



Anna Freud  
National Centre for  
Children and Families

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# North West London CCGs'

Children and young people's  
mental health and well-being  
system review

## **FINAL REPORT**

Royal Borough of  
Kensington and Chelsea



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## Executive Summary

The Anna Freud National Centre for Children and Families (AFNCCF) was commissioned through the North West London Collaboration of Clinical Commissioning Groups (CCGs) to provide a review and propose options for consideration by the CCGs for improvement of the children and young people's mental health and well-being system across seven North West London CCGs. The aim was to come up with options which may be shared across all seven boroughs as well as recognising the specific requirements of each borough.

This is the final document in a series of reports, which have included needs analysis, service mapping and workforce and training review, and a series of stakeholder engagement events which have already been delivered.

The options for consideration presented in this report arose from a 3 month data collection period (April – July 2016) within which we; reviewed key documentation for each borough (including JSNAs, Ofsted reports, Local Transformation Plans, and results of local consultation and data), conducted a series of focus groups (56 in total) across the boroughs with parents, young people and professionals – including 6 in RBKC, and held series of interviews with key professionals and other CYP interest groups, over 70 in total of which 16 were RBKC specific. The options proposed (and summarised below) are a result of what we have heard from our field work along with detailed consideration of preliminary options in whole day borough based seminars in the majority of boroughs.

Based on this extensive field work across seven boroughs, we have developed two key suggestions that are shared across all seven boroughs. These were, firstly, the development of Mental Health Coordinator roles (MHeCOs) in nurseries and schools and secondly the development of joint agency Multiple Access Points (MAPs) to facilitate improved access to effective help. For each borough, these core options are included while taking account of the individual arrangements within each borough.

Across the boroughs, our fieldwork suggested that there is a clear commitment to develop and maintain quality services that enable children and young people to thrive. From our fieldwork it was clear that services are operating in a challenging environment, with insufficient resources available to meet need, as is the case nationally

Children, young people and their families who live in the Royal Borough of Kensington and Chelsea (the locality covered by West London CCG), are largely well served by the early years services, schools and range of universal services that enable them to thrive and succeed. Across the Borough, a range of high quality targeted services have been developed to address the needs of those children, young people and their families who have additional needs or

vulnerabilities. This includes the innovative early help teams, where clinicians work alongside social workers to deliver systemic early intervention work with vulnerable families. Across the borough, mainstream services and particularly schools, can access quality advice and support from mental health practitioners based within CAMHS – alongside a range of support for those children and young people who have emerging difficulties; through targeted services such as the Behaviour Support Family Service and the Early Help Teams. Through our focus groups and interviews, we heard numerous examples of positive practice that practitioners were involved in – across health visiting services, early years settings, schools, targeted services and specialist CAMHS services. We also heard from parents and young people about the services that they had found particularly helpful.

Within Kensington and Chelsea, as with other with other boroughs involved in this review, and CCGs and local authorities nationally, there are significant challenges. Enabling and supporting all schools, so that they can support children and young people’s emotional wellbeing and mental health, and deliver effective early intervention work, particularly for those children with more complex and challenging needs, was seen as being a key issue for Kensington and Chelsea (RBKC). Access to specialist CAMHS, particularly for those children and young people who require in-patient provision and for those families for whom existing CAMHS services are not appropriate, were also seen as being important issues for RBKC to address. The importance of addressing the needs of children and young people (CYP) with ASD/LD and NDD and the continuing lack of integration across mainstream, targeted services and CAMHS for all children was seen as being important. This was particularly highlighted for those children and young people with complex needs – so that they can experience a more coherent ‘pathway’ of services and support that can address the full range of their needs; in settings and locations that are familiar and where support is provided wherever possible by known and trusted professionals.

We used the THRIVE framework to consider the different needs of key groups of young people across all seven boroughs, along with principles of integrated working and promoting effective and transparent practice. The following recommendations for Kensington and Chelsea are based on both shared and specific observations about services and needs across the whole of the North West London CCG collaborative. We have put forward the following options for consideration:

1. To promote **Thriving**: To enhance interagency prevention and promotion by mainstream services; it is proposed that early years settings, schools and colleges nominate and support key individual(s) to take a lead role in promoting children's mental health. These **Mental Health Needs Coordinators (MHeNCOs)** will provide advice, leadership, a key point of liaison and offer on-going training and support to other staff in the setting
2. To promote Advice and Signposting: To enable improved access and clarified referral we propose the development of **Multiple Advice (or Access) Points (MAPs)**. This involves formalising existing multi-agency teams/co-located teams which are working in new ways (such as the Early Help Team) and developing additional integrated provision with input from specialist CAMHS.
3. To promote **Getting Help and More Help** The priority of developing **'needs led' integrated pathway** systems for all children requiring mental health support, so that this includes a coherent and 'cross system' approach is recognised by all. In addition for those young people transitioning to adult services, it is proposed RBKC considers piloting a **'tapered approach to transition'** to developing a more integrated approach to transitions across children's and adults services; focused initially on young people who have high functioning ASD and associated conditions (learning difficulties, mental health problems, challenging behaviour). Building on the **Out of Hours (OOH) pilot** and the **new tier 4 commissioning pilot** we propose RBKC continues to develop new ways of delivering and providing specialist mental health support in ways and settings that address the needs of young people who have not historically engaged with existing specialist CAMHS services. Such services, would be delivered within accessible 'youth focused or orientated services' and would include a focus on effective preventative and promotional work alongside access to more specialist interventions where required.
4. To promote **Getting risk support**. The priority is to further build on existing models of innovative integrated work that RBKC is involved in developing, particularly the Early Help Teams for example. The aim is to focus on the needs of those 'at risk' young people, who are known to multiple agencies, who have a range of complex and enduring needs and in relation to whom, a health based intervention from a specialist CAMHS service may not be the most appropriate way of engaging with

or supporting them, but for whom a 'team around the professional approach'; drawing together all those professionals currently working with them, to review new approaches to intervention, may a better way forward.

5. To achieve **integrated practice RBKC** should consider increasing opportunities for **joint training and/or cross system training**, colocation and environments that support collaborative encounters wherever possible; for example there should be clear liaison and close working between MHeNCOs and MAPs.
6. To promote **effective and transparent practice**, RBKC should consider that all practice draws on **best evidence** where it exists, so that **outcomes** and the impact of all interventions are routinely considered and that appropriate data is collected to allow this to happen.

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## Remit of this document

The Anna Freud National Centre for Children and Families (AFNCCF) was commissioned through the North West London Collaboration of Clinical Commissioning Groups (CCGs) to provide a review and recommendations for improvement of the children and young people's mental health and well-being system across seven of the North West London CCGs.

This document is the final report for the project and builds on the work summarised in the previous reports and presentations delivered so far:

- Interim Report
- CAMHS Needs Assessment – UCLP
- Service Mapping
- High Level Training Matrix
- Strategic Seminar
- Draft Final Report

The report sets out our analysis of those areas where services within RBKC are delivering really effective work to promote children and young people's mental health, prevent difficulties from emerging and escalating and intervening where help and additional help is required. It is based on our review of the range of evidence, interviews, focus groups and discussions with a range of individuals from across the system that we have been involved with over a 6 month period, as well as drawing on national and international sources of information and the expertise of the AFNCCF and associated consultants to this project. We have set out a number of suggestions for RBKC to consider, some of which we have had the opportunity to test out with stakeholders from within RBKC and across the other North West London Boroughs involved in this project. None of these are set in stone, and it is our expectation that this report forms a 'starting point' for a series of conversations within RBKC and across the Tri-borough, on those aspect of our suggestions that chime with local priorities and from this, to develop a local plan for taking this forward.

We recognise that the national context is challenging with a lack of sufficient resources to meet need nationally, and that any proposals for improvement need to be considered in the light of this. We have tried to focus on recommendations:

- That are small incremental changes, rather than whole system change, that may lead to small but significant improvements in the system;

- That are pragmatic and recognise the limited resource in the system – rather than making grand plans for whole system change;
- That build on the existing quality that is already present in the rich and varied system;
- That aim to make best use of a limited resource;
- That acknowledge that changing complex systems cannot be done at speed, but that timely incremental changes that are well managed and implemented lead to improvement;
- That focuses on the needs of the child - not the needs of the system.

## **Overview of context, challenges and proposed ways forward in RBKC**

As set out above, children, young people and their families who live in the Royal Borough of Kensington and Chelsea (RBKC), are largely well served by the early years services, schools and range of universal services that enable them to thrive and succeed.

According to the analysis of need, carried out by UCLP, children and young people living in the Borough has the lowest level of mental health disorders in North West London (this could reflect population)<sup>1</sup> and CYP who receive free school meals in the Borough achieve a good level of development by end of reception year<sup>2</sup>. However the borough does face a number of challenges. For example, there are high levels of health inequality for both men and Women in RBKC<sup>3</sup>.

Across the Borough, there are a range of high quality universal services that address children, young people and their families' emotional well being and mental health needs, alongside innovative and cutting edge targeted services that focus on meeting the needs of children and families with additional vulnerabilities. Through our focus groups, interviews and the strategic seminar, practitioners, parents and young people shared their experiences of what was working well within the Borough and those areas where challenges remain. These include; a continuing focus on developing ways to support all schools to have the skills, confidence and ongoing support to enable them to provide effect intervention work with those children and young people experiencing difficulties; developing new ways of delivering mental health services for those young people and families for whom existing CAMHS services are not meeting their needs; and addressing the issue of the lack of integration across targeted services and specialist CAMHS.

In considering how best to address these challenges (which are shared in common with many areas across the country) we are proposing that colleagues in RBKC may find it helpful to consider the THRIVE conceptual model.

### **How can RBKC promote interagency prevention and promotion?**

#### **Promotion and preventions - What is working well**

Within Kensington and Chelsea there are a range of preventive and promotional services delivered by schools, youth clubs and sports clubs. The issue for many schools however, appeared to be that within schools there was a lack of clarity

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<sup>1</sup> UCLP, North West London CAMHS Needs Assessment – Kensington and Chelsea, 2016. P8

<sup>2</sup> UCLP, North West London CAMHS Needs Assessment – Kensington and Chelsea, 2016. P10

<sup>3</sup> UCLP, North West London CAMHS Needs Assessment – Kensington and Chelsea, 2016. P17

as to who was responsible for 'mental health'. Also that practitioners lacked access to on-going training and support in respect of mental health and the range of services available locally. And a sense of 'system fragmentation' across SEN, generic advice and support agencies, early help teams and CAMHS.

#### **Suggested option for consideration:**

- Encourage all mainstream services, early years settings, schools, colleges to nominate and support key individual(s) to take a lead role in promoting children's mental health. These **Mental Health Needs Coordinators (MHeNCOs)** will provide advice, leadership, a key point of liaison and offer ongoing training and support to other staff in the setting.

#### **How can RBKC promote greater access to quality mental health advice and support so that children, young people and families and those working with them in mainstream and targeted services, have greater confidence and ability to address their needs and can access specialist help when required?**

Within the Borough, there are established mechanisms in place for some schools to access initial advice and support and gain a referral to CAMHS, through a 'link worker', and for those schools that don't have access to this, through the CAMHS 'information line'. However, across the system, access to quality advice and support is inconsistent and access to early intervention support remains fragmented across different disciplines, with practitioners lacking ongoing training and support in respect of mental health.

#### **Suggested option for consideration:**

- Consider developing **Multiple Advice (or Access) Points (MAPs)** where children, young people, parents and professionals can access immediate and high quality advice and support about their presenting difficulties. They could also access immediate advice on potential approaches to addressing their difficulties (where appropriate). The MAPs will act as a conduit to additional support where required, including referral to, and on-going support to access, specialist assessments. This could include formalising the relationship with specialist mental health services with existing multi-agency teams/co-located teams which are working in new ways (such as the Early Help Team). As part of this, the relationship between mental health professionals/practitioners in these teams and specialist mental health practitioners working with specialist CAMHS can be agreed and reviewed. We suggest that RBKC considers locating mental health practitioners within such co-located or multi-agency teams where this is not already in place. Specialist CAMHS could provide on-going support and supervision to mental health practitioners working within such targeted teams, and engage in opportunities to co-deliver interventions

for children and young people who require more specialist input and support.

- Formalise multi-agency working relationships – across social care and CAMHS in particular, in respect of the delivery of such new models of working.

### **How can RBKC develop clearer pathways particularly for ASD/LD and NDD?**

Despite having access to high quality services, and in particular the BFST, access to timely diagnosis and early intervention support for children with ASD/LD and ND was raised as an issue of concern by stakeholders within RBKC.

#### **Suggested options for consideration**

- Build on our proposed 'needs-led' integrated pathway system for all children requiring mental health support, so that this includes a coherent and 'cross-system' approach to addressing the needs of children who present with difficulties that could be as a result of ASD/ADHD and NDD (details are provided in Chapter Three of the report).

### **How can RBKC develop more integrated and coherent services across targeted and specialist services?**

Within the Borough a range of 'cutting edge' practice has been developed in respect of vulnerable children and families. These developments, such as the Focus on Practice, are enabling clinicians to work in new ways with social care professionals, to deliver effective early intervention work for children and families. This work however, is not jointly owned by health and social care, and there remains a lack of system integration across these teams and CAMHS.

#### **We propose that:**

Health and social care commissioners and providers review their existing ways of working, so that they can, over time, work in more collaborative ways with key partners across the system to deliver services that:

- Are needs led rather than assessment and diagnosis driven,
- Deliver interventions and support as close to the child and family as possible, by known and trusted professionals, and are embedded and integrated as far as possible within the child and family's 'core' services or support,
- Are underpinned by 'pathways' that draw resources and services to the child, rather than pathways that are diagnostic driven, and
- Will involve mental health 'CAMHS' clinicians working in new ways with other professionals working in the community – so as to offer mental

health support in ways and settings that engage with the most vulnerable children and young people.

### **How can RBKC reduce pressure on crisis services?**

Within the Borough, important developments in the provision of a specialist eating disorder service and a pilot out of hours crisis services are in train. A challenge for the Borough, as with many other areas nationally, remains the development of new more responsive ways of delivering specialist services within community based settings, which can further address the needs of disaffected and disengaged young people and young people experiencing crisis in their mental health, for whom existing services may not address their needs effectively.

#### **Suggested option for consideration:**

- Utilise existing opportunities – building on the out of hours pilot and the new tier 4 commissioning pilot – to develop new ways of delivering and providing specialist mental health support in ways and settings that address the needs of young people who have not historically engaged with existing specialist CAMHs services.

### **How can RBKC improve transitions?**

Developing better transitions across children's and adult's mental health services, has been highlighted by multiple stakeholders as a challenge across all the NW London Boroughs. This is also recognised as a national challenge. It is recognised that creating more coherent and seamless services however will take time and considerable commitment.

#### **Suggested option for consideration:**

- RBKC might want to consider piloting, along with other Boroughs, a 'tapered approach' to developing a more integrated approach to transitions across children's and adult's services; focused initially on young people who have high functioning ASD and associated conditions (learning difficulties, mental health problems, challenging behaviour).

We have set out a more detailed discussion on these priorities and potential next steps in chapter three.

Finally it is important to note that across all boroughs throughout the background research we have undertaken for this report and despite the backdrop of the difficult national context, we have found nothing but commitment from all we have spoken to. All have expressed their views and commitment, even when critical, with passion and enthusiasm, to build on the quality that already exists across NWL. All of the comments and challenges we have heard have come from a place of compassion, care and concern.

## **Chapter 1: Introduction to national context and underlying principles applied in this report across boroughs**

In the following section we set out the backdrop on which this review has taken place. It sets out the national and local contexts and the inherent challenges and opportunities these pose to service improvement; the underlying principles of our suggestions for improvement, and highlights key challenges and recommendations for change.

### **The National Context**

A whole raft of recent national reports into the state of the mental health system for children and young people have concluded that the current provision for mental health for children in the UK is 'inadequate', and this is largely due to historic underfunding, leading to a neglected and fragmented system<sup>4</sup>. It is important to acknowledge from the start the complexity and difficulty that all stakeholders in the system face in changing and improving the state of mental health and well-being services for children. Without this acknowledgement, it is easy for the lack of resource to lead to frustration and feed a culture of blame as to whose fault it is that the system is not working - blaming the commissioners for 'withholding resource', the providers for 'withholding services', schools for 'not taking responsibility for their pupils' well-being', even blaming families and young people themselves for 'refusing services offered to them' and so on. None of this is helpful, and none of it will solve the issue we face in trying to transform and improve services.

What is needed is to harness the passion and enthusiasm that lies behind the rhetoric to acknowledge the difficulties, and work together to collaborate across the system to improve the lives of children. We want to be clear from the start that these issues are endemic and global and not just a problem for NWL CCGs.

There is some glimmer of hope that this national picture may be beginning to improve. First, there is a great deal of interest in children's mental health across:

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<sup>4</sup> Future in Mind (2015); Five Year Forward View for Mental Health (NHS, 2016); Lightening Review: Access to Children and Adolescent Mental Health Services (Children's Commissioner, 2016); and NSPCC It's Time Campaign (2016) Centre Forum commission on the state of children and young people's mental health: state of the nation (2016).

- Government – Future in Mind (2015) is the first ever children and young people’s mental health policy driver across health, social care and education, and
- The Media – Centre Forum (2016) note a massive increase in media attention about children’s mental health.

Second, with this interest has come some new money into the system. First through CYP IAPT in 2011; and more recently, and more substantially, the £1.25 billion plus, announced in 2015 to support the implementation of Future in Mind through Local Transformation Plans (LTPs). The reality remains however that the resources is inadequate to fully meet the need.

The new money and new interest in children’s mental health is to be welcomed but pragmatism is required. The problems of the system are not solely due to a lack of resource. Meeting the mental health needs of children and young people will not be achieved simply by increasing the numbers of staff in current CAMHS. Different forms of psychological help provided in a wider range of community contexts will be needed<sup>5</sup>.

As a consequence, the proposals in this report have tried to reflect this. We have therefore tried to focus on recommendations:

- That are small incremental changes, rather than whole system change, that may lead to small but significant improvements in the system;
- That are pragmatic and recognise the limited resource in the system – rather making grand plans for whole system change;
- That build on the existing quality that is already present in the rich and varied system;
- That aim to make best use of a limited resource;
- That acknowledge that changing complex systems cannot be done at speed, but that timely incremental changes that are well managed and implemented lead to improvement;
- That focuses on the needs of the child - not the needs of the system.

### **The proposed model of delivery:**

We have not gone for a radical redesign of the system – even so, there will be some that see it as radical – but rather we have sought to amplify and

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<sup>5</sup> Future in Mind, 2015

emphasise principles that already are embedded in the best parts of the system. We propose a delivery model made of three complementary components: needs lead, integrated and effective & transparent.

1. **Needs led** - The THRIVE model<sup>6</sup> provides a promising starting point for designing services that is consistent with this approach<sup>7</sup> It provides a way of focusing the resources in the system to the needs of the child - it makes services focus on what the needs of the child are, and makes explicit the needs based offer to the family and young person so all are clear on what is needed and, through effective shared decision-making, what they are working together to achieve.
2. **Integrated** - Much of what works well is where different parts of the system work together, sharing expertise and knowledge in the best interests of the child. A diversified system of multi-agency work that is community based and links in with the people who know the child best and whom the child knows best. This can be strengthened by underlying structures that support and encourage this approach, but the real key to an integrated system is the quality of the professional relationships within it.
3. **Effective and Transparent** – Effective services are those that use resource in the most effective way, and can show the impact they have on the lives of children and young people. There is good evidence of the kinds of interventions that are more likely to be effective on children’s mental health, both to prevent problems starting and to deal with problems if they appear. This section focuses on ensuring all parts of the system deliver evidence-informed practice AND implement rigorous outcomes monitoring to measure the effectiveness of interventions and different parts of the system. It is essential to build evidence where none currently exists to ensure transparency across the system.

### **Implications and Aspirations for Services:**

All functioning systems rely on the collaboration and participation of the people who make up the parts of the system. It is people, not structures that ultimately make systems work, and the better the quality of the relationships of those people, the more likely the system works effectively. This relies on all members of the system agreeing to work together, knowing each other and understanding the challenges of each other’s’ part of the system.

Positive effort must be given to promote and facilitate the building and sustaining of these professional relationships. This requires the spirit of collaboration to run through everything people do and how they behave. This is

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<sup>6</sup> Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A.,... Fonagy, P. (2015). THRIVE Elaborated. London: CAMHS Press;

<http://www.annafreud.org/media/3214/thrive-elaborated-2nd-edition29042016.pdf>

<sup>7</sup> Future in Mind 2015

challenging at a time when resource is scarce and insufficient – but time spent in building better relationships between people in different parts of the system (NHS England with clinical networks, clinical networks with commissioners, commissioners with providers, providers with the wider community, health with social care with education) will have dividends of a better functioning and integrated system that works better for the children and young people it aims to provide for.

These relationships can be strengthened by:

- **Joint working** – Where people work together in multi-disciplinary and multi-agency teams, they get to share skills and knowledge day-to-day, build better relationships and engender a culture of on-going organizational learning and change.
- **Joint training and/or cross system training** – Either where parts of the system come together for a training event provided by an external facilitator (joint training), or where one part of the system trains the other in some skill or knowledge that they have (cross system training). This could be reciprocal skills sharing, where, for example, CAMHS professionals might facilitate a workshop with schools staff on some aspect of mental health e.g. say 'self-harm' – and the schools staff facilitate a workshop back to CAMHS workforce on managing difficult behaviour.
- **Colocation** - Simply by being in the same building, people have casual encounters that strengthen the connections in the system – a social worker asking for some advice from a clinical psychologist over coffee, a psychiatrist hearing about the early years work that a health visitor is engaged in, for example. Colocation is not always possible in a diversified and community based system, but, where possible, it should be considered.
- **Collaborative encounters** – Finally, there are the sorts of encounters between different parts of the system that, depending on how they are approached, could lead to better relationships and a better functioning system: contract meetings between commissioners and providers, team meetings and case discussions, 'team around the child' meetings, meetings between teachers and parents, for example. If these are adversarial in nature, they build the frustration and suspicion named at the very start of this document. However, if all the workforce can hold in mind that the frustrations are due to limited resource (both time and money) in the system that cannot be changed, they may help professionals approach these encounters with a collaborative spirit of: "*How best do we pool our limited resources and work together as best we can for the benefit of the children and young people of NWL?*" This may be the biggest challenge of all.

## Chapter 2: Methodology

Data was collected through focus groups, interviews and an online survey. The process by which this took place is outlined below.

### Focus groups

For the borough of Kensington and Chelsea we aimed to engage key groups of local professionals, parents and children and young people, by holding two hour focus group sessions with these different stakeholders. These focus groups were organised by *Anna Freud – National Centre for Children and Families* (the Centre) in collaboration with the local Commissioning Group and local community groups. Kensington and Chelsea CCG/West London CCG provided assistance in participant recruitment for local professionals, Kensington and Chelsea Youth Forum provided assistance in participant recruitment for children and young people, and West London Action for Children and the Westway Development Trust assisted with the recruitment of parents. A specialist consultant generally led the focus group with support from a research assistant from the Centre. The sessions were audio recorded, and written material developed by participants during the sessions was collected (e.g. post it notes, lists, etc.). All collected material was later summarised in a form specifically developed for the purpose.

Two focus groups were held for each target group. The first session aimed to gather a wider picture of service provision and needs; the second session then aimed to capture more detailed information, by sharing the previous session's findings with participants and giving them a chance to comment and elaborate. The same participants could take part in both focus groups taking place in the borough, but in the majority of instances participants did not attend more than one group. Focus groups were held in varying locations across Kensington and Chelsea.

### Focus group participants

For the majority of individuals, demographic data was collected using forms devised for this purpose, however in a small number of instances participants did not wish to impart this information or logistical issues prevented the collection of this data. Counts of the total number of attendees to each group were not collected and so numbers presented here are the approximate values of overall attendance.

Demographic data was collected from 23 professionals in Kensington and Chelsea, with four participants having attended both phases. One participant classified as a professional attended a parents' focus group. Professionals largely worked within mainstream or targeted organisations (mainstream: 39.1%, targeted<sup>8</sup>: 34.8%, specialist<sup>9</sup>: 26.1%). For the types of services represented,

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<sup>8</sup> Targeted services offer more specific types of support to CYP such as YOT or drug and alcohol misuse

most professionals were either from a healthcare or social care background (healthcare: 26.1%, social care: 26.1%, mental health: 21.7%, education: 17.4%, other mainstream children's work: 4.3%, unknown: 4.3%).

For parents, data was collected from nine attendees in one focus group. Logistical difficulties prevented demographics from being collected from the second group. No participants attended both groups. Of the data collected all attendees were female. The majority of attendees were of black ethnic origin (black: 77.8%, Asian: 22.3%). They ranged in age from 26 years to 55 years (26-35 years: 44.4%, 36-45 years: 33.3%, 46-55 years: 22.3%) and had between one and five children under their care (one CYP: 11.1%, two CYP: 33.3%, three CYP: 33.3%, four CYP: 11.1%, unknown: 11.1%).

For children and young people, data was collected from 13 attendees. No participants attended both groups however data was collected from one CYP who attended a parents' focus group. The majority of attendees were female (female: 69.2%, male: 7.7%, unknown: 23.1%). The most common age of attendees was between 14 and 16 years (11-13 years: 30.8%, 14-16 years: 61.5%, 17-20 years: 7.7%), and attendees were predominantly of black ethnic origin (black: 38.5%, white: 23.1%, other: 23.1%, mixed: 4.3%, unknown: 4.3%).

### **Additional Voluntary and Charity Sector Events (VCS)**

One focus group was held with key voluntary sector organisations from West London CCG and Central London CCG. This aimed to explore the same focus group content while specifically addressing the voluntary sector and how each attendee's organisation may be best supported. Attendees were largely from mainstream organisations (mainstream: 52.9%, targeted: 35.3%, unknown: 5.9%) and were from the following sectors: other mainstream children's work: 29.4%, education: 29.4%, mental health: 17.6%, healthcare: 11.8%, social care: 5.9%, and other: 5.9%.

### **Interviews**

Interviews were held with key local stakeholders and targeted groups of children and young people. These were organised by the Centre, in collaboration with the local commissioning group and local community groups and services. Professionals from the following backgrounds were contacted via email and telephone: foster carers/residential care staff; members of faith groups/community groups including local churches, mosques, and faith groups; staff working in mainstream services including children's centres and schools; and key staff within specialist and targeted services. Interview uptake varied, with some groups of professionals being less available or harder to contact (e.g. faith leaders) than others. Interviews were largely conducted over the telephone, with a small number taking place face to face, and were

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<sup>9</sup> Specialist services include CAMHS services and those that offer specialised mental health services to young people e.g. child development teams/clinics and school nursing

approximately 30-40 minutes in length. Interviews were conducted by key leadership staff or research assistants within the Centre. Interview content aimed to address the stakeholders' key priorities for change and how this best could be achieved in their borough.

### **Interview participants**

Fourteen interviews were carried out with key local professionals, including those that worked across the Tri-borough. Professionals from specialist organisations were the most common (specialist: 50%, targeted: 42.9%, mainstream: 7.1%). Professional background was also registered: those from a mental health background were the most frequently interviewed (50%), followed by social care (21.4%), education (14.3%), healthcare (7.1%), and Youth Offending Teams (YOT) (7.1%). Job titles of those interviewed were:

- CAMHS - Clinical Director
- Head of YOT
- Head of LAC
- CAMHS Joint Commissioning Manager
- Consultant Clinical Psychologist
- Director of social care
- CCG Head of SEN
- Head Teacher
- Adult Mental Health Lead for Central/West London
- Tri-borough Senior Commissioning Officer LD and Carers
- Adult Mental Health Lead Central London CCG
- Health Education Partnership Coordinator
- Clinical Director of CAMHS and Developmental Services at West London Mental Health Trust
- Service Manager of CAMHS West London Mental Health Trust

Two additional face to face group interviews were held totalling seven CYP, as requested by Kensington and Chelsea CCG. One interview was allocated for CYP with special educational needs and the other for children who were currently or had been previously under care (looked after children). The majority of attendees were male (male: 85.7%, female: 14.3%), of black or mixed ethnic origin (mixed: 42.8%, black: 42.8%, white: 14.2%) and aged 17-20 years (17-20 years: 71.4%, 14-16 years: 28.6%).

## **Strategic Seminars**

A one day long seminar was delivered in Kensington and Chelsea. This was aimed at strategic and operational managers, practitioners, parents and carers. Within the seminar, the 14 participants who attended reviewed key findings and priorities for the borough, developed from previous engagement work.

## **Survey**

A survey was developed covering different sets of topics around the borough's workforce and services offered to CYP, parents and carers with regards to their emotional health and well-being. It was based on a pre-agreed service specification between Kensington and Chelsea CCG and the Centre. Following development, survey content was revised by key experts at the Centre, then revised by key commissioners and key stakeholders across North West London (e.g. head teachers from schools in NWL boroughs), and finally tested before launch.

The survey was programmed using the online software SurveyMonkey<sup>10</sup>. Services to receive the survey were identified through a preliminary mapping process, along with input from commissioners regarding key stakeholders in the borough. The survey was open for 19 days in total from 14<sup>th</sup> April 2016 to 3<sup>rd</sup> May 2016. Valid data was collected from a total of 42 organisations. The following types of organisation completed the survey and were used in the analysis:

- CYP mental health specialist NHS services (CAMHS): 3
- Non-CYP mental health specialist NHS services: 4
- Early help / targeted / placement services (including placement and vulnerable families teams): 10
- Early years: 6
- Education: 10
- Other: 9

## **Other data sources**

A formal analysis of need for children and young people aged 0-17 and 18-25 living in RBKC based on publically available prevalence data was also undertaken. Information from this was presented to stakeholders in July 2016. Given that the last national child mental health survey was conducted over a decade ago, there is a risk that some of the information contained within this report could be misleading. We have therefore based our proposals on the wider range of data, interviews, focus groups and discussions that we have been involved in during the course of this project.

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<sup>10</sup> <https://www.surveymonkey.net/>

Data was additionally requested from two mental health trusts: West London Mental Health Trust and Central and North West London trust. The Health Consultation report, CAMHS JSNA and Borough Ofsted report were consulted, among other documents and sources.

## Chapter 3: Applying a needs-based approach to Kensington and Chelsea

We considered mental health provision in terms of the five needs-based groupings outlined in the THRIVE model:

- Thriving: prevention and health promotion – the child or young person has no mental health issues and their need is to be kept emotionally healthy through the application of active prevention and health promotion strategies;
- Advice and support – the CYP/Family has issues but all they need is some advice and support to manage it;
- Getting help – the CYP/Family has a clearly identified mental health issue that is likely to be helped by a goal-focused intervention working with a professional (part of this intervention may also include advice and support, and management of risk, but this will be part of an ongoing intervention);
- Getting more help – as above but the CYP needs higher level multi-agency intervention;
- Risk Support – this group of CYP present with high risk though for various reasons there is not a goal -intervention that is thought likely to help but the CYP needs to be kept safe.

### Promotion and preventions - What is working well

Within Kensington and Chelsea there are a range of preventive and promotional services delivered across the borough. Twenty nine (29) services that responded to the survey stated that they deliver promotion or preventive work to children and families. These include 21 mainstream services and six targeted services including voluntary organisations. Activities include parent training, after school activities, curriculum-based activities and befriending work.

Parents and young people highlighted in focus groups that there are a range of valued well-being activities delivered by youth clubs and sports clubs, for example Parents Courses delivered at Westway children's centre.

100% of the schools who responded to the survey stated that they were engaged in whole school work to promote children's mental health. This includes utilising the Healthy Schools Programme's PSHE well-being framework.

## Promotion and Prevention - Challenges

Local stakeholders identified three key areas of challenge:

- **Stigma:** A parent focus group discussed the taboo around speaking about mental health and the stigma that surrounds it among some members of the community with one parent stating: "Mental health is 'crazy', they don't know what mental health means". In particular there is stigma and suspicion around mental health that is deeply rooted in different cultural understandings, a parent from the same group voiced "Before I came to this country, mental health was straight jacket and things like that, now I know they might be dressed professionally and have their stuff together but they could actually have issues."
- **The accessibility of current provision:** There are suspicions around speaking to professionals about mental health and a lack of a holistic overview of child's health within schools; with wellbeing programmes disseminated in schools being seen as quite general in nature, by parents in the borough. There is also an issue around not knowing what provision is available; within a group interview with Looked after Children one young person stated: "Young people need to know where they can go, because I don't, like know, where can we go?" .
- **A lack of proactive preventative work:** There was a sense within focus groups of a lack of priority given to proactive preventive work around mental health within the Borough. "The assumption is you either have mental health problems or you haven't. We all know from experience that does not make sense." [professional interview]. The needs assessment undertaken for the borough also noted "Nowhere in London has significant expenditure on prevention and health promotion for CYP with mental disorders."<sup>11</sup>

## Promotion and Prevention - Local stakeholders priorities

- To tackle stigma among local families, stakeholders wanted to see additional support for early years services to carry out preventative work. One nursery professional surveyed noted:

*"We do not have many concerns for children and family's mental health but we often have concerns about their well-being and about how this could become more of a problem as the children get older. We feel that we need to build strong relationships with all parents as soon as possible to support them and their children as they move through the education system. Often parents may have not had a good school experience themselves."*

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<sup>11</sup> UCLP

- A key link which joins up all borough activity across schools, services and the community to address the challenge around **accessibility of current provision** was felt to be a priority;
- Training to support CYP to build up resilience and maintain good mental health, and deliver consequent training to other parents. It was felt that this should target 'both mums and dads' with one parent within the group noting "Sometimes there's conflict because one parent gets trained and then it's destroyed in 5 seconds by the other parent!".

### Promoting Thriving - Proposed options for consideration

- We are proposing that within all mainstream services; early years settings, schools, colleges etc., a key individual is nominated and supported to take a key role in promoting children and young people's mental health. We have provisionally called these 'MHeNCOs', though areas will want to use a terminology that best suits their local context. We are not suggesting creating additional posts, but formalising this function within an existing professional, and providing them with the necessary training and ongoing support to enable them to deliver this. These **Mental Health Needs Coordinators (MHeNCOs)** will provide advice, a key point of liaison and offer ongoing training and support to other staff in the setting.

### Advice & Support - What is working well?

There are a range of agencies in Kensington and Chelsea offering advice/information and assessment services for children and young people and their parents/carers. Thirty one (31) services who responded to our survey stated that they offer advice/information<sup>12</sup>. In addition, 25 services stated that they offer signposting<sup>13</sup>, and 15 services stated that they offer assessments<sup>14</sup> for children and young people. Access to many of the services who responded to this survey is by third party referral (18 services), and many also accept self-referral (15 services). Fourteen services decide who should access their service by a process of ongoing/regular review to agree those children and young people who most require support, and seven undergo processes of active recruitment/assertive outreach. Finally the majority of schools that responded to the survey offer advice and support programmes to CYP.

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<sup>12</sup> 19 mainstream, nine targeted, CAMHS MST service, the Behaviour and Family Support Team, and another unknown service

<sup>13</sup> 12 mainstream, 10 targeted, CAMHS MST service, the Behaviour and Family Support Team, and another unknown service

<sup>14</sup> Seven mainstream, five targeted, CAMHS MST service, the Behaviour and Family Support Team, and another unknown service

Within the Borough, there are established mechanisms in place for some schools to access initial advice and support and access to a referral to CAMHS, through a 'link worker'. For those schools that don't have access to this, there is a CAMHS 'information line', which was viewed extremely positively by those who had used it. Within RBKC, early help support workers were also seen to be important sources of help and support, particularly by primary schools.

### **Advice & Support - Challenges:**

The issues for many schools however, appeared to be that there is a lack of clarity as to who was responsible for 'mental health'. Practitioners also highlighted a lack of ongoing training and support in respect of mental health and the range of services available locally; and the issue of system 'fragmentation' across SEN, generic advice and support agencies, early help teams, and CAMHS. There was a sense expressed, that the range of advice and support provided by different agencies is difficult to navigate and to understand how and where to access support prior to and after a diagnosis of need had taken place.

For parents, this includes inconsistency within GPs' knowledge and the information they provide around mental health and emotional well-being.

### **Advice & Support - Local stakeholders' priorities:**

Stakeholders within the borough highlighted the need to address the lack of clarity on which services are available and how to access them. There should be community level knowledge regarding information about 'what's out there'.

Parents within the borough felt there should also be greater support for GPs around the identification of need, embedding a standard level of competencies and level of knowledge.

Strengthening the provision of help and advice in schools was also highlighted by focus groups and interviews. According to a parent focus group, schools should be the primary site for information and advice.

### **Advice and Support - proposed options for consideration**

- Within RBKC, there is already highly effective work taking place within schools, including ELSA training, provision from Mind, and from CNWL. We are proposing that RBKC builds on this work and considers developing a system of 'locality based' Multiple Advice (or Access) Points (MAPs) – building on the work of the Early Help Teams, where children, young people, parents and professionals can; access immediate and high quality advice and support about their presenting difficulties; access immediate advice on potential approaches to addressing their difficulties (where appropriate); and , which will act as a conduit to additional support where required, including referral and on-going support to access specialist assessments.

## Getting Help & Getting More Help - Mainstream Services

### What is working well

Within Kensington and Chelsea, there appears to be a range of effective early intervention work being delivered within mainstream services including; robust perinatal services, high quality health visiting services, and a range of parent groups delivered in early years settings and schools. Health visitors and school nursing teams within the Borough offer advice/information, signposting, parent/carer/family support groups and parent training in schools.

Within schools, a range of a universal and targeted provision is also available. 100% of schools who responded to the survey offer a 'whole school approach' alongside some more targeted activities, such as, positive activities and social skills groups. A number of primary schools who responded offer nurture groups, self esteem groups, anger management and anti-bullying work, alongside parenting groups. Both secondary schools who responded to the survey offer counselling. Early intervention work between schools and voluntary sector organisations was also highlighted as being positive within focus groups, with one young person noting that their school was soon to be starting a programme with the UK Eating Disorders charity BEAT. Staff in schools were felt by many of those taking part in focus groups to be effective in identifying need.

Finally, the Tri-borough's Educational Psychology Team was seen by those participating in focus groups as providing valuable support to schools, through its 'consultation model'. Those schools that have access to a link worker, highlighted in particular the effectiveness of their CAMHS link worker's involvement in the 'team around the school meeting once a term'.

Other effective support noted by stakeholders included; a local mental health walk-in clinic and training for GPs on identifying mental health needs, by using CAMHS educators (delivered by Connecting Care for Children).

### Challenges

A number of challenges were highlighted. These included:

- **Stigma.** As set out above, stigma around mental health and the fear of judgement from others was felt to be a significant barrier in young people and parents accessing help and support. There was also felt by parents and young people to be a lack of understanding around children's behavioural difficulties, with a sense that children experiencing difficulties were perceived as 'misbehaving' rather than understanding any underlying difficulties they may be experiencing.
- **Inconsistency of current provision.** Parent focus groups in particular highlighted an inconsistency in available provision within schools, an

inconsistency in the level of GP's expertise and knowledge in respect of mental health, and a lack of GP skills around the identification of need. They also noted a lack of quality control and governance over service provision within schools.

- **Trust.** A lack of integrated working between schools and CAMHS, and a lack of trust and professional cohesion between social care, CAMHS and school staff was also highlighted by a professional focus group as being a barrier to the provision of effective early intervention work in schools and other mainstream settings.
- **Service design.** Poor design of support services in schools (which impact on children and young people's willingness to engage with them) and which included a lack of confidentiality and inaccessibility were also highlighted as challenges by those taking part in focus groups.
- **Supporting key staff.** The lack of support / supervision for teachers dealing with children's emotional problems was raised by young people as being a concern.

## Local stakeholders' priorities

Those taking part in focus groups and interviews set out the following priorities for improvement:

- Embed Family Support Officers within the school to improve communication between school staff and families;
- Have a designated teacher appointed to deal with children's mental health concerns and to combat stigma through school lessons;
- Embed awareness and education around mental health within the curriculum;
- Embed a standard level of competencies and knowledge in GP provision. A parent focus group saw GPs as the 'gateway' to many other services and support through referrals and therefore support here should be robust;
- Clarification over thresholds, pathways and service provision;
- A&E should have CAMHS workers covering weekends;
- Develop a support system for teachers dealing with children's emotional problems – include workforce training as part of support package.

## Proposed options for consideration

- All mainstream services; early years settings, schools, colleges to nominate and support a key individual to take a lead role in promoting children's mental health. The MHeNCO will provide leadership, a point of liaison and a training and support role vis-a-vis other staff in the setting. In order for each MHeNCO to have access to high quality training, alongside ongoing advice and support, we suggest that Kensington and Chelsea considers the development/provision of a small network of MAPs, building on the early help teams, to deliver this.

- Such Multiple Advice (or Access) Points (MAPs) will enable children, young people, parents and professionals to access immediate and high quality advice and support about their presenting difficulties; access immediate advice on potential approaches to addressing their difficulties (where appropriate), and which will act as a conduit to additional support where required, including, referral to and on-going support to access specialist assessments.
- We suggest that RBKC considers locating mental health practitioners within such co-located or multi-agency teams where this is not already in place. And for specialist CAMHS to provide on-going support and supervision to mental health practitioners working within such targeted teams, and to engage in opportunities to co-deliver interventions for children and young people who require more specialist input and support.
- MAPs, will have a clear remit to provide advice, support and initial consultation work to staff in schools (teachers, TAs, etc.) in respect of which interventions might be most appropriate for particular children. These will be based on NICE guidelines, particularly in respect of ADHD/ASD/ND. Our expectation is that, in line with NICE guidance, initial parent training or group based and individualised support will be offered to children and families, where their presenting needs suggest that this would be helpful, prior to or being dependent on any formal assessment being carried out.
- Where interventions are delivered (parenting interventions or group based interventions in schools, for example), these will be discussed and agreed with the child/young person and/or family or professional working closely with the child/young person (drawing on the evidence of what is likely to be effective), and shared decisions should be made as to the best way forward. These will reflect the unique context, needs and wishes of the child/young person and family. An initial plan, involving the child, their family and relevant professionals will be developed – to address the child’s needs within the early years/school setting.

## Getting help and more help in Targeted Services

### What is working well

Within Kensington and Chelsea, there are a range of highly effective targeted services delivering effective mental health support and early intervention work with vulnerable children and families. The borough has considerable expertise in delivering effective multi-agency initiatives, a number of which have worked well

over a period of time, and have demonstrated good collaboration between agencies as well as good examples of joint working on individual cases. These include the Family Nurse Partnership, which is targeted, focused, well monitored, has well documented outcomes and has been documented as extremely effective, being recommended by current NICE guidelines<sup>1516</sup>.

Across the Tri-borough, Early Help Teams have been developed, with their proactive focus on practice and their integration of therapists with social workers, so as to focus on addressing systemic issues. 'Excellent services are consistently delivered using the Tri-borough's well-developed 'Focus on Practice' model of social work which places high value on relationship building between child and social workers. Exemplary application of this highly innovative model is supported by low social work caseloads'.<sup>17</sup>

The model sees that therapists integrate with social workers, with the aim of a proactive focus on practice and on addressing systemic issues. It places high value on relationship-building between families (and through this the children within them) and social workers, and is shown to lead to a reduction in duplicated support and inappropriate referrals, thus reducing the workload for CAMHS and social care staff.

Within Kensington and Chelsea, there is an extensive network of Tri-borough and in-borough services to help children and families address difficulties regarding; domestic abuse, substance misuse and parental mental ill health. Within Children's Centres, the multi-agency programme, Best Start in Life, is being delivered.

There are also range of Tri-borough services focused on children and families which address a range of vulnerabilities. These include the monthly multi-agency (MASE) meetings for CYP at risk of CSE, which identify, map and track vulnerable young people and intervene to reduce risk.<sup>18</sup>

A Specialist CAMHS post for Looked After Children exists in the borough, alongside a CAMHS psychologist, who works in children's homes one day a week, with the aim of helping children and support workers put 'a face to CAMHS', reduce stigma and thus increase engagement with services.

Finally a range of voluntary organisations delivering effective targeted support for vulnerable children and families exists in Kensington and Chelsea. These were identified by focus groups. Examples include West London Action for Children (which works across Hammersmith and Fulham and RBKC and was described as "amazing" by parents), Family Friends (set up to support vulnerable

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<sup>15</sup> <https://www.nice.org.uk/guidance/ph40/documents/social-and-emotional-wellbeing-early-years-expert-report-42>

<sup>16</sup> Public Health England (2016) Best start in life and beyond: Improving public health outcomes for children, young people and families  
Guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services

<sup>17</sup> Ofsted March 2016.

<sup>18</sup> Tri-borough Local Safeguarding Children Board Strategy to Prevent Child Sexual Exploitation: March 2014

families through mentoring programmes), Family Forward (who offer post-divorce support and after school and weekend support sessions), and Redthread (a charity that aims to reduce gang violence in the borough).

## Voluntary sector

As set out above, there is a range of voluntary sector services providing mental health interventions across the Tri-borough. Services provide consistent, flexible and holistic support that is accessible and welcoming and works with the whole family. However representatives from a voluntary sector focus group reported that whilst integration across the Borough was improving, there remained issues around a lack of 'whole system integration', a lack of parity of esteem across statutory and non-statutory providers and a feeling of 'being on the outside'. It was noted at a Tri-borough VCS professional focus group that voluntary organisations are also under pressure from a lack of resources and are particularly vulnerable to funding cycles. There was a sense that voluntary organisations deliver "more for your money as they are less concerned about whose budget work comes from and will just do it if it's needed".

## Challenges

Despite the positive examples of effective collaborative working between agencies, there was a strong sense by those taking part in focus groups and interviews that CAMHs and social care is still too separate; with a lack of systematic joint working and that a greater focus was required on ensuring greater integration of services at all levels, across Social Care and specialist CAMHs in particular.

The difficulties for some families, engaging with CAMHS as it is currently provided was highlighted. With some very vulnerable families needing 'something that works on an outreach basis and that is more flexible. Trusted services delivered by trusted people and trusted environments'. [professional interview]. This was seen to be particularly important for families, including refugee and asylum seeking families, who find the idea of mental health difficult. It was highlighted that 'their lack of engagement can result in CAMHS referring cases back to social care as a safeguarding issue', and that this can lead to further delays'.

Professionals noted a lack of clarity around thresholds and referral pathways and a lack of effective communication between professionals within the child's network.

Finally despite the range of positive working taking place, some professionals highlighted a reduction in the number of services, particularly operating within the voluntary sector, as being a significant risk for vulnerable children and

families living in the Borough. It was highlighted that a lack of available support left schools “holding the risk” [professional interview].

### Local stakeholders’ priorities

- The importance of CAMHS workers being embedded within social care and the need to build on the “Focus on Practice” initiative was consistently highlighted in interviews with those working in children’s social care.
- Having a named CAMHS clinician for each targeted service who can get to know staff, support training, develop similar assessment tools and thus reduce the number of assessments that families go through, provide better joined up working, and as a result deliver ‘a more responsive service for families and better outcomes’.
- Create more coherent integration across targeted and specialist services including streamlining the interface between Tier 2 and Tier 3 services across the Tri-borough to enable the development of a shared culture and identity.

### Proposed options for consideration

- For RBKC to consider developing MAPs (as set out above), with clearly agreed protocols in respect of ‘joint working’ across existing multi-agency and targeted teams and CAMHS. This could include thresholds, waiting times for accessing specialist CAMHS and expectations around the roles and responsibilities of each service before, during, and after particular interventions and approaches have been delivered;
  - ‘protocols’ could be developed by a process of co-production across teams, followed by a programme of joint training and on-going review, to monitor implementation issues, impact and to review where required.
  - Where appropriate, ‘CAMHS’ mental health professionals could be co-located within such teams, so as to provide ongoing support/advice, training and co-delivery of evidence based interventions for children, young people and families.

We would also suggest that clinical and targeted teams review how clinical staff working across targeted teams and specialist CAMHS are supervised and managed – alongside the delivery of opportunities for regular catch up and practice sharing.

At the RBKC strategic seminar, there was broad agreement for the notion of MHeNCOs and a MHeNCO plus, and for the idea of the development of a small number of defined Multiple Points of Access.

### Getting help and more help in Specialist Services

RBKC receives mental health services from Central and North West London Mental Health Trust (CNWL).

The Kensington and Chelsea CAMHS service provides:

- Targeted Tier 2 services, which aims to promote the capacity of non specialist CAMHS to support the emotional health and well being of children and young people;
- Specialist Tier 3 service, which assesses and treats children with moderate to severe mental health difficulties;
- An additional commissioned service for looked after children, and support to young people with learning disabilities or neurodevelopmental difficulties in the Behaviour Family Support Team (BFST).

Collingham Child and Family Centre, an inpatient facility for children with complex and severe mental health problems, also operates within the Borough.

In addition, across the Tri-borough there operates a multi-systemic therapy team. This offers intensive support for young people aged 10-17 with challenging behaviour known to Children's Services or Youth Offending Teams.

### Data provided by CNWL

According to data provided by CNWL, during 2015/2016, RBKC CAMHS (CNWL) received 1073 referrals and accepted 853 CYP. During the month of August 2016 79% of young people waited under 11 weeks from referral to assessment, and 22% of young people waited over 11 weeks from referral to assessment. Across CNWL on average children received 5.5 follow up appointments for every first in 15/16. CNWL increased the proportion seen outside of CAMHS buildings to above 10%, with on average 14% of first appointments and 18% of follow up appointments. During August RBKC CAMHS offered 40% first appointments in locations other than CAMHS building and 30% of follow up appointments were offered in locations other than the CAMHS building. In August 2016 53% of young people discharged from the service had outcome measures that were matched pairs (collected at acceptance and discharge). Of all the first appointments held in August 2016, 22% recorded DNAs. Of all the follow up appointments held in August 2016, 17% recorded DNAs.<sup>19</sup>

### What is working well

There was a sense within Kensington and Chelsea of a great deal of positive practice taking place in respect of CAMHS, both in relation to; the quality of services that children, young people and families received when they could

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<sup>19</sup> CNWL Monthly Information Return, August 2016

access a specialist CAMHS service, and in respect of accessing advice and support from the Tier 2 CAMHS service. Those schools in particular who had access to advice and support from CAMHS via a link worker system were extremely positive about the service they receive: 'CAMHS is on speed dial for our centre (for advice and support)'. It was felt by these schools, that this 'easy access' to CAMHS and their access to 'early help support' was enabling them to work with children and young people with emerging mental health/behavioural problems. 'Our communication with our link worker is invaluable, precious and we don't want to lose it'. Those schools involved in this work, also highlighted the important role that multi-disciplinary termly team meetings with CAMHS played in enabling them to support vulnerable children, 'we have good access to CAMHS for queries and referrals'. Those schools who don't have access to this service, can access the CAMHS 'information line', which again many found invaluable.

There was a sense within RBKC of well-developed practice in respect of the CAMHS role and relationship with mainstream services and with schools in particular – 'we have always had integrated Tier2/3 service; psychologists and family therapists delivering targeted practice in schools'.

In addition, there was a strong sense from focus groups, of CAMHS working successfully with a range of different disciplinary teams, not just focusing on schools.

The Behaviour Family Support Team, with its support for children with learning disabilities, was highlighted by professional and parent focus groups as working well – and delivering an effective service for this very vulnerable cohort of children and young people.

In addition, many parents and young people were positive about their experience of accessing help from the team, once they had been able to access this. [CAMHS is...a] 'high quality service which really helped my child'. Professionals that frequently refer CYP to CAMHS reported that in their view access routes, relationship with professionals and interagency working was 'good'.

## Challenges

Despite these strengths, our engagement work, children, young people, parents and families highlighted a number of challenges.

The issue of accessing Tier 4 services within the Borough was highlighted as being a significant issue and linked to this, the lack of educational provision for those children and young people accessing Tier 4 services. There was a sense that whilst waiting lists for specialist support were shorter in Kensington and Chelsea than in other areas, the length of wait was still preventing likely

engagement with some services amongst families ' as families often only feel comfortable about seeking support for short lengths of time – as professionals we 'get them ready' and then moment passes' [professional focus group].

The importance of integrating multiple agencies/services particularly in respect of meeting the needs of young people and families with more complex needs was also highlighted, with the importance of professionals being able to work 'with flexible boundaries between services and for the referral to be kept open throughout the journey through the system'. This was linked to confusion about existing referral pathways particularly for children and young people with more complex needs.

A lack of effective communication across services was highlighted, resulting in duplication of work and waste of resources.

Access to services and confusion over CAMHS referral pathways, particularly where there was effective links across mainstream, targeted and specialist services, was felt by many to be a 'postcode lottery' within the Borough.

#### Tier 4

As set out above, professional and parent focus groups highlighted the lack of Tier 4 provision within the Borough. There was also a strong sense of the need for more 'community based' services to be developed, particularly for those children, young people and families for whom existing CAMHS services are not appropriate and do not effectively address their needs. The following data was obtained from the North West London CAMHS Needs Assessment for Kensington and Chelsea. Currently an estimated 68% of the need for Tier 4 services is being met in Kensington and Chelsea<sup>20</sup> – this is the highest of any NWL borough. However there is also an anticipated 14% reduction in occupied bed space in 2015/2016 compared with 2013/2014 rates (728 days in 2015/2016 from 842 in 2013/2014)<sup>21</sup>.

The average length of stay in beds occupied by Tier 4 patients has also fallen by 15% between 2013/2014 and 2015/2016 (forecast outturn at Month 8)<sup>22</sup>. The centralised commissioning by NHS England of Tier 4 services, removes control from local services and commissioners and fragments services between Tiers 3 and 4. Finally there is a lack of London-based Tier 4 provision – especially for under 12s – leading to out of borough and out of London placements.

Reasons for in-patient admission are usually a combination of mental health need, perceived levels of risk and the quality of the home or care environment. Fluctuations in use are unlikely to represent a change in level of need in the

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<sup>20</sup> UCLP, North West London CAMHS Needs Assessment – Kensington and Chelsea, 2016. P108

<sup>21</sup> UCLP, North West London CAMHS Needs Assessment – Kensington and Chelsea, 2016. P88

<sup>22</sup> UCLP, North West London CAMHS Needs Assessment – Kensington and Chelsea, 2016. P88

population but are related to a combination of service factors as to how well services feel able to manage high risk young people in a community setting.

## Local stakeholders' priorities

Within RBKC, as with the other CCGs, new services are already in place and being targeted to better meet the needs of children and young people experiencing mental health problems. These include:

- an Eating Disorder Service (a specialist service developed across the five boroughs of Brent, Hillingdon, Kensington and Chelsea and Westminster). The new service was launched and operational in June 2016. It accepts self-referrals and there are reduced waiting times for service; and
- a pilot Out of Hours Crisis Service was launched earlier this year

Amongst front line practitioners and young people themselves, there was a strong view that despite this innovative service delivery work there are still challenges in meeting the needs of some disaffected and disengaged young people experiencing crisis in their mental health, and that new ways and models of delivering mental health support, with greater use of community based settings and within particular localities, might help to address this challenge.

In addition, the importance of developing community based services, located in familiar community based settings, was highlighted as a key priority – 'for those families who wouldn't go near a CAMHS service'.

Taking forward work to design and develop a new model of 'community based inpatient provision' was also highlighted by those attending the strategic seminar as being a priority for RBKC – which could be linked to the new Tier 4 commissioning pilot being taken forward by the two Mental Health Trusts.

Greater information about what CAMHS offer and how to access this support was highlighted as being a priority by parents – 'families find themselves asking, what is CAMHS? Is it for crazy people'

## Getting help and more help – considering children with complex needs

There are some children and young people who have greater vulnerability to mental health problems but who find it more difficult to access help. If we can get it right for the most vulnerable, such as looked after children and care leavers, then it is more likely we will get it right for all those in need.

The aim is to support staff who work with vulnerable groups by providing access to high quality mental health advice when and where it is needed. Co-ordinated services should be provided in ways in which children and young people feel safe, build their resilience, so that they are offered evidence-based interventions and care, drawing on the expertise and engagement of all the key agencies

involved. Children, young people and their families who have additional vulnerabilities and complex mental health needs should not have to fight for services, nor be offered services that are well-meaning but are not evidence-based or which fail to meet their needs.

Mental health services need to work effectively within and in partnership with existing service delivery structures to help vulnerable children and young people – such as Early Help Services, services for Troubled Families, Child Protection and Safeguarding Services, as well as education, youth justice services and Multi-Agency Safeguarding Hubs. Staff in mental health services need to utilise and build on existing opportunities where agencies are already working with the child.

(Adapted from *Future in Mind*, 2015)

Within Kensington and Chelsea, addressing the needs of children and young people with ASD/LD and NDD was seen to be a priority.

As set out above, there is already considerable 'good practice' taking place within the Borough in respect of meeting the needs of this group of children, young people and families. Of particular note was the work of the Behaviour and Family Support Team, which provides a range of support and assessment work children with ASD/LD and NDD.

However, despite this, there was still a sense amongst practitioners and parents that early screening and diagnosis for children with ASD/LD and NDD needed to be improved, early intervention support particularly around positive behaviour support needed to be more readily available for children and families in mainstream settings, and the current confusion around referral routes which was resulting in delays needed to be addressed.

At the strategic seminar, the following actions were agreed in respect of improving services and supports for CYP with ASD/LD and NDD to be in place within the next year, and three years.

In year one:

- The multi-agency BFST works in children's homes, with schools, and in partnership with social care to deliver a high quality service for children with a range of needs;
- Effective early screening and diagnosis is in place with clear 'pathways' and more effective working across health, education and social care.

In year three:

- Greater 'reach' into community groups is achieved, to effectively engage with minority ethnic communities;

- Effective training in early screening is in place across education and social care;
- Positive behaviour support is available for children with ASD/LD and NDD across the Borough which is consistent across mainstream services.

To take this work forward we would propose that RBKC builds on our proposal to create a 'needs led' integrated pathway system for all children requiring additional support and, as part this, to ensure that the needs of children and young people with ASD/ADHD and NDD are being addressed.

We propose that such a pathway – will be clearly linked to existing 'systems' in place to support children/young people, parents and mainstream professionals access advice, support and more specialist interventions where required. Fundamental to this 'pathway' and underpinning its effectiveness is that of enabling and supporting the development of effective relationships between professionals.

Such a system, will therefore involve – enabling young people, parents/carers and professionals to understand where within the system they can:

- access initial advice and support (via a shared system of multiple points of access) which is focused around 'immediate help' and accessing community based services;
- access support for referral for more specialist assessment and diagnosis – via a pathway agreed by all agencies and understood by all those working as a part of the 'points of access' and;
- which is supported by an understanding by those involved within the system of who will provide any specialist help and support where required, which will be delivered as close to the child, young person and family and by 'known professionals' as far as is possible.

We have set out below suggestions for a 'pathway' for children with ASD/ADHD/Complex needs, that RBKC might want to consider:

1. For children and young people who are presenting with a range of difficulties, we would expect all children's needs to be reviewed by a MAP, who will in the first instance offer an initial 'review' of a child's needs by a professional who has sufficient skills to make a needs assessment. Each MAP will have a shared approach to;
  - a. initial advice and support on how the child/yp who is displaying ASD/ADHD and NDD characteristics may be supported at home/within their community setting; and
  - b. which agencies may be best placed to work with them to deliver this.

- c. It is our expectation that there will be prior agreements in place in respect of drawing down this support e.g. with the BFST that the MAPs understand. The MAP will also, proactively, signpost the cyp/parent/professional to other sources of community based support available to them.
- d. Interventions delivered, which will be based on NICE guidelines (evidence informed parenting interventions, group based interventions in schools etc.) will be discussed and agreed with the CYP and/or family or professional working closely with the CYP (drawing on the evidence of what is likely to be effective) and shared-decisions made as to the best way forward depending on the unique context, needs and wishes of the CYP and family.
- e. Where the child/young people requires more specialist assessment, it will be the role of the MAP in the first instance, to draw on the appropriate team to carry this out (who will in turn form part of the 'team around the child' to deliver any intervention/support within the most appropriate setting for the child/family). Agreements will be in place, re timescales for assessments – from the MAPS to specialist teams, and ongoing roles of those teams in respect of children/yp who require intervention – in respect of delivery of the intervention within appropriate settings for the child.

We would suggest, as part of a programme of work to take this forward, that RBKC takes forward an additional programme of focused analysis, review and consultation work that includes:

- A review of parent/carers expectations and experiences of receiving a diagnosis of ASD/NDD for their child – to include a review of what 'earlier' help might have been useful prior to a diagnosis of ASD being required;
- A review of the level of training/support required by staff working as part of initial 'access and support teams' – to review staff confidence and competence in reviewing children's initial presenting needs and which services may be best placed to support them in the immediate term alongside whether a more specialist assessment may be required and by which service;
- A review of the impact of receiving a diagnosis of ASD/NDD by parents/carers and services – and for which groups of children and young people, particularly taking into account the needs of high functioning children with ASD with associated difficulties. This to include the effectiveness of current community based and specialist supports, and how parents/carers and mainstream professionals might be able to access advice/training and on-going support to address these. This work, could

in turn, feed into a programme of training and development for 'MHeNCOs' and 'mental health practitioners' working as part of a Single or Multiple Point of Access service.

### Getting help and more help: considering transitions

Transition from children's to adults' services can be a complex process, spanning a range of agencies and specialisms. The absence of a coordinated approach to providing services across health, education and social care can result in ineffective communication, poor engagement, discontinuity of care and staff feeling unclear about the process and their role in it.

Adults' and children's services need to come together to pool funding, addressing the structural and cultural barriers that prevent them from achieving this. Transitional care should become a shared priority, despite the current pressures on public funds.

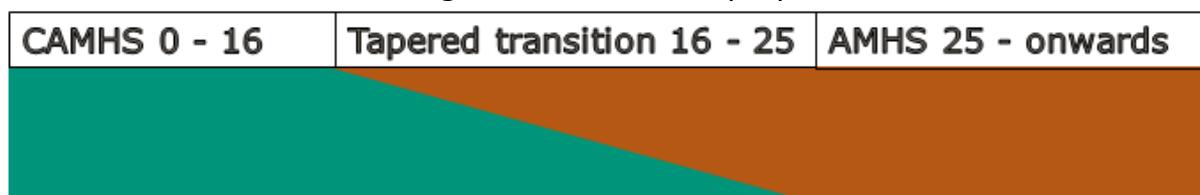
(Adapted from NICE Transition from children's to adults' services for young people using health or social care services (NG43) 2016)

### What is working well?

A particular challenge for RBKC, and other Boroughs across North West London was felt to be the issue of transition for children and young people with complex needs, and particularly those children and young people with high functioning ASD/NDD, who had complex associated difficulties but who may not reach the thresholds of adult social care involvement.

A cross Borough seminar on transition was held.

At this seminar, the development of a 'tapered' transition period between CAMHS and AMHS between ages of 16 - 25 was proposed.



It was agreed that this could work in the following way:

- Between ages of 16 – 25, young people would have a choice as to whether they wanted to access services in adult or child mental health.
- Young people already receiving services would have the choice as to when they might transition over to AMHS if this were needed. This would allow

greater flexibility for transitions led by the needs and wishes of the young person.

### Tapered Transition

Overall, developing a tapered model of transition between CAMHS and AMHS was regarded by the majority of stakeholders as the preferred approach above extending the age range of CAMHS to 25. There were a number of key benefits and strengths of a tapered approach to transition that were identified during the seminar. These were:

- that a tapered approach would enable CAMHS and AMHS to work together more flexibly. This would enable better response to and support of young people's individual needs, context and preferences, rather than being prescriptive on the basis of age, service thresholds, or referral criteria;
- this approach was regarded as more likely to give young people greater choice and control over their support, who they were supported by and when and how they transitioned to AMHS;
- it could ensure better support for young people who would not meet the threshold for AMHS and could more realistically respond to the changing developmental, emotional and mental health needs of young people between the ages of 16 and 25;
- it has the potential to facilitate better links with relevant agencies to connect young people to appropriate services and community organisations outside of mental health (e.g. housing, education and social care), and to ensure a more holistic, needs led approach;
- it would enable mental health services to be better aligned with education and social care, e.g. for looked after children, and education or young people with learning difficulties.

### Challenges to implementing a tapered model of transition in Northwest London

A number of challenges were highlighted:

**Joint commissioning** – this is complex in both children's and adults services, leading many participants to question how this could work in practice and how integrated this really can be, especially given that this may need to be tapered in line with the transition process.

- **Funding and thresholds** - concerns were raised as to whether a tapered transition model could increase the financial responsibilities of both child and adult mental health services, both of which are already experiencing financial pressure and are underfunded. Funding arrangements would need to be explicit to prevent difficulties in arranging packages of care and to prevent tensions over 'who pays for what'. There are also

commonly held assumptions that would need to be acknowledged and challenged to ensure CAMHS and AMHS could work together collaboratively, including for example, that transition arrangements would cause an influx of young people into AMHS.

- Different cultures, priorities and practise across CAMHS and AMHS were highlighted, including the language of diagnosis and working with individuals versus families.
- Potential lack of clarity about **the roles and responsibilities** of CAMHS and AMHS professionals, was highlighted, especially regarding risk management

## Requirements and priorities for implementing an improved model of transition

To address the challenges, several priorities for implementing a new model of transition were identified. Key recommendations included:

**Leadership and commissioning:** High-level arrangements across CAMHS, AMHS, social care and education to be prioritised to support the required change in the commissioning and provision of services. This might include: clear agreements on the allocation and pooling of funding, supported by a funding matrix; accountable care partnerships to reduce barriers between providers; and using outcomes based commissioning to potentially reduce the importance of age on funding. Clinicians also expressed the need for clarity on these arrangements and the key responsibilities of senior figures in the trust.

It was suggested that the pilot Out of Hours Service could be a good place to begin the implementation of a new transition model, as they have already begun working on joint arrangements. Another suggestion, was a pilot focused on young people with high functioning ASD and associated difficulties.

**Clarity on values and culture:** The importance of exploring and clarifying the values, culture and practice of CAMHS, AMHS and any new approach to transition was highlighted.

**Training and development needs:** The key training needs identified included the need to increase knowledge of what the key issues are for young people and families during transition; training for CAMHS and AMHS staff on the differences in child and adult mental health legislation (particularly for 16-18 year olds); joint training to support knowledge and skills sharing between AMHS and CAMHS; training to understand the different roles and responsibilities of CAMHS and AMHS staff.

**Existing providers:** Engaging with existing providers in the development of new models of transition, particularly those in the voluntary sector, was seen as a key priority.

**Shared Point of access and colocation:** The need for community hubs and shared points of access for CAMHS and AMHS to support the co-location of practitioners and shared appointment spaces to support joint working was identified as key priority. Existing AMHS spaces should also be made more welcoming for young people and staff should be trained by young people on how to engage and respond to young people.

**Coordinated change management:** The need for a team to support any change process was clearly identified. This pilot team should include a CAMHS commissioner, AMHS commissioner, CAMHS practitioners and managers, AMHS practitioners and managers, young people and families. This team should be responsible for coproducing shared transition protocols and the required systems for information sharing, before the changes to services go live. Change should be incremental, prompt, evaluated, and adapted or as one participant explained “get on with it, learn, adapt”.

### **Proposed options for consideration**

Consider moving to a tapered transition model for a core group of young people (young people with high functioning ASD and associated difficulties) by **involving CYP and parents** in developing the model and **working jointly with commissioners from CAMHS and AMHS** to develop a pilot tapered commissioning model.

Training and workforce development, to support this pilot, to be co-designed and delivered by young people **to CAMHS and AMHS professionals**. This would be in order to increase their insight and awareness of the issues and anxieties for young people around transition

## **Risk Support**

This THRIVE grouping acknowledges that there is *"a substantial minority of children and young people who do not improve, even with the best practice currently available"*<sup>23</sup>. Some of these young people will pose a substantial risk to themselves and need significant support to manage and mitigate that risk, but would not benefit from active, goal focused ‘treatment’. This is not to say that this group of children and young people will not benefit from therapeutic ‘treatment’ in due course (the hope is that they will), but that, at that moment, the primary focus of the work is to manage and reduce risk.

There are many different ways of providing ‘risk support’ - what is important is that, although there needs to be clarity on who is leading the support, it should not be seen to be the sole responsibility of one person or one part of the system (albeit social care, or specialist CAMHS, or a specialist foster placement, or crisis

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<sup>23</sup> Wolpert et al., 2015

team). All parts of the system around the child need to share responsibility and play their appropriate role in supporting the young person and their carers to keep safe.

The parts of the system that may play a lead role are:

- Crisis teams – social care leads, multi-agency teams that can provide both 'risk support' and 'getting help';
- Inpatient units – to provide a safe environment, whilst aligning with the local system and providing active assessment and formulation;
- A&E and paediatric acute inpatient services - for emergency and short term places of safety.

Within the Borough, important developments in the provision of a specialist eating disorder service and a pilot out of hours crisis services are in train. A challenge for the Borough, as with many other areas nationally, remains the development of new more responsive ways of delivering specialist services within community based settings, which can further address the needs of disaffected and disengaged young people and young people experiencing crisis in their mental health, for whom existing services may not address their needs effectively.

### **Getting Risk Support: options for consideration**

Continue with the development of multi-agency teams that are linked with and support other parts of the systems, including specialist CAMHS, schools, and social care.

We would recommend that as part of its further roll out of multi-agency teams, that RBKC considers further training in 'teams around the professional' approaches, for staff working within and linked to these teams.

An additional priority, that has emerged across the 7 CCGs, is that of building on the existing Out of Hours Pilot, to develop a comprehensive crisis service for young people. We would propose that RBKC considers working in partnership with other CCGs and the CNWL Mental Health Trust to take this forward.

The following suggestions for what a 'good crisis' service should look like, has been put forward by the participants of strategic seminars held for the other NW London Boroughs taking part in this project. RBKC might want to review these ideas, alongside the guidance published this month by [Healthy London Partnership \(HLP\)](#) and against national guidance from NHS England due later this year.

Developing new ways of delivering mental health support for core groups of children and young people, that are more effectively embedded within

community resources will of course, have implications for the 'whole system'. It will require services and specialist CAMHS services in particular to review their existing ways of working, so that they can over time work in more collaborative ways with key partners across the system to deliver services that:

- Are needs led and led rather than assessment and diagnosis driven,
- Deliver interventions and support as close to the child and family as possible, by known and trusted professionals, and are embedded and integrated as far as possible within the child and family's 'core' services or support,
- Where specialist support is required, professionals delivering such interventions work closely with other mainstream professionals involved in on-going work with the child or young person and family to ensure that appropriate pre and post intervention support is in place,
- Are underpinned by 'pathways' that draw resources and services to the child, rather than pathways that are diagnostic driven,
- Are underpinned by clarity around the roles, remit and the available resource of different agencies across the system so that help, advice and support is requested from appropriate agencies, and is delivered within appropriate timescales,
- Are supported by the development of more integrated, multi-agency and community-based ways of working across all services.

This way of working requires the whole system to see itself as part of the work that will improve a child's mental health. It will also have implications for how specialist services are configured and delivered. For specialist CAMHS it will mean:

- Specialist clinicians doing fewer direct interventions themselves in clinic settings and moving, in time, to a model of delivering more consultation, advice and support to those closest to the child
- Clinicians working in new ways with other professionals working in the community – so as to offer mental health support in ways and settings that engage with the most vulnerable children and young people
- Clinicians working more proactively with other professionals who have an on-going relationship with the child or young person – particularly where a short term or longer term intervention is delivered within a clinic based treatment/intervention.

## **Case Study: Camden CAMHS: Risk Support**

*What is Camden's Risk Support model?*

A Whole Family Team is co-located with the local authority Children in Need team and other local authority support services. This team is primarily for families where there is a multi-agency network and the needs of the family would be best met by CAMHS being an integrated part of the network, rather than providing intervention separately.

*How is it needs led?*

Families are more likely to have a lead professional who can assess their needs and then bring in other professionals (such as CAMHS) as needed, at the right time and sequenced correctly.

*How is it integrated?*

Training was provided for social workers and the wider children's workforce to acquire more intervention skills as well as training from the Tavistock in a model of reflective practice. These trainings took place alongside a drive from local authority senior management that social workers and other practitioners would lead on cases using a "team around the worker" model (such as [AMBIT](#)) rather than an "assess and refer on" model. They also redesigned services so that the needs of the whole family could be met rather than just a child in the family or an adult in the family.

This includes; increasing the proportion of CAMHS time dedicated to the consultation/reflective practice, providing a more even spread of CAMHS staff across Local Authority Services (so the offer was more equitable, and adopting a whole family approach with better integration between CAMHS and parental mental health services

## **Case Study: Surrey Extended Hope Service**

### *What is the Extended Hope Model?*

'Extended Hope' is an innovative model offering emergency evening support and a house providing intensive short-term crisis care, Extended Hope helps young people when and where they need it. If a young person aged 11-18 needs intensive support during a mental or emotional health crisis they may be referred to an in-patient service. While these facilities provide essential support, they aren't designed to assist with early intervention and being admitted may not be in the young person's best interest.

For some young people suffering a mental or emotional health crisis their home placement can become at risk either in foster care, children's home or with their family. In these cases a short period of respite whilst work is carried out with young people and their families and carers can help to support and stabilise their home placement.

Hope Service identified these issues and has established a new programme, Extended Hope, to prevent premature hospital admissions or a change in home placement, allowing young people to remain in their own communities.

### *How is it needs led?*

Extended Hope seeks to care for a young person through a crisis as well as supporting families, carers and young people where and when they need assistance. Extended Hope has two main services:

A house where young people can go to be assessed and supported in a safe environment for a maximum of seven days. As well as providing respite during a crisis, 'Hope House' and its staff also support the family to create a plan of care, hopefully preventing the situation escalating and a hospital referral.

An out-of-hours emergency support service which can be reached by telephone 5pm – 11pm, seven days a week. This service is maintained by psychiatric nurses who can give support and care when most day services are closed.

### *How is it integrated?*

Hope Service is a pioneering joint partnership between Surrey County Council, Surrey's NHS Clinical Commissioning Groups, Surrey and Borders Partnership (SABP) NHS Foundation Trust. It is one of the innovative projects funded by the Department of Education Social Innovation Fund, aimed at improving outcomes for vulnerable children.

Find out more:

<http://www.hopeservice.org.uk/>

## Chapter 4: Workforce development and training

We have set out a considerable potential change programme above. Implementing all of parts of this programme will require considerable workforce development and training. We have set out below, recommendations in respect of this that are applicable to all the boroughs.

We suggest the following training and workforce development options be considered to facilitate the effective delivery of the suggested proposals outlined above.

**Conflict of interest:** we are aware that the Anna Freud National Centre for Children and Families provides much of the training suggested here. We believe that this is good quality training some of which is free to providers.

Core principles to workforce development:

- Prioritise training in **Evidence-based** interventions where this exists. Drawing on the evidence base interventions and training set out by NICE, the Early Intervention Foundation and Centre for Mental Health<sup>2425</sup>;
- Use a model of **Joint training and/or cross system training** – either where parts of the system come together for a training event provided by an external facilitator (joint training), or, where one part of the system trains the other in some skill or knowledge that they have (cross system training). This could be reciprocal skills sharing, where, for example, CAMHS professionals might facilitate a workshop with schools staff on some aspect of mental health e.g. say 'self-harm', and the schools staff facilitate a workshop back to the CAMHS workforce on managing difficult behaviour;
- Consider training that has **train-the-trainer models** (where this is available) to build capacity in the system to deliver further training and builds skills and knowledge across the system;
- Take advantage of evidence-based training that is provided **free or at reduced cost** supported by Health Education England (e.g. CYP IAPT) and freely available e-learning (e.g. MindEd);
- **Involve experts-by-experience** in the training development and delivery;

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<sup>24</sup> Centre for Mental Health, Missed Opportunities, 2016

<sup>25</sup> Early Intervention Foundation, Best Start at Home Review, 2015

- Make use of expertise within the borough in the delivery of training so that reciprocal arrangements can be delivered;
- Make use of local outcomes data as part of training.

### For parents and carers

For parents and carers we who have worries about their child:

- Encourage all parents who have concerns or worries about mental health in children to use free, evidence informed, online learning resources such as '**MindEd for families**' [www.minded.org.uk](http://www.minded.org.uk) which provides safe information on common mental health issues for parents;
- Stakeholders were enthusiastic about peer-to-peer models to build knowledge between parent groups – this should also be considered for young people;

For parents with a child with a diagnosable mental health problem:

- Provide effective **psycho-education by professionals** – this could also be backed up by the use of '**MindEd for families**' for specific presenting difficulties (see Family Support in Children's Mental Health: A Review and Synthesis, by Kimberly E. Hoagwood Mary A. Cavaleri S. Serene Olin Barbara J. Burns Elaine Slaton Darcy Gruttadaro Ruth Hughes);

### For professionals

For front-line workers who are non-mental health specialists working with children across RBKC we suggest:

- All staff with contact with children in a professional capacity should be encouraged to work through the relevant sections of **MindEd 'core content'** as part of their induction and professional development.
- **Mental Health First Aid training** may be an option for teaching and educational support staff and was perceived positively by stakeholder groups. The train the trainer model should be considered for a core of the workforce (in particular MHeNCOs or equivalent staff).

To support MHeNCOs to work closely with MAPs we recommend:

- Interagency training - Anna Freud National Centre for Children and Families provides '**CASCADE training**' (currently being independently evaluated) to support better systems integration between schools and Maps;

- Specific training in front –line response to specific mental health issues such as the ‘Taking About Self-harm’ training delivered by Common Room;
- MindEd training – CASCADE has created a ‘bespoke pathway’ for school staff in relation to MindEd, comprising of six key foundation modules. We would suggest that all MHeNCOs or their equivalents are supported to undertake this training;
- Training to understand evidence based whole schools approaches to emotional health and well-being. We would recommend that schools are supported and encouraged to use the Islington MHARS framework to review current strengths and gaps, so as to inform any training plan in this area. Early Intervention Foundation, what works in promoting children's social and emotional development, suggests that there is ‘strong’ evidence for the effectiveness of a number of programmes that support whole school approaches, these include; Paths, Friends, Zippy’s Friends, UK resilience, Lion’s Quest and Positive Action<sup>26</sup>.

To support the targeted and specialist workforce

- **Make full use of the training in evidence based interventions though the CYP IAPT training programme.** We would highly recommend that full use is made of this free and subsidised resource. CYP IAPT training is available in evidence based interventions; CBT, Parent Training, Systemic Family Practice, Inter Personal Therapy for Adolescents (IPT-A), ASD, under 5s and counselling, for all staff in the targeted and specialist workforce.
- Ensure staff are trained to deliver evidence based interventions as set out by NICE and the Early Intervention Foundation
- Build on the training in AMBIT (or INTEGRATE) team around the professional models of care
- The main workforce development need is to facilitate the development of better network relationships across the system through joint training, colocation and network forums

## To support the development of tapered transitions

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<sup>26</sup> Early Intervention Foundation - Review of social and emotional skills based interventions, 2016

- The key training needs identified included the need to increase knowledge of what the key issues are for young people and families during transition; training for CAMHS and AMHS staff on the differences in child and adult mental health legislation (particularly for 16-18 year olds); joint training to support knowledge and skills sharing between AMHS and CAMHS; training to understand the different roles and responsibilities of CAMHS and AMHS staff;
- Training and workforce development, to support this pilot, could be co-designed and delivered by young people to CAMHS and AMHS professionals. This would be in order to increase staff insight and awareness of the issues and anxieties for young people around transition.

### **To support the development of outcomes focus and transparent services**

- The workforce (including commissioners) should consider developing its skills and knowledge round the development of appropriate measurement procedures and processes, and in the meaningful use of these tools and meaningful analysis of data.
- Targeted and specialist services should use the standards and guidance set out by NHS England (CYP IAPT) and CORC around the effective use of outcomes in CAMHS and the training on offer from both organizations

### **Regular Workforce Audit**

In order to ensure the workforce has the necessary skills and knowledge:

- Workforce data - skills audit of the workforce should be repeated regularly to ensure the workforce has the right skills and knowledge to provide effective services and to guide future training and workforce development needs via the new Local Workforce Advisory Boards (LWABs). It may be useful to review and consider SASAT and or the new CAMHS modeling tool
- Commissioners should consider leading regular (at least every two years) audits of the workforce (particularly in targeted and specialist settings) to ensure the skill set in the workforce is appropriate for the role of the services and benchmark this against national data where this exists - such as the HEE workforce audit

## Chapter 5: working towards more integrated systems

The development and delivery of a needs based integrated model of delivery has a number of core elements applicable to all boroughs:

- An approach that is needs based and led rather than assessment and diagnosis based,
- Interventions and support that are delivered as close to the child and family as possible, by known and trusted professionals, and are embedded and integrated as far as possible within the child and family's 'core' services or support,
- Where specialist support is required, professionals delivering such interventions work closely with other mainstream professionals involved in on-going work with the child or young person and family to ensure that appropriate pre and post intervention support is in place,
- Multiple points of advice and support (MAPs)– which address presenting needs so that initial help and support is available, appropriate, and accessible and supports children, families and professionals working with them in the 'here and now', and (where appropriate) prior to, during and after more specialist interventions are delivered,
- 'Pathways' that draw resources and services to the child, rather than pathways that are diagnostic driven,
- Clarity around the roles, remit and the available resource of different agencies across the system so that help, advice and support is requested from appropriate agencies, and is delivered within appropriate timescales,
- Development of more integrated, multi-agency and community based ways of working across all services.

Central to the development and delivery of a needs led system, is the provision and development of a coherent system of initial advice and support – which has multiple access points (MAPs) for all those requiring information, advice, support, and signposting – i.e. children and young people, parents and carers and professionals. The aims of such a system of multiple points of access to advice and support could be to:

- Provide initial high quality advice and support to children and young people, families, and professionals, so that, wherever possible, those who are closest to the child or young person (e.g. family or mainstream professional) gain the support they need to address the child or young person's needs

- Such advice and support 'points' will be available in multiple locations, depending on needs of the child. This becomes in effective a 'virtual' single point of access, being delivered, in a number of agreed locations (building on the work of existing successful teams) by mental health professionals working within such teams, who have the opportunity to come together regularly to:
  - review the effectiveness of the 'advice and support' they are offering, and opportunities for shared training and skills sharing across mental health professionals working in such teams
  - review what is available locally (so that they colleagues within the MAP can signpost to a range of community and voluntary sector provision), and,
  - gain updates and shared criteria in respect of; which organisations are best placed to meet the needs of particular children, waiting times, and which services can offer support whilst children and young people and families are waiting for assessments.
- For children and young people whose difficulties are causing concern, (either to themselves, their parents or carers, or to mainstream professionals working with them) the MAP will, in the first instance, be able to offer them an initial 'review' of their needs by a professional who has sufficient skills to make a needs assessment, leading to a 'choice point' where possible. This advice and support may be sufficient. It may comprise of initial advice and support to a professional in a school on how to support a young person, or it may comprise of advice to parents and carers concerning how to manage a particular issue.
- Such teams would also provide initial advice and support to mainstream professionals in respect of which interventions might be most appropriate for particular children. These will be based on NICE guidelines – particularly in respect of ADHD/ASD/LD. In line with NICE guidance, initial parent training, group based, and individualised support will be offered to children and families, where their presenting needs suggest that this would be helpful. It is important that such support is offered prior to and alongside more formal assessment of needs being carried out.
- Where interventions are delivered (such as parenting interventions, or group based interventions in schools), it is important where possible that these are discussed and agreed with the child or young person, family, or professional working closely with the child or young person (drawing on the evidence of what is likely to be effective). Shared decisions should be made as to the best way forward depending on the unique context, needs and wishes of the child or young person and family. For some children and young people, this will not be sufficient and the MAP may suggest that

other professionals may need to be involved in drawing up a plan to support the child or young person and/or family. Where this is the case, the MAP will have a role to:

- signpost the child or young person to the appropriate service, which may be other community based or voluntary sector services able to offer on-going help and support (based on the child or young person's presenting needs)
  - provide an on-going liaison and support role in respect of those other services.
- Agreements are agreed and communicated to all 'MAP teams' on a regular basis as to:
  - which agencies are 'leading' on specialist assessments and interventions in respect of presenting needs,
  - timescales for assessments and on-going interventions.
- Where a child requires more specialist assessment – i.e. ASD/ADHD/OCD/Eating Disorders – it is important that all those linked to and working as part of MAPs have a shared understanding of:
  - Which agency to bring into the child/young person's sphere of care based on their need;
  - Waiting times for accessing assessment and support;
  - Which other agencies can offer support during waits for assessment and post-assessment and continue contact with the child and family;
  - What other community-based support is available for the child or family – to help them 'manage the system' and join up the different processes.
- Where a view is taken within the 'MAPs' team that a child or young person requires a more in depth assessment/intervention, the MAP team contacts the specialist team to carry this out. The specialist team will in turn form part of the 'team around the child' to deliver any intervention or support within the most appropriate setting for the child and family
- Where children or young people and families are already in receipt of targeted support, these teams are themselves the 'MAPs'. Working with the clinicians, as part of their teams, professionals within these will carry out any necessary initial needs assessment and 'choice point' of the child or young person and family. They will put in place, with their team, an appropriate package of support. Where more specialist input is required

(either assessment or intervention) there will be agreements in place as to how the targeted and specialist teams will work together to deliver this. Wherever possible, key professionals from the specialist service will work and liaise with professionals from the targeted team to deliver any interventions needed.

This way of working requires the whole system to see itself as part of the work that will improve a child's mental health. It will also have implications for how specialist services are configured and delivered.

For some services it will mean:

- Specialist clinicians doing fewer direct interventions themselves in clinic settings and moving, in time, to a model of delivering more consultation, advice and support to those closest to the child.
- Clinicians working in new ways with other professionals working in the community – so as to offer mental health support in ways and settings that engage with the most vulnerable children and young people.
- Clinicians working more proactively with other professionals who have an ongoing relationship with the child or young person – particularly where a short term or longer term intervention is delivered within a clinic based outpatient or hospital setting, so that the child, young person and family experiences a continuity of care and support before, during and after treatment/intervention.

## **Case Study: Manchester Integrated Care Pathway (ICP):**

### *What is Manchester's Integrated Care Pathway?*

Manchester's Integrated Care Pathway brings specialist CAMHS into the community by embedding specialist mental health provision in over half a dozen sites that operate to deliver treatment to young people who suffer from varying levels of mental health difficulties.

### *How is it integrated?*

By bringing together different agencies the ICP enhances referral and communication systems between sites, leading to the creation of more standardized services. It focuses on multi-disciplinary working, and by offering integrated care pathways for treatment of complex conditions, Manchester's ICP offers an example of how to reduce barriers both for the patients and for those delivering the services between sites.

The aim is to make sure that there is a named lead in CAMHS Manchester for each school and a number of commissioned targeted/specialist teams will be created based on a community outreach model.

### *How is it needs led?*

The ICPs act as a "one house" model, or umbrella for providing services. This is achieved by bringing together community outreach, intervention, and signposting in an evidence-based fashion with a focus on easing the transition into more specialist systems

Underpinning the entire effort is a system that works to ensure that staff in all localities are equipped with strong and robust training around risk management, and systems are in place to escalate risk cases.

### *Is it effective?*

In terms of breaking down barriers and enhancing the referral process, the situation for service users has improved markedly. Questionnaire data is routinely collected to provide a running audit of services and all concerns are flagged and addressed by the services. To date, the feedback has demonstrated that clients are satisfied overall with the services they've received.

## Chapter 6: Working Toward Effective and Transparent Systems across all boroughs

### Evidence-informed practice

There is good evidence that certain interventions are more likely to be effective than others. Much of this evidence is documented in NICE guidance (see the interim training matrix produced earlier as part of this NWL CCGs project for a summary of the NICE guidance as is related to CYP mental health). There is a much wider evidence base of:

- interventions that are likely to be effective across prevention and health promotion<sup>27</sup> in schools and other settings,<sup>28</sup>
- interventions that are likely to be effective across different age groups,<sup>29</sup> and,
- interventions that are likely to be effective with certain presenting problems (and importantly evidence of the interventions that are likely to cause harm)<sup>30</sup>.

It is important to take a wide view of what a mental health 'intervention' is and not be bound by limited traditional views of mental health interventions as being talking therapies or drug treatments. The evidence base covers a range of intervention types. It is important to note making changes to the child's environment can have profound effects beyond those that individual or family interventions can achieve.

- Commissioning should take into account the full range of evidence and interventions likely to have positive effect on young people's lives including environmental and community based interventions alongside more traditional talking therapies and drug treatments,
- At the very least, the workforce across the system should have the skills and knowledge and resource to provide NICE evidence informed interventions, and,
- The system must support and encourage a culture where evidence informed practice is the norm.

### Workforce development and training

- A training strategy should be developed to ensure that the workforce is able to deliver the full range of NICE approved therapies (see also the

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<sup>27</sup> WHO 2014

<sup>28</sup> Stallard et al

<sup>29</sup> Khan et al 2016

<sup>30</sup> Fonagy et al 2015

interim training matrix report). Services are encouraged to take up the offer of free training provided by the CYP IAPT programme

- All of the workforce needs to know and understand the evidence base of their particular area of expertise albeit healthy schools approaches, preventative work, or clinical treatments
- Work must take place in a culture that supports evidence informed practice and evaluation
- School heads, supervisors, mentors, consultants, managers and commissioners must understand and support the application of evidence-informed practice by questioning why a particular interventions was chosen over another when working with a child.

### **Outcomes Focused: Building the evidence base**

Future in Mind acknowledges that there are some areas of child mental health where evidence is lacking and calls for this issue to be resolved by using; *"reliable routinely collected comprehensive outcomes data"* to build evidence of what works in real world settings where children and young people present with mental health difficulties. By the rigorous use of outcome monitoring across the whole mental health system we can begin to test out if the research evidence holds its effectiveness when applied to real life settings, and as importantly begin to build an evidence base for interventions.

### **Standards for data collection and transparency**

Good services must be able to measure the effectiveness of the interventions they offer. Both CORC and CYP-IAPT have developed guidance on how this should be done in a way that adds value to the clinicians and young person, as well as helps collect good data on the quality of services.

Routine Outcome Measures (ROMs), or feedback and outcome measures, are usually short questionnaires that help gather information about; the difficulties a person is experiencing or the impact of a problem on a young person's life, the things they want to change and goals they want to reach, or their satisfaction with a service or clinician. There is not one tool or measure that can capture clinical change – good models use a range of different tools and measures – ideally these should include:

- **Personalised goals** – measures that capture changes to the unique goals a child or young person wants to change as a result of a service intervention, using tools such as the Goals Based Outcome (GBO) tools,
- **A measure of problem change or impact** – a measure that captures the child or young person and/or family's view of changes in the

problems, and/or changes in the impact the problems are having on their lives, such as the SDQ, RCADS or ORS,

- **Experience of service** – the tools to capture change should be used alongside a measure of service satisfaction and experience of the service, using tools such as the CHI-ESQ or SRS.

Whatever tools are used, they must fit with the needs of the child or young person or family, as well as their cultural understanding and developmental level. Practitioners must be careful to use tools in a clinically and culturally sensitive way to avoid the imposition of white western medicalised views of mental health that may be alien and unhelpful to some. Personal testimony and qualitative data in general, used alongside quantitative data, promotes better inclusion of outcomes and voice across communities.

(Adapted from 'What good looks like in psychological services for children young people and their families' 2015)

### *Using data effectively*

In good services the information received from outcome and feedback tools completed by children and young people and families will be used, along with other information, at a number of different levels:

- Individual children and young people and families – to see if an intervention is working and to guide changes if necessary
- Practitioner / mental Health worker / counsellor – to reflect on their own practice, to spot interventions that may be moving 'off-track', and as information to guide self-reflection and learning
- Team / service / school – to reflect on the overall impact of the team – what it does well and where it may wish to improve; and to monitor the impact of service changes and innovation
- Commissioning – data of this sort should facilitate dialogue between providers and commissioners
- Cross borough / nationally – at a NWL wide and national level there is the opportunity for the analysis of data to help build practice based evidence of the types of interventions that work in real world children and young people's mental health settings

At all of these levels, the data needs to be interpreted with great caution and always must be understood in context. The numbers from any of these data sources should only be seen as guides to facilitate discussion, and never seen as

facts that speak for themselves<sup>31</sup>. To collect and use data effectively there needs to be IT Systems that support the collection and use of outcomes data and these IT systems need to be funded<sup>32</sup>

- All parts of the system that actively seek to have impact on children and young people's mental health: schools, voluntary sector, and specialist or targeted services must use some form of evaluation tool to monitor the impact of what they do
- These methods should be meaningful to the part of the system that is using them and to the children and young people and families who are involved in the interventions
- These methods of measuring change should be co-produced with commissioners, providers and young people who use or have need to use services

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<sup>31</sup> Wolpert et al., 2015

<sup>32</sup> (adapted from 'What good looks like in psychological services for children young people and their families' 2015)

## Chapter 7: Suggested Next Steps and Cross Borough Implementation

We are aware that there is a considerable potential programme of change, set out within this report. Much of this has been drawn directly from discussions with children, young people, parents and professionals living or working in RBKC. Some of it is drawn from our analysis of what an effective 'needs led' pathway might contain for children, young people and their families.

We are not suggesting that RBKC takes on all of our suggestions, but rather uses this report as a starting point for further discussions within the CCG and Local Authority on next steps.

With this in mind, these next steps might include:

- Further discussions with parents and carers, children and young people on the broad suggestions contained within the report;
- Review with key senior staff, as part of RBKC's current CAMHS transformation delivery arrangements, and the work of the Health and Well Being Board, the main proposals contained within this report;
- Develop an implementation plan for any emerging programme of work. This could include:
  - Consultation work with schools and early years settings, and managers and staff involved in the wider delivery of children's services including the voluntary sector;
  - Costed proposals for the delivery of:
    - Relocation of key specialist staff within community based settings, including the potential impact of this on the delivery of core business and a plan to manage this; and
    - The delivery of a training and development programme for key 'nominated' staff within mainstream settings. A way forward may be an initial 'pilot' with a small group of schools, to review with them how best this might be delivered, before rolling out more widely;
  - A potential programme to develop the capacity and skills of existing advice and support and early intervention services (such as existing multi-agency teams) to deliver a 'Multiple Points of Access service'. As above, a way forward may be that RBKC carries out an initial 'pilot' for the

development of this – working with 1-2 existing teams to review wider implementation and training issue.

## APPENDIX 1: The THRIVE Model

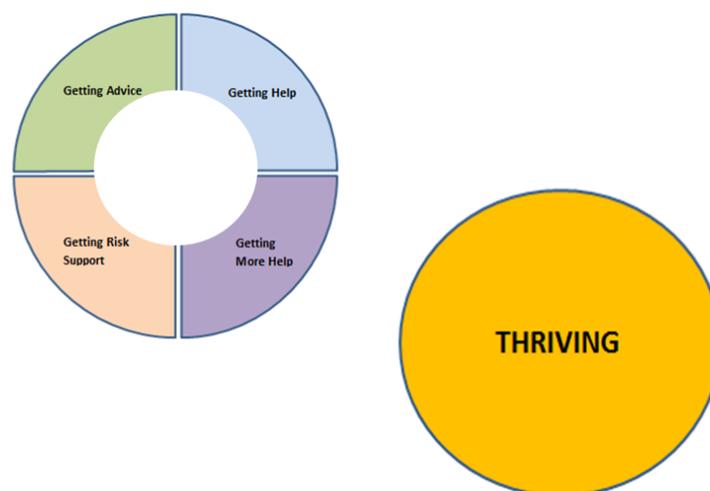


THRIVE is a delivery model to help focus the system on the what the primary need of a child or young person is with regard to their mental health issues.

There are five needs based groupings:

- Thriving: prevention and health promotion – the child or young person has no mental health issues and their need is to be kept emotionally healthy through the application of active prevention and health promotion strategies
- Advice and support – the CYP/Family has an issues but all they need is some advice and support to manage it
- Getting help – the CYP/Family has a clearly identified mental health issue that is likely to be helped by a goal focused intervention working with a professional (part of this intervention may also include advice and support, and management of risk, but this will be part of an ongoing intervention)
- Getting more help – as above but the CYP needs higher level multi-agency intervention
- Risk Support – this group of CYP present with high risk but for various reasons there is not a goal focused intervention that is thought likely to help – but the CYP needs to be kept safe

### Prevention and Promotion



There is a well-used analogy for health systems that are under pressure due to high demand as being like 'over flowing sinks'<sup>33</sup>. Ill health is like the water cascading out of the sink onto the floor. Currently much of health care focuses on dealing with demand once people are unwell, 'mopping up the water', and innovation tends to focus on finding better and more effective way of dealing with increasing demand by driving service improvement into more effective and efficient delivery models of care, 'mopping and building better mops'. However, the more effective solution comes when the system works at stopping the problems starting in the first place - prevention and health promotion, or, 'turning off the taps'.

Turning off the taps means reducing the demand into services and keeping CYP healthy by reducing the risk factors that lead to mental ill-health, this is prevention. And/or encouraging children to develop healthy lifestyles that are likely to lead to better and sustained psychological well-being, this is health promotion.<sup>34</sup>

The majority of children and young people are in the 'thriving centre', and have sufficiently robust families, communities and access to 'good enough' mainstream services to enable them to thrive - emotionally and psychologically. They have sufficient emotional resilience to manage setbacks and the 'ups and downs' of life. The majority of these children and young people will maintain their resilience and, the development of the range of social and emotional skills necessary for them to achieve in school, make positive friendships and take part in a range of activities that will further promote their emotional well-being.

<sup>33</sup> Burkitt, D. P.; Trowell, H. C. (1981). *Western diseases, their emergence and prevention*. Cambridge: Harvard University Press

<sup>34</sup> adapted from *What good looks like in integrated psychological services for children young people and families - in press 2016*

It is anticipated that, at any one time, around 80-90% of the total population of children will fall into this 'needs based' grouping of 'thriving'<sup>35</sup>.

It has been suggested that the promotion of community-based initiatives, that support mental wellness, emotional well-being and the resilience of the whole population, is an area that has been neglected by mental health professionals and commissioners over the years, but is one where 'the potential impact could be great'<sup>36</sup>. By understanding the factors likely to lead to psychological harm, services can apply strategies to tackle these causes and prevent harm to individual children. This requires rigorous understanding of the environmental causes of potential harm to children and young people's psychological health, and the active application of strategies to try to reduce or remove these as far as possible before they affect a child's emotional well-being: primary prevention.<sup>37</sup>

To promote a 'thriving' core of children and young people, areas need to actively implement those interventions and approaches that evidence suggests are most likely to reduce the risk of developing mental health difficulties and promote well-being and mental health. Evidence suggests that universal approaches to promoting mental health, via awareness raising campaigns etc., do not deliver as convincing results as targeted strategies, focused on key 'at risk' populations.<sup>38</sup> And as such, in the development of effective promotional and preventive work, areas need to consider those approaches and interventions which the evidence suggests have most effect. In delivering such interventions however, as was highlighted throughout our focus groups and strategic seminars, consideration must be given to the appropriateness and acceptability of such interventions for particular communities and organisations, and where adaptations are required, to have in place effective mechanisms to review the effectiveness of these.

## Getting Advice and Support

Research suggests that for the majority of children and young people who experience mental health problems, that the most frequently occurring number of sessions accessed from mental health practitioners, is one session, with many children and young people being seen for less than 3 sessions.<sup>39</sup> It also suggests

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<sup>35</sup> Green, H., McGinnity, A., Meltzer, H., et al. (2005). *Mental health of children and young people in Great Britain 2004*. London: Palgrave ( Based on Green et al's (2005) view that around 10-20% of children and young people have problems significant enough to warrant specialist help)

<sup>36</sup> Wolpert et al., 2015..

<sup>37</sup> Adapted from THRIVE 2015

<sup>38</sup> (Early Intervention Foundation 2015, p7).

<sup>39</sup> (Thrive elaborated, p.19).

that a significant proportion of this group find relatively few contacts, even one single contact, enough to normalise their behaviour, re-assure families they are doing the right thing to resolve the problem without the need for extra help and to signpost sources of support.<sup>40</sup> Our engagement with practitioners from mainstream services, as part of this programme, also suggests that for many professionals and para-professionals working in mainstream services, being able to access 'help and advice' from professionals with mental health expertise and skills, would enable them to develop greater confidence in meeting the needs of children and young people they are concerned about.

The THRIVE model of provision suggests that the provision of quality advice and support whereby; mental health practitioners are able to offer initial consultation work signposting to community based support, and support to access more specialist assessment and diagnosis where required, is a fundamental part of a well-designed and effective integrated model.

## Getting Help and More Help in Mainstream Settings



There is increasingly sophisticated evidence for what works, for whom, and in which circumstances, and increasing agreement on how service providers can implement such approaches. Evidence suggests that many effective interventions for children, young people and their families, can be and are increasingly delivered within mainstream settings; early years settings, and schools. Many of these interventions are delivered in a partnership approach, with well-trained para-professionals accessing training and on-going support

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<sup>40</sup> (Thrive Elaborated, p.19).

from mental health professionals to ensure consistency and quality of delivery. As part of this, the THRIVE model suggests that at the start of each intervention, an explicit agreement is made as to what a successful outcome would look like, how likely this was to occur by a specific timeframe, and what would happen if this was not achieved, i.e. there is planning around the before, during and after work in respect of interventions for individual children, young people and their families.

## Getting Help and More Help in Targeted Settings



For the purposes of this report, we have included an additional 'getting help' category provided by targeted services for key groups of children and young people who are known to services as being more vulnerable than their peers. Such children, young people and their families are likely to have additional needs by virtue of the vulnerability of their families. They are

- children in need
- on the cusp of or involved in child protection services
- in receipt of services due to their special educational needs or disability,
- looked after or formerly looked after children, or,
- involved in youth justice services for example.

This wide group of children are more likely than their peers to be at risk of experiencing mental health difficulties, and will already be involved with

networks of professionals and para-professionals. As such any approach to addressing their mental health needs, must to take into account the particular circumstances, vulnerabilities and existing relationships with services that the young person and their family are already engaged with.

## Getting Help and More Help in Specialist Services



There has already been considerable focus and attention on improving the delivery and quality of specialist services. This has been the major focus for CYP IAPT, Future in Mind, much of the NICE guidelines, and various policies from NHS England's CAMHS Team, e.g. the commissioning model of Tier2/3 CAMHS – all of which we will not repeat here.

However, it is challenging to gain objective data to back up these reports; on access and waiting times for example, and even harder to get evidence of effectiveness of this part of the system. It does not mean that lack of evidence suggests lack of effectiveness, but rather points to the real challenges of collecting analysing and using data in real world settings.

What should an effective specialist service look like?

In brief, the service should be:

- evidence-informed
- outcomes orientated
- transparent

These are a challenge for every part of the system. However, they should be less of a challenge for specialist services, where there is much stronger evidence,

better outcomes tools, and more work on data systems than elsewhere in the system.

## Getting Risk Support



The THRIVE team acknowledge that this is "*the most contentious aspect of the THRIVE model*"<sup>41</sup>, and it is the needs grouping that is often misunderstood as to what this means for commissioners and providers. The grouping acknowledges that there is "*a substantial minority of children and young people who do not improve, even with the best practice currently available*"<sup>42</sup>. This is either due to the fact that mental health interventions are not developed or sophisticated enough to be of use to all young people who have a mental health issue, or that for some young people who may potentially benefit from a therapeutic intervention, for a range of good reasons, they are not in a position to benefit from therapy at that time. Some of these young people will pose a substantial risk to themselves and need significant support to manage and mitigate that risk, but would not benefit from active, goal focused 'treatment'. This is not to say that this group of children and young people will not benefit from therapeutic 'treatment' in due course (the hope is that they will), but that, at that moment, the primary focus of the work is to manage and reduce risk. For many, they will move quickly from this needs grouping into the 'getting help/more help grouping'. For others, they may remain with the primary 'risk support' need for some length of time. What is important in the THRIVE model is that the young person, their carers, and the system are all clear and explicit that what they are being offered 'risk support' and is clearly distinct from accessing

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<sup>41</sup> Wolpert et al., 2015

<sup>42</sup> Wolpert et al., 2015

an evidence based treatment. It should be emphasised that risk support is a task that many agencies spend a great deal of time on already. It is not a new activity but one that needs to be more clearly defined.

Of course, part of the 'risk support' may have therapeutic effects in the same way that part of 'getting help' is to manage and support risk. An aim of 'risk support' should be to move to a place where getting therapeutic help may be an option.

THRIVE suggests the children and young people in this group are those "*who routinely go into crisis but are not able to make use of help offered, or where help offered has not been able to make a difference, who self-harm or who have emerging personality disorders or on-going issues that have not yet responded to treatment*"<sup>43</sup>. It is estimated that this group represents about 5% of all children currently accessing services. They are often a small, but resource intensive group who create high levels of anxiety in the system.

### **What sort of support is helpful?**

THRIVE suggests that, for this group:

- Close interagency collaboration (using approaches such as those recommended by AMBIT, to allow common language and approaches between agencies);
- Clarity as to who is leading - social care may often be the lead agency, with specialist mental health input from staff trained to work with this group and skilled in shared thinking with colleagues in social care;
- Support to children and parents/carers during periods when they did not feel safe and were unable to take action to regain safety;
- Access to support from someone who they know, who they had helped select and in whom they had confidence and trust in, and who is responsible for coordination of the support backup-team (this could be anyone in the system, not necessarily a social care worker);
- Children and families would have an agreed written safety plan which they participated in drawing-up, and which explicitly lists agreed actions to be taken by everyone concerned (including the back-up team).<sup>44</sup>

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<sup>43</sup> Wolpert et al., 2015

<sup>44</sup> (Adapted from THRIVE 2015)

## What might it look like?

There are many different ways of providing 'risk support' - what is important is that, although there needs to be clarity on who is leading the support, it should not be seen to be the sole responsibility of one person or one part of the system (albeit social care, or specialist CAMHS, or a specialist foster placement, or crisis team). All parts of the system around the child need to share responsibility and play their appropriate role in supporting the young person and their carers to keep safe. The better a system is integrated, the easier it is to share the responsibility and be more effective in providing the necessary support. What is important is that it is not seen as a separate part of the system - it is not helpful to segment services into 'the risk support team'.

The parts of the system who have a lead role in providing 'risk support' should develop an understanding of the young person and the context in which their risk exists through biopsychosocial assessment and formulation, to understand the underlying difficulties and how best to provide support.

The parts of the system that may play a lead role are:

- Crisis teams – social care leads, multi-agency teams that can provide both 'risk support' and 'getting help';
- Inpatient units – to provide a safe environment, whilst aligning with the local system and providing active assessment and formulation;
- A&E and paediatric acute inpatient services - for emergency and short-term places of safety.

## **Appendix 2: Meeting the needs of children with ASD/LD**

### **What is working well**

A cross borough seminar was held to review the specific needs of children with ASD/LD and what can be done to meet those needs. It has been identified that across the seven CCGs, there is a great deal of positive practice in respect of these children;

### **Challenges**

Despite the good practice that has been happening in regard to the needs of children with ASD and LD, a number of gaps and challenges have also been identified by stakeholders. For instance, some stakeholders have said, there are difficulties accessing services, as mental health support is often located in clinics which are not set up for and are not friendly to children and young people with ASD/LD. Mental health and therapy services (SaLT, OT, Physiotherapy) may have a significant positive impact for children and young people with ASD/LD. However, it was feedback that waiting times, assessment, length of support and discharge without consultation are routine issues. Mainstream settings were also felt to require more input to support their understanding of issues for children with ASD/LD, for example by having quiet areas and time out for children with autism.

A number of stakeholder said, crisis support for CYP with ASD and LD needs to include an alternative to A&E. Parents want other options on managing risk as a trip to A&E can make the situation worse. Finally multi agency and joint team working would benefit from the development of a specific mental health programme or pathway for children and young people with ASD/LD. It was felt that currently, services operate individually and 'ping' families between them which can result in parents feeling like they are doing a full time job in finding and accessing support.

### **Recommendations**

In regard to prevention, early intervention and early help it is necessary to increase the understanding and awareness required in working with children and young people with a range of needs. For example; providing time out, using different formats for information, explaining what will happen beforehand in a session, and, making adjustments to activities should be routine in mainstream settings in order to include young people with ASD/LD.

Supporting families is necessary to ensure children and young people with ASD/LD achieve the best outcomes. In relation to accessing services and resources, 'information' might include support from a link worker, support from the local Independent Support Programme or from peer support. Specialist

services based in community settings such as GP surgeries and children's centres is effective in engaging children with ASD/LD as they are more likely to be places they know and to be nearer home. CAMHS working with other services could run workshops for parents providing information, support techniques, and giving parents the space to share learning and discuss issues.

In schools, teachers and other staff need basic training to understand the communication needs for children with ASD/LD and to be confident in managing challenging behaviour.

### ***Multi-agency and joint working***

The special educational needs and disability code of practice 0-25<sup>[1]</sup> underlines the importance of joint working, as does the joint CQC and Ofsted SEND inspection framework<sup>[2]</sup>. **Improved integrated working** was seen as being essential to providing effective support.

To meet the challenges of support for young people after 16/18 in transition to adult services, **earlier joint planning should occur between children and adult services**. This should be carried out with a **person centred approach** in order to identify all available support to be in place. Finally, link workers can improve outcomes across services at such times, for example, the Designated Medical Officer could work across paediatrics and adult clinics/GP's to promote using pathway planning to ensure young people understand the impact of taking risks e.g. in managing their own condition, or, disengaging from services.

### ***Training and workforce development***

The need is for staff from both mainstream and specialist services to be familiar with the needs of children and young people with ASD/LD and feel confident in working with young people coming into their services. Three priorities around this emerged. Firstly, there is a need for **awareness training** on common communication needs and support for children and young people with ASD/LD. Secondly, there is a need for a greater **understanding of behaviour**, including challenging behaviour, and managing this. This includes managing risk and knowing when and how to draw in specialist support. Finally, staff need to understand the idea of **planning for outcomes** and be able to work with young people and families to identify what these are and how to access a range of support (in and beyond statutory services) to achieve them.

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<sup>[1]</sup> Department for Education; Department of Health (2015) Special Educational needs and disability code of practice. Retrieved from:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/398815/SEND\\_Code\\_of\\_Practice\\_January\\_2015.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf)

<sup>[2]</sup> CQC & Ofsted (2004): The framework for the inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities

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