Regional Reviews of Tier 4 Child and Adolescent Mental Health Services
Summary and Comment

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<table>
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Executive Summary

1. Context and purpose of the reviews and of this summary and commentary

1.1 This report summarises, analyses and comments upon the findings from Reviews of Tier 4 Child and Adolescent Mental Health Services (CAMHS), undertaken during the past year or two, in the nine regions of England.

1.2 Each review reported on the type, amount and quality of provision and on commissioning arrangements within the region and, in many cases, was the latest in a series of local investigations into tier 4 services.

1.3 The underlying reasons for the regional reviews can be summarised by the following list of problems areas, identified on the basis of findings from the National In-patient Child and Adolescent Psychiatry Study (NICAPS) carried out by the Royal College of Psychiatrists for the Department of Health (2001):

- Increasing referrals to in-patient CAMH services, particularly significantly increased numbers of emergency referrals
- A national shortage of adolescent in-patient beds and a particular lack in developmentally appropriate provision for those aged 16 to 18
- The inability of services to always respond in a timely way to requests for urgent admission and the consequent usage of paediatric and adult psychiatry wards as an interim resource
- Significant gaps in provision including long term therapeutic provision and post discharge services
- Significant problems in recruiting staff, especially nursing staff
- There has been much inter-agency confusion, in particular about the needs of children with conduct disorder and challenging behaviours

1.4 In addition, a major concern is the particularly distressing situation that children with mental health problems find themselves in when admitted to adult wards, which has been taken up by The Office of the Children’s Commissioner (OCC) in its report Pushed into the Shadows (OCC, 2006). The report gives 20 recommendations aimed both at preventing the inappropriate admission of young people onto adult psychiatric wards and at effectively safeguarding those young people who are admitted. The recommendations most relevant to this Summary Review are given at Appendix 2.

1.5 “For many years the idea of tier 4 specialist CAMHS was synonymous with psychiatric in-patient provision, sometimes with day hospitals attached. Tier 4 has more recently come to be understood as multi-faceted, with multi-agency services
that can include inreach, outreach, intensive and crisis community initiatives, day provision, therapeutic fostering and other services that may be described as ‘wrap around’” (Cheshire and Merseyside). Tier 4 services are defined somewhat differently in the individual regional reviews, with many taking a pragmatic definition of tier 4 as “very specialised services in residential, day patient or outpatient settings for children and adolescents with severe and/or complex problems requiring a combination or intensity of interventions that cannot be provided by tier 3” (as described in York and Lamb, 2006).

1.6 The needs that tier 4 CAMHS are required to meet are for children and adolescents with the most severe and complex problems, a relatively small number in any Primary Care Trust (PCT)/Local Authority (LA) area, unpredictable in any one year. These services require highly specialist expertise and/or newly developed approaches and ways of working that are not commonly available across the country and are often expensive. Specialised services at tier 4 are also expected to provide input from a multi-disciplinary perspective involving education and social services, and in a child and family friendly environment.

1.7 The material presented in the regional reviews represents differing stages in the individual regions in working with a strategic approach to the planning and development of tier 4. In some regions, such as the South West, the process of gaining local ownership and agreement to what are the relevant unmet needs in the child population, how local services could be developed to meet the needs, and how commissioning could be arranged so that service developments are robustly funded and well monitored are well advanced. In others, this process clearly still presents considerable difficulties, and the findings and recommendations from their regional reviews, largely carried out by independent consultants, are at an early stage of discussion, with the implications not yet worked through or agreed.

1.8 Differences in how the reviews were undertaken and in the material presented arise, in good part, as a result of the political and organisational context within which they were carried out: at a time when major changes in the configuration and roles of Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) and government regions were being implemented, again with differences in different parts of the country in the ease and speed with which this is happening.

1.9 The individual reviews have different strengths and acknowledge differing purposes (set out in Appendix 1). Different types of data and information are therefore presented. Thus, it has not been possible in this Summary Review to present a complete, nor coherent national picture for any of the areas of interest. And the regional reviews frequently reveal that a complete coherent regional picture is also almost impossible to obtain. It is clear from all the reviews that the data upon which to base demand, unmet need, and costs are patchily available to local providers and commissioners alike, and are often incomplete, collected by different methods and under differing categories from provider to provider even within the same PCT and are generally of questionable quality. However, usually the
information gathered at interview and from consultation with key stakeholders in each review shows significant agreement on the key local issues. This material is taken together in ‘answering’ the following questions posed for this Summary Review.

2. Findings

This Summary Review was asked to address a number of questions, as follows:

2.1 The extent to which the number and distribution of CAMHS specific beds are sufficient or inadequate at national and regional level

The data from the regional reviews are incomplete in describing the current bed numbers, but recent studies from the Research Unit of the Royal College of Psychiatrists (O'Herlihy et al, 2007) reliably give these numbers. This study shows that four regions of England (North West, Yorkshire & Humber, Eastern Region and South West) are still well below the recommended minimum of 20 beds per million population, while the “total bed numbers in England have increased by 284. Sixty nine percent of the increase is due to the independent sector whose market share has risen from 25% in 1999 to 36% in 2006. Regions with the highest number of beds in 1999 have increased bed numbers more than areas with the lowest number of beds in 1999 (8.3 vs. 3.6 beds per million population). In units that admit only children under the age of 14, there has been a 30% reduction in beds available (123 to 86)” (O'Herlihy et al, 2007).

The figures for in-patient bed numbers given in the regional reviews can hide an almost total lack of provision in some areas in individual regions, such as the north west of Yorkshire and Humber. In addition, it is noted that the available beds in a unit variably include a number that may not, in fact be available to a particular referrer because they serve a national catchment or may be purchased by another Primary Care Trust (PCT).

2.2 Provision in the independent sector

Placement of young people in independent facilities, usually out of area, varies considerably between regions and between PCTs within regions; in the Eastern Region for example, these make up nearly 38% of the total tier 4 CAMHS admissions, whereas in Oxfordshire there are none. The explanations repeatedly given in the regional reviews were that out of area treatments (OATS) were rarely made because a young person has an unusual condition requiring supra-regional or national provision but were directly related to the lack of locally available in-patient provision or alternative appropriate provision able to offer accessible and intensive
support on a community basis. There is widespread concern that OATS provide services poorly matched to the needs of the young person and that there is a lack of communication between the independent sector and local tier 3 providers. However, even with their very low bed numbers *Yorkshire and Humber* have very few OATS and their review states that: "It is not only actual bed numbers that need to be considered, but also the balance of provision available, where units are located, their links with other services and the capacity of tier 3 CAMHS".

### 2.3 What types of bed are needed

CAMHS Tier 4 comprises beds described according to:

i) the type of care required by the needs of the young person (covering a range with considerable variation in individual reviews): emergency/acute; intensive care; medium to long term; in-patient; day patient; community based (outreach, home treatment, post discharge, ‘wrap around’); low secure and high secure;

ii) the type of condition indicating certain needs: eating disorder; learning disability; dual diagnosis; conduct disorders; autistic spectrum disorder

iii) age group: children under secondary school age or thereabouts; older adolescents; those about to be classified as ‘adult’/transition;

iv) legal status: young offenders; sectioned under the Mental Health Act 1983

Thus, any description of the ‘types of bed’ that are needed should be read as what ‘types of provision’ are needed.

The type of bed listed as particularly needed in each of the regional reviews is as follows:

- **Emergency provision**: North East and North Cumbria; Yorkshire and Humber; Eastern Region
- **Early intervention**: Eastern Region
- **Intensive care facilities**: North East and North Cumbria; Greater Manchester; London; Thames Valley
- **Community based**: Yorkshire and Humber, as a ‘bridge’ between tier 3 and tier 4; Eastern Region
- **Low secure**: North East and North Cumbria; Greater Manchester; Eastern Region; South West
- **Eating disorders**: London, in-patient provision
- **Learning disability with mental health needs**: North East and North Cumbria; Yorkshire and Humber; Cheshire and Merseyside; East Midlands; London; Eastern Region; South West, severe learning disability with mental health problems
- **Dual diagnosis**: Cheshire and Merseyside; East Midlands; Eastern Region
- **Conduct disorders/challenging behaviour**: Yorkshire and Humber; Eastern Region
- **‘Low incidence needs’, also Autism, Aspergers, Attention Deficit Hyperactivity Disorder (ADHD)**: Eastern Region
- **Under 12s in-patient provision**: East Midlands; London
• Provision for older adolescents and transition: Yorkshire and Humber; London
• Young offenders: Cheshire and Merseyside; London

Generally, the situation is different in different areas within each region, differentially for different types of bed and to meet different types of need. The large question is one of access.

2.4 The use of tier 4 services by those children and young people most at risk, such as looked after children

There is virtually no information in any of the reviews on this matter.

2.5 The use of tier 4 services by children and young people from black and minority ethnic (BME) groups

None of the three reviews that include mention of children from black and minority ethnic (BME) groups gives an analysis of their use of tier 4, relative to that by white British young people, relative to their respective needs. It is otherwise noted that BME groups are under represented among staff.

2.6 The extent to which beds cannot be used because of lack of capacity

Concerns are expressed regarding vacant and frozen posts, shortages of key staff, e.g. social work in some units, and a high turnover of unqualified nurses. This means that certain types of work cannot be carried out and that units may not stay open for 7 days a week, but not that beds cannot be used. However, where it is reported that there is a need for extra staff to ensure security, it may mean that beds cannot be used. Staff retention was reported as difficult due to increased opportunities, higher financial rewards and greater working flexibility and autonomy available within other tiers and services. The level of use of agency staff tends to have a demoralising effect and adds to difficulties in staff retention.

Quality Network for In-patient CAMHS (QNIC) reports reinforce the message regarding difficulties in staff recruitment and retention reducing the ability to offer a wide range of treatments, and report a number of aspects of unsatisfactory quality of provision, most significantly where there is limited or no education provision, although this does not lead to beds not being used. Furthermore, isolation of different parts of the tier 4 service from each other, from tier 3 services, and from other related services can diminish effective capacity.

A number of reports comment on the unsuitability of buildings, lack of space and facilities and generally a poor environment for therapeutic purposes, including one that is not age appropriate. It is nowhere mentioned that this leads to beds not being used. However, it is implied in a number of instances that staff shortages and increasing demand to take children with difficult behaviour, may lead to an inability to admit even when a bed is theoretically available.
2.7 The impact of incompatible potential or actual case mix on admissions and the impact of emergency admissions on the provision of therapeutic services in tier 4.

The admission criteria for in-patient units give an explicit or implicit indication of the types of cases that, if admitted, are likely to give rise to problems because of the case mix usually managed by the unit. It is widely reported that the capacity to admit emergencies varies depending on bed availability, staffing levels and the level of disturbance on the unit. In particular, the needs of those with acute psychosis are felt to be different from those of other groups in a unit, and that this can sometimes lead to difficulties and to the service becoming inaccessible because of bed blocking.

In a survey of all adolescent in-patient psychiatric units in England and Wales (Cotgrove et al, 2007), lead consultants reported that 34% could never admit as an emergency in 2005 and 44% could never admit out of hours. The consultants estimated that, in 2005, they turned away 72% of referrals for emergency admission. Concern was expressed that services are not configured to accept emergency admissions, and that the problem is unlikely to be resolved by requiring units to accept both emergency and planned admissions, as these groups have very different needs.

2.8 The impact of poor staff development or competence/confidence to deal with cases

Very little information is given in the reviews of the extent to which the availability of staff skills and expertise leads to under use of in-patient facilities, except when a lack of a particular type of staff, such as an occupational therapist or over reliance on agency or unqualified nurses means that particular kinds of work, such as group therapy, cannot be carried out. The capability of the staff in working with an age group and a range of conditions is implicit in the admission criteria of most units (see Appendix 4). Concerns are expressed regarding the levels of staff supervision during challenging periods, along with access to specialist and in-house training. However, some reviews comment on the positive capability of staff in a particular unit to manage children with very complex needs or with challenging behaviour.

In general, throughout descriptions of the type of work carried out by current tier 4 services and of new developments to meet the improved recognition of young people’s needs, there is mention of the concomitant need to have staff with particular skills and competence in particular ways of working. This situation is succinctly expressed, although in the particular, for one of the units in the Yorkshire and Humber review: “Oakwood, like most adolescent units is in a period of transition. Previously established as a modified therapeutic community, the demands from referrers are for a general purpose acute admission ward for adolescents. Many of our patients suffer significant and sometimes florid mental illness. And the culture, philosophy and skills of the unit have to adapt to meet this need”.

2.9 The use of adult psychiatric beds by children and the reasons

It is generally reported that while accurate figures are almost impossible to obtain, there is a decreasing trend in admissions of children to adult mental health wards. A few examples were given of adult wards with designated beds for young people, and where there is a close working relationship with the CAMHS. Variable availability was reported of protocols for the use by children of beds on adult psychiatric wards and the necessary quality of care.

2.10 The impact of young people with mental health needs on paediatric beds

The data collected was extremely sparse but the view was widely expressed that children and adolescents with mental health problems admitted to paediatric wards could get a poor service. This is because staff are not equipped to deal with these young people, relying heavily on tier 3 support, which often proves inadequate. In addition, admissions are often prolonged due to lack of availability of services from partner agencies; this places the child at risk and can increase risk to other children on the ward.

2.11 The relationships between emergency provision, available beds, outreach teams, and supporting tier 3 provision

Although the complex interrelationship between the availability of beds and emergency provision, supporting tier 3 provision, and outreach teams is a major theme in the reviews, only dual or possible chain relationships are described, as there is very little direct evidence as to the impact of one element on another. The reviews agree that tier 4 cannot be defined in isolation from tier 3 and that the appropriate role and the effectiveness of tier 4, depend crucially upon integrated working with local tier 3 CAMHS. The reviews therefore, agree that the number of in-patient beds that exist within their boundaries is not really the central issue, although it is a matter for concern where this number falls too low. All stress that the type of intervention and care that needs to be carried out within a psychiatric in-patient setting requires closer definition than at present and will be strongly influenced by service capabilities that can be developed in day patient, outpatient, outreach and community based services. At present, the existence of these kinds of services is patchy, both geographically and in terms of the expertise and facilities they can provide.

2.12 The impact of on-call services on in-patient admission trends

No direct information is given on this topic although, in some reviews, there is mention of an on-call service and that if it is linked to an appropriate specialist team, its use may well prevent in-patient admission. It is of note that the Eastern Region reports concerns at the lack of on-call arrangements by tier 3, which may reflect the
consultants’ reluctance to be on-call because the lack of local in-patient beds means that they cannot place children.

2.13 The pressures on Tier 4 caused by lack of Tier 3 capacity

There is frequent mention of very great variability in Tier 3 services and of a general lack of capacity. The North East and North Cumbria report gives a comparison of tier 4 placements according to the size of 5-15 year old PCT populations, noting that it needs to be interpreted with caution and needs more investigation of the comparative rankings. But a surprising result is that Sunderland, with the fourth highest population, was twelfth in the use made of tier 4 facilities, with “the level and strength of tier 3 as a probable factor”. Greater involvement of tier 3 consultants in assessment and decision making for tier 4 is seen as highly desirable, partly to upgrade their skills. Tier 3 is especially important for young people resident in outlying areas of a region, including its role in improving access to tier 4, when necessary.

In London, while accepting that there would always be a need for in-patient beds, many providers and commissioners felt that improved resources at tier 3 would lessen demand on tier 4, either by preventing admission or reducing lengths of stay. This included more day care provision, assertive outreach and more work on identifying and putting in place alternatives to in-patient care such as home treatment. Alongside this, local authority services, such as supported housing would also help to prevent delayed discharge from in-patient care.

2.14 The cost of in region and out of region placements, by region

With very few exceptions, it was reported as difficult to obtain accurate costs for tier 4 services, let alone comparable information for placements in the independent sector, within and out of region. Information on costs was widely reported to vary considerably from provider to provider in terms of the range of staffing and activity covered; also, it was often not possible to separate costs of tier 3 and tier 4 outpatient services provided by the same Trust. Data was often not given separately on the amount spent on independent sector placements by the NHS and by the Local Authority. The information that is available in the reports is given in the main body of this report, but comparisons between regions of figures reliably derived in the same manner, of total costs per annum, are well nigh impossible as they relate to differing population numbers calculated on differing bases; and figures for cost per case are often not given.

It is clear that there is considerable variability in the costs of both in region and out of region placements, both between PCT and providers within individual regions and between the regions. The links between in region and out of region placements are discussed at 2.2 above. But as an example, the South West reports that the distribution of expenditure within the region in 2006 was found to “show great variation from place to place. The highest spending PCT spends more than twice as
much per child as the lowest; for local authorities the spread is more than three
times. The differences are not proportionately reflected in workload, there are places
with above average expenditure and below average workload, and vice versa,
raising significant questions of value for money”.

The South West report, further states that any attempt to compare costs across the
regions should compare the activity that is funded, i.e. that “it will be more useful to
analyse total CAMHS cost per child population, or total CAMHS system cost per new
tier 2/tier 3 case (a broad and relatively robust measure of load on the whole
system) than, for example, tier 4 cost per in-patient day, which obscures the greater
cost issues of the number of tier 4 cases and of length of stay”. Bearing in mind all
the provisos regarding the major inadequacies of the data, the following table (taken
from the South West report) shows this:


<table>
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<th>Region</th>
<th>cases in sample period</th>
<th>annualised cases</th>
<th>cases / 1000 children aged 0-17</th>
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Note: London data differs in many respects from the rest of England, so a line
showing the average for England excluding London has been given as possibly
more useful as a comparator.

### 2.15 The level of joint commissioning and bi and tri-partite funding

Very little information is reported, on local authority funding in particular, and even
less on the education component. Generally, the impression is that one or more
agencies jointly sign up to placements on a case by case basis, with little specific
commissioning and mostly spot purchasing. Clearly, commissioning arrangements
and joint funding vary: in a few places, protocols and at least ‘virtual’ pooled budgets
are operating; in others, several separate CAMHS partnerships within a region, each
with a small budget, mean that no economies of scale have been achieved.
2.16 The potential to develop regional commissioning arrangements and the outcomes of these collaborative arrangements

Weakness in the commissioning process was identified in many parts of individual regions and, in some cases, an absence of effective provider and commissioner dialogue through which to reach agreement on the priorities for tier 4 to address, both locally and across the whole of the region. Providers find it difficult to deal with so many commissioners and there is lack of a shared vision about what tier 4 services should be delivering and to whom. It was suggested that, potentially, greater problems could result from new NHS organisational perspectives, where larger geographical areas may encompass an increased number of organisations. Most of the regions have begun to set up a variety of collaborative commissioning arrangements, or plan to. In Yorkshire & Humber commissioning has tended to sit with individual PCTs, but this is undergoing considerable change, with South Yorkshire operating a consortium arrangement (covering 13 PCTs) through NORCOM (North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium). And in the North and West of Yorkshire, PCTs are in the process of coming together, with one commissioning team covering both areas. There is indication that regional commissioning in some form will take place in 2007. The East Midlands is planning to develop a Regional Collaborative Commissioning Framework Project, involving Local Authorities, PCTs, and other organisations concerned with planning and commissioning. The aim is for each children and young people’s partnership in the East Midlands to achieve the desired outcomes for their children and young people and best value through a common framework which promotes effective commissioning of local and regional provision.

North East and North Cumbria recommend that PCTs agree a lead commissioner for tier 4 CAMHS and equivalent services for children and young people with a learning disability. Four of the five sectors in London have a designated lead PCT and hold a sector wide meeting to monitor the block contract they have with the local provider Trust and discuss service issues. A pan-London collaborative commissioning strategy is recommended to achieve more effective and efficient use of resources and ensure that care is provided in the right place at the right time. Such commissioning arrangements would harmonise PCT contributions, share risk and give providers greater stability of committed funds.

In Cheshire and Merseyside a ‘Tier 4 Zonal Group’ provides a network that works with the Specialist Services Commissioning Team; this collaboration has begun to develop performance management of both existing in-patient units. In Greater Manchester, where the current situation is that commissioners spot purchase in the independent sector, the review reports that a North West region wide group is developing to work on in-patient provision for children and young people with severe learning disabilities and challenging behaviour, and has been recommended to consider the feasibility of setting up low secure provision for the local population. The report recommends that commissioning arrangements are led by Manchester PCT and become part of the Greater Manchester mental health collaborative.
Finally, in the South West, an agreed framework for a regional commissioning strategy recommends that commissioning for the majority of CAMHS provision should be done by PCTs in partnership with Children’s Services, although some—with the relatively scarce skills and resources required to meet the more complex needs of some children, will need to be commissioned with other PCTs/LAs within wider, but still ‘local’, partnerships.

The South West region framework stresses the need, recognised more widely, to develop the skills, capacity and expertise of commissioners within a multi-agency training programme.

2.17 The use of national and specialised commissioning arrangements

Very little information is given about specialised commissioning arrangements at the present time, although some are mentioned, usually for a particular type of work or the work of a particular unit. But the thinking in other regions is typified by the recommendation in the South West Commissioning Framework for the establishment of a “multi-agency regional commissioning structure under the Specialised Commissioning Group (SCG) to drive local partnership development and commission highly specialised services on a regional or national basis”.

Currently, national commissioning arrangements remain those for PCT top sliced services, commissioned by the National Commissioning Group, formerly NSCAG (National Specialist Commissioning Advisory Group): the secure adolescent forensic mental health in-patient services in Newcastle, Manchester, Birmingham, London (2 units), and Southampton; the in-patient service for deaf children with mental health needs in London, with a related service model in York and Dudley; for Obsessive Compulsive Disorder (OCD) in London; and the Newcastle unit for young people with learning disabilities, with some beds at St Andrew’s in Northampton.

2.18 Any solutions identified that might ensure sufficient tier 4 capacity and capability to meet the needs of local population

The reviews all acknowledge that the over riding ‘solution’ lies in knowledgeable and effective commissioning of tier 4, closely linked with, and informed by, what is commissioned in terms of tier 3 CAMHS. A number of reviews mention that a proper needs assessment for tier 4 is required for the regional population, essentially matched with all aspects (access, appropriateness, effectiveness etc.) of the services and resources that are currently available in, and for, the region. In this way, gaps will be identified in relation to current understanding of the needs of children, young people and their families and not limited to the aspirations of individual providers. The gaps need to be filled with clear specification of the service responses to particular types of need, with creative use of the available evidence for what will make a positive difference in outcomes for these young people. The reviews also give details of numerous promising initiatives that have been set up to improve tier 4 capacity, from which a very great deal can be learnt and built upon in
all parts of the country. These include well known examples that can be referred to in the National CAMHS Support Service (NCSS) website www.camhs.org.uk and the CSIP Knowledge Community http://kc.csip.org.uk/ and less well established services such as:

- Assertive Outreach teams to prevent in-patient care
- Early Intervention in Psychosis services to reduce demand for in-patient admission and length of stay
- Crisis Intervention/Home Treatment teams to support young people on discharge from in-patient units, reduce length of stay and prevent readmission. Home Treatment teams may also be successful in engaging with groups who would not typically take up tier 4 services
- Multi-disciplinary Referral Panel to reduce the level of inappropriate in-patient admissions
- Peripatetic Specialist Assessment team to enable children to stay at home, while ensuring that admission, if needed, is made to the appropriate service
- Community based delivery of new treatment modalities, such as Dialectical Behaviour Therapy (DBT).

3. Conclusions and Recommendations

3.1 The regional reviews present a wealth of material, which often also refers to fairly recent previous reviews related to tier 4 CAMHS. Each acknowledges that the review is a part of work in progress, aiming for a strategic approach to develop more comprehensive, equitable and effective tier 4 responses to the complex mental health needs of children and adolescents. However, the reviews clearly reveal that attainment of this aim is at very different stages in different parts of the country.

3.2 These differences arise in good part as a result of the political/organisational context within which the reviews were carried out, at a time when major changes in the configuration and roles of PCTs, SHAs and government regions were being implemented, again with differences in different parts of the country in the ease and speed with which this is happening.

3.3 Because of these changes, the reviews often found it difficult to relate data, which almost exclusively still comes from the providers, to populations. Individual PCTs varied considerably in their capacity to provide information on this client group. And with so many PCTs and SHAs, often with new boundaries, a 'regional' picture was also, understandably, difficult to obtain. Thus, the reviews vary considerably in the type of material presented and the amount of detail.
3.4 A lack of information and poor data is a major theme throughout the regional reviews. This is a longstanding issue and includes: problems with poor data collection systems, unreliable data, commissioning structures being short circuited by direct consultant referrals leading to patchy recording of basic information, and a general wariness to share information about tier 4 needs and activity, including both NHS and independent providers, because of commercial interests and reputation issues. Thus, this Summary Review has not found it possible to pull together a credible coherent national picture of many of the aspects of tier 4 provision, nor, indeed, to make meaningful comparisons of provision between the regions. However:

3.5 With regard to services with a national catchment, for the very highly specialised needs of deaf children and those with severe learning disability and mental health problems, the current moves, via NCG commissioning, at least to increase the provision and to locate the still very few units in both the north and the south of England are promising. More information is required to determine the impact of these recent developments on equitable access and improved outcomes; much of this information should become available from specific evaluation studies that are in train. More information is also required to make the case for national commissioning of emerging models of provision for the mental health needs of young sexual abusers and others with similarly complex conditions that are becoming better understood.

3.6 However, the national perspective is crucially important in identifying the relevance for tier 4 services of existing policy, such as *Pushed into the Shadows* (OCC, 2006), and of potential policy development. Implementation of national policy that will influence how effectively and appropriately the needs of the relatively small group of young people with severe and complex mental health problems also depends largely on national oversight.

Thus, we recommend

- the continuing support of a National Working Group (such as already exists for tier 4), charged with gathering continuing intelligence on all matters related to how and how well the needs of children with severe and complex mental health needs are being met across the country. This will include attention to data systems (as at 3.12) and may include funding for evaluative research on tier 4 service developments.
- continuing support for mechanisms by which to share this intelligence, such as a database of promising and good practice;
- continuing support to regional/local commissioners and providers in identifying and sustaining appropriate service developments to meet the needs of their populations; this will include innovative approaches that have still to be evaluated.
- support for tier 4 commissioning by the National Specialised Commissioning Group, one of the tasks of the National Working Group (see 1st bullet point above)
3.7 At a regional level, four regions currently have in-patient bed numbers well below the recommended level. However, it was widely acknowledged that simply increasing the number of in-patient beds would not solve the well documented unmet needs among children with complex mental health problems. There is enough evidence to show that children’s needs will be met most appropriately and cost effectively by a range of types of in-patient, day care, and community (and home) based services. In every region, the picture is different of the provision that already exists and does not exist, what is working well and what is not working well.

Thus, we recommend

- That each region builds on the work carried out for its regional review by improving and refining its intelligence on the access, appropriateness and quality of the within region provision of facilities by which comprehensively to assess, hold safely, manage in the short term and treat, if necessary, children who present in crisis. It is essential that these children are enabled to engage with helping services and are supported beyond any crisis situation by provision in a child and adolescent psychiatric unit, by a community/home based treatment programme. In this way, each region will take on recommendations 1, 2, 3 & 5 of *Pushed into the Shadows* (Appendix 2).

- The first stage in this process is to map, on a population basis, not from a provider perspective, the access for local children to the range of facilities that they may need. And on this basis, commissioners with their local NHS providers and where appropriate, local and out of area independent sector providers should develop plans for services that will fill the gaps in equitable access to a level and quality of provision that can meet the needs of young people. This mapping is already being supported by the National Tier 4 Working Group.

3.8 The mapping described above is an essential part of the commissioning process. The regional reviews make it clear that the overriding need at present is to develop the commissioning and specification of tier 4 provision, and that commissioners need developing as well as commissioning. The poor development of comprehensive commissioning can be seen in the striking differences in the establishment of innovatory approaches on a local basis, such as intensive home treatment. A commissioning framework needs to accommodate these different starting positions and incorporate them into the relatively complex system formed by CAMH services, from non specialist primary intervention through a range of referral and access arrangements to different levels of specialist services. The details of these arrangements also vary from place to place, but everywhere share the characteristics of a system: the parts are interdependent. And demand for tier 4 services depends in part on the capacity, capability and confidence of tier 3 services to manage risk and complexity; access issues for tier 4 services may influence the direction of tier 3 development. The ‘system’ must include integrated working between child and adolescent and adult mental health and health services, and local authority services. For example, pooled budgets for low secure provision with tier 3/tier 4 could well obviate inappropriate admissions to psychiatric in-patients.
3.9 Close working with the commissioning of tier 3 is strongly implied. As indicated by York and Lamb (2006), the capacity and capability of tier 3 does, indeed, largely ‘define’ what tier 4 is. This leads to great variability in access to tier 4, in the ways in which the needs for tier 4 are defined, in the skills and resources required, and in the ‘outcomes’ of tier 4 services. Lack of data means that it is barely possible in certain instances to draw coherent boundaries, on the basis of numbers and needs, between what tier 3 and tier 4 services would best be providing for young people with conditions such as autistic spectrum disorder and emerging personality disorder. But this also applies to our increasing understanding of conditions such as clinical depression in the young. In many ways, it would be helpful if it was not seen as desirable to draw exact boundaries between tier 3 and tier 4 but to define the elements of these specialist services that should be available, with the skills and resources attached, and how they should integrate with each other to meet the continuum of young people’s needs.

3.10 All the reviews recommend that tier 3 services be developed in order to establish optimum provision for the needs of children, young people and their families. Even the review for Cheshire and Merseyside, where it is well recognised to be poorly served in terms of in-patient beds, states: “there has to be more to a new model than extra in-patient capacity” (p 23). And stresses the need for a whole systems perspective to development, with flexible budgets across tier 3 and tier 4 and a need to overcome competition between tier 3 and tier 4 services locally.

We recommend that
- the commissioning of Tier 4 services is given due priority in each region of England. This should take account of the absolute necessity for commissioning tier 4 services in collaboration with the commissioning of tier 3 and jointly, by mental health commissioners of children’s and adult services, with the appropriate commissioners of social care. This attends to recommendation 7 of Pushed into the Shadows.

3.11 It is highly important to identify leadership for the commissioning process to work within each region and collaborate on issues that would benefit from the sharing of scarce time and expertise, such as identifying unmet needs, development of core service specifications, monitoring data sets and setting standards (HASCAS standards for in-patient units are given at Appendix 3 of the North East and North Cumbria review). Immense support would be given to regional commissioning with the establishment of regional clinical networks.

We recommend that
- where leadership for Tier 4 commissioning is lacking in a region, that it is sought with urgency. The CAMHS Regional Development Workers play an important role in this as do, or should, the appropriate Specialised Services Commissioners.
• We further recommend that it is fully acknowledged that commissioning of complex services such as Tier 4 CAMHS requires specific knowledge and skills, and that funding is specifically designated to support the education of the commissioners. This should be regarded as important as the clearly indicated requirement for skills development in the provider workforce.

3.12 If commissioning is to be effective in the strategic development of effective provision for tier 4 type needs, there is an urgent requirement to improve the quality of the data and information that describe what is being provided, to whom it is being provided, its cost and the outcomes of provision.

We recommend that
• PCT and regional commissioners and the National Working Group work together with providers to specify their data requirements and agree a range of standard measures in common. Contracts and service level agreements with providers should include the requirement for provision of the agreed data. This is in accordance with recommendation 6 of Pushed into the Shadows.

3.13 The experiences of young people and their families should inform both commissioners and providers on the way in which services are provided and what is provided. To date, their views and opinions have been incorporated into practice in relatively limited ways. Good use should be made of the learning presented in some of the regional reviews, (e.g. North East and North Cumbria) regarding the incorporation of user views into commissioning, monitoring, and evaluating tier 4 provision.

We recommend that
• providers and commissioners find effective ways of regularly obtaining user views; that these inform service development and practice and that feedback on this is made readily available.
Summary and Commentary on the Findings of the Reviews

1. Context and purpose of the reviews and of this summary and commentary

1.1 At some time over the past 2 years, eight government regions in England have undertaken a review of the provision and commissioning arrangements for Tier 4 Child and Adolescent Mental Health Services (CAMHS) for the population in their area. This report summarizes the findings from these reviews, as requested, and comments, where possible, on:

- the extent to which the number and distribution of CAMHS specific beds are sufficient or inadequate at national and regional level
- the use of tier 4 services by those children and young people most at risk, such as looked after children
- the use of tier 4 services by children and young people from black and minority ethnic (BME) groups
- the extent to which beds cannot be used because of lack of capacity
- the impact of incompatible potential or actual case mix on admissions
- the impact of poor staff development or competence/confidence to deal with cases
- the impact of emergency admissions on the provision of therapeutic services in tier 4 provision
- the use of adult psychiatric beds by children and the reasons
- the impact of young people with mental health needs on paediatric beds
- the relationships between emergency provision, available beds, outreach teams, and supporting tier 3 provision
- the impact of on-call services on in-patient admission trends
- the pressures on tier 4 caused by lack of tier 3 capacity
- the cost of in region and out of region placements, by region, and the links between availability of beds in region and out of region placements
- the level of joint commissioning and bi and tri-partite funding
- the potential to develop regional commissioning arrangements and the outcomes of these collaborative arrangements
- the use of national and specialised commissioning arrangements
- any solutions identified that might ensure sufficient tier 4 capacity and capability to meet the needs of local populations

1.2 Broadly speaking, the underlying reasons for the regional reviews and for this exercise in pulling together their findings are as expressed in the Introductions of a number of the review reports; first, noting the recent change in what is meant by Tier 4: “For many years the idea of Tier 4 specialist CAMHS was synonymous with psychiatric in-patient provision, sometimes with day hospitals attached. Tier 4 has
more recently come to be understood as multi-faceted, with multi-agency services that can include inreach, outreach, intensive and crisis community initiatives, day provision, therapeutic fostering and other services that may be described as ‘wrap around’” (Cheshire and Merseyside).

1.3 Yet somehow, along with more imaginative thinking in this area, in-patient provision specifically has become reduced in many areas of the country: “During the late 1980s and the 1990s bed numbers decreased but not as a result of policy guidance or in the light of clear cut alternatives to in-patient care being developed” (Dr Bob Jezzard, Senior Policy Adviser for CAMHS, Department of Health in the Foreword to the Tier 4 Strategy for Improving In-patient Child and Adolescent Mental Health Services in the West Midlands).

1.4 Since the National Service Framework (NSF) for Children, Young People and Maternity Services (DH, 2003) was launched, significant progress has been made in CAMHS, noted as follows by the November 2006 Report on the Implementation of Standard 9:

- That expenditure on CAMHS has risen from £248 million in 2002/03 to an estimated £513 million in 2005/06
- An increase in CAMHS staffing of 27%
- An increase in the number of cases seen
- Children and their families are seen sooner
- In June 2006, over 85% of PCTs were commissioning 24 hour and emergency services compared to 2002 when there were less than half
- In June 2006, 59% of PCTs were commissioning CAMHS for children and young people with learning disabilities, an increase of almost half compared to the end of 2004/05.

But a good deal of evidence shows that tier 4 services have not made similar progress: the National CAMHS Mapping Exercise 2005 reported that, nationally, there was only a small growth in tier 4 teams during 2004: that staffing increased by 7%; and that only 5% new investment was made in this area.

1.5 There is widespread concern about the shortage of in-patient beds and that children and young people are admitted inappropriately to both paediatric and adult mental health units, as well as the placement of young people in units that are a long distance away from their families and home services. Children and young people are increasingly placed in independent sector units, which may be desirable when these cater specifically for those with particular problems but otherwise may not offer best practice or best value.

1.6 The particularly distressing situation that children with mental health problems find themselves in when admitted to adult wards has been taken up by The Office of the Children’s Commissioner in a major report, Pushed into the Shadows (OCC, 2006): “Their needs are very different to those of adults, and their management demands specialised skills in the staff caring for them, particularly in understanding what it is like to be a young person today and the impact a mental health problem
has at a time of rapid physical and emotional development. We cannot say at present that a young person should never be admitted to an adult psychiatric facility. Some will, in certain circumstances, prefer it, whilst there will be little choice for others, for example those in need of emergency care who live some distance from the nearest adolescent facility. Too often the reason for admission to an adult facility is that there are simply no suitable beds” (p 5-6).

The report gives 20 recommendations aimed both at preventing the inappropriate admission of young people onto adult psychiatric wards and at effectively safeguarding those young people who are admitted. The recommendations most relevant to this Summary Review are given at Appendix 2.

1.7 The needs that tier 4 CAMHS are required to meet are for children and adolescents with the most severe and complex problems, a relatively small number in any PCT/LA area, unpredictable in any one year. These services require highly specialist expertise and/or newly developed approaches and ways of working that are not commonly available across the country and are often expensive.

1.8 Tier 4 services are defined somewhat differently in the individual regional reviews. Many take a pragmatic definition of tier 4 as “very specialised services in residential, day patient or outpatient settings for children and adolescents with severe and/or complex problems requiring a combination or intensity of interventions that cannot be provided by tier 3” (as described in York and Lamb, 2006).

1.9 Other reviews adopt the definition first proposed in Together We Stand (HAS, 1995): “Tier 4 services involve working with children and young people who have highly specific and complex issues requiring intensive outpatient, outreach, day patient and in-patient provision, secure provision or other very specialised assessment, consultation and intervention services. These require considerable resources, including, for example:

- in-patient psychiatric provision for adolescents
- secure provision
- specialist facilities for those with sensory handicaps
- very specialised services (outpatient, day and in-patient) for young people with severe eating disorders
- specialised neuropsychiatric outpatient and in-patient services
- consultation services for rare paediatric disorders

All tier 4 services are regarded as specialised, which require considerable multi-disciplinary working and resources not normally found at tier 3. Specialised services at tier 4 are expected to provide input from a multi-disciplinary perspective involving education and social services, and in a child and family friendly environment”.

1.10 The multi-disciplinary, multi-agency nature of tier 4 is thus explicitly recognised, as in the Children’s National Service Framework: “The care of seriously disturbed children and young people (tier 4) should be provided by a network of services that include NHS, social care and youth justice provision, voluntary sector
and the private sector offering in-patient/residential, day patient, in and out reach and therapeutic foster care. These services should be closely linked to the local community CAMHS. In many parts of the country and for some groups of children, for example those who are learning disabled, this will require a significant investment in, and development of, new staffing, additional buildings and refurbishment of current facilities” (DH, 2003).

1.11 The National CAMHS Mapping Process gives more detail to an expanded definition of ‘Tier 4 Special Care Teams’: “Special care is for those cases whose treatment or care requires more than can be provided in weekly or twice weekly sessions. This may take the form of whole or half day activities, in-patient care, or outreach support (such as emergency or after care) as an alternative to in-patient care. Day, in-patient and intensive fostering services will always fall into this category, as will intensive home visiting and/or frequent and unscheduled attendance at day care to avert the need for residential care. Some services may provide more than one of these types of care. Tier 4 Special Care teams provide care and treatment for children and young people in phases of acute disturbance; professionals are increasingly exploring the possibility of managing crises at home through intensive home support and use of day attendance at specialist units”.

1.12 The idea that well designed community based services can obviate the need for in-patient admission has probably been one of the factors in the reduction of in-patient provision in many areas of the country. And it was reported that differences in the definition of tier 4 services, and an inability so far for PCTs, SHAs, or ‘sectors’ (in London) within a region to agree on a definition, is a considerable barrier to their cost effective development. While all the reviews acknowledge difficulties in drawing boundaries that define tier 4 and largely acknowledge that the implications arising from any review must take account of these services as embedded within a CAMH service system – indeed, a children’s services system, they vary in the extent to which they provide information covering both the largely agreed core elements of tier 4 (listed at 1.8) and the tier 4 type provision that is integrated or linked with the other CAMHS ‘tiers’ of provision and children’s (and adult) general, multi-agency provision.

1.13 The review from the South West region tackles this issue head on. It does not, strictly, present a review but sets out a strategic commissioning framework, based on several previous reviews within the region. They “have largely avoided the description ‘Tier 4’…” as “we do not believe it will be practical or helpful at present to attempt a universal clinical definition of tier 4 services which will be sufficiently robust to allow the services to be commissioned independently of arrangements for commissioning other CAMH services. ‘Highly specialised’ is a description which (while still having the connotations of case complexity, or scarcity of treatment skills or facilities) may be adapted in different places to the context of local service commissioning”. .... “We recommend a programme of commissioning development which will lead to a convergence in understanding of ‘highly specialised’ CAMHS over a period of time. .... We think it useful to distinguish three levels of CAMHS:
• *domestic* services, where the level of demand and the level of specialist skills required mean that a service can be provided for the population of the core PCT/Children's Services Department (CSD) partnership alone;
• *local* services, where a small number of neighbouring PCT/CSD partnerships have together a sufficient population to provide more highly specialised services. Evidence from around the region suggests that a total population of about 700,000 people (or a 0-17 population of about 135,000) would be sufficient to support a range of services, including a generic in-patient unit, capable of meeting a very high proportion of the more complex needs at an appropriate balance of accessibility and economy; and
• *regional* (or national) services, where the needs are so complex and the cases so few that a more remote solution must be provided. The regional services might stand alone, but might also with advantage be attached individually to one of the local service centres as a special interest.

The *South West* is among the few regions that sought primarily to approach their review of tier 4 from a population needs perspective. However, probably because the available data largely are based on provider demand and activity, the reviews, essentially, describe what services are available; and in some cases, data is not given of the beds available but limited to the number of bed days used over a year in individual units.

1.14 All the reviews describe their purpose as ‘work in progress’ in developing a strategy for tier 4. The review, often, is one of several recent reviews of local tier 4 provision, recognising inequities in geographical access and in provision for certain age groups, types of condition or types of service response and acknowledging poorly documented indications of inadequacies in the quality of provision. The reviews report differing stages in the local progress in regional and more local strategy development.
2. Findings

2.1 A note on data quality

Individual reviews have different strengths and acknowledge differing purposes (see Appendix 1). Different types of data and information are therefore presented. Thus, it has not been possible in this Summary Review to present a complete nor coherent national picture for any of the areas of interest. And the regional reviews frequently reveal that a complete coherent regional picture also is almost impossible to obtain. It is clear from all the reviews that the data upon which to base demand, unmet need, and costs are patchily available to local providers and commissioners alike, and are often incomplete, collected by different methods and under differing categories from provider to provider even within the same PCT and generally, are of questionable quality. However, usually the information gathered at interview and from consultation with key stakeholders in each review, and frequently from previous relevant recent reviews and small scale studies, shows significant agreement on the key local issues. This material is taken together in ‘answering’ the questions posed for this Summary Review.

2.2 The extent to which the number and distribution of CAMHS specific beds are sufficient or inadequate at national and regional level

2.2.1 There is no absolute standard for bed numbers, based upon evidence for either population needs or the effectiveness of in-patient (IP) provision. A proxy measure of 20-40 IP beds per 1,000,000 total population is generally used, as suggested by the Royal College of Psychiatrists (Cotgrove et al, 2004). Data on population numbers and in-patient beds are given below as presented in the reviews themselves.

No attempt has been made in this summary to calculate these numbers, check their accuracy, or to estimate the desirable number. Where this is not stated, it is assumed that population denominators are taken from the Office for National Statistics (ONS) 2001 census. At Appendix 4 are tables for each region, giving (where this is given in the reviews) the number of in-patient and day patient beds for the younger (children) and the older age groups (adolescents), respectively, provided in each unit in the region.
## Population numbers and in-patient beds per region

<table>
<thead>
<tr>
<th>Region</th>
<th>PCTs</th>
<th>SHAs</th>
<th>Population</th>
<th>In Patient (IP) beds</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East &amp; North Cumbria</td>
<td>13</td>
<td>2</td>
<td>2,545,073 6,827,170 495,000</td>
<td>102</td>
<td>80 IP beds 22 day places</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber</td>
<td>14</td>
<td>1</td>
<td>5,038,849 (review figures) 4,964,833 (ONS 2001) (0-19) 1,270,475</td>
<td>44</td>
<td>If intensive day provision, home treatment &amp; outreach places from local CAMHS/NHS are added, this figure rises to 141, with the ‘other’ provision used by residents, the figure is c.180 beds. Based on the RCP recommendation of 20-40 beds per 1 million population, there should be between 99 - 198 IP beds in the region.</td>
</tr>
<tr>
<td>Cheshire &amp; Merseyside</td>
<td>15</td>
<td></td>
<td>2,400,000</td>
<td>14</td>
<td>8 LAs recommended bed nos. 40 - 60</td>
</tr>
<tr>
<td>West Midlands</td>
<td>17</td>
<td>1</td>
<td>5,300,000</td>
<td>44</td>
<td>14 LASSDs 45 commissioners of ‘secondary’ MH services and also a Specialised Commissioning Services agency</td>
</tr>
<tr>
<td>East Midlands</td>
<td>1</td>
<td></td>
<td>4,172,174 (ONS 2001) (0-18) 991,406</td>
<td>56</td>
<td>36 IP beds 20 day places</td>
</tr>
<tr>
<td>Eastern Region</td>
<td>3</td>
<td></td>
<td>5,388,140 (ONS 2001)</td>
<td>65</td>
<td>10 for children up to the age of 12 10 are in the independent sector; recommended bed nos. 106 - 212</td>
</tr>
<tr>
<td>London</td>
<td>31</td>
<td>5</td>
<td>7,500,000 (NHS London) (0-17) 1,618,575 (ONS 2001)</td>
<td>138</td>
<td>There are 37+ day places for adolescents, 2 for children and 4 for both age groups. Reports that, including the use of the independent sector, sufficient beds are available but also, that bed capacity is not being fully utilised.</td>
</tr>
<tr>
<td>South East</td>
<td>6</td>
<td></td>
<td>Thames Valley 2,139,000 (10-14) 139,700 (15-19)142,000</td>
<td>Estimated required bed nos. 19-32 for Berkshire and 32-53 for Oxfordshire, Buckinghamshire &amp; Milton Keynes, Hampshire, Portsmouth, Southampton &amp; Isle of Wight</td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td>14</td>
<td></td>
<td>(0-17) 1,051,800</td>
<td>52 IP and 15 day patient beds</td>
<td>Limited information as to the age group covered; there is the possibility of some beds for young people with learning disabilities.</td>
</tr>
</tbody>
</table>
2.2.2 The information shown above is not given for the southern part of the South East and the South West. In the South West, Tier 4 activity is given as a comparative measure: “Data from the CAMHS atlas show that there is broad consistency to the national pattern of CAMHS provision at Tier 2/Tier 3 service relative to population. Moreover, the pattern of activity is consistent with estimates made by Kurtz and others of around 3% of children and young people per annum needing to access these services. Levels in the South West are not significantly different from those in other regions. Levels of Tier 4 service, on the other hand, show as much as six fold variation from one English region to another, and offer an unreliable guide to what might be required in the South West. There are several reasons why tier 4 access levels might be so variable: differing abilities of tier 3 services to manage complexity and risk; very high or low levels of tier 4 service availability; very variable use of external placements”.

2.2.3 While the data from the regional reviews are incomplete in describing the current bed numbers, recent studies from the Research Unit of the Royal College of Psychiatrists (O’Herlihy et al, 2007) reliably give these numbers, as shown below:

Table 1  Total CAMH and general bed numbers per million population in English regions

<table>
<thead>
<tr>
<th>Region</th>
<th>Beds per million population, CAMH (general)</th>
<th>1999</th>
<th>2006</th>
<th>Change %</th>
<th>Total beds managed by the independent sector</th>
<th>1999</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>27.8 (11.9)</td>
<td>36.2 (12.7)</td>
<td>30 (7)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>London</td>
<td>26.5 (19.5)</td>
<td>44.2 (28.6)</td>
<td>67 (47)</td>
<td>27</td>
<td>41</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>East Midlands</td>
<td>24.9 (9.7)</td>
<td>29.7 (10.2)</td>
<td>19 (5)</td>
<td>61</td>
<td>66</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>South East</td>
<td>23.2 (18.6)</td>
<td>25.5 (20.9)</td>
<td>10 (12)</td>
<td>41</td>
<td>52</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Eastern</td>
<td>11.9 (10.0)</td>
<td>12.6 (10.8)</td>
<td>6 (8)</td>
<td>19</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Yorkshire/Humber</td>
<td>11.3 (11.3)</td>
<td>9.1 (9.1)</td>
<td>-19 (-19)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>South West</td>
<td>11.1 (8.1)</td>
<td>12.8 (10.5)</td>
<td>15 (30)</td>
<td>0</td>
<td>21</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>West Midlands</td>
<td>10.4 (10.4)</td>
<td>25.8 (12.5)</td>
<td>148 (20)</td>
<td>16</td>
<td>38</td>
<td>0</td>
<td>38</td>
</tr>
<tr>
<td>North West</td>
<td>9.8 (8.3)</td>
<td>12.0 (10.5)</td>
<td>22 (27)</td>
<td>0</td>
<td>25</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>ALL ENGLAND</td>
<td>17.2 (12.6)</td>
<td>23.0 (15)</td>
<td>34 (19)</td>
<td>25</td>
<td>36</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Units that admit children and/or adolescents with a wide range of diagnoses and problems are categorised as ‘general’.
2 English regions are based on boundaries set in 2003; the areas are ranked in order of the total beds per million total population in 1999.
This study shows that four regions of England are still well below the minimum of 20 beds per million population, while the “total bed numbers in England have increased by 284. Sixty nine percent of the increase is due to the independent sector whose market share has risen from 25% in 1999 to 36% in 2006. Regions with the highest number of beds in 1999 have increased bed numbers more than areas with the lowest number of beds in 1999 (8.3 vs 3.6 beds per million population). In units that admit only children under the age of 14, there has been a 30% reduction in beds available (123 to 86).” (O’Herlihy et al, 2007).

Data from the National Child Health, CAMHS and Maternity Service Mapping Exercise for 2005/06 are given for the following at Appendix 5: Tier 4 Capacity; Alternatives to in-patient care (non-tier 4 teams); Tier 4 forensic; Tier 4 forensic workforce; Tier 4 case and staff costs; and Tier 4 forensic case and staff costs.

2.2.4 The figures for in-patient bed numbers, given in the regional reviews, can hide an almost total lack of provision in some areas in individual regions, The necessary information to describe within region differences to date is sparse. The Yorkshire and Humber review for example, asks why there is no analysis of why different parts of the region have different numbers of admissions each year. What is the trend? And is this because of larger populations, different types of problem, the nearness of suitable units, or tier 3 capacity? …. In the North East and North Cumbria, in-patient activity in the Newcastle tier 4 services was 72% from 4 PCTs, all close to Newcastle, although one that is close, Gateshead, had few admissions. In addition, it is noted that the available beds in a unit variably include a number that may not, in fact be available to a particular referrer because they serve a national catchment or may be purchased by another PCT.

2.3 Provision in the independent sector

2.3.1 The regional reviews give bed numbers for units that are within their boundaries and variably, report their usage of the independent sector, within and without their boundaries, for what types of problem, with costs (see 2.16). In Greater Manchester it is reported that with “under investment in tier 4 services resulting in the fewest number of beds in England outside the East Midlands, there is overdependence on young people being managed on paediatric and adult wards and the independent sector.” A report from the West Midlands focuses entirely on mental health independent sector placements for children as well as adults, including the voluntary and private sector and placements in residential schools for ‘mental health’ reasons. Details are given for each SHA of the demographic characteristics and psychiatric problems of those admitted; where they were placed; reasons for placement; and opinion as to whether placements were appropriate. There was variable use of independent sector facilities and spend by different PCTs; use was due to a lack of NHS capacity and specialised placement opportunities. Reasons for placements were eating disorder, psychosis, depression and learning disability, with a high proportion of young people aged between 15 and 18 years. Often placements were made in emergency situations with poor matching to the
needs of the young person. A lack of communication was noted between independent sector and local tier 3 providers.

2.3.2 Nearly always, the independent sector is reported as being used to admit a young person as an emergency because no local unit has a suitable bed available. In London beds are used on a regular basis where no local bed is available out of hours for psychiatric intensive care, and for a specialty such as eating disorders. In all the reviews a number of concerns are expressed about the usage of, and care provided in, the independent sector, including long lengths of stay and difficulties with discharge; reporting and monitoring, and communication in general between the child’s home resident PCT and the independent unit; and about the type and quality of care. Many commissioners said that they did not have sufficient information about a service upon which to base a placement decision.

2.3.3 Given the situation of very low bed numbers per size of population in Yorkshire & Humber for example, their reported 15 admissions to independent beds, compared with a total 279 admissions to NHS tier 4 in 2005/2006, seems modest. The Yorkshire and Humber review states that: “It is not only actual bed numbers that need to be considered but also: the balance of provision available, where units are located, their links with other services and the capacity of tier 3 CAMHS. … In tackling the longstanding concerns regarding tier 4 provision in the region (including the very low number of in-patient beds) a range of factors need to be addressed, including current development of new community based services that may prove to provide an alternative to traditional in-patient provision as well as planned development of provision within the independent sector”.

2.3.4 In the Eastern Region where the number of in-patient beds available also falls very far short of the RCP recommended number, independent sector placements (148) made up 37.7% of the total number of tier 4 admissions (393) in 2004/05. The explanations repeatedly given in the regional review were that out of area placements were rarely made because a young person has an unusual condition requiring supra-regional or national provision but were directly related to the lack of locally available in-patient provision or alternative appropriate provision able to offer accessible and intensive support on a community basis. It is of note that the Thames Valley review reports for both Berkshire and Oxford/Buckinghamshire/ Milton Keynes, where the average number of beds per million population (9.8 and 10.6 respectively) are also less than the average for England (15), and where “there are some out of area admission, that there are not enough to suggest a need for a 50% increase in bed numbers” (p 44). Here, the number of out of area treatments (OATS) are decreasing and there are currently none in Oxfordshire or Buckinghamshire. OATS are paid for by the Mental Health Trust for Oxfordshire and Buckinghamshire, and by the PCT in Milton Keynes and Berkshire; this may suggest an incentive in reducing the numbers in the Mental Health Trust. It is also suggested that the decrease in OATS in Milton Keynes may be due to the provision of more rapid assessment of patients in A&E by specialist CAMHS nurses available over 24 hours every day of the week so as to avoid admission.
2.4. What types of bed are needed

2.4.1 CAMHS Tier 4 comprises beds described according to:

- the type of care required by the needs of the young person (covering a range with considerable variation in individual reviews): emergency/acute; intensive care; medium to long term; in-patient; day patient; community based (outreach, home treatment, post discharge, 'wrap around'); low secure and high secure;
- the type of condition indicating certain needs: eating disorder; learning disability; dual diagnosis; conduct disorders; autistic spectrum disorder
- age group: children under secondary school age or thereabouts; older adolescents; those about to be classified as ‘adult’/transition;
- legal status: young offenders; sectioned under the Mental Health Act 1983

Thus, any description of the ‘types of bed’ that are needed should be read as what ‘types of provision’ are needed.

2.4.2 The following list of the types of bed needed is taken from the summaries and overarching recommendations of each report, not from an analysis of the information given about the provision or its lack in the individual local services (shown at Appendix 4).

- Emergency provision: North East and North Cumbria; Yorkshire and Humber; Eastern Region
- Early intervention: Eastern Region
- Intensive care facilities: North East and North Cumbria; Greater Manchester; London; Thames Valley
- Community based: Yorkshire and Humber, as a ‘bridge’ between tier 3 and tier 4; Eastern Region
- Low secure: North East and North Cumbria; Greater Manchester; Eastern Region; South West
- Eating disorders: London, in-patient provision
- Learning disability with mental health needs: North East and North Cumbria; Yorkshire and Humber; Cheshire and Merseyside; East Midlands; London; Eastern Region; South West, severe learning disability with mental health problems
- Dual diagnosis: Cheshire and Merseyside; East Midlands; Eastern Region
- Conduct disorders/challenging behaviour: Yorkshire and Humber; Eastern Region
- ‘Low incidence needs’, also Autism, Aspergers, ADHD: Eastern Region
- Under 12s in-patient provision: East Midlands; London
- Provision for older adolescents and transition: Yorkshire and Humber; London
- Young offenders: Cheshire and Merseyside; London

2.4.3 Generally, the situation is different in different areas within each region, differentially for different types of bed and to meet different types of need. The large question is one of access. Information is however, beginning to be available that
also indicates whether provision that may be available within an accessible service has the capacity and capability to deliver the services that it purports to. At present, descriptive use of what type of bed is needed, or provided, obscures what types of need require appropriate and effective provision. The following examples are taken from individual review reports and add some background detail to the very summary list above:

**Cheshire and Merseyside**

Broad themes identified, including unmet need and service gaps:

- **Young offenders** – 5 secure units within the region; problems accessing NHS forensic units and in relations between specialist CAMHS and Youth Justice.
- **Learning disability** – Newcastle figures show high demand for forensic services, with St Andrews as the main provider but possibly beds for learning disability with the rare neurodevelopmental, epilepsy, and post head injury behavioural problems.
- **Eating disorder** - Cheshire and Merseyside Eating Disorder Service provides responsive assessment and comprehensive treatment and has never had a significant waiting list.
- **Dual diagnosis** – No dedicated Tier 4 dual diagnosis provision and no detox beds.
- **Clinical depression** – Can be admitted to the Young Peoples Centre for safety, intensity of treatment and treatment of comorbidity.
- **Acute beds**

**East Midlands**

- The only CAMHS tier 4 provision for under 12s within the region is based in Leicestershire and in Nottingham. There are no in-patient beds for under 12s.
- **Learning disability** - Leicestershire has CAMHS and Learning Disability tier 4 provision, based at Rathlin House, which provides some inreach to Oakham House in Leicester. There is a recent addition of a highly specialist but currently limited learning disability service (not in-patient) in Lincolnshire. Otherwise, access to tier 4 CAMHS for children with learning disabilities is poor. Children with autistic spectrum disorder present a major challenge to all services in terms of provision and accessibility.
- **Eating disorder** – a lack of capacity at tier 3 and knowledge and skills at tiers 1 and 2; high use of out of area placements with little evidence of improved outcomes; only occupied bed days are commissioned with no access to day care or part time placement as step down from in-patient care. Where areas have a specialist eating disorder service they report a decrease in the use of paediatric beds and CAMHS in-patient use.
- **Conduct disorders** – The tier 4 services in Leicester and Nottingham (but not in Lincoln) will work with children who have a conduct disorder or are exhibiting challenging behaviour as part of an emotional difficulty, taking a multi-systemic approach and involving a range of statutory and non statutory agencies. But emergency beds are needed to admit children with conduct disorders who have clear mental health needs.
• **Substance Misuse** – No dedicated beds or tier 4 services and no detox in-patient beds, where there is no comorbidity with mental health needs. Oakham House has provided in-patient care for two young people who required this type of treatment.

**Eastern Region**
Factors influencing the delivery of CAMHS and the use of tier 4 and other residential resources include:

• The gap between tier 3 and tier 4 services, so that when young people need intensive support, they may often end up being admitted to a tier 4 or other health facility because of a lack of community resources – and then may end up remaining as an in-patient for longer than perhaps necessary due to a lack of appropriate services to support them upon discharge.

• Independent providers receiving referrals of young people whose mental health needs, when assessed on admission, do not, in their opinion, warrant admission. By then, the young person and their family have gone through the anxiety and disruption of admission and returning them to their community may not immediately be possible.

• Widespread and significant shortages in local provision for young people with complex needs, including autism and learning disabilities. The lack of respite and short term provision (a safe place for assessment that is not custody nor in-patients) is of serious local concern.

**London**

• Services for children and young people with learning disabilities and mental health problems. There is no in-patient care available at all in London or the South of England for those with severe or profound learning disabilities. The number requiring this service is low but emergency admission may be needed and this is not available even in the units in Coventry and Northumberland.

• Children’s in-patient services. Recently a number of units around the country have closed down, leaving London with 3 of the remaining 6 children’s in-patient units available. During the review exercise, children’s services were not often mentioned and there appears to be a lack of strategic thinking about them. These services are used infrequently and where a block contract exists it is easy to reduce investment or ‘pull’ the funding without appreciation of the consequences.

• Psychiatric Intensive Care is a major issue but not consistently across London. London has three beds specifically for this purpose but otherwise anyone requiring this level of care is either admitted to an adult Psychiatric Intensive Care Unit (PICU) or the independent sector (often some distance from home). For a young person in a highly disturbed state either option would be terrifying.

• In-patient facilities for young people with eating disorders

• Forensic services, especially on discharge and especially for girls.

• Flexibility around appropriate provision for older adolescents and young ‘adults’
2.5  The use of tier 4 services by those children and young people most at risk, such as looked after children

2.5.1  There is virtually no information in any of the reviews on this matter. The North East and North Cumbria review mentions that the Newberry and Westwood Centres discharges some children to local authority residential care settings or foster carers. The East Midlands review identifies children in each tier 4 service who are in the care of the local authority and mentions the work with looked after children (LAC) and adoptive parents of Tanglewood Children’s Service in Leicester. And in London, the Mulberry Bush Unit makes special mention that its clients include looked after children.

2.5.2  Another vulnerable group of children, those held in secure placements, when they are released, can derive particular benefit from tier 4 services, especially community based services such as therapeutic fostering. Services such as these are being developed under the NSF Development Initiative Grant and are included in the forthcoming Offender Health Strategy.

2.6  The use of tier 4 services by children and young people from black and minority ethnic (BME) groups

Almost the only review to mention access and engagement with tier 4 CAMHS by young people from BME communities is the East Midlands review, as part of a section on Equality and Diversity (p 51), which includes those with a learning disability and with sensory impairments. This review report gives the ethnic profile of clients of each of the local tier 4 services in Appendix 4, taken from the National CAMHS 2005 Mapping Exercise, with the usual proviso that data on ethnic background is frequently incomplete. And in spite of a full report on the workforce in this review, “it was not possible to gather information regarding the ethnic mix of staff working at tier 4 CAMHS.” Ethnic profile of independent sector placements is given in the West Midlands review. Neither of these two reviews gives an analysis of the use of tier 4 made by BME groups relative to that by white British young people, relative to their respective needs.

The Yorkshire and Humber review reports that there are very few admissions from BME groups at the West End Adolescent and Children’s Units and that all the members of staff are white British. It is otherwise noted that BME groups are under represented among staff.

2.7  The extent to which beds cannot be used because of lack of capacity

2.7.1  ‘Lack of capacity’ is taken to mean staff shortages and inadequate or inappropriate facilities, leading to under occupancy according to the number of beds theoretically available or an inability to admit particular children with particular kinds of problem. The Yorkshire and Humber review gives the staffing in all the local units and reports that there are concerns regarding vacant and frozen posts,
shortages of key staff, e.g. social work in some units, and a high turnover of unqualified nurses. This means that certain types of work cannot be carried out and that units may not stay open for 7 days a week, but not that beds cannot be used. However, where it was reported that there is a need for extra staff to ensure security, it may mean that beds cannot be used, although this is not stated.

2.7.2 Further, the *East Midlands* review reports that Ash Villa in Lincolnshire has experienced difficulties in recruiting to posts, highlighting its location as a particular issue with regard to this, although a new unit manager in post is addressing these issues. Other units report little or no difficulty in recruiting to junior nursing posts, though it is more difficult to attract experienced workers from other areas. Across the region, it is noted that there is difficulty recruiting child and adolescent consultant psychiatrists. Also, that staff retention is difficult due to increased opportunities, higher financial rewards and greater working flexibility and autonomy available within other tiers and services. The level of use of agency staff tends to have a demoralising effect and adds to difficulties in staff retention. QNIC reports from units in other regions (notably *North East and North Cumbria*) reinforce the message regarding difficulties in staff recruitment and retention, reducing the ability to offer a wide range of treatments.

2.7.3 Although, again, this does not lead to beds not being used, a number of aspects of unsatisfactory quality of provision is recorded in some units, often from QNIC Reviews; most significant is where there is limited or no education provision. Furthermore, isolation of different parts of the tier 4 service from each other, from tier 3 services, and from other related services can diminish effective capacity, as noted in the review of tier 4 services at Birmingham Children’s Hospital.

2.7.4 A number of reports comment on the unsuitability of buildings, lack of space and facilities and, generally a poor environment for therapeutic purposes, including one that is not age appropriate – in some of their units. It is nowhere mentioned that this leads to beds not being used. However, it is implied in a number of instances, that this, together with staff shortages and increasing demand to take children with difficult behaviour, may lead to an inability to admit even when a bed is theoretically available.

2.8 The impact of incompatible potential or actual case mix on admissions

The admission criteria for the in-patient units give an explicit or implicit indication of the types of cases that, if admitted, are likely to give rise to problems because of the case mix usually managed by the unit.

In a survey of all adolescent in-patient psychiatric units in England and Wales (Cotgrove et al, 2007), lead consultants reported that 34% could never admit as an emergency in 2005 and 44% could never admit out of hours. The consultants estimated that, in 2005, they turned away 72% of referrals for emergency admission. Concern was expressed that services are not configured to accept emergency
admissions, and that the problem is unlikely to be resolved by requiring units to accept both emergency and planned admissions, as these groups have very different needs.

The situation reported by Cheshire and Merseyside is widespread in units around the country: a lack of access to emergency beds. For example, whilst the Young People’s Centre (YPC) has 3 beds allocated for emergency admissions, its capacity to admit immediately is very variable depending on bed availability, staffing levels and the level of disturbance on the unit. The reported case mix at the YPC is: 20-30% acute psychosis; c.20% eating disorders; remainder with emerging personality disorder, behavioural and emotional disorder and complex post traumatic stress disorder. The unit staff feel that the needs of those with acute psychosis are different from the other groups in the unit, and that this can sometimes lead to difficulties and to the service becoming inaccessible because of bed blocking; it may also compromise the therapeutic environment and the quality of service.

2.9 The impact of poor staff development or competence/confidence to deal with cases

Very little information is given in the reviews of the extent to which the availability of staff skills and expertise leads to under use of in-patient facilities, except when a lack of a particular type of staff, such as an occupational therapist, or over reliance on agency or unqualified nurses means that particular kinds of work, such as group therapy, cannot be carried out. The capability of the staff in working with an age group and a range of conditions is implicit in the admission criteria of most units (see Appendix 4). The East Midlands review raises concerns regarding the levels of staff supervision during challenging periods, along with access to specialist and in-house training. However, in some of the reviews, comment is made about the positive capability of staff in a particular unit to manage children with very complex needs or with challenging behaviour (at the Woodward Centre in Middlesbrough, for example).

In general, throughout descriptions of the type of work carried out by current tier 4 services and of new developments to meet the improved recognition of young people’s needs, there is mention of the concomitant need to have staff with particular skills and competence in particular ways of working. This situation is succinctly expressed, although in the particular, for one of the units in the Yorkshire and Humber review: “Oakwood, like most adolescent units is in a period of transition. Previously established as a modified therapeutic community, the demands from referrers are for a general purpose acute admission ward for adolescents. Many of our patients suffer significant and sometimes florid mental illness. And the culture, philosophy and skills of the unit have to adapt to meet this need”.
2.10 The impact of emergency admissions on the provision of therapeutic services in tier 4

Cheshire and Merseyside report that emergency admissions are often said to have quite different needs to others on a unit, particularly affecting young people with severe clinical depression. The disruption that may be caused means that emergencies often cannot be admitted (see also 2.8).

2.11 The use of adult psychiatric beds by children and the reasons

2.11.1 Yorkshire & Humber report 66 admissions/1541 bed days in adult psychiatric beds by children in 2005/06, but give no data on this as a proportion of all admissions of children. The report from North East and North Cumbria reports the common experience that the data to show the use each PCT makes of adult in-patient beds for young people aged 14 to 18 was hard to obtain and that there are doubts as to its accuracy, stating that the number of bed days is a better indication of the amount of use made by CAMHS of adult beds. In this region, the trend is given as: 2003/04: 67 admissions; 2004/05: 43; and 2005/06: 55. Other regions, while also admitting that accurate figures are almost impossible to obtain, report that admissions to adult wards seem to be fewer, with speedier transfer to an adolescent bed.

2.11.2 The London review also reports a downward trend, from information from the London Health Observatory on the number of London residents aged under 18 admitted to adult mental health wards, i.e. 228 in 2003/04; 156 in 2004/05; 94 in 2005/06. The reasons given for child admissions to adult beds were:

- It was felt that the young person could not be managed safely on an adolescent ward
- When a young person is admitted on Section 136 of the Mental Health Act 1983. None of the adolescent units is designated as a ‘Place of Safety’.
- For intensive care
- There is no CAMHS on-call provision or the local adolescent unit does not admit out of hours
- If the young person is nearing their 18th birthday
- If the young person expresses a wish to be admitted to an adult ward

In London, protocols for young people on adult wards exist in 6 of the 8 Mental Health Trusts and one of the Trusts has a designated ward for under 18 year old admissions. With the exception of those nearing their 18th birthday, admission to an adult ward is kept to as short a time as possible, with transfer to a local adolescent bed or the independent sector as soon as possible. Elsewhere, protocols were not commonly reported and hardly a designated ward for under 18 year old admissions seemed to exist.

2.11.3 Acknowledging that the data are incomplete, the Eastern Region reported 74 admissions to adult mental health wards in 2004/05, including 8 admissions to an adult ward with 2 ring fenced beds for adolescents. A working group to review...
services for acutely ill children with mental health problems who were being admitted to both adult mental health and paediatric services was set up in 2004 by the provider trusts for Bedfordshire: Luton & Dunstable Hospital and Bedford General Hospital. The aims of the group centred on data collection, improving patient pathways, identification of service deficits and recommendations for service development. A Commissioner for Social Services attended the group and advised on existing protocols and policies relating to children’s care and welfare. Working relations between all services have been enhanced as a consequence of the work of the group. More detail on the work and impact of this group, particularly on identification of staff training needs, is given at 8.2 of the Eastern Region review.

2.11.4 In East Berkshire in the Thames Valley, it is the policy that 16-18 year olds who are out of school are cared for by adult community mental health teams and are admitted to adult wards. This has changed slightly with the admissions of minors policy which means that all such admissions should be notified to Berkshire Adolescent Unit and assessed by them within 48 hours; some are then moved to CAMHS units. But admission to adult wards also occurs out of hours, when the adolescent units are closed or full and when patients require intensive care.

2.12 The impact of young people with mental health needs on paediatric beds

Very little information was presented on this topic in the reviews. However, in Yorkshire and Humber, 316 admissions in 2005/06 were reported. In the North East and North Cumbria, the data collected on the use made of paediatric beds was extremely sparse and was not included in the review. The London review stated: “No paediatricians were interviewed but admissions to paediatric wards of children and adolescents with mental health problems was not viewed positively and that, as a result, they could get ‘a poor service’. Cheshire and Merseyside commented on one concern: that young people with severe depression had recently been admitted to paediatric wards, often requiring long stays and because the staff are not equipped to deal with these young people, relying heavily on tier 3 support. For these young people, the best means of providing appropriate care was felt to be in the independent sector. A good deal more detail is given by the Eastern Region, noting that children admitted onto paediatric wards are not supported by CAMHS out of hours and that admissions are often prolonged due to lack of availability of services from partner agencies. This places the child at risk and can increase risk to other children on the ward. A special study in Cambridgeshire found that of 59 admissions for children aged under 18 where there was an ICD-10 mental health primary diagnosis, 20 were to paediatric wards and 23 to adult mental health wards (Whyman, 2005). There are also a number of children attending A&E departments who are not subsequently admitted, with concern about their adequate follow up. There may also be concerns that children admitted to wards from A&E, with drug and alcohol problems and who self harm, are not seen by CAMHS. See also the note about a working group at 2.11.2.
2.13 The relationships between emergency provision, available beds, outreach teams, and supporting Tier 3 provision

Although the complex interrelationship between the availability of beds and emergency provision, supporting tier 3 provision and outreach teams is a major theme in the reviews, in fact only dual or possible chain relationships are described. This is in line with the availability of any evidence as to the impact of one element on another. An example is given by Cheshire and Merseyside: “When the Royal Liverpool Children’s Hospital Trust (RLCHT) has had long waiting times for admission, staff have offered ad-hoc outreach work, felt in some cases to have prevented admission”. It was noted that the admission of more local residents by the Young People’s Centre in Chester preferentially enables outreach and continuity of care. In Greater Manchester, a variable range in the provision by tier 3 is reported, and that no agreement has been reached among tier 3 providers on their role in supporting as short an admission as possible to tier 4 in-patient beds. Analysis of occupancy levels for Newcastle Young People’s Unit in North East and North Cumbria show that, at 95.8%, it would be unable to guarantee to admit a young person in an emergency. This region reports low use of tier 4, with investment in tier 2 and tier 3 by the PCTs in recent years. But it is a very rural area and when a rapid response is required, there being no designated emergency beds in Newcastle, children are admitted to adult wards, with the staff supported by the CAMHS team. Newcastle CAMHS have only 60% of the recommended level of staffing at tier 3 and it was felt that an intensive community treatment service would help to reduce the service’s dependence on tier 4 admission to hospital. The interrelationship between in-patient and day patient provision is highlighted in the Fleming Nuffield Unit, where for most patients, the length of stay is a six week assessment admission, followed by a further six weeks of treatment. Admission to in-patient care can be tailored to individual clinical need as the day patient and in-patient units operate seamlessly together, so that an in-patient can use day patient facilities and, where necessary, a day patient can be offered in-patient care.

The reviews agree that tier 4 cannot be defined in isolation from tier 3 and that, essentially, it is a multi-disciplinary service that, to be effective, incorporates vital social care and education elements. The appropriate role and the effectiveness of tier 4, depend crucially upon integrated working with local tier 3 CAMHS. The reviews describe the extent to which the rare tier 4 service works with several tier 3 teams, each of which will have its own strengths and weaknesses and will be likely to require something different from tier 4, while having differing capacities and capabilities to continue work with a young person when tier 4 care is no longer needed. All the reviews, therefore, agree that the number of in-patient beds that exist within their boundaries is not really the central issue, although it is a matter for concern where this number falls too low. The type of intervention and care that needs to be carried out within a psychiatric in-patient setting requires closer definition than at present and will be strongly influenced by service capabilities that can be developed in day patient, outpatient, outreach and community based
services. At present the existence of these kinds of services is patchy, both geographically and in terms of the expertise and facilities they can provide.

2.14 The impact of on-call services on in-patient admission trends

No direct information is available in the reviews on this topic, although, in some, there is mention that an on-call service exists, and that its use may well prevent in-patient admission if linked to an appropriate specialist team (see the EIS at 2.15.2). However, the Eastern Region reports concerns because of the lack of on-call arrangements by tier 3. This, however, reflect the consultants’ reluctance to be on call because the lack of local in-patient beds means that they cannot place children.

2.15 The pressures on Tier 4 caused by lack of Tier 3 capacity

2.15.1 There is frequent mention of very great variability in tier 3 services and of a general lack of capacity. For example, Cheshire and Merseyside reports a huge diversity in tier 3 services and in general, a lack capacity to manage young people with highly complex needs. Greater involvement of tier 3 consultants in assessment and decision making for tier 4 is seen as highly desirable, partly to upgrade their skills. Tier 3 is especially important for young people resident in outlying areas of the region, including its role in improving access to tier 4, when necessary. Good practice examples are found in the Eastern Region, e.g. in Norfolk, of attempts to improve the interface and collaboration between tiers 3 and 4, and develop joint protocols that can be built upon.

2.15.2 In London, while accepting that there would always be a need for in-patient beds, many providers and commissioners felt that improved resources at tier 3 would lessen demand on tier 4, either by preventing admission or reducing lengths of stay. This included more day care provision, assertive outreach and more work on identifying and putting in place alternatives to in-patient care such as home treatment. Alongside this, local authority services, such as supported housing would also help to prevent delayed discharge from in-patient care. In North East and North Cumbria, the Early Intervention Service (EIS) in Northumberland NHS Care Trust, with access to the Crisis Team and the Home Treatment service for those aged 16 and above has transformed the way in which the 16-18 years age group is managed. It is clear that less use is made of tier 4 in-patient provision since the EIS was started over two years ago. The team wishes there was a similar service for 14 and 15 year olds, whereby they could have access to a crisis team and home treatment services. The North East and North Cumbria report gives a comparison of Tier 4 placements according to the size of 5-15 year old PCT populations, noting that it needs to be interpreted with caution and needs more investigation of the comparative rankings. But a surprising result is that Sunderland, with the fourth highest population, was 12th in the use made of tier 4 facilities: “the level and strength of tier 3 is a probable factor” (p 36).
2.15.3 In another example from North East and North Cumbria, regional services have not been commissioned to provide a specialist Eating Disorders Service. But tier 4 is obviously providing an eating disorders service in Newcastle, largely undertaken to meet the needs of young people referred from tier 3. In-patient treatment for eating disorders is generally considered to be a last resort reserved for very severe cases, yet 10 out of the 20 beds available in the Young People’s Unit (YPU) and the Fleming Nuffield Children’s Unit are often used. This is thought likely to be due to a lack of services at tiers 1, 2 and 3. There is limited pre and post hospitalisation treatment but the tier 4 teams have good working relationships with the tier 3 CAMHS with arrangements for consultation and some joint working. The complexity of relationships between tier 3 and tier 4 is indicated by the situation in Gateshead, which is reported as having good access to Newcastle tier 4 services but where the YPU has sent cases of young people with psychosis back to tier 3 as ‘too difficult’. It is suggested that this is because of the case mix of the YPU and the number of current in-patients with eating disorders.

2.15.4 A good example of a positive integration of tier 3 and 4 is again in North Cumbria, where children with learning disabilities and their families are served by four qualified community learning disability nurses and by the North Cumbria Mental Health and Learning Disabilities Trust Challenging Behaviour Team, which can admit 17 and 18 year olds to the adult service when necessary. CAMHS is generally reported to be well integrated with these services, although there are no shared care pathways.

2.16 The cost of in region and out of region placements, by region

2.16.1 Apart from the West Midlands region, it was generally reported as difficult to obtain accurate costs for tier 4 services, let alone comparable information for placements in the independent sector, within and out of region. Information on costs was also widely reported to vary considerably from provider to provider in terms of the range of staffing and activity covered. It was reported that the figures collected by the Yorkshire & Humber regional review indicate a significant spend on tier 4 services (which is likely to be an underestimate) and yet at the same time, often patchy and with limited knowledge about the reasons for tier 4 usage. This seriously impedes the ability to monitor performance, to ensure that budgets are being used effectively and crucially, to be able to consider new and potentially more appropriate ways of meeting the needs of children and young people through the realignment of budgets and Invest to Save development options. The information that is available in the reports is given below for each region, but comparisons are nearly impossible and, in any case, would be invidious.

North East and North Cumbria
Figures for the expenditure by PCTs on CAMHS Tier 4 are given for 2005/06 for the Northumberland, Tyne and Wear NHS Trust = £5,928,041 (North Cumbria = £186,619 of this) and for the Tees, Esk and Wear Valleys NHS Trust = £1,127,067.
However, these figures are approximate because it was impossible to separate the costs of tier 3 and tier 4 outpatient services provided by the same Trust.

Yorkshire & Humber
In total, £5,457,138.50 was spent on NHS and independent sector tier 4 admissions during 2005/06, of which £1,411,194.26 was for independent sector provision.

Cheshire and Merseyside
Data given on 5 children placed in independent facilities (unknown whether these are out of region); 3 of these were said to be because of lack of local capacity. No data on costs (census of the North West Region on 28th June 2004, from 22 PCTs, 22 LASSDs, the Regional Secure Commissioning Team)

Greater Manchester
Currently, tier 4 services in the two providers have not been specifically costed. No figures were available for the significant number of cases that are managed in adult and paediatric services and the independent sector.

West Midlands
Total of 110 children: Birmingham and the Black Country SHA 61
West Midlands South SHA 10
Shropshire and Staffordshire SHA 39

Birmingham and the Black Country:
average weekly costs PCT £3186
PCT&SSD £2781
PCT & SSD & Education £1546
total NHS&SSD weekly costs of 55 placements in census week £145,480
total weekly costs to NHS funders £97,368
estimated annual costs c. £7.57m (no information on LEA costs, which, therefore, are additional)

West Midlands South:
average weekly costs PCT £4337
PCT & SSD £3789
total NHS&SSD weekly costs of 10 placements in census week £40,114
total weekly costs to NHS funders £33,481
estimated annual NHS&LASSD costs £2.09m

Shropshire and Staffordshire:
average weekly costs PCT £1377
PCT&SSD £5366
total NHS&SSD weekly costs of 33 placements in census week £77,210
total weekly costs to NHS funders £48,204
estimated annual costs c. £4.02m
West Midlands overall *spend on independent sector CAMHS* has grown from £1.8m in 1989 to £7m in 2005 and again in 2006

**East Midlands**
Over £6 million was spent on CAMHS tier 4 in 2005/06 for the population of the East Midlands; c. £4,567m on adolescent in-patient services. It is not specified that these are the costs to the NHS, and it is acknowledged that it is difficult to obtain an exact breakdown of finance costs and that there are differences in accounting from different units, i.e. what's included in the costs, e.g. managerial costs and what's not. Out of Area placements were 29 in 2005/06, with a cost to the NHS of £2,707,362

**Eastern Region**
The East of England total spend on in-patient admissions to NHS and independent sector facilities in 2004/05 was £12,407,556. The cost of 239 admissions to NHS facilities was £5,084,706 and of 148 Independent Sector out of area placements, £7,322,850.90. Striking differences were found in the costs for each of the 3 SHAs; it is suggested that these are likely to be connected to lengths of stay. The total spent on 188 bi and tri partite placements (where health made a contribution) was £4,949,447. The need for caution in interpreting data concerning bi and tri partite funded placements and packages of care was noted; this is because of deficits in information, in different authorities, about how funding splits are agreed and which children have been included, and because the needs of this group of young people are very diverse and may largely be other than mental health with minimal psychiatric input.

**London**
It was extremely difficult to put together an accurate picture of usage and spend in the independent sector due to lack of available data. Data requested consisted of number of referrals to the independent sector, the reasons for this and the costs involved, both a day bed rate and the total spend. For 2005/06 only 15 of the 31 PCTs were able to provide some if not all of this information. What was gathered indicated:

- A total spend of somewhere in the region of £5.5 million
- Total costs paid to each provider varied from a maximum of £484,745 to a minimum of £7,616
- One placement in one unit cost £407,784
- The average costs was £109,466

A variety of daily rates and 1:1 costs were given by commissioners, and these may relate to some of the independent sector providers offering reduced rates dependent on the number of beds used, i.e. the more beds used the cheaper the rate. Rates given varied from £691 per day to £421 per day. The Thames Valley reports 2004/5 costs of occupied bed days for Highfield (£1,129,575) and for Berkshire Adolescent Unit (£283,286), with a total of £1,412,861. Costs for day patients, including those attending Wycombe Day ward, totalled £457,869, and out of area transfers, £705,849.
South West
The total expenditure on CAMHS for 0-17 year olds, for 2005/06 was £41.5 million by both PCTs and Local Authorities (although LA expenditure appeared to be under reported). It is suggested in the report that “it will be more useful to analyse total CAMHS cost per child population, or total CAMHS system cost per new tier 2/tier 3 case (a broad and relatively robust measure of load on the whole system) than, for example, tier 4 cost per in-patient day, which obscures the greater cost issues of the number of tier 4 cases and of length of stay” (para 18). The distribution of expenditure within the region in 2006 was found to “show great variation from place to place. The highest spending PCT spends more than twice as much per child as the lowest; for local authorities the spread is more than three times. The differences are not proportionately reflected in workload – there are places with above average expenditure and below average workload, and vice versa – raising significant questions of value for money.” And financial reporting was not consistent between commissioners and providers (Annex 3).

2.16.2 Any attempt to compare costs across the regions should compare the activity that is funded. Bearing in mind all the provisos regarding the major inadequacies of the data, the following table (taken from the South West report) shows this:

Table 2 New Tier 4 cases in England (from National CAMHS Mapping Atlas 2005)

<table>
<thead>
<tr>
<th>Region</th>
<th>cases in sample period</th>
<th>annualised cases</th>
<th>cases / 1000 children aged 0-17</th>
<th>T2/T3 cases to generate one T4 case+</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Midlands</td>
<td>124</td>
<td>248</td>
<td>0.27</td>
<td>90</td>
</tr>
<tr>
<td>Eastern</td>
<td>182</td>
<td>364</td>
<td>0.30</td>
<td>95</td>
</tr>
<tr>
<td>London</td>
<td>950</td>
<td>1900</td>
<td>1.17</td>
<td>28</td>
</tr>
<tr>
<td>North East</td>
<td>229</td>
<td>458</td>
<td>0.86</td>
<td>36</td>
</tr>
<tr>
<td>North West</td>
<td>400</td>
<td>800</td>
<td>0.53</td>
<td>61</td>
</tr>
<tr>
<td>South Central</td>
<td>261</td>
<td>522</td>
<td>0.60</td>
<td>59</td>
</tr>
<tr>
<td>South East Coast</td>
<td>92</td>
<td>184</td>
<td>0.20</td>
<td>91</td>
</tr>
<tr>
<td>South West</td>
<td>172</td>
<td>344</td>
<td>0.33</td>
<td>103</td>
</tr>
<tr>
<td>West Midlands</td>
<td>190</td>
<td>380</td>
<td>0.32</td>
<td>125</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber</td>
<td>121</td>
<td>242</td>
<td>0.22</td>
<td>147</td>
</tr>
<tr>
<td>England</td>
<td>2721</td>
<td>5442</td>
<td>0.50</td>
<td>63</td>
</tr>
<tr>
<td>England – London</td>
<td>1771</td>
<td>3542</td>
<td>0.38</td>
<td>82</td>
</tr>
</tbody>
</table>

Note: London data differ in many respects from the rest of England, so a line showing the average for England excluding London has been given as possibly more useful as a comparator.

2.17 The level of joint commissioning and bi and tri partite funding

Very little information is reported on this topic, on local authority funding in particular and even less on the education component. Generally, the impression is that one or more agencies jointly sign up to placements on a case by case basis, with little
specific commissioning and mostly spot purchasing. The information that is given is shown below.

**North East and North Cumbria**
All PCTs and LAs visited in the course of the review had panels to agree funding of placements, some of which were funded jointly. The Regional Commissioning Unit plans to undertake more work in this area but, at present, information is not available in usable form.

**Yorkshire & Humber**
East Yorkshire has a multi-agency agreement to discuss urgent cases between education, social care and health, with a written protocol and a ‘virtual’ pooled budget.

**Cheshire and Merseyside**
Currently, financial information on the National CAMHS Mapping database is not reliable. Arrangements for commissioning and joint funding of out of area placements varies across the patch and with 5 separate CAMHS partnerships or strategy groups, each with a small budget, no economies of scale have been achieved. There is a three agency local panel and protocol lead by St Helen’s.

**West Midlands**
The Specialised Commissioning Group is operating joint commissioning for both NHS and independent CAMHS in-patient beds on behalf of the West Midlands PCTs. The arrangements are overseen by a development group made up of commissioners, providers, a Government Office representative, and the CAMHS Regional Development Manager. Placements are co-ordinated by a care manager, following assessment by the NHS commissioned service.

**East Midlands**
There are a variety of commissioning arrangements, in a state of reorganisation, about which it has been difficult to gain information. CAMHS is mostly commissioned by a lead PCT, with isolated specification of multi-agency involvement. This review gives details of the funding arrangements and contribution from each agency, for 'low incidence need' placements made by each local authority; it is not always possible to identify whether the young people had mental health needs.

2.18 **The potential to develop regional commissioning arrangements and the outcomes of these collaborative arrangements**

Weakness in the commissioning process was identified in many parts of individual regions and, in some cases, an absence of effective provider and commissioner dialogue through which to reach agreement on the priorities for tier 4 to address both locally and across the whole of the region. Providers find it difficult to deal with so many commissioners and there is lack of a shared vision about what tier 4 services should be delivering and to whom. Potentially, greater problems could result from
new NHS organisational perspectives, where larger geographical areas may encompass an increased number of organisations.

**North East and North Cumbria**
A key recommendation of the regional review is that the PCTs should agree that one commissioner will take the lead in commissioning CAMHS tier 4 services and equivalent services for children and young people with a learning disability. The single commissioner should be appointed and able to commence work by April 2007.

**Yorkshire & Humber**
Commissioning has tended to sit with individual PCTs. This is undergoing considerable change. In South Yorkshire, a consortium arrangement operates through NORCOM (covering 13 PCTs across South Yorkshire, North Derbyshire and North Nottinghamshire) and in the North and West of Yorkshire, PCTs are in the process of coming together, with one commissioning team covering both areas. There is indication that regional commissioning in some form will take place in 2007.

**Cheshire and Merseyside**
Specialised commissioning requires a network and there is a ‘Tier 4 Zonal Group’ that provides that. This group, with the Specialist Services Commissioning Team, have begun to develop performance management of both existing in-patient units.

**Greater Manchester**
In the current situation whereby commissioners spot purchase in the independent sector, the review reports that a North West wide group is developing to work on in-patient provision for children and young people with severe learning disabilities and challenging behaviour. The review also recommends that the North West region wide group be led by the CAMHS Regional Development Worker (RDW) to consider the feasibility of setting up low secure provision for the local population. The report recommends that commissioning arrangements are led by Manchester PCT and become part of the Greater Manchester Mental Health Collaborative in shadow form from October 2007, moving to full collaborative arrangements and risk sharing from April 2008. It is recommended that a tier 4 clinical network is established, with senior representation from providers and commissioners, to oversee the development of service specifications, and agree the bed numbers required and a model for intensive care.

**East Midlands**
Is planning to develop a Regional Collaborative Commissioning Framework Project, involving Local Authorities, PCTs, and other organisations concerned with planning and commissioning. The aim is for each children and young people’s partnership in the East Midlands to achieve the desired outcomes for their children and young people and best value through a common framework which promotes effective commissioning of local and regional provision.
**London**

Commissioning presents a very complex picture with little consistency across London. Commissioners work very much on a sector basis with no apparent links between sectors. Four of the five sectors have a designated lead PCT and hold a sector wide meeting to monitor the block contract they have with the local provider Trust and discuss service issues. A pan-London collaborative commissioning strategy is recommended to achieve more effective and efficient use of resources and ensure that care is provided in the right place at the right time. Such commissioning arrangements would harmonise PCT contributions, share risk and give providers greater stability of committed funds.

**South West**

The report sets out a framework for a regional commissioning strategy (described at para. 1.13). This recommends that commissioning for the majority of CAMHS provision should be done by PCTs in partnership with Children’s Services, although some – with the relatively scarce skills and resources required to meet the more complex needs of some children, will need to be commissioned with other PCTs/LAs within wider, but still local, partnerships. In order to make the best use of scarce services, PCT/Children’s Services Departments partnerships need to build consensus about what they require from these shared services and develop some kind of organisational co-operation. The framework stresses the need to develop the skills, capacity and expertise of commissioners within a multi-agency training programme.

### 2.19 The use of national and specialised commissioning arrangements

**2.19.1** Specialised commissioning indicates a specific organisational structure and arrangements to cover groups of PCT populations together, within SHA or a regional boundaries and organisations. Very little information was given about specialised commissioning arrangements at the present time. However, its report mentions that Cheshire and Merseyside commissions beds, flexibly taking young people up to 14 years of age, in the Dewi Jones Unit through the Specialist Commissioning Team, while other areas have access to the unit through historical block contracts. The South West Commissioning Framework recommends the establishment of a “multi-agency regional commissioning structure under the Specialised Commissioning Group (SCG) to drive local partnership development and commission highly specialised services on a regional or national basis” (para 27).

**2.19.2** Apart from the general shortage of commissioning expertise in PCTs in the field of CAMHS and of tier 4 in particular, the reviews recognise the sense of the basis for specialised commissioning, given in the Review of Commissioning Arrangements for Specialised Services (DH, May 2006): “The risk to an individual PCT of having to fund expensive, unpredictable activity is reduced by PCTs grouping together to collectively commission such services and share financial risk”. The Cheshire and Merseyside report states the need to get collective commissioning by all PCTs to ensure equity of access and provision for specific groups and
problems, and development of the necessary community based tier 4 services, such as ROSTA, wherever a child/young person may live. Furthermore collective commissioning would enable the development of tier 3 services so that, taking into account all in a region, capacity and capability can be improved. Shared working among tier 3 services will also support development of a variety of tier 4 approaches matched to the needs of young people and working in line with the evidence base for effectiveness, in a consistent locally agreed manner. The London review also recommends that a pan-London collaborative commissioning strategy be developed to these ends.

2.19.3 Currently, national commissioning arrangements remain those for PCT top sliced services, commissioned by the National Commissioning Group (NCG), formerly NSCAG: the secure adolescent forensic mental health in-patient services in Newcastle, Manchester, Birmingham, London (2 units), and Southampton; the in-patient service for deaf children with mental health needs in London, with a related service model in York and Dudley; for OCD in London; and the Newcastle unit for young people with learning disabilities, with some beds at St Andrew’s in Northampton.

2.20 Any solutions identified that might ensure sufficient tier 4 capacity and capability to meet the needs of local populations

2.20.1 The reviews all acknowledge that the overriding ‘solution’ lies in knowledgeable and effective commissioning of tier 4, closely linked with, and informed by, what is commissioned in terms of tier 3 CAMHS. A number of reviews mention that a proper needs assessment for tier 4 is required for the regional population, essentially matched with all aspects (access, appropriateness, effectiveness etc.) of the services and resources that are currently available in, and for, the region. In this way gaps will be identified in relation to current understanding of the needs of children, young people and their families and not limited to the aspirations of individual providers. The gaps need to be filled with clear specification of the service responses to particular types of need, with creative use of the available evidence for what will make a positive difference in outcomes for these young people. The following section outlines some of the numerous promising initiatives that have been set up to improve tier 4 capacity, from which a very great deal can be learnt and built upon in all parts of the country.

2.20.2 The Cheshire and Merseyside review highlights that there is “a paucity of resourced, systematic, published investigation into newer models of care within the UK” (p 11). This review describes the evidence for reducing the need for tier 4 in-patient admission by the Outreach Team at the Phoenix Centre for Eating Disorders in Cambridge, The Behaviour Resource Centre in Southampton, day provision as a step down from in-patient care at Snowsfields in London, and the Community Intensive Treatment Team in Pontypridd (p 10). Other well known examples are described at 11.2 to 11.9 in the North East and North Cumbria review report, at
Appendix 6 of the *Yorkshire and Humber* report, and at section 10.3 in the *Eastern Region* report.

2.20.3 A Multi-disciplinary Referral Panel for Ash Villa Adolescent Unit, Lincolnshire (*East Midlands*), where referrals can be talked through to reduce the level of inappropriate referrals to the unit. The Education Unit at Ash Villa is an example of good practice, which can make a significant impact on tier 4 capability and capacity.

2.20.4 A peripatetic specialist assessment team that enables children to stay locally and ensures that admission is appropriate and to the appropriate service.

2.20.5 Plans for Assertive Outreach Teams as an alternative to in-patient care e.g. Children’s Assertive Outreach Team for the residents of Merton, Sutton & Wandsworth. This team began accepting referrals in October 2006. It offers a 3 month intensive service to those children up to the age of 13 and their families who require tier 4 input because of the complexity and severity of the child’s mental health needs (more details in the *London* report, (p 23). Evaluation indicates that length of stay is reduced in many cases and has even prevented admission altogether. A similar community based service for eating disorders is attached to the in-patient unit at The Royal Free Hospital in north London.

2.20.6 A Formative Evaluation of Three Adolescent Outreach Teams in the *Eastern Region* by Yvonne Anderson and Roseanne Tobin (July 2004) reported variable progress in the teams being established. The evaluation report noted that: “The most significant impediment to the linking of tiers 3 and 4 was the geography – the sheer scale in size of the regions – and the number of the tier 3 services covered by what are very small tier 4 teams”. It also indicated that though at an early stage of development – and having been set up without the benefit of national standards – these teams indicated the potential for reducing lengths of in-patient stay. It was noted however, that a reliable analysis of whether overall bed usage had decreased would not be possible.

2.20.7 There is evidence that one of the new treatment modalities, Dialectical Behavioural Therapy (DBT) is reducing demand on tier 4. This service is offered on an in-patient basis at the Priory Ticehurst for young people who self harm and or are suicidal. As a project funded under the National Service Framework CAMHS Development Initiatives grant, access to this therapy is being offered in the community in *Oxfordshire*. Whether this can either prevent admission or at least speed up the discharge process, with care continuing to be provided in a more local setting, is being evaluated.

2.20.8 Early Intervention in Psychosis (EIP) services are under development throughout the *East Midlands* region, aimed at the 14 to 35 year old age range during the first 3 years of psychotic illness. Once developed across the region, demand for places and length of stays within tier 4 for psychosis should be reduced. In Northamptonshire, for example, there is a CAMHS funded Clinical Nurse
Specialist post based within the EIP service. The service has good liaison through secondary care services and is developing a referral route from primary care. It has been reported that since the service has been in place referrals to tier 4 in Oxford and Cambridge has been 'quicker when needed' and is resulting in shorter hospital stays. In the North East and North Cumbria, development of EIP services are also reported to have brought a new dimension to the capability of local teams to maintain some young people at home through having access to Crisis Resolution Teams and Home Treatment resources. Some of these services (also noted in Lambeth), which have been running for two years or more, have made an impact on the admission of young people to tier 4 or the adult mental health acute admission ward. In Yorkshire and Humber, first episode psychosis is often managed in the community by GPs with support from PMHWs who are able to offer quick outreach assessment but the GPs are unhappy that they cannot refer directly to tier 4. However, a promising innovation is the development of a Recovery After Psychosis Team (p 26).

2.20.9 In some areas in East Midlands, CAMHS crisis teams have been developed using the concepts behind Crisis Home Treatment Teams or Assertive Outreach Services. The Assertive Outreach model has been used primarily to support young people on discharge from in-patient units, to reduce length of stay and prevent readmission. From September 2006, the south area of Northampton intends to operate a High Dependency Team (HDT). This will be the initial phase in the development of a Crisis Intervention/Home Treatment Team (CHRT). More details, including the learning disability service are in the East Midlands review.

2.20.10 An Intensive Treatment Team is being developed in West Norfolk in the Eastern Region. This is similar to the well established multi-disciplinary FAST (Family Assessment and Support Team), with more clinical input added to the social care/looked after children aspects of the work. It aims to prevent admissions to tier 4 and offer flexible, intensive support including out of hours and weekends. The potential is being explored with the local tier 3 service, of developing an existing women’s intensive support service, run by a charitable organisation in Norfolk (Ashcroft at Wymondham).

2.20.11 Yorkshire and Humber – Bradford Home Treatment Service for adolescents who have or are developing a severe mental illness such as psychosis, severe depression, eating disorder or manic depressive psychosis, and may be at high risk of suicide. The approach is based on a 'virtual' team, drawn from existing tier 3 staff as required for each individual’s needs. The core components of the multi-disciplinary package are:

- Referral picked up and virtual team mobilised within 24 hours
- Initial assessment
- Intensive clinical activity over 7 to 10 day period
- Activity typically includes home visits and telephone calls between family and professionals
- Longer period of diminished clinical activity
Sometimes a further period of intensive clinical activity

The Home Treatment approach also works with/offers:

- Links with the Early Intervention in Psychosis (EIP) team
- Support for young people making the transition to adult services
- A specialist nurse to support young offenders
- A young people's Psychotherapy Group, run by a group analyst and a CPN, providing long term weekly group work throughout the year. This has proved to be of considerable help to some depressed risk taking young people
- The Access group, which supports a recovery and normalisation/social skills programme through activities and peer support
- TRACKS school refusal project, provided jointly by education, CAMHS and Connections in a dedicated purpose designed pupil referral unit.

The Home Treatment approach was evaluated by Leeds University, showing that 19 young people potentially needed the service during the year beginning April 2005, and that there was:

- reduced use of adolescent in-patient beds
- reduction in the average length of stay for those young people who did require admission from 100 days to 50 days
- a more ethnically sensitive service
- apparent user and carer satisfaction
- success in engaging with groups who would typically not be admitted to tier 4, e.g. young offenders, those with substance misuse problems, and young people with learning disabilities (through shared working with the local CAMHS lead for Learning Disability (LD)/Autistic Spectrum Disorder (ASD) and links with the Behaviour and Education Support Team (BEST) project (a day service run by social services with CAMHS consultant input and the facility to offer some overnight short term residential provision).

2.20.12 Information on Workforce Development in the East Midlands review, stresses the vital role of staff training, including a CAMHS in-patient module being developed by St Andrew’s Hospital as part of an existing MSc at Northampton University.

2.20.13 Studies that would be of interest
Local as well as nationally and internationally published, studies have the potential to yield much useful information and ideas on how best to develop tier 4 services. It is recommended that a database for these is set up, or defined within a current database. Furthermore, it would be useful to hold a workshop for commissioners at which current innovative developments are succinctly presented and discussed, with the evidence on their impact on improving tier 4 capacity and capability. Similarly, these examples of service innovation and good practice could be presented in fuller detail as Appendix 4 of this report and critically reviewed on a database.
One such study is mentioned in the Yorkshire & Humber review, where a previous review of in-patient provision, revealed how little provision there was for admission to tier 4 places, with the result that children and young people in crisis were placed in paediatric wards, adult psychiatric wards or the private sector until a place becomes available. This situation was exacerbated by the lack of CAMHS staff to support these placements. It was also not certain how often these crises occurred and that information on this was needed. As a result, West Yorkshire are currently undertaking an audit of clinicians’ requests for admission to tier 4 provision, and what happens to the young person after the request.
3. Conclusions and Recommendations

3.1 The regional reviews present a wealth of material, which often also refers to fairly recent previous reviews related to tier 4 CAMHS. Each acknowledges that the review is a part of work in progress, aiming for a strategic approach to develop more comprehensive, equitable and effective tier 4 responses to the complex mental health needs of children and adolescents. However, the reviews clearly reveal that attainment of this aim is at very different stages in different parts of the country.

3.2 These differences arise in good part as a result of the political/organisational context within which the reviews were carried out, at a time when major changes in the configuration and roles of PCTs, SHAs and government regions were being implemented, again with differences in different parts of the country in the ease and speed with which this is happening.

3.3 Because of these changes, the reviews often found it difficult to relate data, which almost exclusively still comes from the providers, to populations. Individual PCTs varied considerably in their capacity to provide information on this client group. And with so many PCTs and SHAs, often with new boundaries, a 'regional' picture was also, understandably, difficult to obtain. Thus, the reviews vary considerably in the type of material presented and the amount of detail.

3.4 A lack of information and poor data is a major theme throughout the regional reviews. This is a longstanding issue and includes: problems with poor data collection systems, unreliable data, commissioning structures being short circuited by direct consultant referrals leading to patchy recording of basic information, and a general wariness to share information about tier 4 needs and activity, including both NHS and independent providers, because of commercial interests and reputation issues. Thus, this Summary Review has not found it possible to pull together a credible coherent national picture of many of the aspects of tier 4 provision, nor, indeed, to make meaningful comparisons of provision between the regions. However:

3.5 With regard to services with a national catchment, for the very highly specialised needs of deaf children and those with severe learning disability and mental health problems, the current moves, via NCG commissioning, at least to increase the provision and to locate the still very few units in both the north and the south of England are promising. More information is required to determine the impact of these recent developments on equitable access and improved outcomes; much of this information should become available from specific evaluation studies that are in train. More information is also required to make the case for national
commissioning of emerging models of provision for the mental health needs of young sexual abusers and others with similarly complex conditions that are becoming better understood.

3.6 However, the national perspective is crucially important in identifying the relevance for tier 4 services of existing policy, such as *Pushed into the Shadows* (OCC, 2006), and of potential policy development. Implementation of national policy that will influence how effectively and appropriately the needs of the relatively small group of young people with severe and complex mental health problems also depends largely on national oversight.

Thus, we recommend
- the continuing support of a National Working Group (such as already exists for tier 4), charged with gathering continuing intelligence on all matters related to how and how well the needs of children with severe and complex mental health needs are being met across the country. This will include attention to data systems (as at 3.12) and may include funding for evaluative research on tier 4 service developments.
- continuing support for mechanisms by which to share this intelligence, such as a database of promising and good practice;
- continuing support to regional/local commissioners and providers in identifying and sustaining appropriate service developments to meet the needs of their populations; this will include innovative approaches that have still to be evaluated.
- support for tier 4 commissioning by the National Specialised Commissioning Group, one of the tasks of the National Working Group (see 1st bullet point above)

3.7 At a regional level, four regions currently have in-patient bed numbers well below the recommended level. However, it was widely acknowledged that simply increasing the number of in-patient beds would not solve the well documented unmet needs among children with complex mental health problems. There is enough evidence to show that children’s needs will be met most appropriately and cost effectively by a range of types of in-patient, day care, and community (and home) based services. In every region, the picture is different of the provision that already exists and does not exist, what is working well and what is not working well.

Thus, we recommend
- That each region builds on the work carried out for its regional review by improving and refining its intelligence on the access, appropriateness and quality of the within region provision of facilities by which comprehensively to assess, hold safely, manage in the short term and treat, if necessary, children who present in crisis. It is essential that these children are enabled to engage with helping services and are supported beyond any crisis situation by provision in a child and adolescent psychiatric unit, by a community/home
based treatment programme. In this way, each region will take on recommendations 1, 2, 3 & 5 of *Pushed into the Shadows* (Appendix 2).

- The first stage in this process is to map, on a population basis, not from a provider perspective, the access for local children to the range of facilities that they may need. And on this basis, commissioners with their local NHS providers and where appropriate, local and out of area independent sector providers should develop plans for services that will fill the gaps in equitable access to a level and quality of provision that can meet the needs of young people. This mapping is already being supported by the National Tier 4 Working Group.

3.8 The mapping described above is an essential part of the commissioning process. The regional reviews make it clear that the overriding need at present is to develop the commissioning and specification of tier 4 provision, and that commissioners need developing as well as commissioning. The poor development of comprehensive commissioning can be seen in the striking differences in the establishment of innovatory approaches on a local basis, such as intensive home treatment. A commissioning framework needs to accommodate these different starting positions and incorporate them into the relatively complex system formed by CAMH services, from non specialist primary intervention through a range of referral and access arrangements to different levels of specialist services. The details of these arrangements also vary from place to place, but everywhere share the characteristics of a system: the parts are interdependent. And demand for tier 4 services depends in part on the capacity, capability and confidence of tier 3 services to manage risk and complexity; access issues for tier 4 services may influence the direction of tier 3 development. The ‘system’ must include integrated working between child and adolescent and adult mental health and health services, and local authority services. For example, pooled budgets for low secure provision with tier 3/tier 4 could well obviate inappropriate admissions to psychiatric in-patients.

3.9 Close working with the commissioning of tier 3 is strongly implied. As indicated by York and Lamb (2006), the capacity and capability of tier 3 does, indeed, largely ‘define’ what tier 4 is. This leads to great variability in access to tier 4, in the ways in which the needs for tier 4 are defined, in the skills and resources required, and in the ‘outcomes’ of tier 4 services. Lack of data means that it is barely possible in certain instances to draw coherent boundaries, on the basis of numbers and needs, between what tier 3 and tier 4 services would best be providing for young people with conditions such as autistic spectrum disorder and emerging personality disorder. But this also applies to our increasing understanding of conditions such as clinical depression in the young. In many ways, it would be helpful if it was not seen as desirable to draw exact boundaries between tier 3 and tier 4 but to define the elements of these specialist services that should be available, with the skills and resources attached, and how they should integrate with each other to meet the continuum of young people’s needs.
3.10 All the reviews recommend that tier 3 services be developed in order to establish optimum provision for the needs of children, young people and their families. Even the review for Cheshire and Merseyside, where it is well recognised to be poorly served in terms of in-patient beds, states: “there has to be more to a new model than extra in-patient capacity” (p 23). And stresses the need for a whole systems perspective to development, with flexible budgets across tier 3 and tier 4 and a need to overcome competition between tier 3 and tier 4 and between tier 3 services locally.

**We recommend that**
- **the commissioning of Tier 4 services is given due priority in each region of England.** This should take account of the absolute necessity for commissioning tier 4 services in collaboration with the commissioning of tier 3 and jointly, by mental health commissioners of children’s and adult services, with the appropriate commissioners of social care. This attends to recommendation 7 of Pushed into the Shadows.

3.11 It is highly important to identify leadership for the commissioning process to work within each region and collaborate on issues that would benefit from the sharing of scarce time and expertise, such as identifying unmet needs, development of core service specifications, monitoring data sets and setting standards (HASCAS standards for in-patient units are given at Appendix 3 of the North East and North Cumbria review). Immense support would be given to regional commissioning with the establishment of regional clinical networks.

**We recommend that**
- **where leadership for Tier 4 commissioning is lacking in a region, that it is sought with urgency.** The CAMHS Regional Development Workers play an important role in this as do, or should, the appropriate Specialised Services Commissioners.
- **We further recommend that it is fully acknowledged that commissioning of complex services such as Tier 4 CAMHS requires specific knowledge and skills, and that funding is specifically designated to support the education of the commissioners.** This should be regarded as important as the clearly indicated requirement for skills development in the provider workforce.

3.12 If commissioning is to be effective in the strategic development of effective provision for tier 4 type needs, there is an urgent requirement to improve the quality of the data and information that describe what is being provided, to whom it is being provided, its cost and the outcomes of provision.

**We recommend that**
- **PCT and regional commissioners and the National Working Group work together with providers to specify their data requirements and agree a range of standard measures in common.** Contracts and service level
agreements with providers should include the requirement for provision of the agreed data. This is in accordance with recommendation 6 of *Pushed into the Shadows*.

3.13 The experiences of young people and their families should inform both commissioners and providers on the way in which services are provided and what is provided. To date, their views and opinions have been incorporated into practice in relatively limited ways. Good use should be made of the learning presented in some of the regional reviews, (e.g. *North East and North Cumbria*) regarding the incorporation of user views into commissioning, monitoring, and evaluating tier 4 provision.

We recommend that

- providers and commissioners find effective ways of regularly obtaining user views; that these inform service development and practice and that feedback on this is made readily available.
References


Appendix 1  Features of the individual Reviews

**North East and North Cumbria** October 2006 (data collected 2005/06) by Health and Social Care Advisory Service (HASCAS)

Methodology: Qualitative data from interviews with 94 staff from all relevant organisations and the views of service users gained by ‘Investing in Children’. A number of local strategies, especially: Child and Adolescent Mental Health Tier 4 Services – Full Service Review (July 2006) by the Northern Specialised Commissioning Group.

Gives comprehensive information about the tier 3 services across the region and their relationship with tier 4.

**Yorkshire & Humber SHA** January 2007 (data collected at the end of 2006) by YoungMinds

Methodology: Information from discussion with key professionals and commissioners in Yorkshire & Humber plus full site visits to tier 4 units and review of activity data and relevant documents. A number of local strategies and a research report from the University of Leeds: Worrall-Davis, A and Marino-Francis, F. (2005) Tier 4 specialist CAMHS in Yorkshire and Humber: a collation of current and proposed provision.

Limited attention to availability, access and range of provision by CAMHS tier 3 and to analyses of multi-agency funded out of area placements, because at the time of the review, it was decided to ‘get our own house in order’, i.e. tier 4 CAMHS, taking full consideration of the related services (email comment from Jane Sedgewick CAMHS Regional Development Worker/NIMHE CAMHS Programme Lead, Yorkshire and Humber).

**Cheshire and Merseyside SHA** October 2005 (data collected February 2005) by HASCAS

Methodology: Content analysis of existing documentation and semi structured interviews with key stakeholders on an intensive site visit for information about tier 4 services
**Greater Manchester** March 2007 by Juliet Eadie, CAMHS Network Manager/Lead Commissioner for Tier 4.

This report sets out, in outline, a clinical model for tier 4 services for the Greater Manchester area, including proposed new service developments such as inreach/outreach teams, intensive care and low secure provision. The need for further work on the development of tier 3 services to support the model is highlighted, as is the collaborative work needed between the current providers and the commissioners to make the case for cost and specify the service system that is required. Note is made of the need for further work to develop satisfactory provision for young people with learning disabilities and for in-patient services for 16 and 17 year olds.

**West Midlands SHA** February 2005 (data collected 28 June 2004) by HASCAS and Manchester University

Methodology: Census collection of information from all 45 commissioners of ‘secondary’ mental health services for information about independent sector placements for mental health needs, covering all ages, including children. Also an Independent Review of Tier 4 Child and Adolescent Mental Health Services at Birmingham Children’s Hospital NHS Foundation Trust, May 2007. Data collected from documentary evidence, meeting staff and visiting the CAMHS wards at BCH.

**East Midlands SHA** November 2006 by Paul Farrell, East Midlands CSIP CAMHS Tier 4 Project Manager

Methodology: Information via a pro-forma from all tier 4 providers and visits to individual services, with feedback from a wide range of stakeholders; consultation with children and young people at the in-patient units and some parents; SWOT analysis with a range of service team members; views obtained from a variety of meetings and networks and documents. The East Midlands report includes specialist provision for low incidence needs through local authorities, such as in non maintained and other independent schools which may or may not have a health funded component. Also gives full data on workforce and reports on workforce issues, including training.

**Eastern Region** November 2005 by Cathy Street, Brenda Allan and Kami Saedi for Young Minds

Methodology: A review of published national data regarding the prevalence of mental health in the under 18 population and the implications of this for tier 4 services and make comparisons between different areas of the country; also draw upon national published data with regard to user views. Analysis of local reports and
documentation on provider activity and PCT/LA placements and funding arrangements. Questionnaire sent to key contacts within each of the 3 SHAs and for local staff. Site visits and interviews with tier 4 providers, and qualitative interviews with tier 3 professionals (20). Special meeting with commissioners in the region. Particularly full details are given on the national policy context regarding the provision of tier 4 CAMHS.

**London,** March 2007 (data collected the second half of 2006) by the London Specialised Commissioning Group

Methodology: Interviews with providers (clinical and managerial staff and data from all Trusts providing tier 4 services) and commissioners (20 of the 31 PCTs in London). Information further checked and validated, plus a consultation workshop involving a wide range of stakeholders. Explicit that only health care was considered as part of the review, while acknowledging the multi-agency involvement in CAMHS. Stated that only health care was considered as part of the project.

**South East/South Central** review from (old) Thames Valley SHA (North South Central), October 2005

Gives particularly full and clear detail on national guidance on tier 4 and on the local care pathways.

- Executive Summary of a review from Hampshire, Southampton, Portsmouth and Isle of Wight (south South Central) by The Public Health Resource Unit (Veena de Souza, Nicky Cleave, Mike Griffin);
- Summary of CAMHS Strategy from Kent & Medway SHA;
- Commissioning details for a review of Sussex, Brighton and Hove by CAMHS Consultants (Stella Charman)

**South West** July 2007 (data collected spring and early summer 2007), by Alan Fender and CAMHS Consultants Ltd.

This report sets out a Strategic Commissioning Framework, following analysis of the latest available data about service use and costs, several previous local reviews, interview information from the relevant providers and commissioners, and three stakeholder days. Full and useful description is given of the attempt and the issues related to user involvement in the process.
Appendix 2   Recommendations from *Pushed into the Shadows*

Measures aimed at preventing the inappropriate admission of young people onto adult psychiatric wards

**End the use of adult wards for the treatment of under 18s**

PCTs and Mental Health Trusts should ensure that adult wards are not used for the care and treatment of under 16s and, wherever possible, adult wards should be avoided for 16 and 17 year olds unless they are of sufficient maturity and express a strong preference for an adult environment. The Department of Health should also monitor progress towards this nationally. The Healthcare Commission should also address this through one of its future annual health checks of individual Mental Health Trusts and PCTs.

**Address the national shortage of emergency beds in Tier 4 CAMHS**

Action must be taken by the Department of Health, Mental Health Trusts and Primary Care Trusts (PCTs) to ensure that the Royal College of Psychiatrist’s recommendations that around 24 to 40 CAMHS beds are required per one million total population and a bed occupancy rate of 85% are met consistently and geographical inequalities addressed. Tier 4 units must include both acute care provision (to be able to respond to the need for emergency admissions of young people who are acutely disturbed or high risk) and medium to long term planned in-patient care.

**Development of alternatives to ‘traditional’ in-patient provision**

The Department of Health should ensure that there is a continued investment into CAMHS at local level, to support the development of both high quality responsive community teams and in-patient units that are closely linked to tier 3 services. This should be backed by a commitment to develop a range of treatment interventions which adhere to the best available evidence and take account of children and young people’s individual needs.

**Meeting the needs of 16 and 17 year olds**

As a part of the continued investment into CAMHS, support must be given by the Department of Health and the Care Services Improvement Partnership to the development of transition services that can support young people who require transfer to, and ongoing support from, adult services post CAMHS. CAMHS should be commissioned and resourced to provide services to all young people up to their 18th birthday.
Safeguards for young people in adult psychiatric wards

Collection of data on the numbers of young people admitted to adult mental health beds

The Department of Health should arrange for the collection of information by an organisation such as the Mental Health Act Commission on the numbers of all children and young people (whether detained under the Mental Health Act 1983 or not) who are admitted to adult psychiatric facilities and the length of each admission. This should be monitored both nationally and locally to ensure that progress is being made to eliminate the use of adult beds as a matter of urgency and any unforeseen increases investigated through performance management and inspection.

Policies and protocols between CAMHS and adult services

Mental Health Trusts (CAMHS and adult mental health services) and PCTs should work together to ensure they have in place a joint policy and/or protocol to ensure the safety & protection of young people admitted to adult wards (including the provision of appropriately segregated sleeping and bathroom areas) and access to the expertise and support of CAMHS staff throughout their in-patient stay in line with the rights set out under the United Nations Convention on the Rights of the Child and the relevant national standards.
Appendix 3  Maps of England showing the location of In-patient Units for Children and Adolescents
**Legend**

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<td>Child and adolescent learning disability unit</td>
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Appendix 4  Number and location of tier 4 services, (in-patient and day patient beds) for younger child and older adolescent age groups, provided in each unit, for each region

For each region:
- a map showing the location and type of the tier 4 services within the region
- a table giving the number of in-patient and day patient child and adolescent beds by age group provided in each unit
- a brief description of the type of provision in each unit

**North East and North Cumbria**
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<td>Unit</td>
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### Name of unit

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<td>9</td>
<td>22</td>
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- **Newberry Centre, Middlesbrough** – Commissioned by Teesside, County Durham, and Darlington PCTs. In-patient service for adolescents 12-18 years who have complex or severe psychiatric disorders, i.e. psychosis, depression, obsessional anxiety, eating disorders, neuropsychiatric disorders, organic disorders with psychotic illness. Does not offer services for adolescents with severe conduct disorders, drug or alcohol misuse, or learning disabilities where there is no psychiatric morbidity. Emergency admissions, including deliberate self harm; CPA implemented.

- **Westwood Centre** – Commissioned by Tees PCTs and on a cost per case basis, by PCTs across the UK; plan that in future should be commissioned largely for young people within the Northern region. Offers unique in-patient low secure/intensive care for 10-18 year olds who present with severe and challenging problems who require assessment in a safe and secure environment, accepting those with mild to moderate learning difficulties and some who have been in serious conflict with the law. Emergency admissions, including deliberate self harm; CPA implemented.

- **Sir Martin Roth Young People’s Unit, Newcastle** – in-patient 7 days a week service for young people with psychotic illness or severe eating disorder and complex other disorders such as OCD, anxiety, self harm.

- **Fleming Nuffield Unit for Children and Young People, Newcastle** – 7 day a week in-patient service and day patient programme including a separate specialist unit for children with pervasive developmental disorders. For children with complex, severe mental health problems, including eating disorders, complex anxiety.
states, depression, ADHD, Autism, complex behaviour disorders and self harming. Assistance for emergency admissions onto the paediatric ward.

- CAMHS Tier 4 Eating Disorder Services – the Fleming Nuffield Unit and Sir Martin Roth Young People’s Unit provide a regional tier 4 service for children and adolescents with severe, complex mental health problems for tier 3 CAMHS in Newcastle, Northumberland, Cumbria, Sunderland, Gateshead, South Tyneside, North Tyneside and North Durham. Have not been formally commissioned to provide a specialist eating disorder service, but a significant proportion of beds in both units are usually occupied by young people with eating disorders. Transition protocol with Regional Eating Disorder Service for adults at the Royal Victoria Infirmary in Newcastle.

- Prudhoe Learning Disabilities Services, Newcastle – take local and national referrals in 3 units: The Ridings for young people aged 4-18 with moderate to severe learning disabilities and severe/complex psychiatric and/or neuropsychiatric difficulties; Fraser House for 13-19 year olds with mild to moderate disabilities and severe/complex emotional, behavioural and psychiatric difficulties; Stephenson House for young people aged 13-19 with mild to moderate learning disabilities and severe/complex mental health and/or offending problems requiring security.

- The Junction/Ashford Young People’s Unit, Lancaster – recently opened 8-bedded in-patient unit; has an additional intensive care bed for any resident requiring additional care. For 24 hour observation and admission for psychosis, bi-polar disorder, depression, eating disorders, obsessive compulsive disorder (OCD), high levels of anxiety, psychosomatic disorders, e.g. chronic fatigue syndrome. Admission also considered for young people presenting with mild to moderate learning disability, autistic spectrum disorder and/or substance misuse when in conjunction with a serious mental illness. Outreach service and 24 hour call system being set up.
### Yorkshire & Humber Region

#### Unit type
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<tr>
<th>Unit Type</th>
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<td>Child and adolescent learning disability unit</td>
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<td>Child beds</td>
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<tr>
<td>Lime Trees, York</td>
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<tr>
<td>Little Woodhouse Hall, Leeds</td>
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<td><strong>Total</strong></td>
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- Lime Trees, York – Prioritises North Yorkshire but has larger catchment, including out of area; provides tier 3 learning disability team serving Selby and York and NCG funded Deaf Children’s MH Team; 7 days a week cover; takes emergency admissions; pre-admission assessment mandatory in the unit, therefore no tier 4 admissions for psychiatric assessment and no bed blocking; due to take high dependency patients
- Little Woodhouse Hall, Leeds – in-patient takes out of area referrals, DP primarily local service with assertive outreach; takes psychiatric emergencies and assessment; shared protocol with adult mental health; post discharge interventions
- Oakwood Young People’s Centre, Sheffield – local consortium commissioned by NORCOM for all the local areas; out of area placements rare; 7 days a week cover; takes emergencies; protocols in place for paediatric and adult MH involvement as part of Sheffield Children’s Foundation Trust plus a transition protocol with AMHs.
- “Oakwood, like most Adolescent Units, is in a period of transition. Previously established as a modified therapeutic community, the demands from referrers are for a general purpose acute admission ward for adolescents. Many of our patients suffer significant and sometimes florid mental illness, and the culture, philosophy and skills of the unit have to adapt to meet this need.” Sheffield Children’s NHS Trust Child and Adolescent Mental Health Services Service Profile 2006
- Shirle Hill, Nether Edge – local consortium commissioned by NORCOM; provides emergency response
- West End Adolescent Unit and Children’s Unit, Hull – The Children’s Unit mainly runs as a day unit; 5 day a week cover but exceptionally, can provide 7 day cover; takes emergency admissions
- Bradford Home Treatment (see good practice examples) – plans in 2007 to extend to other areas
Other in-patient and specialist MH provision used for Yorkshire & Humber young people:
- Ash Villa Unit, Lincolnshire Partnership NHS Trust
- Rhodes Farm Clinic, North London (independent)
- The Orchard Unit, Cheadle Royal Hospital, Cheshire (independent)
- Maple House, Rotherham
- Joint Agency Support Programme (JASP), Doncaster (education provision)
- Riverdale Grange Eating Disorders Clinic, Sheffield (private healthcare provider)
- Aldine House Secure Children’s Centre, Sheffield
- The Dual Diagnosis Team (learning disability and mental illness), Sheffield
- The BEST Project, Bradford

New forms of tier 4 or other intensive support services that are under development include: Crisis Response Team, Rotherham; Crisis team and Crash Pad, North East Lincolnshire; Assessment and Immediate Response (AIR) Services, Wakefield; Early Intervention in Psychosis (EIP), Wakefield; Specialist Foster Care Service, North Yorkshire; Multi-agency Fostering Scheme, East Riding; Tier 4 CAMHS, Humber; Home Treatment extension, Airedale and Craven.

### Cheshire and Merseyside

<table>
<thead>
<tr>
<th>Name of unit</th>
<th>Adolescent beds</th>
<th>Child beds</th>
<th>Both ages beds</th>
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<th>Child d/p</th>
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- Dewi Jones Unit, Royal Liverpool Children’s Hospital Trust at Alder Hey – flexible cut off in the age of child accepted, depending on child’s functioning and development. Two beds are theoretically set aside for emergency admissions but are rarely used for that purpose. A further two beds for rolling intensive assessments taking place over 6 weeks, for children with very complex needs and/or comorbidity such as psychosis or Autistic Spectrum Disorder. There are long stays because of difficulties in discharging, notably for North Wales children. The average length of stay is 3 months but some children with entrenched problems have extended admissions. Also, at times, long waiting times for admission. It is believed that the unit has never operated at full capacity. There are high numbers of high dependency children, often requiring three or four members of staff to one child. The unit does not take children with mild to moderate learning difficulties.
- Young People’s Centre, Chester - tends to admit more local residents preferentially. Reported case mix: 20-30% acute psychosis; c.20% eating
disorders; remainder with emerging personality disorder, behavioural and emotional disorder and complex post traumatic stress disorder. 3 beds are allocated for emergency admissions but these admissions may be refused because of their likely impact on treatment of others already in the unit. There are no in-patient intensive care beds. Young people resident in Cheshire and Merseyside receive better continuity of care.

- ROSTA (Residential and Outreach Support and Therapy for Adolescents) offers intensive community support, intended as an alternative to psychiatric in-patient care and to accommodation in a children's home or a secure children's home.

**Greater Manchester**

<table>
<thead>
<tr>
<th>Name of unit</th>
<th>Adolescent beds</th>
<th>Child beds</th>
<th>Both ages beds</th>
<th>Adolescent d/p</th>
<th>Child d/p</th>
<th>Both ages d/p</th>
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</thead>
<tbody>
<tr>
<td>McGuiness Unit</td>
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<tr>
<td>Galaxy House</td>
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<tr>
<td><strong>Total</strong></td>
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</tbody>
</table>

- McGuiness Unit, Bolton, Salford and Trafford Mental Health Services NHS Trust - possibly takes emergencies; has outreach team but cannot manage many 16 and 17 year olds.
- Galaxy House currently treats younger children and has good links with paediatrics
<table>
<thead>
<tr>
<th>Unit type</th>
<th>NHS Units</th>
<th>Independent units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent secure unit – low</td>
<td></td>
<td></td>
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<tr>
<td>Adolescent forensic unit</td>
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<td>General children’s unit</td>
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<td>Eating disorder unit</td>
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<td>General adolescent unit</td>
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<tr>
<td>Child and adolescent learning disability unit</td>
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</tbody>
</table>
The West Midlands currently has 54 beds within the NHS provision. This is commissioned regionally by the Specialised Commissioning Team (SCT) on behalf of the 17 PCTs in the West Midlands.

Following a major piece of work in September 2005 which reviewed the use of the NHS and Independent Sector (IS) provision and cost within the West Midlands, the PCTs decided to embark on the regional commissioning of ALL CAMHS Tier 4 inpatient placements (both NHS and IS) from April 2007. This service is now commissioned by the SCT on behalf of the PCTs.

This decision was taken owing to high costs, an often un-coordinated monitoring of placements and the placement decision being taken without ensuring the needs of the young person were able to be met in some of the IS provider units. Independent Sector placements in terms of cost and volume rose dramatically from 2001-2005, £1.8M to around £9M with a stabilising from 2005 to present date.

The West Midlands SCT now has a robust case management process in place and clear admission pathway and protocol into tier 4 services. In addition existing contractual arrangements were formalised with current Independent Sector providers of CAMHS Tier 4 to enable better procurement and performance monitoring to take place.

Birmingham Children’s Hospital (BCH) Foundation Trust is the largest NHS provider for the region with 44 beds. This operates over 4 units, 3 on one site (Parkview Clinic) and 1 on the main BCH site.

Parkview Clinic
- Ashfield Unit - has 8 beds and is an in-patient assessment unit for adolescents aged 12 to 16 years and those young people presenting with severe psychiatric disorders such as psychosis, depression.
- Irwin Unit - has 14 beds and is a general adolescent unit for severe and longer term mental health problems i.e. eating disorders, young people may be transferred from Ashfield to Irwin following a period of initial assessment.
- Heathlands unit - has 12 beds and has a focus on the neuro-psychiatric and developmental disorders

BCH Main site
- Ward 3 - is the only unit currently that has capacity to take children of primary school age (5-11 years). In addition the unit does admit young people up to the age of 16 years. It is a generic ward with a focus on children with co-morbid problems including physical disorders which can be managed more effectively owing to its location on the main Children’s hospital site.

North Staffs Combined Healthcare

Darwin Unit - is a 10 bedded unit which admits adolescents up to their 18th birthday. This is the only NHS facility in the West Midlands which is currently able to do so.
Typically presentations include severe mental health problems - psychosis, depression, OCD, Eating Disorders.

Independent Sector provision within the West Midlands
Currently in the West Midlands there are two main providers of Independent Sector care. These are:

Huntercombe Hospital, Stafford
- This has an Eating Disorder Unit, which has 7 beds.
- PICU, which has 4 beds (admits young people only who are detained under the MHA)
- A recently opened Assessment Unit - 10 beds

Woodbourne Priory Hospital, Edgbaston
- This is a provider of general adolescent care and treatment and has 12 beds available.

Both these Independent Sector providers are national providers and although based within the West Midlands region any PCT throughout the country can access the care and treatment at these providers if they so wish.

Placements in the independent sector may also be with a range of providers from outside of the West Midlands although the majority in terms of cost and volume of placements do remain within the providers within the region.
East Midlands Region

<table>
<thead>
<tr>
<th>Unit type</th>
<th>NHS Units</th>
<th>Independent units</th>
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<tbody>
<tr>
<td>Adolescent secure unit – low</td>
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<tr>
<td>Adolescent forensic unit</td>
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<td>General child and adolescent unit</td>
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<tr>
<td>General children’s unit</td>
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<tr>
<td>Eating disorder unit</td>
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<tr>
<td>General adolescent unit</td>
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<tr>
<td>Child and adolescent learning disability unit</td>
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<td>▲</td>
</tr>
<tr>
<td>Name of unit</td>
<td>Adolescent beds</td>
<td>Child beds</td>
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<tr>
<td>----------------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>Ash Villa</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Oakham House</td>
<td>12 + 2</td>
<td></td>
</tr>
<tr>
<td>Thorneywood</td>
<td>12 + outreach</td>
<td></td>
</tr>
<tr>
<td>Rathlin House LD &amp; CAMH service</td>
<td>2 + outreach</td>
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</tr>
<tr>
<td>Tier 3 Tanglewood</td>
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<td></td>
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<tr>
<td><strong>Paediatric</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuropsychiatry/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurodevelopmental Disorders Service</td>
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<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>36 + 2 LD</td>
<td></td>
</tr>
</tbody>
</table>

- **Ash Villa Adolescent Unit, Lincolnshire** (in a village 20 miles from Lincoln) – generic in-patient unit, operating 7 days a week; takes young people 10-16 years, with some provision for the 16-18 age group. It currently has 4 day places but no financial provision to support access to this provision. Emergency referrals are accepted and with occupancy levels at c 75%, the aim is to have a bed vacant at all times to support this. Young people with a wide range of problems are admitted: psychosis, self harming behaviours, eating difficulties, long standing emotional and/or behavioural issues. There are no specific services for eating disorders, learning disability and mental health issues (tier 4), substance misuse issues, conduct disorder or forensic services. No intensive care facility for management of more severe symptomatology including challenging behaviour. No dedicated outreach services although staff will carry out some short term outreach activity.

- **Oakham House Adolescent Unit, in the city of Leicester** – operates 7 days a week; takes young people aged 12-16 with severe and complex needs: primarily psychotic illness, emotional disorder, self harm, eating disorders. Offers a highly flexible range of placements options from day care to part time to in-patient, which aims to support young people as they progress through their treatment. Placements can encompass evenings, weekends etc. emergency referrals are accepted for any school age person (or at sixth form college) where there is concern about their mental health. Oakham House will see young people with conduct disorder as part of a mixed picture; there are no forensic services. Provision is currently being reshaped for 4 beds dedicated to eating disorders. Rathlin House will provide inreach on an individual basis for learning disability with CAMHS needs.

- **Thorneywood Adolescent Unit, Nottingham** (close to the city centre) – a generic in-patient unit for 12-18 year olds with severe and complex mental health issues. Has attached Assertive Outreach Team. Operates 7 days a week. Exclusion criteria include high risk patients requiring secure accommodation or specialist forensic care, drug use where it is the main problem, moderate to severe learning
disability, history of arson, and a level of aggression/disturbance which would need to be assessed in the context of the current client group and staff capacity. There is an Early Intervention in Psychosis team.

- Tanglewood Children’s Day Resource, Leicester city centre – offers a specialist sessional day provision for children under the age of 12 with a mental health problem and their families. Referrals are only accepted from CAMHS outpatient teams in Leicestershire and Rutland for problems that would benefit from an in depth assessment and/or a much broader range of treatment options. The service is for children who present with conduct disorder, emotional disorder (including anxiety, depression, school refusal, separation anxiety and phobic disorder), elimination disorder, eating disorders, autistic spectrum disorders, psychological difficulties secondary to emotional, physical and sexual abuse, and psychological difficulties secondary to mild learning difficulties or physical disorder. The Tanglewood Outreach Therapy Service (TOTS) is under development.

- Thorneywood Children’s Day Unit, close to Nottingham city centre – for children aged 5 to 11 years of age and their families. Open 5 days a week offering a flexible programme for children with complex mental health needs requiring further assessment and/or intensive intervention. Children present with hyperkinetic disorders (including ADHD and attention disorders), emotional disorders (including anxiety, low self esteem, depression, phobias, school avoidance, post traumatic stress disorders and negative feelings around abuse), conduct disorders, experience of negative relationships, autistic spectrum disorders and developmental disorders.

- Rathlin House Learning Disability and CAMH Service, Leicester – is a tier 4 service that provides comprehensive seamless care to meet the needs of adolescents with moderate/severe/profound learning disability with mental health problems, between 11 and 19 years of age. It offers crisis intervention, home treatment and outreach services, focusing on individualised intensive treatment (2 in-patient beds) and supported rehabilitation back into the home and community.

- Paediatric Neuropsychiatry/Neurodevelopmental Disorders Service, CAMHS Directorate, Nottinghamshire Healthcare Trust, Nottingham – a specialist tertiary district and regional service offering assessment, consultation and treatment of neuropsychiatric disorders in childhood and adolescence up to 18 years of age. Takes referrals from across and external to the East Midlands; does not accept emergency referrals. Offers specialist expertise in complex ADHD, Autistic Spectrum Disorder (including Aspergers syndrome), Tourettes Syndrome and tic disorders, behavioural aspects of epilepsy and other brain disorders, childhood onset psychoses, and paediatric psychopharmacology.

Other in-patient and specialist mental health provision used for East Midlands young people (Full details of these services are given in the regional review)
- 3 secure children’s homes within East Midlands: Clayfields, Nottinghamshire; Tiffield, Northamptonshire; Lincolnshire Secure Unit
- Rainsbrook Training Centre
- St Andrews Group of Hospitals (independent), Northampton
- Lowther Adolescent Unit (secure mental health)
- Malcolm Arnold House (adolescent secure learning disability)
- Wall Lane House Adolescent Unit, Staffordshire
- Phoenix Centre, Cambridge
- The Croft Child and Family Therapy Unit, Cambridge
- Shirle Hill Children’s Unit, Sheffield
- Oakwood Adolescent Unit, Sheffield

**Eastern Region**

<table>
<thead>
<tr>
<th>Unit type</th>
<th>NHS Units</th>
<th>Independent units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent secure unit – low</td>
<td>🟦</td>
<td>🟦</td>
</tr>
<tr>
<td>Adolescent forensic unit</td>
<td>🟥</td>
<td>🟥</td>
</tr>
<tr>
<td>General child and adolescent unit</td>
<td>🟢</td>
<td>🟢</td>
</tr>
<tr>
<td>General children’s unit</td>
<td>🟣</td>
<td>🟣</td>
</tr>
<tr>
<td>Eating disorder unit</td>
<td>🟦</td>
<td>🟦</td>
</tr>
<tr>
<td>General adolescent unit</td>
<td>🟠</td>
<td>🟠</td>
</tr>
<tr>
<td>Child and adolescent learning disability unit</td>
<td>🟤</td>
<td>🟤</td>
</tr>
<tr>
<td>Name of unit</td>
<td>Adolescent beds</td>
<td>Child beds</td>
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<td>------------------------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>The Croft</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>The Phoenix Centre</td>
<td>10 + outreach</td>
<td></td>
</tr>
<tr>
<td>The Darwin Centre</td>
<td>12 + outreach</td>
<td></td>
</tr>
<tr>
<td>Forest House</td>
<td>12 + outreach</td>
<td></td>
</tr>
<tr>
<td>Lonview Adolescent Unit</td>
<td>11 + outreach</td>
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<tr>
<td>Priory, Chelmsford</td>
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<td></td>
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<tr>
<td>Total</td>
<td>55</td>
<td>10</td>
</tr>
</tbody>
</table>

- The Croft, Cambridge and Peterborough Mental Health NHS Trust is open 5 days a week with negotiation about weekend arrangements. Children with complex problems, e.g. autistic spectrum, severe psychosomatic problems are referred, often from Paediatrics. It offers family admissions and all admissions are planned, although can admit very promptly. Therapeutic work with families is also carried out pre admission and post discharge in liaison with tier 3. Modernisation monies funds a part time liaison worker and this has led to shorter lengths of stay.

- The Phoenix Centre, Cambridge and Peterborough Mental Health NHS Trust is a specialist unit for Eating Disorders for young people aged 11-17 years, open 7 days a week, and with an outreach service. All referrals, including emergencies are responded to quickly; this may include admission to a paediatric ward or outreach support and not necessarily admission to the unit.

- The Darwin Centre, Cambridge and Peterborough Mental Health NHS Trust admits young people from a wide area of the Eastern Region. It takes young people with severely disturbed young people, some of whom may otherwise need secure services All admissions are planned, with no emergency admissions. There is some day provision, which works as a stepping stone towards full discharge. Support for some young people, also involving the outreach team working post discharge, may continue until handover at age 18.

- Forest House, Hertfordshire Partnership NHS Trust – the majority of patients present with severe depression and self harm, psychoses, Autistic Spectrum Disorder, severe OCD, and Post Traumatic Stress Disorder. It does not admit in an emergency but has formal arrangements whereby the outreach team works with these admissions at Snowsfield Adolescent Unit for under 16s and St Julian’s ward at St Albans City Hospital.

- Longview Adolescent Unit, North Essex Mental Health Partnership NHS Trust – The unit strives to be a short term acute unit rather than providing long term care. All referrals are assessed with a view to admission for 24 hour stay, day care or sessional attendance; it is open 7 days a week. It also provides an Intensive
Outreach Team, working with tier 3 from the point of referral to 3 months post discharge.

- Priory, Chelmsford, Priory Healthcare (independent sector) – this is one of the units, which is within the Eastern Region area, of the Priory Group of Hospitals, a number of which are frequently used by the Eastern Region. All the units are open 7 days a week and accept young people aged 13 plus. Admissions are made within 24 hours. The 14 child and adolescent units, spread across 8 sites cater for a wide range of problems, something that CAMHS would find near impossible to provide for the few patients with each type of need in each locality.

Other in-patient and specialist MH provision used for Eastern Region young people: (A brief description of the services offered by the following units is given in the Eastern Region Benchmarking report.)
- Alpha Hospital, Woking
- Ash Villa, Sleaford, Lincs.
- Brookside, Ilford
- Capio Nightingale Hospital, North London
- Collingham Gardens, West London
- Ellern Mede Eating Disorders Unit, North London
- Highfield Unit Oxford Mental Health Partnership), Oxford
- Huntercombe, Maidenhead
- North London Priory (Grovelands at Southgate)
- Oak View, Orpington (secure)
- Priory Hospital, Ticehurst
- Rhodes Farm, North London
- St Andrew’s Hospital, Northampton
- Snowsfields, London SE1
- Spectrum, Cornwall

New services and changes underway:
- Intensive Treatment Team in West Norfolk
- Family Adolescent Support Team in Bedfordshire
- New in-patient units are proposed in Norfolk and Essex
London Region

Unit Types NHS
1. Adolescent Secure Unit-Low
2. Adolescent Forensic Unit
3. General Child and Adolescent Unit
4. General Children’s Unit
5. Eating Disorder Unit
6. General Adolescent Unit
7. Child and Adolescent Learning Disability Unit

Unit Types Independent
1. Adolescent Secure Unit-Low
2. Adolescent Forensic Unit
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5. Eating Disorder Unit
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<td>Child and adolescent learning disability unit</td>
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<tr>
<td>Name of unit</td>
<td>Adolescent beds</td>
<td>Child beds</td>
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<td>------------------------------</td>
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<tr>
<td>Collingham Gardens</td>
<td>12</td>
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<tr>
<td>Cassel Hospital</td>
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<td>Wells Unit</td>
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<tr>
<td>New Beginnings</td>
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<tr>
<td>Coborn</td>
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<tr>
<td>Brookside</td>
<td>18</td>
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<tr>
<td>Aquarius</td>
<td>8</td>
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<td>Bethlem Adolescent Unit</td>
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<td>Bill Yule</td>
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<tr>
<td>Snowsfields</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>138</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

These figures do not include beds in the independent sector and do not take account of beds that are used for national referrals only and, hence, are not available to local residents.

**North West London**

- Collingham Gardens Child & Family Psychiatric Services, Central & North West London Mental Health NHS Trust – takes a wide range of presenting problems, both complex and severe, including acute onset MH problems, behavioural problems, severe anxiety disorders, early onset psychosis, eating disorders, OCD and emotional disorders, severe depression, suicidal behaviour, and school based problems. Admission may be dependent on the current unit context, such as when a child cannot be contained due to the level of violence. Speedy admission but not emergency. Also manages NW London psychiatry on call service (5pm to 9am Mon to Fri and throughout the weekend) for any child or young person aged up to 18 who presents to A&E departments or is referred from a paediatric ward.

- The Cassel Hospital Young Person’s Unit, West London Mental Health NHS Trust – Therapeutic community setting for young people aged 16 to 23, with specialist outreach and assessment and consultation services. The young people usually have different forms of incipient personality disorder, eating problems, self harm and suicidality, have suffered trauma. Normally excluded are young people with prodromal psychotic conditions, schizophrenia, severe and active addiction problems with alcohol and drugs, those with a high risk of violence to
others. The Cassel does not accept young people currently on Section. It assesses and treats babies, children and young adolescents from age 0 to 16, while resident with their families.

- The Wells Unit at St Bernard’s Hospital, West London Mental Health NHS Trust – a secure service for boys, with a national catchment and admission criteria and funding from the National Commissioning Group (formerly NSCAG).

**North Central London**

- New Beginnings at Edgware Community Hospital, Barnet, Enfield & Haringey Mental Health NHS Trust – for young people registered with a GP in Barnet, Enfield, Haringey, Camden & Islington. Provides acute psychiatric care for young people presenting in crisis from the 5 local PCTs. Treatment is focused on helping young people achieve the minimum changes that have been identified for them to be able to return home. The unit will not admit those whose primary problem is caused by learning difficulties, substance misuse, severe eating disorder or conduct disorder. Serious forensic risk may also preclude admission.

- Northgate Clinic at Edgware Community Hospital, Barnet, Enfield & Haringey Mental Health NHS Trust – has an open catchment although the majority of referrals come from North London and the Home Counties. Offers a medium term therapeutic service, specialising in helping adolescents who are experiencing significant complex and enduring mental health difficulties. The unit accepts complex problems involving a wide range of diagnoses but not someone with a learning disability severe enough that they cannot understand the treatment programme, someone with an eating disorder that requires closely supervise re feeding, nor a primary diagnosis of substance misuse, nor anyone on Section or who cannot be managed on an open unit, or anyone seriously dangerous or physically or sexually violent.

- Simmons House at St Lukes Woodside Hospital – referrals of young people, only from the London boroughs of Barnet, Enfield, Haringey, Camden & Islington, with severe and complex psychiatric disorders; significant breakdown in family or educational functioning; treatment at tier 3 unable to meet the clinical needs. The unit does not admit anyone who is acutely disturbed, whose primary presenting problem is substance misuse, severe eating disorder, severe learning difficulties, anyone on Section or requiring secure accommodation or who pose a serious risk to patients or staff. The unit will not admit unless there is firm commitment of a community placement post discharge and is unable to care for patients with high physical nursing dependency needs.

- Great Ormond Street (GOS) Hospital, Mildred Creak Unit - has a particular interest in severe psychosomatic disorders, with close links to the main hospital paediatric teams; also outpatient teams: GOS Feeding & Eating Disorders Services, Social and Communication Disorders Clinic, Centre for Interventional Paediatric Psychopharmacology (CIPP), ADHD Complex Problems Clinic, Parenting & Children Service, Traumatic Stress Clinic.
• Royal Free Hospital Eating Disorders Team – assertive outreach aimed at maintaining young people at home and continuing to support them after discharge from hospital.

• The Tavistock & Portman NHS Foundation Trust, Mulberry Bush Day Unit is a psychiatric day service and an educational unit, accepting referrals from all over London. Children usually have complex and longstanding health, social and educational needs that cannot be met by local community mental health, education and social care services. A number are ‘Looked After’. Also 4 outpatient clinics: Munroe Young Families Centre, Learning and Complex Disabilities Services, Portman Clinic, Gender Identity Development Service.

North East London

• The Coborn Centre for Adolescent Mental Health, East London & The City Mental Health NHS Trust – provides specialist care for young people in acute crisis and has 3 beds designated for psychiatric intensive care. Not able to accept young people with a severe learning disability, primary diagnosis of eating disorder or of conduct disorder in the absence of treatable psychiatric diagnosis, nor with substance misuse. The unit does not provide forensic services or medium term care.

• Brookside Young People’s Unit at Goodmayes Hospital in Essex, North East London Mental Health NHS Trust – provides a range of specialised psychiatric services both in the short and medium term, with acute admissions from Tier 3 supported by a consultant psychiatrist. Anyone with severe learning disability, severe/complex eating disorders, requiring psychiatric intensive care, low secure or secure services are not able to be accommodated.

South West London

• South West London & St George’s Mental Health Trust – Adolescent Resource Centre is, with the in-patient unit and the day service, an integrated service with a single referral pathway, aimed at reducing and managing risk whilst the mental state of the young people is assessed, treated and stabilised. This enables the young people to have access to the level of care they require at different stages of their illness and recovery and retain links with their local area.

• Aquarius Ward provides specialised assessment, treatment and support to young people, their families or carers during a period of acute crisis, such as acute psychosis. Referrals will generally not be accepted where a young person has a primary diagnosis of: conduct disorder/mixed emotion and conduct, substance misuse, moderate and severe learning difficulties or pervasive developmental disorder, as well as young people experiencing a social crisis. It is an open unit and therefore not suitable for requiring secure accommodation.

• St George’s Eating Disorders Service

• Corner House Deaf Child and Family Service provides advice and consultation to children, families, professionals and other agencies, and offers outpatient and inpatient assessment and treatment for a wide range of conditions, including
behavioural disorders, emotional disorders, pervasive developmental disorders and psychiatric disorders. The in-patient service takes referrals from all over the country, commissioned via the NSCG (formerly NSCAG).

- Children’s Assertive Outreach Team is a new three month rapid response intensive service offered to children up to the age of 13 and their families, resident in Merton, Sutton & Wandsworth, who require Tier 4 input because of the complexity and severity of the child’s mental health needs.
- The Loft is a new multi-agency day programme for young people who are resident in Sutton and have a primary problem with either alcohol or drug misuse.

**South East London**

- South London & Maudsley NHS Foundation Trust – Acorn Lodge at Bethlem Royal Hospital provides assessment and treatment for children suffering from severe or complex child psychiatric disorder, including neuropsychiatric conditions, psychosis, attention deficit and hyperactivity disorder, obsessive compulsive disorder, severe anxiety disorder, depression, moderate eating disorders, autism and developmental disorders. The unit cannot provide for children with severe learning disability or for older children with a pure conduct disorder.
- Bethlem Adolescent Unit – offers an acute psychiatric service for young people with severe mental health problems, including depression, psychosis, affective and bi-polar disorders, obsessive compulsive disorder, neuropsychiatric conditions, attention deficit and hyperactivity disorder, Aspergers and Autistic Spectrum. A small number of national beds are reserved for young people with treatment resistant psychosis. The unit does not provide for young people with complex eating disorders; those with moderate to severe learning disabilities; those whose behaviour is attributed to their social circumstances; substance misusers who need a specialised detoxification programme; psychiatric intensive care; secure forensic patients; those requiring long term rehabilitation or long term in-patient psychotherapy. The unit also is not able to provide for young people with extensive physical health requirements.
- Snowsfield Adolescent Unit – provides for young people with problems similar to those provided for at the Bethlem Unit The same exclusion criteria apply, except that at the Snowsfield Unit, learning disability, drug related problems, pervasive developmental disorder or homelessness are not exclusion criteria provided there is evidence of acute mental health disturbance.
- The Bill Yule Adolescent Unit – provides a secure service for adolescent boys suffering from mental illness associated with difficult or offending behaviour. This has a national catchment, commissioned by the NSCG (formerly NSCAG), with the same admission criteria as the five similar units in different parts of England. These do not accept young people with complex eating disorders, with moderate to severe learning disability, those whose behaviour is attributed to their social circumstances alone, substance misusers who need a specialised detoxification programme, those with extensive physical health care requirements, or very high risk patients requiring a high security hospital setting.
Outpatient clinics: Adoption & Fostering; Anxiety Disorders; Brain & Behaviour; Child Care Assessment Team; Child Traumatic Stress; Conduct Problems; Child & Adolescent Eating Disorders; Child & Adolescent Forensic Team; Child & Adolescent Learning Disabilities Team; Neuropsychiatry; Obsessive Compulsive Disorders; Pervasive Developmental Disorder.

Oxleas NHS Foundation Trust – The Youth in Need Service – provides an outpatient forensic service for older adolescents.

Independent Sector Tier 4 provision utilised by London:
- St Andrews Hospital, Northampton – Malcolm Arnold House and the Lowther Unit
- Oakview, Orpington
- The Priory Ticehurst House
- The Priory Hospital Hayes Grove – The Chrysalis Centre
- The Priory Hospital North London
- The Priory Hospital Roehampton
- The Priory Hospital Chelmsford
- Cygnet Hospital Godden Green
- Capio Chelsea
- Huntercombe Hospital Maidenhead
- Ellern Mede Centre for Eating Disorders
South East/South Central Region

Unit type
- Adolescent secure unit – low
- Adolescent forensic unit
- General child and adolescent unit
- General children’s unit
- Eating disorder unit
- General adolescent unit
- Child and adolescent learning disability unit

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<th>Unit type</th>
<th>NHS Units</th>
<th>Independent units</th>
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<tr>
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<td>Eating disorder unit</td>
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<td>Name of unit</td>
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<td>------------</td>
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<td>Highfield Unit</td>
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<tr>
<td>Wycombe Day Unit</td>
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<tr>
<td><strong>Total</strong></td>
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</table>

- Leigh House, Winchester – provides 7 days a week care.
- Behaviour Resource Service (BRS), Southampton
- Berkshire Adolescent Unit, Berkshire Healthcare NHS Trust, Wokingham – 5 days a week in-patient unit for 12-18 year olds with severe mental illness, with some 7 days a week care. Provides intensive day programmes and specialist outpatient assessment and treatment clinics (for eating disorders, early onset psychosis, OCD, severe affective disorders, learning disability with self harming, Aspergers or school refusal. Contributes to on-call service but has no social worker and no link worker for the 6 community tier2/tier3 teams in Berkshire.
- Highfield Unit, Oxfordshire and Buckinghamshire Mental Health Partnership NHS Trust (OBMHT), Oxford – 7 days a week service with assertive outreach for Oxfordshire; has no intensive care facilities, patients go to adult ICU remaining under the CAMHS team
- Oxfordshire Tier 4 Outreach Service, OBMHT – can cater for 12 children (aged 13 to 18) needing intensive home support/outreach at any one time. It runs 7 days a week with flexible times and a help line open until 8pm.
- Wycombe Day Unit/Child and Adolescent Support Service, OBMHT at Wycombe General Hospital – for Berkshire residents; it runs on week days, with no out of hours cover.
Unit type | NHS Units | Independent units
--- | --- | ---
Adolescent secure unit – low | ▲ | ▲
Adolescent forensic unit | ▲ | ▲
General child and adolescent unit | ▲ | ▲
General children’s unit | ▲ | ▲
Eating disorder unit | ▲ | ▲
General adolescent unit | ▲ | ▲
Child and adolescent learning disability unit | ▲ | ▲
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<tr>
<th>Name of unit</th>
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<th>Child beds</th>
<th>Both ages beds</th>
<th>Adolescent d/p</th>
<th>Child d/p</th>
<th>Both ages d/p</th>
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<td>The Priory Hospital, Bristol</td>
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</tr>
<tr>
<td>Maple Service/Pine Cottage</td>
<td>4 + intensive outreach team</td>
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<td>Lumsden Walker Service</td>
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<td><strong>52 + LD + outreach</strong></td>
<td></td>
<td></td>
<td><strong>15</strong></td>
<td></td>
<td><strong>outreach</strong></td>
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</table>

- Plymouth, Tier 4, Plymouth Hospitals Trust – PCT catchment: Cornwall, Devon, Somerset, Torbay & Plymouth; possibility of another 3 ‘risk’ beds
- Marlborough House SAS, Swindon & Marlborough Trust – PCT catchment: wider, including Gloucestershire
- Riverside Adolescent Unit, North Bristol Trust – PCT catchment: Bristol, BANES, Gloucestershire
- Orchard Lodge Young People’s Unit, Somerset Partnership Trust – PCT catchment: Cornwall, Devon, Somerset, Torbay & Plymouth
- Castle Hill House learning disability Unit, Dorset Healthcare Trust – PCT catchment: East Dorset
- The Priory Hospital, Bristol, Priory Group – catchment: South West Region, South Wales, Hants, Surrey
- Maple Service/Pine Cottage, Dorset Healthcare Trust – catchment: Dorset
- Lumsden Walker Service, United Bristol Healthcare Trust – PCT catchment: Bristol, BANES, North Somerset, South Gloucestershire
- Young People’s Service, Avon & Wiltshire Mental Health Partnership Trust – PCT catchment: North & West Wiltshire, BANES
## Appendix 5  Data from the National Child Health, CAMHS & Maternity Service Mapping Exercise 06/07

### Tier 4 Capacity

<table>
<thead>
<tr>
<th>SHA</th>
<th>No. Tier 4 Special Care Teams</th>
<th>Teams with acute IP beds available¹</th>
<th>Nos of acute IP beds available¹</th>
<th>Inpatient units with commissioned beds</th>
<th>All commissioned beds²</th>
<th>Teams with forensic beds available¹</th>
<th>Nos of forensic beds available¹</th>
<th>Teams with forensic beds commissioned</th>
<th>Number of forensic beds commissioned²</th>
<th>Teams with other IP beds available</th>
<th>Nos of other IP beds available¹</th>
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¹ The number of beds available on 1st November of the mapping year, taking into account the needs of patients, for example if you have a young person requiring constant observation and therefore additional nursing staff your actual capacity.

² This is the fully funded permanent bed capacity. This number should stay the same year on year unless there are expansions or reductions in the contract.
## Tier 4 Capacity (continued)

<table>
<thead>
<tr>
<th>SHA</th>
<th>Teams with other beds commissioned</th>
<th>Number of other beds commissioned&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Teams with day places</th>
<th>Day Places</th>
<th>Teams with Intensive home support</th>
<th>Intensive home support places</th>
<th>Teams with Intensive foster care</th>
<th>Intensive foster care places</th>
<th>Teams with other intensive outreach</th>
<th>Other intensive outreach places</th>
<th>No. Tier 4 teams members of QNIC&lt;sup&gt;3&lt;/sup&gt;</th>
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<sup>2</sup> This is the fully funded permanent bed capacity. This number should stay the same year on year unless there are expansions or reductions in the contract

<sup>3</sup> Quality Network for Inpatient CAMHS
### Alternatives to inpatient care (non-tier 4 teams)

<table>
<thead>
<tr>
<th>SHA</th>
<th>Total number non-tier 4 teams</th>
<th>Intensive home support</th>
<th>Intensive day support</th>
<th>Early intervention service</th>
<th>Intensive treatment in foster care</th>
<th>Other intensive outreach</th>
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### Tier 4 forensic

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<th>Teams with forensic beds available</th>
<th>Number of forensic beds available&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Teams with forensic beds commissioned</th>
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<th>Total Tier 4 Forensic Staff (wte)</th>
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<sup>1</sup> The number of beds available on 1st November of the mapping year, taking into account the needs of patients, for example if you have a young person requiring constant observation and therefore additional nursing staff your actual capacity.

<sup>2</sup> This is the fully funded permanent bed capacity. This number should stay the same year on year unless there are expansions or reductions in the contract.
## Tier 4 forensic workforce

<table>
<thead>
<tr>
<th>SHA</th>
<th>Total Tier 4 Forensic Staff (wte)</th>
<th>Nurses (wte)</th>
<th>Doctors (wte)</th>
<th>Clinical Psychologist (wte)</th>
<th>Educational Psychologist (wte)</th>
<th>Social Workers (wte)</th>
<th>Psychotherapists CAF (wte)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>45.300</td>
<td>35.600</td>
<td>2.000</td>
<td>-</td>
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<tr>
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<td>-</td>
<td>3.000</td>
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<td><strong>Total</strong></td>
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<td><strong>216.660</strong></td>
<td><strong>13.650</strong></td>
<td><strong>7.200</strong></td>
<td>-</td>
<td>5.800</td>
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¹ Child, adolescent and family psychotherapists with the formal qualification and employed within this staff group.

<table>
<thead>
<tr>
<th>SHA</th>
<th>OT (wte)</th>
<th>Family Therapist (wte)</th>
<th>Other Qual Therapist (wte)</th>
<th>Other Qual (wte)</th>
<th>Other Unqual (wte)</th>
<th>PMHW (wte)</th>
<th>Managers (wte)</th>
<th>Admin (wte)</th>
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<tbody>
<tr>
<td>London</td>
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<td>-</td>
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<td>-</td>
<td>-</td>
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<td>-</td>
<td>3.000</td>
</tr>
<tr>
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<td>6.000</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
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<td>-</td>
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<td>-</td>
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<td>-</td>
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## Tier 4 case, staff, cost

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<tr>
<th>SHA</th>
<th>Local caseload tier 4</th>
<th>Tier 4 Wide Caseload</th>
<th>Total Tier 4 Cases¹</th>
<th>Total Tier 4 Special Care Staff (wte)</th>
<th>Tier 4 Total Cost (£)</th>
<th>Total new cases (tier 4)</th>
<th>Total cases waiting (tier 4)</th>
<th>Tier 4 Total Cost per Case (£)²</th>
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<td>147.350</td>
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<tr>
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<td>1615</td>
<td>1839</td>
<td>574.330</td>
<td>29309180</td>
<td>886</td>
<td>303</td>
<td>15937.564</td>
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<td>449</td>
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<td>614</td>
<td>259.550</td>
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<td>South East Coast</td>
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<td>Yorkshire and the Humber</td>
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<td>118</td>
<td>280</td>
<td>163.520</td>
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<td><strong>Total</strong></td>
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<td><strong>3221</strong></td>
<td><strong>550</strong></td>
<td><strong>16317.935</strong></td>
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</table>

¹ From 6 month sample period
² Annual reported team cost to cases in 6 month sample period

## Tier 4 forensic case, staff, cost

<table>
<thead>
<tr>
<th>SHA</th>
<th>Tier 4 Forensic Caseload</th>
<th>Total new cases (tier 4)</th>
<th>Total cases waiting (tier 4)</th>
<th>Tier 4 Total Cost (£)</th>
<th>Tier 4 Cost per Case (£)¹</th>
<th>Total Tier 4 Forensic Staff (wte)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>-</td>
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<td>45.300</td>
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<td>90.450</td>
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<td>6</td>
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<td>1755440</td>
<td>97524.444</td>
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<td>-</td>
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<td><strong>Total</strong></td>
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<td><strong>1220282</strong></td>
<td><strong>156446.423</strong></td>
<td><strong>288.270</strong></td>
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</tbody>
</table>

¹ Annual reported team cost to cases in 6 month sample period