coram Research Unit for the Department of Health. It examines the issues raised for providers and commissioners of child and adolescent mental health services (CAMHS) by the national target to provide on-call and 24-hour specialist cover by December 2006. The report includes the results of an electronic survey of CAMHS providers in late autumn 2006, which investigated the quality and configuration of on-call services in place by the target date.

Methods

The study draws on information from:

- Initial consultation with key experts in the National CAMHS Support Service and elsewhere;
- a focused review of literature on the effectiveness of different models of 24-hour CAMHS cover and on the views of young people using this provision;
- telephone interviews with 18 commissioners and providers from 14 CAMHS in England;
- an electronic survey of CAMHS providers to determine the cover provided for emergency presentations, to gather data on audits of out of hours presentations and the costs of providing emergency cover.

Literature review

There are few robust evaluations relating to the emergency management of children and young people presenting with a mental health crisis out of working hours. Intensive home-based interventions may reduce the need for out-of-hours crisis admissions, although the evidence is not conclusive. Young people with experience of mental health crises emphasise the importance of the way they are treated when accessing services in an emergency. To be treated by staff who are approachable, non-judgemental, empathetic and able to make things happen appears to be of greater value to them than the particular organisational arrangements or the profession of the person they see. Young people also value community-based services which offer 24-hour access to a drop-in or telephone service providing advice and reassurance, which may help them to avoid hospital admission.

The extent of 24-hour cover

Although the majority of CAMHS providers reported being able to provide an on-call service by CAMHS professionals by the target date, and most of the rest could offer a next-day emergency response by CAMHS staff, it remains difficult to accurately assess the current extent of provision. The survey conducted by this study suggests that 9% of services are unable to provide an on-call CAMHS response to provide emergency assessment at any time, and around 30% have no CAMHS staff on call to undertake assessments at weekends. The study found evidence that the data provided for the national mapping exercise and for local delivery plans are based on different interpretations by providers of the 24/7 PSA target, and indeed of what constitutes an 'emergency'. The situation is further complicated as some out-of-hours cover arrangements do not depend on formal protocols or agreements but instead rely on informal systems of goodwill which may disappear if particular members of staff are unavailable or may apply only in specific locations of a service area. Additionally, some 24-hour cover remains under review due to limited resources, restructuring or fixed period funding.

Types of provision

The main models of 24-hour CAMHS cover reported in this study are:

- a consultant child psychiatrist on call round the clock, with various arrangements for first- and second-level on-call before reaching the consultant;
- the same model, but with the consultant providing telephone-only advice;
- informal shared arrangements for on-call with adult mental health services; and
- partnerships with other agencies to offer a multi-agency response.

Where services provide 24-hour access to a CAMHS consultant psychiatrist there appears to be a reluctance to consider alternatives, even when difficulties in maintaining this level of cover are experienced. Among the shared arrangements that had been considered or adopted, often by smaller providers, combining with a neighbouring CAMHS to provide a bigger pool of staff for an on-call rota had generally been the *least* successful due to the variety of contractual and service delivery arrangements. Purchasing consultant psychiatrist cover from a neighbouring area appears a more successful and cost effective solution, but not one that is available to all. Partnerships and multi-agency collaboration with adult mental health or social care services have proved effective solutions, but have frequently required considerable tenacity from commissioners to steer and sustain the interest and commitment of partners through protracted negotiations.

Barriers

The main barriers to developing 24-hour on-call CAMHS are perceived to be resources, lack of staff (especially for smaller providers or where there has been a history of under-investment in CAMHS) and the frequently reported reluctance of existing staff – from nurses to consultants – to contracting to provide 24-hour cover. At the same time, an underlying ethos of patient care means that most services report a culture of responding when a situation is perceived to be a real emergency which the formalising, through contractual on-call arrangements, may undermine. There is some evidence, however, that when staff are provided with a realistic picture of the demands of on-call work, through audits or pilot schemes, they are more willing to participate in formal rotas.

Conclusions

The 24/7 target has encouraged CAMHS and other services to critically review the wider issues concerning young people experiencing a mental health crisis, and to consider the services that need to be in place both before and after the point of accessing an emergency assessment. There is a growing interest in the role of CAMHS in supporting staff in other services such as A&E to undertake assessments, and in developing closer links with a range of agencies to offer better pathways of care for children and young people who present as a mental health emergency. Setting up and providing specialist cover out of hours has in some cases diverted resources from other aspects of the service and may be unsustainable in the longer term. Whilst the great majority of CAMHS providers report 24/7 services in place to meet the proxy target at the end of 2006, it is likely that further changes in out-of-hours provision may develop as pressure on CAMHS resources focuses on other aspects of providing a comprehensive service.

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1. Introduction

1.1 Background to the study

Standard 9 of the National Service Framework (NSF) for Children, Young People and Maternity Services (Department of Health, 2004) highlights the need to ensure that children and young people are able to receive urgent mental health care even when their needs arise out of normal working daytime hours.

Developing a comprehensive Child and Adolescent Mental Health Services (CAMHS) by 2006 is a high priority for government and the subject of a Public Service Agreement 2003-6, with the overall aim to produce faster and fairer services to deliver better health care and to tackle health inequalities. One of the three proxy targets identified as a key indicator of progress towards a comprehensive CAMHS¹ service is that of 24/7 access².

The target is defined as arrangements to ensure that 24-hour cover is provided to meet children's urgent needs, and a specialist mental health assessment is undertaken within 24 hours or during the next working day where indicated.

A lack of adequate resources, including workforce limitations, has resulted in a variable out-of-hours specialist response. Consequently the Royal College of Psychiatrists has acknowledged that it is not possible to recommend how provision should be provided, and that a lack of CAMHS psychiatrists in some areas may preclude the provision of any on-call psychiatric services (York and Lamb, 2006). The NSF (sections 6.8 - 6.10) suggests that a variety of approaches may be taken to provide the necessary level of cover. These include:

- arrangements with adult mental health services to provide first on-call;
- specialist registrars from a rotation to provide specialist CAMHS on-call, across several providers;
- consultant child and adolescent psychiatrists having collaborative arrangements with neighbouring services; and
- multi-disciplinary on-call arrangements with psychiatric back up.

1.2 Research objectives

The current study was commissioned by the Department of Health to provide information on the different ways in which CAMHS commissioners and providers in England are addressing the requirements for providing 24/7 cover to children and young people at times of mental health crisis. The main objectives were:

- to identify the difficulties involved in commissioning and providing 24/7 services and to explore the strategies that providers have employed to ensure efficient and appropriate cover;
- to identify the perceived benefits and disadvantages of different approaches and configurations;
- to highlight good and innovative practice, both in the administration and delivery of 24/7 cover; and
- to provide examples of how service configurations might vary in different settings, for example between rural and urban areas, and in response to differing population demands.

¹ The focus of this study is on specialist CAMHS (excluding residential Tier 4 services), whilst recognising that an effective emergency response may well involve Tier 1 services as well.

² The other two proxy targets are services for 16-18 year-olds being delivered through CAMHS, and access to CAMHS for children and young people with learning disabilities.

1.3 The Research

The study was undertaken in two parts:

- Stage 1: Consultation and scoping work (April - July 2006) including a focused review of the relevant literature and telephone interviews with interest groups at national and regional level and with key contacts in a sample of commissioning and provider trusts. An interim report was submitted to the Department in August 2006.
- Stage 2: A national electronic survey of CAMHS providers (November 2006) to determine the quality and configuration of the on-call services in place by December 2006. The results of this survey have been incorporated with the Stage 1 findings in this final report.

Stage 1

Initial consultation with selected informants

During an initial scoping phase, telephone interviews and email correspondence were conducted with six key informants (including CAMHS specialists, a National CAMHS Support Service regional development worker and representatives from Strategic Health Authorities) in order to gain a picture of the range of services in operation and to identify significant issues related to the 24/7 target.

A request for information was sent out to members of the National CAMHS Support Service and this generated six useful responses about the range of services in operation and services planned. Some responses highlighted particular localised problems of establishing 24/7 provision.

Review of selected literature

Initial discussions with the Department of Health indicated that there might be published literature evaluating models of 24-hour CAMHS cover in operation in other countries, particularly Australia and North America, which could inform developments in the UK. The importance of taking account of user views was also raised. The study undertook a focused review of recent literature on these two topics.

National datasets and documentation

The Department of Health supplied the latest returns from the Local Delivery Plans (LDP), which identified those Primary Care Trusts (PCTs) reporting no 24/7 cover. Figures were also obtained from the National CAMHS Mapping Exercise (Wistow et al., 2006). In addition, an internet search identified a range of documents from CAMHS Strategy Groups, PCTs and other specialist Trusts concerning the provision of CAMHS 24/7 cover and the proxy target.

Interviews with commissioners and providers

Based on the outcome of the initial scoping phase outlined above, three broad approaches to 24/7 provision were identified. Geographically diverse areas were then selected to provide examples of this range of provision for further study. Key personnel were identified for interview from the previous contacts in the initial phase, from internet searches and in some cases by telephoning PCTs to establish who might be the best contact. Generally, initial contacts were either appropriate to interview or willingly identified other more suitable interviewees. Sixteen different areas were contacted, and interviews were conducted with commissioners and/or providers in 14 (Appendix 1). Interviewees included directors of commissioning and a director of young people's health within PCTs, a director of children's services with responsibility for education, care and health services, and the joint commissioning and development manager of CAMHS in a county council. A total of 18

telephone interviews were conducted, as both commissioners and providers were interviewed in four areas to gain a fuller picture of the issues in those localities.

A semi-structured schedule was devised for the telephone interview. This included questions about current provision and its quality, any difficulties encountered in providing 24/7 cover, details of audit or demand data and future plans to develop the service. The schedule continued to develop as themes and issues emerged with each interview. Interviews ranged in length from 20 to 50 minutes. In addition to the telephone interview, around one half of interviewees also supplied documents relating to their on-call and out-of-hours service provision.

Stage 2

Towards the end of 2006, the study undertook an electronic survey of CAMH services to determine the extent, coverage and configuration of the on-call services in place.

Development of the survey questions

The survey aimed to identify the extent to which services were complying, or had arrangements in place to be in compliance, with the proxy PSA target for 24/7 cover by December 2006. The survey also sought to provide further insight into how services were providing cover, bearing in mind the variety of arrangements disclosed in the first stage of the study; and to gain some view of the quality of the provision, as perceived by those providing the service.

The interviews in the first stage of the study informed the design and form of the survey questions, and valuable assistance was also provided by a local CAMHS Regional Development worker. The survey asked about cover provided during weekdays as well as out of hours, and whether these arrangements were supported by formal protocols or agreements and if they included the care of young people aged 16 and 17 years. It also asked for any available data on the demand for and costs of on-call provision, and invited respondents to comment on the service offered. Copies of relevant documents such as protocols or audit data were also requested.

The survey form

The questions were incorporated into an electronic form which could be either completed on screen and returned by email, or printed and the completed hard copy returned by post (Appendix 2). The majority of forms were returned electronically. Each form was given a unique identifier code, which proved invaluable when surveys were returned from a different email respondent to that which the request had been originally sent, reducing the unnecessary prompting of services that had already returned surveys.

Identifying the survey sample

Identifying the most suitable contacts for the survey proved more problematic than had been anticipated. The team at Durham University responsible for the National Mapping exercise provided a list of CAMH services in England, but was able to supply email contacts for less than 10% of these. The name and email address of the most appropriate contact was obtained through telephone calls to each remaining service. This procedure, although time consuming, had the added benefit of revealing that the reconfiguration of Primary Care Trusts during 2006 had relocated some CAMH services, at least in name if not geographically.

Survey distribution and response

The survey and the method of distribution were piloted in two regions 10 days before the main emailing. The survey was emailed to the remaining regions during the last week of October with a return date of 7th November. As each survey form contained a unique

identifier, emails were sent individually with the accompanying email letter personally addressed.

Reminder emails were sent on the 10th November. A week later, those who had not responded were prompted again, some by email and some by telephone. Four respondents contacted by telephone answered the survey questions by interview as a more convenient option to completing the survey themselves.

The calculation of an accurate response rate to the survey is complicated by several factors. The survey responses identified several services for which the 24/7 PSA target was not applicable (for example a forensic service or a specialist residential Tier 4 service that would not be expected to provide a first response to an emergency presentation), and which would therefore be inappropriate for inclusion in the survey. A number of other services responded that they were covered by another service that had also been contacted and that the combined response would come from that source. A further complication arose from variations in on-call services within some localities, necessitating respondents to forward copies of the survey for completion by local areas and thus generating multiple responses. Table 1 presents the number of survey responses. However, for the reasons just described, the number of surveys completed and coded for analysis together with the number of non-responses and the number not included (such as forensic services) does not sum to the number of surveys originally sent. The response rate to the survey is probably best described by the non-response rate of 31% (43/138), giving a response overall of 69%. (A regional breakdown of responses is set out in Appendix 3)

Table 1 Survey responses

Number of surveys sent	138
Returned surveys coded	84
Returned responses not included	18
No response	43

Coding and Analysis

Survey responses were coded into the Statistical Package for the Social Sciences (SPSS) and frequency tables generated. Nearly half of returned surveys contained additional comments which were separately collated. Eight respondents appended protocol documents, the majority relating to the referral of young people who self-harm, and four provided other documents mainly relating to audit data. These additional sources of data were thematically analysed in relation to the issues addressed by the study and linked to comments on the same topics by interviewees in Stage1.

1.4 Structure of the report

This final report draws together information from both stages of the study. Chapter 2 provides a brief overview of relevant literature, including children and young people’s views on emergency CAMHS provision. Chapter 3 describes the 24/7 provision reported in the survey and assesses the reliability and quality of estimates of on-call cover. Chapter 4 reviews the demand for emergency provision in the light of the audit material submitted to the study. Chapter 5 offers a fuller account of CAMHS provision, looking at some of the problems that services report as they attempt to improve or implement their 24/7 cover, whilst Chapter 6

considers the role of other providers such as adult mental health services and social care agencies and the issues around multi-agency working. Chapter 7 examines the very limited data available to the study on the costs to services of providing out-of-hours cover, and Chapter 8 considers the place of CAMHS emergency provision in the care pathway of children and young people presenting with a mental health problem. Finally, Chapter 9 summarises key conclusions from the study. The appendices contain a list of those interviewed in the first stage of the study, a copy of the survey form and a regional breakdown of survey returns.

2. Evidence from the literature

2.1 Evaluations of 24/7 provision

A *Medline* and internet searches of recent (post 2000) literature revealed very few evaluations relating to the emergency management of children and young people with mental health problems, especially when presenting out of normal working hours.

There has been some dialogue on the value of crisis interventions undertaken in the community against those that are conducted in conventional health settings, although most of this discussion refers to provision for adults. Several papers advocate the value of crisis home treatment teams as successful services to support adults in crisis, offering a bridge between routine community care and care in an in-patient unit. Smyth and Houlst (2000), based on experience in Australia, list the advantages of these teams to be their availability 24 hours every day and their potential for a rapid response. In addition, by treating in the home setting, such services are able to address the social issues surrounding the crisis from the beginning, offering practical problem-solving help and providing advice and support to carers. Protheroe and Carroll (2001) have described how psychiatrists in Victoria, Australia have relinquished their gate keeping role to a Crisis Assessment and Treatment Team (CATT) composed of non-medical mental health professionals. These community-based teams offer acute psychiatric care, and those with serious psychiatric illness are managed at home without removing them from their usual social networks. Similar teams offering home-based treatment elsewhere in Australia have also been documented, such as the Hospital-in-the-Home for mental health consumers based in South Australia (Kalucy et al., 2004)

There is little robust evaluation of home-based compared with clinic-based treatment. A randomised evaluation of an assertive community treatment for adults in north London (Killaspy et al., 2006) demonstrated no difference in clinical outcomes. However, there was evidence of greater patient satisfaction with the assertive community team compared to the community mental health team, with more success in maintaining contact with patients and therefore improved engagement with patients. Craig et al. (2004) and Johnson et al. (2005) have both demonstrated improved clinical outcomes using early intervention and crisis resolution services.

Most of these studies relate to provision for adults, and evidence in the literature of the success of intensive community support for children is scant. Ahuja et al. (2006) described a community intensive therapy team, using a home-based model, operating in one trust area in South Wales which demonstrated a reduction in in-patient admission. The team were reported to be receiving approximately one referral a week, generally of children and young people with a range of disorders including psychosis, affective disorders, eating disorders and repeat self harm.

In Bradford, evaluation of an adolescent intensive home-based intervention (Worrall-Davies and Kiernan, 2005) also found that this approach was able to reduce in-patient admissions, and was very acceptable to families. Nine young people were referred for the home-treatment approach over a six-month period. A key aspect of the service was that referrals could be picked up and the 'virtual' team (drawn from existing CAMHS staff) mobilised within 24 hours. Staff were willing to provide 7 day cover until new posts were developed, since they had been involved in development of the scheme from the beginning.

Outside the UK, Carroll et al. (2001) have described the work of the Northern Crisis Assessment and Treatment Team (NCATT) of North Melbourne. This provides services to adults during office hours, but manages all urgent referrals out of hours regardless of age. The authors outline the problems that arise in operating a multi-disciplinary community psychiatric crisis team. Unless the team maintained a clear focus on their patient group, the

service risked being flooded with cases involving minor emotional and social problems. Clear and effective filtering of cases was essential, demonstrated by the level of cases taken on by the team compared with the number of referrals. During the 12-month period 1999-2000, the service received 4,374 referrals of which it assessed around a third (1,422) and took on less than 10% for ongoing care. Others who had worked in the same team have argued however that CATTs tend to attract the most skilled clinicians and foster a strong, elitist team culture, depleting skilled staff from other, less glamorous teams in the area and straining effective working relationships between the two areas of work (Leonard et al., 2002).

More specifically applicable to the current research is the report of a Canadian study of a Rapid Response Model for accessing child psychiatry via Accident and Emergency (A&E) services (Parker et al., 2003). The study was aware of A&E departments in the locality being used as a route to psychiatric assessment by professionals and families frustrated by long waiting times via conventional referral. Presentation at A&E offered a short-cut into specialist services and was frequently used as a drop-in service or for accessing psycho-social support. The Rapid Response Model distinguished between emergency consultation and urgent consultation for children and young people presenting in two A&E departments, and provided a differentiated response. Emergency consultation offered immediate contact with a child psychiatrist or Senior House Officer (SHO) or their equivalent, in A&E or over the telephone. Urgent consultation offered daily urgent appointments within A&E and for community service providers. The aim was to prevent urgent cases reaching emergency proportions and to avoid inappropriate crisis admission to the in-patient unit. The model ran in two A&E departments and resulted in a reduction in the proportion of young people admitted. Importantly, there were fewer night-time admissions in crisis, with admissions more likely to take place from daytime consultations. There were fewer brief admissions of low risk, uncooperative patients who previously were routinely admitted and then discharged as soon as the regular clinical team conducted its assessment.

Although the Rapid Response Model meant that most consultations were deferred from the evening or weekend to the next working weekday, a survey of staff working in the two A&E departments produced the perhaps unexpected finding that many believed that the urgent consultation service had improved the efficiency of their departments. The authors interpret this as reflecting the staff's improved ability to handle patients more competently and make speedier decisions, resulting in fewer patients languishing in A&E. The urgent consultation appointment system resulted in fewer requests from A&E staff for emergency consultations, and a more skilled employment of their triage skills. The availability of an additional facility of brief intervention follow-up clinic appointments within a week gave families and other professionals more confidence in dealing with risk and in their ability to contain a crisis. The study emphasised the importance of training for A&E staff to help them adjust their skills towards implementing risk assessment and short-term management of cases.

2.2 Young people's views of emergency CAMHS provision

One of the underpinning principles of a comprehensive CAMHS is that the views of all stakeholders, including children and young people, should inform the commissioning and delivery of services (Department of Health, 2004). There is very little literature specifically addressing the views of users of out-of-hours CAMHS provision in the UK, or their experiences at the point of admission to an in-patient service, but there are consistent messages from studies of what children and young people want from mental health services in general (Street, 2004; Buston, 2002; Gibson and Possami, 2002; Armstrong et al., 2000). These include:

- the importance of information sharing;
- feeling that their views are listened to;
- services that are accessible and able to offer help promptly; and
- staff who are approachable, non-judgemental, empathetic and able to make things happen. Possession of these skills seems to be more important to young people than the actual profession of the helpful adult.

A project by the Mental Health Foundation to develop and pilot models of community-based services for young people experiencing a mental health crisis included consultation with 45 young people (aged 16 to 25) who had themselves experienced a mental health crisis (Smith and Leon, 2001). Their views reinforced the importance of a 24-hour service, and their suggestions for what would be helpful included:

- a place to go which was open at weekends and through the night (or offered a telephone support service) so they could 'talk things through', ideally with people who had had similar experiences;
- a call-out service providing support in their own homes to help prevent a crisis escalating; and
- crisis houses with emergency beds and trained nurses who could treat wounds.

When asked which aspects of a crisis service young people would consider most important if they were setting up or running such a service, answers again focused on the way they were treated rather than on any particular model. Young people spoke of the 'need to be understood, respected, acknowledged and supported rather than being patronised, smothered or blamed for their situation' (Smith and Leon, 2001:32). The emphasis was on reassurance and the need to feel that there was someone there for them who would come if they needed help. This kind of contact needed to be immediate if it was to be effective in avoiding hospitalisation.

A study by Young Minds of in-patient mental health services for young people (Svanberg and Street, 2004) included interviews with over 100 young people. This study highlighted the importance of services being age-appropriate, and suggested there may be a need for in-patient provision specifically for older adolescents. Sixteen percent of the sample had at some point spent time on a paediatric ward, and a quarter of those said that the provision was inappropriate to their needs. Another 20% had been admitted to adult psychiatric provision, of whom 13% had found the experience 'frightening'. A quarter said that with more help earlier, they may not have required in-patient admission.

In a small-scale study of younger children (aged 8 to 13) admitted to an in-patient unit, the children were interviewed shortly after admission and before discharge to explore how they made sense of the experience. At admission, it was reported that the children expected to be passive recipients of help, with staff 'taking charge', and valued the experience of containment provided by the unit. By the end of admission, however, children's

understanding of their role in 'getting better' had shifted to incorporate an increasing sense of their own agency, and they valued being taught strategies for managing anger or anxiety that helped them to feel more in control of their lives (Hepper et al., 2005)

The majority of emergency presentations to CAMHS are likely to be due to self harm (Healy et al., 2002). A study of young people admitted to Birmingham Children's Hospital after taking overdoses (Dorer et al 1999) reported children's views (although only a third agreed to take part, with an average age 14.3 years). The majority (40) had been admitted, with less than half rating the experience positively. Two 16 year-olds had found the experience of being the eldest on a ward difficult. All saw a member of the CAMHS team and just over half found this positive or very positive, with talking through problems in detail with another person being seen as a very positive outcome.

The 'talking through' experience may however vary, especially at the point of crisis. An in-depth study of young people who were repeat attenders at A&E departments because of deliberate self harm (Storey et al., 2005), found that some had found talking helpful but generally that was later. In the immediate situation of the emergency, many found talking a problem. Not talking and not wanting to be assessed was a recurrent theme with the young people interviewed in this study. Some reported that staff on A&E or on the children's wards displayed a judgemental attitude towards them, reinforcing their feeling that they were not 'deserving' of medical treatment. Others, frightened or exhausted by the events which had led to their arrival or depressed and withdrawn, provided unwilling candidates for assessment. In an A&E setting, it was difficult for staff to address the complex needs and issues that had brought them there. Nearly half of the young people required little medical treatment beyond tests and monitoring for several hours. For most, lengthy waits for test results, sometimes wholly in the public waiting area during busy times, added to their sense of 'punishment' rather than treatment.

3. Emergency provision for children and young people

Access to mental health assessments as defined in Standard 9 of the children's NSF is one of the measures for assessing the progress of CAMHS in achieving a comprehensive service by December 2006. In Stage 1, the study attempted to gain a picture of the progress services had made towards achieving that target by mid-2006, using national data sources and by consulting with a sample of commissioners and providers on progress to improve services in line with the target requirements. The subsequent survey provides evidence of how successful services have been in establishing emergency provision by the target date of December 2007. This section of the report looks firstly at the evidence from several national sources of the provision of emergency mental health services for children and young people, and then goes on to describe the data provided by the survey.

3.1 Evidence from a range of sources

Two sources, the National CAMHS mapping exercise coordinated by Durham University and the Local Delivery Plan (LDP) returns to the Department of Health, provided some preliminary data on the provision of emergency cover. Both ask if arrangements are in place to ensure that 24-hour cover is available to meet urgent mental health needs of children and young people, and for a specialist mental health assessment to be undertaken within 24 hours or the next working day where indicated. The information is obtained from different sources: from CAMHS providers in the case of the mapping exercise, and from PCTs in the case of the LDP.

The latest available results from the Durham mapping exercise relate to 2005 and report that 44% of CAMHS providers were able to offer an on-call service by CAMHS professionals. Whilst 43% did not have an on-call service they reported a next day emergency response by CAMHS professionals. However, 7% had no on-call service and offered no next day emergency response by CAMHS staff. (Wistow et al., 2006).

The Local Delivery Plan (LDP) returns for September 2006 indicate that 12% of PCTs were reporting that they had no 24/7 cover in place.

Two further sources of data on out-of-hours provision were also identified.

The National CAMHS Support Service encourages all CAMHS partnerships in England to complete a self assessment matrix to assist them to review and evaluate their progress towards achieving a comprehensive service. The 2005-6 matrix includes a section that addresses requirements for achieving the 24/7 target, with the following recommended level of provision:

24/7 emergency and crisis service likely to comprise as a minimum a senior/ experienced clinician available on rota, out of office hours, for consultation and to assess and respond to emergencies. The main service able to respond to crises arising out of hours and managed pending resumption of normal office duties. This service available to hospital A&E and paediatric wards, covering self harm and linked to the social services led Emergency Duty Team (EDT) as well as to any emergency services for children (NCSS and HASCAS, 2005).

Services self assess their score from 0-3, where 0 denotes 'not achieved', 2 represents 'good progress' and 3 means 'achieved fully'. The average score for this item was 2.07 (based on a response rate of 83%) with 37% of the responses scoring 3, suggesting that 'good progress' was being made. (Anderson, personal communication, January 2007).

The Royal College of Psychiatrists, in conjunction with the Royal College of Paediatrics and Child Health and the British Association of Emergency Medicine, have been conducting a survey of all A&E departments in the UK to establish what arrangements they have for 24/7 CAMHS cover. (Waine, personal communication, June 2006). Results were not available in time to incorporate into this report.

3.2 Evidence from the survey

The electronic survey of CAMH services asked what consultation or assessment would be available by December 2006 (the target date for providing a comprehensive CAMHS), at locations such as A&E departments, for those seeking advice for a young person aged under 16 who presented with a mental health problem. The cut-off age of 16 was used in this section of the survey since Stage 1 interviews suggested that, despite the NSF target, not all CAMHS were providing a service through to age 18. By asking separately about services up to age 16 and for 16-17 year olds, the study was able to gain a more complete picture of the cover available.

Information was requested about cover during three periods of time: weekday daytimes from around 9am until 5pm, weekday nights (ie Monday to Thursdays 5pm until 9am), and weekends from 5pm Friday until 9am Monday.

Table 2 shows the CAMHS cover reported to be available at the three time periods. Whilst most services report CAMHS personnel available to undertake emergency assessments, this is not universal, even during weekdays. Sixty-five services (79%) report a consultant psychiatrist, Senior House Officer (SHO) or Specialist Registrar (SpR) available to undertake assessments during the week and a further eight services have other non-medical staff available. As might be expected, fewer services are able to report that level of service continuing into evenings and at weekends.

During weekdays, five services report that CAMHS can offer only telephone advice and a further four that even this is not provided, suggesting that nine services (13%) cannot provide an urgent assessment. Data for weeknights and weekends indicate a higher proportion of services not providing assessment or telephone consultation. In total, 24 services (30%) did not offer emergency assessment at nights or at weekends.

Table 2 Provision of cover by CAMHS at three time periods

	Weekdays	Weeknights	Weekends
Assessment by CAMHS medical team	65	57	55
Assessment by non-medical CAMHS team but with medical support by telephone	3		1
Assessment by non-medical CAMHS team with no medical support by telephone	5	1	1
CAMHS team telephone consultation only	5	8	5
No CAMHS team cover	4	16	19
<i>Total</i>	<i>82</i>	<i>82</i>	<i>81</i>

Source: TCRU survey, November 2006

The survey also asked about the availability of consultation and assessment facilities offered by other services. Table 3 presents the reported extent to which CAMHS have access to other services, such as a paediatric department, an adult psychiatry team or an emergency duty team (EDT). The most common sources for assessments were paediatric teams and Children's EDTs. The table suggests that where arrangements with paediatric services and child EDTs are in place, these are likely to be available at all times, with 21% of services reporting the combination of these additional assessment facilities during weekdays and 26% at nights and weekends. Arrangements with adult psychiatric services and or Adult EDTs were less common, with only 10% reporting one or both of these options for assessment during weekdays. However, over a quarter of services reported access to these adult services at night or weekends.

Table 3 Other providers of emergency assessments

Emergency Assessment	Weekdays	Weeknights	Weekends
Paediatric Team	9(1)*	7(2)	8 (2)
Paediatric Team and child EDT	17	21 (6)	22(8)
Paediatric Team/Children's EDT plus adult psychiatry and/or adult EDT	5	12(7)	12(5)
Adult psychiatry or adult EDT	3(1)	10(3)	9(3)
Telephone access only to any of the above services	1(1)	2(1)	2(1)
Services reporting no additional providers of emergency assessments	47(6)	30(5)	28(5)
<i>Total</i>	<i>82</i>	<i>82</i>	<i>81</i>

Source: TCRU survey, November 2006

* numbers in parenthesis indicate services with no CAMHS assessment facility

The table suggests that these additional sources of assessments during weekdays tend to be available for those CAMHS which already provide assessments at that time and are thus supplementary rather than the sole source of emergency assessment. Only two of the nine services lacking a daytime facility for CAMHS emergency assessment report access to one of these additional sources (one to paediatric services and one to adult services) to provide assessment during normal working hours. However, more use is made of non-CAMHS providers as the sole source of emergency assessments at nights and weekends. Eighteen of the 25 services with no facility for providing a CAMHS assessment at those times reported access to urgent assessment from other services.

3.3 Provision for 16-17 year olds

The survey focused on services provided for under 16 year olds, but mindful of the PSA target of extending CAMHS to young people age 16 and 17 years, the survey also asked about emergency provision for this older age group. Almost two-thirds of services (52) reported that their arrangements for under 16s also applied to young people age 16-17. Of those services for whom provision is limited to under 16s, six services mention continuing full time education as the criterion on which CAMHS undertakes assessments with patients presenting over age 16. Two other services added the additional information that whilst adult psychiatry services assesses all those aged 16 and over, the care of any patients who are already known to CAMHS is transferred to them. Two others noted that a CAMHS

consultant psychiatrist was available to advise or support adult psychiatry services with younger patients if required.

Several services reported anomalies arising in the management of patients in the 16-17 age band. Two reported that the site of presentation dictated the care pathway, with young people who arrive at the hospital being referred to CAMHS, whilst community referrals were routed to the adult crisis service. Another two services mentioned that the extension of CAMHS to young people aged 16 and 17 had raised an issue that had yet to be fully resolved. Paediatric departments were unwilling to accept admissions of patients aged 16 and over, so their care had to be managed under adult admissions procedures. Several services mentioned the presence of recently established 'early intervention in psychoses' teams as available to respond to emergency referrals for those aged 16 and over.

3.4 Interpreting the data

Discussions with CAMHS specialists and with commissioners and providers in Stage 1 of the study suggested that some caveats should be attached to accounts of how services respond to the requirements of the 24/7 target, and that figures on emergency cover from mapping exercises and returns to the DH need to be treated with some caution. Some services that report that they do not have arrangements for cover in place appear to differ little from others that say they do. As one specialist interviewed in the initial scoping phase of the study told us:

People tend to tick the box if they think they can get away with it and only if they have glaring problems do they not. The reality on the ground may be slightly different from what they are reporting. There will be a lot of covering up and self reporting. You don't recognise the services from the mapping results.

Whilst a view persisted that some creativity was implicit in the figures provided by some PCTs in their returns, it was also suggested that differing interpretations of the target requirements could be a cause of unreliability and variance in data regarding provision. A commissioning manager for an area covering four PCTs commented on the 2005 LDP return for the area, which stated that no 24/7 service was provided:

Someone in the PCT does the LDP returns and it seems that they seem to be answered slightly differently each year. I think that will be about definitions [of the 24/7 target]. I think it means within 24 hours, some people think it means there and then, on-call 24 hours a day – if it's the middle of night. So there wasn't next day cover [in 2005] but there has always been next working day cover. (Commissioner, Area 13)

The services in the four PCTs in this area at the time the LDP return was completed did not differ from those offered in another area consulted in our study, where PCTs had reported that they *did* provide 24/7 cover.

However, those who could confidently say that they were providing the cover required acknowledged that this was sometimes variable, and that improvements were still necessary.

We can tick the box that says we see children the next working day for CAMHS professional – but there are a million ways of doing this and it's a variable quality and yes, 80% good, 10% excellent and 10% not so good. (Commissioner, Area 9)

The 'next working day' was seen by many as the point at which the service failed the needs of the users, with waits over the weekend or longer at bank holidays. The majority of

providers and commissioners cited memorable cases of protracted waits in inappropriate settings, but thought that *'most consultants will turn out if required even though it's not in their contract to do so'*.

The survey undertaken by this study attempted to encourage frank responses by emphasising the independence of the researchers and the promise of confidentiality and anonymity in reporting the findings from the survey. The response rate (estimated to be in the region of 70%) means that the TCRU survey does not offer a complete picture of on-call CAMHS arrangements across England. However, by asking about the specific cover available during different time periods, the survey provides a more accurate and detailed picture of emergency arrangements and the role of other providers of emergency assessments

The survey suggests that of the 30% of CAMHS unable to offer assessment at night or at weekends (ie assessments by the team are likely to be in the 'next working day' category rather than within 24 hours) around 60% are able to call on paediatric departments or Children's EDTs to provide emergency cover out of hours. A further 16% rely on an adult service (either a psychiatry team or an EDT) to provide urgent assessments.

There are both similarities and differences in the findings of the latest National Mapping exercise carried out at Durham University and the TCRU survey. Both offer comparable estimates of services not providing emergency cover: The Durham exercise suggests 7% of services offer no on-call service and no next working day assessments, whilst the TCRU survey indicates that 9% of services are unable to provide an urgent assessment during weekdays, nights or at weekends. Although this does not preclude the possibility of assessment within 24 hours, it would suggest that this is unlikely to be available.

A more substantial difference appears between the findings of the Durham exercise and this survey in the reported percentage of CAMHS providers offering an on-call service. The mapping exercise indicates 44% offering on-call and 43% providing a next day service, whilst the survey suggests nearer 70% of services have CAMHS team staff available to undertake assessments at night or at weekends. There are a number of possible explanations, although it is not possible to say which is correct. The difference could possibly be a result of bias in the response rate to the survey, with a higher response from services that provide on-call at all times rather than those with more limited provision (although the TCRU survey also found a slightly higher proportion of services with no cover). An alternative explanation might be the terminology employed in the survey compared with that of the Durham Mapping exercise. For example, the 'available' service may have been more liberally interpreted by respondents to the TCRU survey.

It could also be the case that the survey captured a real increase in the availability of 24/7 cover between the date of the mapping exercise earlier in 2006 and the TCRU survey in November 2006. During the late summer and early autumn, a series of workshops designed and led by the National CAMHS Support Service were held across the country, to help services produce action plans to meet the target by December. Results from the LDP for December 2006 (Department of Health, 2007) show a significant acceleration in the rate of progress between September and December, with 96% of PCTs achieving the target. This suggests that the TCRU survey results offer a reasonably true picture of the 24/7 situation.

4. Assessing the demand for emergency provision

The Royal College of Psychiatrists has raised questions about the lack of knowledge on the extent of demand for an out-of-hours CAMH service (York and Lamb, 2006). In stage 1 of this study, interviewees commented that the level of demand for on-call services was low. However, whilst acknowledging the need for sound data, few commissioners were able to locate any robust and relevant information on the level of need for the service in their area. A number reported that they were engaged in a needs analysis, but were unclear regarding the quality of data that this would provide in terms of assessing out-of-hours services. Two areas reported that their newly established pilot schemes to provide weekend out-of-hours services would collect demand data to offer a sound basis from which to estimate the future level of cover required.

In Stage 2, the survey asked respondents for any recent audit data on the number of emergency mental health referrals to their service, distinguishing telephone and assessment referrals during weekdays, weekday nights and at weekends where possible.

This section brings together the audit evidence collected in both stages of the study to consider the extent of demand for emergency provision by CAMHS.

4.1 Audit evidence

Only about a quarter (21) of survey respondents were able to supply information on the number of emergency referrals their service received or the number of assessments undertaken. This data often related to varying time periods and to different types of referral, with some being unable to offer both telephone referral data and assessment data. Where services offered audits for shorter periods than 12 months, the data have been adjusted to an estimated annual figure. Most audits (11 reports) related to referrals during weekdays, when an average of 77 assessments (with a range of 10 to 190) were undertaken annually. Nine respondents were able to provide data separately for the three periods requested (Table 4), showing significantly fewer referrals at night and at weekends.

Table 4. Emergency referrals and assessments undertaken during 12 months*

	Weekdays		Nights		Weekends	
	Telephone	Assessment	Telephone	Assessment	Telephone	Assessment
Service 1		34		71		
Service 2		50		0		0
Service 3		120		12		
Service 4		14		50		18
Service 5		125		60		60
Service 6		106				32
Service 7	316	120	30	4	40	24
Service 8	60	50	8	4	4	2
Service 9	0	68	0	41	22	0

Source: TCRU survey, November 2006

* Audits for shorter periods have been adjusted to provide a 12 month estimate.

The absence of data in some sections of the table should not be interpreted as representing no referrals. Whilst it is possible to offer only limited comment on these data in terms of the level of demand for provision, the exercise highlights the problems of comparing audit data across services. The wide range of reported weekday assessments suggests that the size

of the population served by each service is likely to be the most dominant factor in determining demand for a service. Data for weekend referrals present marked differences in the ratio of telephone consultations to assessments, for example in one service 40 telephone consultations and 24 assessments compared to 22 telephone consultations but no assessments reported by another service. This almost certainly reflects the service protocols in place, and perhaps the availability of staff to undertake weekend assessments.

The survey asked about the number of assessments that took place under the Mental Health Act Section 12. Only 19 services offered information on this, with 10 services reporting no such assessments, three services reporting one or two, four services reporting 3-5 assessments and just two services reporting eight or more.

More detailed audit material was provided by some of the areas contacted In Stage 1 of the study and several services responding to the survey. One service with a three-level out-of-hours response reported a three-month audit in 2004 which recorded a monthly average of eight calls to the first level Senior House Officer (SHO) on call, and five each to the second level Specialist Registrar (SpR) and third level consultant psychiatrist. Whilst three of the eight contacts with the SHO were face-to-face, the majority of contacts at the higher level were by telephone. The consultant attended once in the three months, and there was one emergency admission to an in-patient unit.

Another three-month audit in early 2006 conducted across three A&E departments in one county reported 48 out-of-hours contacts (evenings and weekends) with children and young people. Eight required face-to-face assessments and five required an application for admission under the Mental Health Act. This audit also indicated that nine presentations (19%) were of looked-after children and that the majority (28) of presentations had had contact with CAMHS in the 12 months preceding their attendance.

An audit of 'inappropriate placement of CAMHS patients' by staff in acute hospital paediatric wards at two hospitals over a 16 month period from January 2004, identified 236 patients up to age 16 with self harm, overdose, alcohol intoxication, recreational drug overdose and underlying mental health issues. The patients represented 297 episodes. Almost half had presented at weekends, i.e. after 5pm on Fridays. Including presentations on weekday nights, 87% of these cases were effectively 'out of hours'. Around 55% of the presentations solely involved alcohol or drug misuse, 42% involved self harm including overdose, and 3% related to depression, psychosis or other mental health problems (Sakare et al., 2005).

An audit of out-of-hours contacts over 20 month by a CAMHS serving a population of 555,000 recorded 176 episodes (ie approximately two per week) of telephone or clinical assessment by medical team of consultants, SHOs and SpRs on weekday evenings or at weekends and bank holidays. Over 40% of the contacts related to episodes of self harm with 65% requiring clinical discussion, 22% a clinical assessment, 12% a protocol discussion and 2% a Mental Health Assessment. Seventy per cent of the contacts were completed by telephone, 11% in attendance at A&E, 11% in a paediatric ward and the remainder in a range of venues, including patients' homes, polices stations, and psychiatric receiving rooms. (Lovell et al.,2006).

An on-going audit of a medical service covering from four to seven hospital sites in the London area provided data for a three year period. This audit recorded an average of two emergency referrals per week, 14% of which required a face-to-face assessment by a SpR. For 15% of referrals, advice was sought from the on-call consultant psychiatrist.

Even without evidence from audits, commissioners interviewed in Stage 1 perceived the incidence of serious cases that required an immediate response to be rare, with implications for the level of service response. Whilst acknowledging shortcomings in emergency

provision, they questioned the need to provide a service for which they considered there was little demand and for which the cost of provision was seen to be expensive in relation to the level of unmet need

Because they don't happen often [...] to commission a whole service is not sensible.
(Commissioner, Area 12)

An argument with some currency is that demand for the out-of-hours and emergency response is service driven, so that where a good established service exists, demand appears. In other locations, where it is generally accepted that there is no access to a child psychiatrist or an assessment out-of-hours, other services do not seek that advice and so no demand registers. The experience of a service consulted in Stage 1 of this study supports this view. A service provider in Area 5 described how the likely demand for a crisis team response had been estimated at around six or seven cases per year. However, when the team began covering this role, they had been called much more frequently - six to seven times a month. There was evidence that the threshold for support had lowered, although the team was also developing its expertise in the area of child and adolescent support and had begun to cover a wider remit of case work than originally anticipated, to include self harm presentations as well as psychiatric emergencies.

4.2 A note on the value of audits

Children and young people can present at any time with a mental health problem that requires attention and appropriate management. However, the audit material collated by this study from a range of services suggests no clear cut picture of demand for a service out of hours. The audit data shows marked variation across services in the numbers of referrals and assessments recorded. These variations are almost certainly a reflection of the type of emergency provision available within each service and the protocols in place for referral pathways. A further factor will be the degree to which other services are involved in the referral process. A&E and paediatric departments and EDTs undertake their own assessments of what constitutes an 'emergency', requiring some level of CAMHS response. This represents a 'grey' area of demand, with each of the agencies involved having different perceptions and expectations of the threshold for on-call. For example, the presentation of young people with drug or alcohol misuse may trigger a CAMHS referral in some localities but not in others.

Despite these conflicting factors, data on the level of demand within each local area would seem to be an essential requirement for planning an appropriate and cost effective response. That this information is apparently lacking in so many services appears a cause for concern. A more systematic approach to audit, with links to the CAMHS Mapping exercise, would strengthen the evidence required to assess the level of need both locally and nationally. However, the results from this study would also suggest that audit data need to be used and assessed in the context of the specific service provision in which they are collected, and that any across cross-service comparisons should be treated cautiously.

5. CAMHS on-call provision

5.1 Introduction

The Royal College of Psychiatrists, the NSF (section 6.8 -6.10) and the National CAMHS Support Service all offer advice on how on-call provision might be provided. These suggest a number of options, from the conventional two- and three-level access to specialist mental health advice (initially a Senior House Officer, then possibly a Specialist Registrar and finally a consultant psychiatrist), through arrangements with adult services, to multi-disciplinary teams with specialist mental health back up. However, there is an acknowledgement that local resources, and the context in which services are set, limit provision and that one model of provision will be unlikely to offer the universal solution.

This chapter offers a more detailed account of the CAMHS provision for emergency cover as described by the commissioners and providers interviewed in Stage 1, incorporating information from the survey. The chapter then considers the advantages and disadvantages encountered in setting up and operating services as described by respondents in both stages of the study.

5.2 Consultant cover – the gold standard?

Commissioners and providers frequently referred to provision offered by a child consultant psychiatrist on-call round the clock as the 'gold standard', the 'holy grail' of CAMHS cover. Three of the services consulted in Stage 1 of this study provided this type of service. They consisted of two or three levels of on-call, either a specialist registrar as the first on-call and consultant psychiatrists as the second level, or a first level of SHOs followed by registrars and then consultants.

Around 40% of services responding to the survey reported at least two tiers of medical cover (consultants and SpRs and/or SHOs) available to undertake assessments during weekdays, with 35% and 37% reporting this system in place at weekends and at night (Table 5). A quarter of services reported that a consultant psychiatrist was available during weekdays supported by non-medical CAMHS team members also on call. In only a very small number of cases (4%) was the consultant psychiatrist the only member of the CAMHS team available during weekdays, although a more substantial proportion of services (12%) reported this to be the situation at night and weekends.

Table 5 Services reporting consultant psychiatrist and other medical cover (survey data)

	Weekdays	Weeknights	Week ends
Consultant undertakes assessments	55 (69%)	46 57%	45 56%
With CAMHS SpRs/SHOs	32 (40%)	30 37%	28 35%
With non-medical CAMHS team	20 (25%)	6 7%	7 9%
With others/alone	3 (4%)	10 12%	10 12%
Consultant available for telephone consultation	10 (12%)	11 (14%)	11 (14%)
With CAMHS SpRs/SHOs	3	6	6
With non-medical CAMHS team	3	0	2
With others/alone	4	5	3
No consultant available	17	26	26
CAMHS SpRs/SHOs	7	5	3
Non-medical CAMHS team	5	0	0
<i>Total services</i>	<i>80</i>	<i>81</i>	<i>80</i>

In both stages of the study, respondents commented that offering a full medical response was not always practicable. Lack of staff was mentioned by several respondents when discussing the disadvantages of providing this intense level of CAMHS cover. One described the normal working hours provision for emergencies as 'robust' - barring sickness, leave and overwhelming demand. Out of hours, a lack of staff could often mean that the first on-call layer of cover, provided by SHOs or SpRs, was missing so calls were referred directly to the second layer. One survey respondent perceived the future situation pessimistically, believing that providing this standard of cover would become increasingly difficult to sustain:

During 'out of hours'. the CAMHS Consultant on call is covering five boroughs, i.e. a large geographical area, total population of 1.2 million, and as we have only two CAMHS SpR's in the Trust each working a 1 in 6 [rota], for 67% of the time, he/she has only an SHO in each borough to work with, and the SHO may be very inexperienced. Also with the implementation of the EWTD [European Working Time Directive], this infrastructure will have to change. There will be fewer SHO's and more non-medical practitioners will have to be involved in the urgent first line assessment of under 16's, and these are likely to be predominantly adult trained. [Survey respondent]

Two areas, both large cities, described problems with maintaining consultant psychiatrist cover arising from long-term vacancies in the consultant posts. This resulted in the rota being maintained and covered by locum staff. One of these services had been initially self-funding when established six years ago, but resorting to locum cover required additional financing to maintain the system. The SpR rota was estimated to overspend by £100K - £120k per year, and the second-level consultant psychiatrist rota required the use of agency staff costing around £8000 each month.

Several survey respondents working in smaller teams identified the 'in hours' weekday provision as more problematic than out-of-hours. One described a day-time service that relied on a part time consultant psychiatrist and a part time SHO 'who is often absent because of exams, EWTD and annual leave, and very rarely a very part-time SpR'. They concluded that without an excellent hospital social work input, the day-time service would be unable to function effectively.

Indeed some services operating with only a limited staff acknowledged that the facility provided out of hours was better than that offered during the working day, especially where the service had resolved its out of hours provision by buying into services offered over a wider area. Others describe the disruption and strain on resources that emergency presentations and referrals create for clinicians during the working day.

The conduct of this work [emergency referrals] during the working day can put small CAMHS teams under strain, and sometimes has to be managed by cancelling or deferring more 'routine' work. [Survey respondent]

Day time on call system means that staff on rota cannot book in many other appointments for that day. This can be quite draining for an already stretched service. [Survey respondent]

Resource having to be set aside to respond to such requests which has a direct impact on the overall resource available to undertake routine casework. [Survey respondent]

Providing out-of-hours cover was also reported to impact on day-time services by creating additional pressure on stretched resources, with SHOs having time off following out-of-hours on call, leaving teams short of staff during the day to undertake the scheduled casework.

5.3 On-call telephone advice

In Stage 1 of the study, some areas that were unable to operate a full on-call rota to provide assessments at all times offered consultant psychiatrist advice and consultation by telephone instead at nights and weekends.

Table 5 (p18) shows that 12% of the services responding to the survey provided on-call emergency telephone consultation and advice from a psychiatrist during weekdays, and 14% at nights and weekends. In about half of these services, other members of the CAMHS team (medical and non-medical) were available to undertake emergency assessments with the consultant psychiatrist providing telephone backup.

The audit data presented in Chapter 4, although limited, suggests that advice may be sufficient in the majority of presentations, and that a physical presence for immediate assessment is likely to be required in only a small proportion of cases. Respondents in Stage 1 emphasised that telephone advice systems are able to assist front line staff in urgent and immediate assessment, even if they do not formally offer immediate and 24-hour access to a CAMHS assessment. Most areas that operated this type of provision were able to fulfil the requirement to assess within 24 hours or the next working day. Providers who offered telephone on-call arrangements commented that although these systems do not guarantee that a referral will receive an out-of-hours assessment from a specialist, in general, the urgent necessity for a face-to-face assessment would not go unmet, despite the lack of formal contracts.

Telephone-only consultation is provided by a CAMHS manager and a consultant who get an on-call allowance for the telephone consultation – they do not go out officially, but they do if necessary [Commissioner, Area11]

Whilst telephone on-call was provided by staff working in Tiers 2 or 3 in some areas, several interviewees and survey respondents reported arrangements with Tier 4 services for providing advice, guidance and consultations at night and weekends. Two services in the survey reported that advice and assessment were available from Tier 4 at all times; one that this was available at weekends only, and five during weekdays. A further three reported telephone advice only (with no assessment) at all times, whilst another two reported this as part of their out-of-hours arrangements and another as available on the weekdays only.

Whilst units that offer emergency admission are often able to offer medical on-call and assessment, it was more common for units to provide advice and consultation but not face to face assessments. In Stage 1 of the study, several areas described an on-call service provided by nurses on duty at a local 24-hour in-patient unit. In one of these, although staff in the unit were unable to travel out to undertake assessments, they would nevertheless undertake assessments if it the patient could be brought to them. Another provider described a local Tier 4 unit that had unofficially served as a source of advice for the district, a system that operated with goodwill and flexibility. Generally, the nurses on duty in the in-patient unit were able to reassure professionals making referrals and rarely needed to contact the higher level of on-call:

When that operated, informally everyone knew that [Tier 4 unit] offered advice – worked without a problem – rarely needed to phone a consultant but whenever they

did, no problem. They were not paid but regarded that as part of their job. [Provider, Area 8]

This respondent reported that the system had been based on good relationships and flexibility and that staff had expressed some feeling of resentment when a more rigid system, with duties written into contracts had been introduced.

5.4 Formal Protocols

As the issue of informal arrangements for on-call provision was raised in Stage 1 of the study, it was decided that the survey would include a section on commissioning and protocols. Only around half of services (43) reported that arrangements for on-call cover were supported by commissioning or by protocols rather than by informal agreements. Sixteen (20%) reported no formal arrangements in place and 18 (23%) that some aspects of the service are covered by formal commission or protocols.

A respondent from one mental health trust noted that whilst the out-of-hours arrangements were covered by formal agreements, none was supported by specific funding from commissioners so cover had to be provided from existing CAMHS resources.

Where arrangements were only partly covered by formal agreements, this sometimes referred to the different commissioning arrangements for different periods of cover. One survey respondent explained that arrangements for weekdays and nights were part of the local CAMHS delivery and had been in place prior to the 24/7 proxy measure, whilst the weekend service operated as part of a wider partnership arrangement. Several services reported that commissioning arrangements and Service Level Agreements (SLAs) were still being formalised but would be completed by the beginning of 2007. Several added the proviso that commissioning was for a pilot period only and would be reviewed later, with continued commissioner support likely to be related to the demand for the service.

One respondent described the commissioning anomalies that arose with a CAMHS based at a hospital serving a population from a wide area. The day-time on-call service was funded by one of the PCTs in the area, but in effect dealt with young people from other PCTs in the hospital catchment area.

Day-time on-call is funded only by one PCT but may see YP [young people] from others without a formalised agreement with their PCT of origin. With YP from outside the PCT, it can also be difficult to arrange for them to be followed up in their PCT of origin and are sometimes not picked up within the required 7 days. This creates an extra drain on limited resources as the department must provide follow up until then. [Survey respondent]

Of those services with no formal protocols, one team reported that all its arrangements had been set up by the local CAMHS team in order to meet national target for 24/7 cover, with an effect on other work:

As yet there has been no commissioning and no support from the PCT to support the on call work, other tasks are being left uncompleted so that the on call can be covered. [Survey respondent]

As found in Stage 1 of the study, several survey respondents working in services with no out-of-hours cover highlighted the role of goodwill rather than specifically commissioned services or formalised agreements:

There are some young people for whom an emergency assessment is important and we really rely on the goodwill of an individual to provide this rather than it being a commissioned service. [Survey respondent]

We are aware that we do not provide an adequate on call service at the weekend. There has in fact been an informal arrangement between the Consultant Child and Adolescent Psychiatrist and the paediatric ward that the young people are admitted to. He will sometimes be called in at the weekend to see young people though this is an informal agreement. [Survey respondent]

5.5 Barriers to CAMHS on-call provision

In areas with sufficient staff and where on-call duties are written into contracts, this provision offers a robust service that combines an appropriate and timely response. However it requires a 'critical mass' of staff resources to set a rota that is not exceptionally onerous. Services that resort to locum or agency staff to fill gaps usually find the system to be financially burdensome, but where these systems for providing 24-hour access to a CAMHS specialist are well established, there is a reticence to change to another form of cover which would be perceived to be of a 'lesser' quality.

Whilst respondents in both stages of this study believed that the services they offer are good in terms of providing appropriate responses in emergency situations, they nevertheless acknowledged a number of problems in maintaining or attempting to improve their services. These related to resources, principally lack of staff or problems with establishing new contractual arrangements to provide out of hours services. For some, more funding was seen as the only answer. Respondents from some smaller services reported that a history of limited investment in CAMHS had resulted in their community services being severely overstretched and the limitations of their services often discouraged potential recruits from applying for vacant posts.

One respondent interviewed in Stage 1 believed that the issue of under-resourcing had not been well managed by the government, and the recent increase in the CAMHS grant, being calculated on a percentage basis, had been of only limited benefit to those services that were already under resourced:

10% where you have a quarter of a child psychiatrist and one Community Psychiatric Nurse is practically nothing, while [for] a good service, well staffed, 10% is a lot. [CAMHS specialist]

It was suggested that a better distribution of the grant would be on the basis of estimated demand in terms of population, so that areas that were poorly funded would have received a bigger boost than those which were already relatively well resourced.

Many areas had considered ways in which they might improve their existing cover, either to conform to the new target or to ensure that their current provision remained viable and cost effective. Widening the staffing complement for out-of-hours rotas by increasing the numbers on the rota or by expanding the skill mix by incorporating different grades of staff was touched on by both interviewees and survey respondents.

To address the issue of overspend in maintaining a medical on call rota, one area had increased the number of training Specialist Registrar posts and negotiated changes in the job plans of staff grades to include rota duties. This had generally proved more easily achieved

than had first been anticipated, as one part-time member of staff at the Tier 4 unit was enthusiastic about joining the duty rota, in which she already participated on a locum basis. At other locations in the area, where there were significant vacancies, staff were more reluctant to renegotiate contracts to take on rota duties. There had been costs attached to renegotiating contracts, but in relation to the cost of locum cover, this was judged more than acceptable. The intensity of the rota was negotiated at 1 to 6 (on call once every six working days) for the first level of on-call cover.

Other areas reported less successful attempts to encourage staff to join on call rotas, particularly where staffing levels were low. Several providers reported that it was not possible to encourage staff to provide on-call when this was not already part of their contracts. One interviewee reported that the nursing staff displayed no enthusiasm to take up the duty, partly because no medical back up would be provided for them and partly because the money offered was not sufficient inducement for the low ratio the rota would require.

If they set up a system of nurse on-call, I think it will be very difficult to persuade them to do it – I don't think they will be happy to do it without back up from a psychiatrist – in other areas of [county] they do have psychiatrist back up. Down there they haven't and so I don't think they would do it. I said to my nurses that they were offering to pay £30 to do a shift from 5pm until 9am for psychiatric emergencies and my nurses all said no. Even with another consultant, you need a critical mass of staff, either doctors or others and offering to pay people isn't going to be enough – I've only got three nurses in the team. [Provider, Area 4]

Another area had faced this problem when trying to set up cover for weekends and the solution had come from employing Tier 4 nurses 'who were used to being on call' and who had willingly agreed to take on the role.

Tier 4 staff are used to coming out at odd hours where our own Tier 3 staff don't do that at the weekends [Commissioner, Area 13]

In another area, a commissioner reported their failure to entice a consultant psychiatrist to work on call.

Money resources have never been an issue – financially no obstacle if we could get access to a service – but no amount of coercion or persuasion has enabled us to get access to a CAMHS consultant out of hours. They don't want to do it – they get paid enough for the day job! [Commissioner, Area 5]

Another area had involved the consultant psychiatrists in re-writing the on-call protocol and attempted to include an on-call requirement in consultants' contracts. However there was resistance by some to taking on the on-call, so with not all consultant psychiatrists participating in the rota, locums continued to be employed to achieve a rota of 1 to 14. The consultants blamed the on-call contract for problems in recruiting for vacant posts, as potential new staff were discouraged from joining, preferring to work in other localities that did not require them to undertake this duty:

Older consultants find it onerous and would say that they have always offered informal arrangements for on-call – and that is partly true - they do attend when called. [Provider, Area 7]

One consultant psychiatrist acknowledged that whilst nursing skills would be a valuable addition to the out-of-hours team, extending the geographic area of the on-call would be less acceptable, even with the incentive that this would reduce the frequency of rota duty.

For those of us who have been doing a 1 in 4 or 1 in 5 [rota] for some time with just an SHO on call with us, the idea that we might have other staff particularly nurses on call as well is very promising. We cover an area of 480,000 and would resist any idea of covering a larger patch. Although the frequency of our on-call is quite onerous, my 4 colleagues and I would not wish to cover a larger area even if the frequency decreased as knowing the local services and staff is an essential part of our OOH [out of hours] success. [Survey respondent]

Encouraging non medical CAMHS staff to join the rota was not the only reported barrier to widening the skill mix for on call. In one area the suggestion had not been received favourably by the consultant psychiatrists. The latter had raised concerns that they would be reliant on non-medical staff to make clinical decisions on their behalf for which ultimately they, as consultants, would be responsible. They believed that where a child presented with a high level of need, the assessment would be required to be undertaken by ‘*someone with a comparable training*’, in other words, a psychiatrist. Another area had piloted a scheme for one year with specialist nurses based in the general hospital as the first on-call. A consultant psychiatrist provided the second level of on-call. The scheme was discontinued as not cost effective because the referrals were generally from ward staff requesting an instant assessment, resulting in the consultant psychiatrist being called in most cases. In addition, the nursing staff reported that the additional payment (approximately £35 per session) was not sufficient inducement to take on the additional responsibility required.

Smaller services reported that they had explored linking with others to create the ‘critical mass’ needed, or to tap into other neighbouring services. Making links across services had raised a number of issues around willingness to cooperate, resources and the plethora of contractual arrangements. One commissioner working across four different boroughs was attempting to marry together CAMHS providers who were working to differing arrangements in relation to 16 and 17 year-olds; consultant psychiatrists working to different contracts and, on top of this, some difficult financial negotiations due to some of the services being wealthier than others.

A CAMHS Strategy Group reported similar problems establishing a county-wide service in an area where CAMHS services were commissioned by three different trusts. Each trust was providing a 1 to 4 rota of consultant psychiatrists as first on-call, and the Strategy Group had explored the possibility of establishing a county-wide rota that would reduce the on-call requirement to 1 in 12. However, several problems had been encountered. Firstly, the consultants’ contracts varied across the three trusts and although they were being used as first on-call this was not a common feature in their contracts. Additionally, consultant psychiatrists in two trusts were reluctant to commit to providing cover for the third trust where a breakdown in protocols with adult mental health services and paediatric departments had led to ward staff demanding immediate consultant psychiatric assessment at all times.

Other areas were not even in the position of being able to start negotiations with their neighbours. Several had found no one wishing to extend their current area of service.

Because they don’t want to cover this area – even if we put our two consultants on the rota, the nearest place with an in-patient unit is [town 40 miles away] and they are not interested in offering cover. There are people here who would be willing to join an on-call rota, to be a one-in-seven or one-in-eight, but there is no one to join up with. So as things stand, not going to do it. [Provider, Area 4]

Another service that relied on ‘spot purchasing’ the services of a child psychiatrist from a city 90 minutes away, and Tier 4 beds from another area, described the constraints:

We've got to work with people who want to work with us and often people have got enough on their own plates already – so they don't want to take on any more. It's not in their interests to travel an hour and a half. [Provider, Area 5]

Another described their natural neighbours as well provided for with 'excellent CAMHS services', but with no incentive to extend this to others:

They wouldn't want to come to us – we are the poor relation and we have nothing to offer them – we often look to them for advice and guidance and whatever. [Commissioner, Area 12]

5.6 A comprehensive change of culture

For some of those interviewed in Stage 1 of the study, the changes required for the 24/7 target needed to be viewed within the wider context of the changes that CAMHS is required to undergo to achieve all the targets of a comprehensive service. There was a feeling that resistance by some services was part of a long-established culture not to move on, and that other agencies and services, faced with the same problems, had actively addressed the issues and developed solutions. One CAMHS specialist believed that services that were not developing new ways to meet the target often had long-standing problems with their working ethos:

Other teams will not touch it [24-hour cover] with a bargepole, it's not what they are paid to do and they are not paid enough...It's team culture and leadership and management. They've been left alone for years with poor management, just to get on with things and they are defensive and difficult. So their response to 24/7 is part of being difficult about everything. So they're likely to have a range of problems – so they need good management and investment – not just money but time. [CAMHS specialist]

Several survey respondents also referred to the need for a change of culture within CAMHS, but noted that the process of change had to be carefully managed and at a measured pace, to ensure that staff remained supportive to alterations to their roles.

At present, it is limited to Consultants on call and this in itself is limited in scope. It is a very different 'mindset' for many staff and therefore we are deliberately introducing it incrementally, to support them during the change process and enable us to more robustly identify need and demand...currently the out-of-hours on-call arrangements are medical, we would like to move towards a multi disciplinary on-call system. However we will need to develop this slowly, our experience of putting in place a multi-disciplinary on-call Mon-Fri 9-5 took many months to support, contain and train staff to feel comfortable and capable of providing this service. [Survey respondent]

There are considerable cultural changes to overcome to enable staff to work in a way they find very different from the clinic-based treatment model they are used to functioning within. This whole process of change is part of the much bigger shifts we are making to modernize our CAMH services, introducing CPA [Care Programme Approach], Care Coordination, a community model of service delivery and "new ways of working" for all staff. There also needs to be associated skill mix review to broaden the range of staff available to support these changes, currently we have a very top heavy skill mix, that make on-call unworkable due to staff numbers. [Survey respondent]

6. The role of other providers

The survey data presented in Chapter 3 described a significant proportion of CAMHS relying on other services, particularly paediatric teams, Emergency Duty Teams (EDTs - both child and adult teams) and adult psychiatric teams to undertake assessments as part of the management of emergency presentations. Additionally, many respondents to the survey commented on the supportive and essential role played by these other services in the successful management of patients, and consequently the need for good working relationships with their partners, even when CAMHS staff themselves able to offer an on-call service.

This chapter considers the particular role of adult mental health services, multi-disciplinary teams and EDTs in managing emergency presentations when CAMHS are unable to provide an on call service at all times.

6.1 Shared arrangement with adult mental health

Whilst only three of the 84 services that responded to the survey relied exclusively on adult services to provide on-call at night and weekends, over a quarter of services indicated that adult services were available to assist CAMHS staff with assessments. Respondents in both stages of this study offered examples of relationships with adult services which suggested that some were easier to engage in partnerships than others. For some CAMHS, cooperation with adult services resulted from long-standing arrangements that had worked with few problems for many years, whilst for others, a lack of resources required a short-term solution towards achieving 24/7 via adult services, perceived to be '*making the best of what we've got*'.

Some long standing arrangements were being questioned, with one adult service reported to be asking why CAMHS did not provide on-call in the same way that other services did. It was customary in that area for the duty adult psychiatrist to be asked to undertake assessments of children out of hours, and although some did this beyond their formal duty, others declined on the grounds that they considered their competence and training to be inadequate for the task. A respondent in another area noted that:

Most [adult service] consultants will turn out if required, even though it's not in their contract to do so. Some will not assess 15 year-olds, so problems come when a child is in a police cell and the psychiatrist will not assess because he or she feels that it is beyond their capability. [Provider, Area 9]

Some areas retained their long-standing 'understandings' with the adult mental health services to provide a first on-call response out of hours to A&E departments or at other sites such as police stations. This first assessment was often backed up with CAMHS advice by telephone.

Advantages of what we have at present is that we have an on-call facility – if someone goes through A&E they are assessed by the on-call adult service SHO - get more than access to adult provision as they can speak to someone from CAMHS. The downside is if someone needs to be physically seen by a CAMHS consultant – then there is no official protocol for that. [Commissioner, Area 11]

One CAMHS specialist believed that access to advice from CAMHS provided the important back up that permitted adult services to safely take charge until the next day.

Often adult mental health practitioners were happy to deal with those young people if they could talk to you on the phone, either from a management point of view, 'Where are we going to move them to in the morning? What is my legal position over Child Protection?' And perhaps speak to a consultant with children's experience about their care overnight, but their biggest concern is to keep them safe and move them out the next day. [CAMHS specialist]

Several CAMHS described initiatives they had undertaken to improve relationships by investing resources into adult services and providing specific training for staff in adult teams. In some cases this was earmarked for use with young people aged 16 and over, as in one service where the CAMHS consultant psychiatrist had become part of the adult rota to resolve a mismatch of provision to 16 and 17 year-olds; in others the CAMHS investment in adult services was to benefit children of all ages:

Our service has a positive arrangement with Adult Psychiatrists providing the first on-call in A&E and undertaking assessments. Supportive to the clinicians involved. The CAMHS invested in a post with the Adult Team (originally self harm team) and developed a post that was CAMHS focussed. [Survey respondent]

Several interviewees in Stage 1 had considered providing cover via adult services, but on balance had decided against this route, often for administrative reasons. In one case, the commissioning team had raised concerns that the low level of demand would result in the team rarely practising its skills and consequently, staff would not gain the experience necessary to undertake assessments of children and young people.

6.2 Multi-disciplinary, multi-agency response

Several areas consulted in Stage 1 believed that a multi-agency response would offer the best provision for children and young people. This would ensure that the range of problems that tend to surround emergency presentations and which frequently require the intervention of social care agencies would be resolved more appropriately than if mental health services alone provided the initial response. The survey data suggest that over a quarter of CAMHS have Children's EDTs on call to assist with out-of-hours emergency referrals and assessments.

In Stage 1 several areas reported that they were engaged in exploring ways of creating a multi-agency response, either to improve their existing 24/7 cover or in some cases to provide a viable response to the PSA target when the CAMHS alone could not sustain the necessary cover.

Negotiation to devise ways of working with other services had proved problematic for several services, faced with either bringing together a range of services or one service working in different ways across one area, or both. A good model of negotiation was provided in Stage 1 of this study where the Director of Commissioning in a PCT convened monthly meetings to bring together key individuals at a senior level in the unitary authority, in order to '*unblock the blockages*'. They included members of the A&E department, children's wards, the Children's Lead in the Local Authority, the crisis team and the LEA. Each month, key actions for individuals were identified and dates set by which tasks were to be completed. This strategy of forming a group had been adopted after eight months when other methods of negotiation had failed to make any progress.

The crisis team were a bit apprehensive to begin with but once we'd talked it through, and they were clear that we could offer training and they had a letter from the Chief Exec to say that the PCT would provide cover in terms for vicarious liability so that they knew that it was legally supported. Once that was done, they found it an

interesting experience.What we did was invest money in the crisis team once they said they were willing to take it on. One, for extra staff to provide the 24/7 cover and two, to provide some focused training for those who were going to provide that support – to A&E and the children’s ward - so that they would feel competent to assess some of these children. [Commissioner, Area 5]

The team consisted of social workers and mental health trained nurses, provided to the PCT and attached to mental health with links with adult psychiatry. Given the ongoing problems of recruiting a CAMHS consultant psychiatrist in the area, members of the crisis team planned to undergo training to enable them to undertake CAMHS assessments themselves. The multi-agency group met monthly to monitor and review the service.

To improve the 24/7 cover offered, two other areas (10 and 13) reported pilot schemes to extend their services to offer mental health assessments at the weekend. Both involved partnerships between CAMHS non-medical staff and local social services teams. One (Area 10) began piloting a scheme for a non-medical member of the CAMHS team to work with the county-wide EDT. The CAMHS input provided mental health assessments from 9am to 5pm at weekends, in cooperation with the Approved Social Workers (ASWs) and a placement stability worker for looked-after children from the EDT. Patients admitted to a ward were assessed by the CAMHS, after initial assessment by the other services so that problems relating to placement breakdowns would have been resolved before the CAMHS worker became involved. A CAMHS consultant psychiatrist provided telephone on-call advice and consultation. The estimated cost for a six-month pilot was around £20,000, which included a portion for funding mental health awareness training for A&E and paediatric staff.

The second service (Area 13) began piloting a similar six-month scheme offering assessment on weekend and bank holiday mornings provided by a nurse and an ASW. An audit of admissions to paediatric wards had identified that many admissions were a consequence of substance misuse, and that mental health assessments were only required about two or three times each month. The pilot was being funded from ‘slippage’, non-recurring CAMHS funding, with an estimated annual cost of £16,000. The nurse (recruited from local Tier 4 services) received £75 per session, but the total cost also covered the budget for the neighbouring trust to provide telephone on-call medical advice when required. Additionally, the substance misuse team attached a worker to the service to offer advice and referrals from the wards.

In the examples described above, the participants were enthusiastic that the key part of any future service should be the multi-agency approach offered by partnership, providing the opportunity for agencies to work together to gain a better understanding of the part each plays, and the challenges that each faces in terms of the resources they are able to access.

We will try to maintain the partnership approach after the pilot. If you just have a health response to those young people, you’ll turn up on the ward and be assessed as having no mental health risk but there may be a social care response if a placement is required. So that everyone - mental health, the ward and the social care staff - will all have an understanding of each others criteria, and thresholds and responses and being to be able to carry that with them in their toolkit so that in the future they don’t both need to be called out. [Commissioner, Area 13]

Concerns were expressed by the commissioners of both these pilot schemes that audits would indicate a low call-out rate and that the schemes would be evaluated as not providing value for money in terms of the number of cases handled. In that event, the alternative strategy would be to encourage CAMHS staff to take on the out-of-hours role, despite their expected reluctance to extend the present contractual arrangements.

7. Costing on-call cover

In the first stage of the study, interviewees commented on the financial cost of offering on-call and out-of-hours provision. For some, an out-of-hours medical response was well established but shortages of staff had alerted some commissioners and providers to the high costs involved in providing two or three layers of medical cover at all times. Others, seeking to establish a new service to comply with the PSA target, sometimes took the view that they might be putting in place a service that would not be cost effective, described by one as "a bit of a sledge hammer to crack a nut", and that the service would cost more than the demand for it would justify.

To find out more about the costs of providing out-of-hours services, the survey asked for any data which respondents could provide on the costs to the service of providing out-of-hours cover, ie at nights and weekends. Only 22 services provided data on costs, with some reporting this as an annual sum whilst others gave a specific rate per out-of-hours session, or reported costs as proportions of pay scales. The information is thus presented in two separate tables but as other contextual data, such as the numbers on rota, was not available the tables are able to offer only a very limited picture of costings .

Table 6 shows the data provided on annual costs of out-of-hours services. There are some substantial differences in the annual costs reported by different CAMHS describing very similar types of provision. This may be a consequence of differences in the size of areas covered, so that some may be dealing with a heavier out-of-hours workload of referrals. Alternatively, some areas may benefit from economies of scale, such as those reported by services that take part in a contracting out of their night and weekend cover.

The cost of services that report a consultant psychiatrist available to undertake assessments at nights and weekends, range from a very economical £20,000 per year to over £270,000, but with several services reporting costs in the region of £100,000. Services offering CAMHS medical and non-medical staff on call, with telephone advice from a consultant psychiatrist, report an annual cost of between £70-80,000. Services that contract out medical cover report costs substantially less than this, £16,000 to £40,000. An adult crisis team supported by CAMHS non-medical telephone advice was reported to cost £25,000, while a service using Child and Adult EDTs reported an annual cost of £80,000.

Table 6 Sample costs of out-of-hours provision, per annum (survey data)

Type of out of hours provision	Annual cost
CAMHS teams available at all times, consultants, other medical and non medical team.	Nurse-On-Call Service @ £25,000(exact) Medics @ £50,000(estimated)
CAMHS consultant and other medical staff available weeknights and weekends. ASW service	£278,650.
Consultant and non-medical CAMHS on call week nights and weekends	£30,000 estimated
Consultant on call week nights and weekends	£90,000 consultant and medic costs. £20,000 for deliberate self harm team.
Consultants on call at all times - paid according to on call contract	£120,000
Consultants on call at all times, Tier 4 telephone back up at weekends	£20,000
Weekend medical and non-medical CAMHS team with consultant telephone backup.	£72,000

Non-medical CAMHS team for assessments. CAMHS consultant available nights/ telephone weekends. Telephone back up from Tier 4.	£88,000
Contracted out evenings and weekends– SHO/Consultant on call, Tier 4 for telephone backup	£16,000
Contracted out- SpR cover + on call consultant backup	£40,000 estimated
Assessments provided by adult crisis team supported by the CAMHS non medical team via telephone advice	£25,000
Assessments provided by EDT (child and adult teams) weeknights and weekends	£80,000

Table 7 presents the data provided by survey respondents who described the costs of out-of-hours cover in terms of staff pay scales rather than as an annual sum. Again, the data submitted by services show substantial variation.

Table 7 Sample rates for night and weekend on- call cover (survey data)

Consultant rate night and weekend on-call cover *	SpR and SHO rates night and weekend on-call cover*	Non medical team and social care teams night and weekend cover*
Consultants paid 50% of their salary pro rata for a 1 in 6 on-call rota		
Consultant salary includes 0.5 pa unpredictable on call	SHO salary appropriately banded	
£30 per hour locum fees for 1 in 8 rota. Rest of rota costs covered by annual allocation in consultant contract.		
On call cost varies with scale		Weekend £64 -£128 per day dependent on whether called/required to attend.
Consultants - Category A (5%)	SpR - 1A (50%) SHO - 1B (40%)	
Consultants on call (2 days in 5) supplement B.	SpRs work 1 in 6 (2 days in 5)	
Consultants <i>weekend cover only</i> , which is 10% of their salary.		Children and Young People's team £6,000 per week. New AFC [Agenda for Change] arrangements 8% of salary (£11,200)
		Advice standby £220 per week ie £20 per night and £30 per 12 hours at weekends. Attendance £30 per hour
		Six staff on rota @ £100 per month (MDT) Weekend locum cover 2 in 8 rota @ £35.00 per hour

* except where otherwise indicated

8. The Emergency Response

The provision of a specialist mental health assessment described in earlier chapters is just one part of the process of care that needs to be activated when a child or young person requires emergency help. There is increasing awareness that a psychiatric assessment alone does not offer the answer to all the issues that need to be addressed when a child or young person experiences a mental health crisis, and that an emergency response is required in a wide range of different circumstances. As one CAMHS specialist observed, the advice needed at the time of an emergency presentation is often not clinical, but concerns more mundane issues such as the availability of resources:

It doesn't have to be medical – sometimes it may have to be, but those occasions are quite rare. It's making sure an admission is safe and reassuring people.....The manager on-call system was the most used – because in the end, it wasn't the clinical questions that people wanted answered, it was the 'What are we going to do with this child tomorrow? Which bed can we put them in?', that sort of thing. It certainly doesn't require a consultant and often it didn't require any specialised clinical knowledge, just a knowledge of local available resources.

This section of the report describes commissioners' and providers' views of the place of the 24/7 CAMHS response within the wider framework of care that children and young people receive when presenting in an emergency. Again, audit evidence and respondents' comments suggest that the majority of emergency presentations and referrals arise from A&E departments and wards of hospitals. Whilst many services offer advice and consultation to a range of professionals, including GPs, police doctors and social workers, only a very small proportion of assessments are conducted outside the A&E or hospital setting, such as in police custody suites.

8.1 Assessment in A&E

Whilst some mental health assessments of children and young people are conducted in A&E during routine hours, many assessments now take place on a ward. This is in response to NICE guidelines for management of self harm patients, the four-hour waiting target for A&E, and because the majority of presentations tend to occur out of hours.

A&E don't feel all that confident about dealing with children with psychiatric problems and they are happier that the four hour wait is the priority. They can get them onto beds quickly – we don't do assessments in A&E, they are done on wards - none are done in A&E. [Provider, Area 4]

However, an important component of the 24/7 target is the initial urgent assessment for which a range of services are responsible, including A&E. Several respondents described the ways in which they had addressed the need for A&E staff and ward staff to be better equipped to make initial assessments. This involved developing assessment tools for use in A&E or by other professionals, to assist decision making regarding the need for mental health assessment. One area described how the introduction of the services of a crisis team had meant that A&E and hospital staff needed to be provided with guidance to help them assess when to call on the crisis team.

A&E staff and other front line workers don't recognise their role in CAMHS and it's down to developing their skills and specifications to deal with this, at the lower level of need and how they will work with CAMHS professionals. [Provider, Area 5]

In this area, the CAMHS team had worked with A&E and the Emergency Duty Team to devise a risk assessment tool which A&E and ward staff were then trained to use, to identify risk when young people presented with self-harm. Patients assessed to be of medium to high risk were then referred to the crisis team. Both the commissioner and the CAMHS provider believed that because of this training, A&E staff were now more competent at recognising risk and had greater confidence to identify when or if a crisis referral was necessary. In two other areas, audits had indicated high levels of substance misuse among young people arriving in an emergency. Additional tools were therefore developed for A&E and ward staff to help them identify risk around intoxication, so that appropriate referrals could be made to other agencies rather than always requesting a mental health response.

For some respondents, identifying appropriate responses at the initial urgent assessment was only one aspect of ensuring that front line non-CAMHS staff were prepared for their initial contact with the child or young person at the time of an emergency. Recognising a potential mental health issue required all staff to be skilled and trained.

Involvement of A&E staff, ward nursing staff and Paediatric Registrars ensures that mental ill health is taken as seriously as physical ill health within the Acute Trust setting. [Survey respondent]

In the TCRU survey, questions were asked specifically about training in dealing with emergency mental health referrals for front line staff in A&E and paediatric departments. Around 80% of services (67) reported that they provided such training, generally on an irregular basis when requested or as needed. Only nine services (approximately 10%) reported that training was provided at least quarterly, 20 (around a quarter) that it happened at six monthly intervals, and for six services, training was offered on an annual basis.

The training typically aimed to provide staff, particularly newly placed SHOs, with a review of protocols for referral. A standard training programme was described by one survey respondent as follows:

The funding for the CAMHS contract is allied to provision of teaching within the Acute Trust and a CAMHS Consultant attends the teaching meetings within the Paediatric Directorate on a six monthly basis to ensure that staff are aware of the protocols in place. Training for new SHO's is delivered in this manner and new nursing staff also receive training. [Survey respondent]

Such training was reported to be part of a Service Level Agreement by less than one in ten of survey respondents, although others commented that the training role was integral to the work of CAMHS.

It is part of the child and adolescent mental health liaison service to provide training and development for hospital staff in the mental health and communicating with, and care of, children and young people. [Survey respondent]

Several respondents referred to the important role of liaison teams in developing relevant training and the importance of regular meetings between departments, particularly CAMHS, A&E and Paediatrics. As well as structured training, less formal instruction through discussion of specific cases helped improve understanding and foster skills among non-CAMHS professionals.

There is a multidisciplinary meeting every week where some of these issues may be discussed in relation to a specific case, of which there are quite a few in an average year. [Survey respondent]

Our consultant psychiatrist provides 3 sessions a week to the acute paediatric service, which includes regular training. We meet on a monthly basis with community paediatricians and have regular input into the SHO training. [Survey respondent]

Only a very few services described specific funding being set aside for training programmes:

CAMHS Learning and Development Co-ordinator post funded non-recurrently through multi-agency CAMHS strategy to provide education across all tiers on a multi-agency basis. This includes CAMHS training to adult mental health, acute paediatrics and A&E. Some additional training also provided on ad hoc basis around particular issues eg DSH [Deliberate Self Harm] by locality CAMHS teams. [Survey respondent]

However the training provided by some services may be limited in scope, for example one service describes the training offered as 'risk management training and child protection training'.

Eleven CAMH services reported in the survey that they did not provide training to other departments, although one had done so in the past and another service reported that its offer to train paediatric colleagues had been declined.

The value of training (or regular meetings) was highlighted by several survey respondents.

Due to the relatively small numbers of children requiring emergency provision, out of hours and at the weekend, the Paediatric Registrar would manage the situation, with second on call back up. This means that we need to ensure that the Registrars are well trained and versed in psychotic illness and deliberate self harm. [Survey respondent]

Also mentioned was the need to work at maintaining a regular programme, to compensate for changes in staffing and also the rarity of presentations which gave staff little opportunity to practise skills.

DSH rota provides non-medic based first point of contact for assessment and reduces unnecessary calls to medics plus this service offers training support and advice to acute trust staff who now feel more confident with their decision making. [Survey respondent]

Respondents commonly reported that relations with their A&E departments and paediatric wards improved as issues around assessment and pathways of care became better defined.

8.2 Admission to a ward

Most 24/7 CAMHS continued to make use of paediatric wards, but were working to minimise risks by reducing the duration of admissions and by improving support to the ward in terms of additional nursing staff, training and contact support to paediatric staff. However, relationships with paediatric wards were sometimes strained if a clutch of patients arrived at the same time, or if negotiation of a placement in a Tier 4 unit was protracted. Despite this, many interviewees and survey respondents, with a minority of exceptions, described enjoying good relations with the paediatric staff:

The on-call arrangements, although somewhat skeletal, work well because of the goodwill of our paediatricians who will admit psychiatric cases over the weekend if a Tier 4 bed cannot be found (this is the rule rather than the exception) and our good relationship with out-of-hours social services in 2 of the 3 areas we cover. [Survey respondent]

There is an understanding that we provide as good a service as we can and that it's a commissioning issue ...they[ward staff] understand that this is not a lack of willingness from the people giving the service and there's a feeling that we are all in this together. Some [young people] are stuck there, waiting for an assessment and some are there because there is no place of safety for them to go to and they present a challenge to the staff. [Provider, Area 3]

Interviewees were aware that where a mental health assessment could not be made until the next working day and a crisis occurred at a weekend, or worse still a bank holiday weekend, this presented challenges to ward staff and did not provide the best option for the young person. This was particularly so if the young person was 'acting out' or being physically aggressive, with complex problems that might include learning disabilities or substance misuse but not specifically mental health problems. A PCT lead on CAMHS strategy described a situation that is almost certainly repeated elsewhere, where paediatric ward staff demanded urgent action from CAMHS in some situations, despite their usual willingness and ability to cope confidently with similar admissions:

Quite often I'll get a call from the ward manager to say, for example they had three 16 year-old girls in there, not wanting to be there but under NICE guidelines they have to remain until assessed and the ward manager's view was that they were causing a bit of a rumpus – 'Get them out of here'. Usually they are fine, they are not lacking the skills to cope with that. Paeds come to the CAMHS Strategy Group. Training is available if they were struggling, but they seem confident to cope. [Commissioner, Area 12]

Several services provided copies of policies concerning the admission of young people to adult wards, outlining the additional support which ward staff could expect from CAMHS when mental health assessments were delayed or when transfer to a Tier 4 unit was held up. Examples were also given of wards making the best use of the facilities available to meet young people's mental health needs such as providing single rooms and individual nursing.

However, some services described pressure from staff in A&E to provide more rapid mental health assessments, on the grounds that ward staff did not feel competent to manage patients, particularly with regard to discharging young people without a CAMHS assessment.

8.3 'Not a mental health problem'

Interviewees in Stage 1 of this study highlighted the issue of emergency mental health assessments that resulted in a young person being assessed as not having a mental health problem. These sometimes occurred in hospital and sometimes in other settings, such as police custody suites when a young person was behaving erratically or had misused alcohol or drugs. They were aware that assessments with this outcome tended to be unpopular with the other agencies involved, who were usually seeking support in managing a young person through a difficult experience.

Mental health disposal is an easy disposal. We are getting better at saying, yes this child has a range of problems but it isn't necessarily a mental health problem, That's hard to disentangle – psychs are getting more robust about saying 'This isn't our problem' and that's when we get into argy bargy about what to do. So if they are depressed or psychotic then okay, but if they have self-harmed and are acting up on drugs, then labelling them with a psychiatric diagnosis for a quick disposal in the middle of the weekend isn't actually the best way'. [Provider, Area 9]

Another interviewee (area 13) described similar events and stressed that a mental health placement was not the best solution in many cases. Another emphasised that looked-after young people encountering difficulties in their placement were not psychiatric emergencies, although they were often perceived as such by the other agencies involved.

Such responses highlight the need for 24/7 CAMHS cover to be seen as part of a multi-agency response to children and young people presenting in a crisis. Several areas reported that they were working to develop the skills of other agencies to reduce the likelihood of problem behaviours presenting as mental health emergencies. One interviewee observed that very few presenting emergencies 'come out of the blue', and so CAMHS had encouraged its partner agencies to identify children and young people with potential problems in advance of crises occurring. The CAMHS had improved the training offered to partners of the Tier 1 and Tier 2 services, to help them recognise when earlier interventions should be initiated.

Another interviewee described how the Local Authority had reviewed its provision for looked-after children, to establish a system of emergency foster care provision that had helped reduce the 'Friday night crisis' when placements broke down. Training for staff in placement teams and care homes to deal with difficult situations had reduced their need to call for a mental health response.

Through a variety of processes we have improved our relationship with local authority providers and support for them in terms of training and competence of their staff to manage those young people and to be able to see crisis as a situation they can deal with and not an aberration that needs to be dealt with by mental health. [Provider, Area 3]

8.4 Accessing a safe place

Whilst some assessments result in little or no further action, others may require referral to other services. It became apparent in the interviews in Stage 1 that the issue of a psychiatric placement is one that many found taxing and which sometimes resulted in a breakdown in what otherwise might have been an efficient and well-managed emergency service. Whilst strictly not part of the proxy target, the frequency with which problems around placement were raised in the interviews indicates the way in which robust procedures for placement are integral to the functioning of an effective on-call service.

Once the need for a placement has been established, a multi-agency approach is often needed to ensure a placement is found in an appropriate and timely manner, requiring managers and clinicians with sufficient authority to make the necessary decisions. Often these are not in place, and this impacted on how the emergency is managed. Issues such as the most appropriate type of provision (for example secure accommodation, a Tier 4 bed or a private out-of-area placement) need to be settled urgently, along with who should fund the placement.

One service reported appointing a 'CAMHS Tzar', after a particularly protracted and difficult placement experience. The new post incorporated a coordinating role and had the authority to order urgent case conferences around placement. Since the appointment, the Tzar had convened two case meetings which had successfully resolved similar cases more speedily. In addition, the service was trying to develop a 'crash' bed as a holding place for up to five days to provide a safe setting, either in the general hospital or in a local authority children's home.

Many Tier 4 services do not admit over weekends, so temporarily a child or young person needs to be held elsewhere. Two services in Stage 1 described admitting 16 and 17 year-

olds to an adult in-patient ward with a bank of CAMHS nursing staff providing additional support. One interviewee reported that it was sometimes several months before a place became available at the adolescent unit, but that CAMHS had written protocols and resources to support young people whilst in the adult in-patient unit:

If admitted to a unit we are signed up to seeing them [young person] on the ward that day and sitting with the staff, care planning and daily visiting, with support workers who go in to take the young people out if they are on a section. So we do quite a bit. We built in resources when we set it up. [Provider, Area 15]

For younger patients, the only option may be a private provider at a heavy cost. An interviewee in Area 9 described situations occurring when the authority to sanction out-of-county spend is held by commissioners who are unavailable out of hours, leaving CAMHS managers to authorise placements and justify these afterwards. In another area, the interviewee explained that access to Tier 4 beds was variable as units within the locality were often full, so that places had to be bought elsewhere. At certain times of year when funding had been exhausted, gaining approval was problematic and managers were unable to contact commissioners to approve funding.

9. Conclusions

This report provides an overview of the extent to which CAMHS have addressed the PSA target to provide 24/7 cover as part of the move towards a comprehensive service. Commissioners and providers were often perplexed by conflicting concepts about what might be the best type of provision to offer and CAMHS consultants, paediatric staff, partner services and national organisations presented different views on what might offer the most appropriate, or acceptable, professional arrangements. Similarly, definitions of what constituted an 'emergency', requiring what level of CAMHS response, represented a 'grey' area of demand, with each of the agencies involved having a different perception and expectation of the threshold at which an on-call service should operate.

Through talking to commissioners and providers and by surveying services, this study has identified some of the difficulties that establishing and maintaining an emergency response have posed. The issues faced by providers in more densely populated areas with a rich supply of hospital based staff are very different from those faced by smaller services with minimal resources.

The interviews conducted for this study and the comments supplied by survey respondents, suggest that adequate resources, and particularly staffing resources, are key to providing on-call services. The principal issues revolved around two aspects of staffing: staff attitudes to providing cover, and a lack of staff.

Many areas attempting to develop new on-call services or to improve existing systems reported difficulties in persuading staff to take on an out-of-hours role. For many CAMHS staff, the concept of emergency cover is foreign, and some may well have been attracted to working in the service for the very reason that its nine-to-five routine fitted well with their out-of-work commitments. Commissioners and providers frequently reported reluctance from staff to take on an out-of-hours role, with nurses through to consultant psychiatrists resistant to changes in their existing contracts of employment. At the same time, an underlying ethos of patient care meant that most services reported a culture of responding when a situation was perceived to be a real emergency. Negotiations with staff require skilled handling to address this resistance, as does the formalising of contracts to include duties that staff view themselves as willing to undertake when necessary from personal commitment to their professional role.

The issue of specialist medical cover as the only effective form of response to an emergency presentation was questioned in both stages of the study. The study found examples of CAMHS struggling to establish or maintain cover by consultant psychiatrists who saw this as the only way to achieve the target. At the same time, others were exploring successfully the use of non-medical staff to operate out-of-hours rotas. Moves from the more traditional service response to innovative non-medical solutions required a shift in expectations by both CAMHS personnel and their partners, such as A&E departments and Paediatric departments, in managing emergency presentations.

In addition to addressing a cultural resistance to becoming a service that operates around the clock, there is also a need to establish the level of demand that providing an out-of-hours service would place on staff. Resistance may be in part a fear of being inundated with callouts, either because services are unable to provide any indication of how many calls might be expected, or because of uncertainty about the level of response that might be required. There was some evidence that where staff had knowledge of what on-call duties actually required, they were more willing to offer themselves for the role. The limited audit data that this study collected, and the lack of consistency in the data supplied by different

CAMHS, highlight the need for more evidence on which to base decisions about out-of-hours provision. A more systematic approach to audit data would be beneficial at both the local and national level, with information on geography, service configurations and demography included to provide contextual background to levels of demand. Locally, services which are able to provide audit data may be in a stronger position to convince reluctant CAMHS staff to take on the out-of-hours role if it can be demonstrated to be less onerous than they imagined. Nationally, reliable audit data would assist the development of guidelines for the management of the emergency assessment process and pathway of care.

Staff shortages were frequently reported as a barrier to providing on-call services, due either to under-investment over many years in creating established posts, or recruitment difficulties because of the serious national shortfall in qualified staff. The ways in which CAMHS providers had attempted to resolve these shortages, at least in the short term, included combining with other services; purchasing from neighbouring providers; and looking to other non-CAMHS staff to provide the cover. However, combining with other CAMHS to create a bigger resource pool often encountered barriers that proved insurmountable. These included neighbouring services having very different contractual agreements and a multitude of service delivery arrangements that made it difficult to establish common ground. Purchasing a service from other providers who were already able to offer an out-of-hours service, for example a county buying consultant psychiatrist telephone cover from a neighbouring county, appeared to have been much more straightforward and could offer a cost effective solution to providing cover.

Other services had looked beyond CAMHS to colleagues such as the adult mental health service or social care teams to take on the role of providing 24/7 emergency cover. Where a willing partner had been found, this had proved an effective solution, although working across services had sometimes involved lengthy negotiations. However, once these were completed, and the necessary training and support, financial backing and indemnity were in place, these services were reported to be operating well and providing valuable partnerships.

Whether directly as a consequence of the proxy target or in response to pre-existing limitations in the ability to provide 24/7 cover, this study found that most CAMHS were actively engaged in reviewing the wider issues around emergency presentations. For some services, the implications of one of the other targets (extending care to 16 and 17 year-olds where these are currently covered by the adult team) has created a keener interest in emergency presentations. CAMHS providers anticipate an increase in emergency presentations as they take on this older age group. This has led to a closer scrutiny of the urgent assessment process and an interest in developing the role of CAMHS in supporting other services, including A&E and Paediatrics, to develop their skills with this assessment stage of the 24/7 response. This in turn has led to better links with social care teams and substance misuse services, and encouraged multi-agency working around emergency presentations. In some locations, the experience of engaging the wider community of service providers within the emergency response has emphasised the appropriate and efficient management of young patients, and questioned the pre-eminence of the psychiatric assessment within the emergency care pathway.

At the same time, cost continues to be an issue in relation to providing 24/7 specialist cover in CAMHS. For established services, based around relatively well-resourced hospital departments staffed by SHOs, SpRs and consultant psychiatrists, the main problems revolve around maintaining expensive cover for rotas and apprehension about the impact on services of the European Working Time Directive. For smaller CAMHS services, where commissioners and providers were faced with introducing new arrangements for 24/7 cover, there was sometimes a view that the requirement was *'a bit of a sledge hammer to crack a nut'*, and that such provision is unlikely to be cost effective.

This study found strong evidence of services trying hard to have emergency provision in place by the target date. However, setting up and providing specialist cover out of hours has in some cases diverted resources from other aspects of the service, and may be unsustainable in the longer term. Whilst the great majority of CAMHS providers report 24/7 services in place to meet the proxy target at the end of 2006, it is likely that further changes in out-of-hours provision may develop as pressure on CAMHS resources focuses on other aspects of providing a comprehensive service.

Areas for further research

This short scoping study set out to answer specific questions about achievement of the 24/7 target, and it was beyond the scope of the project to obtain objective measures with which to compare and validate interviewees' and respondents' reports and perceptions. Even with more time, this would have been a difficult exercise. There appears to be a strong case for developing formalised data collection to audit the demand for and costs of emergency provision. For this to happen, further work is required to reach consensus on definitions of what constitutes an emergency and an emergency response. This would enable the information from national mapping, from LDP returns and the self assessment matrix to fully complement each other in the future.

The following topics emerged as fruitful areas for further research:

- User views from children and young people who have been eligible for emergency cover (whether or not they received it).
- Clinical outcomes for children resulting from different models of 24/7 cover
- Further investigation of the role of other services in supporting the work of CAMHS in emergencies, identifying the groups of professionals involved in assessing young people and any issues that such non-CAMHS assessments might raise.
- Training needs of non-CAMHS professionals involved in managing children and young people experiencing a mental health crisis, and how such training should be provided (content and delivery).
- Information management as part of the emergency assessment process, for example how telephone advice informs the care pathway.
- Economic evaluation of 24/7 cover

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Appendix 1. Interviews conducted with CAMHS providers and commissioners, Stage 1

Area	Type of Area	Region	Interviewees
1	City	North West	Commissioner
2	City	South West	Provider
3	County	South West	Commissioner and Provider
4	Unitary Authority	South West	Commissioner and Provider
5	Unitary Authority	Yorkshire and S. Humberside	Commissioner and Provider
6	County	South Central	Commissioner
7	City	West Midlands	Provider
8	County	North West	Provider
9	County	South East	Commissioner and Provider
10	County	South East	Commissioner
11	County	South East	Commissioner
12	Unitary Authority	North West	Commissioner
13	County	South East	Commissioner
14	Unitary Authority	South West	Provider
15	Unitary Authority	North East	Provider

Appendix 2 Electronic Survey Form



On call CAMHS: A Survey of provision

The Thomas Coram Research Unit, Institute of Education, University of London are carrying out a short survey of all CAMHS in England to find out how services are responding to the proxy target for 24/7 cover. We know that some services have struggled, and that some are continuing to struggle, to achieve the level of service required for the PSA by December 2006. With this survey we are trying to establish a true picture of what and how services will be in place at the end of 2006.

The survey is being conducted with the assistance of the CAMHS Mapping Team. The results of the survey will be reported to the DH who commissioned this work and will be aggregated so that no individual service will be identified. All responses in the survey will be treated confidentially by TCRU. We will send you a short resume of the main findings from the survey in early January 2007.

The questionnaire should not take long to answer, and can be completed in Word - just click on the box and start typing for open-ended responses, or to put a cross in the box for ticked responses. If you want to remove a cross, click again on the box. **NB:** Boxes for open-ended questions do not expand as you type - you only have the space provided. You can add further comments at the end of the questionnaire.

When you have completed the questionnaire, please remember to save it before printing it or before emailing it back to us. Only the research team will have access to the information you give, and your responses will not be attributable to your service, unless we contact you to gain your specific permission.

The questionnaire can be returned to us by email - CAMHSstudy@ioe.ac.uk. However, if you prefer to print the questionnaire and complete it by hand, please post it to Pamela Storey at Thomas Coram Research Unit, 27/28 Woburn Sq, London WC1H 0AA.

Please return the questionnaire by 7th November 2006

If you have any queries please email Pamela Storey (CAMHSstudy@ioe.ac.uk) or call her on 020 7612 6929.

1. By the end of December 2006 which of the following will be available to offer consultation and /or assessment at locations of referral, such as A&E departments, to those seeking advice for a young person aged under 16 who presents with a mental health problem?

a) Weekdays (approximately 9am-5pm)

	Weekdays 9am-5pm	
	Telephone Advice	Assessment at location of referral.
CAMHS On-call Provided by a) Non medical CAMHS staff b) Medical SHO/SpR c) Medical Consultant Rota d) Tier 4 Provider e) Other CAMHS arrangement	a) nurses <input type="checkbox"/> psychologists <input type="checkbox"/> others <input type="checkbox"/> b) <input type="checkbox"/> c) <input type="checkbox"/> d) <input type="checkbox"/> e) <input type="checkbox"/>	a) nurses <input type="checkbox"/> psychologists <input type="checkbox"/> others <input type="checkbox"/> b) <input type="checkbox"/> c) <input type="checkbox"/> d) <input type="checkbox"/> e) <input type="checkbox"/>
Paediatric On-call	<input type="checkbox"/>	<input type="checkbox"/>
Adult Psychiatry On-call	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Duty Team a) Children & YP's team b) Adult team	a) <input type="checkbox"/> b) <input type="checkbox"/>	a) <input type="checkbox"/> b) <input type="checkbox"/>
Other provision please specify		

b) Evenings and Nights (approximately Monday - Thursday 5pm- 9am)

	Evenings and Nights Monday - Thursday 5pm- 9am	
	Telephone Advice	Assessment at location of referral.
CAMHS On-call Provided by a) Non medical CAMHS staff b) Medical SHO/SpR c) Medical Consultant Rota	a) nurses <input type="checkbox"/> psychologists <input type="checkbox"/> others <input type="checkbox"/> b) <input type="checkbox"/> c) <input type="checkbox"/>	a) nurses <input type="checkbox"/> psychologists <input type="checkbox"/> others <input type="checkbox"/> b) <input type="checkbox"/> c) <input type="checkbox"/>

d) Tier 4 Provider e) Other CAMHS arrangement	d) <input type="checkbox"/> e) <input type="checkbox"/>	d) <input type="checkbox"/> e) <input type="checkbox"/>
Paediatric On-call	<input type="checkbox"/>	<input type="checkbox"/>
Adult Psychiatry On-call	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Duty Team a) Children & YP's team b) Adult team	a) <input type="checkbox"/> b) <input type="checkbox"/>	a) <input type="checkbox"/> b) <input type="checkbox"/>
Other provision please specify		

c) Weekends (approximately Friday 5pm - Monday 9am)

	Weekends Friday 5pm - Monday 9am	
	Telephone Advice	Assessment at location of referral.
CAMHS On-call Provided by a) Non medical CAMHS staff b) Medical SHO/SpR c) Medical Consultant Rota d) Tier 4 Provider e) Other CAMHS arrangement	a) nurses <input type="checkbox"/> psychologists <input type="checkbox"/> others <input type="checkbox"/> b) <input type="checkbox"/> c) <input type="checkbox"/> d) <input type="checkbox"/> e) <input type="checkbox"/>	a) nurses <input type="checkbox"/> psychologists <input type="checkbox"/> others <input type="checkbox"/> b) <input type="checkbox"/> c) <input type="checkbox"/> d) <input type="checkbox"/> e) <input type="checkbox"/>
Paediatric On-call	<input type="checkbox"/>	<input type="checkbox"/>
Adult Psychiatry On-call	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Duty Team a) Children & YP's team b) Adult team	a) <input type="checkbox"/> b) <input type="checkbox"/>	a) <input type="checkbox"/> b) <input type="checkbox"/>
Other provision (please specify)		

2. Do the arrangements for under 16's also cover young people aged 16-17?

Yes No

If no, what arrangements are in place for young people aged 16-17?

3. Are the arrangements for the under 16s supported by commissioning and by protocols rather than by informal agreements?

Yes, all Yes, some No

If arrangements are only partly supported by commissioning and by protocols, please indicate which provision is not covered by formal agreements.

Please supply copies of any commissioning documents or protocols.

4. Do CAMHS provide any regular training for frontline staff in A&E and Paediatric departments on CAMHS presentations, interventions and local resources / referral pathways?

- Yes
- No
- Don't Know

How often is this training provided?

- 3 monthly
- 6 monthly
- annually?
- Irregularly, as requested?

Is this training supported by service level agreements or funding?

- Yes
- No
- Don't Know

If yes, please give details.

5. Please supply any recent audit data you have on the number of emergency mental health referrals your service receives.

	Number of emergency mental health referrals	Over what period of months eg 3 months, 6 months, 12 months?
Weekdays 9am-5pm		
Telephone Advice		
Assessment		
Weekdays 5pm-9am		
Telephone Advice		
Assessment		
Weekends		
Telephone Advice		
Assessment		

How many assessments were undertaken under the Mental Health Act Section 12 in the last period of collection?

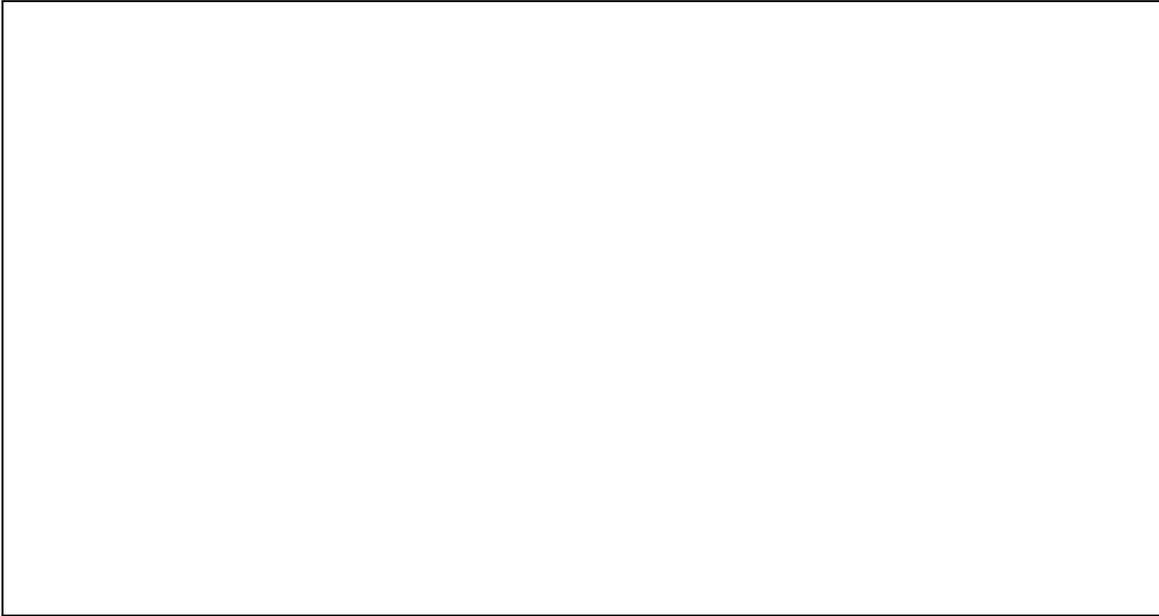
6. Please supply any recent data on the costs to your service of providing out of hours services ie evenings and weekends (either separately for advice and attendance or for both combined)

Out of hours advice

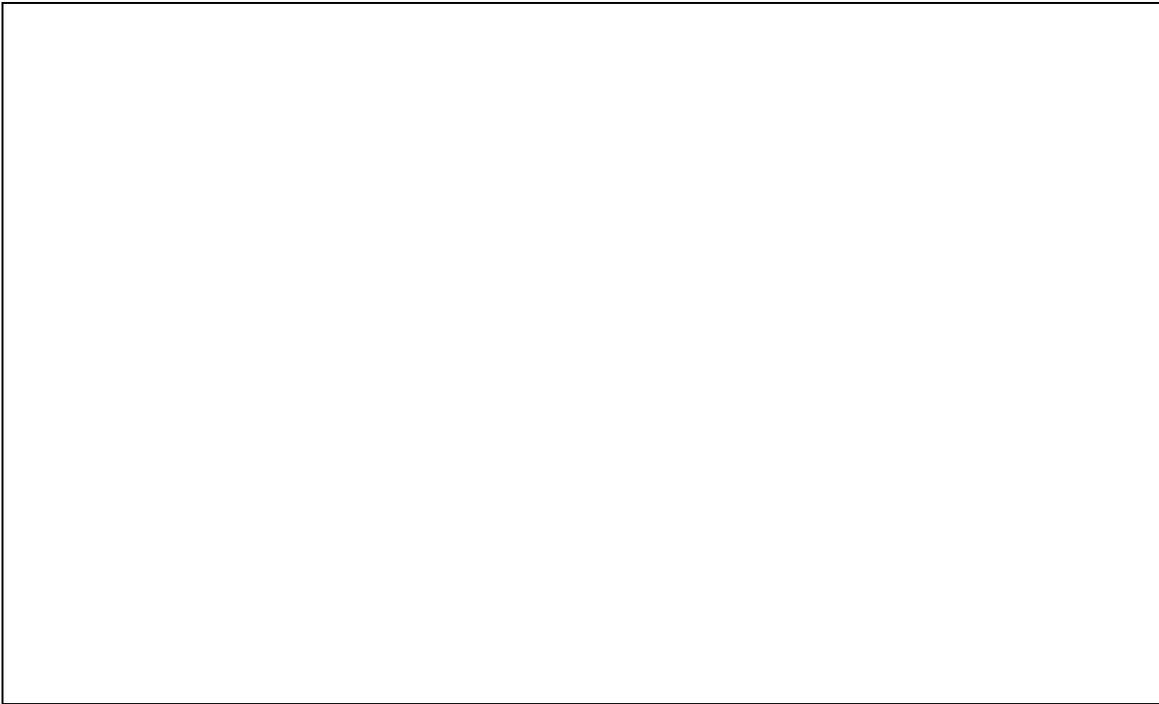
Out of hours attendance

Out of hours, combined advice and attendance

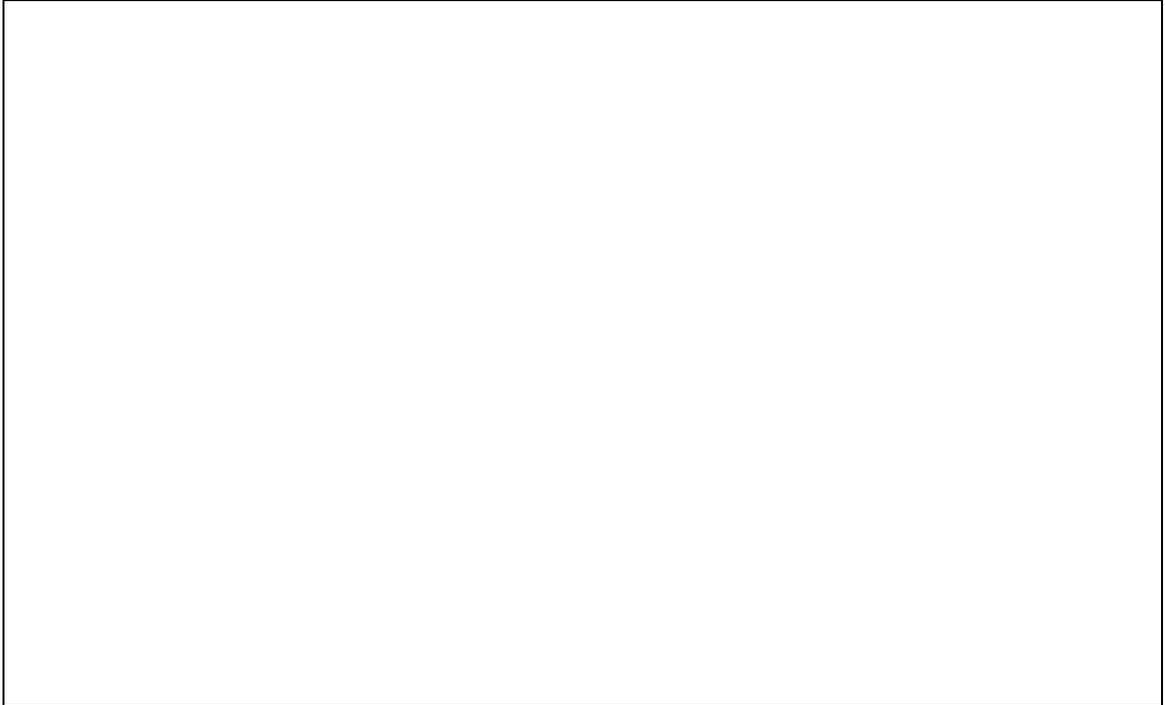
7. What do you see as the advantages of the on call provision provided by your service?



8. And what if any, are the disadvantages of your provision?



9. We would welcome any further comments on your on call services.



If you would be willing to tell us more about any specific issues your service has with on call provision, please indicate whom we should contact.

Name

Tel:

Email:

It would be very helpful to have copies of commissioning documents, protocols and any other relevant documents. Could you please send these to:
Pamela Storey at Thomas Coram Research Unit, 27/28 Woburn Sq, London WC1H 0AA
or Email: CAMHSstudy@ioe.ac.uk

THANK YOU FOR YOUR HELP

Appendix 3 Survey returns by region

Table 1 Survey returns by region

	Copies sent	Coded surveys	Responded not included	No response
East Midlands	8	5	1	2
East England	13	8	2	3
London	19	11	3	5
North East	8	11	1	0
North West	22	9	7	6
South Coast	17	10	3	4
South East	9	3	0	6
South West	15	8	0	7
West Midlands	15	11	1	4
Yorkshire and Humber	12	6	0	6
<i>Total</i>	<i>138</i>	<i>84</i>	<i>18</i>	<i>43</i>

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