Anna Freud
National Centre for
Children and Families

North West London CCGs'

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

FINAL REPORT

Westminster

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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 months 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 Westminster, and held series of interviews with key professionals and other CYP interest groups, over 70 in total of which 19 were Westminster 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, schools and where appropriate other mainstream settings, 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.

In Westminster there were clear strengths in many areas including services in the community and specialist services. However those involved in the consultation highlighted challenges in access and integration of agencies and professional groups. For example one parent participant said 'Tri-Borough have parenting groups but they do not run often enough, so parents sometimes have

to wait 6 months before they can get onto one. There is also an assumption that parents don't work, so courses run during the day rather than the evening.' [Focus groups and interviews].

We used the THRIVE framework to consider the different needs of these 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 Westminster are based on both shared and specific observations about services and needs across the whole of the North West London CCG collaborative. The following options for put forward for consideration:

1. To promote **Thriving**: To enhance interagency prevention and promotion by mainstream services; it is proposed that early years settings, schools, colleges nominate and support key individual(s) to take 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

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 Westminster consider 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 Westminster continue 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 those existing models of innovative integrated work that Westminster is spearheading; the effective joint working with CAMHS in respect of the

Integrated Gangs Unit for example, to further develop greater integration across targeted services and specialist CAMHS in respect of highly vulnerable and complex young people.

5. To achieve integrated practice we propose that there be joint working, 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 we propose that all practice draws on best evidence where it exists and the outcomes and impact of all interventions are routinely considered and appropriate data 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 all boroughs 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 4 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 Westminster to consider, some of which we have had the opportunity to test out with stakeholders from within Westminster 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 Westminster 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 Westminster

Westminster is a borough which is engaged in considerable proactive, innovative and high quality promotional, preventive and early intervention work with respect to children and young people's mental health. Children, young people and families living in Westminster do experience a number of challenges. For example,

Westminster has significantly higher percentages of CYP living in poverty than London and England – approximately 30.7% of children under 16 living in Westminster.[1]

Nonetheless, services in Westminster were seen as being effective for children with diagnosable mental health problems who require specialist CAMHS – where children and young people can access these. There is also a clear commitment within the borough to develop and test new ways of working. In addition, there is an impressive commitment and innovative approach to addressing the needs of those children and young people who have complex and challenging needs (for example, young people at risk of Child Sexual Exploitation (CSE), Gangs, missing children) – through the development of new, creative ways of working across agencies.

There are, of course, significant challenges. Our analysis is that these challenges reside in a number of core areas. We have set these out below, alongside suggestions for how Westminster might want to consider addressing these.

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 Westminster may find it helpful to consider the THRIVE conceptual model.

1. How can Westminster promote interagency prevention and promotion?

Currently, there are examples of excellent promotional and preventive work being delivered within the borough, but stakeholders reported that this is not consistent. Finding ways of enabling agencies to engage in effective promotional/preventive and early intervention work within an increasingly fragmented system and where resources are becoming more stretched is a real challenge for all areas, including Westminster.

Suggested option for consideration:

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[1] UCLP, North West London CAMHS Needs Assessment – Westminster, 2016. P20

- 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.

2. **How can Westminster 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 access specialist help when required?**

Interviewees reported that although there are currently highly effective models of advice and support in operation between mainstream services and specialist CAMHS in Westminster, this was not consistent throughout the borough. Being able to access high quality advice, support and direct intervention from mental health practitioners, who were in turn linked to specialist CAMHS, was seen as being key to enabling mainstream and targeted services to better meet the needs of children and young people experiencing difficulties. Many parents, young people and professionals highlighted a lack of clarity about where to go for help and a lack of consistency across services in the quality of help, advice and signposting to other services. In turn, specialist CAMHS highlighted the high number of inappropriate referrals that they receive – which results in a drain on their resources and reduced capacity to deliver intervention work with children and families who need this.

Suggested option for consideration:

- Consider building on plans to develop locality based hubs in Westminster to develop **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 Westminster 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.

3. How can Westminster develop clearer pathways particularly for ASD/LD and NDD?

Access to specialist assessments for children with ASD/LD or NDD, and a lack of clarity as to which agencies are responsible for specialist assessments and for which groups, was raised by stakeholders. They were concerned that this may be resulting in agencies feeling overwhelmed, long waiting lists, and children and their families not accessing the services that they need.

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 further in Chapter Three).

4. How do we develop more responsive mental health services for vulnerable families and young people, who do not engage with services as they are currently delivered?

Stakeholders reported that there remains a significant gap in provision for vulnerable families and young people, who do not engage with services as they are currently delivered. This is despite the significant focus on preventive and promotional work across the borough, and on the delivery of innovative ways of delivering services, including a mental health component to 'at risk' young people which has taken place within Westminster. Although Westminster children's services have developed a range of impressive and responsive services for vulnerable families and young people – the Early Help Team and the Integrated Gangs team for example – there remains a sense that CAMHS and social care are still too separate. As a result, opportunities to develop more co-ordinated and co-located responses to addressing the most vulnerable young people and families' needs are being missed.

Suggested options for consideration:

- Build upon plans to create locality based Hubs within Westminster, to serve the function of locality based MAPs; and, as part of this, co-locate mental health practitioners based in CAMHS within these teams. Their role will be to provide advice and support to practitioners within the teams who are delivering intervention work with vulnerable families and young

people, to deliver interventions with them and, where appropriate, deliver interventions alongside social care and voluntary sector colleagues within community-based/youth-orientated settings.

5. How can Westminster 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 and more responsive ways of delivering specialist services within community-based settings, which can further address the needs of disaffected and disengaged young people, as well as 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 settings that address the needs of young people who have not historically engaged with existing specialist CAMHS services. Such services could 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. This work will, in effect, comprise a new 'crisis' pathway, linking with the Westminster 'MAPS' – and their strong connections to community-based and mainstream organisations – schools, colleges and youth provision.

6. How can we 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

- Westminster 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 the later sections.

Finally it is important to note that 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 the individuals we have spoken to across all boroughs. All have expressed their views, even when critical, with passion and enthusiasm, and their wishes 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

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[2]. 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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[2] 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, however 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[3].

As a consequence, the recommendations 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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[3] 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[4] provides a promising starting point for designing services that is consistent with this approach[5] 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 exits 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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[4] 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
[5] 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, an online survey and consultation with other local stakeholders through various events. The process by which this took place is outlined below.

Focus groups

For the borough of Westminster 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 Clinical Commissioning Group and local community groups. This included: Westminster CCG, that provided assistance in participant recruitment for local professionals; Westminster Youth Council, that provided assistance in participant recruitment for children and young people, The Churchill Gardens Children's Centre and The Paddington Development Trust that assisted with the recruitment of parents. A specialist consultant generally led the focus group with the support from a Centre Research Assistant. The sessions were audio recorded and written material developed by participants in the context of the session was collected (e.g. post it notes, lists, etc.). All collected material was later summarised in forms (one per focus group session) specifically developed for the purpose.

Two focus groups were each held for professionals and parents, and one combined group was additionally held for local children and young people. Within the first session content was aimed at gathering a wider picture of children and young people mental health service provision and needs. The second session then aimed to capture more detailed information by sharing findings from the previous sessions with participants, and subsequently giving them chance to comment (e.g. whether they agreed with previous findings) and elaborate. The same participants could take part in more than one focus group 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 Westminster.

Focus group participants

For the majority of individuals demographic data could be collected by 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 participant data. Counts of the total number of attendees to each group were not collected and so numbers presented are of approximate value of overall attendance.

Demographic data was collected on 14 professionals in Westminster, with one of these participants having attended two sessions. The greatest number of attending professionals worked within specialist organisations (specialist[6]: 64.3%[7]; targeted[8]: 21.4%; mainstream: 14.3%). For the types of services represented, professionals from a Social Care background were the most common attendees (Healthcare: 21.4%; Mental Health: 21.4%; Social Care: 35.7%).

Parents' data was collected on 15 attendees; two of these attendees were not parents of children or young people (classified as caring for those up to 25 years of age); all attendees were female. The majority of attendees were of White ethnic origin (White: 26.7%; Black: 20%; Asian: 6.7%; Mixed: 6.7%; Unknown: 33.3%). They ranged in age from 26 years to 65 years (26-35 years: 26.7%; 36-45 years: 26.7%; 46-55 years: 33.3%; 56-65 years: 6.7%; unknown: 6.7 %) and had one to five children under their care (1 CYP[9]: 13.3%; 2 CYP: 40%; 3 CYP: 6.7%; 4 CYP:6.7%; 5 CYP: 6.7%; Unknown: 13.3%; no CYP or CYP 25 years+: 13.3%).

For children and young people, data on 12 attendees was collected; 41.7% of whom who were male and 58.3% of whom were female. The most common age of attendees was between 14-16 years (41.7%) with the remaining attendees being 17-20 years (58.3%). The most commonly represented ethnicity was Black ethnic origin (Black: 50%), with substantial minorities from other backgrounds also being present (White: 25%; Asian: 8.3%; other: 16.7%).

Additional Voluntary and Charity Sector Events (VCS)

One focus group was held with key voluntary sector organisations from West and Central London. This aimed to explore similar content as that of the remaining focus groups but specifically addressing the voluntary sector and what were the needs of each attendee's organisation in relation with CYP's mental health service provision. Over half of attendees were from mainstream organisations (mainstream: 52.9%; targeted: 35.3%; unknown: 5.9%) and were from the following sectors: Education: 29.4%; Other mainstream CYP's work: 29.4%; Mental Health: 17.6%; Healthcare: 11.8%; Social Care: 5.9%; Other: 5.9%.

Interviews

Interviews were held with key local stakeholders and targeted groups of children and young people. These were also organised by The Centre in collaboration with the local clinical commissioning group and community groups and services. Professionals from the following backgrounds were contacted via email and telephone: foster carers or residential care staff; members of faith groups or

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[6] Specialist services include CAMHS services and those that offer specialised mental health services to young people e.g. Child development teams/clinics; school nursing
[7] In a small number of cases percentage figures do not total 100% due to rounding error.
[8] Targeted services offer more specific types of support to CYP such as YOT or drug and alcohol misuse.
[9] CYP: Child or Young person

community groups including local churches, mosques and other 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 than others, for example, faith leaders. Interviews were largely conducted over the telephone and were approximately 30-40 minutes in length; a small number were conducted face to face. Interviews were conducted by key leadership staff or Research Assistants, within The Centre. Interview content aimed to address stakeholder's 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 area[10] (rather than solely in Westminster). Professionals were equally represented from specialist and targeted organisations (specialist: 50%; targeted: 50%). The professional background of interview participants was also registered; the most frequent background registered was healthcare (Healthcare: 35.7%; Mental Health: 28.6%; Social Care: 21.4%; Education: 7.1%; Youth Offending: 7.1%). Job titles of those interviewed included: CNWL CAMHS Clinical Director; Head of YOT; Head of LAC; CAMHS Joint Commissioning Manager; Director of Social Care; Head of Child Protection; Head of Clinical Practice; Senior Commissioning Officer LD and Carers; GP/Lead Medical Secretary; Paediatric at St Marys Hospital; Tri-Borough Lead Clinical Psychologist; Delivery Manager Adult Mental Health-Central London CCG; Head of SEN-Tri-borough; Healthy Schools/Health Education Partnership Co-ordinator.

Additional face to face individual and group interviews were conducted with five children in total. For the group interview participants were currently, or had been previously, Children in Care/Looked after children. The majority of interview attendees were female (female: 80%; male: 20%), identified as of Black ethnic origin (Black: 40%; White: 20%; Mixed 20%; Unknown: 20%) and ranged in age from under 11 to over 25 years (Under 11: 20%; 17-20 years: 60%; 25+ years: 20%).

Strategic Seminars

A one day long workshop was delivered in Westminster in September 2016. This was aimed at strategic and operational managers, practitioners, parents and carers. Within the workshop participants were asked to review key findings and priorities for Westminster. There were around 15 local attendees to this workshop from a variety of organisations including early help, social care, CAMHS, and parents groups.

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[10] Including Westminster, Hammersmith and Fulham and Kensington and Chelsea

Survey

A survey covering different topics around workforce and services offered to CYP, parents and carers in regard to their emotional health and well-being was developed by The Centre, based on a pre-agreed service specification between Westminster CCG and The Centre. Following development, survey content was revised by key experts at The Centre and later revised by key commissioners and key stakeholders across North West London (e.g. head teachers from schools in NWL boroughs) and tested before launch.

The survey was programmed using the online software Survey Monkey. Services were identified by 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 the 14April 2016 to the 3 May 2016, with valid data on a total of 53 organisations being collected on closing. The following types of organisation completed the survey and were used in the analysis:

- CYPMH specialist NHS services (CAMHS): 1[11]
- Non-CYPMH specialist NHS services: 11
- Early help/targeted/placement services: 10
- Education (schools): 15
- Early Years: 10
- Other: 6

Other data sources

A formal analysis of need for children and young people aged 0-17 and 18-25 living in Westminster, 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.

Data was additionally requested from two mental health trusts: *West London Mental Health Trust* and *Central and North West London Trust*. Documents regarding the *CAMHS Strategic Needs Assessment for Westminster*, the Tri-borough *Children and Young People Mental Health Task & Finish Group* and the most recent Westminster Ofsted report (2016) were consulted as sources, among others.

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[11] One CAMHS – Central and North West London (CNWL) NHS Foundation Trust – reported being based in Westminster; another one – the Tri-borough Multi-systemic Therapy Team – reported offering input to Westminster.

Chapter 3: Applying a needs-based approach to Westminster

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.

Promoting Thriving: What is working well?

Within Westminster, there are a range of agencies who are delivering prevention and promotion activities. Thirty four organisations responding to the AFNCCF survey, stating that they offer prevention/promotion work. This included work in schools, within voluntary sector organisations, after school clubs and effective promotional/preventative work within early years settings.

It appears from the focus groups that Westminster has a committed team of community champions, who are delivering a range of promotional mental health activities within the community. These include initiatives such as 'Wellbeing Wednesdays' which are delivered in partnership with the Depression Alliance, training in schools on Mental Health First Aid, healthy eating programmes and support for expectant and new parents.

Westminster CCG is implementing a comprehensive training programme to promote mental health which includes:

- Supporting schools, in partnership with public health, to develop mental health policy actions plans, alongside a programme of teacher training (currently active in ten schools)

- Two free days of training for all professionals in the borough (schools/LA/voluntary sector), provided by the Mental Health Trust and Educational Psychology

- Training on mental health for teachers in five schools in Westminster, delivered by Rethink Young Mental Health Champions.

Those attending focus groups highlighted the following:

- '*The Healthy schools/mental health workshop was brilliant!*' [Professional focus group]

- '*There is good work happening in nurseries in the borough. Needs are being identified and parents being informed and encouraged.*' [Parent focus group]

- '*There are great after school clubs (judo and yoga) which have helped my children's behaviour.*' [Parent focus group]

- '*Mental health education for young people – a mental health day at school, mental health as an extra-curricular option and a tri-borough mental health conference were all really good.*' [CYP focus group]

- Working with Men, an organisation which provides support to young men at the primary to secondary school transition, was mentioned positively in a number of professional and parent focus groups.

Promoting Thriving: what are the challenges?

The lack of a strong public health focus across the Tri-borough was felt to be a challenge to the promotion of effective public health campaigns and promotional work in this area.

In parent focus groups, the lack of information about mental health, and about services or programmes which may support the mental health needs of CYP, emerged as a key challenge. In their view, there is a lack of effective mental health education in secondary schools with lessons focusing on behaviour rather than mental health and wellbeing. Parent focus groups also highlighted the difficulty in identifying what services are available in the borough.

Stigma, alongside taboo and community mistrust towards statutory agencies in particular, were highlighted as a challenge by CYP and parents in focus groups.

'*Stigma and taboos around mental health means that many parents do not seek help until the situation has become much worse.*' [Parent focus group].

The lack of, or reduction in, preventative services was highlighted as a challenge by all stakeholder groups consulted in the borough. For example, the reduction in 'Tellit' availability – a community tool where CYP can report gang and drug activity anonymously – was seen as being a real challenge for minority communities. A lack of support for young people transitioning from primary to secondary school was also raised within parent focus groups as a challenge, particularly within the context of gang culture and the prevalence of drugs which can result in CYP being frightened of going to secondary school. Current work with boys through Working with Men was highlighted positively but it was felt that more focus was needed with regard to girls.

The effectiveness of current promotional and preventive work was also highlighted – and in particular whether enough is known about 'what works' in this area.

Promoting Thriving: local stakeholders' priorities

Prioritising greater investment in accessible and flexible community resources for children and young people was highlighted by focus groups.

'*More is needed in the community, school is just 9–3; the community is 24/7*.' [Parent focus group].

'*[We want] a place to chill… we just want people not to be in your face… to have a place to be.*" [CYP focus group].

Accessible, community-based resources and information sources for families and communities were seen to be priorities by professional and parent focus groups. Professionals stressed the need for more accessible parenting classes, which are outside of working hours and offered in multiple languages, and parents asked for more accessible children centres which take account of school timings for parents with more than one child.

Having access to mental health first aid training for the community that includes signposting was raised as a priority by parent focus groups. Ensuring a focus on community level drugs and alcohol awareness work was also highlighted as a priority.

Having access to better mental health education both for CYP and for teachers was prioritised by young people, with schools being seen as the obvious place to deliver this.

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 central 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.

Getting Advice and Support: what is working well?

Within Westminster there are a range of organisations delivering advice and support on mental health issues to children, young people and their families. Thirty six services in Westminster responded to our survey, stating that they offer advice or information; 30 services in Westminster said that offer signposting (18 mainstream, 10 targeted, the CAMHS MST service and an unknown service) and 17 services said that they offer assessments. Twenty services accept self-referral from young people or their families, and 8 services are engaged in assertive outreach work with regard to young people and their families.

Getting Advice and Support: what are the challenges?

A lack of consistent information about what is available across the system was highlighted by focus groups. Waiting times for services was also felt to be an issue by parent focus groups.

Getting Advice and Support: Local stakeholders' priorities

Ensuring the availability of accurate and accessible information and advice was felt to be a pressing priority. Having access to high quality digital information was seen to be an important aspect of this, alongside a published and well-distributed children's 'mental health offer'.

Having access to universal mental health education for CYPs, parents and professionals, which should involve significant signposting to relevant services, was also felt to be a key priority.

Getting Advice and Support: proposed options for consideration

- Within Westminster, there are already plans to develop 0–19 family hubs. We are proposing that Westminster builds on this work, and considers 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. From these, they can also access immediate advice on potential approaches to addressing their difficulties (where appropriate) which will act as a conduit to additional support where required, including referral to, and on-going support to access, specialist assessments.

Note: We consider three contexts for provision of help and more help: mainstream, targeted and specialist settings.

Promoting Getting Help and More Help in mainstream settings: what is working well?

Within Westminster, there is considerable high quality early intervention work taking place within early years settings and schools, for those children and young people with emerging difficulties. This includes support/training for parents.

Provision within schools was identified as an area of strength within the borough, with a majority of those who responded to our survey offering some form of counselling to CYP and also universal and targeted specialist provision for specific groups and individuals. In total 15 schools responded (25% of all schools contacted). Of these, 14 (93%) offer whole school approaches, 13 (87%) offer early intervention work; these include social skills groups and arts or creative therapies. Six schools also stated that they offer parent training.

In addition to the above, AFNCCF clinicians are currently working in 20 schools in Westminster (funded by the school), delivering 1-1 work with children, multi-family groups and the Smart Gym. A primary mental health worker, from CNWL, is also working with a number of schools in Westminster; providing advice, support, training and 1-1 work with families.

Eight nurseries, one children's centre and one childcare company responded to the survey. These also offer a range of whole setting approaches to promoting mental health, social skills groups, positive activities and group activities for children, alongside parent support groups and training.

Access to support and information in schools was viewed positively by professionals, parents and young people. Participants in a CYP focus group stressed the important role of schools in providing a school counselling service or pastoral care. The Healthy Schools programme was seen to be making a positive contribution to the PSHE and well-being framework, and supporting schools to implement mental health and well-being policy.

The role of children's centres in delivering positive engagement work, especially with vulnerable families, was highlighted as being positive and, in particular, their ability to engage positively with local communities, offering peer support and developing their strengths.

The provision of parenting groups in schools and other mainstream settings was viewed positively. However, the lack of access to these was seen to be an issue.

> '*Tri-Borough have parenting groups but they do not run often enough, so parents sometimes have to wait 6 months before they can get onto one. There is also an assumption that parents don't work, so courses run during the day rather than the evening.*' [Focus groups and interviews].

Those parenting groups delivered by Working with Men were viewed very positively by focus groups attendees, as these are delivered in multiple languages and after 5pm.

Training on how to identify and support CYP with early signs of mental health difficulties, delivered by the Educational Psychology Service, was identified by some professionals as being very effective.

Getting Help and More Help in mainstream settings: what are the challenges?

A number of challenges were highlighted. These included:

- A lack of knowledge about children's behaviours that may be rooted in mental health difficulties;
- A lack of consistency in the availability of early intervention help and support within schools;
- Funding issues resulting in the closure or threat of closure of services.

> '*I feel that it is essential that children's mental health needs are recognised and addressed. There needs to be a greater understanding of how these manifest themselves in the classroom and strategies that teachers/support staff can use to support vulnerable children.*' [Survey response]

> '*Funding has affected our use of services [in our school]. We used Marlborough/Anna Freud/ Talking & Drawing/Circle of friends/male mentor/nurture groups. These are no longer happening because of funding and staffing costs.*' [Survey response]

Whilst a number of schools appear to be delivering a range of effective early intervention work, there was a sense from those attending focus groups that

schools require greater support and training to be able to support vulnerable children and young people more effectively. Participants in a professional focus group suggested that identifying needs isn't done well in mainstream settings. CYP focus group participants also felt that teachers lack understanding of mental health difficulties, and that the 'quality of the support received is dependent on the school attended'.

Other challenges highlighted included GPs perceived limited knowledge of mental health difficulties. One parent said, 'My GP is the last person I'd go to with a mental health problem.'

Issues of early identification of need, lack of communication between schools, CAMHS, GPs and other agencies, and lack of support around transition, were raised as being particular challenges by parents of children with SEND.

> '*There is not enough awareness with schools to identify when a child is suffering, so therefore the support is not going to be brought in early*.'

The impact of reductions in funding was highlighted as being a significant challenge to the delivery of effective intervention work in mainstream services. For example, CAMHS in schools, including CAMHS staff working in schools with a specific remit to work with vulnerable groups (including refugee and asylum seeking children), is currently working well but 'it is being rolled back which could limit its reach'.

Getting Help and More Help in mainstream settings: local stakeholders' priorities

Ensuring and promoting easier-to-access services and support was identified as being a key priority by parents. Improving communication across services and improving clarity across current pathways was also identified:

> '*There is a pressing need to improve communication between schools and targeted services*.' [Professional focus group]

> '*We need greater clarity over the referral process, e.g. a guide to referral*.' [CYP focus group]

> '*Clarity of offer and pathways would improve access to services. Clearer links to general practice would be good – much better recently with CAMHS attendance at the Connecting Care 4 Children MDTs*.' [Survey response].

Delivering more effective support for schools was one of the core priorities reviewed within Westminster's strategic seminar. This set out the following priorities to improve support for schools:

- Embed primary mental health workers in schools to provide advice, support and training (building on the work of the AFNCCF and the current primary mental health workers provided through CNWL).

- Create a dedicated space in schools where families are safe and supported (could be a pop-up space). This was felt to be a major challenge.

- Disseminate knowledge – both in terms of (mental health) skills and the evidence base with regard to what works in a school setting.

- Help for parents to support other parents, in particular around managing behaviour, mental health and working with the schools.

- Ensure staff are well supported both in terms of their wellbeing and in terms of effective advice and support from the wider system.

With this in mind, we have set out the following suggestions for Westminster.

Getting help and more help in mainstream settings: 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: MHeNCos. They will provide leadership, be a point of liaison and provide a training and support role, vis-a-vis other staff in the setting. Each MHeNCo should have access to high quality training, alongside ongoing advice and support. We suggest that Westminster considers the development/provision of a small network of MAPs, in order to deliver this.

- Consider developing MAPs where children, young people, parents and professionals can access immediate and high quality advice and support for their presenting difficulties; 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.

- As set out above, we suggest that this could include building on plans to create locality based 0–19 family hubs and as part of this, agree and review the relationship between mental health professionals/practitioners in these teams and specialist mental health practitioners working with specialist CAMHs.

- We suggest that Westminster considers locating mental health practitioners within such co-located or multi-agency teams where this is not already in place. Specialist CAMHS should also 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.

- MAPs will have a clear remit to provide advice, support and initial consultation work to staff in schools – teachers, TAs etc with regard to which interventions might be most appropriate for particular children. These will be based on NICE guidelines, particularly in respect of ADHD/ASD/CD. Our expectation is that, 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, prior to or being dependent on any formal assessment being carried out.

- Where interventions are delivered (parenting interventions, 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 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 settings: what is working well?

There are highly effective targeted services for vulnerable children in Westminster. For example, the Family Nurse Partnership is a targeted, focused and well-monitored service which was highlighted by those attending focus groups as being very effective. 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*.' Ofsted, March 2016.

Within Westminster there is also an extensive network of Tri-borough and in-borough services to help children and families address difficulties with regard to domestic abuse, substance misuse and parental mental ill health. The well-established Tri-borough Family Recovery Project is part of the service network

for young people at risk of sexual exploitation. This includes the innovative multi-agency sexual exploitation panel (MASE) and the multi-agency gangs unit (IGU) which identifies early risks in respect of gangs and, with its dedicated young women's worker, is able to engage with young women at risk of CSE through their gang association. CAMHS involvement with multi-agency teams appears to be well developed, with no waiting list being in place and children and young people usually being seen within two weeks (immediate if the risk is high).

Within the borough, there are examples of highly effective relationships between practitioners and clinicians; for example the psychiatrist linked to Integrated Gangs Unit was highlighted as a particularly positive example of effective joint working.

> '*The consultation she provides to the team, along with a CPN who is also working with them, is highly valued.'* [Professional interview)]

There is also a range of **voluntary sector and community organisations** which deliver early help and support for groups of CYP and families in Westminster. Fourteen services were identified during service mapping, these include:

- *ZAP* (London) which is a free one-day workshop for children and young people who have experienced bullying, aged 9–16, funded by the Big Lottery Fund. It encourages the development of assertiveness skills and raises young people's confidence so that they are able to deal with bullying situations effectively. They also offer a separate workshop for parents.

- The *Family Space Drop In* offers a programme of activities for children and parents/carers and offers access to visiting professionals, e.g. Child Psychologist, Speech and Language Therapist, Social Worker.

- *Caxton Youth Organisation* works to advance the education and social development of young people with disabilities who live in the City of Westminster, and to develop their social, educational, citizenship and life skills.

- *A Place to Talk* provides walk-in counselling for young people aged 13 to 25.

Getting Help and more help in targeted settings: what are the challenges?

Despite the strengths outlined above, CAMHS' lack of engagement 'at all levels' with social care was highlighted by a group of senior managers as being a significant barrier to joint working and to supporting families and young people effectively:

> '*At the moment it feels as if we are quite separate services, with social care on one side and CAMHS on the other*.' [Professional interview]

'CAMHS is very under represented at strategic meetings e.g. Safeguarding Boards – this filters down to team meetings. It is difficult with a small service and limited numbers but significant relationships are not strong enough.' [Professional interview]

There was a recognition by those interviewed that Westminster CAMHS at Tier 2 has recently shrunk, but the importance of working together across social care and CAMHS with respect to vulnerable families was seen as being vitally important:

'We need 'to do' assessments differently, at the point when a family is referred to social care and issues are presenting, the CAMHS team could come along, advise and input into the assessment, this would prevent multiple assessments and the families and services would get a better result.'

Professionals and parents across the Tri-borough identified that some families will not engage with CAMHS as it is currently provided. It was felt that some families:

'Need something that works on an outreach basis and that is more flexible.'

'The idea that some of our families will ever go to a clinic based setting is misguided.'

It was highlighted that some families need trusted services delivered by trusted people and in trusted environments. This was seen to be particularly important for families, including refugee and asylum seeking families, who find the idea of mental health difficult (from professional interviews and focus group).

The lack of engagement by some families was seen to result in CAMHS referring some families back to social care as a safeguarding issue and that can lead to further delays for the CYP (from professional interview/focus groups).

Supporting families to parent very difficult children was seen to be a priority for children's social care but services currently struggle to deliver this. It was felt to be a challenge for social care to develop the skills to intervene more effectively with families where there are early signs of mental health problems or disability.

'Currently, [Family Services] look to CAMHS for the answers but this is not tenable, so we need to skill ourselves up to do this.' [Professional Interview]

Getting Help and more help in targeted settings: local priorities

The importance of CAMHS workers being embedded within social care was consistently highlighted by those working in children's social care. To do this, the new planned Early Help Service was seen as providing an important opportunity. Professionals working at Family Services suggested that *'more joined up visits and meetings are needed with CAMHS, just like we do with clinicians 'in house' which has proved to be effective'*.

Having a named CAMHS clinician for each targeted service was also seen as being a priority. This would enable the named clinician to get to know staff, support training and develop similar assessment tools in order to reduce the number of assessments families go through and provide better joined-up working. It was felt that this could result in a more responsive service for families which would lead to better outcomes. It was also considered important that there is a role for CAMHS to support social care, education and youth work practitioners in order to be less reactive to incidents and think long term with regard to managing risk.

Another priority highlighted was the importance of exploring the availability of funding for support groups for young people with specific needs. Examples given by those taking part in interviews and focus groups were: the *Kids Time Group* for young people who have parents with mental health issues, *Talking without fears* for young people who have been exposed to domestic violence and a support group for young people who self-harm.

Getting Help in targeted settings: proposed options for consideration

- Westminster could consider designating the planned 0–19 hubs as MAPs (as set out above), with clearly agreed protocols in respect of 'joint working' across targeted teams and CAMHS with individual children/young people and families. 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:

  o '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.

o 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. There was broad agreement within the Westminster strategic seminar for the notion of a MHeNCo and for the idea of the development of a small number of defined Multiple Points of Access.

It was felt that the co-location of mental health professionals from specialist CAMHS could support and enable the development of more effective joint working across targeted and specialist services (by joint visits to chaotic families, for example) and enable services in Westminster to engage with vulnerable young people in more creative ways. It was also felt that this could result in mainstream and targeted services having greater access to ongoing consultation, advice and support from 'specialist CAMHS' professionals. It was suggested that this would enable professionals working within these services to deliver more effective intervention work with children, young people and families themselves. This would, in turn, lead to more appropriate referrals being made to specialist CAMHS within the community, and which are addressing the needs of very vulnerable young people.

Getting Help and More Help in specialist settings: what is working well?

Central and North West London Mental Health NHS Foundation Trust (CNWL) is one of the main providers of mental health support to CYP and their families residing in Westminster. CNWL provides tier two and three community CAMHS to CYP living in Westminster, as well as working with young people up to age 18 across a number of boroughs in Central and North West London. Additionally they are providers of tier four support to children under the age of 13 at the Collingham Child and Family Centre.

Professionals that frequently refer CYP to CNWL CAMHS said that the services, their access routes, the relationship with professionals and the interagency working are 'good'.

The majority of the work carried out by the Trust is directly with CYP aged 12–18, seeing approximately 2282 children per year in this age bracket. They also work directly with approximately 1298 CYP aged 5–11, 50 CYP aged 0–4, and 3

YP aged 19–25 per year (for all the boroughs the Trust offers input to). Over the course of a year, the Trust reported it had worked directly with children experiencing a range of difficulties. These included (at trust level, not Westminster specific):

- 918 children and young people with ADHD/Hyperactivity
- 265 with Behavioural Difficulties
- 237 with Depression
- 210 with Self-injury or Self-harm
- 137 with Eating Issues
- 134 with OCD
- 122 with Generalised Anxiety
- 69 with Panic Disorder
- 30 with Difficulties Managing Relationships
- 16 with Bipolar Disorder
- 14 with Psychosis
- 4 with Specific Phobias
- 4 with Attachment Issues
- 2 with Habit Problems

Multisystemic Therapy (MST) Service

Operating under CAMHS, this service offers input to the borough of Westminster. The service reported working with CYP aged 12–18 and their parents and carers; they report seeing approximately 35 CYP, parents and carers per year. Within the borough, the MST service delivers their mental health and emotional well-being interventions at the client's home, at school, at community locations such as youth clubs and spiritual centres and via the telephone.

CNWL CAMHS 2015–16
Presenting Problem or Diagnosis (at trust level)[12]

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[12] *Data provided by North West London CAMHS; not Westminster specific*

NWL CAMHS Data Requirements - CNWL CAMHS 2015_16 Presenting Problem or Diagnosis (Unable to provide by Age and Sex) Total number of Children seen in the recent 12 month = 2001	
Behavioural Difficulties	1807
Emotional Disorders	1770
Hyperkinetic Disorders and ADHD	700
Other Mental Health Difficulties and Less Common Disorders	779
Grand Total	**5056**

Westminster CAMHS data: 2015–2016[13]

According to CNWL's Performance and Information Department during 2015 / 2016, Westminster CAMHS (CNWL) received 623 referrals and accepted 536 CYP. According to CNWL's Monthly Information Return provided by Central London CCG during the month of August 2016 70% of young people waited under 11 weeks from referral to assessment, and 31% 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. During August Westminster CAMHS offered 25% of first appointments in locations other than CAMHS building and 18% of follow up appointments were offered in locations other than the CAMHS building. The Trust reported that in August 2016 52% of young people discharge 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, 14% recorded DNAs.

Tier 4 services - Admissions

The needs assessment carried out by UCLP collated additional trust data on Tier 4 service admissions. This suggests that Westminster has far fewer young people accessing crisis and inpatient care than would be expected based on projections and compared with other areas of London. These rates are lower in spite of its generally higher levels of deprivation. The data suggests that Westminster has the 2nd lowest rate in London of hospital admissions of CYP for mental disorders and the 7th lowest rate in London of emergency admissions of CYP for self-harm[14]. It suggests that the average length of stay in beds occupied by Tier 4 patients had an 18% increase from 2013-2014 data to 2015-2016 data. Additionally, the forecast outturn for total number of bed days occupied by Tier 4 patients in Westminster in 2015-16 (473) is about twice the

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[13] Data provided by CNWL, 2016
[14] UCLP, North West London CAMHS Needs Assesment – Westminster, 2016. P85

2013-14 numbers (255). The majority of Occupied Bed Days are from those in acute beds with a substantial number in beds classified as low secure LD.

A number of services have been established recently. This includes the new Community Eating Disorder Service which offers an intensive home treatment service for children anda new 'Out of Hours' pilot; an in-depth evaluation of which is taking place. Additionally, a project group has been established to develop and implement plans for a comprehensive crisis pathway for children and young people.

Many professionals, parents and young people were positive about their experience of accessing help from specialist support, once they had been able to access it. One parent stated that it was a "high quality service… really helped my child."

Getting Help and More Help in specialist settings: what are the challenges?

Issues with access such as long wait times and strict catchment areas were highlighted by local stakeholders and particularly by young people as a challenge to CYP's access to specialist services.

In total, of the eight services that gave survey feedback on CAMHS waiting times, two responded positively, two neutrally, and four negatively. Waiting times were also identified as a significant challenge in focus groups and interviews. In a professional focus group the problem of strict catchment areas was explained as prohibitive for referring CYP to specific services outside the borough.

Finally, it was felt by CYP that CAMHS is too clinical and focused on younger children, whereas it needs to also be responsive to the needs of teenagers and young people, e.g. by making the waiting rooms more youth orientated.

The lack of clarity on thresholds for CAMHS was highlighted as a challenge by a number of focus groups and interviews senior staff.

"from a strategic view point, it's not clear to us at all what the CAMHS thresholds look like." (professional interview).

Other professionals in focus groups suggested that as budgets are tightened, the continuously increasing thresholds exacerbate the challenge.

Getting Help and More Help in specialist settings: Local stakeholder priorities?

Improving specialist services' flexibility and communication was an overarching priority for participants in CYP, parent and professional focus groups.

A core priority put forward was the need for specialist services to improve the way that they communicate with CYP and parents or carers and with other services.

CYP also stressed the need for specialist services to be better advertised and less clinical.

' Services need to adapt the language they use when talking to CYP about MH. Currently only *Working with Men* do so successfully'. [Prof FG]

' Support for families, including keeping parents informed about CYP's position in waiting lists. [Parent FG]

'Better advertised and less clinical' [CYP FG]

Professionals who participated in focus groups also called for the reduction of waiting times for specialist services to be a priority.

A core priority for Westminster that has emerged strongly from this review, is the importance of Westminster developing new ways for young people and families to access 'mental health' interventions and support' from practitioners working alongside specialist clinicians, so as to address the needs of those for whom existing services are not appropriate. Such services, would be delivered within accessible 'youth focused or orientated services' or community based services and would include a focus on effective preventative and promotional work alongside access to more specialist interventions where required. There are a number of models of how such services can be delivered such as MAC-UK, and Surreys Extended Hope crisis model, with clinicians delivering interventions within drop in and outreach services, whilst being managed and supervised from within core CAMHS services.

Building on Westminster's existing Out of Hours Pilot, an additional priority was felt to be the development of a comprehensive crisis service for young people.

Creating an effective crisis service links in turn, to the shared priority, across the two Mental Health Trusts, and recently confirmed by NHSE, to lead the pilot into new commissioning structures between specialist and inpatient services.

Getting Help and More Help: considering children and young people with complex needs

There are some children and young people who have greater vulnerability to mental health problems but who can 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.

What is working well?

It was clear from our interviews and focus groups, that for many young people living in Westminster who have additional vulnerabilities; looked after children, children and young people at risk of CSE/gangs, children with Special Education needs for example, services are experienced as being responsive and of a high quality.

However, what was also highlighted was the challenges of effective working across the system that currently takes place between targeted services and specialist CAMHS in respect of these groups of children and young people. There are pockets of extremely effective practice – however it appears that these might be dependent on the commitment of and relationships between particular groups of practitioners and clinicians. In addition, there were key groups of children and young people in respect of whom it was felt there were particular challenges. This was particularly the case for children and young people who display ASD characteristics and who have a range of difficulties associated with this.

Within Westminster, according to DfE statistics t 2.6% of children and young people had EHCP plans in 2016 (DfE SFR, SEN 2016). This compares to 2.8% of children nationally. And within this, 6.2% primary aged of children and young

people were designated as having ASD. This is in comparison to a national average of 6.3%. 2.7% of secondary aged children had a primary desgintation of ASD in Westminster, compared with 8.3% nationally. Within the focus groups addressing the needs of this cohort of children and young people was highlighted as being significant challenge for the Borough.

One of the particular areas of concern, was that linked to the length of time required to gain an assessment of ASD, and linked to this, the question of what appropriate support and help could be given to children and young people prior to receiving a formal 'diagnosis' of ASD/LD/NDD and to consider what 'offer' could be made for children and young people who display ASD/LD/NDD characteristics prior to receiving a formal diagnosis (if this were felt necessary following some further assessment or intervention).

Currently, a number of stakeholders raised concerns that there was confusion in the system, as to who is responsible for carrying out specialist assessments of children and young people with complex ASD/LD and NDD needs.

It has been suggested, that alongside a lack of clarity as to who is responsible for carrying out assessments, and a lack of capacity to deliver those assessments required, that a perceived lack of services for those children who do not have a formal diagnosis of ASD but who are displaying ASD 'like' behaviours, may be resulting in more referrals for assessments being made than might otherwise be requested.

We have not, as part of this review, been able to carry out the detailed review work, necessary to unpick some of the key issues set out above. We have however, through our review of the data, our focus group sessions and discussions with individuals, developed an overall analysis of a potential 'pathway' approach that Westminster might want to consider in respect of this group of children, young people and their families.

Our suggested priorities for Westminster, in respect of this very vulnerable group of children and young people, is to build on our proposal to develop 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, 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 virtual 'points of access' and 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 Westminster 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 be to 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 CYP 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 CDT, the SEN team etc [need to be clear what is in place in Westminster re this group} that the MAPS understand. The MAP will also, proactively, signpost the yp/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 intervention within appropriate settings for the child.

We would suggest, as part of a programme of work to take this forward, that Westminster 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 – the effectiveness of current community based and specialist supports, and how parents/carers and mainstream professionals might be 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.

Next Steps:

The issue of meeting better the needs of children with ASD/LD/NDD was a priority for Westminster's strategic seminar. At the seminar, the following local priorities for improvement were suggested by stakeholders as needing to be taken forward in the first year:

- Additional Paediatrician to be appointed to reduce assessment waiting times;

- Review the extension of the Springhallow School outreach service; and

- Review the support on offer for high functioning children and young people with ASD and associated difficulties (ADHD/attachment difficulties etc)

And by year three, the following was suggested:

- Children who do not meet the threshold for specialist services, to have access to support in mainstream settings; and

- 0-25 services to be in place, including mentors, for young people with ASD/LD and associated difficulties (We have addressed this in section xxx below).

To take this work forward we would propose that Westminster 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.

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.

A particular challenge for Westminster, 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.

CAMHS 0 - 16	Tapered transition 16 - 25	AMHS 25 - onwards
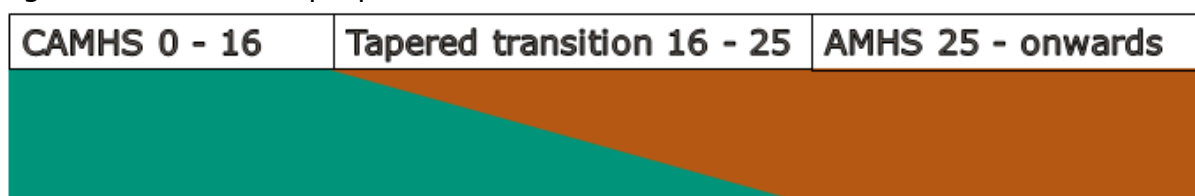
It was agreed that this could work in the following way:

- 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 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 giving 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 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

The THRIVE team acknowledge that this is *"the most contentious aspect of the THRIVE model"*[15], and it is the needs grouping that is often misunderstood as to what this means for commissioners and providers. 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"*[16]. 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 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;

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[15] Wolpert et al., 2015
[16] Wolpert et al., 2015

- A&E and paediatric acute inpatient services - for emergency and short term places of safety.

Getting Risk Support; what is working well

Our assessment of Westminster, is that this is an area where the Borough has extremely well developed services and is 'leading the way' in many respects in its approach to working with young people who are 'at risk' to themselves or others. This can be seen in the innovative work of the Integrated Gangs team for example.   We would proposed that Westminster seeks to further develop its innovative work in this area and as set out in the section on targeted support, that Westminster develops more integrated working across its current targeted services and specialist CAMHs – to develop new ways of delivering responsive services for these very vulnerable young people.

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 Westminster 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 Westminster 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, have been put forward by the participants of strategic seminars held for the other NW London Boroughs taking part in this project. Westminster might want to review these ideas, alongside the guidance published this month by Health London Partnership (HLP) https://www.myhealth.london.nhs.uk/system/files/Improving%20the%20care%20of%20CYP%20with%20mental%20health%20crisis%20in%20London%20-%20Emerging%20findings%20November%202015.pdf 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 how 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 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: 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

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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 much of the training suggested here is provided by the Anna Freud National Centre for Children and Families. 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[17][18];

- 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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[17] Centre for Mental Health, Missed Opportunities, 2016

[18] 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 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 Westminster 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 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[19].

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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[19] Early Intervention Foundation, What works in enhancing social and emotional skills development during childhood and adolescence? 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, the HEE Workforce Audit tools or the CAMHS Workforce 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:

  o 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

  o review what is available locally (so that they colleagues within the MAP can signpost to a range of community and voluntary sector provision), and,

  o 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:

- o 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)

- o provide an ongoing 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:

  - o which agencies are 'leading' on specialist assessments and interventions in respect of presenting needs,

  - o 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:

  - o Which agency to bring into the child/young person's sphere of care based on their need;

  - o Waiting times for accessing assessment and support;

  - o Which other agencies can offer support during waits for assessment and post-assessment and continue contact with the child and family;

  - o 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[20] in schools and other settings,[21]

- interventions that are likely to be effective across different age groups,[22] and,

- interventions that are likely to be effective with certain presenting problems (and importantly evidence of the interventions that are likely to cause harm)[23].

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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[20] WHO 2014
[21] Stallard et al
[22] Khan et al 2016
[23] 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[24]. To collect and use data effectively there needs to be IT Systems that support the collection an use of outcomes data and these IT systems need to be funded[25]

- 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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[24] Wolpert et al., 2015

[25] (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 Westminster. 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 Westminster 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 Westminster'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 Westminster 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
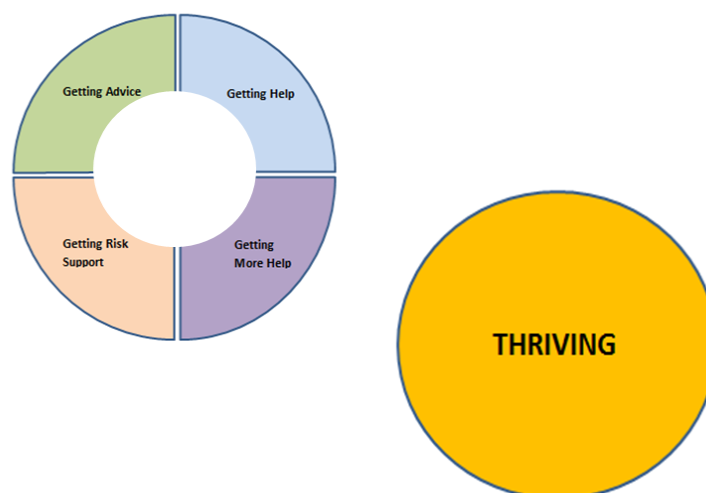
There is a well-used analogy for health systems that are under pressure due to high demand as being like 'over flowing sinks'[26]. Ill health is like the water cascading out of the sink onto the floor. Currently much of health care focuses on dealing with demand once people are unwell, 'mopping up the 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.[27]

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[26] Burkitt, D. P.; Trowell, H. C. (1981). *Western diseases, their emergence and prevention*. Cambridge: Harvard University Press

[27] *adapted from What good looks like in integrated psychological services for children young people and families - in press 2016*

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.

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'[28].

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'[29]. 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.[30]

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.[31] 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.

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[28] 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)

[29] Wolpert et al., 2015..

[30] Adapted from THRIVE 2015

[31] (Early Intervention Foundation 2015, p7).

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.[32] It also suggests 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.[33] 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

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[32] (Thrive elaborated, p.19).
[33] (Thrive Elaborated, p.19).

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 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"*[34], 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"*[35]. 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

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[34] Wolpert et al., 2015
[35] Wolpert et al., 2015

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 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 ongoing issues that have not yet responded to treatment*"[36]. 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);

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[36] Wolpert et al., 2015

- 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).[37]

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.

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[37] (Adapted from THRIVE 2015)

Appendix 2: Child Sexual Abuse (CSA), Exploitation (CSE) and Female Genital Mutilation (FGM)

Experiencing abuse, exploitation, or neglect has major impact on the developing child and is linked to long term chronic problems in adulthood. Many mental health services users of all ages have problems directly attributable to severe neglect and/or trauma in the early years. An extensive body of research provides evidence that exposure to childhood adversity, such as abuse, increases the risk of developing mental illness.

(from NSPCC Transforming mental health services for children who have been abused 2016)

Voluntary Sector[38]

A mapping of existing services for victims of CSA, CSE & FGM in Westminster revealed the following voluntary sector counselling services offered support for domestic violence and abuse:

- the Angelou project which works in the Tri-borough to support women and girls experiencing domestic or sexual violence and other harmful practices including FGM; North London Rape Crisis - provides free counselling and support for women and girls aged 13+, a helpline, one to one counselling (up to a year) and pre-trial therapy;

- the Dahlia Project - is a therapeutic support group for women who have undergone FGM and it is run by the Health Advocacy Service;

- ADVANCE advocacy - is for 16-18 year olds and provides one to one support, advocacy

- the Minerva project which is for survivors of domestic violence who have a history of offending;

- the Women's Trust offers one to one counselling in English, Italian, Gujarati, Turkish and Romanian and they also offer support groups and workshops.

Although these are not necessarily located in Westminster they are open to people from Westminster.

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[38] Thanks to Emma Harewood & KCL

CAMHS[39]

In Westminster CNWL provides Tier III and parenting assessment team (as well as tier II and LAC) for victims of CSA and CSE. Data collected by Emma Harewood's team at KCL states that Westminster CAMHS, 'prefer not to start therapy until case has gone to court (1 year)', also that 'services used to be based in Children's Centres but now centrally located'. And finally "General support for parenting a traumatised child has stopped. Prevention work no longer commissioned" (CAMHS manager, Westminster).

Recommendations

The borough should build on existing multi agency approaches to dealing with CSA, CSE and FGM; these should involve the health, social care, education and criminal justice system. It should develop a whole system approach to these issues and include strategies for prevention, early intervention and specialist help. Services that have shown effective examples of this for each of these headings in the borough are outlined below.

We recommend NWL CCGs works together to bid for the pilot of the **'Child House' Model** which would form a focus for the work recommended above and a hub to integrate and evaluate the impact of the current range of interventions available across health and voluntary sectors. This should be done in line with recommendations that come from the current **Kings Collage Hospital/NHSE programme** looking at CSA across London.

Prevention

Effective prevention strategies which aim to achieve a reduction in incidence, increased awareness, self-protective resources and a reduction in risk behaviours around CSA, CSE, & FGM are the key here as post abuse treatments are limited in their effectiveness.

Any prevention strategy should start with **education and awareness for the community**, with workshops aimed at parents and professionals within children's centres and schools. There should also be c**ommunity engagement and local strategy development** – 'What Works for Us' is a forum aimed at giving young people a way to share their views on issues linked to sexual exploitation so that professionals working to safeguard CYP from exploitation have a better understanding of what is happening and what can help (NWQ Network). There should also be e**ducation and awareness for CYP** (educating children and young people and raising their awareness of the issues), and e**ducation and awareness for professionals** (including a Child Protection Training Course so that health professionals have a higher understanding of CSA, CSE and FGM).

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[39] Thanks to Emma Harewood & KCL

Early Intervention

Skills based programmes should be implemented, such as the NSPCC Protect and Respect programme aiming to support children and young people who have been, or are at risk of being, sexually exploited with skills to protect themselves. **Family work** should also be carried out, for example see Barnardo's Families and Communities against Sexual Exploitation model (FCASE, 2015). PACE developed the Relational Safeguarding Model, focussing on maximising the capacity of parents and carers to safeguard their children and contribute to the prevention of CSE (PACE, 2014).

Development activities work as a protective factor for children and young people, giving individuals the chance to engage in pro-social activities, learn new skills and develop trust within communities. Many organisations, such as the Prince's Trust, help young people get into jobs and education. Finally, HM Government (2015) guidance suggests that effective **safeguarding** arrangements in every local area should be underpinned by two key principles. Firstly, the principle that safeguarding is everyone's responsibility - to be effective, each professional and organisation should play their full part. Secondly, the principle of a child centred-approach - to be effective, services should be based on a clear understanding of the needs and views of children.

Specialist Help

There are three areas to bear in mind regarding specialist help: crisis care, criminal justice, and direct therapeutic treatment.

Firstly, regarding **crisis care**, working with and safeguarding CYP in crisis in such a way as the Child House Model, which brings together health, social care, and criminal justice agencies together under one roof to do deal with abuse and exploitation (due to be piloted in London early next year), is recommended.

Secondly regarding **criminal justice**, it is important to ensure that appropriate intervention is made at early stages. Relationships with young people can be built and evidence can be gathered with increased convictions of perpetrators of abuse.

Finally, regarding **direct therapeutic treatment**, sexual abuse and trauma can lead to a wide range of mental health issues such as fear, anxiety and PTSD. There has been some evaluation of direct mental health input to treat specific symptoms but with limited effect[40].

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[40] Bronger et al, 2012

Appendix 3: 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. These include:

- Family support is being provided through the use of short break services like '**Shooting Stars'** in Brent, providing social activity for children and young people. Also, building parents' skills and networks through groups like the **Six Weeks** group, for parents of children with ASD ran by Hounslow CAMHS;

- Accessing services is supported by organisations like **BOAT** in Brent, who offer home visits and attend multi-agency meetings with families. A local VCSE organisation attend Northwick Park Hospital once a month, to support families with consultant appointments;

- Support in schools including training and advice for teachers in communication, e.g. **Early Bird Plus** and **Talkabout** programmes used in Westminster. Also, mental health support based in special schools, 1 or 1/2 day per week, works really well. Additionally, **ESCAN** (Ealing Services for Children with Additional Needs) service offers one central referral point, combined assessment and co-ordinates appointments, for families in the borough;

- Multi-agency working is seen as very important and effective in service improvement. Examples included having SaLT and OT as part of multi-disciplinary teams across the Tri-borough; co-location of the CD Team with CAMHS and Paediatric service in Hillingdon, and the use of the **Positive Transitions** plan in Hammersmith and Fulham.

Challenges

Despite the good practice that has been happening in regard to the needs of children with ASD and LD in Westminster, a number of gaps and challenges have also been identified in the borough. For instance, 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. Mainstream settings were seen as not appropriately supporting children with ASD and LD, with few services/organisations having quiet areas or time out for children with autism, according to participants of a Focus Group in Westminster.

Mental health and therapy services (SaLT; OT; Physiotherapy) may have a significant positive impact for children and young people with ASD/LD. However, waiting times, assessment, length of support and discharge without consultation are routine issues, which affect the extent to which these children are benefiting from support. Some parents felt that it was often not until "Something serious has happened" concerning the safety of the CYP, that an assessment (ASD) or therapeutic intervention was carried out. Other parents described the waiting list for CAMHS as "ridiculous".

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.

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. 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; this was discussed both by parents and professionals in the borough.

Recommendations – ASD & LD

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, 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 are effective in engaging children with ASD/LD, as they are more likely to be in places families know and are nearer to 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[41] underlines the importance of joint working, as does the joint CQC and Ofsted SEND inspection framework[42]. **Improved integrated working** was seen as being essential to providing effective support in the borough. Parents participating in focus groups voiced that organisations were often disjointed in their approach, and that parents often had to repeat information to each organisation involved in their child's care, a burdensome process.

Using the **'Team around the Child' model** so issues can be resolved more quickly, could reduce waiting times and referrals. Additionally, professionals questioned in borough focus groups, felt making staff available to provide advice and information at the point of referral to a service as part of a multi-agency approach, may speed up the process.

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 via a **person centred approach** and identify all available support to be in place. Professionals felt that Link workers may be a useful resource for this process. It was suggested, within professionals focus groups, that a Designated Medical Officer could work across Paediatric services' and adult clinics (or GP's), promoting the use of pathway planning, in transitionary periods. This could assist young people in understanding the impact of taking risks e.g. through difficulties emerging from 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. Two priorities around this emerged from professionals attending focus groups in the borough. Firstly the need for Awareness training on common communication needs and support for children and young people with ASD/LD. The second a greater Understanding of behaviour, including challenging behaviour, particularly for staff based within schools and how they may manage this. Those working with CYP would benefit from training on how to effectively manage risk themselves and how and when to draw in specialist support. Finally, staff need to understand the idea of planning for outcomes, having the skills to 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 such outcomes.

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[41] 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
[42] 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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