The Highland Council

Agenda Item	14.
Report No	ACS/74/13

ADULT AND CHILDREN'S SERVICES COMMITTEE
21 August 2013

Primary and Child and Adolescent Mental Health Services

Report by Director of Health and Social Care

Summary

In April 2012, as part of the process of Integrating care between the Highland Council and NHS Highland, the Primary Mental Health Worker (PMHW) Team transferred from NHS Highland to the Highland Council. This service is part of the wider Child and Adolescent Mental Health Service (CAMHS), within the NHS and is required to meet the expected targets of other CAMHS services in providing intervention for all new referrals within 26 weeks of the referral being made. This has not always been possible for the service, and this report provides detail about the issues arising for PMHWs in meeting this target.

1. Background

1.1 Primary Mental Health Workers (PMHWs) are specialist Child and Adolescent Mental Health Service (CAMHS) workers who are qualified and registered with a professional body and have a duty to work to that body's code of practice and ethical guidelines. To meet requirements of professional registration, PMHWs are expected to have regular continuing professional development to maintain and update their knowledge and skill base in relation to specialist CAMHS.

1.2 In Highland, PMHWs come from a variety of backgrounds e.g. mental health nursing, social work, paediatric nursing and allied health professionals. They provide consultation and training regarding child and adolescent mental health to universal services and accept cases directly where focussed, targeted, therapeutic intervention at an early stage is likely to have a long-term benefit to the mental welfare of a young person and his/her family. They provide a service based around associated school groups, local to the centres of population in Highland.

1.3 As part of a Highland wide CAMHS Service, PMHWs are strategically led by the CAMHS Implementation Group, chaired by the Child Health Commissioner for NHS Highland. Since April 2012 however, the PMHW service has been managed within the Highland Council as Lead Agency, by the Principal Officer Additional Support for Learning and Early Education.

1.4 The Phoenix Centre is the central base for CAMHS. It incorporates the services previously known as the Department of Child & Family Psychiatry, the

Clinical Psychology Service for Children & Young People and the Clinical Psychology Service for Children & Young People for Children with Learning Disability &/or Autism Spectrum Disorder. Services are offered direct from the Phoenix Centre or at peripheral clinics across Highland depending on demand and staffing levels.

1.5 PMHWs are not a centrally based service. They provide a service across Highland from 9 geographically spread bases.

1.6 The role of the PMHW is to act as an interface between Tier 1 services (e.g. Children's Services Workers, school staff, Social Workers, School Nurses, Health Visitors) and Specialist Tier 3 CAMHS (Clinical Psychologists, specialist nurses, therapists and Psychiatrists based at the Phoenix Centre). Their aims are to:

(a) Support and strengthen Tier 1 support for mental health through building capacity and capability within Community and Primary Care staff (Statutory and Non-statutory sectors).
(b) Promote the emotional health of young children, young people and families in the community.
(c) Identify mental health problems in children and young people early in their development.
(d) Facilitate appropriate access to Specialist Tier 3 CAMHS and other relevant provision according to the level and nature of need.
(e) Provide a direct service to children and young people with mental health needs at Tier 2, and their families.

1.7 HEAT targets are priorities set by the Government to improve health care in Scotland. They are set for a three year period and progress towards them is measured through local delivery plans. HEAT stands for:

- **H**ealth Improvement for the people of Scotland - improving life expectancy and healthy life expectancy.
- **E**fficiency and Governance Improvements - continually improve the efficiency and effectiveness of the NHS.
- **A**ccess to Services - recognising patients' need for quicker and easier use of NHS services and
- **T**reatment Appropriate to Individuals - ensure patients receive high quality services that meet their needs.

1.8 Timely access to healthcare is a key measure of quality, that applies equally in respect of access to mental health services. Early action is more likely to result in full recovery, and in the case of children and young people will also minimise the impact on other aspects of their development such as their education, so improving their wider social development outcomes.

1.9 The Scottish Government set a national target of 26 weeks from referral to treatment, for patients referred to CAMHS services. This target came into force in March 2013.

1.10 In December 2014, the national target for the wait time from referral to intervention will become 18 weeks.

2 The Primary Mental Health Worker Service

2.1 The PMHW Service currently has 8.7FTE members of staff, spread throughout Highland, providing a locally based service, within each geographical area. Staff work closely with other NHS and Council services and provide both direct intervention to children and young people and also consultation to other professionals working with children and young people. There is a specific responsibility on them to provide training to both universal and targeted services, and this accounts for around 50% of their time.

2.2 Training

The PMHW will identify within ASGs, training needs around mental health promotion. The training packages delivered by PMHWs form part of the training framework detailed on the *For Highlands Children* website and is delivered to Universal Services, Tier 1 staff and foster carers.

Consultation

The aim of consultation within health promotion is to raise awareness of issues affecting children and young people's mental health through the identification of individual mental health needs, and consideration of appropriate ways of meeting these by the multi-disciplinary team around the child. There is likely to be a psycho-educational element within many consultations that can be offered to all Universal and Tier 1 staff.

Direct Contact with Service Users

All direct contact with service users incorporates an element of health promotion. The PMHW will promote mental health and wellbeing through a variety of means, for example:

- Therapeutic work with service users, including individual work with children and young people or work with parents, families, siblings.
- PSE/Curriculum for Excellence programmes, health fairs, management of exam stress, other initiatives with pupil cohorts.

2.3 Direct Therapeutic Services offered by PMHWs

PMHWs provide direct therapeutic services to children, young people and their families from birth to 16 years (or 18 if still at school). Resource and capacity challenges mean that only a limited direct service is available and direct case work will be prioritised appropriately.

There are a range of issues affecting children and young people that can be addressed with direct therapeutic intervention by PMHWs:

- Adjustment difficulties following bereavement and loss
- Low mood
- Anxiety
- Self Harming Behaviours
- Emotional and Behavioural problems
- Relationship difficulties with family or peers where these difficulties are having a significant impact on an individual's functioning.

2.4 Intervention can be provided at different levels but direct intervention by a PMHW is generally provided at Tier 2.

Tier 1 PMHW Intervention

Through joint work with Tier 1 professional with the aim of:

- Undertaking joint assessment on the level of mental health need
- To support the practitioner in work that they are already undertaking
- To provide education and support about specific management techniques
- To provide advice regarding appropriate referral to CAMHS or other agencies

Direct intervention may also include the development and provision of targeted group work programmes such as mental health awareness, relaxation, mindfulness, parenting etc. Delivery of such programmes may be carried out alongside professionals in education, health, social care or voluntary agencies.

Tier 2 PMHW Intervention

PMHWs provide direct specialist mental health assessment and therapeutic interventions to children and families where they have not responded to interventions at Tier 1 and "where the level of need appropriately matches the type of intervention normally provided in a primary care environment. Direct interventions should be brief and tailored to the child/young person's and family's identified needs. Direct work should be evidence-based and drawn from a range of interventions for particular approaches with specific age-groups and life-stages, for example, Cognitive Behavioural Therapy or Solution Focused Brief Therapy. It may also include the provision of targeted group work programmes." (Child and adolescent Mental Health services Primary mental health work Guidance Notes for NHS Boards/Community Health and Social Care partnerships and other partners February 2007 p7)

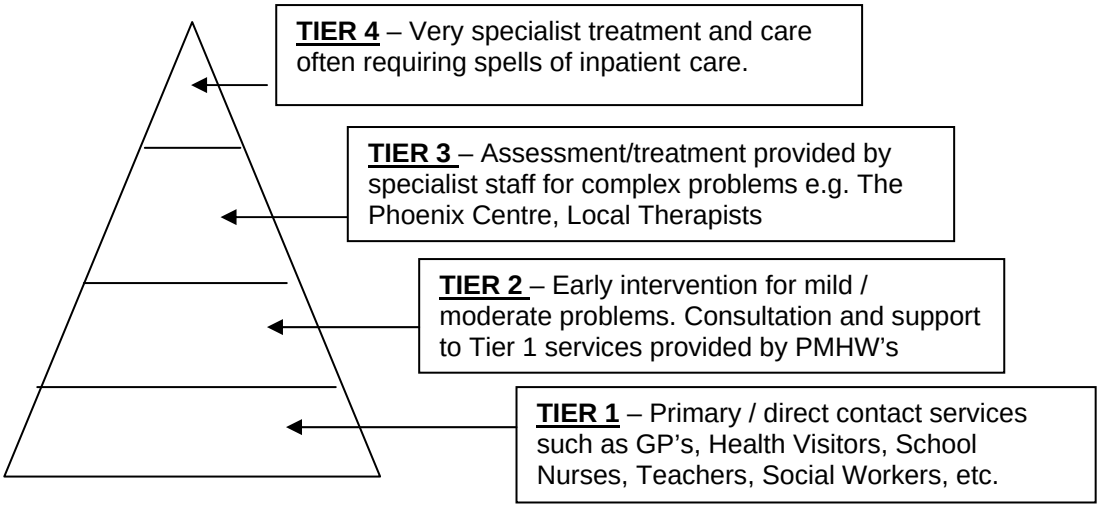
Tier 3 PMHW Intervention

Tier 3 work is the remit of the Phoenix Centre although it has been agreed that a maximum of three Tier 3 cases can be held at any one time by a fulltime PMHW, in partnership with a case holder from the Phoenix Centre. This is dependent on capacity and must be agreed and supported by the PMHW's manager.

Tier 3 cases are distinguished by systemic complexity, chronicity, severity of mental health symptoms or degree of risk. Due to their complexity, these cases usually require containment by more than one mental health clinician.

Tier 4 PMHW Intervention

It is not the Remit of the PMHWs to do Tier 4 work, although they may support other workers who are involved or assist with part of the additional support work that may be required.



3 Achievement of the HEAT Target

3.1 In Highland, the CAMHS implementation and Improvement group has been working with the CAMHS, including the PMHW service, to establish processes for providing effective services and monitoring progress in relation to the HEAT target.

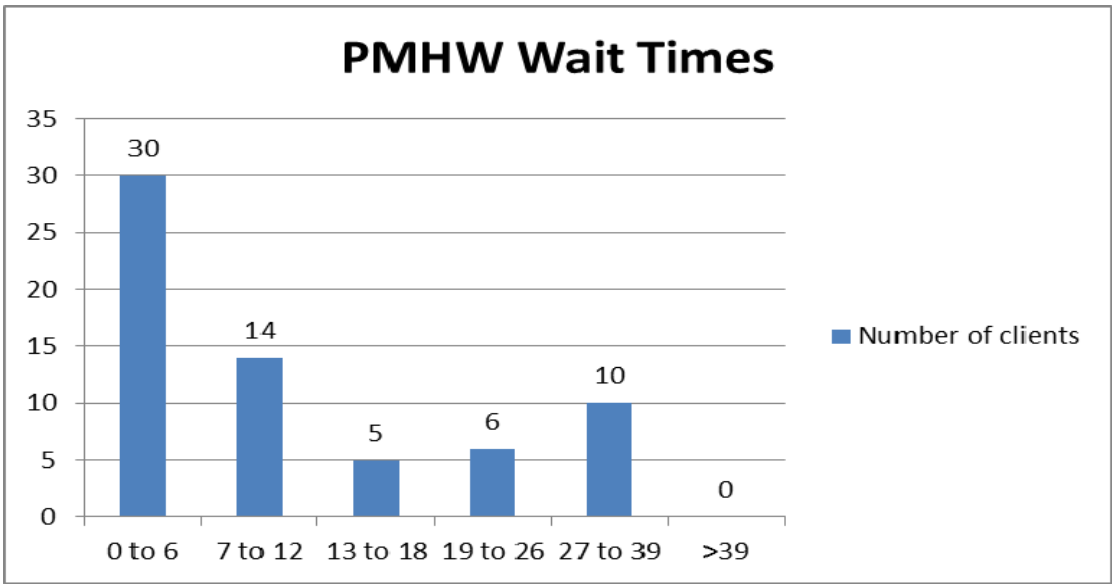
3.2 As part of the monitoring process, PMHWs complete a monthly return and forward this to the CAMHS Service Manager, who collates this information alongside that for the Phoenix Centre Team. This data is analysed monthly and provides information to the Management Team within Health and Social Care.

3.3 Because the HEAT target is applied overall to CAMHS, the wait experienced by patients starts from the point when referral is received by any CAMHS worker. Requests for service to a PMHW may come from a school, directly from a parent, from another professional working with a child/young person, from a GP or other health practitioner, or from the central CAMHS team based at the Phoenix Centre in Inverness.

3.4 Generally, where PMHWS are involved in the consultation directly with a school or other practitioner working with a family, they can provide direct advice to the team. Alternately, they can negotiate the type of intervention that would be appropriate for the child/young person, if direct support is indicated. The team encourages negotiated referrals as they can be clearer before accepting the referral that it is appropriate and can often schedule these into their calendar at the point of referral. Research and experience has shown also that consultation to other Tier 1 services is as effective in containing and addressing the needs of children and young people with lower levels of need and at the point of negotiation, a consultation can be appropriately agreed, rather than more time consuming direct intervention.

3.5 From March 2013, when the 26 week HEAT Target came into force, there have been a total of 65 children and young people who have received

intervention for the first time from the PMHW service. Of these, 55 (85%) have waited less than the 26 Week HEAT target and 49 (75%) have been seen within 18 weeks. A significant number, 46% have been seen within 6 weeks of the request for service being made. The longest wait for any child/young person referred since March has been 36 weeks.



4 Breaches of the HEAT Target

4.1 Since March 2013, there have been 10 breaches of the 26 week target. Where there is a breach of the HEAT Target waiting time, individual workers are asked to provide a report as to why the target has not been achieved. Analysis of this data shows several reasons, which are outlined below.

4.2 In some cases, families do not turn up for the arranged appointments and require a second or third appointment date to be given before the assessment can be undertaken to assess what intervention may be appropriate. These situations can significantly delay the start date for intervention by several weeks.

This accounts for 2 of the 10 breaches of the HEAT Target.

4.3 Although, the guidance from the Scottish Government is that the waiting time clock is reset to zero from the date the second appointment is refused, this has not been the practice of PMHWs to date, but work is planned to ensure consistency in recording these cases.

4.4 In some cases, the initial referral has been received by the central CAMHS team at the Phoenix Centre. They may take several weeks to offer an appointment to the child/young person and then after an initial discussion, may consider that the intervention would be more appropriate to be undertaken by a PMHW and refer the child/young person on. Because of other scheduled commitments, there will then be a further delay before the PMHW will be able

to see the child/young person. The wait time continues at this point however, and so even if this is just a few weeks, if the child/young person has already waited for a CAMHS intervention for several months, by the time the PMHW sees the child/young person, they may have breached the HEAT Target and this will be counted against the PMHW, as the person providing the intervention. Discussions are on-going with the CAMHS management team around reducing wait times across CAMHS.

This accounts for 2 of the 10 breaches of the HEAT Target.

4.5 In some cases, the volume of work and number of referrals is the issue, with delays being caused by other priorities being picked up by the PMHW and less urgent concerns being left longer. While there is a full understanding that early intervention is by far the best model for children and young people with mental health issues, sometimes the workload can result in longer waits. In some of these cases it is felt that better consultation processes may have been appropriate to deal with some of the lower level cases initially, and discussions have been scheduled to discuss how consultation can be used better in some ASGs that up to now have been reluctant to engage in this method of service provision.

This accounts for 6 of the 10 breaches of the HEAT Target.

4.6 As a team, there has been work done on looking at different ways of working and establishing a wider consultation model to ensure that other professionals have some support from the PMHW, especially if there is a delay in picking up a referral. Work has also been undertaken to look at the spread of population and pressure points within the team, with a view to considering a redistribution of staffing to provide additional capacity where this is required - in particular in Inverness and in Fort William.

4.7 All of the 10 breaches of the HEAT Target have been experienced by children and young people in the West, living in Lochaber. Although the population in Lochaber is not greater than in some other areas in Highland with a similar level of PMHW resource, there are 5 ASGs and a large geographic area. It is recognised that there is a need to augment the service in Lochaber and also to make sure that referrals are always necessary and appropriate. There is therefore a need also to invest more time in using consultation as a means of supporting school staff to support young people, rather than direct referrals being made to the PMHW, where the need could be met in some cases by Tier 1 services.

4.8 Adding to the pressure in Lochaber has been an issue with changes to accommodation including clinic space in the Health Centre in Fort William, which is important when seeing young people for therapeutic work. This led to some delays in April/May 2013.

4.9 There has been a vacancy in Wester Ross, arising as a result of the previous worker moving to another job at the start of 2013. This post has now been filled but there are a small number of children who were referred prior to the

summer break, who will have experienced slightly longer than expected wait times due to the vacancy. It is thought that these children will be seen very soon and will not breach the 26 week HEAT Target.

4.10 In all cases where there has been a delay in meeting the HEAT Target, Tier 1 services have remained involved with the child/young person and their family. In several, this has included the support from a Children's Service Worker and in some, an Educational Psychologist and Social Worker were also involved with the family and in supporting school staff. In all cases, the young people had an identified lead professional who could have escalated their concerns if the situation merited this. However, it is recognised that the level of expertise and support that practitioners at this level can provide is not sufficient to meet the therapeutic requirements of young people with moderate mental health needs.

5 Next Steps

5.1 The CAMHS Implementation and Improvement Group will continue to monitor the waiting times for children and young people referred for an intervention from CAMHS. The Principal Officer ASL and Early Education, will continue to be involved in the overall process and specifically in monitoring the work of the PMHW team.

5.2 The systems used to record wait times by the central CAMHS team and the PMHWS are slightly different. To ensure the system for collation of data is robust, consistent with the system used within the central CAMHS team, and can identify the differential waits that are due to the central team and PMHWs when referrals are passed on, a training session has been arranged with the data analyst from NHS Highland and the PMHW team in August 2013.

5.3 The PMHW team will continue their work on looking at the most effective models of working that provide an equitable and effective service to the children and young people across Highland, aiming to provide early intervention that is well within the CAMHS HEAT Target.

5.4 Where there are breaches of the HEAT Target in respect to the PMHW service, each case will be considered with a view to using the information about the issues that have arisen to cause the longer wait, to inform service improvement.

6 Implications

6.1 **Resources**

There are no additional resource implications at present, although an enhancement to the PMHW service is being considered as part of the preventative spend proposals, to ensure earlier intervention and support, specifically in the early years. This would enable an enhancement of resource to those areas with the greatest need.

6.2 **Legal**

There are no legal implications in relation to this issue but there is a requirement on all NHS Boards to work within the national HEAT Targets and the PMHW service will support this national requirement and the local implementation plan.

6.3 **Equalities**

The PMHW service is provided locally, in the geographical areas where children and young people live. The aim of the service is to meet the needs of children/young people with mental health needs timeously. Monitoring this process and considering service improvements where families have waited longer than expected, will enable us to meet our equalities duties for this group of children/young people, who all have a Protected Characteristic.

6.4 **Climate Change**

One of the service models that is being considered is the option of using video conferencing/Skype/Office Communicator/Facetime etc, to provide a therapeutic input to some children/young people, once a relationship has been established. This has been shown to be helpful in working therapeutically with some client groups. This will reduce travel time in some of our remote areas and will therefore both save time, which can then be used in direct intervention with other children/young people, and also reduce the emissions cause by car travel to and from appointments.

Recommendation

Members are asked to note and comment on the contents of this report and the commitment to continue to closely monitor access to the PMHW service with an aim to retaining its focus as an early intervention service.

Bill Alexander

Designation: Director of Health & Social Care

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