Scrutiny Report Emotional and Mental Health Services Leeds

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1.0 Purpose of Paper

The purpose of this paper is to inform the Scrutiny Board of the services for children and young peoples' emotional and mental health currently commissioned by partners in Leeds. The paper sets out the work programme recently agreed at the Integrated Commissioning Executive (ICE) for partners to work together to improve the system, to create coherent pathways and to improve the experiences and outcomes of children and young people.

2.0 Introduction

There is recognition nationally, regionally and locally of the need to improve emotional and mental health services for children and young people.

Following a recent Health Select Committee, established to collect evidence on children and Young Peoples' emotional and mental health services, a National Mental Health and Wellbeing Taskforce has been established.

Key policy links are:

- NHSE CAMHS Tier 4 Review (2014)
- Closing the Gap: Priorities for Essential Change (DH, 2014)
- CMO Annual Report (2012 and 2013)
- CYP Health Outcomes Forum Report (2012)
- No health without mental health: A cross-government mental health outcomes strategy for people of all ages (2011)
- Talking Therapies: a four-year plan of action (2011)
- The Coalition: Our programme for Government (2010)

This paper begins by setting out some of the challenges within the current commissioning system before presenting information on services commissioned in Leeds. Finally the paper describes the recently initiated commissioning review of emotional and mental health services.

It is worth noting that most mental illnesses become apparent in the teenage years and can become long lasting. It is known that 50% of mental illnesses in adult life (excluding dementia) start before age 15 and 75% by age 18. Getting it right in childhood and then facilitating smooth transitions to adult mental health services is critical

3.0 Tiered model and commissioning responsibilities

The increasing complexity of the system and commissioning environment of children and young peoples' emotional and mental health services is demonstrated in the table below.

Responsibility for commissioning dependant on specialism/location	Responsibility for commissioning

	Service Type	Responsible Commissioning Agency			
		School	Local Authority	CCG	NHS England
Universal Services (Tier 1)	GPs practice staff				
	School nurses				
	Health Visitors				*Moving to LA 2015*
	Social workers				
	Youth workers				
	Teachers				
Targeted (Tier 2)	Outreach into schools by CAMHS				
	School counsellors				
	Educational Psychologists				
	Community based counselling				
	YOT Health workers				
	Parenting Programmes			*In specialist CAMHS*	
Specialist (Tier 3)	Looked after children/adoption			*In specialist CAMHS*	
	Specialist CAMHS (T3) community		*Social workers/Ed psych /MST*		
Specialist (Tier 3/4)	Specialist Outreach services to prevent admission/speed discharge		*Social workers*	*In some areas commissioned locally*	*In some areas Specialist Commissioning*
Highly Specialist (Tier 4)	In patient or regional specialist community e.g. deaf CAMHS				

Key issues to note are:

- At tier 1 much of the work is commissioned by organisations not directly involved in children and young people's mental health (although commissioners of mental health services frequently commission specialist consultation, training and support to tier 1).

  Leeds CAMHS is commissioned to provide training and consultancy, as well as direct assessment and delivery of care. A commissioning intention is to

strengthen this further, to enhance the confidence, capacity and capability across the city.

- The four-tier system was conceptualised in the 1990s and as services have developed the boundaries have blurred between the tiers, i.e., tier 3.5)

  Children's Education and Social Care services use the model of universal, targeted and specialist, rather than the traditional CAMHS tiers.

- The demand and delivery of tier 4 in-patient services is significantly impacted upon by the effectiveness of the local commissioned service and there maybe opportunities to work to co-commission the interface between tier 3 and 4 services that can provide intensive wrap around support and prevent the need for admission.

  Currently in Leeds there is an effective tier 3.5 service; in a recent regional review of such services the Leeds model in particular has demonstrated savings in terms of reduced demand on tier 4 beds. Commissioners in Leeds are having early conversations with NHSE commissioners about co-commissioning opportunities.

- Financial pressures across the system of public sector spending has led to a national concern of the reduction in spend on children and young peoples' emotional and mental health services.

  In Leeds the Local Authority has disinvested £0.5m from targeted/specialist emotional health and wellbeing provision, the majority of this from CAMHS, by April 2015.The NHS also has to achieve cost efficiencies and there are conversations between commissioners and the CAMHS provider on both the extent this impacts on CAMHS, and how best to achieve the savings without compromising the service offer.

  However, there has also been investment in emotional and mental health services by partners in Leeds, in the investment in the TaMHS offer in the city; in the expansion of the MST teams and in the commissioning of new pathways of care, such as the Care leavers blended offer (of either online or face-to-face counselling).

4.0 Leeds Services

Nationally many schools commission their own pastoral support (including counselling), frequently these arrangements are ad hoc, disconnected from local emotional and mental health pathways and do not always have clear quality standards.

A significant strength in Leeds is the achievement of a citywide TaMHS offer; this is summarised below:

4.1 Targeted Mental Health in Schools (TaMHS)

The TaMHS project[1] ran as a successful 3-year pilot in 4 school clusters in Leeds 2007-10, improving the mental health of school age pupils. Clusters bring together managers and resources from a range of universal, targeted and specialist children's services in each local area. Cluster working arrangements are designed to ensure that families are offered the right intervention at the right time, as early as possible in the life of a problem, to prevent issues escalating which may result in poor outcomes for the family.

The model is based on:

1. Building on existing effective universal practice
2. Evidence based approaches
3. Capacity building in schools
4. Specialist mental health 'in-reach' support, as part of cluster multi-professional teams and as a school facing service.
5. Early Intervention and short-term work

All pilot areas re commissioned the service from their own budget.

The 2011-13 expansion of TaMHS to 9 new clusters was funded through a joint investment fund (JIF) from Schools Forum, Children's Services and NHS Leeds. The clusters were required to engage through an open application process which involved committing match funding of 55% (JIF) /45% cluster.

The commissioning model is one where clusters commission the TaMHS service within guidelines, based on the needs within the cluster, rather than the direct employment of staff. Current providers are drawn from the third sector and the NHS.

A successful evaluation has led to:

1. 100% re commissioning of TaMHS services by these clusters from their own budgets with many examples of increasing the capacity in the cluster team.
2. Further JIF funding for all the remaining clusters in the city for support from September 2013 – September 2015
3. CCGs starting to invest in clusters to increase capacity and pilot direct GP referral access

Current spend on TaMHS in the city is circa £2m: The details of TaMHS funding in Leeds, since the original pilot is set out in appendix 1.

The evaluations, (1 year interim and end of project) show measurable improvements in mental health, very good user feedback, cluster satisfaction and improvements in school attendance. The most recent evaluation has the some of the best performance in mental health improvements.

[1] National DfE programme

Demand is high as a large majority of cluster referrals for guidance and support require TaMHS, whether consultation, assessment, direct individual work, group work, case organisation, or one off support. A continued focus on short-term support enables a reasonable throughput of cases.

Many clusters report a gap between their service offer (TaMHS - early intervention and short term) and the specialist CAMHS thresholds.

CAMHS typically works at a higher level of need than TaMHS, though there are a number of cases that are supported successfully by TaMHS that would meet the CAMHS threshold. There is an established referral pathway that permits swifter, easier and more accurate onward referrals from TaMHS as a result of short term work not fully meeting a pupil's needs or identification of a need that can be better met by specialist CAMHS.

4.2 Specialist CAMHS

Specialist CAMHS is commissioned by Leeds CCGs from NHS LCH and managed through the LCH contract management arrangements, led by Leeds South and East CCG. Prior to the disinvestment this year the LA contributed to the specialist CAMHS provision in the city £0.5 million (partially through embedded staff and to a lesser extent through cash contracts for management, training delivery and adoption support services).

The majority of referrals to CAMHS are currently from GPs, though some come via A&E, school clusters and other health professionals.

NHS Specialist CAMHS is multi-disciplinary (psychiatrists, therapists, nurses, psychologists) and works with children and young people up to 18 with:

- Moderate / severe depression
- Attentional / hyperkinetic problems
- Autistic spectrum disorders
- Moderate to severe anxiety
- Significant conduct problems at home and school
- Mental health problems with learning disabilities
- Eating disorders
- Significant attachment / relationship difficulties
- Obsessional Compulsive Disorder
- Habit disorders

Indications of a need for referral to NHS CAMHS are:

- Serious deterioration in self-care
- All/most family members highly distressed
- Non-school attendance as a result of mental health presentation
- Serious deterioration in academic attainment related to mental health presentation

- Social withdrawal (no contact with friends)
- Relations with peers leading to serious risk-taking.

Accepted referrals are offered an initial appointment for assessment; sometimes one appointment is sufficient to resolve difficulties; however, people generally attend more than once. Depending on the presenting problem various approaches may be offered including; individual therapy for a child or young person, family therapy, work with parents, or carers and sometimes medication.

4.2.1 Urgent & emergency referrals

Where there is concern about immediate safety CAMHS urgent referrals are made and prioritised, e.g.,

- Serious self-harm
- Attempted suicide or high risk of suicide
- Severe restricted eating
- Low Body Mass Index
- Psychosis

There is an on call rota for urgent issues out of hours.

CAMHS is also commissioned to provide an embedded service for some vulnerable groups, for example there are CAMHS practitioners in the Therapeutic Social Work Team and the Youth Offending Team.

4.2.2 Quality

There is an evidence base of effective interventions (i.e., NICE guidance and the CYP IAPT programme), and measures and existing quality improvement networks (QNIC[2], QNCC[3], CORC[4]) to underpin comprehensive high quality CAMHS.

The Leeds service follows NICE guidance and CYP IAPT standards (Children and Young Peoples Improving Access to Psychological Therapies). This is a national programme that is transforming existing CAMHS through workforce development, to embed evidence based pathways, outcome based decision making and increased participation by children, young people and families in service delivery. The Leeds service is a founding member of CORC, and a member QNCC and QNIC.

The new CAMHS minimum data set will provide comparative data in time, though this is limited to NHS commissioned services and as yet there is no timescale for national analysis and publication. Leeds CCGs receive information from the CAMHS provider as set out in the CAMHS minimum data set.

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[2] QNIC – Quality Network for Inpatient CAMHS
[3] QNCC – Quality Network for Community CAMHS
[4] CORC – Child Outcome Research Consortium

There is an intention to merge the CAMHS minimum dataset and CYP IAPT database; the latter particularly holds data relating to the quality of services.

Leeds compares well against established CAMHS performance indicators and service user experience measures. Jon Rouse (DH, Director General Social Care, Local Government and Partnerships) visited the Leeds CAMHS service 8 October as part of the fact finding of the National task force (of which he is co-chair).

4.2.3 Investment

The Leeds CCGs' commissioning investment into CAMHS specialist services is circa £7.9m; this is part of a block contract arrangement and has not been subject to disinvestment by NHS commissioners. However, all NHS organisations were subject to 1.8% efficiency in 2014/15, this was allocated to the LCHT contract via an overall reduction of 1.8% in the contract. However the Leeds CCG's chose to reinvest this 1.8% tariff reduction back into LCHT services so the net impact for 2014/15 was zero.

4.3 Therapeutic Social Work Service

It is well recognised that children in need and children looked after have high levels of mental health difficulties related to their experiences of abuse, neglect and loss; these difficulties may be compounded by experiences in the care system. Currently in Leeds the Local Authority provides a Therapeutic Social Work Service that specifically works with children who have a social worker (so who are identified as a 'child in need', on a child protection plan or who are in the care system).

The team comprises 12 full time and three part time therapeutic social workers with support from experienced clinical psychologists (embedded from CAMHS service), a small admin resource and 1.5 FTE of management support. The team has a strong diversity of practice training from mainstream interventions such as Cognitive Behavioural Therapy (CBT) to creativity based approaches such as play and art therapy and systemic approaches such as family therapy. The team received 553 referrals in 2013-14, the main presenting difficulty was behavioural difficulties and the main client group was children in care. Outcomes have been traditionally defined against caseworker goals but more recently patient and carer defined goal based measures have been introduced. Strengths include increases in placement stability, reductions in carer stress, reductions in measures of symptomatic behaviour and increased resilience reported in child/carer relationships. Current LCC investment in the model is approximately £680K per annum.

4.4 MST

Leeds invests around £1.5 million per year to support 3 area based multi-systemic therapy (MST) teams and a citywide MST Child Abuse and Neglect team.

MST is an intensive family and community based intervention. The team works with young people (aged 11-17yrs) who are at risk of coming into care, are involved with the Youth Offending Service and/or are exhibiting a high level of anti-social behaviour. Typical referral behaviours for the young person will include a number of the following: serious disrespect and disobedience; truancy and academic problems; aggressive behaviour (violence, fighting, property destruction); criminal behaviour; drug and alcohol problems; other high risk behaviours e.g. self-harm; and running away.

4.5 The Market Place

The three Leeds Clinical Commissioning Groups have a contract with the Market Place focusing specifically on emotional mental health and counselling services. They have made further investment - £30k in 2013/14 and £35k in 2014/15 and the total contract value for 2014/15 is now £177.5k. The contract also now contains a CQUIN where 2.5% of the contact value is retained until specific agreed targets have been achieved – this includes use of an outcome monitoring tool 'How do you rate your life' and further development of the activity monitoring system.

The Market Place has different ways the young people can access services for example drop in and one to one counselling. The young people are offered an 'intro' session. This session is not described as an 'assessment', but rather a meeting for the young person to find out about the one to one services on offer and how they work. It is also the place for the worker to assess how the young person is coping, what the issues are, levels of risk and whether the young person is able to manage in a one to one setting on their own and competent in relation to the Fraser guidelines [1985].

My Plan offers flexible one-to-one support, which assists young people to facilitate their own development. It allows 13-19 year olds to build their confidence and work on complex issues, by making a plan and deciding how they want to move forward with whatever aspects of their lives they choose to work on. My Plan evolved out of an identified need for one to one solution focused support that is more informal than counselling using a Youth Work model. This suits the younger age group with 8-12 sessions focusing on the young person's needs. Feedback clearly demonstrates how popular and appropriate this service is, particularly to those young people who may not feel counselling is for them, even though they may be vulnerable and coping with complex issues in their lives, they choose to work with a Youth Worker.

Counselling at The Market Place is primarily Person Centred. This is a model of counselling that keeps the client at the centre of the work. It offers a safe, supportive space in a counselling relationship, in which to explore issues at the young person's pace, in their own way towards a sense of self-valuing and self-worth. During the year the Individual Support work ended as the worker is now a qualified counsellor.

With the additional investment the Market Place is working with Commissioners to provide a service for care leavers. Also a bereavement service has been

developed which commenced in March 2014 and in the first quarter has undertaken sessions for five young people. Posters about the service have recently been circulated including to all Leeds GP practices.

4.6 Specific Pathway/ Innovation

During the last two years there have been a number of programmes of work to develop specific pathways and areas of service development; these are

- Effective support and management of young people presenting in A&E with self-harm (use of a CQUIN across LTHT A&E and Paediatric wards and LCH CAMHS)
- Work with universal settings (particularly schools) to support young people who self-harm (policy, guidance, training, play, pathway)
- Working with young people to develop an emotional and mental health website/service (website developer procured with young people - September 2014)
- The commissioning of the care leaver blended model pilot service offer (digital counselling and face to face via the Market Place) – commenced July 2014
- Current work to improve the support for children who have experienced a bereavement (reported to CTB September 2014)
- Exploration of a TaMHS partnership seed funding model for the SILCs (Specialist Inclusive Learning Centres – schools for children with very complex physical and learning disabilities)

Despite the significant strengths in the city, the complexity of the commissioning picture and diverse funding streams poses challenges, and partners in the city are committed to working together to improve this.

5.0 Whole system review

ICE has agreed that the current situation needs improvement. Whilst there are examples of innovation and excellent teams in the city, there is too much variability and the whole system does not function well together. This therefore introduces inefficiencies, poor experience for children and families as they try to navigate the system and frustration for professionals (those referring into and delivering within the system).

A Joint Commissioning Steering Group has been established to develop recommendations to take back to ICE, on how partners can improve the emotional and mental health service provision in Leeds and address some of the complexities within the system summarised above.

There are some key principles and deliverables integral to the work programme:

- The need to co-design with parents and young people;

- Support emotional wellbeing and resilience through a public health programme
- To strengthen and sustain the city-wide TaMHS offer
- To develop and strengthen the local cluster service delivery model by aligning specialist CAMHS and Therapeutic Social Work service resource to this model (training, supervision, swift access to advice, joint working) and clearly defining what they directly deliver.
- To create one point of access for referrers of children's mental health services
- To maximise the digital opportunities to enhance self-care, improve access and facilitate flexible service provision
- In addition to the local offer, ensure a strong city centre provision (for young people)
- Analysis of information to understand need (refresh current needs assessment document), demand and future requirements of the service (future proof developments)
- Improving services within existing resource envelop by maximising the value of every Leeds pound spent
- Underpin the service developments with the available evidence base of effective interventions
- Establish a whole system method of monitoring delivery and outcomes

Appendix 1
TAMHS spend since the national pilot began in 2007

- **Levels of spending – past, current and future projections[5];**

	2008/09		2009/2010		2010/11		2011/12		2012/13		2013/14			2014/15		
	Cluster	TaMHS	Cluster	TaMHS	Cluster	TaMHS	Cluster	JIF	Cluster	JIF	Cluster	JIF	CCG	Cluster	JIF	CCG
Pilot areas (2 clusters + The Place2Be)	£50,000	£225,000	£50,000	£225,000	£80,000	£194,100	£462,000	£0	£452,000	£0	£452,000	£21,100	£10,000	£452,000	£21,100	£41,000
Expansion #1 (9 clusters)	£0	£0	£0	£0	£0	£0	£794,000	£395,500	£637,083	£395,500	£535,000	£39,051	£0	£675,000	£39,051	£60,000
Expansion #2 (13 clusters)	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£399,853	£506,000	£0	£399,853	£517,000	£0
	£50,000	**£225,000**	**£50,000**	**£225,000**	**£80,000**	**£194,100**	**£1,256,000**	**£395,500**	**£1,089,083**	**£395,500**	**£1,386,853**	**£566,151**	**£10,000**	**£1,526,853**	**£577,151**	**£101,000**
	£275,000		**£275,000**		**£274,100**		**£1,651,500**		**£1,484,583**		**£1,963,004**			**£2,205,004**		

[5] Cluster spending once support is needed i.e. Pilot clusters 2011 onwards and Expansion #1 2013 onwards is estimated.