Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

CAMHS Crisis and Intensive Home Resolution Team

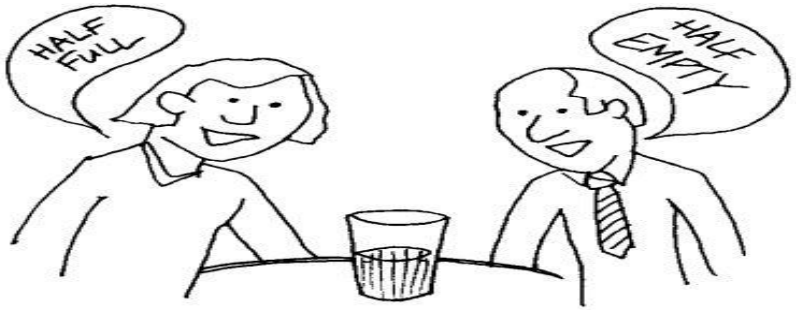
“Crisis doesn’t end at 5 o’clock”

John Barnard, Project Lead

Mita Saha, Crisis Team Manager

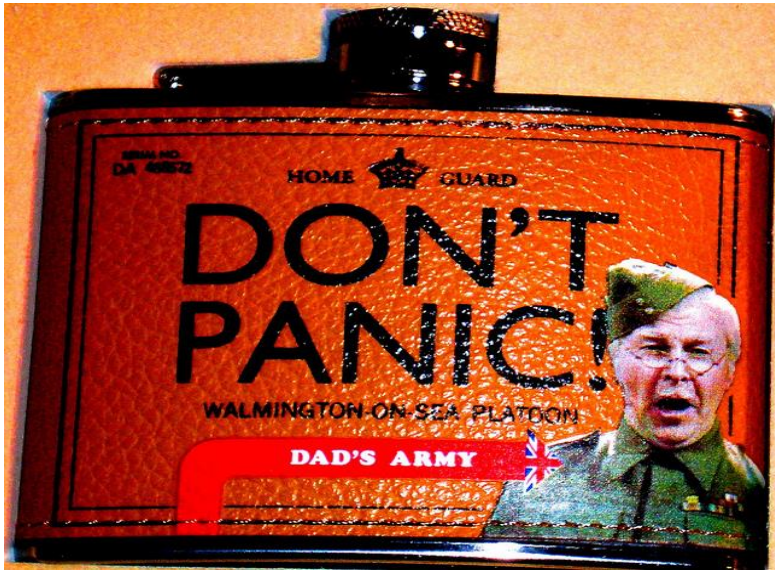
Sarah Watson CNS

making a difference together

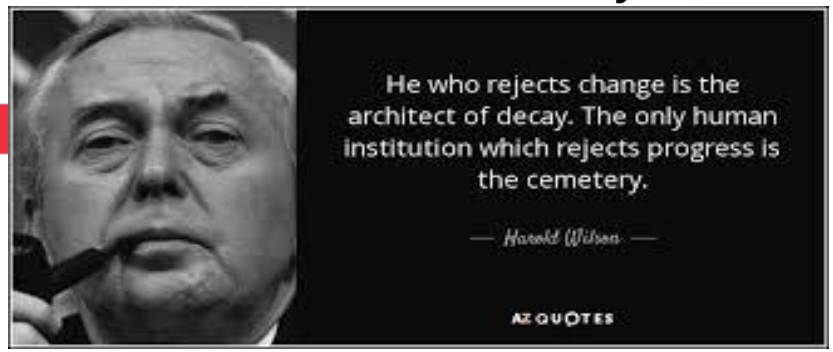


Define Crisis

- A time of intense difficulty or danger
- A crucial or decisive point or situation, especially a difficult or unstable situation involving an impending change.
- A point in a story or drama when a conflict reaches its highest tension and must be resolved.
- An emotionally stressful event or traumatic change in a person's life.



Tees, Esk and Wear Valleys NHS



Case for change

- No current out of hours specialist mental health support for young people
- Existing services cancelling patients.
- Young people admitted to acute hospital beds with complex physical needs often have an emotional or mental health component that is not considered priority at the time.
- Admissions to acute hospital beds for self harming behaviours in the North, triple those of London SHA (hscic 2012) at a huge cost to the global health economy of the region.
- Young people spend extensive periods of time in busy ,overstimulating environments ,with no privacy at a time of acute distress
- Re referral rates for Urgent Care attendance/ hospital admissions for children remain high. Young people are separated from their support network at time of most need

Model

The service will provide (in the long term)

- 24/7 crisis/ intensive home treatment- (shorter term10am-10pm in some areas) dependent on investment
- Alternative to tier 3 model which does not fit some young people (estimate 30%-40%)
- Open access to crisis services
- Access to IHT via – crisis team, CAMHs LDCAMHS or Tier 4
- Closer liaison with acute hospitals and emergency/ statutory and voluntary agencies

Crisis Stats were telling us in Tees

- 1660 referrals (as of Jan 1st 2017)
- 83% reduction in acute hospital admissions
- 38% Reduction In patient admissions with 30% reduction in bed days
- 97% of young people seen within 1 hr (where apt)
- Consistent FFT of 95+%
- Consistent increase in CORS and ORS (Child outcome rating scales)
- Reduction of face to face assessments of known young people
- Increase use of telephone triage/ advice
- Increase in booked assessments
- Reduction in A and E attendance (all other areas in north increasing)

TEWV New Models of Care Pilot

- Mentioned in NHS England's 'Five Year Forward View for Mental Health'
- National pilot
- Opportunity for secondary mental health providers to take responsibility for tertiary commissioning budgets and demonstrate ability to innovate and transform services in the best interests of service users and their families – available for CAMHS Tier 4, Adult Secure and Adult Eating Disorders services
- Implement a new care pathway for young people living within the TEWV geography: County Durham, Darlington, Teesside, North Yorkshire and York

New Models of Care

- Enhance community resource, enabling young people to be supported at home in times of crisis
- Reduce the number of young people who need to be admitted, and for it to be as close to home as possible
- Reduce lengths of stay
- Increase community resources with equity across the Trust area for access to CAMHS Crisis and Intensive Home Treatment .This will be based on savings made
- Initial Vanguard funding for 1 year to support IHT and crisis in North Yorkshire

At month 7

Tees CCGs

Occupied Bed Days - Tier 4

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
A&T	188	228	183	123	137	133	103
LSU	23	0	34	62	62	41	32
ED	150	103	42	36	87	86	46
PICU	30	31	25	0	0	0	0

Hambleton, Richmond & Whitby CCG

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
A&T	52	63	36	0	0	0	0
LSU	0	0	0	0	0	0	0
ED	0	0	0	0	0	10	46
PICU	0	0	0	0	0	0	0

- Planned Expenditure as at October £5.6m
- Actual Expenditure as at October £4.8m

People are saying

Tees, Esk and Wear Valleys NHS

NHS Foundation Trust

“ I felt listened to and the time it took to be attended to was prompt’- Service User “

Diane McPartland
Associate Modern Matron: *For many years we’ve had young people who struggle to cope after discharge when initially back in the community following their in-patient stay and this has led to re-admissions which were not the best therapeutic option but necessary due to levels of risk and resources available. We know that since the Crisis Team has been in operation the incidences of re-admission for our Teesside patients has significantly reduced, and young people are being supported by your team to a point of managing better in the community and seeing some hope in their future outside of hospital.*

The staff are very understanding and don’t judge you. They also take the time to listen and help” – Service user

Cathy Brammer: Clinical Matron for Children and Young People: South Tees Hospitals NHS Foundation Trust

‘I would like to say that the crisis team has made a big impact on the number of young people admitted to the ward. We have found the team to be responsive to our requests for support and advice and feel well supported should a situation arise that we are unsure of how to respond to.

Mr K Adeboye: Consultant in Emergency Medicine: (North Tees and Hartlepool FT)
‘Thank you for the opportunity to comment on the excellent service provided by the new 24hour CAMHS provision . This has contributed in no small measure to the management of young people presenting to our department with social/mental health issues such as self-harm, acute psychosis, poisoning and expression of self-harm. The responsiveness of the service to needs particularly the 1 hour response has been great as this is consistently met.

“ Because they are the best people to go to in this area” – Service User

CQC inspection:
‘It was clear that whilst this is a very new team, who are currently piloting 24 hour working that they are cohesive, motivated, knowledgeable (including around safeguarding), enthusiastic and very focussed on meeting the needs of service users and carers.

making a

Where are we now ?

PHASED INTRODUCTION

Tees24/7 fully operational Crisis and Home Treatment –June 2017

- Hambleton and Richmondshire operational 24/7 1st July with provision from established Tees base.
- Scarborough- 10-10 provision
- Harrogate- 10-10
- York -10-10
- Communications have taken place with key services via communications and project group- wider information sharing will continue over coming months.
- Option appraisal for nights in with executive board

Intensive Home Treatment

- Service extension – 8-12 week intensive support package
- Focussing on high risk young people who are at risk of hospitalisation
- Aiming to provide an alternative to hospital admission
- Supporting young people in hospital in facilitating early discharge
- Targeting those young people who are often hard to reach and require a more assertive approach

IHT Team

- Nurse led service
- 3 IHT clinicians – RMN and RNLD
- 4 Health Care Assistants working 7 days a week
- Clinical Psychologist

Service Aims

- Working collaboratively with inpatient and outpatient CAMHS teams as well as partner agencies
- Closely monitor risks in the community as well as continually assessing mental state
- A minimum of 3 contacts per week with the ability to see daily if needed
- Improving engagement and adherence to treatment
- The ultimate aim is to reduce inpatient admissions to hospital

Service extension – Intensive Home Treatment

- Children of all ages
- 8 week involvement period (with flexibility)
- Minimum of 3 contacts per week
- Model with 4 possible strands
  - 1. Intensive assessment with assertive engagement
  - 2. ‘Classic’ IHT
  - 3. Assertive engagement
  - 4. Recovery and ‘staying well’

1. Intensive assessment with assertive engagement

- Indicators of risk
- Indicators of safeguarding and vulnerability
- Indicators of disengagement (poor attendance, multiple referrals to camhs)
- No change or improvement – yet increased/ongoing risk and clinical concern

- Expectations of IHT
  - Senior members of team leading case on behalf of IHT (CNS, psychologists, CAMHS clinicians)
  - HCA involvement (where appropriate)
  - Regular and timely review of case progress with tier 3 (direct or telephone)
  - Assessment report/summary of current clinical picture

- Our expectations from tier 3:
  - Remain care coordinator – and fulfil all aspects of this role
  - Maintain appointments with young person
  - Prioritise liaison with IHT
  - Comprehensive safety management plan in place
  - Clear risk formulation

2. 'Classic' IHT

- Enhancement of tier 3 role
- Using therapeutic models in an 'intensive capacity' to *support* established and ongoing tier 3 intervention lead by tier 3 clinician
  - Facilitating / supporting implementation of practical elements of CBT, DBT, PBS, Family Therapy in the home / community
  - ROMS

- Expectation of IHT
  - Predominantly HCA involvement
  - Regular and robust feedback system – updates on case progress
  - Minimum of x3 contacts per week, but can be more frequent where required
  - Tailoring involvement to the needs of the young person
  - Provide written feedback using template

- Our expectations from tier 3
  - Remain care coordinator and maintain weekly appointments with young person whilst IHT are involved

3. Assertive engagement

- Present in crisis, previous disengagement(s) from camhs, resistance to return to tier 3 camhs – but mental health need identified

- Expectation of IHT
  - Case lead of CNS, psychology, or CAMHS Clinician
  - Predominantly HCA involvement
  - Minimum of x3 contacts per week
  - Assertive outreach / positive engagement
  - Aim =
    - Improved understanding of mental health needs and issues
    - Discharge (where appropriate)
    - To signpost to appropriate services
    - To support (re)engagement with tier 3 camhs

- Our expectations of Tier 3
  - Seamless transition into tier 3.
  - Accepting case referral with prompt response (middle ground between ‘urgent’ and ‘routine’ allocation)

4. Recovery and 'staying well'

- Supporting leave periods
  - Via telephone support, planned involvement to support established tier 4 intervention underway
- Engaging with young person prior to discharge and developing collaborative step down plan of intensive home support
  - Facilitating / supporting implementation of practical elements of CBT, DBT, PBS, Family Therapy in the home / community
  - ROMS
- Supporting re-engagement with community living (practical support)

- **Expectations of IHT**
  - Case lead of CNS, psychology, or CAMHS Clinician – monitoring mental state
  - HCA involvement (where appropriate) – focus on practical support
  - Minimum of x3 contacts per week
  - Close liaison with tier 3 and tier 4 leads on case progress
- **Our expectations of tier 4**
  - To give clear guidance and support about interventions underway
- **Our expectations of tier 3**
  - To maintain care coordination role
  - To plan regular therapy appointments post discharge
  - To maintain close liaison with IHT

Case studies

Case Study 1

A call was received from the paramedics expressing concerns about a young person's mental health aged 16. They had been to visit at home following parents contacting them that they were unable to stop a nose bleed.

Crisis clinicians attended the home to find the bedroom covered in blood and the young person laid in his bed in a catatonic state. Parents report that their son had been in bed for weeks and was refusing to eat and drink. They reported that they had been to see their GP who had refused to come out to the home.

On reviewing the care records, the young person was referred to EIP as he had talked to his YOS worker about some unusual experiences. The young person admitted that he has been smoking cannabis. Also at the time, the family reported a change in his behaviour, he was presenting as more aggressive both verbally and physically. Due to non-engagement with EIP he was discharged.

Due to concerns both physically and mentally, on call psychiatry attended the home with crisis team clinicians and it was negotiated for the young person to be admitted to the paediatric ward until a bed was found.

The ward expressed their concern about this young person being on the ward as they did not feel they were skilled to manage him on the ward. It was arranged for crisis staff to sit with the young person on the paediatric ward and observe him as well as support the nurses in managing any potential risks.

Due to the young person presenting as mute and the risks he posed to himself and potentially to others he was detained under the Mental Health Act. IHT staff have remained involved and have been able to support the young person with keeping in touch with his local community and observing him in different settings. Staff have also visited him several times per week on the ward to try and establish and therapeutic relationship and prepare him for his reovery.

Case Study 2

The family contacted the crisis team due to increasing concerns around aggressive behaviours at home. The family reported that Callum became verbally aggressive when asked to get up and get washed. Further information gained from the family is that Callum has not left his bedroom for a number of months, he was not keeping on top of his hygiene and dietary intake was poor. Callum was assessed by the crisis team at home.

Callum is a 14 year old boy and is under the care of the locality camhs team due to him presenting as highly anxious resulting in him not leaving his bedroom. The locality team have been working with the family for a number of months offering weekly appointments with very little change. Due to lack of progress and increasing concerns around mental health, the team were considering requesting an inpatient assessment. Over the years, Callum has had multiple referrals to the locality teams indicating an underlying anxiety. Callum also has a diagnosis of ASD.

When the crisis team arrived, Callum was much calmer however his family presented as highly distressed stating that they could no longer cope and ‘something needed to be done’ Callum was difficult to engage and refused to come out of his bed room. A risk assessment was completed and did not indicate any imminent risk to self. It was identified that Cullum’s problems are longstanding and that without a change in approach, there is an increased risk of hospitalisation. It was agreed with the family that the crisis team would liaise with the locality team arrange to a CPA meeting. In the meantime however an IHT support worker would visit Callum at home every other day in order to try and engage Callum.

Initially, Callum did not respond to this, and the visits were short, however the family found this initial contact helpful. Over the next few weeks, using this intensive approach, Callum started to come out of his bedroom and engage with the support worker. Goals were set with Callum and this was for him to go out in the local community with long term goal of him going back to school.

With support and guidance from IHT psychology and through clinical supervision, support workers were able to support Callum in challenging some of the anxieties in helping towards overcoming them.

The results of the IHT intervention have been positive. IHT support workers got back involved after the summer holidays in order to re-integrate Callum back into school, which so far has been successful.

Questions

Contacts

John Barnard- Project/ Service Lead

03000132000 (option 6) johnbarnard@nhs.net

Clinical Leads

Hambleton and Rich	Mita Saha 03000132000 (option 6)
Harrogate	Clair Osburn 01423 726947
Scarborough	Emma Cory 01723 346035
York	Kirstie Reynolds 01904 615348