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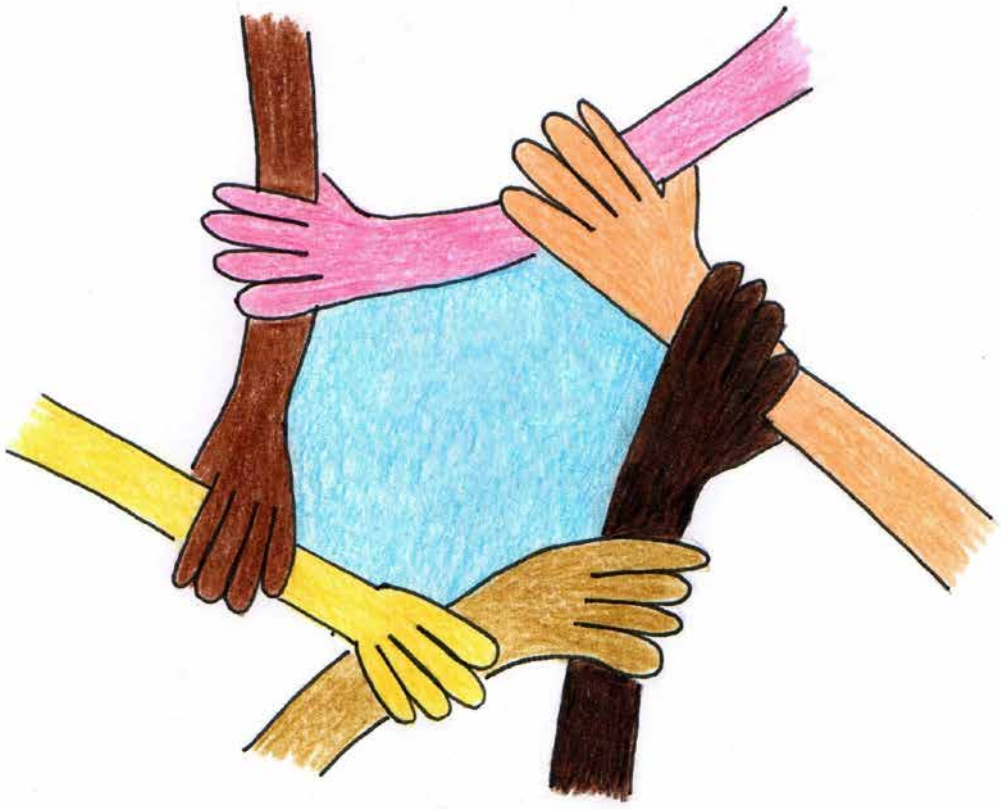

What good could look like in integrated psychological services for children, young people and their families

Preliminary guidance and examples of practice

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The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Telephone 0116 254 9568 Facsimile 0116 247 0787
E-mail mail@bps.org.uk Website www.bps.org.uk
Incorporated by Royal Charter Registered Charity No 229642

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Executive summary

Demand for psychological wellbeing services for children, young people and their families far outstrips capacity. Current services are over-stretched and fragmented, which leads to duplication, complex referral systems, long waiting times and young people falling through the net. There are also great inequalities that result in the most vulnerable people being more disadvantaged.

We need to rethink psychological services to nurture a cohort of children and young people who have good emotional health and wellbeing. Providing support for all those who need it requires system transformation focused on integration and prevention. We must reduce the level of need, and increase the capacity within the system.

Building resilience in children, families and communities

The limited resource available to support the psychological wellbeing of children and young people is concentrated in services that provide help when problems have already arisen, like CAMHS. Furthermore, within those services, resource is focused towards cases with more severe and complex psychological difficulties. Work has been done to improve the effectiveness and efficiency of services, but we must reduce demand by keeping children and young people healthy and tackling the risk factors that lead to mental health conditions.

Reducing demand can be best achieved by investing in primary prevention, for example interventions that address poverty and social inequality; health promotion, for example in schools or maternity settings; and early intervention. Community psychology can also be extremely beneficial. This approach encourages whole communities to shape their own environments to be psychologically safe, to build resilience and promote healthy lifestyles for children and young people. This community led approach is likely to lead to better and sustained psychological wellbeing.

Recognising, harnessing and increasing capacity

Effectively supporting children and young people's psychological health and wellbeing means changing our understanding of what is considered a 'mental health intervention' and how they should be delivered. Increased capacity in the system could be best achieved by investing in workforce development, changing the way the workforce works to be more flexible, and by actively engaging young people and families to help themselves and others.

Key to meeting demand is effective planning, developing and monitoring the psychological workforce to ensuring that there is a high standard of clinical leadership and sufficient staff with the right skills, including specialist therapy skills and those with the flexibly to create tailored interventions. We can also change ways of working by deploying psychological professionals in a way that enables the benefits of using psychological science to be disseminated as effectively and broadly as possible.

There is untapped potential to positively impact children and young people's psychological wellbeing among those in closest contact with them – their parents, schools, youth workers, and residential care staff. This systemic approach has the potential to create significant and sustainable change.

Integrated provision

Integration between services and sectors will be key in achieving these aims. Integration means a unified, holistic system where services are delivered by organisations working in partnership with shared vision and values, infrastructure and resources, thus removing duplication and revealing gaps. The benefit for the child or young person is an integrated care pathway that enables seamless access to different interventions.

This requires health professionals in physical health care settings to consider the whole child and also pay attention to the psychological wellbeing of their parents or carers. It requires mental health professionals to think about the physical health needs of the child, young person and family sitting in front of them, and to feel that it is part of their responsibility.

As well as integration across mental and physical health, true integration means better links between community and specialist services, between different agencies, across traditional age barriers and across the whole system. The key to building an integrated service is the development of collaborative relationships across the system.

Recommendations

As well as outlining the difficulties currently faced within psychological services for children, young people and their families, this briefing paper offers case studies of best practice and recommendations for improving service.

Chapter 2: Supply and demand

1. All involved with commissioning and providing psychological wellbeing services for children, young people and their families need to plan services and systems that nurture good emotional health not just those that help when problems arise.
2. At a local level, local authorities and CCG commissioners must have an accurate assessment of the

emotional health and wellbeing needs of children in their areas. It is important that joint, high quality, regular mental health needs assessments are conducted, that can feed into the Joint Strategic Needs Assessments and identify gaps.

Chapter 3: Building resilience: Promotion, prevention and early intervention

3. Robust assessments of how new policies impact upon the mental health of families, including children and young people, should be carried out at all levels from central governments down to local areas.
4. Policy, guidance and interventions to reduce the prevalence of known risk factors, need to be developed based on psychological evidence and implemented at a local level, in order to reduce the long-term impact of these problems on mental health. This will require care pathways across sectors and agencies to be developed at a local level in addition to national initiatives.
5. Commissioners should prioritise more community-based interventions for the prevention and early identification of trauma and emotional harm. This should include raising awareness of warning signs, ensuring safeguarding is in place and providing more resources to enable positive action when warning signs are identified. There should be more emphasis on supporting families and positive strategies to work alongside parents.
6. Leaders in health, education and community services should work together to develop mechanisms to support local communities and ensure local areas promote good mental health and challenge the stigma of mental health and challenging behaviour. This is a task for both local Health and Wellbeing Boards and the Boards managing sustainability and transformation plans across wider geographical areas
7. Commissioners should seek ways to build resilience into the system to strengthen communities, schools, and family support systems. They should use a community psychology approach and build psychological resilience into existing community settings, particularly primary care, community child health and in the education services, including early years.
8. All services for children and young people should be delivered in a range of culturally and age appropriate settings in their local communities, to improve access for young people and families. Commissioners, providers and people who use services need to work together to develop local plans to enable this to happen in a meaningful way.

Chapter 4: Recognising, harnessing and increasing capacity

9. Commissioners and providers should ensure they perform regular joined-up assessments of the skill mix of the existing workforce and plan joint workforce development to meet local need.
10. Commissioners and providers should shift from a one-to-one treatment model to a flexible model where psychological interventions are delivered indirectly through consultation, training and supervision of people in the systems around children and young people, in order to increase effectiveness and improve the sustainability of change.
11. Providers should involve young people who use services, parents, schools, youth workers, community health, voluntary and residential care staff, in the delivery of psychological interventions and provide training, consultation and supervision to develop their skills.

Chapter 5: Integration provision

12. Providers should ensure that all those working with children, young people and their families take a holistic view including their health, family, community context, school, social and economic context to ensure that all their needs and resilience factors are taken into consideration in care planning and to facilitate coordinated care.
13. Priority should be given to the commissioning of universal, preventative skills training on psychological wellbeing and mental health to front line staff who are working with children, young people and their families every day.
14. Commissioners and providers in local areas need to develop integrated structures by developing a shared language and understanding of health and wellbeing as well as build relationships.

About the authors

This preliminary guidance has been written by a team of clinical psychologists and commissioning managers with input from Young Minds activists and other psychologists within the British Psychological Society. It builds upon the publication *What Good Looks Like in Psychological services for Children, Young People and their Families (2016)*, which outlines the essential elements of a psychological approach to services and how this can be applied in a range of health, education and social care settings. It is free to download from: www.bps.org.uk/networks-and-communities/member-microsite/dcp-faculty-children-young-people-and-their-families.

- Julia Faulconbridge
- Fred Gravestock
- Amanda Laffan
- Duncan Law
- Sara O'Curry
- Kate Taylor
- Jenny Taylor
- Sally Zlotowitz

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  - Beatrice Morris
  - Irum Rela
  - Heather Watts-Brooke
  - Jasmine Wyeth

To get in touch with the authors please contact the DCP Child Lead
Email: dcpchildlead@bps.org.uk

Foreword

We cannot address the needs of children, young people and their families by providing discrete pockets of care, however good they are. The existing fragmentation of services leads to:

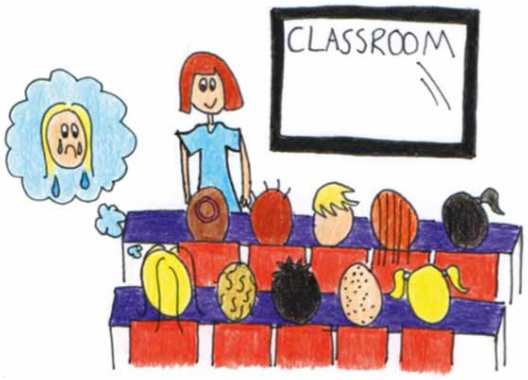
- duplication of provision;
- complex referral systems;
- long waits for treatment;
- people falling through the net; or
- inequalities according to presentation, postcode and ability to access services, with many of the most vulnerable groups being more disadvantaged.

This means that many children, young people and their families become more distressed and relationships break down further with long-term consequences for their future mental and physical wellbeing, *and* the cost of helping and caring for them goes up. In addition, it leads to frustration and demoralisation in the existing workforce, who cannot meet the increasing demands on their services and at the same time feel underutilised in service models which limit their ability to do the jobs they were trained to do.

In this paper we shift from *today* and making the existing models work, to *tomorrow* and thinking more broadly about the challenges in terms of capacity, demand and workforce development. We propose integrated models of psychologically informed care to overcome these challenges. This will demand a radical shift in thinking, with a focus on prevention, and, potentially, a change in the metrics that commissioners and providers use to measure performance.

This paper is the prelude to the next stage of developing a more comprehensive vision of integrated psychological care and how it can be achieved, and we welcome you to join us if you want to help by contacting the authors via email: **DCPChildlead@bps.org.uk**

In the meantime, please don't wait to start making changes; you can start implementing these ideas today.



Chapter 1: Introduction

This preliminary guidance on how to achieve integrated psychological services has been developed by the British Psychological Society's Faculty for Children, Young People and their Families, working with children's and mental health commissioning managers. It is a prelude to a comprehensive publication that we hope will be published in late Autumn 2017.

It builds upon the publication 'What good looks like in psychological services for children, young people and their families' published in the *Child and Family Clinical Psychology Review, No 3 Summer 2015* that outlines all the essential elements of a psychological approach in services together with chapters showing how these can be applied in a range of health, education and social care settings. It is free to download from: http://www.bps.org.uk/networks-and-communities/member-microsite/dcp-faculty-children-young-people-and-their-families. http://www.bps.org.uk/networks-and-communities/member-microsite/dcp-faculty-children-young-people-and-their-families.

We are describing a system level of commissioning and model of care. The main audiences for this paper are policy makers, community leaders, training institutions, commissioning managers (including those in local authorities, CCGs, NHSE, social care, education, police forces and criminal justice) service managers and providers whose work is related to the social, emotional, mental health and wellbeing of children, young people and families. This will include professionals and others from universal services, third sector services, schools and colleges, policing and the criminal justice system, health services, general youth and mental health services.

We hope this paper will be a valuable resource for community development and policy makers, as well as local commissioners and service providers to support their thinking and planning in system transformation and service redesign following the publication of important policies and recent reports.[1] As there is no 'one-size-fits-all', we aim to provide preliminary guidance on how to tailor system planning and redesign to fit local situations, and suggest some practical ideas, case studies, and tools that can be used by a broad range of organisations and professionals.

Transformation and redesign are essential processes for all involved in delivering health and wellbeing services and we advocate for more resources being made available to enable this process to reach its potential in improving the psychological wellbeing of our children and young people. However, the prevailing economic environment has not only reduced the funds available to Local Authorities and NHS commissioning agencies, but an anticipated funding gap of £30 billion, identified in the Five Year Forward View, can only be closed through transformational systemic changes. Currently senior leaders in the Health and Care system are developing their Sustainability and Transformational Plans (STP) that use new approaches to ensure health and social care are planned by place rather than around individual organisations. This will inform how local services work together to improve the quality of care, their population's health and wellbeing and how finances available to local authorities, voluntary sector organisations, and CCGs can be best deployed.

1 This includes: *Future in mind* (DoH, 2015); *Five year forward view* (NHS, 2014); *Five year forward view for mental health* (NHS, 2016); *Delivering with, delivering well* (NHS England, 2014) *Transforming care partnerships* (NHS, 2015); *THRIVE: Model for CAMHS* (Wolpert et al,2014); *Lightening review: Access to children and adolescent mental health services* (Children's Commissioner, 2016); *CAMHS: A time to transform* (iMPOWER, 2015); and the NSPCC 'It's time' campaign (2016).

What do we mean by 'system transformation'? – Moving towards prevention

Over recent years much of the limited resource that is available to support the psychological wellbeing of our children and young people has become concentrated in the services that try to help when problems have arisen – the Child and Adolescent Mental Health Services (CAMHS). Even within those services, the resources have been largely directed towards the more severe and complex difficulties and away from provision (which existed in the past) that focused on early intervention and prevention in the community. The impact of this has been higher levels of distress and difficulty within the population who do not receive any meaningful input until their difficulties are more severe and entrenched, and thus harder to treat.

We are advocating for a whole system approach that considers the ways in which our society can support families and promote the healthy psychological development of our children and young people, and develops service models to maximise this. Finding helpful terminology to describe this model is problematic. Within this paper we are going to use the overarching term of 'Psychological Health and Wellbeing Services' (PHWBS) to describe the whole system. Traditional CAMH services sit within this system and are part of the solution for those children and young people who develop the more severe difficulties but most of the focus of this paper will be on how we can work to promote psychological wellbeing and, if necessary, intervene early to reduce the numbers needing that type of help.

What do we mean by 'integration'?

The focus of this paper is 'integration', a process identified by governments as a key initiative in delivering efficiencies as well as improving patient outcomes (KPMG, 2013).

By integration we mean:

- a highly unified, holistic system where services link;
- removing duplication and overlap;
- delivered by organisations sharing a common vision and values; and
- working in close partnership, sharing infrastructure and resources.

This requires joint working, integrated care pathways, and consultation between different sectors so that access to specialist advice and treatment is seamless for the child or young person and their family. In particular, we will advocate for integration between physical health, mental health, social care, local authority and community services, education, the third sector, youth, police, and criminal justice services.

A holistic focus that supports children, young people and families who use services to be healthy, independent and resilient is preferable to a purely clinical focus on managing or treating symptoms. Effective communication based on good working relationships between members of the multidisciplinary and multi-agency teams is essential. Shared electronic health records can support the process. While there is no single best practice model for integration, care co-ordination programmes should be localised so that they most closely address the priorities of specific communities.

Leadership and commitment, from commissioners and providers alike, is vital to establish a shared vision and overcome silo-based working. The consensus is that integrated health and social care commissioning, combined with integrated service delivery, is the only way that long-term economic sustainability, service stability, and improved outcomes can be achieved. (See: 'Options for integrated commissioning: Beyond Barker'. Kings Fund June 2015, http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf)

Integration within services for children and young people also requires co-production in designing and evaluating services provided. For example, following consultation in a number of areas, mental health commissioning managers generally find that children and young people:

- don't want to tell their story more than once
- want care close to home;
- don't want to go miles away from home to receive inpatient care;
- want to go somewhere fairly anonymous that would not attract unwelcome notice from their peers;
- want easy access to advice, guidance and support;
- want help and support at school, including peer support; and
- want a community based 'place to go' that is safe, supportive and strengthening.

A further note on language

Given the wide range of professional groups for whom this paper will be relevant, it is worth noting that there are likely to be some differences in the use of language, terminology and concepts. We hope that this paper will be useful, in fact, in providing clarity and a shared understanding over definitions and the concepts discussed.

We are aware that there is a lot of debate around how best to describe some of the issues discussed in this paper. The use of diagnostic and medical language is often considered problematic in psychological services, and we have tried to use non-medical language in as much of this publication as possible. There are some instances, however, when we have used medical language (such as when discussing other published

work which has used a medical framework). Using these terms does not mean that we support medical explanations of mental health difficulties in children and young people. For more detailed discussions of these issues please see:

- DCP Position Statement *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift* (May 2013); and
- *DCP guidelines on language in relation to functional psychiatric diagnosis* (March 2015);

Both available from: http://www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology/publications

A note on the examples and case studies used in this paper

The examples used are those known to the authors and are provided in the spirit of sharing ideas and potential contacts. Where there have been service evaluations we have referenced these; however we are not saying that we have quality assured these services or that they are necessarily the best examples available. There are many more positive innovations across all sectors and we hope that it will be possible to provide a more comprehensive list, in the full volume.

Chapter 2: Supply and demand

What is the problem?

We need to rethink psychological services for children, young people, and their families if we, as a society, are committed to nurturing a cohort of children and young people who have good emotional health and wellbeing, and if we are serious about providing good psychological services and support for those who need it.

All children and young people's Psychological Health and Wellbeing Services (PHWBS) are chronically underfunded and under resourced, and are struggling to cope with the increasing demand on the system. Demand for traditional outpatient CAMHS is up four per cent and inpatient demand is up 11 per cent (NHS Benchmarking), including substantial increases in self-harm, ADHD diagnoses, and eating disorders. Even so we do not know the full extent of the potential demand for services, as national prevalence data is so out of date. The anecdotal evidence of increased demand from the lived experience of front-line staff working in services, and from young people wanting to access services, is becoming increasingly documented

> 'Young people and their parents have described "battles" to get access to CAMHS services, with only the most severely affected young people getting appointments; they also described the devastating impact that long waits for treatment can have. Even amongst those providers implementing quality and efficiency improvement programmes there was concern that improvements were being stalled or even reversed because of increasing demand and reduced funding.' http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34203.htm

Issues for looked after children can be found in the Education Select Committee report: http://www.parliament.uk/business/committees/committees-a-z/commons-select/education-committee/news-parliament-2015/mental-health-children-report-published-15-16/

Other information is available at https://psychagainstausterity.wordpress.com/everyday-austerity/ and https://www.theguardian.com/healthcare-network/2016/feb/17/were-not-surprised-half-our-psychologist-colleagues-are-depressed).

The crisis in Tier 4 beds and the scandal of children with psychological problems being held in police cells as there were no appropriate places of care prompted a Health Select Committee Enquiry into Children and Adolescents' Mental Health and CAMHS services. The Select Committee Enquiry reached the conclusion that there were some 'serious and deeply ingrained problems' (House of Commons, 2014, p.10) across the whole system. The government minister responsible for services described them as 'dysfunctional' (p.75). In turn, the coalition government set up the Children and Young People's Mental Health and Wellbeing Taskforce to look at how services should be organised, commissioned and provided to improve their impact, accessibility and reach. This led to the publication of *Future in mind* (Department of Health, 2015) which echoed these issues and made proposals around how to begin to resolve them – but the fundamental issue remains that the current demand for children and young people's PHWBS far outstrips the capacity for the system to deliver good quality services for children and young people. There is also significant variation between different areas, socioeconomic and cultural groups.

Although the data is not recent, estimates suggest around three quarters of children and young people with serious psychological problems may make contact with services due to a range of barriers including: lack of awareness and recognition of such problems in children and young people, stigma and the lack of resources.

This is not entirely a resource issue – it is compounded by the continuing silos in service commissioning and delivery:

- the separation of psychological health services (NHS) from social care services (CSC);
- the division within the NHS between mental and physical health services; and
- the lack of integration between adult mental health and the children and young people's PHWBS, at both ends: perinatal mental health and the transitions cliff edge at 18 (or 25).

What we need, and what children and young people deserve, is change.

Every report on the mental health and wellbeing of children and young people, from the National Service framework for Mental Health (1999) to CentreForum (2016), states that things need to change, and all point to the need for an integrated whole system approach that:

- involves health, social care, education, statutory and voluntary, and third sectors;
- is community and asset focused;
- is children and young people centred, driven by collaborative practice and shared decision making;
- offers input that is evidence-based, goal focused and outcomes oriented; and
- involves more co-production of services or as a minimum more user participation.

It is easy to list what is needed but hard to engender the change, so **– what are the solutions?**

Recognising the levels of 'demand' and 'need'

National data is not sufficiently robust because it is at least 12 years out of date . We cannot therefore tell exactly what the gap is between demand and capacity in the system – but all indicators suggest that the capacity does not currently meet the need by some margin. We need to be careful when considering terms such as 'demand' on the system as this can take two forms:

- First is the 'visible demand' – the numbers of children and young people who are presenting to services. For many reasons this is not a good predicator of 'actual demand' for, as we discussed above, the majority (76 per cent) of children and young people who need help and support do not make contact with existing mental health services (Green et al., 2004), and that it takes on average 10 years for a child who develops a mental health issue to get the help they need (https://www.centreformentalhealth.org.uk/news/children-wait-ten-years-for-mental-health-support-says-review-from-centre-for-mental-health).
- This amounts to a very large 'hidden' demand on services (the word 'hidden' is used advisedly here as these children are very much aware of the significant distress they suffer). A great deal of this distress is hidden from the people around the child or young person. As an example, the quiet child who sits at the back of the class with few friends may not be seen as a problem in a class where there are children whose more actively problematic behaviours demand attention. The demand is also 'hidden' from the service providers and commissioners who are often not aware of this level of demand, as the children are not being referred to services that could help because of issues like stigma, lack of recognition of problems and lack of knowledge about who can help.

A much better predictor of demand is the prevalence of mental health difficulties in the community. Our ambition should be to provide children and young people's PHWBS that can cater for all who need it. This is somehow seen as a radical ambition for mental health, in a way that is not contested at all in physical health services for children. We may not be able to help all children with serious physical health problems, but if we had a system that was known to be failing the majority of children with a problem such as asthma or childhood diabetes, there would rightly be an outcry. This phenomenon reflects the institutional stigma and misunderstanding around mental health issues. As a society, we still struggle to see psychological and mental health problems as a 'real' problem. There is still a narrative of blame and a discourse of 'mad, bad or lazy'. This leads children who are disruptive in class being punished to try to make them behave, rather than the background to their difficulties being assessed leading to changing their circumstances where necessary and possible, and helping them to self-regulate and cope when it is not possible. Similarly, families can be labelled as 'troubled'; which can emphasise the family members individuals deficits, underplaying the impact of situational or contextual factors on family psychological wellbeing.

So what can we do?

At a local level, local authorities and CCG commissioners will need to know what the needs are in their areas. It is important that joint, high quality, regular needs assessments are conducted, which can feed into the Joint Strategic Needs Assessments.

How we can move to more of a balance between the capacity and demand?

There are two solutions working from either end of the system:

1. **Reduce the level of need in society**
   By increasing mental health and psychological wellbeing in the population.
2. **Increase the capacity within the system**
   This has been the focus of much of health policy over recent years: to improve the efficiency and effectiveness of services. This has been the role of CAPA and CYP IAPT along with other initiatives,
   - CAPA (the Choice And Partnership Approach) is a transformation approach with emphasis on using goals and collaborative practice to ensure limited resources are used effectively in services.
   - CYP IAPT is the CAMHS transformation programme from NHS England and Health Education England designed to support the implementation of Future in Mind. It builds on the ideas in CAPA and promotes better service user participation and evidence based practice alongside the use of feedback tools and outcome measures to demonstrate impact of interventions. The training to help implement these principles is backed up by the core principle that the starting point for any interventions should be a sound biopsychosocial assessment and evidence-informed, collaborative formulation.

   Both CAPA and CYP IAPT build capacity in ensuring the best use of resources by doing what is most likely to be effective. More recently still CYP IAPT has expanded to recruit new staff into the workforce to train in evidence-based practice through its Psychological Wellbeing Practitioner (PWP) roles.

Stop mopping and turn off the taps

There is a well-used analogy for health systems that are under pressure due to high demand as being like 'overflowing sinks' (Burkitt & Trowell, 1981). Ill health is like the water cascading out of the sink onto the floor. Much of the emphasis on improving children and young people's mental health services in recent years has focused on improvements in services, either making them more effective (CYP IAPT) or more efficient (CAPA) – 'mopping'. Both are, in the main, excellent models but neither focus on reducing the demand into services or in the general population, the more effective solutions come when the system works at stopping the problems starting in the first place: 'turning off the taps' or, at very least, turning them down.

Turning off the taps means reducing the demand into services and keeping children and young people healthy by reducing the risk factors that lead to mental ill health. This means encouraging whole communities to lead and shape their environments to be more psychologically safe and build resilience and to promote and support healthy lifestyles for children and young people that are likely to lead to better and sustained psychological wellbeing

We argue for three main approaches, to reducing the need for services are:

1. Primary prevention
2. Community Psychology
3. Health promotion and early intervention

These are discussed in more detail in the following Chapter.

Recommendations

1. All involved with commissioning and providing psychological wellbeing services for children, young people and their families need to plan services and systems that nurture good emotional health not just those that help when problems arise
2. At a local level, local authorities and CCG commissioners must have an accurate assessment of the emotional health and wellbeing needs of children in their areas. It is important that joint, high quality, regular mental health needs assessments are conducted, that can feed into the Joint Strategic Needs Assessments and identify gaps.

Chapter 3: Building resilience: Health promotion, prevention and early intervention

The value of this approach is two-fold. By improving the psychological wellbeing of our families and young people we are making their lives better and helping their communities function more effectively. It is also the most effective means of reducing the high levels of demand on specialist services.

We need to address issues across systems and at different levels of these systems. In prevention, and particularly primary prevention, it is essential to take a wide view of the system.

Primary prevention – addressing risk factors

Prevention strategies are primarily focused on reducing the risk factors that we know can have a detrimental impact on psychological development. By understanding the factors likely to lead to psychological harm, public health strategies can be applied to tackle these causes of psychological distress and ill-health in children and young people. The UCL Institute of Health Equity and Michael Marmot focus on national and international policies that would improve the health of children and young people, including mental health. https://www.instituteofhealthequity.org

There are many factors that may lead to the development of mental health difficulties in children and young people. The World Health Organisation categorises these into three broad areas:

- social circumstances: like loneliness, bereavement and neglect;
- environmental factors: like injustice, discrimination and exposure to trauma; or
- individual factors: like cognitive/emotional immaturity and medical illness.

Poverty and social inequality

In order to tackle many of these issues there is a need to work at the highest levels of influence and policy and to take a cross party, cross governmental, approach – for example, in terms of environmental factors there is substantial evidence that poverty is a major risk factor for developing mental health problems in childhood.

According to the Child Poverty Action Group (CPAG), 28 per cent of children were living in poverty in 2014–5 and there has been an increase of 0.5 million in the figures since 2010 www.cpag.org.uk/child-poverty-facts-and-figures

We know that social and economic factors have a significant impact on mental health, and the Government has started to acknowledge this, to some extent, with the Family Impact Assessment on Government Policy announced in 2014, (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368894/family-test-guidance.pdf). If this proves to be effective, this is a welcome step. However, for this policy to have a sustainable impact, there needs to be a robust assessment of how new policy impacts upon the mental health of the family, not least on children and young people. A robust mental health impact assessment of government policy could start to have a real systemic impact on awareness of mental health and the environmental impact of mental health within society. Such an impact assessment could also begin to have a powerful impact on the future mental health of children and young people across the lifespan.

An example of a mental health and wellbeing impact assessment tool that can be used in local areas can be

found here http://www.maudsleyinternational.com/our-services/mental-well-being-impact-assessment.aspx and http://www.tavinstitute.org/news/mental-well-being-impact-assessment/

Tackling poverty can be seen as a major primary prevention strategy, but clearly cannot be the responsibility of local services to solve. Prevention at this level needs to be coherent across government, certainly at a national level, but also at a European, and ideally global, level. It can be done. CPAG figures show that child poverty reduced dramatically between 1998/9 to 2011/12 when 800,000 children were lifted out of poverty.

Examples

1. The End Child Poverty campaign is a coalition of over 100 organisations that exists to hold the Government, and all main political parties, to account for their commitment to eradicate child poverty in the UK by 2020. It offers practical suggestions to support its arguments that:
   - every child should live in a family that is able to afford the basic essentials;
   - every child's need for decent living standards must be at the heart of any parental employment strategy;
   - every child should be able to make the most of their learning and development;
   - every child should have a secure and warm home; and
   - every child should have enough good food to keep them healthy and help them grow.

   To which we would add that every child needs to be able to access the social world around them and have the opportunities to make relationships with their peers in social and recreational activities
2. The Joseph Rowntree Foundation is developing a comprehensive, evidence-based strategy to reduce poverty for all age groups and each UK nation. It has commissioned 33 evidence and policy reviews to better understand the existing body of knowledge on issues influencing poverty. These reviews examine the links between poverty and a specific policy area, and look for evidence about effective solutions in policy and practice. As part of this strategy, it has launched the Hartlepool Action Lab to bring together community members, businesses, community groups and the public sector to work together on issues such as child poverty. (Ref) https://www.jrf.org.uk/press/jrf-launches-new-hartlepool-action-lab-help-tackle-poverty
3. A 'Mental Wellbeing Impact Assessment' has been developed to provide a toolkit which can support anyone to assess the impact of new policies or proposals on mental wellbeing of target groups in advance of implementation: http://www.apho.org.uk/resource/view.aspx?RID=70494

Trauma and maltreatment

Childhood maltreatment and trauma is now known to be one of the biggest risk factors for children and young people developing mental health difficulties Maltreatment can take a number of different forms, including neglect, emotional abuse, physical abuse and sexual abuse. The harm caused by child maltreatment can have wide ranging effects on the child or young person's emotional, psychological, behavioural, educational and interpersonal functioning. Recent evidence is pointing to child maltreatment as perhaps the biggest risk factor in the development of short and long-term psychological problems (Patalay et al., 2015, http://www.ncbi.nlm.nih.gov/pubmed/25906794). Child trauma has a negative effect on the quality of the relationships a child is able to make with people close to them, both now and in the future with their own children – thus making trauma an intergenerational issue. Reducing trauma and maltreatment may be one of the biggest primary prevention strategies available to us.

- **Adverse Childhood Events (ACEs):** There is a growing body of research in this field that is providing an evidence base demonstrating that childhood experiences, both positive and negative, have a very significant impact on lifelong health and opportunity. Early experiences are an important public health issue. The negative childhood experiences are being researched under the umbrella term of Adverse Childhood Experiences (ACEs). Examples are: multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence.

  Adverse Childhood Experiences have been linked to:
  - risky health behaviours;
  - mental health difficulties;
  - chronic health conditions;
  - low life potential; and
  - early death.

As the number of ACEs increases, so does the risk for these outcomes. An excellent summary of the research and what preventative strategies can be developed can be found on the American Centers for Disease Control and Prevention website: https://www.cdc.gov/violenceprevention/acestudy/

Changes to how trauma and maltreatment are identified and prevented are needed urgently. People working with CYP across all sectors need to be able to

recognise warning signs and ensure safeguarding is in place. This requires ongoing training and support both face to face and through e-leaning options such as Mind Ed. https://www.minded.org.uk/

However, it is also essential that more resources are made available to enable positive action when warning signs are identified, with much more emphasis on supporting families rather than on the current practice of crisis management and removing children. Positive strategies to work alongside parents who can be predicted to have a higher likelihood of difficulties should be developed.

Whilst intergovernmental and cross-agency strategies are of great importance, not least in terms of priorities and making resources available, local initiatives can make a very real difference.

Examples

1. Pause's 'Preventing Repeat Removals' project received £4.3m of funding for their work to break the cycle of children being removed into care, often related to complex trans-generational patterns of neglect or abuse. Pause's aim is to break these cycles by intervening at a point when women have no children in their care, working intensely with them through a systemic, integrated model. Pause is currently delivering across seven areas in England working intensively with up to 20 women at each area over an 18 month period and are on course to be working with 160 women by the end of July 2016.

   Evidence has so far demonstrated a number of positive outcomes as a result of the intense therapeutic, practical and behavioural support, provided through a one-to-one practitioner relationship. Pause is reaching their target of working with 160 women who have had 568 children removed between them, across the current seven Pause practices, in London and in Yorkshire. As well as a reduction in pregnancies and removals, many women are now in safe accommodation, receiving help and support from domestic violence or mental health services, and engaged in training and education, as well as volunteering and employment. Some women have engaged in positive and consistent contact with their children, with emerging evidence of a positive impact on children. www.pause.org.uk
2. The Family Nurse Partnership (FNP) is a voluntary home visiting programme for first time mothers who are aged 19 years or under. The scheme runs throughout England and is underpinned by a robust evidence base. Specially trained family nurses visit young mothers throughout their pregnancies until their child is two years of age. They work together to help mothers have a healthy pregnancy, improve their child's health and development, and plan their own futures and achieve their aspirations. Nurses work with some of the most disadvantaged children and families in society, using a psycho-educational approach and focus on positive behaviour change as part of their preventative programme. The provision of psychological supervision for the nurses is integral to the programme. The programme aims to improve social mobility and break the cycle of intergenerational disadvantage, as well as to foster positive relationships between mother and baby, see fnp.nhs.uk
3. The Children and Parents Service (CAPS) is a city-wide early intervention service in Manchester that aims to promote psychological wellbeing and resilience within pre-school children by providing support to families. It is a multi-agency partnership between CAMHS, Early Years and Play (Manchester City Council) and the Family Action (voluntary sector organisation). CAPS works to support children to become ready for school, improve school attendance and attainment, improve and prevent behaviour difficulties, improve parental mental health, and to empower parents (in terms of reduced service use and increased employment). By providing early intervention, CAPS aims to be cost-effective and reduce the need for later, more expensive services. CAPS has demonstrated significant improvements in child behaviour problems and parental mental health; and has improved the aspirations of both the parents and children with whom they have worked.
4. The National Implementation Service (NIS) is a UK based service that oversees a number of evidence-based interventions that are delivered nationwide to children, young people and their caregivers where there is history of trauma and maltreatment. The interventions that it delivers specifically in this area include AdOpt, Treatment and Foster Care Oregon – UK (TFCO-UK) and Multisystemic Therapy – Child Abuse and Neglect (MST-CAN), For further information, see http://www.evidencebasedinterventions.org.uk/about/national-implementation-service

Social isolation and bullying

The importance of having friends and feeling accepted by other children or young people of the same age cannot be overstated. Children who feel rejected by their peers can experience a range of difficulties as well as feeling isolated and lonely. Social isolation also means that a young person will have fewer resources to help them deal with any difficulties in their lives, as they will not have people to turn to for advice or support.

There has been considerable research into this field and a significant amount of guidance is available from

Government and the voluntary sector for both the general population and specific groups. What is needed is for this to be implemented at local levels, particularly in schools and youth services.

There is an important role for schools particularly to identify and intervene with bullying and social isolation. Provision of social opportunities through play schemes and youth services can be crucial to developing a child's social world outside of school and must not be restricted to those children whose parents can pay. Moreover, sporting opportunities are often only available to those who are 'good' at the sport: they need to become more inclusive.

The issues around social isolation and bullying need to be tackled across agencies through joined up commissioning that enables the development of a local strategy. There are a number of approaches that can be taken. Below are some Examples

1. **Reducing social isolation:** The Public Health England and UCL Institute of Health Equity have published a Practice Resource 'Reducing social isolation across the life course' (September 2015) which covers children and young people and parents, and contains much valuable information on incidence and patterns together with ideas for cost-effective interventions: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf
2. **Preventing bullying**: There has been much work developing both anti-bullying strategies for schools and ways to support children and families who experience it. The rising importance of social media in the lives of children and young people with the impact of cyber bullying has also been recognised: Useful resources can be found at a government level: https://www.gov.uk/government/publications/preventing-and-tackling- bullying#history and within the voluntary sector:
   https://www.kidscape.org.uk
   http://www.anti-bullyingalliance.org.uk
   http://www.youngminds.org.uk/about
3. **Developing a focus on the groups who are more likely to have such problems:** There are a number of groups who are more likely to experience both isolation and bullying. Identification of these groups can enable preventative strategies to be put in place. These groups include Lesbian, Gay, Bisexual, Transgender and Asexual (LGBTA) young people, ethnic minorities, refugees, and those who are obese, or have long-term conditions or disabilities.

Young carers

An example of what can be done is the work being undertaken to support young carers.

There are an estimated 400,000 young carers aged 0–24 according to the 2011 census. Increasingly a caring role is being taken by children as young as five to 10 years old. Without support, young carers' educational achievement and development can be significantly affected, with little time to do homework and coursework, or socialise with friends. There can also be a significant impact on the young person's mental health and wellbeing.

Early identification of the children and young people in caring roles is essential and should be facilitated by the changes to the Children and Families Bill which entitles young carers to request a statutory assessment of their caring role from April 2015. However, many young carers remain 'hidden' and all adults working with children and young people need to be aware of the issues and how help can be obtained.

There are a number of charities that are working to highlight the needs of young carers and to develop provision to help prevent or ameliorate the adverse effects on their development. These include: Action for Children, Carers Trust, Barnardos and The Childrens Society. Local authorities and local voluntary sector initiatives are also key to this.

Example:

1. Family Action runs a number of Young Carers Support Services across England, taking a whole family approach and working collaboratively with parents, children and young people, the wider community, schools and statutory services. The services differ according to local need and provision but include direct work with young people and their parents providing:
   a. parenting support to strengthen parenting skills, capacity and confidence in order to reduce the caring role and the impact for the child or young person;
   b. help to access other services in the community.
   c. advocacy on behalf of the young carer and their family, e.g. with housing and social care services;
   d. information, e.g. about a parent's illness or disability;
   e. support with any issues at school;
   f. workshops run in partnership with further education organisations focusing on career opportunities;
   g. a listening ear and arranging counselling if needed;
   h. group work, regular clubs or individual work depending on what each child or young person needs, e.g. chill out groups and theatre groups;
   i. activities with other young carers, or children and young people in the community, to give them a break and have fun, e.g. canoeing, pond-dipping and cinema visits;

j. chances to have new experiences, learn new skills and be involved in how the service is run, e.g. trips during Easter and summer holidays; and including whole family activities to strengthen family relationships;
k. structured time limited child or young people and family sessions;
l. programmes designed to develop self-esteem and reduce the impact of the caring role on emotional wellbeing; or
m. peer mentoring.

Bereavement and loss

The death of a loved one is an experience that many children and young people are likely to face; this can include pets as well as people. Feelings of loss and grief are, of course, completely natural reactions to losing someone, although everyone responds differently in such times and there is no 'right way' to respond to someone dying. In the majority of cases, the feelings of sadness and grief tend to ease over time and with the support of friends and family. However, for some children and young people these feelings can feel overwhelming for a lengthy period of time, leading to significant difficulties in them moving on with their lives. In particular, the death of a parent or sibling has been shown to lead to mental health difficulties in around 25 per cent of bereaved children, who experience more 'internalising problems' (such as major depressive episodes; Stikkelbroek, Bodden, Reitz, Vollebergh, & van Baar, 2015).

Very often support for children and families is provided by the voluntary sector and there is no consistency in terms of what, if anything is provided. Joint needs assessments between local authorities, CCGs and NHS Trusts are needed to determine both what is available and the quality of what is available, and to consider how these provisions can be tied in to care pathways for both general bereavement support and more specialist help for those who need it.

There is a need for training and support for teachers and others in the community who come across bereaved children in their work so that they both understand what normal distress is and what is likely to help, and also recognise when more specialist help may be needed. The provision of support to parents though psycho-educational materials, support groups, and befriending services are all recommended. Local authorities, schools and academy chains should consider using some of their training budgets to facilitate this. In addition, developing a collaborative approach between education, voluntary bodies, health and social care can support joint training initiatives and help to build good care pathways will support all agencies in developing good quality care for bereaved children

Examples

1. Cruse Bereavement Care is a national charity offering support, advice and information to anyone facing bereavement, including children and young people. They have a dedicated website for children and young people, Hope Again, which provides a safe place for young people who are facing grief to share their stories with others. Young people can be offered weekly counselling sessions with trained volunteers, in addition to telephone and email support and group sessions. Cruse also offers awareness-raising training days for teachers, parents, carers, social workers, and other professionals working with bereaved children and young people.
2. Child Bereavement UK supports families and educates professionals when a baby or child of any age dies or is dying, or when a child is facing bereavement. In addition to telephone and email support, the charity works nationwide providing face-to-face support sessions for individuals, couples and families, and a range of training courses for professionals and schools. They run Children and Young People's groups (CHYPS) for children to attend with an adult, and host a Young People's Advisory Group (YPAG) for bereaved young people up to the age of 25 years.
3. Winston's Wish offers practical support and guidance to bereaved children, their families and professionals. They have a dedicated website for young people, which provides support, advice, and a place to share with others. They also provide a telephone helpline, email support, face-to-face sessions (including individual work, group work and age-specific groups and events), and training and publications for professionals and schools. Winston's Wish work alongside a team of Young Ambassadors who have experienced bereavements in their own lives.
4. Macmillan Cancer Support provides practical, medical and financial support for those diagnosed with cancer, and pushes for better cancer care. They provide advice regarding how to talk to children and young people about cancer, information about cancers that can affect children, and a range of resources specifically for children and young people.
5. The Loss Foundation encourages social support through its work in London and Oxford http://thelossfoundation.org

Community psychology

The most effective next step would be to have system wide resilience building – to help communities (including schools) and families to build support systems that can begin to build resilience at a wider

level. There is good evidence that there are communities that experience higher than average levels of mental health difficulties (and, not by coincidence, these are also the communities that have the highest incidences of physical health problems).

Thus effective interventions, at a whole community level, that target these poor health 'hot-spots' have to be the way forward. These interventions should be evidence-based, where evidence is available, and should contribute to research and building better practice-based evidence where the evidence is lacking.

Often neglected in clinical psychology, and in other mental health training professions and approaches is the field of community psychology. Community psychology is not just 'psychology in the community' (like therapy based in GP practices) but takes a wider view of mental health and wellbeing. The focus is not on changing individuals, although this does occur, but on transforming social conditions and contexts to enable better mental health and wellbeing. For example, the focus is on changing 'unhealthy' social forces such as inequality, discrimination, stigmatisation and exclusion. In other words, social (in)justice issues are placed in the foreground of explanations of the distress of individuals from marginalised communities or who have more unusual experiences (Orford, 2008).

Consequently interventions aim to actively raise our consciousness, or awareness, (Freire, 1972) of these links between social justice and individual and group distress and generate community-led action for social change, rather than just 'one to one' therapy (see Kagan, Burton, Duckett, Lawthom & Siddiquee, 2012). Community psychologists take a facilitatory, non-expert role within such interventions, appreciating that they may have a different, set of lived experiences than the community members they hope to serve. By mapping and harnessing the resources and strengths in a community by equally valuing other ways of knowing (e.g. the importance of lived experience) and by taking a partnership approach with community groups, agencies and other professionals, the impact is capacity and social capital building (Kagan et al., 20122012; Nelson & Prilleletnsky, 2010). Wider social transformational effects can sustain change and prevent further distress (Orford, 2008).

Many tools and models exist to support the mapping and exploring of resources present in communities that can be harnessed to bring about healthier social and economic conditions in partnership with the community (see Chapter 6 in Kagan, Burton, Duckett, Lawthom & Siddiquee, 2012). NICE guidelines on community engagement recommend such co-production and asset-based approaches, amongst others, to foster community-led change.

Examples

1. Anglin (2015) reports a case study of a community in America that began its community change process by holding participatory workshops with different stakeholders and community groups and exploring their ideas of resources, pride and assets in their community, based on the Community Capitals Framework (Flora & Flora, 2004). A range of community stories, resources and experiences were uncovered and linked to the different community capitals. These action research workshops also generated future change plans and priorities for the community change agents, such as new arts murals combined with intergenerational 'storytelling days' to increase social, human and cultural capital. Focusing on positive community assets, fostering connections and empowering community members generated hope and change; which can lead to a virtuous circle of wellbeing
2. Creating community level change is both preventive and cumulative. For instance, Stoddard and Pierce (2015) found that adolescents are more likely to report positive future expectations when they perceive higher levels of neighbourhood collective efficacy (the sense that the community can and does create change) and when they report higher engagement in community activities. Future positive expectations are linked to better wellbeing and fewer negative outcomes for adolescents. As the authors argue, when adolescents feel safe and valued by their community, their motivation to 'give back' to the community and serve others is enhanced, as is collective efficacy (Collins et al., 2014; O'Brien & Kauffman, 2013). Thus a virtuous cycle is created between community level factors and individuals experience and wellbeing.
3. The INTEGRATE approach developed by the charity MAC-UK, its multi-agency partners and young people, is an innovative approach to meeting the needs of excluded young people (such as those affected by 'gangs'). It creates group and systems change) through a multi-level community and clinical psychology intervention (see Chapter 6 of *What good looks like in psychological services for children, young people and their families*, 2015; Zlotowitz et al., 2016) for INTEGRATE's early development and 'AMBIT' below, which INTEGRATE also implements. Key processes of the approach are community mapping and identifying key community gatekeepers who can broker trust with excluded young people in their community. Young people from the community are employed to co-produce projects, and ensure their perspectives are included in all components of service developments. Young people relish the opportunity to support younger people in their area

(Zlotowitz et al., 2016; Centre for Mental Health, in prep). In some cases, ex-service users have gone on to develop their own services and social enterprises to continue the community change.

As per the systems change vision of the charity, the INTEGRATE approach is now being implemented by statutory services, such as the NHS and local authorities. However, there are bureaucratic and governance issues in these institutions that create barriers to co-production of flexible services with community members and to community level interventions that need to be overcome. Peer support is certainly starting to demonstrate its own benefits and shift mental health provision from a medical model towards recovery, inclusion, social context and social networks (e.g. Perkins & Slade, 2012; Rapper & Carter, 2010).

4. The Borough of Lambeth has also developed its own co-production network, the Lambeth Living Well Collaborative (http://lambethcollaborative.org.ukhttp://lambethcollaborative.org.uk), which involves those with lived experience, GPs and other partners. It is really leading the way in developing co-production commissioning models, collaborative processes and governance to 'change how we 'do' mental health'.
5. Other community psychologists use their skills in evaluation to support the work of local community groups (such as participatory arts activities for those with mental health distress), and help them demonstrate their impact on mental health and wellbeing (Kagan et al., 2005) and build their evaluation capacity, as well as support the processes of participatory action research and social change (Lawthom et al., 2015). The links between the community, voluntary sector and mental health services could be vastly improved to support reciprocal learning and systemic capacity building.
6. Schools can be viewed as communities of staff and students and their families. Creating a community approach within a school could be of great value where the students and staff co-produce and implement a psychological health and wellbeing strategy for the whole school. Schools are now required to promote the psychological wellbeing of their students. Teachers are seen as key to this and yet most have had no significant training in psychological development or how to identify and help children with difficulties and teachers themselves are suffering from very high levels of psychological distress. The Health and Safety Executive found teaching to be the most stressful occupation in UK with suicide rates 40 per cent above general population. By using the tools and approaches of Community Psychology, working whole school level and with all involved in a genuinely co-produced way could build resilience, develop better relationships, change working practices to prevent problems in staff and student rather than just trying to help and support when problems have developed
7. On a larger scale there are whole community approaches to improving psychological wellbeing – notably the 'El Sistema' movement (Tunstall, 2012) started in Venezuela and now with projects across the globe. In Scotland, the project is known as 'The Big Noise' and encourages whole communities to become empowered and take an active role in their lives and community. The vehicle for this change is music, giving instruments to children and encouraging them to put on concerts which brings together the community and engenders feelings of belonging, self-efficacy and wellbeing (provision
8. Finally, there are also national and international reports that consider how social and economic inequalities are linked to health inequalities and how to address these issues to facilitate good mental health and wellbeing in children, young people and families, including the World Health Organisation (Friedli, 2009).

Health promotion and early intervention – working in the community

There are many opportunities to build psychological resilience into provision already in place in community settings, particularly in primary care and community Child Health and in the education services, including early years. Achieving this will require investment in both the training of the staff working in these settings and providing them with ongoing supervision and consultation from specialist staff.

Working in schools

There is detailed discussion in Chapter 8 of *What good looks like in psychological services for children, young people and their families* (2015) of the types of work which can be undertaken in school settings with a particular focus on early intervention. These can range from the provision of psychological assessment and support, to group work and parental support, through to having CAMH services based in schools.

Schools can also play a role in mental health promotion in PHSE lessons and out of lesson activities. The approaches can include:

- provision of information about psychological wellbeing and the problems which can arise;
- increasing understanding of the causes of difficulties and what they can do when these develop;
- working with parents to increase their understanding of child development and what they can do to help; and
- teaching of techniques to help, like managing exam anxiety and mindfulness.

The report by the Centre for Mental Health *Missed Opportunities*, published in June 2016, is also an excellent source of examples and ideas that can be implemented in local areas. As an example, the section on 5–10-year-olds lists 'Examples of effective universal programmes supporting healthy emotional, behavioural and social wellbeing', https://www.centreformentalhealth.org.uk/missed-opportunities

Working in perinatal and early years settings

Again, there is more detailed discussion of this in Chapter 7 of *What good looks like in psychological services for children, young people and their families* (2015). Universal services in pregnancy, the perinatal period and early years settings are ideally placed to develop psychologically informed approaches to supporting parents. Incorporating psycho-education materials on child development and managing common difficulties can lead to both helping to prevent some problems and developing a framework where parents know where they can turn for support when problems arise. This can also be very valuable in targeted services for children with additional needs, disabilities and health problems.

Recommendations

1. Robust assessments of how new policies impact upon the mental health of families, including children and young people, should be carried out at all levels from Central Governments down to local areas.
2. Policy, guidance and interventions to reduce the prevalence of known risk factors, need to be developed based on psychological evidence and implemented at a local level, in order to reduce the long-term impact of these problems on mental health. This will require care pathways across sectors and agencies to be developed at a local level in addition to national initiatives
3. Commissioners should prioritise more community-based interventions for the prevention and early identification of trauma and emotional harm. This should include raising awareness of warning signs, ensuring safeguarding is in place and providing more resources to enable positive action when warning signs are identified. There should be more emphasis on supporting families and positive strategies to work alongside parents.
4. Leaders in health, education and community services should work together to develop mechanisms to support local communities and ensure local areas promote good mental health and challenge the stigma of mental health and challenging behaviour. This is a task for both local Health and Wellbeing Boards and the Boards managing Sustainability and Transformation plans across wider geographical areas
5. Commissioners should seek ways to build resilience in to the system to strengthen communities, schools, and family support systems. They should use a community psychology approach and build psychological resilience into existing community settings, particularly primary care, community Child Health and in the Education Services, including Early Years.
6. All services for children and young people should be delivered in a range of culturally and age appropriate settings in their local communities, to improve access for young people and families. Commissioners, providers and people who use service need to work together to develop local plans to enable this to happen in a meaningful way.

Chapter 4: Recognising, harnessing and increasing capacity

There is a need to recognise, harness and increase the capacity of systems to deal more effectively and efficiently with children and young people's Psychological Health and Wellbeing (PHWB) problems. This also means reconstruing what is considered a 'mental health intervention' and who and what delivers such interventions.

Workforce development

Workforce planning and monitoring

One key to meeting demand is ensuring that there are sufficient staff with the right skills to meet the likely demand, based on an understanding of epidemiology and the evidence base for treating psychological problems in children and young people. For more detail on methods of planning workforce based on the evidence base, see Chapter 2 of *What good looks like in psychological services for children, young people and their families* (2015). We intend to develop these models to provide illustrations for integrated services in our 2017 document. Key principles here are:

- recruiting staff based on their skills, rather than their professional titles;
- recruiting both staff with specialist therapy skills and staff with the ability to flexibly create tailored interventions; And
- ensuring clinical leadership able to constantly review and develop the skills of the workforce.

Any workforce planning requires robust monitoring methods, an issue that needs urgent resolution in terms of NHS monitoring of the psychological workforce, which is currently counted in different ways in different Trusts due to lack of clear definitions. Our recommendation would be an immediate move to clarifying the workforce as being made up of medical doctors specialising in mental health, nurses specialising in mental health, applied psychologists, and psychological therapists. All of these groups then exist at different bandings, but for clarity of planning it is essential to be able to monitor the number of staff who are applied scientists (the medical doctors and applied psychologists), how many are nurses, and how many are trained psychological therapists. Trusts need clear guidance from Health Education England on these categories, and central data needs to reflect these categories to allow good quality forward planning.

Examples of Workforce Development Strategies:

1. The Paediatric Psychology workstream within NHS Education for Scotland (NES) has a remit to increase psychological capacity and capability across the multidisciplinary paediatric healthcare workforce by developing and delivering teaching and training on evidence based psychological skills, with a focus on improving adjustment, self-care and adherence, in line with Scottish Government priorities. Over the course of the past five years, the workstream has developed five core half day skills based training modules for paediatric staff (Communication; Reducing Distress; Promoting Positive Behaviour; Motivational Skills; and Chronic Pain); two half day skills based training modules for neonatology staff (Communication; Identifying and Managing Distress in a neonatal unit); and several e-learning resources (including Psychosocial Interventions in Neonatology and Identifying and Managing Chronic Fatigue in Children and Young People), and further modules are currently in development. The workstream aims to deliver 400 skills based training module places per year across Scotland and to date over 1850 multidisciplinary paedi-

atric healthcare staff have attended training (33.9 per cent nursing, 24.8 per cent AHPs, 14.2 per cent doctors and 27.1 per cent other). Evaluations across all training modules demonstrate statistically significant increases in both knowledge and confidence in the use of psychological skills within daily practice, and staff report that the skills they have learned improve the quality of care that they are able to provide to the children, young people and families that they see. More information can be found at http://www.knowledge.scot.nhs.uk/child-services/education/psychology-education-specialist-children's-services-(paediatric-psychology).aspx

2. NES is currently commissioning UCL to develop a Paediatric Competence Framework that will define the skills needed for all staff working with children in hospital or with long-term conditions. There is already a competence framework in existence for staff working in mental health services: http://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Psychological_Interventions_in_Child_and_Adolescent_Mental_Health_Services
3. HEE are currently developing models to increase the workforce who are able to support children and young people though new training routes and career pathways. In particular a psychological wellbeing practitioner role is being created that will increase the number of staff trained to deliver short-term therapy for mild to moderate difficulties. In addition, it is hoped that more staff already working with children and young people will be trained in mental health work and that this will create a more diverse and locally accessible workforce especially by developing non-graduates pathway to training. Such posts and new flexible training routes will be a very useful addition but the blending of these roles into services and providing the supervision and support required to deliver safe and effective care must be addressed as part of the planning.
4. Increasing the skills of the current workforce in universal and targeted services in psychological well being and mental health is crucial in supporting the prevention and early intervention agenda. An example is the new training course developed by HEE in Devon for staff working with children aged 0–5. There is also a range on online training resources available at MindEd. https://www.minded.org.uk
5. There is also a workforce which is already engaged with children and young people with complex difficulties e.g. in secure settings, with looked after children, in forensic and criminal justice settings. Investment in additional mental health training for these workers would markedly enhance what they are able to provide although the investment in a support infrastructure still needs to be made. There are examples of organisations or policies already trying to 'make mental health everybody's business' in this way, for example: www.theintegratemovement.org and https://thrivenyc.cityofnewyork.us

Changing the way the workforce works

Modern services need to be clear that the scope of mental health professionals' roles, and where and how psychological principles are applied, is not limited to the direct provision of therapy. It makes more sense in economic terms as well as in terms of effectiveness for psychological professionals to adopt more of a teaching, supervisory and consultation role, so that their skills and knowledge of the science of psychology can be disseminated as effectively and broadly as possible.

Many services continue to be commissioned and monitored on the basis of their number of face-to-face contacts, which significantly biases the type of work they focus on delivering. This pushes services in the opposite direction to the evidence-base, which clearly emphasises the need to consider and create change in the systems around the child, rather than focusing primarily on trying to create change via individual therapy.

A significant amount of the change that would positively impact on children and young people's psychological wellbeing can and should be carried out by those in closest contact with them – their parents, schools, youth workers, and residential care staff (Stallard & Buck, 2013). This more systemic approach not only has the potential to create more significant change, but also, and even more importantly, *sustainable* change. It is time for commissioning and monitoring structures to stop prioritising the hypothesised change mechanism of 'one-to-one' work, and move instead to commissioning and monitoring based on actual outcomes, thus allowing psychological professionals to work out with young people, their families, and the systems around them, what are the most likely ways of creating those outcomes in each particular situation.

Example:

Adolescent Mentalization-based Integrative Treatment or AMBIT (Bevington et al., 2012) is a framework which emphasises the importance of trusted relationships when working with young people typically considered 'hard to reach' by services. AMBIT advocates for a 'team around the worker' as opposed to a 'team around the child' approach. In others words, the worker with the strongest relationship with the young person becomes the key worker, with other professionals offering indirect support. For instance, a youth worker may be supervised by a substance use worker to provide some substance use support to the young

person. From the young person's perspective, who may find help-seeking and multiple professionals a challenge, this is preferred, and this approach also builds ongoing capacity in other parts of the professional support network.

Empowering young people and families to help others

It is not always necessary, or even desirable, to increase numbers of professional staff in order to increase capacity. Working in partnership with young people and families can lead to them becoming actively involved in supporting others through voluntary engagement, becoming trained and paid members of the team or becoming the leaders of the provision. A number of schemes have recruited parents to help and support other parents – an approach which was pioneered by NewPin in the 1980s. There are also models operating in schools e.g. peer mentoring and buddying systems, and in youth services where older teenagers help in the work with both younger ones and with their peers. This way of increasing capacity leads to additional positive outcomes for the individuals concerned, the people they are able to reach out to and to the communities they live in. This will be explored in more detail in another volume, due to be published in 2017, and a few examples will be given here. It is crucial to successful implementation of such models especially where young people are involved, that high quality customised training and ongoing support is provided to the individuals involved.

Examples

1. Parents and Communities Together (PACT) is a community capacity building partnership project between the community organising agency, Citizens UK, The Institute of Psychology, Psychiatry and Neuroscience at Kings College London, Southwark statutory maternity services and Citizens UK member organisations (including schools, churches, mosques and smaller community organisations). PACT brings together these different community groups and partners to 'tackle social isolation and break down barriers to accessing health services for pregnant women and parents with babies.' It is especially for those parents and carers who tend to fall through gaps and not access services. The partnership has created a range of community-led initiatives involving local parents and community members. For example, peer-to-peer support groups (e.g. 'Dadspace' and 'Mumspace'), 'Parent University' (a parent and health professional co-designed course for pregnancy and the first year of life, supporting parents to be better informed about healthy behaviours, access to services, and how to articulate their health needs), and parent leadership action projects. The aim is to 'work collectively to improve health services and to tackle the broader social issues negatively impacting on parents and ultimately babies' developmental outcomes'. Kings College London are evaluating the impact as these projects develop.
2. Fixers is a group of almost 20,000 young people from across the United Kingdom who use their past experiences to help others and 'fix the future'. They use their personal experiences to make positive changes for themselves and those around them across a diverse range of issues (including physical health difficulties, mental health difficulties, substance misuse, bullying, etc.). Fixers use digital, print and broadcast media in order to get their messages heard, as well as engaging in other activities such as meeting with MPs and setting up their own charities.
3. Home-Start is one of the leading family support charities in the United Kingdom. A group of 18,500 parent volunteers work to help families with young children to overcome challenges, improve confidence, and build better lives for their children. Families struggling with difficulties such as post-natal depression, isolation, physical health problems, bereavement and many other issues receive the support of a parent volunteer who will spend around two hours a week in a family's home supporting them in the ways they need. Home-Starts across the UK also support families in groups, hold day trips and parties, and help in accessing local services.

   In 2015, Home-Start supported 70,000 children in 33,000 families, with the following outcomes:
   - 95 per cent of families felt their children's emotional and physical health and wellbeing had improved;
   - 95 per cent of parents felt more involved in their children's development;
   - 94 per cent of parents felt less isolated;
   - 94 per cent of parents said their emotional health had improved; and
   - 95 per cent of parents felt more able to cope with the day-to-day running of the house.
4. Empowering Parents, Empowering Communities (EPEC) – is a community-based programme, training local parents to run parenting groups in schools and children's centres developed and run by the Centre for Parent and Child Support. It has been developed in Southwark over the last 10 years, and has received a national Sure Start award for innovation and user involvement. The model assumes that parents find it less stigmatising and more supportive to attend parenting groups run by local people who are in very similar circumstances to themselves.

This is one of three evidence programmes run by the Centre. Information on all is available at: http://www.cpcs.org.uk

5. Axis @ the Hive is a joint project funded by Camden Council and Camden Clinical Commissioning Group to help bridge the gap between child and adult health and wellbeing services, particularly for young people who are currently not engaging with any services. Managed by Catch22 in partnership with local specialist organisations it from a youth base that has been co-designed by young people. Axis employs a team of young people who are trained to help other young people in many areas of their lives and who can relate to the challenges that young people face on their journey to adulthood. Young people can access help and support with education, employment, housing, sexual health, substance misuse, personal development and health and wellbeing. Axis is a young person centred service, with young people choosing where and when to meet. https://www.catch-22.org.uk/services/axis-the-hive/

Recommendations

1. Commissioners and providers should ensure they perform regular joined-up assessments of the skill mix of the existing workforce and plan jointly workforce development to meet local need.
2. Commissioners and providers should shift from a one-to-one treatment model to a flexible model where psychological interventions are delivered indirectly through consultation, training and supervision of people in the systems around children and young people, in order to increase effectiveness and improve the sustainability of change.
3. Providers should involve young people who use services, parents, schools, youth workers, community health, voluntary and residential care staff, in the delivery of psychological interventions and provide training, consultation and supervision to develop their skills.

Chapter 5: Integrated provision

Across physical and mental health

The mind-body split in how we, in Western society, view health is singularly unhelpful for children and young people who use services. Children and young people with long-term physical conditions are significantly more at risk of developing mental health problems than their peers (Hysing et al., 2007) which means that many children and young people need to access both physical and mental health services rather than be bounced between the two. There is now a large body of evidence for the effectiveness (Palermo (Ed); *Special Issue of the Journal of Pediatric Psychology*, 2014) and cost-effectiveness (Janicke & Hommel (Eds); *Special Section of the Journal of Pediatric Psychology,* 2016) of psychological interventions in paediatric (physical health) populations.

What is needed is:

- a holistic view of person centred care;
- a holistic view of the child and young person in their family context, community context, school and their social and economic context, with their health condition; and
- a health system understood as an interlinking part of a wider biopsychosocial system.

This requires health professionals in physical health care settings to consider the whole child and pay attention to the psychological wellbeing of the child or young person and their parents/carers. It requires mental health professionals to think about the physical health needs of the child, young person and family sitting in front of them, and to feel that it is part of their responsibility to improve overall wellbeing, including physical health.

The King's Fund uses a wealth of evidence from adult research to argue for a whole person approach. They define the *professional attributes* required, such as being able to take a 'whole person' perspective and including communication and consultation skills. They also define the *system attributes* such as co-ordination of care and proactive care, and define a *role for service users/carers* in terms of peer support and self-management as well as support for family and carers. http://www.kingsfund.org.uk/publications/physical-and-mental-health?gclid=Cj0KEQjwzZe8BRDguN3cmOr4_dgBEiQAijjVFjUckuaCxxA41v5JeRT7pt7EJx7ukIQgY2WyPmg1XKUaAsiV8P8HAQ)

We expand upon the King's Fund's recommendations and propose that integration should be along a continuum from:

- incorporating mental health awareness into public health programmes and promoting physical health among young people with severe mental health difficulties;
- improving the management of long-term conditions and medically unexplained symptoms in primary care;
- empowering parents/carers and young people to self-care and thus develop independence;
- ensuring that the dental and physical health needs of young people with addictions or mental health issues in the community are met by primary care;
- supporting the mental health and wellbeing of children and young people with long-term conditions and their carers;
- supporting mental health and wellbeing in acute hospitals;
- addressing physical health in mental health inpatient facilities through the commissioning of dedicated GP or Community Paediatrician sessions; and
- providing integrated support for perinatal mental health.

(Adapted from King's Fund, 2016).

If, at all these levels, all front line staff took a holistic view of wellbeing and saw both physical and mental health as their responsibility, we would get much closer to genuine integration between physical and mental health. This would require:

- **workforce development** (as outlined in chapter 4) so that this integration is part of the training of the whole workforce;
- **supervision and consultation structures** in place to support front line staff delivering psychological interventions; and
- **joint continuing professional development** across professions, sectors and services to enable people to learn from each other, build local relationships and thus facilitate communication, joint working and integration.

Moreover, it would require structures such as regular cross-sector, multi-service meetings, for complex case management and to develop policies and pathways so that joint solutions to local problems can be found. This could be supported by children and young people focused version of The Making Every Adult Matter coalition.

We are a long way from providing integrated care along the continuum outlined by the King's Fund above, however there are services that have managed to do this, particularly in acute hospital settings, and there is good practice to build on. Some examples are outlined below. However, this remains the exception rather than the norm, with fragmented care being a common experience.

In addition, the existing psychological provision for children and young people in acute hospitals has huge inequalities in terms of access to psychological support. All children's hospitals and most teaching hospitals have some paediatric clinical psychology provision, some have liaison psychiatry, counselling and family therapy. Very few district general hospitals or community health services have any psychosocial support and there are very few child and family specialists in primary care.

Moreover, there is inequality between medical conditions, with some services mandating psychosocial or even clinical psychology provision, thanks to NICE Guidelines (e.g. paediatric oncology) or NHS England service specifications such as diabetes, paediatric intensive care (2010), and cystic fibrosis (2011).

Where psychosocial or psychological provision is embedded into the medical team, children, young people and their families receive very good holistic care, with the psycho-social practitioners playing a role in keeping psychological wellbeing in the team's mind in multidisciplinary meetings, during consultations and helping the team to make sense of behaviour such as problems with adherence to medical regimens. They also deliver teaching, supervision and consultation to front line practitioners such as clinical nurse specialists who have pre-existing relationships with children and families and are often best placed to deliver simple psychological treatment, leaving the expert practitioners to take on the more complex cases for specialist therapy. These practitioners treat a range of problems related to physical health conditions including anxiety, depression, family conflict, school or peer difficulties, and the complex overlap between medical and psychological symptoms such as for example, pain in young people with rheumatology or gastroenterology conditions, or anxiety or depression symptoms that mimic/overlay physical health symptoms such as respiratory or cardiac conditions. In this sense then, these services meet the child and family's need for integration, and the multidisciplinary teams will liaise with a child's school, social care and general practitioner.

The limitations of these services are that they are not equipped to deal with complex psychiatric problems that require medication, psychiatric assessment or multidisciplinary mental health management, and few services have robust pathways of care, with the exception of A&E, from the acute hospital to mental health and community services. This leads to children and families falling through the net, having long waits, undergoing unnecessary assessments, and duplication and inequalities, depending on the presentation, where the child and family lives and their ability to access services. What is needed are defined pathways for children and young people with long-term conditions and their families, including agreements for joint clinical management of medically unexplained symptoms, complex cases and risk management between acute services, community services, child health services and mental health services.

At the other end of the continuum, what is needed is for psychological practitioners expert in the psychological wellbeing of children with long-term conditions to deliver universal, preventative skills training on the psychological aspects of long-term conditions to school nurses, teachers, social care staff, health visitors and primary care physicians who are working with children, young people and their families every day. This would enable problems to be identified and dealt with quickly, preventing more complex difficulties from developing and creating additional demand on services further up stream.

Examples

At a simple level, some services have managed to work towards developing integrated pathways for children presenting with a range of different problems that require similar follow up care, such as:

1. The neuropsychology pathway for children with acquired brain injuries and brain tumours

in Cambridge that is commissioned by a range of different services (Addenbrooke's Hospital, Cambridge and Peterborough Mental Health Trust and a number of charities) and provided mainly by two teams, based in both the acute trust and specialist community children's neuro-rehabilitation service.
2. The diabetes clinic that takes place in a West Suffolk College and is run by a diabetes nurse and clinical psychologist from West Suffolk Hospital.
3. East London Foundation Trust and Barts Health partnership that has six paediatric clinical psychologists, one psychiatrist and one social worker. The team jointly covers psychological and psychiatric aspects of short- and long-term health conditions and medically unexplained symptoms for paediatric in- and out-patients. It is involved in paediatric assessments when underlying mental health conditions need to be considered as a differential or additional diagnosis and provides a joint formulation and management plan from a psychological and psychiatric perspective. The team also provides a duty system with immediate response for any paediatric urgent and emergency cases (excluding self-harm). This can include acutely disturbed or violent behaviour (organic or non-organic in nature), acute deterioration in mental state and acute breakdown in communication that escalates risk.

Across community and specialist services

There is a wide range of services operating at a community level from both statutory and voluntary sectors. The working relationships and communication between them and the specialist or acute sectors can be very difficult for staff and very confusing for young people and families. Within the NHS, the majority of children with psychological or physical difficulties are seen and supported within primary care and community services all of the time or following on from a more specialist intervention. Even when referrals are made to more specialist services because of the seriousness or complexity of the problems, there are many young people and families who do not attend either through fear, access difficulties or difficulty in navigating a system which is not designed to meet their needs. This has a particular impact on schools, which are often in the position of being the only setting that is in regular contact with the children and whose capacity to support them may be severely strained.

We argue that all services for children and young people should be delivered in their local communities or other community settings that are accessible to them, unless there is a requirement for them to be in a more centralised setting, perhaps because of a need for specialist equipment. Within health, management of the specialist services can be within the same organisation that delivers other community services or at least co-located with them. This has many benefits if the specialist services interface every day with other providers in the community. If a significant part of the specialist staff workload is training and supporting other services in the community, this markedly increases the overall provision for young people and families as well as making help more accessible.

Within health, key links would be with community paediatricians, school nurses, health visitors and primary care. Working with schools and early years services and social care would be a vital part of the role, as would building connectivity with any voluntary sector organisations in the local area. Developing robust care pathways that also facilitate good step-up and step-down transitions leads to significantly better services and reduces the waste and duplication that so often exist in the system. Working closely together in community settings enables joint working and the development of innovative solutions to local issues that comes with shared knowledge and expertise.

Such models were fairly widespread until about 10 years ago. Nottingham and Liverpool were examples of such community based psychological services but the trend shifted to incorporate them into CAMHS. This was often motivated by the desire to integrate psychological provision but the actual result was that most areas lost their community base and community focus and the gulf between community and specialist services grew wider.

Across agencies

The separation of psychological services for children, young people, and their families from social services for the same group frequently leads to either duplication or lack of delivery when families fall between two stools. Families who come to the attention of children's social care are, by virtue of that referral, struggling or thought to be struggling with the care of their children, an issue that usually means they are in need of some level of psychological advice or intervention. Yet, unfortunately, these families can sometimes find it hardest to access psychological help, due to inadvertent effects of silo-working, whereby they are seen to have 'social' problems, rather than 'psychological' problems, and thus not seen as eligible for a service from CAMHS.

Although there is also overlap between families who need physical healthcare services for their children, and families who need psychological services for their children, this overlap is not as extensive, which does bring into question whether the traditional placement of mental health services within broader (predominantly physical) healthcare services, rather than, for example, within broader social care services, is the best fit.

Innovative ways of working with families with

complex social and psychological needs include the embedding of psychological staff within all children's social care teams, locating CAMHS teams within social care buildings, and ensuring the joint commissioning and joint ownership of outcome monitoring that will allow these ways of working to be sustained.

Examples

1. An example of an integrated CAMH service that supports system capacity-building is the Clinical Service integrated within Hackney Local Authority Children and Young People's Services. Clinicians in this service are co-located with social care, youth justice and generic youth and family support units. As such, clinicians, as well as providing direct psychological support, are readily available for consultation and supervision of the social workers, youth workers or family practitioners, who may be better placed to provide therapeutic support. Clinicians also provide in-house training on topics such as attachment-focused care to a range of staff in the system, including foster carers. Through this integration the service is able to up-skill the workforce in mental health and psychological reflective practice. Indeed, in Hackney Children and Young People's services all staff have a minimum training in systemic theory and practice.
2. NHS England is currently working with the Secure Children's Homes on a transformation program, SECURE STAIRS, which aims to shift the focus of psychological expertise in the secure estate from an 'in-reach' model, whereby clinical staff come to homes on specific days to see specific referred clients, to an integrated care model, where psychological staff support care workers to develop psychological formulations and whole unit interventions for each and every child.
3. The NIS offers a number of different interventions that are typically delivered by various provider organisations including health, social care and the voluntary sector. These include Multisystemic Therapy (MST), a well-evidenced intervention that works with young people and families that are at risk of care or custody. Professionals working in MST teams come from a range of different disciplines such as psychology, family therapy, social care and youth justice. There are over 35 teams across the UK. These include MST adaptations that work with issues such as substance abuse, problem sexual behaviour and child abuse and neglect. For further information see http://www.mstuk.org/mst-uk/mst-uk-teams

Across traditional age barriers

A number of young people still need support or on-going treatment when they reach the upper age threshold for the service – for CAMHS this has traditionally been the young person's 18th birthday. There are long-standing concerns about the difficulties which frequently surround transition, meaning that many young people are lost to services at this time and, if they do move onto adult services, experience a drawn out and very difficult process at a time of significantly increased vulnerability. Positive transition improves clinical, educational, economic and social outcomes for young people. In contrast, poor transition leads to disruption in care that can be associated with increased risk of non-adherence to treatment and loss to follow up. At a time when young people need to access support, it is also evident they are at greatest risk of disengaging from services.

Transition from children's to adults' services can be a complex process, spanning a range of agencies and specialisms. The absence of a coordinated approach to providing services across health, education and social care can result in ineffective communication, poor engagement, discontinuity of care and staff feeling unclear about the process and their role in it. Adults and children's services need to come together to pool funding, addressing the structural and cultural barriers that prevent them from achieving this. Transitional care should become a shared priority, despite the current pressures on public funds. (Adapted from NICE Transition from children's to adults' services for young people using health or social care services (NG43) 2016)

Think Family

If we consider the child and young person within the context of their family, it is common to find that adults in the family also have psychological problems and may be being seen by AMHS. Parental mental health difficulties are a known risk factor for their children also developing problems, and yet the services dealing with them are often completely different and may have very little contact with each other.

Think child, think parent, think family: A guide to parental mental health and child welfare

This influential guidance was produced by the Social Care Institute for Excellence and last updated in 2011. It can be accessed at: http://www.scie.org.uk/publications/guides/guide30/introduction/thinkchild.asp

In its introduction, SCIE describes 'Think Family' as a concept, and outlines its implications for practice:

'The Think Family' agenda recognises and promotes the importance of a whole-family approach which is built on the principles of 'Reaching out: think family':

- **No wrong door –** contact with any service offers an open door into a system of joined-up support. This is based on more coordination between adult and children's services.

- **Looking at the whole family –** services working with both adults and children take into account family circumstances and responsibilities. For example, an alcohol treatment service combines treatment with parenting classes while supervised childcare is provided for the children.
- **Providing support tailored to need –** working with families to agree a package of support best suited to their particular situation.
- **Building on family strengths –** practitioners work in partnerships with families recognising and promoting resilience and helping them to build their capabilities. For example, family group conferencing is used to empower a family to negotiate their own solution to a problem.

Changing the age range of services

The issues around this were clearly recognised in the Government Task Force Report *Future in Mind (*DoH, 2015, p.48–50), which lays out the case for increased flexibility to meet needs. It is also very important that services recognise that for a significant number of young people, work with their family is not appropriate or helpful and the provision of support to them as an individual is essential.

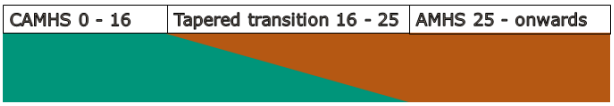
There are initiatives taking place around the UK which are exploring alternatives to traditional 0–18 services:

Examples

1. The Child Family and Young Person Service in Central Norfolk offers specialist help for children, families and young people experiencing emotional and mental health difficulties up to the age of 25 years. Their website, Whatsthedealwith.com provides information and resources for children and young people across Norfolk and Waveney, as well as information for parents, carers and professionals that are involved in children and young people's mental health.
2. Birmingham Forward Thinking delivers mental health services and facilities focused around the individual needs of young people and families aged 0–25 years old. The service is based around prevention, access, choice, integration and joined up care. The Forward Thinking Birmingham partnership is commissioned by Birmingham South Central Clinical Commissioning Group (CCG) on behalf of all Birmingham CCGs, and combines the expertise of Birmingham Children's Hospital, Worcestershire Health and Care NHS Trust, the Priory Group, Beacon UK and The Children's Society.

Creating flexible transitions between CAMHS and AMHS

Within current service configurations, the development of 'tapered' transition period between CAMHS and AMHS between ages of 16–25 can be considered.



In this model, 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 setting. 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.

The key benefits and strengths of a tapered approach to transition include:

- 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.
- 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 18 and 25.
- 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.
- Enabling professionals from CAMHS and AMHS to work in partnership would support them to share knowledge, expertise and resources, thereby improving the quality, capacity and culture of both.

Across the whole system

A whole system approach would mean:

- putting the wellbeing of the child, young person and family at the centre of policy making and provision;
- integration in terms of commissioning training for health, education, voluntary sector, police and criminal justice and social care practitioners;
- building in supervision and consultation to ensure adherence to the models; and
- joint CPD across professions and services to break down barriers, build relationships and facilitate joint solutions to local problems.

A basic foundation for building an integrated service is the development of collaborative relationships across the system

A recently published systematic review of outcomes, facilitating and inhibiting factors in interagency collaboration in children and young people's mental health provides some early evidence to guide services who are

aiming to move in this direction (Cooper, Evans and Pybis, 2016)

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 made 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 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.

At a local level, these relationships can be strengthened by:

- **Joint working**: Where people work together in multidisciplinary and multi-agency teams, they get to share skills and knowledge day-to-day, build better relationships and engender a culture of ongoing organisational 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 skill sharing, where, for example, CAMHS professionals might facilitate a workshop with schools staff on some aspect of mental health e.g. 'self-harm' – and the schools staff facilitate a workshop back to CAMHS workforce on managing difficult behaviour.
- **Co-location:** 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. Co-location is not always possible in a diversified and community based system, but, where possible, it should be considered.
- **Effective Communication systems** are needed, even where there is co-location. This is a particular issue with IT systems and records that can serve to prevent collaboration and integration. Where shared systems are not possible, other IT solutions need to be developed
- **Collaborative (not adversarial) 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, this 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?' This may be the biggest challenge of all…

An example of how building working relationships can be successfully placed at the centre is the Adolescent Mentalisation-Based Integrative Therapy (AMBIT) programme.

http://discovery.ucl.ac.uk/1385449/2/Fonagy_AMBIT_for_CAMH_finalSubmission.pdf

http://discovery.ucl.ac.uk/1385449/2/Fonagy_AMBIT_for_CAMH_finalSubmission.pdf

All of their materials are open access and can be found at:

http://tiddlymanuals.tiddlyspace.com

A whole system approach requires investment in people and in systems to audit, review and monitor effectiveness and this will be another focus of Volume 2.

Recommendations

1. Commissioners and providers should ensure they perform regular joined-up assessments of the skill mix of the existing workforce and plan jointly workforce development to meet local need.
2. Commissioners and providers should shift from a one-to-one treatment model to a flexible model where psychological interventions are delivered indirectly through consultation, training and supervision of people in the systems around children and young people, in order to increase effectiveness and improve the sustainability of change.
3. Providers should involve young people who use services, parents, schools, youth workers, community health, voluntary and residential care staff, in the delivery of psychological interventions and provide training, consultation and supervision to develop their skills.

Chapter 6: Summary and future direction

We are not proposing 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 emphasise principles that already are embedded in the best parts of the system. We propose a commissioning model made of four complementary components: 'needs lead', 'integrated', 'co-produced' and 'effective & transparent'.

1. **Needs led:** The resources in the system should be focused on what the needs of the child are. These should be agreed through effective collaboration and a model of shared-decision making and goal setting to ensure all are explicitly aware and agreed on what and how these needs might best be addressed.
2. **Integrated:** Much of what works well in systems is where different parts work together, sharing expertise and knowledge in the best interests of the child. A diversified system of multi-agency work that is community based, preventative focused 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. **Co-produced:** Co-production draws on the strengths and assets that already exist within communities. At it's best, co-production means community members become partners in all aspects of service development, from design through to evaluation. It takes into account a diversity of views, working with communities to support their priorities for change, doing 'with' rather than 'to' and so moving beyond user participation. Co-production harnesses the shared expertise of the community and professions and ensures services are acceptable, meaningful and accessible to the children, young people and families they seek to serve requires flexibility, responsivity and a willingness to share power and expertise.
4. **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 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.

We feel these are principles that should drive transformation and change and shape how services are delivered across the whole mental health and wellbeing systems. It is down to all of us to continue to work to implement these ideas further – there are already good examples of where this is starting to being done. This preliminary guidance will be expanded in another volume, due to be published in 2017, which will share more of these examples and ideas.

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St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel 0116 254 9568 Fax 0116 227 1314 E-mail mail@bps.org.uk www.bps.org.uk

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