

# Report of the Tri-borough Children, Young People and Mental Health Task and Finish Group

November 2014

## Contents

### *Summary of recommendations*

#### 1. Introduction

- Background
- National Context
- Local Context
- Methodology
- A new vision?

#### 2. Ensuring early intervention and prevention in relation to children and young peoples' mental health and wellbeing.

- Access, outcomes and a Single Point of Access
- Awareness and confidence for frontline staff
- Cyberbullying
- Self Harm
- Mental Health and Gangs
- Eating disorders
- Recommendations

#### 3. Reducing the impact of parental mental health disorders on children and young people.

- Data collection and information sharing
- Multi-agency working
- Staff awareness and training
- Recommendations

#### 4. Improving the transition from Children's to Adult Mental Health Services.

- National Context
- Local Context
- Service Model
- Leadership
- Recommendations

#### 5. Acknowledgements.

## Summary of recommendations

### Ensuring early intervention and prevention in relation to children and young peoples' mental health and wellbeing

1. An Out of Hours CAMHS Consultation, Advice and Referral (CAR) telephone line should be established across Tri-borough to ensure that young people are referred to the right service at the right time.
2. A programme of training accessible for front line professionals and 'co-produced' with young people should be developed for 2015-16 to improve mental health and emotional well-being awareness.
3. The Health and Wellbeing Board should support the Local Safeguarding Children Board's (LSCB) call for a 2015-16 programme of 'guidance, support and prevention' activities in schools to address: the stigma of mental health; managing self harm; suicide prevention; and cyber bullying.
4. Local commissioners and senior clinicians should continue to be engaged and contribute to NHS England's work on improving the care and treatment pathways for young people with eating disorders.

### Reducing the impact of parental mental health disorders on children and young people.

5. All services providing mental health care to adults should be contractually required to demonstrate that the patient has been asked about their parental responsibilities and assessed the potential impact of their mental health problems may have had on the children they are responsible for.
6. Health and Wellbeing Boards should make improving local data and information sharing a priority for improvement. An inter-agency Data and Information Sharing Protocol or Policy should be developed to cover all services for families in the Tri-borough area.
7. A *Think Family* or 'Whole Family' approach should be adopted and championed in adult mental health services, with a view to: improving

'holistic' assessment processes, improving multi-agency planning and interventions and encouraging 'joint work' with families with multiple problems.

8. *Think Family* champions should be established, with the support of Health and Wellbeing Boards, Clinical Commissioning Groups (CCGs) and Public Health to develop a programme of engagement with ante and post-natal services.
9. Health and Wellbeing Boards should encourage local Health, Social Care and Voluntary providers to collaborate in publishing a 'local offer' explaining what services are available to support mental health and emotional well-being.
10. Health and Wellbeing Boards should support the development of a Young Carers Strategy across Health, Adult and Children's Social Care and the Voluntary Sector to improve inter agency working maximise outcomes for young people.

#### The transition from Children's to Adult mental health services

11. Further discussion is required with both Central and North West London NHS Foundation Trust (CNWL) and West London Mental Health NHS Trust (WLMHT) to clarify the position on numbers of young people in transition to clarify whether:
  - A business case exists to develop a 16 to 25 service
  - Whether young people are leaving CAMHS support prematurely at 16 plus
  - Whether current transition data over or understates actual or potential movement between CAMHS and Adult Mental Health Services (AMHS).
12. With a successful outcome in mind, both WLMHT and CNWL should identify Transition Champions – one in CAMHS and one in AMHS, who together are challenged to deliver the improved transition planning envisaged by the CQC and the forthcoming NICE guidance.

## 1. Introduction

### Background

- 1.1 On 12<sup>th</sup> December 2013, the North West London Commissioning Support Unit presented a paper to the Westminster Health and Wellbeing Board that summarised the current mental health and emotional wellbeing needs of young people and described the local NHS Child and Adolescent Mental Health Services (CAMHS) and council mental health services for young people and families.
- 1.2 The Westminster Health and Wellbeing Board commissioned a Task and Finish Group to consider:
  - a. **A new vision** – to think boldly about whether the current services delivered what young people needed
  - b. **Immediate key changes** - how the Health and Wellbeing Boards could use their levers to ensure that services were arranged and commissioned now and in the future to achieve improved outcomes for Children and Young People in relation to mental health and wellbeing.
- 1.3 Subsequently, the London Borough of Hammersmith and Fulham Health and Wellbeing Board and the Royal Borough of Kensington and Chelsea Health and Wellbeing Board asked for this work to be undertaken on a Tri-borough basis.
- 1.4 On 4<sup>th</sup> March 2014, Dr Ruth O'Hare, Chair of NHS Central London Clinical Commissioning Group convened a summit of practitioners and experts to launch this work and to agree the areas of focus for the Task and Finish Group.
- 1.5 Based on the themes raised during this summit, the Task and Finish Group agreed to focus on three particular areas where it was agreed that more could be done to improve the outcomes for children and young people. These areas were:
  - i) Ensuring early intervention and prevention in relation to children and young peoples' mental health and wellbeing.
  - ii) Reducing the impact of parental mental health disorders on children and young people.
  - iii) The transition from Children's to Adult mental health service

## National Context

- 1.6 The debate around children’s mental health care in England has accelerated over the past year and has culminated in charities and local councils warning of a “national crisis” in young people’s mental health.<sup>1</sup> This discussion comes at a time where local authority and health partner budgets are under increasing pressure. However, it provides a unique opportunity for partners across the health, social care and voluntary sector to come together and discover new ways of working to ultimately improve the mental health outcomes for children and young people across Tri-borough.
- 1.7 The Government has challenged the health and social care community to go further and faster to transform the support and care available to children with mental health problems, and has committed to starting early to promote mental wellbeing and prevent mental health problems.<sup>2</sup> Norman Lamb, Minister of State for Care and Support, has also described CAMHS as ‘not fit for purpose’ and operating in the ‘dark ages.’<sup>3</sup>
- 1.8 The Royal College of Psychiatrists has recently issued a manifesto with six asks the next government to improve the nations mental health. This publication includes calls for national investment in evidence-based parenting programmes to improve the life chances of children and the well-being of families.<sup>4</sup>
- 1.9 The Health Select Committee has been holding an inquiry into CAMHS. The committee heard evidence from experts<sup>5</sup> who described a service with inadequate data, multiple commissioners, reductions in funding, growing demand and a historic 4 tier system that is out of step with current initiatives to modernize, develop and deliver a more flexible, personalized NHS.
- 1.10 A national CAMHS Taskforce, to be led by Jon Rouse, Director General, Social Care, Local Government and Care Partnerships, has also been launched to make recommendations to improve commissioning and mental health services

---

<sup>1</sup> [http://www.youngminds.org.uk/news/news/2094\\_devastating\\_cuts\\_leading\\_to\\_childrens\\_mental\\_health\\_crisis](http://www.youngminds.org.uk/news/news/2094_devastating_cuts_leading_to_childrens_mental_health_crisis)

<sup>2</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/281250/Closing\\_the\\_gap\\_V2\\_-\\_17\\_Feb\\_2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf)

<sup>3</sup> <http://www.theguardian.com/society/2014/aug/20/child-mental-health-dark-ages-norman-lamb>

<sup>4</sup> Royal College of Psychiatrists, Making Parity a Reality; Six asks for the next government to improve the nation’s mental health, September 2014.

<sup>5</sup> Including written and oral evidence from local commissioners, Jacqueline Wilson and Steve Buckerfield – NWL CSU. Local NHS providers and Child Outcomes Research Consortium also submitted evidence.

for young people and their families. The CAMHS Taskforce will report in the Spring 2015.<sup>6</sup>

### Local Context

- 1.11 West London Mental Health Trust (WLMHT) provides CAMHS for young people in Hammersmith and Fulham.<sup>7</sup> Central and North West London Mental Health Trust (CNWL) provide CAMHS for Kensington and Chelsea and Westminster young people.<sup>8</sup>
- 1.12 The majority of the funding is provided by the three Clinical Commissioning Groups: Hammersmith & Fulham, West London and Central London CCGs. All three local authorities also provide funding usually for specialist services such as CAMHS for looked after children, or to support targeted interventions by CAMHS in schools.
- 1.13 CAMHS is organised across 4 tiers of service:

**Tier 1** - includes all front line health, social care and education services: social workers, teachers, Health Visitors and GPs. Tier 1 services do not have CAMHS training but may identify emotional and mental health issues, provide support or activate more specialist expertise;

**Tier 2** – is composed of staff that have received CAMHS training and would typically include Primary Mental Health Workers who in reach into schools; staff employed by voluntary agencies e.g. West London Action for Children;

**Tier 3** – is where clinicians with specialist and expert mental health knowledge and training are found: child psychiatrists, family therapists, psychologists; and

**Tier 4** – this describes all psychiatric care for young people with severe and complex mental health needs that cannot be managed by Tier 3. Tier 4 provision includes inpatient units but also day programmes and specialist outpatient services, for example specialist services for Autism or

---

<sup>6</sup> <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/childrens-and-adolescent-mental-health-and-camhs/oral/11442.html>

<sup>7</sup> WL MHT also support young people in Ealing and Hounslow and provide an extensive Forensic Service which includes Broadmoor.

<sup>8</sup> CNWL also provide mental health and community health services across 10 of more London authorities, as well as services in Hampshire and Milton Keynes.

Eating Disorders. The Tier 4 provision locally would include the CNWL Collingham Gardens Unit and private provision operated by the Priory Hospital Group (e.g. Roehampton).

- 1.14 Tier 2 and Tier 3 services are often delivered (but not always) by the same community providers: WLMHT and CNWL. Tier 2 and 3 is effectively the local community children's mental health service.
- 1.15 Tier 4 in-patient provision was originally commissioned by local Primary Care Trusts (PCTs). A North West London PCT Consortium operated a contract with the Priory Group and spot purchased specialist in patient support as required (e.g. for eating disorders). The NHS Reforms removed Tier 4 from local control and tasked NHS England with commissioning in-patient child psychiatric provision. This development has complicated the pathway in and out of hospital for young people.
- 1.16 Prior to the Health and Wellbeing Boards establishing this Task & Finish Group, Councillors in Kensington and Chelsea led a working group which looked at CAMHS in the borough and took evidence from schools, local voluntary agencies and CNWL. Additionally, the Commissioning Support Unit (CSU) CAMHS Commissioner, Jacqueline Wilson, reviewed the Tier 2 and targeted mental health services (looked after children, young offenders and young people with learning difficulties).
- 1.17 Furthermore, as part of the annual contract round, consistent service specifications and performance indicators have been agreed with WLMHT and CNWL and with the support of the North West (NW) London Mental Programme Board, a review of NW London CAMHS Out of Hours support is underway.
- 1.18 Finally, members in Hammersmith and Fulham have confirmed that they intend to launch a CAMHS Taskforce in November to look in detail at provision for young people in the borough.

#### Local figures

- 1.19 To provide some local context, a table detailing the Tri-borough Children's Services customer profile is shown below:



Table 1: Children's Services customer profile

	<b>LBHF</b>	<b>RBKC</b>	<b>WCC</b>	<b>Total</b>
All ages resident population	182,493	158,649	219,396	560,538
Black, Asian & Minority Ethnic (BAME) Population [all ages]	58,271	46,632	84,066	188,969
0-19 resident population	35,996	29,720	41,005	106,721
0-4	11,900	9,189	12,617	33,706
5-10	10,172	9,027	11,537	30,736
11-19	13,924	11,504	16,851	42,279

1.20 In Hours CAMHS Tier 2 and Tier 3 funding for Hammersmith and Fulham CCG, West London CCG and Central London CCG (2014-15) are outlined in the table below.

Table 2: In Hours CAMHS funding across Tri-borough

<b>CCG</b>	<b>CAMHS Tier 2</b>	<b>CAMHS Tier 3</b>	<b>Total for CCG</b>
Hammersmith and Fulham CCG	£414,000	£1,956,863	£ 2,370,863
West London CCG	£140,562	£2,063, 000	£2,203,562
Central London CCG	£547,347.00	£1,084,000	£1,631,347

1.21 There are a range of professionals including mental health nurses, psychologists, psychotherapists, medical staff and systemic therapies employed in CAMHS. CAMHS Tier 2 and targeted services funded by the Local Authorities are outlined in the table below.

Table 3: CAMHS Tier 2 Staff breakdown across Tri-borough

Local Authority	Contract WTE	2013/14 charge
London Borough of Hammersmith and Fulham	8.40 posts	402,701
Royal Borough of Kensington and Chelsea	7.10 posts	490,968
Westminster City Council	10.20 posts	675,436

1.22 Current CAMHS caseloads at the end of August 2014 are as follows:

- West London CCG (CNWL) - 690
- Central London CCG (CNWL) - 437
- Hammersmith and Fulham CCG (WLMHT) - 491

#### Methodology

- 1.23 The Task and Finish Group has drawn on the expertise of professionals and clinicians from across the local health and care system, the Voluntary and Community Sector (VCS) and the experience of users of local CAMHS. Full acknowledgements are listed at the end of this report.
- 1.24 The Task and Finish Group has shaped its thinking around the role of the Health and Wellbeing Board in providing system leadership, with particular emphasis on opportunities for integration and joint commissioning. The Task and Finish Group has recognised the value of using the Board's influence over the wider determinants of health and discussions have incorporated this where appropriate.
- 1.25 The Task and Finish Group's recommendations have been informed by national research, data provided by Tri-borough Public Health and local providers, and experiences of experts working on the ground. Colleagues from mental health charity Rethink have also provided an invaluable contribution to this work through

sharing their own research and offering a service user insight into the issues discussed.

- 1.26 Over 9 months the Task and Finish Group has identified some thoughts and ideas to share in relation to a **new vision** for mental health services for young people.
- 1.27 In addition, a series of recommendations on **immediate key changes** for the Health and Wellbeing Board and individual organisations to take forward to improve mental health outcomes for young people across the Tri-borough have been proposed.

### A New Vision?

- 1.28 To decide whether a 'new vision' for mental health and emotional wellbeing support for young people in Hammersmith & Fulham, Kensington & Chelsea and Westminster is needed, we firstly need to clarify what local child and adolescent mental health services are for. This means asking challenging questions about what exactly the services have been put in place to do and whether there is agreement on this between key stakeholders.
- 1.29 Clearly there are other important questions such as whether services are adequate, whether children wait too long and ways to improve transition that need to be explored. However, addressing the fundamental question of 'purpose' is the first step in developing a new vision for young people's mental health support.
- 1.30 The language used in relation to young people's emotional and mental health is ambiguous: emotional wellbeing, mental illness, mental health, emotional or mental disorders all suggest a slightly different take on the support and services provided for young people with problems in these areas.
- 1.31 An important consideration to grasp therefore is that young people's support and services for emotional well-being and mental health seek to address a spectrum of need, set out in the diagram below.

Table 3 - Young people and mental health services – a spectrum of need

**Birth to school      Primary      Secondary      16 plus      Young adulthood**

—————→

***Attachment***      ***ASD***      ***anxiety***      ***longer term issues***  
***Emotional vulnerability***           ***ADHD***      ***depression***

- 1.32 During primary and secondary school a number of issues can arise for young people, particularly behavioural difficulties, anxiety and/or depression which vary considerably in their impact.
- 1.33 In most cases, CAMHS expertise is required, but in milder manifestations, parents, teachers, school counsellors, GPs and voluntary or faith groups may be able to provide the required support, encouragement and reassurance.
- 1.34 Locally, schools have explained that they are seeing a rise in these typically teenage issues. Anecdotal evidence suggests schools feel ill-equipped to respond to mental health issues and have insufficient time to do so, whilst much of the CAMHS expertise that could help is in short supply. Specialist services in the main are clinic based with some outreach work in schools where commissioned.
- 1.35 This leads us to return to the key question:

**Do we expect the current children’s mental health service to respond to the entire spectrum of need?**

If realistically, current CAMHS is not able to respond to such a comprehensive demand then two additional challenges follow:

*1. Should we re-commission CAMHS to take a more holistic approach to emotional well being, as well as treating young people with clear mental illness?*

There are a number of ideas that could take this idea forward:

- Norman Lamb<sup>9</sup> has spoken about establishing a 'one stop shop' free of stigma, which could flexibly respond to young people's emotional and mental health needs
- Alternatively, CAMHS provision could move towards integration with children's social care with the new 'focus on practice' and/or educational psychology

*2 Alternatively we could accept that CAMHS expertise has its strength in responding to diagnosed mental illness in a targeted, evidence based and hence effective way.*

To complement this however early intervention could be strengthened:

- A voluntary organisation(s) could be commissioned to provide the stigma free support required, strengthening the tier 1-2 offer locally, with close links to CAMHS, schools and GPs.
- Schools could consider pooling resources to develop a school based support service for young people.
- Building on current work with adult patients in primary care, GP based care co-coordinators could extend their role to work with young people.
- A drop-in hub could be established as a pilot locally, drawing on national and international best practice examples, providing a range of services including mental health under one roof.
- Public Health prevention and promotion of positive mental health and well-being could be refreshed and re-launched.

1.36 These are just two options. This work will also inevitably be informed by the conclusions of the national CAMHS Taskforce and efforts have been made locally to maintain engagement with these national developments.

1.37 Another idea gaining credibility is that 'crisis intervention' support should be significantly improved for young people to avoid inappropriate admission to hospital and also support safe and speedy discharge.

---

<sup>9</sup> Minister for Care and Support

- 1.38 Whilst these thoughts are a combination of reconfiguring existing services, or commissioning alternatives with different thresholds for intervention and service re-design or re-commissioning, these should be underpinned by a **new vision** on how to respond to young people's spectrum of needs: emotional vulnerability to diagnosed mental illness.
- 1.39 The Task & Finish Group therefore recommends that the Tri-borough Health and Wellbeing Boards support a programme of activities to address these questions and develop a new vision for young peoples' emotional and mental health services which can then inform service development and strategy.
- 1.40 This vision will of course need to be informed by the overarching work happening on a national level through the CAMHS Taskforce and requires a recognition from all partners that the issues outlined will not be solved in one report. This does however represent a unique opportunity for partners to establish new ways of work together and ultimately improve the mental health outcomes for children and young people across Tri-borough.

## 2 Early Intervention and Prevention

- 2.1 Prevention requires taking measures early to stop a problem occurring in the first place. In the context of mental health, this could be activity to avert the initial onset of a mental disorder, identifying and targeting those at risk.
- 2.2 Early intervention requires taking action as soon as possible to tackle problems that have already emerged for children and young people and is generally provided in a community setting.<sup>10</sup>
- 2.3 Childhood and adolescent mental health problems are a significant risk period for the emergence of pervasive mental health problems in later life. Up to 40-50% of chronic and severe psychiatric disorders in adulthood started in late adolescence. This psychopathology often persists to a considerable degree into adulthood and as a result is likely to require ongoing and long term engagement with Adult Mental Health Services (AMHS).<sup>11</sup>
- 2.4 The case for early intervention and prevention has been strongly argued In the Michael Marmot's Review (Fair Society Healthy Lives<sup>12</sup>) and Graham Allen's work (Early Intervention: Next Steps<sup>13</sup>). Care Minister, Norman Lamb has also complained that children's mental health only receives 6% of national mental health spending and has urged commissioners to address this issue.<sup>14</sup>
- 2.5 The benefits of intervening to prevent mental illness early in life and the importance of early identification and treatment of mental disorder in children and young people has been highlighted by the World Health Organisation's Mental Health Action Plan 2013-2020.<sup>15</sup>
- 2.6 The Annual Report of the Chief Medical Officer (CMO) 2013 also states that early treatment for young people could prevent later life problems such as substance misuse, crime, unemployment and antisocial behaviour.<sup>16</sup> The CMO report also focused specifically on the impact of digital culture, cyber bullying, self-harm, access to services and transition - areas which this Task and Finish Group has considered.

---

<sup>10</sup> National CAMHS Support Service, Better Mental Health Outcomes for Young People, CHIMAT.

<sup>11</sup> Royal College of Psychiatrists, Introduction to conduct disorder, [http://www.rcpsych.ac.uk/files/samplechapter/80\\_3.pdf](http://www.rcpsych.ac.uk/files/samplechapter/80_3.pdf)

<sup>12</sup> Sir Michael Marmot, Fair Society Healthy Lives, February 2010

<sup>13</sup> Graham Allen, Early Intervention: The Next Steps, January 2011

<sup>14</sup> [http://www.youngminds.org.uk/news/news/2094\\_devastating\\_cuts\\_leading\\_to\\_childrens\\_mental\\_health\\_crisis](http://www.youngminds.org.uk/news/news/2094_devastating_cuts_leading_to_childrens_mental_health_crisis)

<sup>15</sup> WHO, Mental Health Action Plan 2013-2020

<sup>16</sup> [Annual Report of the Chief Medical Officer, 2013](#)

- 2.7 The London Health Commission, an independent inquiry chaired by Lord Darzi, has also made a number of recommendations in relation to children, young people and mental health. The report entitled 'Better Health for London' calls for better, more innovative support for young people suffering from mental illness, recommending that the NHS must find better ways to adapt to meet the needs of potential mental health sufferers, such as by using smartphone applications to monitor mood.<sup>17</sup>

Access, Outcomes and a Single Point of Access

- 2.8 Experts and professionals have said that they wanted to be able to support the children and young people they worked with by being able to talk in a safe way about emotional wellbeing and mental health issues. Furthermore, children and young people themselves who have contributed to discussions, wanted to be more empowered to manage their emotional health and wellbeing and their mental health issues.
- 2.9 Local teachers have reported that they frequently refer young people to CAMHS and fear they will not meet the threshold for support but are uninformed and unsure of the appropriate local alternatives.
- 2.10 Research undertaken by mental health charity Rethink has shown that young people want to raise their mental health concerns with professionals that they know or are close to. This is a particularly the case for 'looked after' young people. The research also found that young people wanted to be able to talk direct to mental health services and would welcome the opportunity to self-refer and access services which could also help with 'normal' teenage problems.<sup>18</sup>

*'Every phone line I called was either only open in the mornings or did not take direct calls any longer; several explicitly stating that this was due to 'government cuts' on their answerphone messages'.*

*'Mental illness tends to be an out-of-hours crisis issue, so "out-of-hours" should not exist; the service needs to be a full service 24/7.'*

**Service Users - Rethink Report on Young People's Out of Hours Service**

<sup>17</sup> The report of the London Health Commission, Better Health for London, October 2014.

<sup>18</sup> Rethink Mental Health, Mental Health in Co-production, <http://www.rethink.org/about-us/mental-health-in-co-production>



- 2.11 The group has also researched and discussed the merits of drop-in hubs for young people such as the Brandon Centre in Camden and 'Headspace' in Australia. Such hubs which provide a multitude of services under one roof can help to reduce the stigma attached to accessing mental health services for young people. Linking mental health with physical or sexual health also appears to be an effective tool for destigmatising the access to services for young people.

"I liked the feeling of not being judged and feeling like my therapist was devoted to establishing and working through my issues. I felt I was in a very safe environment. I think overall the sessions were really good for me as they helped me ground my issues and develop an understanding of them. The people here are very friendly, the service quick and the facilities are plenty and comfortable."

***Service user quote taken from the Brandon Centre Annual Report.***

- 2.12 Data and evaluation gathered from these innovative drop-in hubs illustrates their success. Since its inception in 2012, Headspace Australia has assisted 100,000 young people through 60 physical centres, online, telephone and school support services. Community awareness of headspace grew from 34% to 47.5% in this period.<sup>19</sup> Of the young people that visited Headspace, almost a third were between the ages of 15-17, almost half were influenced to visit headspace through a family member or friend, and over 85 per cent were satisfied or extremely satisfied with their experience.<sup>20</sup>

---

<sup>19</sup> <http://www.headspace.org.au/core/Handlers/MediaHandler.ashx?mediaId=27768>

<sup>20</sup> Ibid

### **Case Studies – Health and Wellbeing Drop-In Hubs for Young People**

*The Brandon Centre* in Camden provides help and advice for young people aged 12-21 and drop-in services up to the age of 24. The services offered include free counselling, psychotherapy and multi-systemic therapy but also provides sexual health advice and parenting classes. It is integrated into Camden and Islington CAMHS but significantly also accepts self-referrals and drop-ins. Its status as a ‘hub’, where young people can access a range of services not associated with their school or GP, contributes to its resistance of helps to reduce the stigma of accessing mental health services, and the provision of a drop-in service means young people can access services before the point of crisis.

Effective examples of best practice also exist internationally.

*Headspace* is a mental health and wellbeing hub with 60 centres across Australia. It is officially the National Youth Mental Health Foundation but operates under a more ‘youth friendly’ name and provides a range of services in addition to mental health and counselling, including general and sexual health; employment services; and drug and alcohol support. It also provides training for schools in relation to suicide prevention. It is this provision of a number of different services which deflects stigma from the physical centres by reducing their perceived association with mental health. The service is aimed at 12-25 year olds with mild to moderate mental health problems and is staffed by a range of professionals including GPs, psychiatrists, social workers and youth workers.

### Awareness and Confidence for Front-line Staff

- 2.13 In addition to feedback from service users, GPs and other agency professionals reported that they would value improved access to expert CAMHS advice on how respond to young people with mental health needs. A recent survey of 500 GPs carried out by *Pulse Magazine* noted that a significant number of GPs felt that they did not have sufficient training in adolescent mental health and therefore often referred young people to secondary care because they lacked confidence

or support in supporting patients locally.<sup>21</sup> Anecdotal GP evidence to this Task and Finish group also reflects these findings.

- 2.14 Work undertaken by Rethink with Looked After Children (LAC) and young people in Hammersmith and Fulham echoes the findings of the *Pulse* article reported above.<sup>22</sup> Anecdotal evidence also suggests that front line social work, youth and teaching staff do not feel confident raising mental health issues with young people or their families.
- 2.15 Rethink's work also concluded that young people themselves often felt it was hard to raise the subject of mental health and that if they did, it was very hard to talk openly and honestly about their concerns.

*"I think if they had more support workers or that, people who maybe young people know have been through mental health problems, they're more likely to maybe... because obviously sometimes psychiatrists are going to be involved and social workers because they're professionals, but if there were people there maybe that while you were waiting to be seen by the psychiatry nurse, people who had been there, been through it, maybe that would be a good way of sort of helping people stay calm."*

**Service User - Rethink Report on Young People's Out of Hours Service**

- 2.16 To address this identified need, Hammersmith & Fulham's Looked After Children CAMHS service has collaborated with Rethink's Co-production Project and devised a training package for front line staff.
- 2.17 The training is designed for non-clinical teams who work with young people in school or community settings: key workers, school staff and social workers. The training aims to:
- a) Improve the quality and consistency of support provided to young people;
  - b) Improve practitioners' confidence in talking about mental health and helping young people to access services where required; and

<sup>21</sup> <http://www.pulsetoday.co.uk/clinical/therapy-areas/mental-health/one-in-five-gps-report-patient-harm-as-mental-health-services-struggle-to-cope/20007397.article#.U-EDVT-Uyt8>

<sup>22</sup> Rethink Mental Health, Mental Health in Co-production, <http://www.rethink.org/about-us/mental-health-in-co-production>

- c) Encourage the resourcing of early intervention and prevention initiatives, co-produced as appropriate with young people.
- 2.18 Young people supported by Rethink have successfully delivered a pilot training package for social work staff and received excellent feedback from participants.
- 2.19 Any generic training for practitioners on having 'difficult conversations' with young people and/ or their parents/carers would have additional benefits beyond the scope of this Task and Finish Group. Frontline workers report finding it as difficult to start conversations about child obesity and female genital mutilation as they do about adolescent mental health.

### Cyber Bullying

- 2.20 The Anti-Bullying Alliance defines cyber bullying as follows:

**'Cyber Bullying** - bullying via electronic means. This could be via the internet, phone, laptop, computer, tablet or online gaming.'

It can take place on a range of online or mobile services, such as text, email, social networking sites, video-hosting sites, messenger, photo sharing services, chat, webcams, visual learning environments and online games.<sup>23</sup>

- 2.21 38 per cent of young people have been affected by cyber bullying, with abusive emails (26 per cent) and text messages (24 per cent) being the most common methods.<sup>24</sup> An estimated 5.43 million young people in the UK have experienced cyber bullying with 1.26 million subjected to extreme cyber bullying on a daily basis.<sup>25</sup>

#### **Case Study – Cyber Mentors**

Cyber Mentors is an online initiative from Beat Bullying charity, which takes young people aged 11-17 through intensive face-to-face training so that they are able to mentor young people both offline within their community and online, through the Cyber Mentors website. This helps to tackle issues such as cyberbullying and wellbeing through peer support.

<sup>23</sup> Anti-bullying Alliance, Cyberbullying and Children and Young People with SEN and Disabilities: Guidance for Teachers and other Professionals, May 2014

<sup>24</sup> Tarapdar, Saima and Kellett, Mary (2011) [Young people's voices on cyber-bullying: what can age comparisons tell us?](#) London: The Diana Award & cited on NSPCC website at June 2013).

<sup>25</sup> Ditch the Label, The Annual Cyberbullying Report, September 2013

- 2.22 Local Head Teachers confirm that cyber bullying is an increasing problem in schools. Although schools have a duty to develop anti-bullying policies<sup>26</sup>, feedback from colleagues in education suggests that it can be difficult to protect young people from cyber bullying beyond the school gates.
- 2.23 There is, however, emerging evidence of local best practice. Westminster Academy's experience of using an E-safe<sup>27</sup> software with its ability to detect inappropriate and illegal images; identify grooming, cyber bullying, radicalisation, suicide and self-harm etc through text and website detection, was encouraging.

*"We were the trial school chosen and we withdrew because we could no longer afford this on the basis that no other school is using it. It is absolutely brilliant for detecting self-harm issues, depression and suicide, gang activity etc. I gave an example of how the programme helped me to prevent what could have been a very serious case of undetected anorexia but there are many others such case studies."*

**Smita Bora – Head Teacher Westminster Academy and member of the Task and Finish Group**

- 2.24 Links are now being made between the Local Safeguarding Children Board, schools, early intervention services and Public Health to consider the wider application of E-safe or other similar alternative cyber bullying solutions.

### Self Harm

- 2.25 Self harm is commonly defined as a deliberate act of inflicting damage on oneself, no matter what the outcome. Self harm causes significant distress to the individual, family, school, and professionals and it is associated with mental health problems. Self-harm also increases the likelihood that the person will eventually die by suicide by between 50- and 100-fold above the rest of the population in a 12-month period.<sup>28</sup>

<sup>26</sup> <https://www.gov.uk/bullying-at-school/the-law>

<sup>27</sup> <http://www.esafeeducation.co.uk/>

<sup>28</sup> Self-Harm: The NICE Guideline on Longer-term Management, May 2012.

- 2.26 There have been a number of programmes put in place by the Government to support those, in particular teenagers, who are self-harming or at risk of self-harming including:
- MindEd, an interactive e-learning programme on mental health designed to help any adult working with children and young people.<sup>29</sup>
  - Department for Education advice for school staff on mental health and behaviour.<sup>30</sup>
  - Self-harm being identified as a priority for action in the Department of Health Mental Health Action Plan.<sup>31</sup>
- 2.27 Local CAMHS providers, CNWL and WL MHT, were contacted to ascertain what data was available on self-harm. However, self-harm is not a separate diagnostic category but a manifestation or consequence of mental illness or distress so specific data on self-harm is not available.
- 2.28 This data deficit is recognised nationally and may well be addressed by the national CAMHS Taskforce. Locally, CCG commissioners are exploring how hospital Accident and Emergency departments, CAMHS providers and Adult Mental Health Liaison Psychiatry can be commissioned through the annual contract round to report the incidence of self harm.
- 2.29 Following the Local Safeguarding Children Board (LSCB) short life group on 'Self harm and Suicide Prevention', recommendations have been made to strengthen the guidance and support offered to schools in responding to self-harm. Although at an early stage the CAMHS Task and Finish Group clearly wants to support this initiative and is keen to see how schools, GPs, CAMHS and local voluntary groups can be brought together to ensure this initiative has maximum impact.

### Mental Health and Gangs

- 2.30 In August 2013, the Westminster Health and Wellbeing Board received a Tri-borough Public Health report, 'Understanding the Mental Health Needs of Young People involved in Gangs'.<sup>32</sup>

---

<sup>29</sup> [www.minded.org.uk](http://www.minded.org.uk)

<sup>30</sup> Department for Education, [Mental Health and Behaviour in Schools](#), June 2014

<sup>31</sup> Department of Health, [Closing the Gap: Priorities for essential change in mental health](#), February 2014.

- 2.31 The report identified increased prevalence of mental health problems amongst young adult gang members. The largest study quoted<sup>33</sup> looked at gang population aged 18-34 in the UK, and noted increased rates of anti-social personality disorder, suicide attempts, psychosis and anxiety disorder.
- 2.32 The report recommended sustaining the mental health input into the Integrated Gangs Unit (IGU) and this is now being considered, although questions have arisen about quantifying and evidencing the impact and outcome of the work.

### Eating Disorders

- 2.33 Eating disorders have high rates amongst young people. Anorexia nervosa is a serious mental health condition which can be life threatening. It is an eating disorder in which people display distorted body image, problematic eating behaviours such as restricting the amount of food they eat, making themselves vomit and exercising excessively and maintaining an unhealthy low weight. Anorexia and eating disorders cause significant physical and emotional implications.
- 2.34 Locally, there are some specialist CAMHS community eating disorder services available from providers. For example, South London and Maudsley (SLAM) NHS Foundation Trust and local CAMHS commissioners have a budget to allow for purchasing of these services when clinically indicated. In SLAM, all community CAMHS refer to the specialist service regardless of the severity as they have a contract with local commissioners. This is not the case for CNWL where clients are only sent to specialist services when they are severe.
- 2.35 The number of CAMHS cases with eating disorder as a diagnosis appears relatively low when taken as a percentage of total caseload. For Westminster and Kensington and Chelsea, CNWL figures show 28 cases of eating disorder as a diagnosis, 2.5% of the total CAMHS caseload. These cases are broken down as follows; anorexia nervosa (12), atypical anorexia nervosa (3), Bulimia nervosa (2), overeating associated with other psychological disturbances (1), other eating disorders (2), eating disorder, unspecified (8).<sup>34</sup>

---

<sup>32</sup> Understanding the Mental Health Needs of Young People involved in Gangs, Tri-borough Public Health report, August 2013.

<sup>33</sup> Gang membership, violence and psychiatric morbidity, American Journal of Psychiatry: Coid, J.W.et al, 2013

<sup>34</sup> Note caveat on numbers as recorded diagnosis is not 100%.

- 2.36 For Hammersmith and Fulham, WLMHT figures report 5 cases, 1 % of the total CAMHS caseload. Three of these are diagnosed as anorexia nervosa, and two as atypical anorexia nervosa.
- 2.37 Eating disorders are often present with comorbidities such as depression or anxiety. If the symptoms of the comorbid condition are more severe and dominant to the eating problems, then a patient sometimes remains under a generic CAMHS team (for example a young girl with depression who displays some eating difficulties but the frequency and severity do not warrant a specialist service).
- 2.38 These low numbers suggests the majority of community cases are not presenting to services. Evidence suggests that the numbers go up when there is an identified specialist service taking direct GP referrals. There is good evidence for Early Intervention Services in tackling eating disorders which makes it vitally important that services are easily accessible to young people who require treatment.
- 2.39 The recently released CAMHS NHS England Tier 4 report<sup>35</sup> has recommended that further work needs to be done to look at developing community provision for specialist eating disorder services. This will be rolled out against the context the NHSE service specifications, guidance recommendations from the Health Select Committee CAMHS Enquiry and the national CAMHS Taskforce.

## **Recommendations**

The Task and Finish Group has focused on a small number of specific issues in relation to early intervention and prevention and proposed a series of recommendations which the Health and Wellbeing Board are asked to consider.

### *Recommendation 1*

A CAMHS Consultation, Advice and Referral (CAR) telephone line should be established for Hammersmith and Fulham, Kensington and Chelsea and Westminster. This 'single point of contact' will ensure that young people are referred to the right service at the right time, to CAMHS or on to a wider network of support. Establishing a CAR service will provide immediate support to GPs, teachers, social workers and parents who are concerned about young people with emotional and mental health needs. The CAMHS CAR service should have

---

<sup>35</sup> NHS England, [Child and Adolescent Mental Health Services, Tier 4 Report](#), July 2014.



the capacity to operate out of hours, in a similar way to the Emergency line provided for adults with urgent mental health needs.

### Recommendation 2

A programme of training, 'co-produced' with young people should be developed for 2015-16 to improve mental health and emotional well-being awareness. The programme should bring together learning from:

- the LSCB work on self harm
- the Kensington and Chelsea councillor led CAMHS working group
- the Tri-Borough Suicide Prevention Strategy Group
- Public Health's leadership on promotion of emotional well-being

The training should be accessible for front line professionals in Hammersmith and Fulham, Kensington and Chelsea and Westminster and should build on the successful Rethink model and Mindfulness programmes.

### Recommendation 3

Building on recommendation 2 above, the Health and Wellbeing Board should support the LSCB's call for a 2015-16 programme of 'guidance, support and prevention' activities in schools to address:

- The stigma of mental health,;
- managing self-harm;
- suicide prevention; and
- Cyber Bullying.

The programme should build on the success of the Public Health commissioned Healthy Schools initiative, include relevant safeguarding professionals (Health, Education and Social Care) and encourage links between schools, GPs, CAMHS and voluntary providers such as West London Action for Children or Young Minds.

### Recommendation 4

Local commissioners and senior clinicians should continue to be engaged and contribute to NHS England's work on improving the care and treatment pathways for young people with eating disorders.

### 3. Parental Mental Health

3.1 The Task and Finish Group combined with the Local Safeguarding Children Board (LSCB) working group to consider the issues outlined in this report around parental mental health.

3.2 Working together, the two groups identified two key areas for improvement:

- Introducing the *Think Family* approach into mental health access opportunities, assessments and care pathways to improve outcomes for whole families.

*Think Family* means reforming systems and services provided for vulnerable children, young people and adults to secure better outcomes for children, by coordinating the support they receive from children's, adults' and family services.

- Improving services for the *young carers* of parents with mental illness.

3.3 The work has also been underpinned by research undertaken by Healthwatch which has looked at how parents engage with services.

#### Background

3.4 Estimates suggest that between 50% and 66% of parents with a severe and enduring mental illness live with one or more children under 18 - approximately 17,000 children and young people across the UK.<sup>36</sup>

3.5 Furthermore, research suggests that the mental health and wellbeing of the children and adults in a family where a parent has a mental health problem are closely linked. Despite this evidence, services are generally structured either around the adult's mental health or children's identified needs. Very few services are structured, lead and designed to systematically take a holistic view of a family's needs.<sup>37</sup>

3.6 The Social Care Institute for Excellence notes that adult mental health services and children's services are usually separated by organisational design;

<sup>36</sup> Gopfert, M, Webster, J, & Seeman, M, (1996) *Parental Psychiatric Disorder*. Cambridge: Cambridge University Press.

<sup>37</sup> Stanley, N., and Cox, P. (2009) *Parental mental health and child welfare: reviews of policy and professional education*, London: SCIE.

professional background and training; policy and legislation; data and recording systems and organisational culture. Practitioners can also be reluctant to work outside established professional boundaries.<sup>38</sup> Whilst these divisions may have emerged to provide the necessary focus and expertise (safeguarding, prioritizing the needs of children etc.) there can be unintended consequences for 'joined up' work with families.

3.7 The 2001 census identified approximately 150,000 young carers aged 5 – 18 in the UK. By 2011 this had increased by 19% to approximately 178,000.<sup>39</sup> Research conducted in 2010 estimates that nationally there are around 250,000 young carers of parents with mental illness.<sup>40</sup> The existing young carers' contract with Spurgeons is based on the 2001 data and equates to:

- 540 young carers in Westminster (19% uplift adds 103)
- 425 young carers in Hammersmith and Fulham (19% uplift adds 81)
- 303 young carers in Kensington and Chelsea (19% uplift adds 58)

3.8 Nationally, these incidence figures are regarded as underestimates with a significant number of young carers remaining "hidden".

3.9 Prior to 2013, services for young carers were provided on a borough basis by separate providers. In September 2013 a Tri-borough young carers contract was awarded to Spurgeons. The Spurgeons' service is based on an outreach model and provides support to young people in the communities where they live.

#### Local progress – performance indicators

3.10 Locally, a Commissioning for Quality and Innovation (CQUIN) performance indicator has been introduced into CNWL's 2014 - 15 contract. The CQUIN seeks to improve the quality of assessment and care planning for parents with mental health needs. The CQUIN was developed because it had become clear that within Adult Mental Health services, children's emotional welfare assessments were not routinely in place and often only generated by a crisis. Similarly, joint assessments between Adult Mental Health, CAMHS and Adult and Children's Social Care remain rare.

---

<sup>38</sup> SCIE. (2009) Think child, think parent, think family: a guide to parental mental health and child welfare, London: SCIE.

<sup>39</sup> Census 2011, Office for National Statistics - <http://www.ons.gov.uk/ons/rel/census/2011-census/detailed-characteristics-for-local-authorities-in-england-and-wales/index.html>

<sup>40</sup> BBC (2010) Young carers are 'four times' the official UK number. [www.bbc.co.uk/newsbeat/11758368](http://www.bbc.co.uk/newsbeat/11758368)

- 3.11 The CQUIN recognises that good quality holistic mental health needs assessments are an essential first step in devising a care plan capable of supporting the parent's mental health whilst at the same time ensuring the children's well-being.
- 3.12 CNWL will now work in partnership with Children's Social Care services to develop joint procedures for parents receiving mental health services where the threshold for children's early help and/or safeguarding is met.
- 3.13 In addition to the contract based CQUIN, the parental mental health group has looked at the application of the 'think family' approach for assessment pathways and improving services for young carers. This led to developing a series of recommendations based on three themes.
- Data collection and information sharing
  - Multi-agency working
  - Staff awareness and training

#### Data collection and information sharing

- 3.14 Across Hammersmith and Fulham, Kensington and Chelsea, and Westminster there is a lack of clarity about what data and information can or should be collected and circumstances in which this knowledge can be shared. This is presenting a significant barrier to improving partnership working between health, social care and adult and children's services.
- 3.15 The introduction of SystemOne for Tri-borough GP practices will resolve some information sharing issues within health but there are many other systems in use by the local agency networks. If improving data collection and information pathways and sharing was recognised as a Health and Wellbeing Board priority, cost effective early intervention or 'early help' solutions for families in crisis will become significantly easier to develop and implement.
- 3.16 Ofsted and the Care Quality Commission (CQC) have both called on the Government to make it mandatory for mental health services to collect data on

children whose parents or carers have mental health difficulties and report this nationally.<sup>41</sup>

- 3.17 At a local level there is concern adult mental health assessments do not clearly identify whether the service user has parental responsibility for a child under 18 or has regular contact with or is living with children.
- 3.18 In recognition of these deficits, Central London CCG's Primary Care Plus initiative is changing mental health assessment and referral forms completed by GPs to include parental information. Some costs arise in adapting forms or computerized referral systems, but these are small scale when compared with the benefits to be achieved by strengthening the current system and ensuring that children and parent's needs are no longer overlooked.
- 3.19 Information sharing is also a barrier to effective identification of young carers at school which can prevent pro-active engagement and intervention. Too often schools only become aware of a young carer's situation when concerns have been raised by behavioural issues, poor attendance, under performance etc.

#### Multi-agency working

- 3.20 Feedback from some professionals suggests that ante-natal and peri-natal support services (midwifery, health visitors and children's centres etc.) may not be assessing the whole family, specifically the needs of fathers, despite evidence linking adverse outcomes with paternal mental ill health and factors such as unemployment. Importantly a review of perinatal services is underway across Tri-borough, which recognises the need to ensure that parental mental health is encompassed as a perinatal mental health service is developed.
- 3.21 For young carers, the existing Tri-borough Spurgeons young carers service is well placed to address the engagement needs of young carers through their activities programme. However, they are less able to and arguably don't have the capacity within the existing contract, to work more therapeutically with the whole family.
- 3.22 Although there is a relatively new young carers' service across the three Inner London local authorities, there is no overarching Young Carers' Strategy which might integrate work with Health and Children with Adult Social Care.

---

<sup>41</sup> Ofsted, [What about the Children? Joint working between Children's and Adult Services when parents or carers have mentally ill health and/or drug and alcohol problems](#), March 2013

Strengthening leadership for young carers' services through a developing a strategy or inter-agency protocol, possibly supported by a strong strategic group would encourage a forward focused and more 'integrated' and *think family* direction for young carers service. Such a development is overdue.

- 3.23 As the new Spurgeons Young Carers' service is at an early stage of delivery, schools currently have little knowledge of the service. Spurgeon's will be addressing this through targeted marketing and awareness raising activities over the next six months.
- 3.24 In addition to raising awareness for young carers, further work should also be done to raise awareness of parental mental health and parental substance misuse issues with schools to: strengthen recognition of signs and symptoms and improve awareness of services and support services.

#### Early Progress

Colleagues in Children's Services are already leading on organising and delivering an initial workshop targeting up to 60 designated teachers, schools nurses and other school staff with delegated responsibility for young carers from Westminster schools. Attendees at the workshop will help develop a young carers resource pack, which will be useful and accessible to all schools across Tri-borough.

The Local Safeguarding Children Board will be taking this work forward with the aim to ensure that all schools across Tri-borough have a named lead for young carers. Rethink and Spurgeons are both involved in the work to ensure that service user views are both heard and reflected in its outputs.

#### **Case Study – Kidstime**

Kidstime is a project that bridges the gap between activity based provision and whole family therapeutic support using monthly workshops for children, young people and their parents who are affected by mental health issues in their family. It's a place where children can have fun, learn and get support from people who understand what's going on in their lives. Using drama workshops, they can explore their concerns and begin to develop the resources to cope with difficult situations at home, in school, or in their daily lives. Parents and children are engaged separately and as a family unit. The project has operated out of the Marlborough Centre in the past.

### Staff awareness and training

- 3.25 Adult mental health and healthcare staff regularly undertake children's safeguarding training and do refer safeguarding issues to children's social care. However, some practitioners view safeguarding referrals as a punitive measure and some are frustrated that the outcome of the referral is not always reported back. Similarly, some of the children's social care workforce have stated that they lack confidence in addressing adult mental health issues.
- 3.26 In Westminster, a Mental Health Exchange programme between Children's Services and the Community Mental Health Team is beginning to yield positive results in narrowing the knowledge and experience gap for both services through the use of joint training, named contacts to seek feedback from on referrals and to clarify referral pathways and thresholds.

#### Early Progress

An awareness raising training package around safeguarding and the range of support available to staff, with Adult Mental Health colleagues in attendance is already being developed. This will save money by increasing early intervention hence reducing the need for more urgent and specialist child protection interventions and improve professional links with mental health teams.

- 3.27 Some frontline workers expressed confusion over the purpose, access routes and range of Early Help services available to families. The development of the Early Help offer and the 'single front door' systems for Children's Services is not always understood outside of Children's Services and is exacerbated by slightly different terminology being used in each of the three local authorities.
- 3.28 The new Focus on Practice initiative, which will be implemented from late 2014 for a three year period, will begin to address some of these issues. It is an ambitious whole system change programme to improve the impact and effectiveness that practitioners have in their work with families. The Focus on Practice Framework will provide a common language and understanding of our practice with families across all three boroughs.

- 3.29 Some schools have reported that there is no current mechanism for up-dating them on new children's mental health support services or voluntary sector initiatives. There is no published 'local offer' for mental health and emotional support services as there now is for other services.
- 3.30 Opportunities to align local authority led 'early help' systems with CCG developed Connected Care for Children (paediatric health hubs), GP networks or villages and Primary Care Plus are at an early stage, although thinking has commenced.

#### Early Progress

A training package is already being developed by Improving Access to Psychological Therapies (IAPT) services explaining the signs and symptoms which non-clinical staff working with children and families should be aware of and lead them to encourage parents to seek mental health support. The provision of this training will also save money by increasing the number of adults who are referred, or who self refer with the encouragement of a professional, with lower level symptoms rather than allowing their situation to worsen, with more impacts on children which would then require greater intervention.

### **Recommendations**

The Task and Finish Group has come up with a series of recommendations which the Health and Wellbeing Board are asked to consider and endorse.

#### Recommendation 5

All services providing mental health care to adults should be contractually required to demonstrate that the patient has been:

- a) Asked about their parental responsibilities and
- b) The service/professional has considered/assessed the potential impact of their mental health problems may have had on the children they are responsible for.

This could also include extending the current CQUIN to include evidence of crisis planning and joint work to assist families.



Recommendation 6

Health and Wellbeing Boards should make improving local data and information sharing a priority for improvement.

An inter-agency Data and Information Sharing Protocol or Policy should be developed to cover all services for families in the Tri-borough area.

This should include the voluntary and community sector and health and social care, so there is clarity about what can be collected and shared to improve outcomes and 'joined up' services for families, whilst adhering to the law and maintaining appropriate confidentiality.

Recommendation 7

A *Think Family* or 'Whole Family' approach should be adopted and championed in adult mental health services, with a view to: improving 'holistic' assessment processes, improving multi-agency planning and interventions and encouraging 'joint work' with families with multiple problems.

This should also include looking at what can be learnt from the Family Recovery and Multi-Systemic Therapy (MST) models.

A training package currently being developed by colleagues in Children's Services seeks to share knowledge and build closer professional working relationships with staff in Adult mental health services. These training sessions should continue to be developed, supported by senior management and rolled out across the Tri-borough.

Recommendation 8

*Think Family* champions should be established, with the support of Health and Wellbeing Boards, CCGs and Public Health to develop a programme of engagement with ante and post-natal services (health visitors, midwifery and children's centres etc.) to:

- a) identify opportunities to improve 'holistic assessments and interventions e.g. work with fathers and extended family and community networks

- b) explore and agree appropriate implementation strategies with 'quick wins'  
e.g. revised assessment tools or awareness training

Recommendation 9

Health and Wellbeing Boards should encourage local Health, Social Care and Voluntary providers to collaborate in publishing a 'local offer' explaining what services are available to support mental health and emotional well-being. This should be hosted on CCG and local authority websites (for example People First) with appropriate links to local providers and where appropriate, national organisations offering support and advice.

Recommendation 10

Health and Wellbeing Boards should support the development of a Young Carers Strategy across Health, Adult and Children's Social Care and the Voluntary Sector to improve inter agency working maximise outcomes for young people.

## 4. Transition from Children's to Adult Mental Health Services

### National Context

- 4.1 More than 40,000 people in England aged under-18 have complex health needs caused by physical disabilities, special education needs, or life-limiting or life-threatening conditions.
- 4.2 Such young people often rely on a range of therapies and treatments, which can get complicated as they move from children's and adult services.
- 4.3 This move, known as transition, is a vulnerable time for young people and their families. This is because they may stop receiving services they have received since birth or at a young age, or they may lose continuity in care.
- 4.4 In June 2014 the Care Quality Commission (CQC) published, 'From the Pond to the Sea – Children's transition to adult health services', looking across the NHS at how effectively young people with complex health needs moved from children's to adult health services.<sup>42</sup>
- 4.5 The CQC report has four key messages which have informed this report to date and will continue to do so as partners work together on improving transition.
  - Young people and their families know what works. Clinical commissioning groups and local authorities must listen and learn from their experiences.
  - There is no excuse for not following existing guidelines which describe the steps to be taken to plan for transition from age 14.
  - GPs should be more involved, at an earlier stage, in planning for transition. A new enhanced service is being introduced in 2014/15 to ensure proactive and personalised care for patients, including young people, with complex health needs.
  - Adolescence and young adulthood should be recognised across the health service as an important developmental phase – with NHS England and Health Education England taking a leadership role. A named lead should co-ordinate care.

---

<sup>42</sup> Care Quality Commission, [From the Pond into the Sea](#), Children's Transition to Adult Health Services, June 2014

- 4.6 The National Institute for Clinical Excellence (NICE) has been tasked to build on the findings of the CQC report produce a guideline on the transition from children's to adult services.
- 4.7 The guideline, although not specific to young people's mental health care, will make recommendations that focus specifically on 'what works' for young people in transition.
- 4.8 The NICE Guidance on Transition will be published in February 2016 and Westminster City Council and CNWL have registered with NICE as contributing stakeholders.

#### Local context

- 4.9 When considering the issue of transition from Children's to Adults Mental Health Services, the Task and Finish Group has noted several positive findings in addition to the national developments explained above:
- West London Mental Health NHS Trust (WLMHT) and Central North West London NHS Foundation Trust (CNWL) both have transition protocols in place to guide staff practice.
  - Both mental health trusts are actively developing plans to modernize or 'transform' local services, and this includes endorsing 'co-production' principles to listen to and work with service users to improve the young person's journey.
  - The recently negotiated 2014-15 mental health contracts with WLMHT and CNWL both include a CQUIN<sup>43</sup> indicator for Safer Discharge/Transfer, focusing on discharge to GPs.
- 4.10 However, whilst both the national and local perspectives suggest an appetite for change and improvement to transition arrangements, there are a number of obstacles to tackle:
- Local data
  - Service Model and thresholds to care
  - Leadership

---

<sup>43</sup> CQUIN – Commissioning for Quality and Innovation

### Local data

- 4.11 Obtaining reliable data for CAMHS is problematic. At the national level for example, NHS England recently concluded in their review of in-patient provision that they simply did not know how many beds were required as the demand and performance data was so fragmented and unreliable. This is a direct consequence of mental health trusts collecting data on numerous different systems against a variety of changing commissioning and performance targets. Although steps have been taken locally with WLMHT and CNWL to report on common Key Performance Indicators (KPI's), performance data is still patchy.
- 4.12 Based on some helpful material provided by CNWL it is estimated that approximately 20 – 30 young people transition into Adult Mental Health Services each year in each of the three local authorities: Westminster; Kensington & Chelsea and Hammersmith & Fulham. Interestingly, WLMHT data seems to suggest lower numbers and CNWL's analysis also points to significant numbers of 16 – 18 year olds curtailing treatment, either at their own request (39) or by failing to attend (90). Conclusions can only be tentative: formal transition numbers seem small; fall out rates for 16 – 18 year olds appear to be significant.
- 4.13 Different thresholds between CAMHS and AMHS mean that sometimes CAMHS clinicians may discharge someone to GP and voluntary sector without referring to AMHS. For example, for young people with Attention Deficit Hyperactivity Disorder (ADHD), once they reach their 18<sup>th</sup> birthday there is no specialist Adult ADHD service

### Service Model and thresholds to care

- 4.14 An obvious question to address in considering 'transition' between children and adult mental health services is whether the answer is simply to remove the fence and move either to a 'life time' mental health service, or introduce a 16 to 25 service. The latter has received some recent attention as the Children & Family Act 2014 extends SEN and Disabilities responsibilities to age 25 and support for care leavers also now extends into young adulthood.<sup>44</sup>
- 4.15 The view of the Task and Finish Group is that, on the current numbers of 20 – 30 in each local authority or CCG, whole scale system change does not seem justified. It should be possible to get transition 'right' for these young people.

---

<sup>44</sup> Children and Families Act 2014, <http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted>

There is also the danger that changing the age range simply moves the transition 'cliff edge' elsewhere – to the age of 26 for example.

- 4.16 However, there are some larger considerations. Norman Lamb recently criticised CAMHS as 'not fit for purpose' and operating in the 'dark ages'. Kids Company have also recently attacked services for vulnerable teenagers and called for a systematic restructuring in favour of more flexible, young people drop in facilities with activities and diversions, as well as clinical staff.<sup>45</sup> These issues are now being looked at by the national CAMHS Taskforce which will report in the Spring of 2015. This taskforce is also looking at the support available to young people in crisis and at risk of admission to psychiatric hospital.
- 4.17 The recommendations of the national CAMHS Taskforce may well have a significant impact on the service model for mental health support for young people and implications for any changes to be made locally for transition planning and structures.

### Leadership

- 4.18 Strong leadership is key to achieving change and driving through improvements, often in the face of organisational difficulties and constraints. Leadership on transition between CAMHS and Adult Mental Health Services (AMHS) appears weak. AMHS has a vast number of complex issues to resolve, of which the young people seeking support post 18 is only one. Whilst this has been the position for some considerable time, the combination of local and national drivers for change should improve the opportunities for success.
- 4.19 The Task and Finish Group has not finished its work on transition and plans to continue to meet with a view to:
- Producing a clear analysis of 16 – 18 discharge and the implications for transition to AMHS and GP services and learning disabilities services;
  - Strengthening engagement with WLMHT on transition planning and action;
  - Exploring with WLMHT, CNWL and Clinical Commissioning Groups whether a 16 to 25 service has advantages for young people's mental health; and
  - Strengthening user input and co-production for transition.

---

<sup>45</sup> Adele Eastman, Enough is Enough, A report of child protection and mental health services for children and young people, June 2014.

- 4.20 The group has also identified some immediate recommendations to ensure that progression in clarifying the picture and improving transition locally so we are well placed to contribute and react to the emerging national debate.

## **Recommendations**

### *Recommendation 11*

Further discussion is required with both CNWL and WLMHT to clarify the position on numbers of young people in transition to clarify whether:

- A business case exists to develop a 16 to 25 service
- Whether young people are leaving CAMHS support prematurely at 16 plus
- Whether current transition data over or understates actual or potential movement between CAMHS and AMHS

This work is required to ensure that we have a comprehensive understanding of local discharge and transition activity, in preparation for the CAMHS Taskforce's conclusions and suggestions next year.

### *Recommendation 12*

With a successful outcome in mind, both WLMHT and CNWL should identify Transition Champions – one in CAMHS and one in AMHS, who together are challenged to deliver the improved transition planning envisaged by the CQC and the forthcoming NICE guidance.

## 5. Acknowledgements

This work undertaken by Children, Young People and Mental Health Task and Finish Group was only possible due to the time, freely given, by a number of individuals and organisations. Their expertise, professionalism and commitment were fundamental to the production of this report and the recommendations within.

Thanks go to:

Central London Clinical Commissioning Group

West London Clinical Commissioning Group

Hammersmith and Fulham Clinical Commissioning Group

Westminster City Council

Royal Borough of Kensington and Chelsea

London Borough of Hammersmith and Fulham

Central and North West London NHS Foundation Trust

West London Mental Health NHS Trust

Healthwatch

Cardinal Hume Centre

Spurgeons

Rethink

Westminster Academy

Local Safeguarding Children Board

Westminster IAPT

Imperial College Healthcare NHS Trust

Central London Community Healthcare NHS Trust