THE CENTRE FOR MENTAL HEALTH

Hertfordshire children and young people's mental health Whole System Review:

Towards a new strategy

May 2015

Centre for Mental Health

NHS East and North Hertfordshire Clinical Commissioning Group

NHS Herts Valleys Clinical Commissioning Group

Hertfordshire

Forward

Childhood is a time of unprecedented psychological development; the events we experience during childhood will have a profound and lasting impact, not just on our own lives, but on the lives of those around us, our families, schools and communities. Our childhood experiences, in turn, affect our own children and, in time, our children's children. The events that shape our development are both the positive and negative emotional experiences we encounter. Before reaching adulthood, all children and young people will experience many episodes of psychological distress. The impact of these events will depend largely on the environment in which the child lives, and the quality of care they receive from those around them. For the majority, the distress will be relatively short lived and help build resilience to future upsets, for others the trauma will be so great that it will have the potential to adversely affect them for the rest of their lives.

We should not seek to prevent all the causes of psychological distress, nor can we remove all the factors in society that cause psychological harm, but we can, and must, create communities that provide children and young people with the best psychological support, that seek to prevent harm, promote emotional health and well-being, and, when needed, provide children and young people with the best psychological care and intervention, at the right time, and in the right place. By doing this, communities ensure the emotional stability that is the moral and economic underpinning of any successful society.

This report heralds a commitment from Hertfordshire to take up the challenge to do better for its children and young people. It sets out a vision to provide services that work with, and for, children, young people and their families, and sets out to provide the sort of services and systems needed to provide children with the psychological environments they need to fulfil their potential. Those of us involved in national drivers for service quality improvement: the Future in Mind taskforce and, Children and Young People's-IAPT, have sought to cross-reference the developing agendas. This report sets out a framework to meet all the recommendations and principles coming from centre, but delivered fit the local context and meet the local need. It will be a challenge to implement a change of this scope and scale. There will be much local and national interest in how things develop from professionals, commissioners and other stakeholder alike – but the real, and only valid, marker of its success will be young children and young people telling us that their lives are better as a result of its implementation.

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Executive Summary

Centre for Mental Health is supporting Hertfordshire County Council, East and North Hertfordshire Clinical Commissioning Group and Herts Valley Clinical Commissioning Group in a whole system review of support for children and young people's emotional health and wellbeing. The review brings together evidence from local sources with an analysis of local policy and good practice. The review makes recommendations for the future development of joint commissioning, strategy, services and self-help.

Key points

At least one child in 10 in Hertfordshire has a diagnosable mental health problem, and many more will need some support to prevent more serious difficulties from emerging**.** While Hertfordshire's children enjoy higher than UK average levels of wellbeing and attainment, there are high levels of worry among children in the county and significant variations between districts.

All children can benefit from effective support to maintain good mental wellbeing, boost resilience and prevent mental health problems. Some children are more vulnerable than others and some may need extra help to restore good mental health.

Current levels of mental health support for children, young people and families are inadequate to meet their needs. . We estimate that just over a third of children meeting the threshold for diagnosis with mental health difficulties are having their needs met.

There are major gaps in the provision of mental health support for children and young people. There is a particular paucity of early intervention services, for example to support women experiencing mental health problems during and after pregnancy, to help children with behavioural problems, and to promote positive mental health in schools.

The system currently tends towards crisis management. Referrals to specialist services vary from month to month and many are sparked by a crisis – for example after admission to A&E.

Neither children nor parents are satisfied with the accessibility of support they receive from child and adolescent mental health services in the county. Major concerns have been raised about the accessibility of services, which are regarded as inflexible and which appear to have very long average waiting times between referral and treatment.

There are major gaps in the availability of essential data: about levels of need among children and young people in the county, about provision of services and spending, and for monitoring the outcomes services are achieving.

We recommend a new approach to supporting the mental health of children, young people and families in Hertfordshire. The new approach should have a bigger focus on prevention and early intervention, with services that offer swift, evidence-based and engaging support to children who need them.

Improving support requires the active involvement of a range of local agencies, including not just health services but schools, early years' practitioners, children's services, the voluntary sector and many more: working together to agree a strategy; pooling funds to

get best value; and planning services in equal partnership with children, young people and families.

A new countywide strategy could help to transform children's emotional health and wellbeing in Hertfordshire. With a new approach, investment could be used to achieve better outcomes for many more children and families, with lifelong benefits.

Levels of need for mental health support

Hertfordshire has one of the highest numbers of children and young people aged under 18 in England (282,100). Children make up a quarter of Hertfordshire's total population. About 23,000 0-19 year olds in Hertfordshire will have a diagnosable mental health problem.

The population of young people in the county is projected to expand by 14% by 2020. This will lead to an increase of about 2,000 in the number of children presenting for help with a diagnosable mental health need over the next five years. Many more children will have borderline needs requiring help to restore good wellbeing.

While Hertfordshire is a good place to live and enjoys higher than average levels of wellbeing, more than 14% of the county's children under 16 are living in poverty: a known risk factor for mental ill health.

24% of school children in Hertfordshire are from a minority ethnic group. Children from some BME communities face greater risk of poor mental health as adults.

In a recent survey, the proportion of children who report they worry is the highest in Hertfordshire compared with other areas of the East of England (85%). In 2012, St Albans Youth Council (SAYC) reported high numbers of young people suffering routinely from stress associated with school life (particularly exam pressure and bullying). And an estimated 17,935 10-17 year olds in Hertfordshire are experiencing cyber bullying.

There are higher levels of fixed primary school exclusions in Hertfordshire. This may be associated with higher levels of early starting severe behavioural problems which are linked with generally poor life chances if untreated.

There has been a sustained increase in the number of A&E admissions requiring child and adolescent mental health expertise. This is reported to be due to rising levels of self-harm. Half of these young people have been previously known to CAMHS.

Views of children, young people, families and professionals

The views of children and young people and their parents and carers provided vital evidence to the review about their experiences and their needs.

The review also engaged with a diverse range of organisations that work with children and young people, including professionals from health and social care services, specialist Child and Adolescent Mental Health Services, from education, and from community, voluntary and youth services.

Widely shared concerns, from all stakeholder groups, included:

- The language of 'mental health' and CAMHS create a barrier to seeking help and reinforce the stigma relating to mental ill health.
- CAMHS are delivered in poor facilities, predominantly in clinic locations with inflexible appointment times
- There is poor communication and information-sharing, for example between CAMHS and schools or GPs
- There are long waiting times to get access to any support
- There are gaps in services for specific groups of children and young people, eg those with eating disorders, multiple or emerging mental health needs or ADHD and for younger children.

The review found that all respondents had a real passion and motivation for seeking solutions where they think change can happen. There was a consensus about:

- The need to build resilience, prevention and early intervention
- The vital role that schools can play in supporting children's mental health
- The need for children and young people's mental health to become a local priority in order to support investment in whole system change

The engagement and participation of children, young people and their families in the development of strategy and solutions was widely agreed to be integral to the transformation of services that are right for them, and the assurance of a skilled and sufficient workforce that can meet their needs.

How are current services meeting young people's needs?

The review examined evidence of how effectively current service provision is meeting local need, and of how need will change in the future.

We found significant limitations in the availability of data, both nationally and locally, from which to draw reliable conclusions about current levels of need, of provision and of spending on services.

We estimate that there are currently about 24,000 people aged 3-19 in Hertfordshire who meet the threshold for a diagnosis of a broad range of mental illnesses. This estimate is projected to rise to 26,000 by 2020.

In Hertfordshire, child and adolescent mental health services (CAMHS) operate a four-tiered model. Tier 1 represents universal services to promote good mental health (e.g. Health Visiting or social and emotional learning in schools); Tier 2 is for children who need early support to regain good mental health (e.g. school-based counselling or targeted parenting interventions); Tier 3 provides specialist multidisciplinary support in the community; and Tier 4 represents inpatient care.

Based on national calculations of the proportion of children who need mental health support at each Tier, we have estimated below how many children in Hertfordshire require a service and compared that with what is known about what is currently available:

	Percentage of children anticipated in each tier	Estimated number of current 0-18 Herts population needing support in this tier	Estimated number of children currently receiving a service at this tier
Tier 1	All children	256,922	Unknown
Tier 2	7%	19,747	3,918
Tier 3	1.85%	5,219	3,800
Tier 4	0.075%	212	93

Tier 1 Universal services

Insufficient information was available for the review to assess how far current provision of Tier 1 services are meeting levels of need and what is being spent on these services.

Tier 2 Early intervention

An estimated 3,918 children and young people are accessing Tier 2 services, which include:

- Community and school-based counselling and psychological interventions, for example the Step 2 service
- Improving Access to Psychological Therapies (IAPT) services for 16-18 year olds.

We estimate that Tier 2 services are currently meeting about 20% of the level of need, leaving a shortfall of about 16,000 children and young people.

Spending data on Tier 2 services are limited: the Step 2 service costs £420,000 a year and voluntary sector community counselling costs a further £152,000. Levels of spending on school-based counselling are unknown.

Awareness of Tier 2 services is poor: for example, over half of all secondary school students said they were unaware of any provision in their school for counselling and 94% of teachers were not aware of Primary Mental Health workers mentioned in the Behaviour and Attendance Tools for Schools Handbook, Step 2 or the Step 2 helpline.

Tier 2 services have good satisfaction rates with children, young people, parents and professionals and hardly any nonattendances.

Tier 3 Community services

Tier 3 services had an average caseload of about 3,500 during the review period of April to December 2014 with average 'accepted referrals' over the year of around 3,800 – reaching about three quarters of the estimated level of need.

Waiting times for tier 2 and 3 services

There is evidence over the last year of lengthy waiting times for access to both Tier 2 and 3 services. Parents described experiencing a number of stages as they waited between referral and first contact with someone, from first contact to assessment, and then from assessment to treatment. Taking a generous approach the median timescale for this overarching wait between referral and the start of treatment was at least 9 months but may well be longer.

During the currency of this review there was evidence from Tier 3 performance data of a month by month improvement in waiting times to access these services moving from 28% of children receiving an assessment within 28 days in October 2014 to 88% receiving their first appointment within this timescale by the end of March 2015.

The budget for Tier 3 services was £10.4 million in 2014/15.

Tier 3 services appear to be reaching around three quarters of need. The average caseload of Tier 3 staff was 40, around the level recommended by the Royal College of Psychiatrists. Most young people who receive treatment from Tier 3 services get between 1 and 5 sessions of input.

Hertfordshire Tier-3 CAMHS work with higher levels of initial severity of need and with children who have more complex health and social presentations (including more children with autism) compared with other areas of the country.

Outcomes for young people using Tier 3 services are poorly monitored, and user satisfaction scores are lower compared with other areas of the country. There is also little information about what happens to young people who are discharged or not accepted following referral to Tier 3 CAMHS.

The number of children and young people who engage in treatment for drug and alcohol misuse in Hertfordshire is low (147) relative to substance misuse hospital admissions in 15-24 year olds (108) in the county.

There is a general need to strengthen the evidence base of interventions being offered across both Tier 2 and Tier 3 (particularly use of CBT in Tier 3). CYP IAPT offer training to enhance the evidence base of both statutory and voluntary providers across Tiers 2 and 3.

National investment in children's mental health

The 2015 Budget pledged extra government spending on children's mental health support, totalling £1.25bn over five years. Plans for spending this £250 million a year are in development but current indications include:

- £118 million would be made available for Adult Improving Access to Psychological Therapies (IAPT) until 2019 (this is relevant for 16-18 year olds)
- £75 million would be invested over five years for perinatal and infant mental health
- £1.5 million would be available for joint training pilots for GPs and teachers and for training designated mental health leads in schools.

These amounts are in addition to existing new investment in Children and Young People's IAPT and eating disorder services.

Essential interventions: what the evidence says

The review examined evidence from international literature and the recent government taskforce report, *Future in Mind*, to identify what 'good' looks like when promoting and supporting the mental health of infants, children, young people and their families.

An effective whole system promoting mental health and responding effectively to children's needs should seek to promote wellbeing, to prevent problems from occurring and to

intervene as early as possible. This means intervening early in life, intervening to reduce risk factors for poor mental health and intervening at the very first sign that a young person's behaviour or emotional wellbeing is moving outside healthy ranges. Inadequate early investment stores up problems later on, damaging children's outcomes, reducing quality of life and building up later crisis costs.

Evidence-based interventions that should be considered as essential to promoting and supporting children's mental health and emotional wellbeing as part of a whole system approach include:

Perinatal mental health support: Improving identification and fast tracking mothers to proven early help should be a priority for primary care workers in contact with mothers during the perinatal period.

Family Nurse Partnerships: Intensive wraparound support for teenage parents and their children from home visiting midwives has a good record of improving children's longer term life chances.

Parenting interventions: Early starting behavioural problems are the most common childhood mental health problem, affecting 5% of children aged 3 to 10 and are a marker for a range of damaging and distressing poor life chances. Well implemented NICE recommended parenting programmes have a good record of improving outcomes for these children. Programmes should be delivered by well trained and supervised workers from early years and parenting teams with ongoing systems of quality control to ensure they achieve results.

Whole-school approach to social and emotional wellbeing: Well implemented primary school based Social and Emotional Learning programmes can make a difference to children's mental health and wellbeing and educational attainment. A universal programme showing particular promise for the primary school age group is the Good Behaviour Game.

Psychological interventions for depression and anxiety: Cognitive behavioural interventions are both effective and cost effective with a good record of improving children's depression and anxiety. Group CBT interventions are effective and appear to represent particularly good value with around £30 return for every pound invested.

Interventions for young people at risk: Interventions such as Multi-dimensional Treatment Fostering, Multi Systemic Therapy, Functional Family Therapy and Aggression Replacement Therapy have a good record of improving mental health outcomes (particularly adolescent behavioural wellbeing) for those on the edges of the care system or youth justice system.

Early Intervention in Psychosis services: There is good evidence that Early Intervention in Psychosis (EIP) services, when delivered in keeping with NICE Guidance, help people experiencing early symptoms to recover and gain a good quality of life.

Evidence from children and families' lived experience

The local offer should be shaped by both robust evidence and the wishes of children, young people and families. Children and families in Hertfordshire said they wanted services:

- That were easy to access, understand and navigate

- That felt 'non-clinical'
- Delivered by empathetic, compassionate and caring practitioners
- Delivered flexibly in a range of welcoming or familiar settings
- Which allowed them choice and flexibility in terms of the variety of services/interventions on offer, who provided them, the timing and location of contact and which involved informal and formal as well as good quality online support.

Most young people felt that teachers and schools could play a bigger role in recognising when pupils are struggling and helping them access appropriate support.

Neither young people nor practitioners in Hertfordshire favour the term 'Child and Adolescent Mental Health Services (CAMHS)' or 'service user'.

A coordinated and accessible system

An effective system should provide a clear offer for all children, young people and families including how to prevent problems, get back on track or get help to de-escalate crisis. Key features of such a system will include:

- A single well promoted gateway to get help
- Support based on a child's needs not their diagnosis
- A multi-sector partnership approach focusing on shared assessment processes and outcomes; also where each partner understands their role in the system
- Improved information-sharing and coordination between universal, targeted and specialist services
- Support for parents, children and young people to give them the knowledge to promote their own wellbeing and to know how to get help if they need it.

All professionals and agencies that come into contact with children and families should have training in child development (relevant to their role) and a duty to promote and preserve children's wellbeing as well as helping them cope and negotiate adversity. Schools have a particularly important role in promoting and investing in children's mental health and emotional wellbeing.

Some children may escalate into crisis, and it is vital to have a safety net in place including:

- Joint working to identify children at risk of crisis and take swift action to de-escalate problems
- Liaison services in A&E and in police stations
- Access to local age-appropriate places of safety
- Efforts to facilitate timely discharge from hospital, with effective support from community specialist services for those at greatest risk
- Use of the Common Assessment Framework and Care Programme Approach.

There is evidence that young adults have the poorest access to mental health support of all age groups, with unhelpful discontinuities between youth and adult services. Early Intervention in Psychosis services show the benefits of high quality support focused on young people's goals and that spans the transition to adulthood, generating significant savings. A more flexible approach to transitions and age boundaries between services, joint training for staff from CAMHS and adult mental health services, better systematic handover

when the time is right and stronger links with Youth Information Advice and Counselling, looked-after children and SEND services working up to the age of 25 may help to improve young people's experiences.

Some groups of young people face a higher risk of poor mental health, including those with learning or developmental difficulties, children in care or the justice system, children from some BME communities, and LGBT young people. Young people from vulnerable groups frequently present with multiple needs that fall below the diagnostic thresholds of individual services. A multi-sector approach is required to identify, assess and meet the needs of children from vulnerable groups in an engaging, co-produced and reaching-out way that avoids stigma, feels relevant and promotes life goals and resilience.

Best practice in commissioning

Best practice commissioning to support children's mental health and emotional wellbeing involves:

- Having effective, strong and clear leadership with multi sector sign up and commitment to a jointly determined and shared vision
- Shifting resources towards preventative activity and invest to save principles
- Building on a comprehensive joint strategic needs assessment which prioritises children's mental health and risk and protective factors compromising and supporting children's wellbeing;
- Developing an integrated multi sector Transformation Plan building on strengths and addressing current problems in the system.

Future in Mind recommends that all local areas develop Transformation Plans and sets out what they are expected to cover. The Action Plan proposed in this review provides a model for a Transformation Plan for Hertfordshire.

Routine use of high quality, timely data is also critical for effective commissioning. This should include data on whole-system activity and spending; on staff numbers, skills and roles; and on referrals, assessments, waiting times and interventions in different services. Prevalence data and national benchmarking are also invaluable to inform commissioning decisions locally.

Developing a model for Hertfordshire

Hertfordshire currently uses the well-established Tiered model to meet children and young people's mental health needs. The Government taskforce report, *Future in Mind*, concluded that this model is no longer fit for purpose. It found that the model was difficult for children, parents and professionals to understand and that it created impenetrable barriers between tiers.

Some local areas have already adopted alternative models. These include the Liverpool emotional health and wellbeing model, and the 'hub' model in Oxfordshire and in Hackney. Other local areas have created youth mental health services extending up to age 25. All of these developments have promising elements but none of them draw together activity into an approach that would meet the needs of children, young people and families in Herts.

A recently developed alternative model is Thrive. The Thrive model is also based on four groupings, based on children's needs for support and allowing for greater movement and flexibility between levels of need.

The Centre recommends the development of a modified, six-level, Thrive model. This would create a new pathway which should be named by children and young people in the county to give it a clear and credible brand.

The six levels of need for the modified Thrive model would be:

1. **I am doing well** and I am supported or know how to develop good emotional health: all local services support children and young people to build resilience
2. **I am coping:** all local services support children and young people to negotiate adversity and build resilience, for example through families and schools
3. **I need help:** prompt help from a choice of providers of evidence-based interventions
4. **I need more help:** more intensive support, offered from a choice of providers in a way children and young people find helpful
5. **I have unmet needs:** children with unclear or multiple needs, who are struggling to cope and at risk of poor mental health, who need multi-agency support
6. **I need help preparing for adult years:** joint working and commissioning with adult services to meet needs as young people mature, with a mix of services from pooled budgets.

The model we are recommending would include the following key features:

A strong foundation of universal mental health promotion and self-care: This will require investment in a systematic programme of training to raise awareness about mental health, about resilience and to enable children to disclose difficulties and help them find support, and investment in primary prevention strategies.

Early help or youth hubs: Hertfordshire should consider how to coordinate and 'glue together' primary and specialist mental health work with other multi sector activity including early years services, schools, children's services, the voluntary sector and youth work. Activity should be underpinned by shared assessments (e.g. the Common Assessment Framework)

A whole system pathway approach: A series of pathways should be developed by a range of agencies for a range of different needs. Priority may need to be given to pathways for children who self-harm, for ADHD, for children with anxiety, for those with conduct problems and for looked-after children.

The primary mental health worker: This worker will become a central reference point in the system, bridging between a range of services, training and advising other professionals, and delivering simple, evidence-based interventions. This role should be backed up by a mixed economy of commissioned services including Improving Access to Psychological Therapy (16-18 years), voluntary sector and online counselling (which is well integrated with local provision).

A highly skilled single-point of access worker: For children whose needs fall outside the skills set of primary mental health support, requiring a highly skilled practitioner who can

triage, refer and negotiate access to effective support; offer help until the young person is successfully engaged; and troubleshoot access problems.

Effective crisis care: Building on the crisis care concordat, with routine monitoring to manage performance and develop action plans to address weaknesses.

Specialist provision: A mixed economy of providers should be drawn together and commissioned through pooled funding to provide evidence-based support where it is needed. All providers will require clear roles and responsibilities and should measure outcomes and satisfaction using standardised tools and processes.

Meeting youth and young adult needs: Commissioners for children's and adult mental health should work together to achieve waiting time standards for Early Intervention in Psychosis and consider further joint commissioning, for example for Youth Information, Advice and Counselling Services.

Meeting the needs of vulnerable young people: Protocols should drive joint work to support vulnerable children and those with complex needs, using multi-agency assessment processes and the appointment of a lead professional favoured by the young person.

Outcome monitoring: All agencies providing therapeutic services should undertake routine and standardised outcomes measurement. A dashboard of indicators should be created centrally to track quality and whole system change.

Essential building blocks for transformation

To achieve a change to the model described, strategic and operational tasks need to be correctly sequenced. Strategic building blocks need to be put in place before operational activity can begin to ensure that change is sustainable.

Each element of this should include the direct participation of local people, including young people and their families.

They include:

National policy

There are a number of significant national policy drivers that will support the process: these include not just *Future in Mind* but the NHS Five Year Forward View, the Crisis Care Concordat and the Mental Health Act review and green paper.

Local strategic planning and thinking

It is vital that this process in aligned with and supported by other strategic priorities in the county. The Health and Wellbeing Board (HWB) is well placed to encourage collaborative working with a range of local organisations. A local commissioning partnership board, building on and broadening out the project board for the review, should be in place to drive the process and report back to the HWB.

Strategic partnership development

A multi-agency CAMHS Strategic Partnership group should be established, comprising commissioners and statutory and voluntary sector providers (including schools, children and young people and parents). This group should develop a CAMHS Strategy for Hertfordshire, to set out a vision for the future and to inform the local Transformation Plan.

Commissioning

Communication between the three major commissioning bodies (the County Council and two Clinical Commissioning Groups) needs to be enhanced, with an agreed approach to commissioning, an agreement about shared principles and the involvement of children, families and clinicians in service design.

Data

A standardised approach to data collection is required across the piece. Service specifications should give clear expectations for this with robust and systematic local and central contract monitoring. This must be supported by adequate IT systems to promote the best use of that data at all levels.

Capacity management

Demand and capacity management systems need to be in place to ensure services do not feel continually under siege from growing levels of demand and rising expectations. Good use of data will ensure that demand and capacity can be tracked appropriately.

Budget

Transparency about spending on children and young people's mental health is vital across the system from all local partners, including Clinical Commissioning Groups , children's services and individual schools where they hold their own budgets.

Quality

A range of quality standards and accreditation schemes is now available, for example those offered by the Royal College of Psychiatrists and the CAMHS Outcomes Research Consortium (CORC). These can be built into commissioning processes to ensure that quality is being improved or sustained.

Action Plan

The whole system review concludes with a detailed action plan, which can be used as a basis for the local Transformation Plan. The action plan is set out in two stages: first, strategic priorities, to create the necessary structural and governance framework on which to base subsequent decisions; and second, commissioning priorities, to put the vision into practice. Each stage lists actions that will be required within the first 100 days and then within six months and one and two years. Each action is linked to an intended outcome, to its impact on children and families, and to measures that will identify successful completion.

1. Meeting young people's needs in Hertfordshire

Key points

There are currently around 282,100 under 18 year olds in Hertfordshire. All these children and young people need support from conception to birth to develop strong emotional wellbeing, healthy behaviour and to promote resilience to help them cope with day to day adversity. It is critical both to prevent problems developing using evidence based strategies. It is also everyone's business (including parents, children and young people themselves) to support Hertfordshire's strong child and youth emotional wellbeing and resilience.

It is also critical to intervene as early as possible at the first sign of poor child mental health to minimise distress, disruption to life chances and to save longer terms costs. Some children and young people may need extra help and early support to help restore good emotional and behavioural wellbeing. Some may have borderline emotional or behavioural difficulties and quick evidence based and engaging support may be able to help de-escalate distressing and damaging later problems. Others may develop more serious difficulties.

At present, roughly 24,000 children aged between 3 and 19 will meet the threshold for a mental health diagnosis in Hertfordshire. By 2020 Hertfordshire can expect to have just over 26,000 children with diagnosable mental health difficulties. Evidence from this Review suggests gaps in critical prevention and early intervention activity; furthermore and worryingly only around a third of children with a diagnosable mental health problem appear at present to get the help they need. Need is most likely to be met as children escalate into more serious crises; it is less likely to be met early on. However these figures are estimated on historical data A new national prevalence survey of child and adolescent mental health will take place in 2015/16 and estimates of need will need to be revised in the light of the findings from that survey.

There is also insufficient centrally collated information tracking universal preventative activity and investment in mental health promotion and early whole system support. What we do know is that there are important gaps in what is provided at this early stage particularly investment in improving identification and proven support for mothers with perinatal mental health problems and in interventions supporting mother and baby attachment where these bonds have become disrupted. There is also inconsistent availability of evidence based programmes supporting strong mental health and emotional wellbeing for those children in schools.

Currently Hertfordshire has a Tiered system of delivery to support children's mental health and emotional wellbeing; going forward we advise using a modified Thrive model to ensure a more needs-sensitive and resilience-focused whole system approach. Analysis of the current tiered system suggests that Hertfordshire has too few resources invested in Tier 2. Tier 2, or targeted provision, reaches around 20% of estimated need in this tier. The recent addition of three more workers to the Step 2 service will increase reach to 22% of estimated need. Waiting lists are high but non-attendances are low and this appears a popular service.

Much of the data made available to the Centre on Tier 3 activity appeared either potentially unrepresentative or unreliable and so conclusions must be drawn cautiously and require improved countywide outcome tracking. Tier 3 CAMHS are generally working with a group of young people with a higher level of severity and complexity of need compared to other specialist CAMHS teams in England. There are some indications of limitations in the range of evidence-based support being offered in specialist CAMHS (e.g. use of CBT was lower than in other areas in England). Questions were also raised concerning the quality and integration of countywide activity to support children with ADHD and with autism. Developing an effective countywide multi sector pathway for both conditions should be a priority in any immediate developmental work going forward.

Tier 4 inpatient placements levels are lower than estimates of need.

Overall, there has been significant effort to reduce waiting lists since October 2014; however parents' descriptions of their experiences in a survey administered in April 2015 during this Review do not yet mirror improvements. Indeed, parents report a number of stages of waiting from referral to the point that they first receive treatment with a median of at least 9 months wait for treatment.

Although current information on universal activity is unclear, there is a need for concerted whole system action in Hertfordshire to strengthen capacity in families, children, young people and schools so that they develop strong emotional wellbeing from the start and develop healthy behaviours. Families and young people also need to know how to help themselves and where to get help should they need it. Providing better support to schools support these aims through Whole School Approaches should be a priority as well as helping school staff identify children needing help and how to access help reliably and swiftly.

There is a need to invest in evidence based prevention and early intervention programmes which have the best chance of supporting and addressing the particular needs of children in Hertfordshire. This should include a specialist perinatal mental health service with responsibility to develop local capability through a local network and training, and introducing evidence based parenting interventions for children presenting with early starting and severe behavioural difficulties.

The current system and pattern of investment in Hertfordshire gravitates towards firefighting. There is an urgent need to considerably increase and improve the capacity and reach of Tier 2 services. It would require five times the current investment to support children with estimated need in this tier.

There is also a need to strengthen the evidence base of interventions being offered across Tier 2 and Tier 3 ensuring that interventions offered have the best chance of dovetailing with local needs and improving children's outcomes. This may include expanding group based CBT in schools for young people facing academic related stress.

Stakeholders raised an urgent need to draw together multi sector activity to develop a countywide pathway supporting children and young people with ADHD. This should focus on dovetailing embedding NICE guidance recommended support and interventions.

There is an need to collect and use better quality information on system activity across all Tiers with comparable data and outcome monitoring tools being completed and information drawn together systematically on a monthly basis for analysis, countywide joint strategic consideration and action planning.

Data on financial investment in children and young people's mental health in Hertfordshire is poorly drawn together and unclear.

Based on national prevalence and Hertfordshire service data, this section will draw broad conclusions on the extent to which current service provision in Herts is meeting local need. It will also provide an indication of future projected need and the implications for service development. All findings must take into account that there is incomplete up to date information available in Herts on what is being provided across the tiers and its quality. It should also be noted that prevalence data is now 10 years old.

Prevalence and the children and young people's population in Herts

There are two critical requirements for Hertfordshire moving forward:

- There needs to be better investment in and coordination of preventative activity supporting children to develop strong emotional wellbeing, healthy behaviour and resilience.
- For those who need help, there needs to be improved early access to good quality and engaging early intervention to de-escalate crisis, restore healthy emotional wellbeing and behaviour thereby improving children's life chances.

It is everyone's business to promote the health and wellbeing of children in Hertfordshire

The CHiMAT Child Health Profiles indicate that the current Hertfordshire 0-19 population is likely to be 282,100 based on 2012 census data. By 2020 this youth population is projected to rise to 307,100 (Public Health England, 2014). There are around 14,000 live births in the county each year. All these families, children and young people will require access to good quality mental health promotion and preventative support strengthening their wellbeing and resilience.

Some children need more help

We have taken the broad prevalence rate of 9.6% for 0-16 year olds and applied it to the child and youth population aged 3-19. This calculation will only provide a very rough guide to anticipated numbers meeting the criteria for diagnosis with a mental health difficulty in Hertfordshire. For example, prevalence data is outdated and Hertfordshire has relatively lower risk for poor mental health compared to other areas of England and prevalence rates are therefore likely to be a little lower; the calculation also assumes a similar proportion of child population across all age bands (and we know this varies by age band). Furthermore, 9.6% is based on a 5-16 population. Those under 3 are likely to have lower levels of emotional crisis but may face developmental or attachment challenges; those over 16 are likely to have higher levels of mental health need.

This estimate tells us that **there are roughly 24,000 children meeting the threshold for a mental health diagnosis at present in Hertfordshire aged between 3 and 19. By 2020 Hertfordshire can expect to have just over 26,000 children meeting the criteria** for diagnosis with a broad range of mental illnesses.

National prevalence data tell us around a quarter of children and young people with clinical needs aged between 5 and 16 access the help they need. It is generally accepted that improving early access to evidence based support for those with clinical needs is a priority to prevent the escalation of difficulties, to reduce damage and distress across the life course and to save longer term costs. Improving access to proven help for those with a mental health diagnosis should be a priority for Hertfordshire. However, this should be combined with evidence-based activity to prevent problems developing in the first place. Achieving this balance and moving the system away from firefighting will require some 'double funding' - sowing the seeds for invest to save whilst also still improving the reach to those in moving into or in crisis.

What is the level of need across the Tiers?

Kurtz (1996) provided the following formula to estimate how many children sit within each tier of need. Ideally, these figures need adjustment to take into account lower levels of deprivation across most of Hertfordshire. Applying these figures to current and projected Hertfordshire child and youth populations aged 0-18 years, we would expect to see roughly the following number of children in each tier of need:

	% of children anticipated in each tier (Kurtz)	Expected number of 0-18 year olds in this tier 2012. (282, 100)	Projected number of 0-18 year olds based on 2020 population (307,100)
Tier 1	All children have access to universal provision		
Tier 2	7%	19747*	21497
Tier 3	1.85%	5219*	5681
Tier 4	0.075%	212	230

Table 1: Hertfordshire prevalence levels by tier

*The numbers in Tiers 2 and 3 roughly correspond with numbers of children in Hertfordshire likely to present with a diagnosable mental health condition (e.g. around 24,000). It should be noted that many more will have borderline needs or will be escalating on a trajectory towards mental health crisis.

This methodology indicates that the total number of children and young people with Tier 2 and 3 needs aged 3-18[1] at present is at least 24000; projected numbers for 2020 are at least 26000.

To what extent are current services meeting need?

Tier 1 services

[1] It is inadvisable to use diagnostic criteria before the age of 3. Terminology will focus on healthy development milestones (including emotional, social, communication and behavioural wellbeing in under five year olds).

The Review had access to little data on available provision in Tier 1 to support children's emotional wellbeing, healthy behaviour and resilience. This could include the extent of Health Visitor focus on supporting maternal, infant and child mental health, mental health promotion as well as universal school based provision focusing on social and emotional wellbeing. Collecting centralised data on, understanding and developing further the contribution of this tier should be a priority for any future commissioning activity. School-based universal interventions such as the Good Behaviour Game or well implemented Social and Emotional Learning programmes (such as the UK Resilience programme used in one area of Hertfordshire) would represent other types of programmes which should be tracked as part of this tier of provision. These school-based programmes have either promising or proven outcomes both in terms of attainment and promoting child's wellbeing and life chances (Knapp, et al., 2011) (Khan, et al., 2015).

Recommendation: collect better quality routine information on the time spent by midwives and health visitors on maternal or infant mental health and wellbeing. Also collect better quality information on school-based universal provision (including school nurse activity focusing on children and young people's mental health).

Tier 2 services

The Tier 2 review (Dosanjh, 2014) identified a range of services contributing to Tier 2 provision in Hertfordshire. These included:

- Step 2 service supporting children's Tier 2 needs commissioned via HCT
- Community counselling
- 'Counselling in Schools' – (a traded service commissioned via Children's Services)
- Other school counselling services commissioned directly via schools
- HPFT CLA Service County Wide
- Relate North Herts
- Signpost West Hertfordshire and St Albans
- The Base St Albans and Hatfield
- Tile House North Hertfordshire and Stevenage
- Young Concern Trust East Hertfordshire and Broxbourne
- Youth Talk St Albans & Harpenden
- Big White Wall County Wide
- Improving access to Psychological Therapies (IAPT) County Wide and for 16 plus.

The 2014 Tier 2 Review provided some insight into the numbers of children and young people accessed via Tier 2 services. Around 2721 children a year were thought to be accessing help at that time. However, since that time a small number of providers have ceased trading.

This document attempts to update information on the reach of Tier 2. However, data from tier 2 providers are not currently (or routinely) drawn together in a form that is easy to compare and analyse (particularly the availability and reach of school counselling).

The Step 2 service

The Hertfordshire Step 2 service provides telephone advice and training to professionals/referrers, as well as providing one to one sessions and group work including Cognitive Behavioural Therapy (sometimes in groups) and other brief interventions. Some questions have been raised about the extent to which provision should be more evidence based during the Review. To access the service children should be in borderline or clinical ranges (e.g. scoring over 15 using the Strengths and Difficulties Questionnaire).

The service currently has just over 10 WTE staff in place but capacity is due to increase to 13 WTE practitioners shortly following recent recruitment.

Data from the Tier 2 Review in 2014 indicated that **the service reached around 1358 children and young people. Data over the last year suggests a similar rate of face-to face interventions.** Planned expansion of the service is likely to boost Step 2 reach by a further 450 allowing approximately 1800 young people a year to access the service.

More recent data indicate that:

- Step 2 receive an average of 130 referrals a month and provide an average of 57 advisory contacts to professionals over the phone. The service experienced a 37% increase in referrals during the last quarter of 2014.
- Quarterly monitoring data from the Step 2 service suggest rising caseloads.
- Step 2 mainly deals with anxiety, depression, self-harm, behavioural problems and ADHD with some support for children with autism and children with longer term physical conditions.
- Whereas Tier 3 CAMHS appear to support an older age group, Step 2 supports a younger age group and has relatively higher referrals for boys aged 5-9.
- Despite high child wellbeing locally, St Albans is a high referrer to this Step 2 service.
- Based on a return from the first quarter in 2014, this service has high satisfaction rates with children, young people, parents and professionals (averaging around 80% satisfaction).

This service is outreach and has hardly any nonattendance (DNA)

School counselling

School counselling can be commissioned directly by individual or clusters of schools. Hertfordshire County Council also contract The *Counselling in Schools* service to deliver interventions to children and young people in primary and secondary schools in Hertfordshire. This service is a traded service, can demonstrate compliance with BACP quality guidance and is directly commissioned by schools in Hertfordshire providing:

- emergency crisis work to CYP, schools or colleges. Counselling and/or Arts Therapy sessions (individual and/or group work) for children and young people affected by exceptional events occurring within school based communities i.e. suicide of a student/traumatic death
- Management time to support/responding to exceptional events, i.e. attendance at emergency planning and follow up meetings.

- Individual/group work in a school community where something unusual has occurred affecting one or more pupils

There is an urgent need to collect better central information on the numbers of schools providing school counselling and the average monthly and annual reach of these services to individual children. Consideration should be given as to how this might best be completed building on existing database systems.

- There is an urgent need to move towards shared outcome monitoring data
- Hertfordshire should work with schools to implement the DfE's guidance on good quality counselling in schools settings.
  Based on the 2014 Tier2 review, it is estimated that these services work directly with around 500 additional children in this tier a year, referring around the same amount to other community based counselling.

Overarching data on the number of individual children and young people reached via school counselling (and its outcomes) are not drawn together and the scale of its reach is currently unknown in Hertfordshire. However, a recent survey of secondary schools reported that nearly all of these schools provided some form of school counselling (although the CAMHS Taskforce raised concerns about the variability of quality from provider to provider). A lack of counselling resources was raised during consultation events below secondary school level although we note from data supplied that Counselling for Schools provide primary school interventions. This Service may need to be better promoted.

Understanding the number of children supported through these services and the contribution they make to improved wellbeing across the county is a critical missing link in working out the extent of unmet need in this tier.

Based on a case study of one area, the Tier 2 Review (2014) estimated that school counselling was likely to be addressing the needs of around 600 children and young people in the county. In 2014/15 the *Counselling in Schools Service provided data indicating that they had delivered interventions to 1260 children.*

Taking all available school data into account (and bearing in mind that this is based on highly unreliable knowledge and may involve some double counting) , we conclude that school counselling may be reaching around 1900 children and young people in Hertfordshire a year.

Community counselling organisations

- **According to the 2014 Tier 2 review, community counselling organisations in Herts delivered interventions to around 500 young people**
- A number of community counselling organisations ceased delivery in 2014 due to financial instability in Hertfordshire.
- Those continuing to operate report that the Single Point of Access and CAMHS are increasingly signposting young people to community-based youth counselling. In

order to meet demand effectively they identify the need to be properly commissioned and resourced to respond to this increased demand.

- All Hertfordshire's counselling providers have waiting lists and on average C&YP are waiting between 8-12 weeks for treatment.

With greater commissioned capacity, they may be able to help address the current shortfall in meeting Tier-2 need. However, there would also need to be closer joint working with targeted and specialist CAMHS colleagues to review activity.

IAPT for 16 to 18 year olds

Support via Increasing Access to Psychological Therapy (IAPT) is available for 16-18 year olds in Hertfordshire and is accessed through referral (including self-referral) via the Single Point of Access (SPA) worker. A mixed economy of adult mental health services and Any Other Qualified Provider [AQP] (e.g. IAPT trained and qualified counselling organisations) deliver this type of therapeutic support. The Tier 2 review in 2014 indicated that only around 2% of those accessing these services are children and young people. Thresholds for adult IAPT are high and are broadly equivalent to Tier 3 thresholds in CAMHS (which may mean that this ultimately cannot be considered a Tier 2 service).

Based on the 2014 tier 2 review, adult IAPT reached out to **160 young people a year.**

There is a recognised awareness that this service requires better promotion with young people, their families and anyone in contact with young people in this age range.

There is also an opportunity for some of the school and community counselling services to become approved IAPT providers and for the whole system to have greater assurance regarding quality and effectiveness of CBT based support for young people needing help. Some investment may be required to strengthen administrative and data collection activity based on advice from the Anna Freud Centre.

Parenting provision

Parenting provision in Herts is at present not delivering interventions noted in NICE guidance to improve outcomes for children with the most common form of childhood mental illness - early and severe and persistent behavioural problems. The CYP IAPT training lead also advised that no training focusing on parenting provision for children with conduct problems has been delivered yet in Hertfordshire. This gap requires urgent attention as we note that there are higher than average primary school exclusions in Hertfordshire.

However, a range of broader parenting provision is available in the county. These programmes measure improved parental outcomes using the TOPSE outcome measurement tool. This provision does not routinely track the impact of any parental improvements on children's emotional health and wellbeing, e.g. using pre and post Strengths and Difficulties (SDQ) scores. Going forward, it would be useful for Herts parenting provision to evidence impact on children's wellbeing and to record and report to commissioners on child as well as parent related outcomes. With greater evidence of impact on children's outcomes, current parenting provision could, together with NICE guidance backed interventions, form part of a

wider stepped approach to supporting parent/carer and child emotional health and wellbeing outcomes.

It must be a priority to train up and quality control proven parenting programmes targeting these at children with severe early starting behavioural problems (Centre for Mental Health, 2012). This provision could support and dovetail with the recently commissioned PALMS service and should form part of any offer and assessment when a child is at risk of primary school exclusion.

Tier 2 waiting lists

- The waiting time for initial assessment for Step-2 is 12-14 weeks. Waiting times for treatment often then involve a further wait of 12-14 weeks.

- In April 2014, Step 2 waiting lists represented 39% of the current caseload; by December waiting lists represented 77% of the current caseload. Although three more staff are in the process of being recruited, this will still leave a waiting list that will be 63% in excess of the current caseload.

- All Hertfordshire's counselling providers have waiting lists and on average C&YP are reported to wait between 8-12 weeks for treatment.

- When asked about their generic waiting period for support from CAMHS services, parents reported long and separate waiting periods between referral and first contact with a CAMHS service, first contact and assessment and finally assessment and parental perception of when treatment began.

Estimates of children with needs reached in Tier 2

A very low number of children appear to be reached via Hertfordshire Tier 2 provision. However, the reach of this tier is projected to increase with the recruitment of 3 new WTE workers.

Services in Tier 2	**Estimated reach in 2014**
Step 2	1358
Community counselling	500
School Counselling	1900
IAPT	160
Total tier 2 reach	**3918**
Total estimated need in tier	19747
Percentage reach in tier	**20%**
Shortfall in meeting estimated need	15,829

Table 2: Tier 2 reach in Hertfordshire

With three new Step 2 workers currently being recruited, the reach of Tier-2 services is likely to increase to around 22% of total Tier-2 need (19,747) in 2015 (based on 2012 population calculations). This will raise the reach to 4368 children.

However, **there would need to be around 5 times the current investment in Tier 2 support to meet estimated levels of need in this tier,** even with the three new workers already recruited.

Expected number of 0-18 year olds in Tier-2 based on current CYP population[2] (282, 100)	Projected number of 0-18 year olds in Tier-2 based on 2020 CYP population[3] (307,100)	Actual numbers being reached in Tier-2 in Herts based on current youth population (282,100)	Numbers reached in Tier-2 with 3 planned extra Step 2 workers in Herts based on current youth population (282,100)
19747* (7%)	21497 (7%)	3918 (1.4%)	4368 (1.6%)

Table 3: numbers of Hertfordshire children reached via current Tier 2 services.

There is one important qualification to this current estimate of the shortfall in Tier 2. Many community paediatricians and Special Educational Needs teams may also be supporting an additional unknown number of young people with Tier-2 needs who may not be in contact with emotional health and wellbeing services. For example, many young people with developmental difficulties will also have a diagnosable mental health difficulty; some will be accessing CAMHS but others will be supported by these other teams directly. There is currently a lack of information on the numbers of children accessing these other services with emotional health and wellbeing needs. However, this lack of information on the numbers of children with needs in contact with these services is not likely to impact significantly on the current shortfall of around 17,000 young people with estimated unmet needs.

Tier 3

Note: The dataset supplied covering Tier 3 CAMHS activity spanned April 2014 and December 2014. It included significant spikes both in accepted referrals (a 4000% increase in October 2014) and discharges which affected the reliability of conclusions for this Tier. A decision was made to exclude the month where this spike appeared. Potential errors have been reported but no clarification has as yet been forthcoming.

Analysis of Tier 3 activity data between April 2014 and December 2014 indicates:

- An average caseload over the period of 3256 for Tier 3 CAMHS workers.
- The data also indicates a reduction in the monthly caseload of around 15% between April 2014 and December 2014. There should be further investigated to monitor if this trend continues or changes and to understand any underlying drivers.

[2] Kurtz,1996
[3] *ibid*

- 'Accepted referral rates'[4] which amount to around 4190[5] per annum. Not all of these children and young people will have followed through and contacted the service; any conclusions about reach to children and young people with diagnosable difficulties must therefore be cautious. It was not easy, from the data provided, to accurately assess the number of children reached with tier 3 interventions.
- An average caseload of around 40 for HPFT Tier-3 workers. This caseload size is as recommended by the Royal College of Psychiatrists workforce guidance for CAMHS (RCP, 2013).

The reach of Tier 3 CAMHS compared with estimated need

Overall, the data supplied on Hertfordshire 'accepted referral rates' between April and December 2014 for Tier 3 CAMHS suggest that the service received the equivalent of 4190 accepted referrals on young people over the year. On this basis, Tier 3 CAMHS appear to reach 80% of estimated need in this Tier (estimated at 5219) (Kurtz, 1996). Not all of these young people will have gone on to receive a service and there is generally evidence of an average of 15% non-attendance/cancellation rates in Tier-3 CAMHS.

If we remove the number of 'accepted referrals' from the C-CATT Crisis Care team in this data (as we may be double counting young people in these accepted referrals), then **this would mean 'accepted referral rates of 3800 which means the Tier 3 CAMHS reach may be 75% of estimated need in this tier.**

Expected number of 0-18 year olds in Tier-3 based on current CYP population[6] (282, 100)	Projected number of 0-18 year olds in Tier-3 based on 2020 CYP population[7] (307,100)	Actual numbers being reached in Tier-3 services in Herts based on current youth population (282,100)
5219 (1.85%)	5681 (1.85%)	3800 (1.35%)

Table 4: comparing expected and projected numbers of children with tier 3 need compared with current reach

Outcome monitoring, engagement, satisfaction and quality

Child Outcomes Research Consortium (CORC) data provide an overview of the nature and quality of service delivery by Tier-3 CAMHS nationwide and in Hertfordshire. They are updated on a monthly basis and provide a benchmark with other Tier 3 CAMHS in the country. These data provide us with the following overview of the quality of services in Hertfordshire:

- There is generally very low data completeness on pre and post changes in children and young people's outcomes - although completions are higher than those submitted in other areas of the country.
- Tier-3 CAMHS in Hertfordshire are working with a young group (predominantly of secondary age) with higher levels of initial severity of need (according to Strengths

[4] It is very difficult to know how useful this is as a proxy for contact with children with diagnosable mental health difficulties. However, it is probably the best proxy we have based on the data made available.
[5]

[6] Kurtz,1996
[7] *ibid*

and Difficulties Questionnaire). Herts data show initial severity ratings of 20 as opposed to an average starting point of 18 in other areas of England Hertfordshire children report reducing to just above the clinical level at the end of treatment. There is generally an improvement in pre and post scores after support has been offered.

- Children and young people attending Tier-3 CAMHS (in comparison with others in the country accessing services at this level) were more likely to have attainment and school-related problems, to have family/community problems, to be more likely to present a risk to others, to have young carer status or deemed to be in need of social service input.
- Tier-3 CAMHS in Hertfordshire are also seeing a group with more complex health and social presentations including more children with autism compared with other areas of the country.
- 9 out of 10 young people in contact with Tier-3 CAMHS in Herts receive between 1 to 6 face to face contacts as part of this care.
- Session-by-session Symptom Tracker completeness is lower for Hertfordshire compared to national benchmarks. This is important as using data on a session by session basis to inform progress can improve children's and young people's treatment outcomes.
- Tier-3 CAMHS in Hertfordshire had some areas of lower satisfaction rates compared with other areas of CAMHS in the country. Generally lower satisfaction was noted concerning how easy staff were to talk to, how capable they were seen to be in terms of helping young people, how well they explained the therapeutic process, and how empowered young people felt with ideas to help them move forward.
- The most common presentations in Hertfordshire Tier-3 CAMHS were anxiety, self-harm, depression, eating disorders, family relationship problems, and out of control behaviour.
- In terms of intervention, these children and young people were less likely to receive Cognitive Behavioural Therapy (CBT) or pharmacology and more likely to receive family or systemic therapy. The lower likelihood of receiving CBT is of some concern given that Hertfordshire children and young people were more likely to present to Tier 3 services with anxiety and depression.

	2013 DNAs	2013 Total	2013 DNA Rate	2014 DNAs	2014 Total	2014 DNA Rate
CAMHS North	1,009	7,131	14.15%	1,149	6,534	17.58%
CAMHS South	664	4,975	13.35%	974	5,340	18.24%
CAMHS West	749	7,757	9.66%	798	6,941	11.50%
CAMHS East	442	4,878	9.06%	519	4,023	12.90%

Table 5: table showing the percentage of children not attending Tier-3 CAMHS appointments.

- Nonattendance rates for 2014 average 15% for Tier-3 CAMHS. DNA rates range from 18% in the south to 12% in the west. We are informed that these nonattendance rates include parental and practitioner cancellations. In 2013 national benchmarking, Hertfordshire had one of the lowest nonattendance rates in the country. It is very difficult to assess whether this has changed because the data is not disaggregated to allow easy comparison. It is essential that there is countywide routine tracking of child and young people's nonattendance, parental and practitioner cancellation as these are key quality indicators. There may also be transferable learning from the working methods used by Step 2 in Hertfordshire who achieve largely 100% attendance rates.

Waiting lists

Quantitative data was made available tracking how many children and young people were provided with a Tier-3 CAMHS appointment within 28 days for routine (non-urgent) needs in Hertfordshire between October 2014 and April 2015.

Two quarterly performance monitoring reports were made available tracking :

- What percentage of young people received their first appointment (or their assessment) within 28 days
- The time between first appointment and the start of treatment

Referral to assessment

HPFT data indicates a sustained improvement month by month during the currency of this Review ranging from 28% of children receiving an assessment within 28 days in October 2014 to 88% receiving their first appointment within this timescale by the end of March 2015. This seems to represent a 215% improvement over this period. Improvements were largely attributed to more efficient SPA activity, using pre appointment telephone calls to reduce wasted appointments and through offering more 'choice' appointments (introduced to improve choice and partnership with young people).

Quarterly returns also report a slight improvement in the waiting period between first appointment and the start of treatment (or what is often called the partnership meeting). In Quarter 3 this was recorded as being around 6 weeks with some longer waiting periods in certain parts of the county (sometimes due to staff vacancies); in quarter 4 the average waiting period from first appointment to partnership or first treatment appointment was 32 days.

Parents' perceptions of waiting times for all CAMHS

On the other hand, these improvements in the systems of support do not appear to have been picked up by parents. Qualitative evidence emerging through face-to-face consultation, surveys (distributed in April 2015) and via the clinical reference group suggested parents were generally unhappy with waiting periods (although it should be noted that this dissatisfaction applies to both Tier 2 and Tier 3 CAMHS). From their perspective, they experienced a number of stages as they waited (between referral and first contact with

someone, first contact and assessment, and assessment and treatment). Between each stage there was a waiting period. Taking a generous approach the median timescale for this overarching wait between referral and the start of treatment was at least 9 months but may well be longer.

In a recently disseminated parent survey (NB on general experiences of CAMHS), a quarter of parents said they received their assessment within 28 days; the median timescale from referral to assessment was 1-3 months. Furthermore, nearly three quarters of parents were unhappy with the time it took from referral to get their child's first appointment.

Waiting periods for treatment appeared longer with a median waiting period of 4-6 months

These disparities may be the result of changes which have occurred very recently (with parents' experiences predating improvements in both tiers). However, it may also be that there is a disparity somehow between how parents experience the system and how it appears from the perspective of services. For all these reasons, access as an issue requires ongoing urgent attention ideally with a multi stakeholder group including children, young people and parents.

There should also be a focus going forward on tracking monthly satisfaction rates with service waiting periods and with the quality of the service provided.

Children and young people in crisis

In 2014, Dosanjh reviewed the crisis care pathway in Hertfordshire noting a 203% increase over two years in referrals to the county's Crisis (Hertfordshire Adolescent Outreach Treatment) team along with mounting caseloads. Just over half of those presenting in crisis were known to specialist CAMHS (either already being treated by specialist CAMHS or waiting for treatment following their initial appointment). A small additional percentage had relapsed after contact with CAMHS. Hours for the Crisis team were extended to 8am to 9am during the week and with morning weekend cover following this review.

Increased crisis presentations must also be considered in the broader context of Tier 2 and 3 CAMHS in Hertfordshire meeting just over a third of estimated diagnosable need in the county. There is a large degree of unmet demand particularly early on in the system. Untreated mental health problems can often escalate into more distressing, damaging and costly crises without earlier identification and action.

Furthermore, if the whole CAMHS system is not considered and prepared when change is made to individual parts of that system (e.g. introducing Crisis teams, reducing crisis management responsibilities in Tier-3 community CAMHS teams etc), then this can create sudden spikes in demand unearthing unidentified and unmet need with a subsequent flood of demand into other areas of the system.

Finally, increases in crisis presentations among those known to CAMHS may be linked to poor crisis planning with children, young people and parents which could help them to know how to recognise and respond to signs early and know who to contact should they experience any worrying deterioration in wellbeing. Interestingly, most parents in the

recently distributed parent survey did not know who to contact in the event of a deterioration of their child's mental health and wellbeing.

Quarterly monitoring data from HPFT indicates an improvement in responses to children in crisis via the relatively newly introduced C-CATT crisis service with 96% seen during the last quarter within 4 hours; 92% of urgent referrals were seen within 7 days.

Tier 4 Hertfordshire placements

Forest House is a 16-bed Tier 4 Inpatient CAMHS located in Hertfordshire but taking referrals for young people across the country.

In 2014, **93 young people from Hertfordshire were placed in a Tier 4 CAMHS inpatient setting**. This is a much lower number of young people in inpatient settings compared with general estimates of Tier 4 need based on the population size (Kurtz, 1996).

Expected number of 0-18 year olds in Tier-4 inpatient setting based on current CYP population[8] (282, 100)	Projected number of 0-18 year olds in Tier-4 inpatient setting based on 2020 CYP population[9] (307,100)	Actual numbers being reached in Tier-4 inpatient setting in Herts based on current youth population (282,100)
212 (0.075%)	230 (0.075%)	93 (0.033%)

A small number of children were also placed on inappropriate paediatric inpatient wards (thus requiring additional back up support from Forest House staff). Forest House has also reported increased use of its Section 136 suite (but this may not be for Hertfordshire children).

Although inpatient placement rates in Hertfordshire are below the national and regional average, a 55% increase in inpatient placements for eating disorders is noted in Forest House comparing 2014 with 2013 rates. CYP IAPT trainers also noted that no CYP training on evidence based provision for eating disorders has yet been delivered to teams in Hertfordshire. This training is logistically challenging since it requires the whole team to complete CYP IAPT training in order to achieve the required cultural shift to change practice.

Overall implications of available data

- There is no information on interventions promoting and supporting children and young people's emotional health and wellbeing in Tier 1/universal services. This needs to be more accurately collected to inform countywide commissioning;
- Data from Tier 2, 3 and 4 suggests that services are currently only managing to reach around a third of young people even with diagnostic needs in Hertfordshire. Many more children with sub threshold or escalating needs may well be getting overlooked.

[8] Kurtz,1996
[9] *ibid*

Tier 2	4368 (including 3 additional Step 2 workers recruited)
Tier 3	3800
Tier 4	93
Total reach	8261 (34% of total estimated)

- Despite significant efforts being made to improve access on the part of services, parents report generally lengthy and numerous waiting periods from the time they get referred to the time they get the help they need. The median waiting period from referral to treatment is at least 9 months.
- Tier-3 CAMHS engages with a group with more complex and severe presentations than other areas of the country and appears to reach around three quarters of need; available data do not easily allow commissioners to assess the reach of Tier 3 CAMHS.
    - CORC data[10] suggests that children and young people are less satisfied with the service experience compared with other national provision at this tier of need.
    - There is also poor use of outcome and satisfaction data together to inform children and young people's experiences and outcomes
    - The Whole System Review and consultation and surveys have revealed a general lack of satisfaction on the part of parents, young people and children about waiting periods and the 'CAMHS' service experience.
- Tier-2 services currently only reach around 20% of estimated need in this tier and should improve their reach to 22% shortly with three additional WTE practitioners. Lower levels of proven prevention and good quality intervention in this tier, suggests that the Hertfordshire system gravitates towards firefighting. Many parents in the parent survey talked about experiencing an 'overloaded' system.
- Step-2 services appear to be popular but may require strengthening to include more systematic use of evidence-based approaches via CYP IAPT training.
- There is an urgent need to increase overall capacity in Tier-2 to meet need early, support early intervention and prevent damaging and expensive crisis presentations.
- There is an overall need to collect and use better quality information on system activity across all Tiers with comparable data and outcome monitoring tools being completed and information drawn together for systematic monthly analysis, countywide joint strategic consideration and action planning.

Addressing the gap between need and current provision

- There is an urgent need to improve whole system activity to build children's emotional assets and to prevent difficulties emerging in Hertfordshire by investing in universal and targeted services.
- There is a need to improve whole system data collected on activity to support children's health and emotional wellbeing in Hertfordshire – but particularly drawing together information on activity at a universal or targeted stage.

[10] Again low number of responses affecting representativeness of the sample.

- There is an urgent need to look at ways of getting children help more swiftly and of supporting children, young people and families while they wait.
- There is also a need to develop a strategy to deal with future increases in the child and youth population in Herts. By 2020, it is estimated that there will be 2000 more children and young people meeting the criteria for a diagnosable mental health difficulty with many more borderline or multiple needs compromising their wellbeing.
- Future commissioning should aim as far as possible to take the whole system into account when building capacity. Through building a whole system strategy and training, it will prepare the whole system to support and manage any change in approach (rather than patching up areas in crisis in the system).
- It would build change incrementally
- It will measure whole system change routinely making adjustments and contingency plans as difficulties emerge in the system
- Should be based on an 'invest to save' principle.

Making sense of available data on current investment

When attempting to draw useful conclusions from the Hertfordshire financial data on CAMHS, the following should be borne in mind:

- Commissioning and contracting takes place via a number of channels, some of which do not perceive that what they are commissioning constitutes CAMHS provision so (particularly at Tier 1) information is incomplete.
- Commissioning in schools is particularly challenging. The introduction of Academies, whose budgets are devolved entirely from the local authority system, has led to a proliferation of purchasers who are not at the moment required to identify spend that supports young people's emotional health and wellbeing as pertaining to CAMHS.

Information regarding Tier 1 provision is patchy at best, but below is a table showing a number of initiatives and (where available) how much has been spent in 2013/14. Unhelpfully there is no indication of how many young people have been targeted or actually reached by these services.

Vulnerable Young People Policy Team Total commissioning spend	£98,000
Targeted support for teachers delivering drugs education	£4,000
Evaluate mentoring service for substance misuse	£10,000
Produce smoking policy for schools	Individual spend unavailable
Training Needs Analysis and course commissioning around substance misuse	£7,000
Resources and information on NPS, cocaine, alcohol and substances	£2,000
Universal Prevention SRE Summit	£4,500
Youth led campaign around substance misuse	£1,000
Conference to promote five ways of	£7,000

wellbeing	
Universal Prevention '@Johnnie_Elf' Twitter Campaign	Individual spend unavailable
Provide counselling support to young people in the Targeted Youth Support Service	£30,000
Universal Prevention Young People's Health & Support 'Numbers you Need' Database and Booklet	£15,000
Implement recommendations of 'Impact of substance misusing parents on families'	Individual spend unavailable
Partnership Fund substance misuse projects	£20,000
Working with 'At Risk' groups promoting wellbeing and physical activity	£25,000
Support for Teachers delivering SRE	£5,000
SRE Progamme in Stevenage	£20,000
Universal Prevention 'You're Welcome' Scheme	£2,000
Universal Prevention SRE Campaign	£1,000

Tier 2 provision currently consists of a combination of services, which only appears to be addressing the needs of 20% of the estimated cohort of young people meeting the criteria for intervention.

Services comprise:

- Step 2 psychological services (provided by HCT) - £420k pa
- Community Counselling (through voluntary sector providers across the county) - £152k pa
- Counselling in Schools – commissioned by schools' integrated Health and Care Commissioning (£1,620k in 2013/14)
- Protective Behaviours training delivered through schools and children's centres (around £42k pa)

A review of Tier 2 services was carried out in May 2014 and as a result the services have been overhauled. It is recognised that these changes are interim and subject to potential revision as a result of the full CAMHS review.

The review recommended an additional financial commitment of £117k pa to reduce immediate pressure.

The recently introduced PALMS (Positive Behaviour, Autism, Learning Disability Mental Health Service) aims to reach 500 families per year at a total cost of £1.5m per year. It is difficult to tell at this stage what impact this service will have in meeting Tier 2 need. The following however should be noted:

- The scope of the service extends beyond standard CAMH service user cohorts
- The service is not yet fully operational and a number of posts remain as yet unfilled.

Centre for Mental Health's report, *Investing in Children's Mental Health* (2015), demonstrates that investing in an enhanced Tier 2 provision can improve outcomes for a large number of young people at minimal cost.

The figures show that between now and 2020 the annual prevalence of mental health problems that could be addressed at Tier 2 in Hertfordshire is around 20,000 individuals. Many more may have multiple or subthreshold needs that compromise their future wellbeing.

Tier 3 services are commissioned entirely within the much broader block contract with HPFT for mental health services, and within 2014/15 the total budget allocated to specialist CAMHS was £10.4m, and Q3 reporting suggests that actual spend to date is almost on budget.

Given that, as identified earlier, around 75% of the young people who meet the criteria are being treated within this group, an initial assumption might be that the figure needs to increase by 33% to £13.53m in order to satisfactorily meet need.

However this is a simplistic view and the required additional investment should be scaled down significantly to take account of the following:

- Actual spend within the HPFT contract hides the number of vacant permanent positions currently filled at a much higher annual cost by interim staff. Shifting to full provision within this contract will significantly increase capacity.
- There is reason to believe that the low provision of Tier 2 services has led to additional pressure being brought to bear on Tier 3. Increasing the (less expensive) provision at Tier 2 should remove this additional pressure and enable Tier 3 meet the demand for service more efficiently and effectively.
- This does assume that additional investment is focussed on better quality assessment at intake, to ensure that young people are referred to the service that will meet their need most effectively, at the lowest effective cost.

As Tier 4 services are commissioned centrally by NHS England, they fall outside the scope of this review. Services are provided by HPFT to meet these needs, and comprise a number of specialist inpatient beds. Nationwide commissioning allows bed spaces to be utilised across local authority borders, and means that young people in receipt of these services may be treated outside Hertfordshire.

New money anticipated in the system

Any new money in the system is not yet certain and will need to be further guaranteed under the new political administration.

The latest estimate of the total CAMHS spend is £700m nationally.

£200m of the £250m announced in the budget following the *Future in Mind* report is for CAMHS. If it is provided, this would bring the total NHS spend on CAMHS up from 0.6% to 0.8%. However, this figure simply takes account of the local NHS spend and does not

include local authority investment in CAMHS which is often additional and challenging to identify.

The *Future in Mind* report makes no clear statement on anticipated increased funds so it is impossible to be certain of the robustness of some of the additional investment touched upon in these documents.

The breakdown from The Treasury Budget Day announcement was as follows:

- £118m would be made available for IAPT until 2019 (this is relevant for 16-18 year olds)
- £75m would be invested over 5 years for perinatal and infant mental health
- £1.5m would be available for joint training pilots for GPs and teachers and for training designated mental health leads in schools.

Narrowing the gap between Herts service provision and need

Our rough calculations indicate that overall 34% of children who meet the threshold for a diagnosable mental health problem are currently being reached by Hertfordshire Tier 2-4 CAMHS services. Most of these children are reached by specialist CAMHS services (not earlier in the system). Furthermore, these calculations do not take into account those additional children who will be on a trajectory towards poor mental health or facing mounting risk factors likely to jeopardise their emotional health and wellbeing in the future.

There are a number of imperatives for Hertfordshire going forward:

1. To better integrate and dovetail multi sector activity and strategy supporting strong emotional wellbeing and mental health. This process will start through multi sector task and finish groups focusing on pathway development in priority areas and will build on Common Assessment and Team Around the Family Frameworks. Developmental whole system CAMHS work will need to dovetail closely with a number of other developmental work streams in Hertfordshire including Childhood Support's work streams on Early Help, the 0-25 offer for children with SEND, Family Safeguarding and PALM developments. Over time, Hertfordshire should aspire to co-locate multi sector Children's and Family Services and health (midwives, health visitors, Tier 2 and 3 CAMHS, paediatricians, SEND teams, school nurses etc.) teams within local Children's Early Help or in Youth Hubs. Appendix E and F of the Needs Assessment include a list of children's centres and youth resources to support future developmental activity.

2. To invest in effective prevention and earlier intervention to reverse future flow towards damaging and costly crisis experiences and settings. This includes:
    a. building capability in perinatal maternal and infant mental health, early years and school settings to strengthen preventative work supporting strong child emotional architecture into daily activity;

3. But as a priority there is also a need to close the gap between those currently meeting diagnostic needs and existing inadequate service coverage:

a. This means building capability and capacity in first response systems when children and young people initially present with needs to ensure that the gap between likely need and available early support is closed. Improved training of all of those in contact with children and young people, the development of better systems of self-help, improved capacity built into the system at the early stages of needing help, and improved focus on support at the right time, in the right place and that has the best chance of helping restore young people's health, is required.

b. All of these changes should promote strong wellbeing, resilience and prevent the escalation of difficulties into crisis.

Priority areas of investment

Note: The effects of introducing effective early intervention services will take some time to work their way through. For this reason some double funding will be required during this transitional period.

Perinatal mental health services

Poor maternal or perinatal mental health is a risk factor for poor childhood mental health, particularly conduct disorder. Severe and persistent behavioural problems potentially affect around 6% of children in Hertfordshire. This will mean:

- 13,778 3-18 year olds across the county based on current child and youth population numbers, or
- 14,999 3-18 year olds across the county based on 2020 child and youth population numbers

Some children presenting with conduct problems not only face damaged life chances but also impose significant costs affecting a range of public services including the justice system, social care, the NHS, schools etc.

At present, around 50% of mothers with maternal mental health problems get identified; even fewer get swift access to evidence based interventions that can make a difference to their recovery and their child's future emotional prospects. As a priority and interim measure Hertfordshire should:

- Ensure a fast track referral process to Improving Access to Psychological Therapies services for these mothers
- Develop a local network supporting improved training and multi sector awareness among midwives, health visitors and GPs.

Hertfordshire should commission a specialist perinatal mental health service to provide direct delivery to those with specialist perinatal mental health needs and also to develop and coordinate a Hertfordshire perinatal network and training for those dealing with common maternal mental health problems. Hertfordshire should also commission parent infant interventions as part of targeted activity for parents and children whose attachment has

been disrupted as a result of poor maternal wellbeing. The estimated costs of implementing these changes are outlined in the final section of this chapter.

Commissioners should also assess the extent to which the expansion of adult IAPT is likely to cover need in Hertfordshire. There may also need to be pooled investment in the expansion of health visitors, who have a key role in identification and signposting to support. Costs for expanding these services to meet the need of all mothers in Hertfordshire with mental health problems is set out fully in the final chapter of publication *The costs of perinatal mental health problems* (Bauer, et al., 2014).

Training to develop capability in the system

During the review, many universal services in Hertfordshire expressed low confidence in dealing with children with poor emotional health and wellbeing and low knowledge of where to get the help they need in what felt like a confusing system. There is also a need to support cultural change with everyone recognising how they contribute to improving children's emotional health and wellbeing, how they support children through short-term adversity and feeling adequately equipped to secure early help.

The Centre recommends the prioritisation of proven training interventions to support whole system change. There is promising evidence that interventions such as Mental Health First Aid can improve awareness, knowledge, identification and confidence in managing mental health issues both in school children and in health professionals (Kitchener & Jorm, 2004).

These could be combined with local Hertfordshire training.

Training should be coordinated and tracked and evaluated to assess reach (including locations in Hertfordshire), the extent to which it represents best value and contributes to the coordinated Whole System Review aims. The most effective training could then be built upon and coordinated to form a systematic offer building capability in the system.

Some additional developmental work is also needed to draw together and coordinate a range of training and awareness-raising for parents, children and young people. Hertfordshire already provide the following training for parents on issues linked to children's and families' emotional wellbeing and mental health:

- My baby's brain
- My teen's brain
- Families Feeling Safe

Further opportunities to support young people may also include:

- Developing and extending the work of Hertfordshire's award winning peer health champions in schools to include emotional wellbeing and mental health. This work will require some further investment, support and coordination to be extended successfully.
- Commissioning an organisation such as kooth.com working with local young people and schools to develop awareness both of what poor emotional wellbeing looks like

and how to seek help. This awareness-raising activity is a standard part of the kooth.com digital counselling service.

It is a recommendation of this Review that a youth participation worker be recruited to develop peer mental health champion support linking with broader school development work and also developing early support models for some children from BME communities.

Strengthening the use of evidence based therapy in Hertfordshire

There is a general need to improve the ability of all practitioners intervening with children, young people and families to offer evidence based interventions to support their emotional wellbeing and mental health. CORC data indicate lower use of CBT approaches among specialist CAMHS practitioners in Herts compared with other areas of the country. CYP IAPT training offers a number of opportunities a year to increase the robustness of what is being offered in local areas. CYP-IAPT is a whole service transformation approach that builds capacity in evidence based interventions, the best use of feedback and outcomes data, and service user participation. CYP IAPT data for Hertfordshire indicate lower training being taken up focusing on parenting interventions for children with conduct problems and lack of take-up of eating disorder training. The evidence base for some of the brief interventions offered by Step 2 also remains unclear.

CYP IAPT involves a significant time commitment but offers free training with some back fill money made available to help deal with staff absence. However, only a few training opportunities are available each year.

The action plan for this review recommends a workforce audit going forward. This audit should take into account gaps between local practice, local need and the evidence base. A training plan should be developed to increase evidence based capability over time.

CYP IAPT training can be made available to both the statutory and voluntary sector. However, voluntary sector involvement in this training would require investment in the required data collection systems (CAMHS Minimum Dataset) to support reporting and practice going forward.

Strengthening Hertfordshire's Whole School Approach

A whole-school-approach is essential to promoting the wellbeing of children in schools. There are pockets of excellence in Hertfordshire but also underdeveloped activity in schools on occasions. Hertfordshire has already produced a number of toolkits for schools and GPs. However, it has been challenging to ensure that toolkits are used systematically in practice.

This Review recommends investment in the following resources to help schools in Hertfordshire build their capability:

- Commissioners should employ a Healthy Minds Coordinator to work closely with clusters of schools and existing pastoral networks and to help develop practice and disseminate learning across all Hertfordshire schools. This role will particularly focus on developing capability in primary schools. This could be a Step-2 worker or alternatively this practitioner could work in the Central Commissioning Support team.

The youth participation worker should work closely with this Healthy Minds Lead and with any digital provider if such an approach is commissioned going forward.

- The Review also recommends piloting the North Herts Emotional Health Support Service proposed (outlined in Appendix B). This service aims to build capacity in and develop therapeutic services for a cluster of North Herts schools. The proposed service should be commissioned on the understanding that pre and post training, therapeutic and satisfaction outcomes will be tracked and fed back routinely to the joint commissioning group to help evaluate its impact and transferable learning.
- Later on in this document, we recommend considering a high quality digital support provider (who provide digital and telephone assistance) to extend current capacity to respond to children who need help in Hertfordshire. As part of their core offer and price, some work with secondary schools to promote awareness of MHEWB and their service in schools and through assemblies. They also provide short term counselling and help children and young people bridge to Hertfordshire provision if children need longer term work. They also support young people during any waiting period. Data on this promotional and capability building aspect of the digital provider's service should be reported centrally every quarter to the joint commissioning board.
- Schools in Hertfordshire should be clustered and given a named Step 2 worker as a key liaison contact for advice and consultation.

Universal SEAL type programmes

There are a few *preventative* and *universal* interventions with proven ability to reduce the risk of conduct problems developing for children.

The most common childhood mental health problem is conduct disorder. The Good Behaviour Game is a primary school based programme which is cheap to deliver and can reduce the rate of future conduct problems. Early persistent conduct problems are highly damaging to children's life chances and costly first and foremost to schools and later to the NHS, social care and mostly to the justice system. Each child meeting the threshold for a clinical diagnosis (5%) will cost the system £280,000 during their lifetime without effective intervention. A further 15% below this threshold will also face poorer life outcomes. **These interventions would appear important for Hertfordshire as we note a general lack of such provision and higher number of primary school exclusions compared with other local authorities.**

Some Social and Emotional Learning programmes (e.g. Families and Schools Together, PATHs, UK Resilience programme,) also have promising evidence of impact on broader emotional health (although evidence suggests that must be well implemented to reproduce outcomes in real life settings).

These programmes are usually commissioned in schools as part of their Whole School Approach.

Ensuring swifter help for children, young people and families needing help with their emotional health

Nice guidance recommended parenting programmes for children with early starting behavioural difficulties

Most children go through stages when their behaviour becomes challenging. However, some children get stuck in these patterns and need help. Proven evidence based programmes supporting parents with positive parenting techniques can often quickly help children stabilise and improve their future life chances. For every £1 invested in these relatively cheap programmes, it has been calculated that there is a £3 return. The first to benefit from savings from these early intervention programmes are schools; later on, it is the justice system that benefits significantly.

In a one year cohort, Hertfordshire is likely to have around 750 children under secondary school age who meet the criteria for these programmes (e.g. those scoring at least 17 plus on the parent or teacher SDQ screening tool). These programmes should be used routinely to support parents concerned about their child's behaviour or to support children at risk of primary school exclusion. Most parents with a child in this higher risk group will approach schools for advice (Green, et al., 2005). One to one versions are available although delivery costs are higher for individual work and research reviews show that parents gain less benefit from one-to-one support (as these interventions are also prove to improve parental mental health). Some investment must also be made in systems of quality control and programme specific supervision (analysing routine trends in data to ensure accurate targeting, effective engagement and tracking outcomes) to ensure programmes are delivered as intended. Supervision costs are built into the delivery costs of £1300 per parent (Centre for Mental Health, 2012).

Although Hertfordshire has some parenting programmes in place, NICE guidance recommended programmes for children under 10 are not currently available and should be commissioned specifically as an intervention to support parents and children early on where children have moved into unhealthy ranges. They can be used with children from 3 to 10 years. For every child they are used with, there is an as yet uncosted impact on siblings as well as the proven effect on a child's and parents' mental health.

In order to meet the needs of the 750 children per year group across the county with severe behavioural difficulties, Hertfordshire would require a considerable number of staff to specialise in this delivery and to be trained up in approaches. Each staff member delivers in pairs with each pair running around 4-5 groups a year (i.e. reaching around 60 parents).

Incredible Years (or Webster Stratton) training would be free via CYP IAPT but it would take a lengthy period of time to train up sufficient staff to be able to meet the need of even half of the 750 children with these needs.

Triple P level 4 training targets 20 practitioners at a time but would require these workers to have the space to specialise in or prioritise this work regularly and systematically to meet the full extent of need. Incredible Years/Webster Stratton also have the ability to offer block

training to groups of staff in this way for broadly similar fees. With both Incredible Years and Triple P a supervisor should be trained up to support fidelity and quality of delivery.

NICE guidance parent training should form a core part of Step 2 service provision (they work more often with this younger age group and tend to see more boys who are more likely to present with externalising behaviour). We recommend that **Step 2 recruits 4 additional practitioners** to train as parenting specialists. In the first year, two parenting specialists could be trained up in Incredible Years (together with a supervisor from specialist CAMHS which needs to start this training 6 months beforehand). However, using free places through CYP IAPT takes a very long time.

Alternatively, 20 Step 2 and CAMHS specialists could be trained up in one go through more intensive Triple P level 4/Incredible Years training. Two of the Step 2 parenting training specialists would then coordinate, co-deliver and supervise the quality of what is provided round the county.

Reducing the gap between need and workforce in Stage 2 (e.g. a child needing help)

This Review estimates that current Tier 2 provision (The Step 2 service, school counselling, community counselling, IAPT) only reaches 3628 children and young people who need help (out of around 19,000). These estimates only include those children with a diagnosable need and do not include those with borderline diagnosable mental health issues who may need support to help de-escalate later crisis. Of course, some children may recover naturally after reaching clinical levels and some may not want help. Even taking this into account, it would still require significant levels of recruitment to address the current shortfall in meeting need.

The Taskforce stated that there may be some merit in exploring use of digital and online interventions; however, it also highlighted the generally poorer proven effectiveness for most digital or self-help interventions. When considering these options, the Taskforce specifically recommended BACP guidance compliant services using digital interventions and helplines that link closely with face to face help in local areas recommending. Some of these organisations can:

- offer moderated online fora, online counselling and telephone assistance for children and young people aged 11-25 years.
- Deliver a service 7 days a week until 10pm
- link closely and proactively with local CAMHS services bridging to local help
- support young people while they wait to attend services.
- Provide a locality manager who completes liaison work with local schools (working with head teachers and pastoral care leads) and who also delivers assemblies.
- provide broader information on demographics and needs of those accessing help to inform needs assessment and commissioning activity.

Such a service could be piloted to consider whether it is fit for purpose in Hertfordshire and extended if necessary. Hertfordshire should consider piloting a good quality digital provider so that it can assess what added reach, satisfaction, quality and value the service brings to young people with a range of needs in the local area.

Community and school counselling

Given the higher numbers being referred to Community Counselling by the current Single Point of Access practitioners and their growing waiting lists, we suggest that additional investment is made in community counselling services, particularly Youth Information and Advice Centres (YIACs) supporting children and young people preparing for adult years. Investment is also required to develop data recording and outcome monitoring to help services prepare for the start of the CAMHS minimum dataset early next year (the database will be piloted in local areas in July 2014). All community counselling should report on data outcomes on a quarterly basis. The entire Hertfordshire system supporting children and young people's mental health and wellbeing should be working towards using consistent outcome measurement tools and processes reporting back to commissioners on a quarterly basis.

There is also scope to better promote the Counselling for Schools Service through current toolkits as a resource for schools and GPs and to further expand investment in this service to support primary schools some of whom have raised concern over a lack of support for this age group in Hertfordshire.

The scale of the challenge in expanding help for children with early or noncomplex needs (e.g. current tier 2)

In terms of investment, the Hertfordshire CAMH system is currently orientated towards later rather than earlier intervention. Even with the proposed increases in services supporting children with Tier 1 and 2 needs, there will still be a significant deficit in the ability of planned resources to meet current and projected levels of need. Although some proposed investments will eventually reap rewards by reducing the numbers presenting with later mental health crisis, there is a need in the here and now for double funding – so investing in earlier intervention whilst also still responding to children in mental health crisis.

Closing the gap between need and resources at level 2 is a huge task and may only be partially feasible. It is nevertheless recommended that a significant increase is injected into Tier 2 type provision to help de-escalate later crisis. This should be achieved through considering costings provided at the end of this chapter and deciding what portfolio of resources (based on as yet on unknown available funds) might have the best chance of narrowing this needs-resources gap. Any changes must be monitored using access, outcome *and* satisfaction data.

Gateway to Help workers: expert Triage

The Review recommends the recruitment of three expert triage practitioners (band 8) whose role it will be to ensure that children, young people, parents and practitioners are able swiftly to get the help they need. These practitioners will be a main gateway for all referrals for children with emotional health and wellbeing needs. They will also hold on to and support children until such a time as they reach a successful final destination.

Additional central commissioning support

Finally, some commissioning support will be required to take this work forward. This additional investment should be made in data collection, collation and outcome monitoring and well as in workforce audit and development.

Improving the quality of evidence based provision provided by specialist CAMHS services

The following appear to be priorities for specialist CAMHS provision:

- There should be an audit of skills and evidence based interventions being used by specialist practitioners with a programme of CYP IAPT training introduced to support the overall service offer over time.
- There is an urgent need to consider ways of reducing waiting periods, required 'hurdles' and improving the experiences of children, young people and parents seeking to access services.
- Gateways and pathways to support with ADHD and autism are inconsistent, prone to duplicated activity and confusing; many of these children and young people will also have multiple needs. Parents comments suggest they can be prone to bounce around the system. Multi sector pathway development should be a priority for these conditions. The Modified Thrive model and hub approach proposed in Chapter 3 will also support these children's needs better.
- There needs to be further investigation into nonattendances in Tier-3 to assess if there has been any deterioration since the benchmark in 2013.
- There is a need for improved central and local monitoring of waiting list, access and nonattendance together with outcome and satisfaction data in specialist CAMHS. Outcome data should be used on a session by session basis, at team, CCG and central commissioning level to inform planning and workforce development.
- Some further investigation is needed, based on Hertfordshire needs and 'pinch points' in the system, into how mixed economy commissioning might more effectively meet children and young people's needs in targeted and specialist CAMHS (needing help; needing more help) in Hertfordshire. This may mean commissioning some trauma based services to support those in the care and justice systems. Trauma-based provision (together with building capability in social workers through whole system training) would aim to reduce the number of Looked After Children being referred to specialist CAMHS (which are high relative to number in Herts) and support their needs more effectively when they have trauma-based needs. Teams have also asked for more Tier 3 advice and consultation and commissioners should consider the feasibility of introducing a liaison role in specialist CAMHS to support paediatric and Looked After Children advice, consultancy and direct work.
- More creative ways are needed to support the wellbeing and reach out to the quarter of young people from BME communities in the county. A community development worker should be considered to develop and integrate services for these children and young people.

- A child and youth participation worker should also support the development of a network of Herts and Minds youth experts countywide who can support better promotion of children and young people's wellbeing and access to help in the county. The participation worker would work closely with the community development worker, schools lead and if commissioned the digital provider to raise awareness in schools.
- Finally, a general concern has been raised during this review concerning the overlooked needs of a small number of children with sexually problematic behaviours some of whom end up in very high cost settings due to underdeveloped early identification and intervention. Consideration should be given to establishing a task and finish group to improve multi sector early help and action.

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A summary of additional investments required to improve prevention, early intervention and access

- Hertfordshire needs to shift towards a system which involves greater investment in prevention and early intervention rather than crisis management and firefighting.
- Investments in prevention and early intervention take time to reap benefits but should save costs across a range of budgets over time. Schools and social care often benefit first. The justice system will be the biggest beneficiary.
- As this transition towards prevention takes place, there will be a need for initial double running costs
- Hertfordshire will not be able to afford all of the provision outlined below, the aim is to provide a menu of options for commissioners to help them consider commissioning options based on their financial envelope.
- Priority areas should be building capacity and capability countywide training all those in contact with children and young people as we'll as supporting greater awareness and ability in families and to self-help. It should also prioritise investment in perinatal mental health services, as well as improving capability locally to deliver evidence based parenting interventions for children with early and severe behavioural problems and extending the reach of services and evidence based help to children and young people with diagnosable mental health difficulties
- The introduction of change should be accompanied by routine centralised monitoring of activity, outcome ***and satisfaction*** data to track any resulting shifts in demand and refine commissioning decisions.

Potential commissioning options to increase the effectiveness and reach of what is provided in Hertfordshire	Cost of implementing change to better meet need	Estimated reach	Cost benefit ratio if known
Investment in perinatal mental health services is required including:[11] [12] -creating and maintaining a regional perinatal MH network - commissioning a specialist maternal mental health service **-** investing in parent infant interventions NB: some investigation is needed to assess current and projected IAPT capacity ensuring that this will adequately meet the needs of the 15% of women with common maternal mental health difficulties. The costs of extending IAPT assessment and this provision are covered in the final chapter of Bauer et. al. 2014.	 **£45,000 per annum** **£825,000 per annum** **£390,000 per annum** **These costs are significant and would involve significant investment of around £2 million.**	Based on 15,000 live births a year in Hertfordshire	
Building capability in the whole system: • Perinatal mental health capability in the whole system should be developed via training by the specialist perinatal mental health team (see costs above).	**An Expectation should be built into the contractual expectations of the specialist perinatal mental health service (see above)**		

[11] Commissioners can take a staged approach to commissioning perinatal service ranging from minimum adjustments such as strengthening health visitor recruitment to commissioning a gold standard perinatal specialist mental health service. This section of the chart sets out the annual cost of each area of activity.
[12] See PSSRU & Centre for Mental Health (2014) The Costs of Perinatal Mental Health Care. London: Centre for Mental Health.

• Commission Mental Health First Aid for those working in early years, schools, youth work, social care etc. • A youth participation and development worker should be recruited to support the ongoing development of mental health peer champions in schools. This worker will work with DSPL staff and the Step 2 school development and the implementation worker and potentially a digital provider • A website should be developed to improve CYP and parents' ability to self-help in Hertfordshire	**Costs available and being investigated by Hertfordshire Public Health Team based on previous delivery.** **An estimate of £35,000 with on costs. Alternatively, this activity could be sub contracted to a digital provider** **Costs not available.**		
Helping schools build capability in emotional health 1. A band 7 FTE Step 2 (TAMHS) lead should be recruited to support Herts schools develop Whole School Approaches supporting 'Healthy Minds' countywide. This band 7 worker would work with either pastoral networks, school champions, school clusters or individually with schools. This Healthy Minds lead would also liaise with and support the 19 'Delivering Special Provision Locally' (DSPL) leads in Hertfordshire. This worker could alternatively be a member of the Central Commissioning	**£45,000 for a band 7 worker**	The band 7 WTE worker would support whole school approaches in Herts' 525 schools either working with pastoral networks and clusters or via individual school developmental work.	

Support team. 2. Commissioners should pilot the North Herts emotional Health Support Service and track its impact based using pre and post outcome data and a survey and drawing out transferable learning to other areas in the county. Outcome and satisfaction monitoring and reporting expectations should be made explicit in the commissioning contract with consistent tools being used across Herts therapeutic services. Quarterly outcome monitoring data should be submitted to the central commissioning support unit. *3.* Commissioners should recruit a digital counselling service whose core offer includes promotional activity via assemblies and working with heads in schools.	**£28,000 (half may be funded through DSPL funding). A small additional amount may also be needed to support administration and outcome monitoring.** **(All activity included in later example of digital delivery costs)**		
Providing Triple P or Incredible Years/Webster Stratton parenting programmes for children: Increase the capacity of Step 2 workers by **4 more WTE band 7 workers** specialising in Nice guidance parenting work.	**£200,000 for 3 band 7 workers and one band 8 to work as Step 2 parenting specialists** Four workers could provide 8 group parenting interventions of this type a year **accessing around 100 parents**. One of these workers should also have a part time quality control and management role supervise	Around 750 **children** (5%) in a year's cohort will present in Hertfordshire over the clinical threshold for severe and persistent early behavioural problems. Many children with developmental difficulties such as ADHD will also have co-existing mental health problems	**For every pound invested, savings of £3 can be anticipated.**

		such as conduct difficulties.	
In the long term, commissioners should plan to train up *all* Step 2 practitioners as well as some specialist CAMHS workers in evidence based parenting interventions for children with early severe and persistent behavioural problems. This must include developing a system for programme supervision and fidelity monitoring. **Training dilemmas and initial training costs for parenting provision**	**NB: To cover just *half*** *(around 370)* of a one year cohort of children with high early behavioural needs in Hertfordshire, **you would need 13 practitioners specialising in this work and delivering 5 groups a year.**		
CYP IAPT could train a small number of additional workers each year in Incredible Years' parenting intervention as well as a supervisor. This would involve minimal initial training costs but on the downside it would take a long time to ensure sufficient practitioners were fully trained (there are only a few CYP IAPT training place opportunities per year). Incredible Years also requires a supervisor to have CYP IAPT training and this clinician should begin training in October 2014.	**£0 – back fill provided.** Supervisor's training should start in October 2014 (6 months before the practitioners begin their training).		
Triple P/Incredible Years: on the other hand, it would cost **£25,740** to deliver training to 20 practitioners in Triple P level 4 (including VAT but not trainer accommodation, venue, catering etc). Training	**£25,740 to train 20 workers and 3 observers.**		

takes place over 3 days; 1 x Pre-accreditation Workshop, and accreditation held over 2 days. This would very speedily increase evidence based capacity to support children in Hertfordshire with conduct problems. Delivery during the year would need to be coordinated and led by the 2 specialist Step-2 parenting practitioners. **Incredible Years (Webster Stratton)** training could similarly be commissioned (outside of CYP IAPT training) to train up a group of workers for roughly an equivalent amount to the Triple P quotation.			
Increasing early help to those with early or noncomplex mental health needs. **Some of the following services will increase reach, access and bridging to help, brief interventions while children wait for help, and access to talking therapies.** **Commissioning a digital counselling service in Hertfordshire 9SAs recommended by Taskforce).**	With one provider, it would cost around **£48,000** to provide 80 hours a month of digital counselling/support and 16 hours of online forum moderation a month via a digital provider**.** The estimated reach of this service would be around a 1000 young		

	people a year. Another provider (using trained volunteers) quoted 35K to reach 3000 young people. In some instances, core costs can cover school promotion and liaison, moderation of online fora, direct online counselling with young people, holding onto young people while they wait to access services, liaison and bridging to local services, routine reporting for commissioners on need and outcomes etc). 120 hours direct counselling hours from one accredited digital provider (using counsellors and mental health practitioners) and 20 hours of moderation a month would costs £58,000 and would reach around 1300 young people. Alternatively it would cost 91K to reach around 2000 young people.		
Extending Community and centrally funded school counselling	A recent business case was submitted in Hertfordshire to extend capacity in Tier 2 and indicated that an additional **£72,000** should be invested in local counselling services to meet current levels of demand		

	extending their reach to a further 180 children and young people. Given the current shortfall in this tier, the commissioning group should consider doubling this additional investment (144K investment to reach 360 children and young people) - monitoring quality, reach, satisfaction and access. Some additional funding should also be made available to facilitate centralised reporting of outcomes, data analysis and greater consistency of outcome measurement tools across Hertfordshire.		
Increasing capacity in Step 2: the scale of the challenge Taking into account the reach of any digital provider (around 1000), new parenting provision (around a 100), the new PALMS service (250 - assuming that half may be children with emotional needs), the increased investment in counselling (reaching 360), increased IAPT provision for 16-18 year olds (estimated at a further 150); the 3 additional Step-2 practitioners already recruited this means that there will *still* be a shortfall in Tier two service provision of roughly 68% compared with estimated diagnosable need in this tier. Projected child and youth population rises will further elevate the scale of	4368/6228		

diagnosable need by a further 14% by 2020. **It would therefore require significant additional investment in Step 2 practitioners (or on top of what is proposed above) to even meet 100% of those meeting the threshold for diagnosis in this tier**). If this gap remains unaddressed, there may be continued risk that children's needs escalate into damaging and costly crisis elsewhere in the system. **Commissioners must consider the portfolio of recommended resources outlined above, what funding is available and on the basis of this information how they might best narrow this gap further building on the above mentioned additional investments.** **Any injection of new resources must be tightly monitored to assess impact on the broader system to inform future decision making. Satisfaction should be an integral part of this outcome monitoring process.**			
Specialist CAMHS for children needing more help **Expert triage:** Additional investment would be required in three band 8 workers who would fulfil an expert triage and liaison role for those referred to CAMHS. Lower level need for children with less complex needs	**Costs not available**		

could also be triaged via *kooth* or a similar digital provider. **Liaison for Looked After Children and paediatric support** Further investment should be considered in providing a system of advice and consultancy to support paediatric liaison and liaison with the Targeted Support team for looked after children	**Costs not available**		
There is a need for additional Central Commissioning Support to monitor contracts and routinely track outcome data. Some central commissioning money should also be made available to support task and finish pathway development. Funding would be required in the longer term to move towards co-location in multi-agency hubs.	**Costs not available**		

Some interventions for primary schools to consider boosting universal and school based provision

During the consultation, questions were raised about how primary schools might improve their universal and early provision to children. Some options are set out below for information.

Investing in the Good Behaviour Game in primary schools. This is a universal programme with a good evidence base in reducing behavioural problems.	**£108 per child**	Universal programme noted to reduce conduct disorder in primary school children aged 6-8 years.	For every pound invested, £27 savings can be expected.
Place2be provide counselling for	**Costs currently being sourced**		

primary schools. Place2be are a well-established school counselling service producing good outcome data on young people accessing their services.	**–not yet available**		

2. What good looks like

This chapter summarises evidence of what good looks like when promoting and supporting the mental health of infants, children, young people and their families. It distils key findings from the recent comprehensive Child and Adolescent Mental Health Taskforce as well as findings from literature. Findings will be used to inform the development of a Hertfordshire-wide whole system of support for children and young people's mental health and emotional wellbeing.

Definitions

Good mental health is not just about being free from illness. It is 'a state of complete physical, mental and social well-being…in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community' (World Health Organisation, 2015). It encompasses both emotional and behavioural wellbeing (since children often communicate distress or developmental problems through behaviour).

Any child's wellbeing can move outside healthy ranges leading them to need a bit of extra help, but some children are at greater risk than others. Positive mental health is determined by a complex interplay of biological, socioeconomic and environmental factors (e.g. poverty, exposure to abuse, experiences of discrimination) which combine to promote or undermine wellbeing. Exposure to early adverse events such as untreated maternal mental illness or prolonged exposure to cumulative risk can over time significantly undermine children's potential and wellbeing (Murphy & Fonaghy, 2012); (The Centre for Community Child Health, 2000). Strengthening protective factors in infants, children and young people or in the families and environments around them is critical to providing children with the best start, helping them achieve their potential, stay healthy and develop resilience (The Centre for Community Child Health, 2000).

Whose business is mental and behavioural health and wellbeing?

Good child mental health and wellbeing benefits everyone. Without good mental health and emotional wellbeing children face poorer life chances and do not achieve their potential. They do poorly in school, have higher rates of poor physical health over their lifetime, may cause difficulties for local communities and have a range of other poor outcomes (Green, et al., 2005) (Fergusson, et al., 2005) (Department of Health, 2015). When children's mental health and wellbeing deteriorates, it not only damages their life chances, it also imposes additional costs on a range of multi sector services such as schools, the justice system, social care and health services (Centre for Mental Health, 2014). Promoting, preserving and restoring children's mental health (like safeguarding) must be the responsibility of all those in contact with infants, children young people and families – not just the duty of those whose core expertise lies in the mental health field (Department of Health, 2015). Communities, families, young people and children themselves can be supported to maximise and preserve child and youth wellbeing (Department of Health, 2015).

An effective system promoting robust child mental health and wellbeing: vision and key features

The recent CAMHS Taskforce outlined 'a vision for our country in which child mental health and wellbeing is everybody's business, where our collective resilience and mental strength is regarded as an asset to the nation in the same way as we prize our levels of attainment, creativity and innovation' (Department of Health, 2015).

An effective system supporting infant, child and youth mental health and wellbeing:

- Puts at its heart the strengths and needs of children and young people (and their families);
- Ensures equal parity of esteem for mental and physical health (Department of Health, 2015);
- Embraces the whole life span from pregnancy through to young adult years (Department of Health, 2015)
- Works together to achieve best outcomes for all children - regardless of gender, sexuality, ethnicity, religion and disability (recognising that some families, children and young people face greater adversity and need more help);
- Is underpinned by whole system passion and commitment to promote children's mental health, wellbeing and holistic life chances:
    - building capacity in children, young people, and families helping them to promote and preserve child and family mental health and emotional wellbeing and to know where to seek help if they need it;
    - building capacity in peers. The taskforce identified that young people, parents and carers have a strong desire to hear from others who have accessed mental health services;
    - building capacity in all professionals and volunteers in regular contact with children and young people so that they too can help children get timely help;
    - ensuring a compassionate, collaborative, needs and choice-led, integrated and engaging response so that children and young people get back on their feet and make progress should they experience a deterioration in mental health and wellbeing.
- Involves coordinated activity and integrated cross sector assessment involving the NHS, public health, local authorities, social care, schools, the voluntary and independent and youth justice sectors working together.

Whole system approach

An effective whole system promoting mental health and responding effectively to children's needs should seek to promote wellbeing, to prevent problems from occurring and to intervene as early as possible. This means intervening early in life, intervening to reduce risk factors for poor mental health and intervening at the very first sign that a young person's behaviour or emotional wellbeing is moving outside healthy ranges. Inadequate early investment stores up problems later on, damaging children's outcomes, reducing quality of life and building up later crisis costs (Knapp, et al., 2011).

Whole system activity should also be guided by best quality evidence to maximise the chances of help making a difference to children and young people's and families. The Taskforce highlighted that:

> *Although lack of evidence should not be used as an excuse for lack of care, it is unethical and a waste of taxpayers' money to invest in interventions that have no evidence base – unless they are subject to rigorous evaluation… There is good evidence that well-meaning interventions, with the best of intentions, can do more harm than good*. (Department of Health, 2015).

Resources

A range of resources exists drawing together knowledge on what works to promote and support improvements in children and young people's mental health. These include:

- The Washington State Institute of Public Policy (WSIPP) league tables of effective and cost effective interventions to support early intervention, healthy behavioural and emotional health (Lee, et al., 2012). These resources are regularly updated.
- The Social Research Unit's Investing in Children web resource which adapted WSIPP content to a UK context. (Social Research Unit, 2013). Although not regularly updated it provides a useful summary of what works for a range of children's needs including mental health and emotional wellbeing.
- London School of Economics Personal Social Service Research Unit's publication on mental health promotion (Knapp, et al., 2011).
- Centre for Mental Health's *Investing in Children's Mental Health* report, which draws together findings from the SRU, Washington State, the PSSRU and the Centre's own research into the economics of parenting programmes and perinatal interventions.
- The Early Intervention Foundation's (EIF) resources including:
    - The EIF programmes library (http://guidebook.eif.org.uk/programmes-library);
    - Effective Interventions supporting 'The Best Start at Home' for children aged 0-5;
    - Effective interventions for children on the edges of care;
    - Social and emotional learning: skills for life and work.
- A wide range of relevant NICE guidance for infants, children, young people and families including those on perinatal mental health, social and emotional learning in schools, eating disorders, ADHD, conduct disorder, anxiety and depression.

Essential interventions

Some of the following interventions should be considered as essential posts in the ground in terms of promoting and supporting children's mental health and emotional wellbeing. Delivery of these interventions relies on a range of sectors working together across an infant, child and youth developmental course to build wellbeing and restore improved mental health when it has been disrupted.

1. Perinatal mental health support

There is considerable evidence of the links between maternal perinatal mental health problems and poor later child mental health and yet reports and studies suggest highly inconsistent provision supporting mother and child mental health (Maternal Mental Health Alliance, 2014) (Bauer, et al., 2014). There is growing evidence that damage can occur to foetal and infant emotional architecture whilst in the womb and following disruptions to mother/infant relationship attachment after birth. Only 50% of mothers with common mental health problems are currently identified; even fewer access good quality interventions with potential to make a difference to their outcomes and to their infants' emotional architecture (NICE, 2014).

Improving identification and fast tracking mothers to proven early help should be a priority for primary care workers in contact with mothers during the perinatal period. An easily accessible Integrated Care Pathway and network should be established and maintained locally as well as access to local specialist perinatal mental health advice to support local activity. There should also be access to interventions promoting the mother and infant relationship where the quality of attachment has been affected (Joint Commissioning Panel for Mental Health, 2012). Improved identification and evidence based support has been linked with considerable savings over time affecting a range of sectors. Three quarters of savings relate to children's improved outcomes and mental health (Bauer, et al., 2014) (NICE, 2014).

2. Family Nurse Partnerships

Teenage parents and their children often face elevated levels of risk which over time have been shown to undermine the wellbeing and broader life chances of children. Evidence highlights that intensive wraparound support from home visiting midwives (called Family Nurse Partnerships) have a good record of improving these children's longer term life chances. This includes improving educational outcomes and reducing teenage behavioural problems particularly for girls (Eckenrode, et al., 2010).

3. Parenting interventions

Early starting behavioural problems are the most common childhood mental health problem, affecting 5% of children aged 3 to 10 and are a marker for a range of damaging and distressing poor life chances. These children are six times more likely to die early, twice as likely to underachieve in school and are more likely to suffer from every type of adult mental illness. They are also 20 times more likely to end up in custody (Fergusson, et al., 2005). By the time they were 32 years old, men who had conduct disorders as children also accounted for around 30% of the days spent in psychiatric hospitals even though they constituted only 11% of birth cohort males (Odgers, 2007). Behaviour spans a spectrum and we know from longitudinal studies that even those 15% who fall just below clinical ranges still face a range of poorer life chances compared with children with mild or no behavioural problems at all (Fergusson, et al., 2005).

Well implemented NICE recommended parenting programmes have a good record of improving outcomes for these children (National Institute for Health and Care Excellence,

2013) (Centre for Mental Health, 2012) (Centre for Mental Health, 2014). Programmes should be delivered by well trained and supervised workers from early years and parenting teams with ongoing systems of quality control to ensure they achieve results. Health visitors, early years and nursery workers, school nurses, paediatricians, Special Educational Needs coordinators, GPs and schools should link closely with programme providers.

These programmes have been linked to considerable economies across the system (social care, health, educational and justice) with savings emerging first within 3-5 years for schools. The majority of savings emerge later in the justice system (Centre for Mental Health, 2014) with, in addition, some promising reductions noted in child protection costs when implemented universally (Prinz, et al., 2009).

4. Whole-school approach to social and emotional wellbeing

Many schools already implement NICE guidance and whole school approaches to supporting social and emotional wellbeing in educational settings (NICE, 2008). Evidence shows that good quality approaches supporting mental health and emotional wellbeing promote educational attainment and mental health and wellbeing. Evidence shows that interventions taking a whole school approach to wellbeing have a positive impact in relation to both physical health and mental wellbeing outcomes, for example, body mass index (BMI), tobacco use and being bullied (Knapp, et al., 2011) (Brooks, 2012).

There is good evidence that well implemented primary school based Social and Emotional Learning programmes can make a difference to children's mental health and wellbeing and educational attainment (Durlak, et al., 2011). A universal programme showing particular promise for the primary school age group is the Good Behaviour Game (Lee, et al., 2012) (Khan, et al., 2015). This programme is relatively cheap to deliver and demonstrates a return of around £30 for every pound invested, boosting children's future emotional and behavioural health and life chances.

5. Psychological interventions for depression and anxiety

Cognitive behavioural interventions are both effective and cost effective with a good record of improving children's depression and anxiety (NICE, 2013b) (Social Research Unit, 2013) . Group CBT interventions are effective and appear to represent particularly good value with around £30 return for every pound invested (Lee, et al., 2012) (Social Research Unit, 2013) (Khan, et al., 2015).

6. Interventions for young people at risk

Interventions such as Multi-dimensional Treatment Fostering, Multi Systemic Therapy, Functional Family Therapy and Aggression Replacement Therapy have a good record of improving mental health outcomes (particularly adolescent behavioural wellbeing) for those on the edges of the care system or youth justice system. Returns range from £2 to £22 for every pound invested in these programmes based on proven improvements in outcomes experienced by young people (Lee, et al., 2012) (Social Research Unit, 2013) (Khan, et al., 2015).

7. Early Intervention in Psychosis services

There is good evidence that Early Intervention in Psychosis (EIP) services, when delivered in keeping with NICE Guidance, help people experiencing early symptoms to recover and gain a good quality of life (Knapp, et al., 2011).

Research highlights that those accessing EIP services had better treatment and employment outcomes compared with treatment as usual. Risk of suicide among affected young people was noted to decrease from 15% to 1% (Melle, et al., 2006). EIP services have also been noted to result in savings through reduced hospital admissions. (Knapp, et al., 2011) (Department of Health, 2015).

Managing gaps in evidence

Where there is poor evidence of what works, this does not mean that no care should be provided. Neither does it mean that any intervention is used. As far as possible NICE guidance and children's preferences should guide choices and activity. Where less tested and promising interventions are selected, pre and post outcomes should be very carefully monitored, ideally supported through rigorous evaluation and tracking of longer term outcomes (Department of Health, 2015).

The local offer and children and young people's wishes

Local offers should be shaped both by evidence and by the wishes of children, young people and families. The Taskforce highlighted that the starting-point is that children and young people and their parents/carers need clearer awareness of how to recognise when they might have a mental health problem as well as where and how to get help, what help is available, what might happen when they access it, and what to do while they are waiting (Department of Health, 2015).

Children and families in Hertfordshire and those who formed part of the broader national Taskforce said they wanted services and a local offer:

- That were easy to access, understand and navigate;
- That felt 'non-clinical';
- Delivered by empathetic, compassionate and caring practitioners;
- Delivered flexibly in a range of welcoming or familiar settings;
- Which allowed them choice and flexibility in terms of the variety of services/interventions on offer, who provided them, the timing and location of contact and which involved informal and formal as well as good quality online support.

Most young people felt that teachers and schools could play a bigger role in recognising when pupils are struggling and helping them access appropriate support.

Neither young people nor practitioners in Hertfordshire favour the term Child and Adolescent Mental Health Services (CAMHS). Young people said they find this term stigmatising. The Herts Clinical Reference Group (set up to steer the Herts Whole System Review) also suggested that it was too narrow favouring instead a broader focus on child, youth and family emotional health and wellbeing.

A coordinated and accessible system

An effective system should provide a clear offer for all children, young people and families including how to prevent problems, get back on track or get help to de-escalate crisis. The offer should be developed in collaboration with parents, children and young people and backed up by a single gateway to get help.

It requires effective multiagency information-sharing and coordination between universal, targeted and specialist services, including early years settings, schools, colleges, Local Authorities, primary care, social care, youth justice, youth counselling, voluntary sector services, and targeted and specialist CAMHS.

Whole system working should be backed up by a clear shared understanding of roles and responsibilities, so that children and young people and their families are able to receive timely and appropriate support and don't fall through the gaps between services.

Emerging and transformational models supporting the emotional wellbeing of children, young people and their families:

- require integrated activity by a range of sectors and stakeholders focusing on prevention and early identification and intervention;
- build in a single gateway for getting help;
- are needs-led rather than being diagnosis-led or alternatively merely focused on what services are available;
- draw together multi sector partnership commitment focusing on shared outcomes and have a step up and step down approach to ensure that children, young people and families receive the appropriate level of care where, when and how they need it (Department of Health, 2015).

High quality whole system activity to promote, preserve and restore children and young people's mental health relies on:

- a workforce working at different stages of the life span and across sectors with competencies in understanding, promoting and preserving healthy emotional and behavioural wellbeing;
- building capacity in parents, children and young people so that they can promote and preserve their wellbeing and also know how to help themselves or where to go if they need extra help (Department of Health, 2015).

The role and responsibilities of non-specialists in regular contact with children, young people and their families

A wide network of professionals and agencies have routine contact with children, young people and their families and have important roles to play in identifying and supporting children and young people to build resilience and achieve their potential. These include (but are not limited to) midwives, health visitors, GPs, early years workers, social workers, speech and language therapist, learning disability services, Youth Information, Advice, and Counselling Services (YIACS), youth offender practitioners, youth substance misuse workers, adult focused mental health and substance misuse specialists in contact with parents, teachers, school nurses, voluntary sector and helpline providers, youth workers and leaders and providers of training and leisure and activities.

Anyone working with children and young people in universal settings should have training in children and young people's development as appropriate to their professional role and should have *a duty to promote and preserve the wellbeing of children, young people and sometimes their families*. This should include supporting children and young people and their families to adopt and maintain behaviours supporting good mental health; supporting broader health and social determinants of positive mental health in the environment around the child, through offering compassionate brief support to children, young people and families; and being alert to children's emotional and behavioural wellbeing and referring on if they need extra help (Department of Health, 2015).

The Taskforce and other key documents have identified low confidence among key professions (such as teachers, paediatricians, nurses, GPs) about children's mental health and emotional wellbeing. Practitioners also lack confidence in communication skills required to support initial discussion and want more information on pathways to support (Department of Health, 2015) (Royal College of Psychiatrists, 2013). Low confidence prevents early activity to promote or restore wellbeing and also prevents early action avoiding escalation and crises. The CAMHS Taskforce made a number of recommendations on workforce development including:

- a commitment by government departments to support improved initial teacher and GP training on child mental health and emotional wellbeing;
- recommending the continuation and expansion of CYP IAPT training for professionals not primarily responsible for treating mental illness in children and young people but who nonetheless come into regular contact with children (including voluntary sector, community and school-based staff such as counsellors and school nurses);
- combining MindEd e-learning sessions with one day face to face training (and for example using this model as part of Inset days for teachers and for broader continued professional development for other professions);
- establishing clear links for GPs and schools to a named and accessible mental health specialist in a local area tasked with providing advice, consultancy and supervision.

This does not mean that professionals working in universal services should step in where a more specialised activity is needed. But it does mean that 'a teacher who sees that a child is anxious, in low mood, not eating or socialising as children and young people usually do, is

withdrawn or behaving uncharacteristically, understands this child may need help' (Department of Health, 2015). The universal workforce should also be able to:

- Recognise the value and impact of mental health and emotional wellbeing in children, young people and families and its importance as part of their duty of care for children and its relevance in terms of their particular professional aims and outcomes;
- Support children and young people and their families to adopt and maintain behaviours promoting good mental health;
- Support children through mobilising protective factors (e.g. creating a mental-health-promoting school environment);
- Identify mental health problems in children and young people, (as well as those at particular risk of developing these problems) as soon as problems arise wherever possible;
- Offer caring and appropriate preliminary support to children and young people with mental health, emotional or behavioural difficulties;
- Refer appropriately to more targeted and specialist support.

Building capacity in parents, children and young people

Children, young people and families can also be supported to help themselves and each other through improved access to mental health promotion and through access to a range of quality controlled information and resources.

There is considerable interest in self-administered and media-based programmes because online resources are familiar to children and young people and are also relatively cheap to implement. However, few have been subjected to rigorous evaluation primarily because they are relatively new technologies. A recent review of existing evidence suggested that, although such interventions appeared promising, they were not as yet conclusively proven to produce positive outcomes (National Collaborating Centre for Mental Health, 2014). Higher quality evidence does, however, support the use of self-administered parenting support interventions where there are emerging signs of child developmental difficulties (Early Intervention Foundation, 2014).

The distinct role, responsibilities and contribution of schools

As well as the skills and competencies outlined above, there are some other important reasons why schools should play a central part in promoting and investing in children's mental health and emotional wellbeing.

- Children with poor mental health, attentional difficulties and emotional wellbeing have lower levels of educational attainment and school engagement than other children (Green, et al., 2005) (Department of Health, 2015);
- Some mental health problems (nationally and in Hertfordshire) have specifically been associated with academic anxieties and pressures by some children and young people (Youth Connexions, 2012);

- Well implemented and good quality programmes promoting social and emotional skills in children have been linked to improvements in attainment levels (Durlak, et al., 2011)
- Well implemented NICE guidance recommended parenting programmes have been shown to improve children's healthy behaviour with schools being the first to benefit from resulting cost savings (Centre for Mental Health, 2014)
- The new draft Ofsted inspection framework 'Better Inspection for All' includes a new judgement on personal development, behaviour and welfare of children and learners which links closely with children's mental health and emotional wellbeing
- Schools have lengthy contact with most children and have an opportunity to act as resilience-boosting environments if whole school approaches are adopted, if attachments with children are strong and if schools feel safe and psychologically informed: a whole school approach (which includes a focus on staff mental health and well-being) with strong leadership and threading mental health promotional activity throughout the curriculum and environment has been shown to benefit children's mental health and emotional wellbeing (NICE, 2008) (NICE, 2009) (Langford, et al., 2014) (Weare, 2015) (CYPC, 2015)
- Young people themselves have identified schools as settings where they would like more support (Department of Health, 2015) (Youth Connexions, 2012)
- Most parents concerned about their children will approach schools as a first port of call for advice; despite this only around a quarter get access to the help they need (Green, et al., 2005).

Early findings from a study on the experiences of LGBT children and young people highlights their experiences of significantly higher levels of mental health distress compared to other children and also emphasizes the critical importance of school settings in both undermining wellbeing and also potentially providing early support (Metro, 2014).

Most secondary schools surveyed in recent CentreForum research (Centreforum Commission, 2014) reported implementing programmes to promote positive mental health universally across the student population, with almost all doing this within the context of PSHE education (Department of Health, 2015) . Almost every school surveyed had pastoral care services and around 9 out of 10 said they had access to trained/qualified counsellor(s).

The recent Taskforce highlighted the importance of having a quality control process in place governing the provision of counselling in schools. A national strategy for schools and guidance has now been developed by the DfE to support schools in the commissioning of evidence-based, outcomes focused counselling (Department of Education, 2015). Schools are advised to ensure that counsellors are experienced, accredited (e.g. through BAAT, BACP, UKCP), have a minimum of a diploma in counselling, are on an Approved Voluntary Register, and have relevant experience working with children and young people. They should also be using good quality outcome measurement tools (such as the Strengths and Difficulties Questionnaire) and service satisfaction measures to track progress and outcomes. Services should routinely use this information to inform their service development and to contribute to local CAMHS planning (Department of Health, 2015).

Schools also have access to school nurses. The recent taskforce identified these practitioners as playing a crucial role in supporting the emotional and mental health needs of school-aged children delivering the Healthy Child Programme (HCP) (Department of Health, 2015). The Taskforce also noted that young people saw school nursing services as non-stigmatising (Department of Health, 2015).

School staff already routinely do much to manage and effectively promote and support children's behaviour, risk and protective factors and general wellbeing on a daily basis. But they also need to know when to seek advice and refer on when what they provide reaches its limits.

The Taskforce makes a number of recommendations about how schools can secure timely advice and responses when children need additional help, provoke concern or are in crisis. These include commissioning good quality counselling services, maximising the use of school nursing and PSHE focus on mental health, having a clear single gateway to ask for help and identification of a specific individual responsible for mental health in schools, providing a link to expertise and support to discuss concerns about individual children and young people, identifying issues and making effective referrals and developing a joint training programme (Department of Health, 2015). These liaison practitioners would make an important contribution to leading and developing whole school approaches.

In addition, a further significant piece of developmental has been completed work by the DfE and PSHE Association to produce guidance for schools in teaching about mental health safely and effectively (PSHE Association, 2015).

Finally, the Taskforce also recognised the role of schools in reducing bullying and supporting digital safety. Reducing bullying has been associated with significantly reduced multi sector life time costs (Knapp, et al., 2011).

Professions with overlapping roles and functions

The roles and responsibilities of some services link particularly closely with health practitioners whose primary business is supporting the mental health and emotional wellbeing of children. For example, good quality voluntary sector counselling services can form an important part of a local offer supporting children's mental health and emotional wellbeing.

Considerable synergies and relationships have also been noted between those working in targeted and specialist mental health roles and the activity of those involved in perinatal, parenting and early years activity, the work of community paediatricians and Special Educational Needs teams and youth substance misuse practitioners (Department of Health, 2015) (Royal College of Psychiatrists, 2013) with recommendations for improved joint planning, working and liaison across these workforces.

Herts Clinical Reference Group has also identified a need for developmental work to reduce potential duplication and to clarify how roles and responsibilities across specialist CAMHS and community paediatrics might better dovetail.

The offer for children needing help to restore good mental health or to prevent crisis

The Taskforce made a number of recommendations about what help should look like for children and young people needing more specialised support. These recommendations included:

- A well promoted, clear gateway with skilled and experienced practitioners at the doorway offering multiagency triage, advice and timely access to additional help for those children, young people and families who need it. These therapeutically skilled staff would work alongside universal and targeted services and be able:
    - to make prompt decisions about who can best meet the child/young person's needs (including targeted or specialist mental health/health or social care services, voluntary sector youth services and counselling services);
    - to complete high quality risk assessment to ensure children and young people at high risk are seen as a priority.
- Services should be remodelled into a simpler, more coherent framework that draws together high quality provision delivered by statutory and voluntary organisations into a single integrated and jointly commissioned system.
- Children, young people and/or parents/carers are partners in determining the choice of care and are consulted on and offered appointments at times and in locations that suit them best (e.g. early evening, at youth/ community-based centres).
- Every effort should be invested to reducing waiting times and a target should be agreed locally and monitored regularly. During any waiting period interim help should be available to support children, young people and their families.
- Creating identifiable, dedicated contact points in specialist CAMHS for educational establishments and primary care providers to discuss referrals, provide consultation and liaison and to promote whole school approaches to mental health and wellbeing in schools (an enhanced model could include specialist CAMHS therapists who work directly in schools/GP practices with children, young people and families).
- Services should not be diagnosis focused but instead be formulation-based in their appraisal of children's and families' needs.
- Professionals should proactively follow up children, young people and families who do not keep appointments, seeing non-attendance as an indicator of need or a prompt for outreaching engagement rather than a reason for discharge.
- Services should use outcome monitoring routinely to review progress with young people and to help adjust what is offered. Outcome monitoring data will also routinely be provided to local commissioners and commissioning units to help shape local planning.
- Every child or young person accessing a mental health intervention should be treated as a 'partner in care' and provided with appropriate information about mental health and their specific condition, self-support resources, and guidance on day-to-day coping in between appointments with professionals.

- Contact with all services and help offered should be delivered in a way that feels caring and compassionate.

Supporting children in crisis

Any child or young person can move outside healthy emotional and behavioural ranges and some children may escalate into crisis. Although lower quality evidence exists on effective interventions that stop children escalating into crisis or inpatient settings, descriptive evaluations suggest that the following provide important safety nets:

1. The entire system of support should be built on compassionate multi sector joint working to prevent, identify early and de-escalate problems rather than waiting to respond once a crisis has crystallised;
2. There should be effective liaison services with Accident and Emergency settings and with justice settings, eg. the police;
3. For children and young people experiencing mental health crisis, it is essential that they receive appropriate support /intervention as outlined in the Crisis Care Concordat. This includes:

    - Access to multi agency support before crisis.
    - Having clear pathways between multi-agency community care and inpatient settings - with a crisis or intensive response team (supported by an out-of-hours children and young people's mental health service) interfacing with inpatient settings to prevent unnecessary escalation and admission. These teams should respond immediately and offer needs centred intensive support in the home, community or in a place of safety if required.
    - Having access locally to urgent, high quality age-appropriate crisis care, places of safety and inpatient treatment. Police custody should not be used as a place of safety.
    - All efforts should be made to shorten duration of stay in inpatient settings, easing transitions out of inpatient care through prompt development of robust discharge plans and 'step down' arrangements. Many factors are noted to contribute to delays in discharge; the top three included social care issues, lack of alternative inpatient placements and lack of community aftercare (Department of Health, 2015).
    - Particular attention should be paid to the transition between Tier 4 CAMHS in-patient units and community specialist CAMHS; this is particularly important for young people hospitalized for a suicide attempt, for whom risk of recurrence is highest immediately following discharge (Department of Health, 2015).
    - Crisis management and planning should be structured through use of Care Programme and multi-sector lead professional approaches.

Transitions to adulthood

The Taskforce noted that 'the current system is weakest where it needs to be strongest' (Department of Health, 2015). Adolescents and young adults have the highest prevalence of mental illness across the lifespan, bearing a disproportionate share of the burden of disease associated with mental ill health (McGorry, et al., 2013). Furthermore, half of the adults in a long term study who had a psychiatric disorder at age 26 had first had problems prior to age 15, and three-quarters had problems before age 18 with early signs often looking different in comparison with adult presentations.

Yet there is evidence that young adults' access to mental health services is the poorest of all age groups (McGorry, et al., 2013) exacerbated by unhelpful discontinuities between youth and adult systems in funding, delivery and in workforce competencies at the very point that there is the greatest opportunity to capitalise on early intervention opportunities and support need (Singh, et al., 2010) (Munoz-Solomando, et al., 2010) (Birchwood & Singh, 2013).

There is also good evidence that some of those who present late and in crisis to adult services have some of the worst outcomes not only in terms of recovery and life chances but also in terms of the costs generated by longer term crisis care (e.g. those who present late to adult services with anorexia have some of the worst prospects of recovery) (Nielsen, et al., 1998).

Finally, there is also good evidence from Early Intervention in Psychosis services (which aim to engage, treat and support holistically those presenting with the earliest and more subtle signs of psychosis) that age appropriate, holistic and engaging services spanning this transition can prevent repeated non-attendance for planned care and avoidable complications while reducing complexity of need and use of urgent /out-of-hours care. This has been noted to generate significant savings (Knapp, et al., 2011).

The Taskforce recognised a need for local areas to address these discontinuities. Local developments should build on new money being made available to support the development of Early Intervention in Psychosis models. Effective commissioning to address transition includes:

- The development of joint working protocols between youth and adult services
- More flexible approaches to transition and age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care (Department of Health, 2015)
- Promoting a more holistic approach across this transition to adulthood recognising the need for wider support involving family, educational settings, employment and life chances
- Joint CAMHS/AMHS training to support better understanding and join up across this high risk period.

- Consideration of different models of CAMHS/AMHS commissioning to maximise continuity of contact across this high risk period. Such approaches are currently being tested in Birmingham and in Norfolk and Suffolk.
- Creating stronger links between adult mental health services and SEND and Looked After Children teams with responsibilities to support young people facing these challenges up until the age of 25 years.

Finally, the Taskforce also saw a role for Youth Information Advice and Counselling Services (YIACS) in supporting transitional arrangements and alternative universal and primary care delivery. These services usually operate over the age of transition, often up to the age of 25.

Consideration should also be given to the development of models of youth mental health services that bridge the traditional age boundary but which at the same time avoid creating raised eligibility criteria for 16 to 18-year-olds or reducing services for younger children (Royal College of Psychiatrists, 2013).

Vulnerable groups

Any child, young person and young adult can develop poor mental health but some young people are more vulnerable than others, often because of exposure to prolonged and cumulative risk. Children with higher risk of poor mental health include:

- those with learning or developmental disabilities
- those in (or leaving) the care or justice system
- children who have experienced trauma
- some children from BME communities
- LGBT young people

(Hagell A, 2002) (Department of Health, 2015) (Metro, 2014)

Some young people from higher risk groups can be particularly affected by the stigma associated with mental illness, and this can prevent them from engaging with early support. Some vulnerable groups also lack family support to get the help they need, or their needs may present in ways which are easily misread and overlooked by those in day to day contact with them (for example when in the form of aggressive, bullying behaviour).

Young people from vulnerable groups also frequently present with multiple subthreshold needs which can fall below the radar of services too focused on severity thresholds (e.g. safeguarding and specialist mental health diagnostic thresholds). For some there are well tested interventions which can make a difference to their outcomes (e.g. Multi systemic Therapy, Functional Family Therapy, Multi-dimensional Treatment Fostering for those on the edges of care and the justice system); for other groups interventions have been less robustly tested.

When supporting the needs of vulnerable children and young people, the Taskforce:

1. Reinforced the particular importance of an integrated and multi sector approach (including health, education, social care, youth justice, the police and the voluntary sector) ensuring that needs are assessed and met in a co-ordinated, early and non-stigmatising manner supporting children and families in ways that feel collaborative and relevant, that promote resilience and that reduce cascading risk. Multi sector joint planning should build on existing systems such as Looked After Children and youth justice reviews, Common Assessment Framework and Children in Need approaches.
2. Stressed the need for greater flexibility in acceptance criteria – using formulation-based approaches rather than waiting for young people to reach diagnostic thresholds and mental health crisis before intervening.
3. Advocated increased use of mental health liaison and consultation approaches to support and empower those in contact with higher risk groups (e.g. frontline youth workers, foster parents, peer workers and families) to support their mental health and wellbeing.
4. Emphasized the need for improved information sharing (both with professionals and with families and young people) to ensure better coordination across all the agencies touching the lives of vulnerable children.
5. Recommended more engaging and outreaching service delivery models with child and youth co-production and needs at the heart of these approaches and with help that is holistic, feels relevant and is future-focused to help restore wellbeing (e.g. emerging approaches such as MAC-UK/Integrate movement; Adolescent Mentalization-Based Integrative Treatment [AMBIT]; community psychology approaches).
6. Suggested targeted outreach approaches with some groups at higher risk of health and social inequalities (e.g. with some BME communities, LGBT young people, young people involved in gangs) using data to evidence effective improvements in tackling inequalities and promoting health improvements.
7. Recommended prioritising routine and compassionate enquiry about experiences of trauma linked to the delivery of trauma- focused care for vulnerable children and young people affected by these experiences.
8. Stressed the need for assertive follow-up of all of those who do not attend targeted or specialist CAMHS appointments with DNA being identified as an indicator of need.

Best practice commissioning

Best practice commissioning to support children's mental health and emotional wellbeing involves:

- Having effective and clear leadership with multi sector sign up and commitment to a jointly determined and shared vision;
- Shifting resources towards preventative activity and invest to save principles;

- Building on a comprehensive joint strategic needs assessment which prioritises children's mental health and risk and protective factors compromising and supporting children's wellbeing;
- Developing an integrated multi sector Transformation Plan (as recommended by the Taskforce) building on strengths and addressing current problems in the system.

The Taskforce report suggests that Transformation Plans should:

- Set out what children, young people and families should be able to expect in any area in order to secure the best possible outcomes for their mental health and wellbeing
- Draw together collaborative multi sector action (including as a minimum Health, Early Years, Social Care, Education and, where present, voluntary/third sector and/or independent sector providers) enabling all areas to accelerate service transformation (Department of Health, 2015) and better meet need;
- Involve sign-up by all commissioners, partners and providers to a series of agreed principles covering how they will meet the range of children's needs, their roles and responsibilities, the choice of treatments and interventions available, collaborative practice with children, young people and families, a commitment to children's needs, and using evidence-based interventions and outcome monitoring data to track quality, review and inform service delivery;
- Establish a set of agreed outcomes with multi sector partners, children, young people and families;
- Require providers to declare routinely what services they provide, including resources/ staff numbers, skills and roles, waiting times and access to information, interventions provided and outcomes;
- Require local commissioning agencies to give an annual declaration of their current investment in children's mental health and emotional wellbeing;
- Cover the whole spectrum of services supporting children and young people's mental health and wellbeing – from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems and those in crisis as well as transitions between services;
- Be designed jointly against whatever commissioning footprint makes sense locally. In most instances, the Taskforce sees clinical commissioning groups drawing up plans working closely with the Health and Wellbeing Board partners including local authorities and partners;
- As a minimum, include a commitment to achieving parity of esteem between physical and mental health by 2020 in line with the Five Year Plan for Mental Health (Department of Health, 2015);
- Involve children, young people and families in the development of the strategy and plan;
- Involve a commitment to review, monitor and track improvements towards the ambition for transformation set out in the Taskforce report, including children and young people having timely access to effective support when they need it;

- Adopt new arrangements with new models of contracting and performance monitoring as a key driver to securing collaborative and co-ordinated working across local areas.

Using data

Quality, timely data is critical to assess the effectiveness of services provided for children, young people and their families (Department of Health, 2015). There is evidence that tracking progress in therapy (particularly experience of help or therapy, change in symptoms and impact on life and general wellbeing) improves engagement and can reduce drop-out, leading to quicker and better outcomes.

For commissioners, routine use of good quality data helps them to understand what is being invested locally, to identify gaps, to make comparisons with regional and national activity, and to track and respond to fluctuations in need, demand or service quality early on (Joint Commissioning Panel for Mental Health, 2012). The Taskforce and other commissioning guidance recommends that all multi sector partners supporting children's mental health and emotional wellbeing being are required contractually to maintain an accurate data set providing timely reporting on agreed indicators and outcomes to commissioners (local, regional and national) and to other national organisations (e.g. Health and Social Care Information Centre, CORC) when requested.

This includes routinely tracking a broad set of metrics covering:

1. Whole system service activity and spend (including mental health promotion, prevention and risk reduction activity, maternity, early years, school, youth and voluntary sector data, SEND and paediatric activity focused on mental health, justice and LAC data, voluntary sector and targeted and specialist mental health provision);
2. Staff numbers, skills and roles;
3. Relevant data from the maternity and child as well as the CAMHS minimum dataset including numbers of:
    a. referrals made and accepted;
    b. assessments offered and taken up;
    c. waiting times – '*in developing any access and waiting time standards, it should be a requirement that access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes';*
    d. evidence based interventions offered and completed (including parenting, school based interventions, CBT);
    e. other interventions offered and delivered to support child and youth mental health and emotional wellbeing;
    f. children and young people who do not attend appointments (DNAs);
    g. presenting difficulties of children, young people and parents/carers and levels of impairment with pre and post intervention outcome measures and service satisfaction measures collected and reported on routinely by all those delivering therapeutic interventions to track shifts - active use of data has been linked to improved performance and outcomes;

h. A & E presentations, inpatient placements and the use of section 136 placements for children and young people under 18;
i. availability of crisis/home treatment.

Best practice data collection should also draw together up-to-date whole sector information on:

- Prevalence and Public Health Profiles for children and young people's mental health and wellbeing needs;
- Data from Quality Networks for CAMHS such as QNIC, and QNCC;
- Public Health Outcome Framework data;
- Data from Strengths and Difficulties Questionnaires (SDQ) completed by looked after children, collected by local authorities;
- Data from the CAMHS Tier 4 database being further developed
- Other relevant information from maternity and child datasets.

In the health sector, key data informing decision-making should include:

- NHS Benchmarking Network data;
- Outcomes data collected by members of Children's Outcomes Research; Consortium (CORC);
- The CYP IAPT datasets and outcome measures; including:
    - Goals based outcomes (GBO)
    - At least two time points on a standardised outcomes measure, and
    - Feedback on experience of services
- Datasets and outcome measures for specialist CAMHS;
- Data collected for CAMHS Currencies;
- Health and Justice data.

Summary table: what good looks like

The table below summarises:

- what good looks like
- to what extent (based on findings from the whole system review) current Herts activity dovetails with national and evidence based ambitions for an ideal CAMHS system
- action required to work towards improving compliance with the national Taskforce ambition

When taking forward these action points, a strict sequencing is required in order to ensure that a firm foundation for change is in place. The transformation process should begin by prioritising strategic and commissioning action planning (see Chapter four). It is the Centre's experience that without a firm foundation of coordinated strategic activity driven by strong leadership, the chances of achieving operational changes and successful transformation will be reduced and change is unlikely to be sustained.

What good looks like	**Current Herts Status**	**Required actions to address gaps**
1. Promoting good mental health and emotional wellbeing is everyone's business.	There are considerable inconsistencies in whole system ownership of CYPs' mental health and emotional wellbeing in Herts. There are gaps in proven early CAMHS provision supporting an early intervention and life course approach.	• Establish a multi stakeholder CAMHS Strategic Partnership with a Chair and Terms of Reference. • Produce a CAMHS strategy and action plan based on known needs (feeding into the Transformation Plan). • Secure sign up by all commissioners, partners and providers to a series of agreed principles • Involve young people, families/carers in the development of the strategy and plan • Agree 'basket' of shared outcomes • Develop Task and Finish groups to focus on priority pathways (behaviour, self-harm, anxiety and children in

		care). • Consider how pathways might adapt activity to fit the adapted Thrive model • explore the strategic and practical feasibility of delivery via local hubs • Adopt new arrangements with new models of contracting and performance monitoring for coordinated working
2. Children and young people's needs must be at the heart of any effective system supporting children's emotional and behavioural health and wellbeing.	CYP needs are not currently the driving force in the Herts CAMHS system.	• CYP and families/carers should be represented on the CAMHS partnership Board and task and finish groups. • Work towards adopting an adapted Thrive model (which places children's needs at its heart). See chapter 3. • Outcome and satisfaction data should be routinely used, analysed and acted upon by all those supporting children's emotional and behavioural health (at service and strategic level).
3. An effective system builds capacity in children, young people, peers, families, and professionals	There is inconsistent evidence across the county of mental health promotion, capacity building and of workforce development supporting	• A workforce audit should be completed • Herts should commission a programme of systematic awareness raising and capacity building targeting

All those in contact with CYP (including families/carers/CYP/peers) understand how to strengthen a child's wellbeing. They also can recognise when MHEWB moves outside healthy ranges and how to secure the right help when problems arise	children and young people's mental health and emotional wellbeing.	professionals, CYP and families. • Improved information should be available through quality controlled on-line systems and sources (co-produced by CYP and informed by evidence). These should build on MindEd, the Youth Wellbeing Directory and other good quality resources.
4. There must be coordinated multi stakeholder commitment and action to: • promote and preserve children and young people's emotional wellbeing • de-escalate crises promptly • and to act quickly to restore mental health following difficulties or crisis	Mental health promotion across the county is patchy and inconsistent. There are gaps in service provision and in priority of attention to CYP MHEWB across the life course There is a lack of parity between emotional/behavioural health and physical health during early years. Coordinated action across sectors is also inconsistent. School and GP toolkits have been produced but these are not always used and implemented. Children, young people, parents and some professionals in Herts say	• Requires robust cross sector strategic development and planning via strong leadership, CAMHS partnership board and introduction of action planning and review • Requires promotion, workforce development and capacity building across CYP and carers. • Better knowledge should be promoted through universal and targeted mental health promotion using MHFA and Herts for Learning awareness training, MindEd resources, updating tools for schools, Multi stakeholder commitment should be well promoted across the county and thread through other key strategies. • Future workforce planning: better knowledge and confidence should be promoted through advice and consultation from primary mental health

	they lack confidence in how to support good mental health and wellbeing. They also lack knowledge on or are confused about how to get help. There are concerns about lengthy waiting lists, lack of early action to de-escalate crisis and about CYP falling between the gaps of services/sectors. There is over use of some crisis support services.	workers (who may mobilise more specialised advice from SPA and specialist CAMHS). • There is a need to draw together other developing strategic activity including Early Help developments, 0-25 and Family Safeguarding and 0-25 SEND work, the proposed substance misuse Reviews etc.
5. An effective system supporting CYP (and broader family) risks and needs from pregnancy to early adult years.	There are gaps in the current overarching pathway supporting CYP and family mental health.	• A series of multi sector pathways will be developed to support children's mental health via Task and Finish Groups. • A review of parenting provision in Herts (as part of this pathway development) and how it contributes to CYP MHEWB. • There is a need to draw together other developing strategic activity including Early Help developments and 0-25 and Family Safeguarding.
6. An effective system works together to achieve the best outcomes for *all* children and young people	There is evidence that Looked After Children are more likely to be referred to CAMHS and to be excluded from school in	• multi sector pathway development must focus on the needs of vulnerable populations

	Herts. They are also more likely to be referred to specialist CAMHS. Although Herts is predominantly white, engaging services must be provided which meet the needs of the 24% who come from BME groups. There is national evidence that homophobic experiences in school undermine mental health and wellbeing.	• the adapted Thrive model will provide a developmental foundation for multi sector activity to support those with multiple vulnerabilities and needs. • Consultation-based approaches should be considered such as AMBIT or Integrate movement. • workforce development must focus on a formulation-based (rather than a diagnostic approach) to supporting children's needs. • A community development worker should focus on developing improved and culturally appropriate early intervention for some at risk BME populations.
7. An effective system is driven by best quality evidence of what will improve children's outcomes as well as by CYP choice.	Herts is lacking key evidence based pillars which must form the basis of a robust evidence based approach to supporting CYP MHEWB.	• multi sector pathway development should build in key evidence based interventions and agree delivery and quality control mechanisms

8. An effective system is based on an invest to save approach	Key invest to save 'pillars' are missing from Herts portfolio of provision supporting child and family MHEWB.	• multi sector pathway development should build in key evidence based interventions and agree delivery and quality control mechanisms. • a basket of shared outcomes should be agreed by all sectors and outcomes should be reviewed to ensure provision is maximising invest to save opportunities.
9. There should be a clear CAMHS offer for CYP and their families re how to get help. This offer: • Should be easy to understand, access and navigate • Should feel non clinical • Should be delivered in the right place at the right time	Children, young people and families are not clear of how to get help and find the CAMHS system confusing. Some professionals working outside targeted and specialist mental health system share this confusion about the Hertfordshire CAMHS offer and what their roles and responsibilities are.	• Strategic activity should develop a clear offer for Herts CYP and families with clear gateways for help and setting out clear roles and responsibilities for all professions in contact with young people.
10. An effective system is underpinned and informed by systematic analysis of outcome monitoring data	Outcome data is inconsistently used and is not currently used routinely to inform strategic decision making countywide.	• Active and routine use should be made of outcome and satisfaction data by all those supporting the wellbeing of CYP in Herts. This data should be used to reflect on and adapt service provision. It should also be routinely tracked and analysed by the CAMHS partnership Board to support swift adjustments

		addressing any implications. • There should be increased capacity in the central commissioning Unit to support tracking and analysis of outcome data.
11. Children receive the appropriate level of care where, when and how they need it.	DNA rates vary across the county for specialist CAMHS Young people want more flexible and non-stigmatising services delivered at the right time and in the right place in Herts Young people don't always want clinical-feeling support.	• a mixed economy of providers should be commissioned to support children who need some help or need more help (see Thrive and Liverpool model in chapter 3) • early multi sector support should be available for those with Thrive 'risk and support' needs (led by children's services but closely involving all sectors). • a task and finish group should be established focusing on improving 'access' including CYP and families. Specialist CAMHS services should learn from other areas where non attendances have been reduced. • CAPA systems should be further re-prioritised
12. All stakeholders should understand their role and responsibilities in relation to supporting CYP mental health	There was general confusion about lower tier roles and responsibilities across Herts	• Pathway development should identify clear multi sector roles and responsibilities for those contributing to healthy emotional and behavioural outcomes for CYP in Herts.

13. Schools play a key role in promoting, managing day to day wellbeing and in early identification of problems and mobilising help when what they A named primary mental health worker should support a cluster of schools and primary care providers provide reaches its limits.	There are inconsistencies in what is provided in schools settings and in the quality of what is provided across Herts.	• update the schools toolkit • provide a short clear guide to the interim and new system • build on national guidance on school counselling • build on national guidance on PSHE • deliver MH awareness raising in schools • extend pastoral care networks • disseminate learning from Time To Change pilot in Herts • establish mental health champions in each school (working with peer champions in secondary schools) • extend peer health promotion champion networks (and evaluate outcomes). • provide a named primary care link worker • create a Healthy Minds lead across Herts to drive and support improvements.
Crisis management		
14. Crisis de-escalation should start early and be a whole system responsibility	There is evidence of significantly lower investment in lower parts of the MHEWB system in Herts. Need is not met early, goes unnoticed until crisis. De-escalation generally occurs too late (e.g. due to lack of early intervention to manage early risk factors, lengthy waiting periods, gaps between services, poor	• build knowledge and capacity in whole system through workforce development activity • systematically use joint assessment (e.g. Early Help assessment/eCAF/TAF) • develop multi-sector pathways (self-harm, anxiety, LAC, healthy behaviour)

	knowledge of how to get help). There is evidence of excessive demand on some crisis support services in Herts	• identify named link workers with schools and GPs and increase PMH capacity to support this liaison and delivery role.
15. Local areas should have an effective Crisis Care Concordat in place. There should be effective planning/ liaison with A&E and justice activity	Herts has a Crisis Concordat in place; it is unclear as yet as to how successfully it has been implemented.	• the CAMHS partnership board and CSU units should regularly audit compliance with this Concordat taking swift action to troubleshoot where local activity falls short of agreement.
16. There should be effective step-up and robust multi sector step-down arrangements for children with MHEWB needs	Inconsistent in Herts	• development of multi sector pathway will support this • development of 'multi-agency hub' approaches should improve joint working and planning. • consistent use of CPA linked to eCAF/TAF and Early Help offers
17. Any new CAMHS models must support: • effective transition to adult services • stronger synergy between activity focused on parental mental health and child mental health.	There is evidence of discontinuities in Herts at the point where risk of developing poor mental health is highest for young people. There is little evidence of synergies between adult mental health work focusing on parents and child mental health.	• The CAMHS strategy and partnership board should include strategic representation from adult mental health commissioners, create a task and finish group focused on transition to and interdependencies with adults services and develop an action plan to improve continuity across high risk periods. • Consideration should be given to the role of YIACS

	Perinatal support for poor mental health is not developed in Herts. This has implications for the future wellbeing of children in Herts and affects future societal costs.	in supporting transitional arrangements • CAMHS commissioners and the CAMHS partnership board should work closely with adult commissioners to learn from and support the introduction of new waiting times for EIP services and to link to perinatal improvements.
18. At all levels, there must be robust systems in place to track and analyse outcomes using analysis to make swift adjustments to provision. This includes CYP and family/carer satisfaction rates with what is provided.	There is evidence of inconsistent use and analysis of outcome, satisfaction and service data to inform service development. Contract monitoring requires strengthening in Herts both at CCG and central commissioning level.	• Contracts and protocols should have a clear expectation that outcome data is tracked, acted upon (where necessary) and shared monthly with CCGs and with the commissioning support unit. There should be evidence that CCGS and CSUs analyse this data. • There is a need for more robust contract monitoring • The CAMHS Partnership Board should routinely analyse outcome data to consider strategic and commissioning implications.
19. There should be a firm commitment to review, monitor and track improvements towards the ambition for transformation set out in the national Taskforce.		• Develop a CAMHS strategic partnership board which includes multi sector, CYP and family/carer representation. • Develop an agreed strategy and action plan Establish a protocol for routine receipt, analysis and benchmarking of outcome/satisfaction data by the Board.

		• Review progress towards agreed transformation priorities.

3. Developing a best practice model for whole system CAMHS

This section considers a range of existing and emerging models designed to support children with mental health and emotional difficulties. It assesses the strengths and weaknesses of each of the summarised models. Taking into account Taskforce recommendations, best practice and Hertfordshire's current resources and specific needs, Centre for Mental Health strongly recommends a modified six Level Thrive model and pathway to drive whole system CAMHS transformation in Hertfordshire.

The Tiered model

In 1995 the 4-tiered model (NHS Health Advisory Service, 1995) was introduced as a blueprint for planning child and adolescent mental health services. Although helpful as a commissioning framework for planning services it is now considered unfit for purpose as a model for CAMHS going forward. Identified disadvantages included that:

- The model was complex to understand for organisations working outside children's mental health (including adult mental health workers);
- It focused excessively on service organisation rather than on children's needs;
- It did not act as the glue that drew multi sector activity together to support children's mental health and wellbeing.

Rather than encouraging early action or a seamless handover across tiers, eligibility criteria for accessing different tiers were experienced as complex and difficult to understand by children and young people in need, their families and professionals alike and the boundaries between some tiers (particularly between tier 2 and tier 3) felt impenetrable.

The former Government's *Every Child Matters* programme attempted to reshape the tiered model and adapt it to the wider children's services agenda and landscape. It saw supporting children's health and wellbeing as everyone's responsibility rather than just the preserve of health services (Department for Children, Schools and Families, 2004). A three tiered model of universal, targeted and specialist tiers was created; this model still persists in some children's services today. However, the children's services model did not eclipse the health 4-tiered model which by this time was embedded in CAMHS commissioning and service planning.

The recent CAMHS Taskforce has recommended that the four-tiered model is no longer fit for purpose. Some local areas have also dispensed with a tiered approach; however many areas still continue with it (even those considered to be best practice models).

The Thrive Idea

The Anna Freud Centre and the Tavistock and Portman NHS Foundation Trust recently proposed a new idea for supporting children and young people's mental health and emotional wellbeing built much more around children's and their families' needs (Anna Freud Centre and The Tavistock Clinic, 2014). This approach is also divided into four groupings based on children's needs as outlined in Table 1.

Table 6: the Thrive model

	Description	System activity	Health role
Phase 1	Children and young people who are thriving	Promotion of children and young people's mental health and wellbeing, parenting and community resilience. All stakeholders (including CYP and families) work together to help young people help themselves and to build strong emotional and mental wellbeing through: • Signposting • Self-management One-off contact	Whole System role Experienced workers should support stakeholders to decide who needs help in this grouping and who needs 'more help'.
Phase 2: **Coping**	Children and young people may face adversity and be coping temporarily with setbacks.	• All stakeholders (including schools, peers, families etc) may contribute to supporting children and young people negotiate adversity and temporary setbacks.	Experienced workers should support stakeholders to decide who needs help in this grouping and who needs 'more help'.
Phase 2: **getting help**	Some children need a little more help	Health workers support CYP by delivering interventions which are: • CYP and parent goal focused • Evidence informed • Outcomes focused	Health would be the lead provider working in partnership with CYP and families.
Phase 3: **getting more help**	Some children and young people need more extensive help.	Health workers provide more extensive evidence informed treatment	Health is the lead provider using health language (ie a language of treatment and health outcomes) and working in partnership with CYP and families. Health input should involve health workers specialised in different treatment.
Phase 4:	'Risk and support'	The THRIVE model proposes explicit	For this group, there needs to be close intera-

		recognition of the needs of children, young people and families where there is no current health treatment available, but they remain at risk to themselves or others. This may be because they are not ready, have difficulties such as emerging personality disorders or unclear and multiple needs.	gency collaboration allowing common language and approaches between agencies and clarity as to who is leading. Social care and CAF processes may often lead activity. Health input should be from staff trained to work with this group and skilled in shared thinking with colleagues in social care, but with explicit understanding that it is not a health treatment that is being offered.

On the plus side the Thrive approach:

- Builds the language of wellness, mental health promotion and self-help into the model and implicitly sees a broader system of activity promoting and supporting young people's wellbeing
- Places young people's needs at the centre
- Recognises that young people often need different intensities of help
- Explicitly recognises that some children may have multiple and non-clear-cut needs or may not engage or respond to evidence-based interventions despite needing multi agency support.

On the other hand:

- Interventions in phases 2 and 3 are seen primarily as being delivered by health workers; this is not what young people said they wanted during the national Taskforce consultation or during the Herts review. Young people wanted a choice of provision and providers.
- The approach also describes health workers in phases 2 and 3 using the 'language of treatment and health outcomes'. Again children and young people have said that they don't like medicalised language and clinical feeling services (Department of Health, 2015); furthermore, some successful mental health 'treatments' don't feel like 'medical treatment' (e.g. parenting interventions, Individual Placement and Support interventions placing and supporting people with poor mental health in employment). Furthermore, longitudinal studies tell us that health, educational and social risk factors are significantly interrelated over the life course. It is therefore unhelpful to think just in terms of 'health outcomes' as if they are somehow partitioned from other child outcomes. Just as some social interventions have an impact on health, so some health interventions also have an impact on social outcomes (such as educational attainment, escalation into local authority care, criminal activity, violence etc.). Given the robustly established interrelationships between social, educational and health risk factors across a child's life, it is therefore better to avoid a siloed focus on sector specific outcomes and it is advisable instead to think in terms of 'a basket' of agreed and shared multi sector child outcomes which all of those focused on children's outcomes do their best to advance.
- Finally, to work in real life settings, there would need to be strong multi agency agreements in place to support children who form part of the group who need 'risk support'. Without a clear set of protocols, a common language and set of tools, these children could continue to fall into the gaps between services.

The Thrive approach is very much emergent and evolving and designers have already recognised the need to include a broader range of providers to meet children and young people's needs. The Thrive idea also has yet to be tested in real life settings although it has recently been adopted as a pilot project in Camden.

Models in practice

A number of CAMHS models have been developing in real life settings seeking to draw together best practice principles in promoting and supporting children's mental health and emotional wellbeing.

The Liverpool model

The Liverpool Emotional Health and Well Being model has been developing for around 10 years and claims a range of improved outcomes as a result of the changes made to the system of support. The model has been jointly commissioned between health, social care and education (with the CCG absorbing the Local Authority contribution in 2014). There has been a strong foundation for collaboration between partners with activity driven by a consistent commissioner from the outset.

The strapline for Liverpool's services is ' In Liverpool, mental health is everybody's business'; and it was co-produced with young people.

Key features of the model include:

1. Cultural change has been built on and driven by whole-system awareness-raising and capability development:
    - Training and awareness-raising are delivered by a mixed economy of voluntary sector and statutory primary mental health providers.
    - Training and capacity-building are available for professionals working in universal children's services as well as for parents, carers, children and young people.
    - Targeted training is also provided to key professionals such as Health Visitors, school nurses, SENCOs and YOS case managers to build capability and confidence in professions with a key role in supporting emotional health.
    - Places are booked via an easy online system
    - Training is backed up by a public mental health self-care website co-developed by voluntary sector CAMHS and children and young people. (A number of other counties are also developing self-care websites.)
    - Training covers raising general awareness on children's and young people's mental health and emotional wellbeing as well as condition-specific issues.
    - Consultation and telephone support are also available from primary mental health workers 8.30 to 5.30 Monday to Friday for professionals, parents and children and young people; consultation and advice is also made available in a more systematic way to social work teams, Youth Offending Service, Family Intervention Projects, workers in social care residential settings, foster carers and schools (all schools have named CAMHS link worker).
    - Since the training strategy's inception, Liverpool has seen an annual increase in professionals accessing training and over the same period it claims a decrease in Tier-3 referrals and an increase in stability of placements for Looked After Children.

- Primary mental health workers support training, link with schools every term to troubleshoot issues, de-escalate and support school staff with the management of children's emotional health and wellbeing. They also provide brief interventions if children's needs are not complex.
- An emotional and behavioural health assessment (linked to the Common Assessment Framework) has been produced for children with sub Tier-3 needs. GPs and police complete a shorter version of this tool.

2. A single point of access team provides a triage service (which draws together multi agency activity if a young person faces multiple challenges). This triage service provides a gateway to early intervention and also alternatively to specialist treatment for those with more severe needs. Triage workers also link to Accident and Emergency Departments during normal working hours. Single Point of Access (SPA) workers in Liverpool assess, signpost, refer on and also directly support children with lower threshold needs as well as providing training, consultation and advice to staff and parents supporting those with early intervention needs.

3. Liverpool has commissioned a mixed economy of providers to deliver specialist CAMHS. Providers include:
    i. An ADHD charity
    ii. Tier-3 multi-disciplinary CAMHS (who support those presenting with high risk and whose day to day functioning is significantly impaired)
    iii. A voluntary sector counselling and psychotherapy service
    iv. A voluntary sector organisation specialising in delivering trauma-related services
    v. A voluntary sector provider supporting young carers

All those providing Tier 3 services are CYP IAPT trained to support quality and consistency.

There is further strong focus on the Choice and Partnership Approach (CAPA) and lean thinking organisational approaches to keep activity focused on reducing waiting times.

Liverpool crisis care

The Liverpool system seeks to de-escalate at all levels, from the very lowest to the highest tiers.

The interface between specialist and very specialist services is further supported through a range of additional resources aiming further to de-escalate crises, manage crisis and assist safe stepdown. These include:

- Robust links and good communication being established with Accident and Emergency departments with next day follow up by the SPA team
- Access to out of hours CAMHS psychiatry for 0-16 year olds (NB they are considering changing this service to out of hours access to an on-call CAMHS clinical manager who it is felt would be better placed to assess risk management plans and coordinate

broader health and social support to support safely the often complex needs of young people in crisis).
- An innovative service coordinating a front line response for psychiatric support to patients 16 and above within an acute hospital setting
- Follow-up within 72 hours by Tier 3 CAMHS after discharge from a ward.
- Flexibility of appointments after crisis: home visits, key worker support, telephone support.

The system is glued together through:

- Whole-system capability building
- a mixed economy of providers working jointly
- use of the Early Help Assessment Offer (EHAF, a replacement for the previously used Common Assessment Framework) for those in need (together with the Care Programme Approach for those in crisis). A shorter pre EHAF has been developed for time-intensive settings such as police frontline work and GP consultations.
- joint assessment procedures, joint working and outcome monitoring processes
- the development of a range of care pathways
- joint funding applications are common drawing together statutory and voluntary resources
- A CAMHS passport supports improved information sharing based on CYP consent.

Strengths of the model

The training offer, combined with clear pathways and an approach which draws together a mixed economy of providers using common tools and outcome monitoring processes, offesr choice to children, young people and families in Liverpool. It also drives multi sector activity to promote and support children's emotional wellbeing and mental health. Liverpool report 90% satisfaction rates for their specialist CAMHS services.

Possible areas for development

- Some of the care pathways produced (e.g. the self-harm pathway) still remain overly clinical in focus and have not yet adequately drawn together multi sector and early intervention activity (e.g. the role of schools in supporting self-harm, what parents/peers can do).
- Liverpool acknowledge that they still have work to do to dovetail CAMHS and paediatric activity, which often overlaps. They are embarking on some developmental work to improve the interface between these two professions. They have already improved the interface between SEN services and CAMHS.
- They also have extensive developmental activity under way to address the CAMHS to AMHS transition
- Liverpool's model is based on less than 200 primary and secondary schools; Hertfordshire has many more schools across the county.

The County Durham early crisis de-escalation model

CAMHS in County Durham have developed their crisis care services, which now operate much earlier in the system, running alongside targeted children's or Tier-2 services.

Any crisis emerging early on prompts a multi-agency plan for the child or young person until the crisis has passed. The crisis service is available 8am – 10pm, seven days a week and offers 72 hour intensive support to between 8-10 young people at any one time.

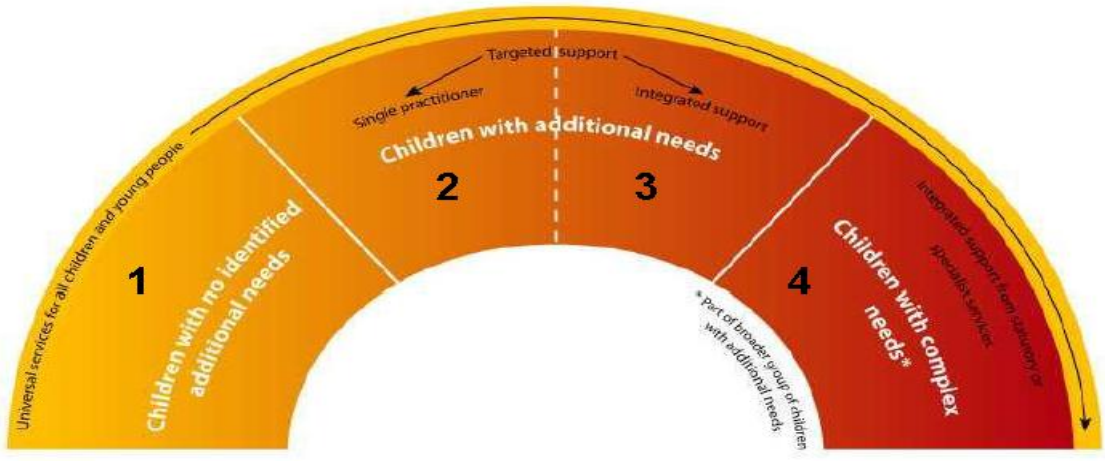
24% of young people presenting with urgent mental health needs have been contained within 72 hours and introduced to appropriate support without needing to go above Tier 1.

Oxfordshire early Intervention hubs

Some areas have developed 'hubs' in local communities which co-locate multi-disciplinary staff and are designed to act as an easily accessible and welcoming front door to get help. They often build on pre-existing resources such as youth centres or Children's Centres.

In Oxfordshire, holistic support is offered to vulnerable children, young people and families through seven hubs, seven satellite centres and 44 Children's Centres which co-locate staff from many different sectors and which aim to improve the holistic welfare and safeguarding of Oxfordshire's children.

Oxfordshire hubs provide mainly targeted holistic advice, consultation and support from pre-birth to 19 years (with an extension to 25 years for those in care or with SEN). A range of needs-led pathways have been developed based broadly on the former Every Child Matters model of support and focusing on early health (including public health), social, safeguarding and educational risk factors and needs. The model focuses on risks and needs and is not



unlike the Thrive model across stages 3-4. However, because Oxfordshire hubs are targeted resources, there is not an explicit emphasis on capability building with those in Tier 1 to prevent difficulties; just an emphasis on intervening very early if difficulties begin to emerge.

The aims of Oxfordshire hubs include:

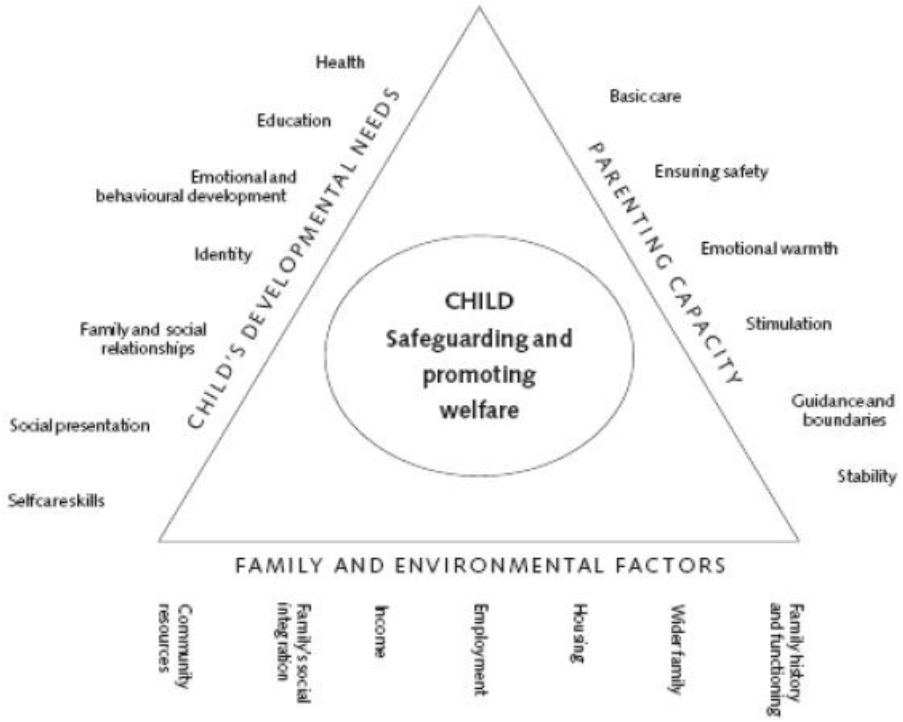
- Improving outcomes and keeping children safe;

- Supporting attachment and understanding child development;
- Taking a whole system approach to integrated planning;
- The importance of early help to prevent more complex and challenging issues developing;
- Involvement of children, young people and families in planning and developing services;
- That there should be an underpinning therapeutic basis to their work;
- All interventions should be high quality and evidence based.

A care pathway has been developed to support early multiagency activity for children in need. This care pathway has a strong focus on healthy child and youth emotional and behavioural development and responses draw together multi agency activity to support children accumulating multiple or worrying risks such as those who go missing and those excluded from school. Responses also reflect the importance of families and schools in strengthening protective factors.

Hubs also provide step down support from social care (although support is not as yet well integrated with step down care for CAMHS inpatient provision).

Due to commissioning complexities, until now, primary mental health and specialist CAMHS have not been co-located in Oxfordshire hubs but developmental work is now under way to attempt to achieve this. CAMHS do regularly contribute to care planning and the Centres are often used as delivery venues for partners.



Benefits of the hub approach

The Oxfordshire hub approach was described by the Oxfordshire lead manager as having considerably cemented multi sector joint working and information sharing encouraging a life course and a joined up approach to intervening at the earliest point and taking prompt action to help to de-escalate or stabilise in the event of a crisis.

On the downside

- Because hubs offered targeted help, there was little focus on capability building. Targeted venues may also be experienced as stigmatising by young people; and attending a hub designed for infants to nineteen year olds might feel patronising for teenagers
- some key professionals such as paediatricians were not yet linked in
- The Oxfordshire Hubs and pathways were predominantly child welfare focused and did not fully integrate clinical and social care pathway development. This said, one piece of promising work had been completed towards this goal in one area of the county after a recent suicide. In this area, primary and specialist CAMHS worked with Social Care and schools to develop a multi sector self-harm pathway. There is scope to build further on this integrated work.

Hackney Youth Hubs

Hackney Hubs are universal drop-ins for children and young people under the age of 19 years. They are essentially universal child and youth activity centres rather than merely being targeted towards vulnerable children. Five years ago, Hackney invested in existing youth centres in the area developing five young Hackney hubs. These Centres involved young people in their design and developed and drew together a range of youth orientated and youth led activity such as access to IT, arts, drama and dance, sports and employment support as well as providing a one stop shop for a range of holistic advice and help.

Many multi-agency providers have been co-located in these hubs; other providers come together for routine multi-agency meetings to discuss referrals and children and young people who were causing concern (because of gang concerns, school crises etc). Two CAMHS primary mental health workers were jointly commissioned by health and children's services to facilitate assessment of children and young people's emotional needs and to help them access appropriate support. CAMHS workers also provided systematic training, advice and consultancy to wider youth and children's services staff.

The CAMHS clinician explained that many of the young people approaching for help or being referred in crisis had unclear or previously unidentified developmental, communication or mental health needs. These workers were able to outreach easily to young people in the Centres, which had a non-clinical feel, or to support others working with them. The CAMHS clinician also felt that joint meetings had improved interagency communication and information sharing, trust and joint working. The Hackney Youth Hub Model and the related multi sector meetings was described as improving multiagency understanding, competency, trust and joint working to support children with multiple and overlapping needs

However, there were also some challenges with implementing and maintaining this approach. Recent cuts to the Children's Services budget had led to a withdrawal of pooled

funds for one of the CAMHS workers. Furthermore, a consultant psychiatrist raised contractual tensions which meant that much of her consultancy and meeting time was not counted as valued activity from a commissioning perspective; only face to face contacts were counted. Finally, Hackney Hubs did not act as a front door for CAMHS referrals which the consultant psychiatrist felt was a missed opportunity. Funding cuts in the future may also reduce the range of activities offered making the venues less attractive to young people.

Services supporting improved care for those transitioning to adulthood

Some local areas (Birmingham and Norfolk & Suffolk) have re-configured the way they commission their CAMHS, creating a new youth mental health service.

Norfolk has realigned its services to develop a 0-25 NHS mental health service through a combination of services previously within child and adolescent and adult mental health services. They now have a series of interlinked services under one management line, which offer evidence-based, developmentally appropriate services. Their service offers treatment via a perinatal service, a 0-14 service, and a youth service, which extends to include the successful Early Intervention in Psychosis model into work with all young adults. In one locality, the successful contractor for a new youth service is not the local mental health trust that previously provided services.

These developments are still very much in their infancy and have not yet had the benefit of longer term evaluation to support learning.

A suggested model for Herts

Many nationally and locally emerging models contain promising elements; however no one model draws together activity into an ideal approach which knits fully with ideal practice and with the needs of children, young people and families in Herts.

In the following section we draw together learning from best practice, the best elements of those models discussed above and existing or developing Herts practice recommending a new model for the county supporting emotional wellbeing and mental health in the future.

The Centre recommends the development of a six level modified Thrive approach for Hertfordshire which places children and young people's needs at its heart. The new pathway and model for supporting children's mental health and wellbeing in the county is summarised in a table at the end of this section and in Figure 1. Children and young people should name this new approach for Hertfordshire.

The six stages in the proposed pathway are:

7. **I am doing well** and I am supported or know how to develop good emotional health: all local services support children and young people to build resilience
8. **I am coping:** all local services support children and young people to negotiate adversity and build resilience, for example through families and schools

9. **I need help:** prompt help from a choice of providers of evidence-based interventions
10. **I need more help:** more intensive support, offered from a choice of providers in a way children and young people find helpful
11. **I have unmet needs:** children with unclear or multiple needs, who are struggling to cope and at risk of poor mental health, who need multi-agency support
12. **I need help preparing for adult years:** joint working and commissioning with adult services to meet needs as young people mature, with a mix of services from pooled budgets.

Key elements of the model

A lead commissioner or partnership commissioning group (with a nominated responsible lead) should be introduced to support this new way of working.

The Herts model should:

- place children's needs at its heart
- outline the critical importance of positive emotional health and mental wellbeing in children, young people and in families/carers
- prioritise early intervention, recognising the importance of early help and schools in supporting strong mental health
- provide a clear definition of what good child and youth mental health and emotional wellbeing means in Hertfordshire with some clearly stated desired outcomes
- reinforce that supporting good child and youth mental health and wellbeing is everyone's business
- secure multi sector sign up to the vision.

Young people in Herts said they did not like the term CAMHS. It is therefore important to work with partners and young people to reach agreement on a clear brand for the Herts offer.

A set of principles should also be developed underpinning the Herts offer agreed and signed up to by multi agency partners including:

- Children's services (particularly family safeguarding and social care, Emergency Duty teams and youth workers)
- Midwifery services
- Health Visitors
- Schools
- SEND teams
- The PALM team
- The Childhood Support Service and Parenting Teams
- Health and mental health providers (including Accident and Emergency teams)
- Early years workers
- Youth Offending teams
- Voluntary sector providers
- Foster carers and those providing support to Looked After Children

Finally, a basket of shared outcomes should also be identified strategically by multi agency commissioners to support the development of whole system CAMHS.

Move away from a tiered approach

The tiered approach now has less utility as broader services modernise and structure commissioning and delivery around early help and intervention. Using tiered approaches may also undermine attempts to achieve system transformation with a risk that activity will gravitate back to previous patterns.

Although not yet tested, the Centre recommends an adapted Thrive approach. The modified approach would make building strong emotional health and wellbeing as everyone's business. It would also ensure a mixed economy (the local authority, services commissioned by schools, the voluntary sector and broader health) of help being made available to support children 'needing help' or 'needing more help'. For the Thrive idea to work, detailed multi-agency planning will also need to take place to support children who risk falling between the cracks in services in phase 4 and who have 'risk and support' needs. These will largely include children and young people with multiple or emerging needs or those with high risks of poor life chances but who struggle to engage with standard services.

Build on a strong foundation of universal mental health promotion and self-care

The Herts Offer for emotional health and wellbeing should build upon a strong foundation of mental health promotion and capability building to support implementation and cultural change. As was the case in Liverpool, promotional activity should be three-pronged focusing on raising awareness and building awareness, self-help and brief intervention skills in children and young people, in families/carers and among those working in universal and targeted settings.

In Hertfordshire this will require some additional investment in a systematic programme of training covering:

- general mental health awareness raising
- specific thematic mental health issues
- what resources and support are available in Herts
- the development of basic skills supporting children and young people with the disclosure of difficulties, to help children access help and to help them find support in the interim while they await their first appointment.

Training will also support a range of networks (such as perinatal and pastoral care networks).

Training should draw together currently commissioned resources creating an overarching plan developed and delivered through partnership between children's services, public and primary mental health and voluntary sector providers (including Herts for Learning: an arm's length training organisation already delivering training on mental health awareness to schools). It will rest on a blended methodology of delivery including:

- using national resources such as MindEd to support continuous professional development
- local provision such as my baby's brain, my teen brain and Families Feeling Safe
- further development of local online resources such as Herts County Council/Public Health Hertfordshire's Health in Herts section of the website www.hertsdirect.org/services/healthsoc/healthherts and ChannelMogo www.channelmogo.org/ which aims to signpost to support and information. This site should be co-produced further with children, young people and their families to ensure that it is accessible and helpful
- registering and accrediting local counselling provision with the national Youth Well Being Directory and linking this site with the recommended Hertfordshire website
- face to face training
- building capability in young people and families through further development of schemes such as the award winning Champions of Youth Health initiative (involving health champions working with their peers in schools to raise awareness about health related issues)
- building on learning currently emerging from Time to Change and other school pastoral networks developing in Herts

A blended approach of face to face training and access to online and other materials was favoured as a preferred approach by those attending a recent conversation café in Hertfordshire.

A whole system pathway approach

A series of multi sector 'conception to 25' pathways should be developed to support children's emotional health and wellbeing. These could be developed through multi sector 'Task and Finish' groups and should focus on the contributions of all sectors to prevention and promoting robust wellbeing and self-care, early intervention and preventing the escalation of problems and supporting children in difficulty. Based on the issues raised so far during this Whole System Review, priority developmental pathways could include:

- a self-harm pathway
- an ADHD pathway
- a pathway supporting children with anxiety
- a pathway supporting children with conduct problems
- a pathway supporting Looked After Children

Pathways should outline clearly responsibilities throughout the system of care and support with clear criteria for acceptance as well as an expectation on all agencies receiving referrals that children who are not accepted are supported to access the right help.

Neither the Liverpool model nor the Oxfordshire model had quite been able to achieve integrated health, children's services, educational and voluntary care pathway development spanning prevention right up to multi sector crisis management. Oxford's model was largely focused on safeguarding with weaker evidence of multi sector care planning and step down for those in mental health crisis; Liverpool's model was largely focused on health and clinical activity with little focus on the interface with early intervention, SEND, schools and children's

services. It is particularly important that pathway development explores multi sector contributions as well as clinical pathways so that everyone is working together to de-escalate, support step-down, minimise gaps and reduce duplication. Children and young people should be part of this pathway development process. The Clinical Reference Group for this review very much favoured the use of the Common Assessment Framework as a consistent tool underpinning multi sector activity suggesting that it is used by all sectors to support identification of the broader issues affecting children's emotional health and wellbeing and also as an aide to ensuring that children's needs are more effectively identified and met.

Pathway development should also link together all other related activity already under way in Hertfordshire including:

- dovetailing whole system CAMHS activity with the 0-19 SEND Access Point developmental work
- the work stream on Early Help
- the work stream on 0-25 and Family safeguarding
- Thriving Families activity

Establish early help and youth hubs

The Clinical Reference Group in Hertfordshire very much favoured an approach which brought multi sector partners together to deliver in early help or youth hubs and underpinning all work with the common assessment framework. Hertfordshire should consider the most effective way of coordinating and 'gluing together' multi sector, primary and specialist mental health work with other work streams such as the Healthy Child Programme, Early Years' work, Family Safeguarding, schools provision, 0-19 SEND developing Access point, PALMS, youth work and other broader early intervention initiatives in Hertfordshire.

The development of locality multi sector pathways may go a long way towards improving coordinated care to support children's emotional and behavioural wellbeing. Commissioners should consider establishing locality multi agency early help and youth one-stop-shop hubs linked to these pathways. This Review notes that the new Hertfordshire PALMS service aims to deliver its service via a range of hubs and consideration should be given to dovetailing activity. Annex E and F of the Hertfordshire Needs Assessment provides an overview of all Children's Centres and Youth Centres in Hertfordshire to assist this process.

The role of the primary mental health worker

The primary mental health worker will become a central reference point in the system and provide a critical bridge between universal services, broader voluntary sector support and resources, Single Point of Arrest workers, specialist and crisis services.

The Taskforce recommends that every school and GP has access to a named primary mental health worker tasked with:

- providing training, consultation and advice to help other professionals support and manage infant, children's and youth mental health and emotional well-being;
- delivering simple evidence-based interventions
- helping children 'bridge' to specialist help through the Single Point of Access outlined below.

In Hertfordshire, Step 2 are commissioned to fulfil this primary mental health worker role. However, there is evidence that this service is oversubscribed and unable to meet current demand. Capacity has never been such that a named worker was available to be linked to the 550 schools across Hertfordshire. If universal services are better supported through training to know how to support children, Liverpool's experience suggests that the current Tier-2 demand may reduce as children get supported earlier and issues are de-escalated. However, going forward , more investment will be required in primary mental health work if estimated need is to be adequately met, if all the above functions are to be fulfilled and if a named worker is available to every school.

Primary mental health work should link closely with wider voluntary sector resources.

CYP IAPT training should be used to develop the evidence base and strengthen quality at this level of support. There is a particular need to train up a team of workers to deliver evidence based parenting interventions for children with early starting conduct

Hertfordshire should consider emerging online resources and support; however, the Taskforce stresses that online tools/resources are still variable in quality and effectiveness. The Taskforce favoured online resources which link with local service offers and face to face support (such as *kooth* or *getconnected*).

All multi sector providers working at this level should use the Common Assessment Framework as well as standard emotional health and satisfaction outcome measurement tools which should actively be informing both individual sessions with young people and also the development of support services. Outcome monitoring and data analysis should be routinely tracked and considered by the multi sector commissioning partnership overseeing whole system support for children, young people's and families' emotional health and wellbeing.

Help point: expert triage practitioner

The Taskforce states that there should be a single point of access (SPA) for those whose mental health needs fall beyond the skill set of primary mental health support. This expert triage function requires a highly skilled and authoritative clinician who can:

- effectively triage and refer on establishing and negotiating effective support that best suits the needs of young people
- support (or find interim support for) them until such a point as they have successfully engaged with the identified service
- troubleshoot access problems.

In Liverpool, SPAs also provide a liaison service with hospitals and Accident and Emergency departments.

In Hertfordshire, SPA workers would need to form part of a team covering the county. With enough capacity, the same workers could also support point of arrest health and justice liaison work (for those not on the statutory YOT caseloads who will be supported by the YOT health practitioner) and work in close partnership with the currently commissioned Crisis Care team (C-Catt) liaising with A&E units.

SPA workers need to have good knowledge of and links with those providing more specialist mental health support, with crisis settings, with broader children's and universal services and voluntary sector teams and with primary mental health workers in Herts. They would ideally be accessed via primary mental health workers or a via a multi-agency one-stop-shop hub.

Crisis care and management

There is a need to agree a common definition of what constitutes crisis.

Effective crisis care should be able to provide support at any level in the system to de-escalate (or advise on managing de-escalation) early on.

Hertfordshire's Crisis Care and Treatment team (C-CATT) currently provides crisis resolution and home treatment which aims to de-escalate crises early on, acts as the gateway into hospital and helps to facilitate early discharge, providing additional support to people in their own homes during standard working hours. However, Taskforce recommendations and Liverpool's experiences also suggest a need for out of hours support from a psychiatrist or from a senior clinical manager to support de-escalation, step down and admission. The Taskforce recommends that out of hours care dovetails as far as possible with social care out of hours provision (such as emergency duty teams) since often stabilisation and risk management plans require multi sector safeguarding approaches and resources.

Further work should build on the crisis care concordat already developed by Hertfordshire. Performance and compliance should be monitored through routine monitoring of activity and outcomes with the development of action plans for weaker areas of performance.

Finally, every child, young person and parent should not only have a risk management plan in place but also a crisis management plan to support de-escalation. A crisis management plan should include co-production with children, young people and families a plan outlining self-management strategies and how to access services in a crisis. A survey completed during this review highlighted that many parents were not aware of what to do or who to contact if their child's mental health and wellbeing began to escalate.

Specialist provision

A mixed economy of providers should be drawn together and commissioned (through pooled funding) to provide evidence based specialist and expert support to for children who need help or need a little more help to support their emotional wellbeing and mental health. This mixed economy should be shaped by needs specific to Herts as set out in the needs assessment and could include a partnership between Tier 3 CAMHS providers, voluntary

sector counselling and other providers, the Hertfordshire PALMs team, evidence based parenting providers and trauma service providers. Clear roles and responsibilities should underpin each provider's activity with a clear process in place to manage the needs of those with multiple or complex needs. Services should be provided in the right place at the right time for children, young people and their families (and should not be predominantly clinic based). Ideally, work would take place in multi-agency Early Help or Youth one-stop-shop hubs.

All providers should receive CYP IAPT training and should be required to monitor outcomes and satisfaction with available support using standardised tools and processes providing regular feedback to CCGs and the Central Commissioning Support Unit.

Specialist staff should also support primary and other mental health providers through consultation and advice and though contributing to the local training offer.

Meeting youth and young adult needs

Hertfordshire commissioners for emotional health and wellbeing should link with adult commissioners to work towards achieving new waiting time targets for young people accessing Early Intervention in Psychosis services. Learning and joint work should inform future strategic joint commissioning action. Commissioners should consider the potential for joint CAMHS/AMHS commissioning of Youth Information, Advice and Counselling Services (YIACS) and drop-ins as a means of supporting youth mental health and early intervention. Joint action to support early intervention in psychosis waiting times will provide useful learning for more coordinated CAMHS/AMHS working.

Commissioners should consider extending one-stop-shop youth hubs to support a more consistent approach to improving outcomes and joint working for young people preparing to transfer to adult services. Hubs could provide a location where CAMHS/AMHS and voluntary sector services come together to help children. This development should be based on co-produced protocols and quality standards to help young people and services negotiate this transition when they are ready. A Task and Finish group should take this work forward.

Meeting the needs of vulnerable young people

Following the Thrive model, a multi sector protocol should drive joint working to support vulnerable children and young people with multiple needs, who struggle to engage with or stabilise after evidence based help, those with unclear difficulties, emerging issues or complex needs or any child with concerning needs for whom it is not possible to find a clear 'home' to access help.

These are essentially those young people who fall in phase four of the Thrive model. These children, young people and families may include:

- ✓ Children and young people who live in residential care, foster care or with adopters

- ✓ Children with learning difficulties, disabilities and developmental disorders including those on the autistic spectrum
- ✓ Children with chronic physical illness
- ✓ Children subject to a Child Protection Plan or a Section 47 enquiry or in need.
- ✓ Care leavers
- ✓ Children who have been abused
- ✓ Children not in mainstream school
- ✓ Children with complex behavioural problems and additional needs
- ✓ Children and young people involved in or on the margins of criminal or gang activity
- ✓ Children from asylum seeking, refugee and migrant backgrounds.
- ✓ Young people in transition
- ✓ Children affected by their own or family drug, alcohol and substance misuse
- ✓ Children affected by family mental illness
- ✓ Children affected by domestic abuse
- ✓ Children with communications difficulties and social needs
- ✓ Children living in poverty
- ✓ Some BME young people from communities over represented in adult mental health or youth/criminal justice settings
- ✓ Children from BME communities and whose first language is not English
- ✓ Lesbian, Gay, Bisexual and Transgender children.

These young people should be managed by multi agency assessment processes (an equivalent to Liverpool's early health and wellbeing or CAF-like assessment) and through the appointment of a lead professional (chosen by the young person).

Integrating Recovery philosophy and principles into the model

There is a need in any new model going forward in Hertfordshire to ensure that Recovery Principles are also at the heart of delivery. The Recovery model is less developed for children and young people than it is for adults and during the consultation young people were generally not happy with the term recovery. Some national developmental work in partnership with young people with lived experience is necessary to further develop these concepts for children and young people experiencing poor mental health.

Recovery principles in a child and youth context mental health should mean:

- Focusing on what children and young people want to achieve moving forward
- Supporting children and young people with living a meaningful life on their terms with or without the symptoms of illness
- A therapeutic focus on self-determined outcomes and a recognition that it is the role of the system to help children and young people achieve those outcomes.

The Recovery philosophy involves a move away from a focus purely on symptoms, 'treatment' and cures and a shift towards attention to hope, self-determined goals and the wider determinants of emotional health and wellbeing including housing and independent living, welfare, relationships and social activities.

Hearts and Minds

For change to be taken forward effectively, it will be essential that hearts and minds of Hertfordshire practitioners are behind proposed changes.

Many of the elements in this proposed model have been developed iteratively through discussions during Clinical Reference Groups. Within the Clinical Reference Group in Hertfordshire, there was significant energy and enthusiasm to try and get things right for young people but also some frustration that despite previous reviews highlighting a need for change in the CAMHS system, and subsequent recommendations, many changes had not been achieved.

To move forward successfully, the model will need robust countywide joint commissioning drive and support as well as the involvement of a CAMHS Partnership Board including children, young people, parents, stakeholders and practitioners.

Outcome monitoring, CAPA systems and the commissioning review process

All agencies providing therapeutic services should undertake routine and standardised outcomes measurement using standard outcomes tools,(see CYP-IAPT toolkit) for example the Strengths and Difficulties Questionnaire, Child Global Assessment Scale, Child Health Inventory and/or Health of the National Outcomes Scales for Children and Adolescents, along side other feedback and outcomes that capture change in the specific goals families want to work on (e.g. GBO)and service satisfaction feedback tools (e.g. CHI-ESQ or SRS)

There is a need to create a dashboard of indicators to track quality and whole system change.

Desired *system* outcomes should be agreed with multi sector commissioning partners, children, young people and families and might include:

- ✓ Children, young people and parents/carers will have improved emotional wellbeing, mental health, self-esteem and confidence and are emotionally resilient
- ✓ Parents and carers have the skills to recognise, manage and respond to their children's emotional needs
- ✓ Children, young people and families and referrers know about and influence services and have easy access to services with quick response of appropriate interventions and individually focused support with respect for privacy and dignity
- ✓ Children, young people and families have confidence in services and their needs are met through help provided by trained practitioners who feel supported through access to consultancy and advice and do what they say they will do
- ✓ The help offered focuses not just on therapeutic outcomes but also on self-determined outcomes helping children and young people live a meaningful life
- ✓ Children, young people and families experience effective transition between services without discriminatory, professional, organisational or location barriers getting in the way
- ✓ Fewer children and young people experience stigma and discrimination through improved public awareness and understanding of mental health.

Dashboard quality performance indicators should also be able to track gaps and challenges in the system and shifts in demand/ need. There should be a clear expectation in contracts that dashboard data are returned monthly to the commissioning partnership and are used to track capacity building, quality and demand, and to inform innovation and improvement .

The Future In Mind Taskforce (Department of Health, 2015) and the Royal College of Psychiatrists (2013) recommend that Choice and Partnership Approach (CAPA, a service transformation model that is founded on collaborative practice) and Lean Thinking organisational approaches should be used to support system transformation. This Review notes that Hertfordshire was central in the development and testing out of CAPA approaches although it has been difficult to assess the extent to which this approach continues to influence current practice.

Such approaches involve the establishment of local implementation groups to support transformation, supported by clear objectives, self-evaluation tools and training/consultation. CAPA activity and system change could benefit from a refreshed focus taken forward with expertise of the whole system CAMHS Partnership Board.

The Thrive concept proposes a three year commissioning cycle with quarterly performance meetings and annual contract reviews. All those responsible for planning services (including education, young people and families and providers) should jointly agree high-level key quality indicators for improving services to each group, using a mix of process and outcome measures. The Centre recommends using this model to strengthen the current commissioning review process.

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Developing a best practice model: core elements

This chapter has drawn together the best elements of national and local models to create a new vision for an overarching service model for Herts. This model will involve a modified Thrive model and will include the following core elements:

- It will led by children, young people's and families' needs and self-determined goals;
- It will build on a foundation stone of strong coordinated multi sector strategic activity seeking to improve children's outcomes;
- It will be based on a life course early intervention approach focusing on invest to save multi sector commissioning;
- A range of multi sector pathways will thread through the six-stage model supporting whole sector and stakeholder prevention, early evidence based intervention, de-escalation, crisis management and safeguarding;
- The model involves six stages of needs (promotion and self-care to build robust emotional and behavioural health and wellbeing , helping cope with adversity, needing help, needing more help, experiencing risks and high needs, and preparing for adult years)
- Stages one and two will build on a strong foundation of mental health promotion, self-care and workforce capability building;
- At stages two and three, a named primary mental health worker will link with a cluster of schools and GPs providing consultation, direct support (at stage three) and bridging to a therapeutically highly skilled Gateway for Help if a child or young person has more complex needs;
- A team of Gateway to Help workers (with a high level of therapeutic skill and excellent knowledge of a range of health, social and voluntary sector resources) will provide expert assessment as well as advice and consultation across the system.
- A Crisis team will work with A&E, justice and inpatient settings to help mobilise resources to de-escalate crisis or to stabilise CYP following crisis;
- A mixed economy of providers (schools-based counselling, voluntary sector, primary mental health workers, evidence based parenting providers) will be commissioned via pooled funds to support children needing noncomplex help at stage three
- A mixed economy of providers will be commissioned via health funding to support CYP with more complex stage 4 needs.
- Multi sector partners (built on pooled funding) will work together in stage 5 to support those small number of young people with multiple, unclear, emerging or underserved needs. Many of these CYP will also have multiple safeguarding, substance misuse, social care and health needs.
- All levels of the modified Thrive model are supported by a crisis resolution/ home treatment team and 24 hours CAMHS or AMHs crisis expertise –for children all must dovetail and work closely with social care Emergency Duty Teams;
- The modified Thrive model would aim to retain CYP at the lowest level in proportion to their risk and need.

This table summarises key features and required strategic and operational developments to help Hertfordshire move toward service transformation and achieve the recommended Thrive model.

A modified Thrive model should be adopted by Hertfordshire focused firmly on CYP needs and drawing together the strengths of emerging local models across the country. The Herts Offer supporting children's emotional and behavioural wellbeing should include the following:		
CYP and family needs	**What can be built upon in Herts**	**Developmental action required**
One: Children, young people and families are supported to thrive The model will build on a strong foundation of mental health promotion and self-care for CYP and family MHEWB. Providing support for MHEWB at this level must be the responsibility of all sectors in contact with children and families. To achieve system transformation, workforce capacity will need to be built on CYP MHEWB at all levels. High priority groups for training include midwives, health visitors, early years workers, parenting providers, school staff, school nurses, SEN staff, GPs, social care	Activity should build on and further mobilise: -pastoral networks supporting schools -Time to Change activity and learning in Herts -peer health champion resources in Herts schools -Herts for Learning partnerships and activity - toolkits schools and GP - the East of England developing early Help Offer -PSHE provision - my baby's and teen brain	- A CAMHS partnership board with strong leadership should be set up including CYP and family representation to drive multi sector commitment and planning for transformation. This could be achieved by reconfiguring and redefining the existing CAMHS Strategic Commissioning Group (CSG). - A basket of outcomes should be developed shaped and agreed by all sectors with data review at least quarterly - Task and finish groups should develop multi sector evidence based pathways which will thread through these five levels of the H-Thrive offer clarifying multi sector roles and responsibilities - Strategic planning and

teams, police etc. Mental health promotion must also address targeted needs of higher risk groups (e.g. LGBT or some BME communities) and use creative and appropriate delivery methods. Everyone will know how to seek help		Task and Finish groups should consider how hub approaches could be incorporated into pathway development and into the evolving multi sector H-Thrive model. - A MHEWB promotion and workforce training strategy should be developed and act as the foundation stone for transformation. This should be based on an audit of workforce skills and confidence. - Toolkits should be updated, including consideration of developing an online resource that can be regularly updated and will be easily accessible. - PSHE provision should be enhanced in line with national guidance - Herts should explore youth organisations in the local area who might effectively deliver MHEWB awareness to parents and children. - School provision should include evidence based universal health provision activity (e.g. the Good Behaviour Game for primary schools)

		- A local online resource could be co-produced with CYP and parents drawing together high quality self-help resources. - Level one would include access to SPA and sometimes to Crisis Support for CYP in crisis (consultation and access to help).
Two: I am coping: All those in contact with children will help children to cope with adversity and support their resilience. Everyone will know how to seek help		- Skills developed through workforce development
Three: I need some help: would provide evidence based help to those children with relatively simple needs and low risk factors (delivered by a mixed economy of providers). A named primary mental health worker would be linked with a cluster of schools and GP practices.	-commissioning at this level should build upon current primary mental health capacity and voluntary sector youth/school counselling as well as simple evidence based parenting interventions. It should provide a choice of providers and care should be provided in a choice of locations.	- there should be a directory of all services (school counselling, voluntary sector and statutory) commissioned at level 2 with transparency re-funding streams and scale of investment. - CAMHS partnership Board should have strategic overview of all provision at this level. It should support the quality of what is provided and draw together consistent information on all those providing as part of level 2

There would be access to SPA and crisis resolution resources to help early de-escalation of crisis for those who need it.		contract monitoring. - all level 2 providers must receive CYP IAPT training -all counselling must be accredited - all providers should report back using standard outcome and satisfaction measures on a quarterly basis. -multi sector Task and Finish groups will develop Pathway development for priority issues affecting CYP in Hertfordshire will thread through all levels of the modified Thrive model. Level two would include access to SPA for CYP in crisis (consultation and access) -primary mental health support should be extended.
Four: I really need help: would provide proven help to those with more complex needs or needing more help (delivered by a mixed economy of providers) There would be access to SPA and crisis resolution resources to help early de-escalation of crisis for those who need it.	Stage 4 would build on, draw together and add value to: -current statutory provision in Tier 3 -community paediatric provision -SEN providers in Herts -voluntary sector and YIACs in Herts -PALMs - Crisis teams	- commissioning should be based on local needs highlighted in the JSNA and via this Review - Multi sector pathway development for key issues (e.g. ADHD, healthy behaviour, anxiety, self-harm etc) will help identify who contributes to work at all levels of the H-thrive model

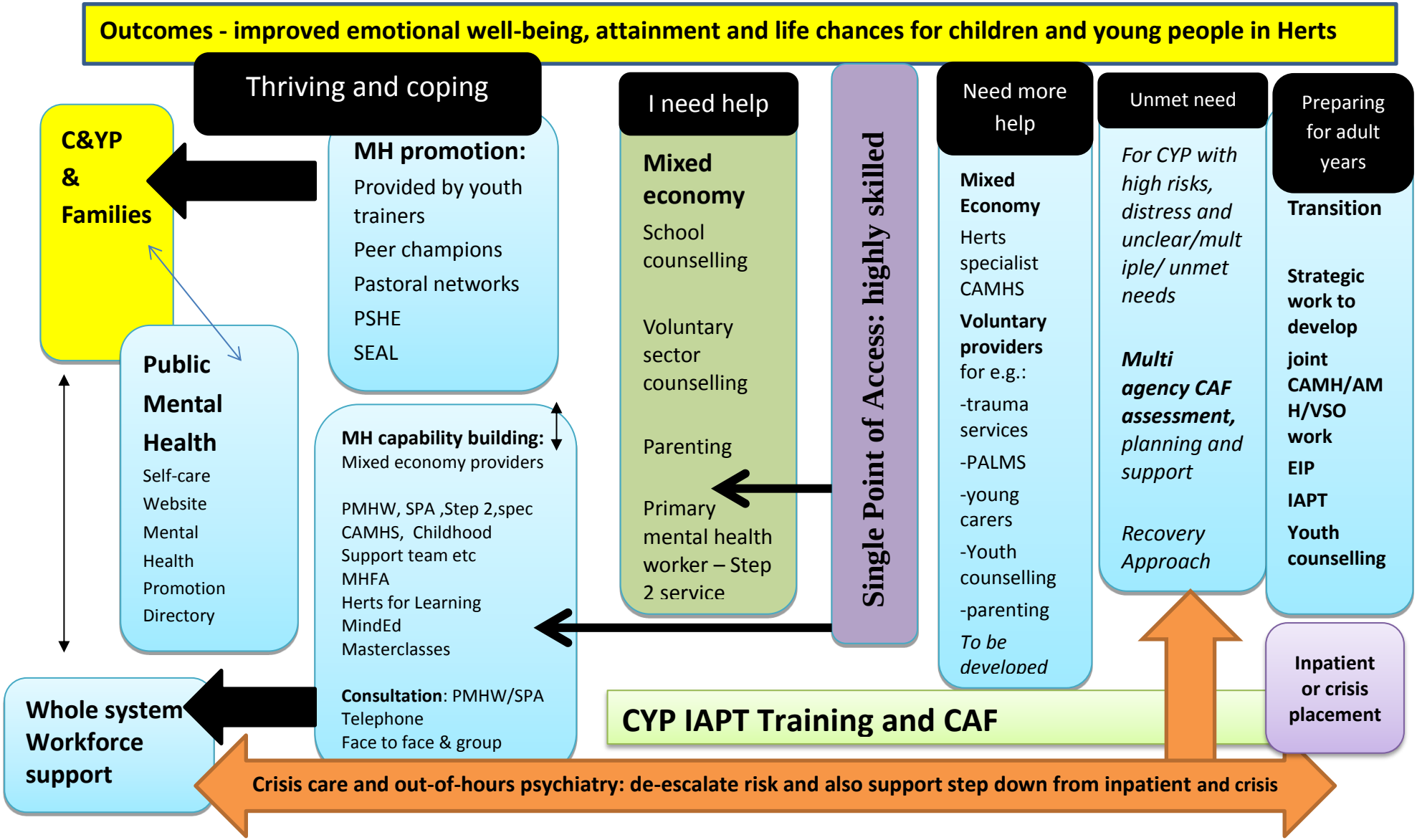
		-a mixed economy of providers (voluntary sector and statutory) should be commissioned to provide evidence based responses to the range of CYP and family needs identified in Herts. Commissioning should include statutory and voluntary sector mental health providers focusing on trauma based service-provision, ADHD provision, evidence based parenting and psychological therapies, early intervention in psychosis etc) -The SPA system in Herts should be enhanced and extended. It requires a higher level of therapeutic expertise and broad knowledge of child, youth, voluntary sector and broader health services. all stage 4 providers must receive CYP IAPT training All work with children should be underpinned by CAF
Five: I have unmet or hidden needs: would focus on those children with unmet needs including those : - with high or unresolved risks and needs - with unclear or emerging needs (e.g. repeated	- Activity will build on current multi agency CAF/TAF/Early help processes - Local Safeguarding activity - Support for underserved groups such as those working with children in care,	A multi sector Task and Finish group (including VYP and parents) will clarify: - which children's needs are best met through this multi-agency action. -how joined up activity is best organised

concerning behaviour, self-harm or emerging personality disorder) -historically underserved by statutory services - with multiple risk factors for poor outcomes - requiring multi agency packages of care following crisis placement (health, educational social or justice) or to de-escalate crisis. - who cannot find appropriate support at other levels (the numbers of these children should be routinely tracked and analysed by commissioners to troubleshoot access issues). Activity will be led by CAF/TAF like processes (but may include health planning approaches such as CPA) The aim of any work with these young people would be to outreach, stabilise and bridge to other lower level resources or services with potential to help them move forward. Or alternatively to bridge to adult services. A very small number may	in the justice system etc.	-partner roles and responsibilities - the most effective model of provision for the small number of children with these needs (AMBIT or Integrate) -how outcomes, risk and satisfaction is most effectively monitored. - findings from tasks and finish groups focusing on multi sector pathway development will also inform level 5 input. -training on formulation based approaches would be important for all those working with children but particularly for this group.

need longer term intervention because of a combination of ongoing risk and need or due. Mental health Crisis teams and local authority emergency duty teams will work together to de-escalate risks at this level		
Six: Preparing for adult years and needs A virtual team and set of processes should be developed to support those in transition to adult services. This developmental work should be supported through joint strategic activity and action planning.	There is little information emerging from the review on transition s to adult services A CQC report in 2014 noted that A-DASH and school nurses work well in partnership to support the well-being of young people in care, although this area of work was challenged by local capacity pressures in the school nursing service. Young people's transitions into adult services were described as well supported and individually tailored to best support each young person within the framework of an effective protocol.	The CAMHS partnership board should include an AMHS representative to support transitional developmental activity. Learning should be drawn from: - the new target supporting improved EIP waiting time access targets; - and from ADASH/school nurse activity supporting children in care across these transitions A Task and Finish group should be developed in time to consider how level five can be enhanced. Protocols should be developed to support

		improved handover Consideration should be given to the role of YIACs in supporting youth transitions. Routine data should be collected and analysed on the success of CAMHS to AMHS transitions.

Figure 1: The CAMHS whole system Herts-Thrive pathway



4. Developing a strategy

In the previous chapter we set out a recommended model for CAMHS in Hertfordshire. This chapter will set out the essential building blocks which should be in place to start to make this model a reality. To achieve successful transformation, it is important that strategic and operational tasks are correctly sequenced. In our experience, jumping to operational activity before strong strategic foundations are in place can jeopardise the sustainability of change. The strategic building blocks described in this section are cultural, strategic, systemic and operational.

This chapter will also set out the national and local strategic drivers for CAMHS, take into account performance data, examine the reach of local services, comment on gaps and quality and whether the data is adequate for commissioning purposes, and make recommendations that will form the framework for the Local Transformation Plan required by the 2015 Children and Young People's Mental Health Taskforce Report *Future in Mind.*

National policy drivers and opportunities

National policy is the primary driver for developing local approaches to enhance the emotional health, psychological wellbeing and mental health of children and young people. They indicate a direction of travel. In the last 18 months a number of significant publications and policy directives have signalled a growing focus on children's mental health and ways to improve current support. Key national policy drivers are listed below.

- CAMHS Taskforce Report
- The Five Year Forward View
- NHS England review of inpatient CAMHS
- Health Select Committee inquiry report
- Crisis Care Concordat
- The Government's Mental Health Act Review

Details of each of these can be found in the Appendix to this report.

Local strategic planning and thinking

The development of local child and adolescent mental health and psychological wellbeing services should be supported by and strategically aligned with other strategic priorities within a county. The Health and Wellbeing Board, informed by the Hertfordshire Wellbeing Strategy and the Joint Strategic Needs Assessment, is positioned to work collaboratively with its partners and contribute to decisions made about priority setting, outcome measures and delivery for both health and children's services, to ensure that children get a good start in life and that local residents have the opportunity to improve their mental health.

A local commissioning partnership should be in a position to agree a common definition of commissioning and its approach to commissioning across universal, targeted and specialist services and then put in place the fundamental building blocks and a clear governance framework that will drive the development of a CAMHS strategy and feed back into the Health and Wellbeing

Board. A CAMHS Partnership Board must also be established to drive change operationally reporting back to the Joint Commissioning Board on progress.

There is strong evidence across the UK that the ability to agree a clear direction of travel with stakeholders is essential. Our findings in other areas of the country have demonstrated that the presence of a number of key elements will improve the efficiency of local systems and governance.

The key features of effective partnerships that inform efficient commissioning and delivery are:

- An up-to-date joint strategic needs assessment
- A Health and Wellbeing Board that has child and adolescent mental health in its strategic vision
- A Joint Commissioning Board at executive level that provides governance for all commissioning activity and a plausible link back into the Health and Wellbeing Board
- A county-wide CAMHS Partnership Board that meets regularly and drives change
- A written strategy, agreement on jointly agreed shared outcomes as well as commissioning priorities for emotional health, wellbeing and mental health for children and young people
- Pathways of care for the main diagnostic and problem categories that reach across social care, schools, primary and specialist care, youth justice and the voluntary sector
- Clear service specifications that are outcomes focussed and include routine outcomes measurement
- Active involvement of children, young people and their families in planning and reviewing services
- Professional development opportunities for all staff
- A workforce development plan
- Data collection methods that are fit for purpose.

Strategic partnership development

Successful local partnerships are the key to developing cross-county and cross-agency working and the presence of such partnerships help scaffold the principles of integrated planning and delivery models and methods of reviewing contracts, performance and outcomes.

Hertfordshire should strengthen its partnerships through ensuring that a multi-agency CAMHS Strategic Partnership group comprising commissioners and statutory and voluntary sector providers works closely together, and maintains critical governance links with its Health and Wellbeing Board and Joint Commissioning Board in order to ensure that there is agreement and sound governance in delivering emotional health, psychological wellbeing and mental health services to its population of children and young people.

This CAMHS Strategic Partnership will be the critical driver for a successful approach to commissioning and delivery. It will make explicit the co-dependencies and synergies between the needs assessment, the Health and Wellbeing Board, Joint Commissioning Board and subsequent local priority setting.

The CAMHS Strategic Partnership, with commissioners and providers integral to the process, should co-construct a CAMHS Strategy for Hertfordshire setting out its vision, the scope and reach of emotional health, wellbeing and mental health services and how they are managed within the

county, and an action plan for putting those into place and reviewing progress. This strategy will dovetail with and build upon synergies in other key strategy developing in Hertfordshire.

The outputs of the strategy should inform the Local Transformation Plan recommended in *Future in Mind* and as a high level driver should set out the actions and priorities to transform CAMHS commissioning and delivery.

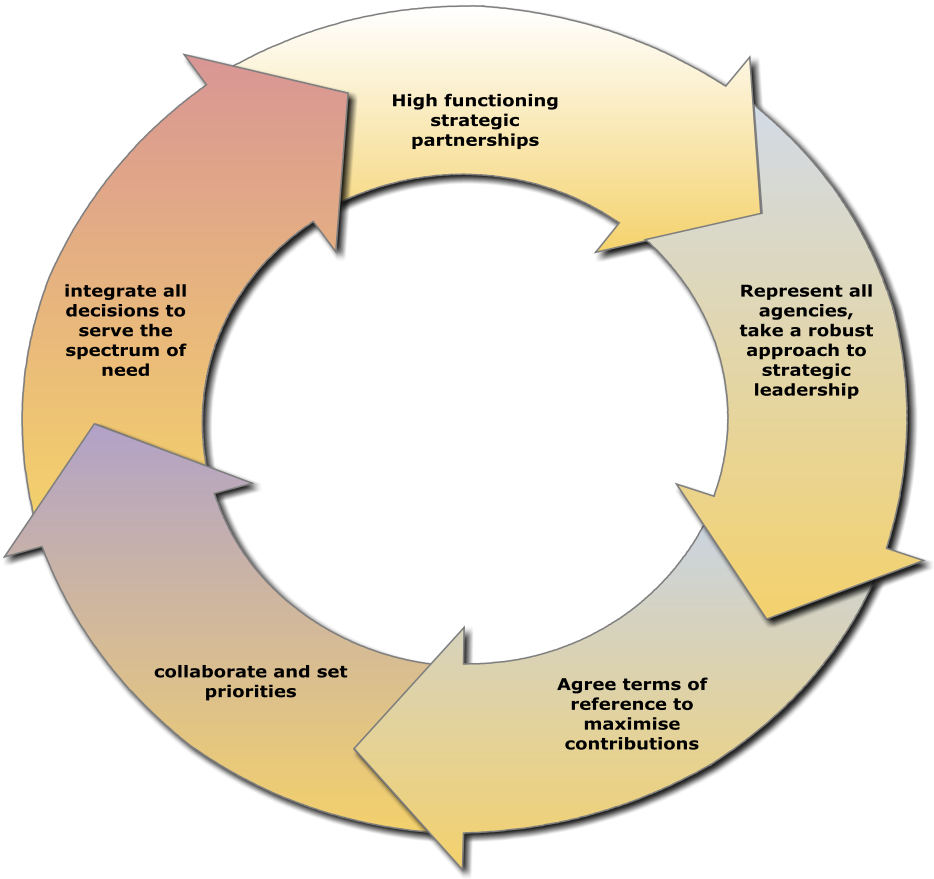


Figure 1: HIGH FUNCTIONING STRATEGIC PARTNERSHIPS

The CAMHS Strategy and Transformation Plan should be supported by a commissioning strategy that takes account of the need and gaps identified in the Joint Strategic Needs Assessment and set out its priorities for commissioning the outcomes it expects to see delivered and a timeframe for delivery.

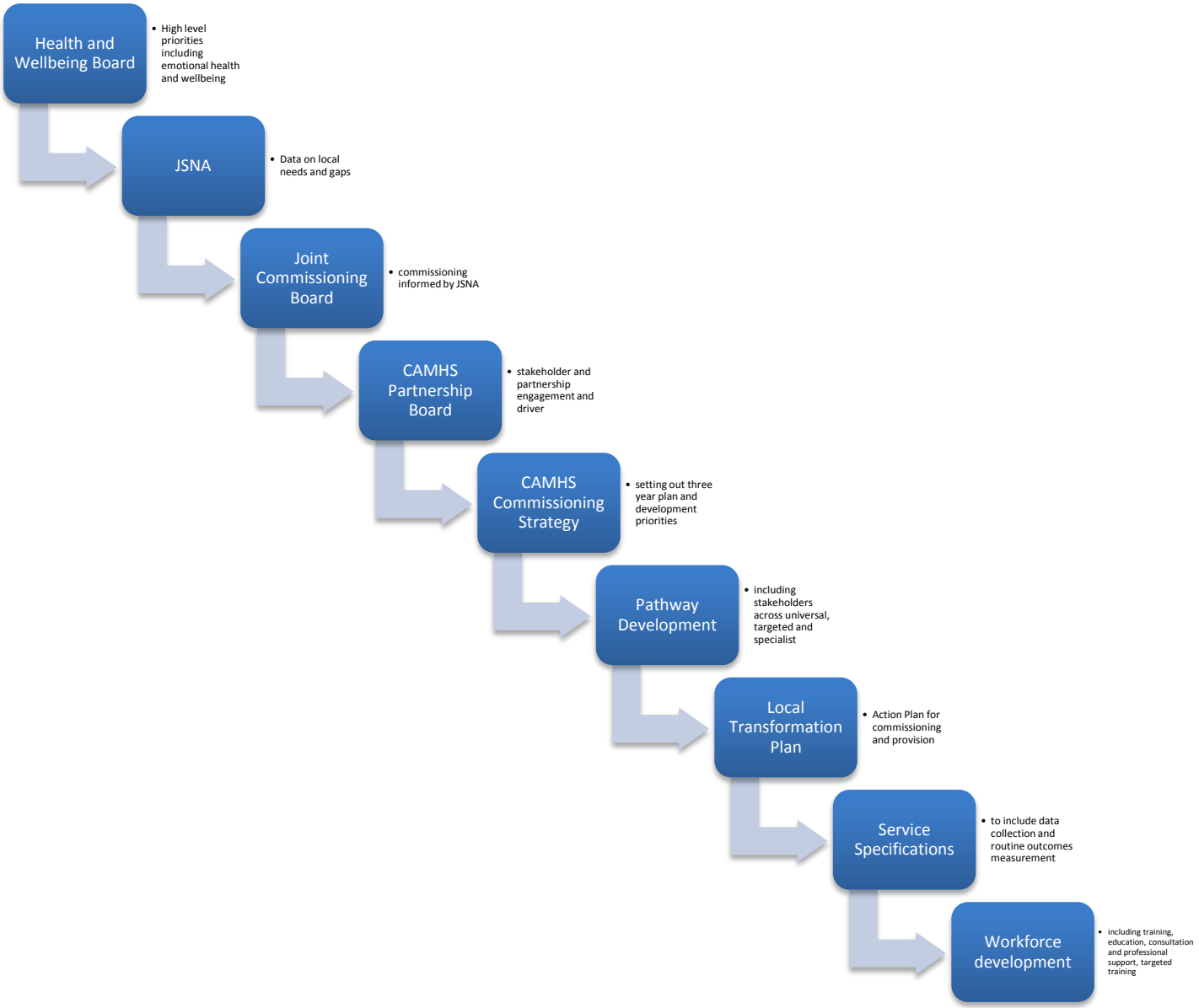


Figure 2: a functional model for a CAMHS Strategic Pathway

Commissioning

Commissioning practice is generally under-powered and inconsistent across Hertfordshire. We found that communication between the two CCGs and the Local Authority could be significantly enhanced by some simple mechanisms which would then enable CCGs, Public Health and the Local Authority to commission services consistently based on the known need across the county. We recommend that there should be:

- An agreed approach to commissioning a modern CAMHS:
    - With all commissioners involved
    - To agree how commissioning will take place and by whom
    - A lead commissioner to liaise across all commissioning activity and to support consistency with strategic intentions
- An agreement about shared commissioning desired outcomes and principles, for example:
    - Promoting early intervention and prevention
    - Supporting integrated multiagency partnership working between commissioners and providers
    - Ensuring the most vulnerable and those at risk of developing mental health problems can access services
    - Embedding choice and the systematic involvement of children, young people and their families in planning and service reviews
    - Improving efficiency and promoting innovation
- Involvement of service users, families and clinicians in service redesign
- Agreement about how and when collaborative and joint commissioning is required
- Agreement about the model of service provision required, from perinatal and infant mental health to highly specialist inpatient care
- The use of service specifications to drive improvement in delivery, with models that are evidence-based and have measureable outcomes
- Effort to ensure that there is sufficient capacity within the commissioning system to monitor and drive the necessary changes
- Support from NHS England where necessary.

Data

Identifying the unifying factor in financial data has proved problematic. Initially this appeared to be because of the difficulties of disaggregating CAMHS data from block contracts with providers. Once this was rectified, however, it remained difficult to make a virtuous circle of investment delivery, quality, outcomes and cost. Data were provided, but often lacked a context and were often offered in the absence of any benchmarking.

Apparent variation in performance data across teams in Hertfordshire should in future be standardised and systematically analysed by managers and commissioners intelligently to inform the goal of appropriate levels of service delivery. For example it might be necessary to adjust the clinical capacity for delivery of the core service across the teams. The performance data collected should accurately reflect the priorities for service delivery across

the whole contract. Data should not be collected if there is no opportunity to analyse it, make use of it and improve local services.

Outcomes data that demonstrate quality and improvement in the patient experience are as important as the data that defines key outputs such as waiting times and should be of equal interest to the commissioners, trust senior managers and clinicians, as well as the users of service. All staff across the spectrum of delivery should understand why outcome measurement is important, how it links to evidence based intervention and the part it plays in measuring quality and change. Staff should be trained in using outcome measurement tools and be able to explain them to children, young people and their families. The use of outcome measures by all staff should be mandatory should be used routinely alongside performance data to inform commissioning decisions

During our analysis of papers and data, we remained unclear about what commissioners were expecting when they examined data, what criteria they used to ascertain clear indicators of quality in addition to quantity, how this impacted on decisions they made about quality and how it informed future strategic planning.

Agreements across the CCGs about consistent data collection and budget allocation across the piece will make it more likely that this is followed by consistent delivery to the whole under-18 population of Hertfordshire. Only when this level of consistency, and the ability to disaggregate budgets, is applied will it be possible to monitor delivery against service specifications, outputs and outcomes.

We therefore recommend that data collection is standardised across the piece. Service specifications should set out the commissioner's delivery expectations; budget, cost, service delivery and methods of routine outcomes collection and should then inform a continuous cycle of reviews of cost, service delivery, user satisfaction, quality and outcomes.

Reach, demand and capacity

Commissioners should understand the features which help them to support delivery and manage demand and capacity in front line services. This is not limited to defined referral process and better information about what other services are available in universal and other children's services. It should also be supported by managing demand and capacity through clear service specifications and local services utilising demand and capacity tools such as CAPA.

We noted the use of the single point of access model – however for this to be successful it requires cross-sector agreements about how emotional health, wellbeing, behaviour support and family support should be delivered through clear care pathways (and agreed in the CAMHS strategy). It also requires an authoritative and experienced practitioner in this role.

Families should routinely be reminded about appointments using text, email etc. and the supporting administrator should be responsible for this. Appointments which are not required can be immediately reallocated.

In the short term there should be a written procedure for managing waiting lists and slippage money should be urgently utilised to resource waiting list management.

We looked closely at the needs assessment and the range of services that are available to children, young people and their families in Hertfordshire. A considerable amount of very helpful additional material was shared with us. We do not intend to repeat in this report the elements included in the needs assessment which found inconsistent delivery across the county and significant differences in waiting times for services. We will comment, however on elements that are not strongly highlighted in the earlier report as we think they are important.

Our examination of CAMHS DNA (did not attend appointment) and cancellations by service users indicated that not only were there differences in DNA rates in local services but that there were problems with collecting and then using data consistently. Data was also not helpfully separated out to allow like for like benchmarking. There were significant gaps in data but no context was offered for why those gaps existed. We found for example, higher numbers of DNA and cancellations in Stevenage, Borehamwood and Watford but it was difficult to draw comparisons with other services where data were missing. These gaps should alert commissioners to the importance of regular monitoring and quality assurance in relation to the data received, and then to discuss the context of the data with the provider.

The trajectory of referrals via the single point of access (SPA) appears to be rising, however. About 50% of referrals through SPA are passed to Tier 3 CAMHS and the number of referrals not accepted by the SPA service is increasing. The former is a common feature found in a number of services across the country, where the impact of developing a clear pathway for referral has a significant positive impact in that it makes it easier for referrers to express concerns but it is also likely to increase the numbers of referrals. This will often reveal the weaknesses in the system, where concurrent developments have not been built into the change system.

Although a SPA might relieve the pressure in primary care, for example, it can create unintended negative pressures in a different part of the system. Where SPA systems in other parts of the country have been successful, they have been supported by significant levels of preparatory work, ensuring that onward clinical and referral pathways have been developed in advance, capacity issues considered, and that the wider system is tuned to keep pace with increased demand and targeted services. The latter is likely to be affected by perceptions of an 'open door', increasing complexity, the paucity of universal services, and the ability of local services to respond flexibly.

The Step 2 service is absorbing a significant proportion of the challenges coming from primary care but community counselling and Counselling in Schools services are clearly providing a critical service in partnership with Step 2. However with levels of complexity and self-harm rising nationally, and an increase in referrals and levels of complexity to Tier 3 and a concomitant reduction in case closures, commissioners should anticipate further challenges on Step 2 and Counselling services.

The new PALMS service for Autistic Spectrum Disorders and Learning Disability is also likely to quickly come under pressure in the near future when the realities of the Health and Social Care Act, opportunities for personalised budgets and the implications of Education, Health and Care Plans, are fully implemented.

As in many areas of England, we found evidence of a range of offers across the spectrum of need but also found services which were pulled in all directions from ever increasing demands: increasing numbers of referrals, increasing case complexity (particularly an issue in Hertfordshire), greater expectation of the types of treatment and interventions provided, as well as a need for more partnership working and consultation. For a service to feel it is not continually under siege robust demand and capacity systems need to be in place.

The delivery of early intervention, prevention and health promotion in primary care (including perinatal and infant mental health), services in Step 2 and in schools, in youth justice and local authority care settings and for children with neurodevelopmental disorders, in acute health settings as well as specialist CAMHS must be fully resourced to adequately respond to need and be set out in service specifications. Service delivery is dependent upon managing demand and capacity and the ability to be flexible in its approach to delivery, to move away from traditional service boundaries and inhabit some of the less distinct areas which will provide a rich opportunity for new types of services to emerge.

The ability to innovate and the flexibility of commissioners and providers to respond to need will require leaps of faith and to transform the approach to managing demand and capacity and thereby reduce the numbers of inappropriate referrals, reduce the number of families waiting for a service and the time they have to wait.

Budget

The transparency and status of the budgets held by the local authority, CCGs, Public Health and individual schools (especially where Academies are not contracting through the Local Authorities) becomes a critical consideration for partners in light of further public sector spending cuts in this financial year.

The importance of clear joint local agreements about a commissioning approach, commissioning priorities, outcomes measurement and the management of low volume, high cost episodes and joint funding became more and more clear to us, and although we were able to identify expenditure on CAMHS Tiers 3 and 4, we found that the clinical outcomes were less transparent and should be an important consideration for commissioners.

We found, too that there were less data on expenditure available relating to early intervention, prevention, promotion and consistent evidence-based delivery models in Steps 1 and 2. This is a common feature in other areas, too, but the rigours that are likely to be required by NHS England in demonstrating transparency and value for money when developing its commissioning support structures for the implementation of the *Future in Mind* recommendations reinforces the opportunities afforded through building a partnership approach to commissioning priorities, budget allocation and clarity of understanding how local commissioners should respond to need, and allocate its resources based on evidence of outcomes.

Quality

In our experience, commissioners still appear to be relatively unfamiliar with the quality markers already identified by the Royal College of Psychiatrists' Quality Network for Community CAMHS and Quality Network for Inpatient CAMHS and the membership organisation the Child Outcomes Research Consortium (CORC). These peer reviewed quality markers are critical standard measures for specialist child and adolescent mental health services and the QNIC and QNCC accreditation along with the CORC data standards can usefully be applied by local commissioners as benchmarks of good practice and markers against which to measure quality and seek further data and evidence to inform local data collection.

The QNIC and QNCC benchmarks include:

- Referral and access
- Rights and safeguarding
- Information and consent
- Multi-agency working
- Care and planning
- Transfer of care
- Commissioning (including a clear statement about performance management, review and service specifications)
- Training and staff development
- Staffing capacity and qualification
- Continuing professional development
- Protecting privacy and dignity and age and gender appropriate provision
- Advocacy

While public health will be commissioning early intervention, prevention and parenting support to strengthen infant attachment and resilience, supported through the Healthy Child Programme and Family Nurse Partnerships, it is critical also to strengthen the system as the child grows and need becomes more acute. Quality standards that support commissioning models and inform elements of service specifications are the framework that scaffold robust commissioning and review processes.

Quality markers are also required in relation to data that will inform future returns to the Mental Health Information Network and local compliance with the CAMHS minimum dataset required by the Health and Social Care Information Centre. All these markers of quality can easily be built into commissioning and review processes.

Conclusion

This report has set out its high level findings relating to need, strategic and commissioning priorities and with the intention of informing the Action Plan found in chapter 5.

We suggest that the Action Plan will also form the framework for the Local Transformation Plan required by the 2015 Children and Young People's Mental Health Taskforce Report *Future in Mind.*

5. Action Plan

The Action plan is presented in two sections:

1) Strategic priorities and
2) 2) Commissioning priorities.

We recommend that strategic priorities and commissioning priorities are the most significant areas that require development over the first six months, in order to create the necessary structural and governance framework upon which to base subsequent decisions relating to the priorities for operational delivery.

In our experience, until strategic partnerships and co-dependencies, commissioning approaches and priorities are agreed and formalised in a written strategy for emotional wellbeing and mental health for children and young people, operational changes should not be considered. The success of future operational adjustments is dependent upon a shared understanding and agreement about what is to be achieved and in what timeframe. Using the first six months to agree and embed strategic and commissioning decisions and governance will strengthen subsequent operational decisions.

SECTION 1: STRATEGIC PRIORITIES **NB First 100 days are quick-wins**					
PRIORITY	**FIRST 100 DAYS**	**ACTION**	**INTENDED OUTCOME**	**IMPACT ON CHILDREN AND FAMILIES**	**MEASURE**
1		Set up terms of reference for a CAMHS Strategic Partnership; appoint a Chair and agree partners to be included and how children and young people are represented. This could be achieved by a reconfiguration and redefinition of the existing CAMHS Strategic Commissioning Group (SCG).	➢ Clear signal of intention ➢ Partnership statement ➢ Line of governance to HWB and JCB	➢ Clarity about who is responsible for what ➢ Ability to contribute and receive regular feedback	➢ Written terms of reference with co-signatories at Executive Board Level

2		With Public Health support, analyse JSNA; interrogate gaps; co-produce a 3 year CAMHS strategy based on known needs	➢ A CAMHS strategy for Hertfordshire	➢ Clarity about what is provided for whom	➢ A written and published strategy available online to all who are interested
3		Produce a simple Action Plan for Years 1, 2 and 3 and review dates	➢ An Action Plan which sets out timeframes, development tasks, task owners	➢ Clarity about what priorities have been made and why	➢ A published Action Plan with review dates
4		Consider the shape of a Transformation Plan for CAMHS as required by *Future in Mind*	➢ Agreement about whether the Action Plan will serve as the Transformation Plan or whether a separate Transformation Plan is necessary	➢ Clarity about who is doing what and how that will result in smooth pathways of care	➢ A published Transformation Plan or agreement that CAMHS Strategy and Action Plan is the Transformation Plan
5		Agree standardised data collection methods and outcomes measures	➢ To collect the same and comparable data across similar service delivery models in Hertfordshire	➢ This will include patient and service user reported measures	➢ 90% data collected
	6 MONTHS				
1		Commission a Children's Workforce and Skills Audit and then write a workforce plan	➢ To better understand the type of skills available in the total children's workforce	➢ Ensure the right staff are available at the right time with the right skills in the right place	➢ A published workforce skills audit
2		Liaise with commissioning leads and agree an approach to commissioning and the commissioning priorities for universal, targeted and specialist services	➢ To achieve 100% agreement on the commissioning priorities and how they link to the strategic priorities in the CAMHS strategic plan	➢ Services will be commissioned to service a coherent pathway of care	➢ Publish a statement about the approach to commissioning and the commissioning priorities for universal, targeted and specialist services
	1 YEAR				
1		Identify and respond to workforce training needs based on skills audit	➢ To match skills to need ➢ To inform commissioning and budget planning	➢ Skills are available at the right level in the right place	➢ Publish a Training and Development Plan for the children's workforce
2		Review strategic priorities, data and information and consider necessary changes	➢ To adjust priorities and take account of data analysis, impact and outcomes	➢ Services received are regularly reviewed and adjusted, ensuring continuous	➢ The CAMHS Strategy & Action /Transformation Plan is formally reviewed and adjusted for the

				improvement	following year.
	2 YEAR				
1		Review strategic priorities , data and information and consider necessary changes	➢ To adjust priorities and take account of data analysis, impact and outcomes	➢ Services received are regularly reviewed and adjusted, ensuring continuous improvement	➢ The CAMHS Strategy & Action /Transformation Plan is formally reviewed and adjusted for the following year.
2		Review training and development plan	➢ To inform commissioning and budget planning	➢ Skills are available at the right level in the right place	➢ A repeat skills audit shows improved skills across the workforce
SECTION 2: COMMISSIONING PRIORITIES **NB FIRST 100 DAYS ARE QUICK-WINS**					
PRIORITY	**FIRST 100 DAYS**	**ACTION**	**INTENDED OUTCOME**	**IMPACT ON CHILDREN AND FAMILIES**	**MEASURE**
1		➢ Commission multi-agency care pathway development task and finish groups to simultaneously co-produce the pathways required to support the implementation of the CAMHS Strategy, to ensure all children are able to access the right service at the right time	➢ Pathways of care for: ➢ Step 1 early intervention, prevention and parenting support ➢ Perinatal and infant mental health ➢ Single Point of Access and improving waiting times initiatives ➢ Step 2 Support and intervention in universal settings ➢ Step 3 Assessment and intervention by specialist CAMH clinicians and practitioners ➢ Responses to first episode of psychosis ➢ Crisis intervention and home treatment ➢ Inpatient care including Eating Disorders ➢ Specialist mental health	➢ Services are available that respond to need	➢ Published pathways of care that are reviewed annually

			assessment and treatment for vulnerable children including LAC, sexually exploited/abused, Youth offending, learning disability, ASD, ADHD, neuro developmental disorder, challenging behaviour, self-harm, suicidal ideation, A&E, transition, LGBT		
2		➢ Agree transparent budgets and areas for co-commissioning	➢ There is clarity about who is commissioning what, based on CAMHS strategy priorities	➢ As above	➢ Budgets agreed as early as possible and separate and co-commissioning areas confirmed
3		➢ Service specifications agreed against the areas prioritised for first 12 months	➢ Providers are clear what is being commissioned, the review cycle, evidence base and outcomes measures to be used	➢ As above. Children, young people and families have regular opportunities to be involved in service design and review	➢ Service specifications are published
4		➢ Opportunities to further develop CYP IAPT are explored	➢ To extend the delivery of CYP IAPT in non-clinical settings	➢ Children and young people experience improved access to psychological therapies	➢ CYP IAPT is extended into specified universal settings
5		➢ Tier 2 (or help for those needing noncomplex help) capacity and scope is extended across the region	➢ To increase the availability of early intervention, consultation, training and professional support	➢ More services are available in non-clinical settings ➢ A range of interventions is offered	➢ Increase in numbers of CYP seen in community settings; decrease in number of referrals to specialist CAMHS via SPA
6		➢ Promote the DfE Promoting Wellbeing in Schools, guidance on counselling and develop support for delivering PSHE on mental health and emotional wellbeing	➢ To take a more strategic approach in engaging and supporting individual schools' approach and school clusters	➢ CYP experience improved responses to their needs in the school environment	➢ Schools report improved understanding of how to develop PSHE and promote wellbeing in schools

		➢ Facilitate promotions through Healthy Mind Lead and Youth Participation lead to support Healthy Minds ambassadors.			
	6 MONTHS				
1		➢ Commissioners specify to statutory and non statutory service providers the evidence based interventions to be delivered against known need and its required outcome measures across the spectrum of need and point of delivery (in collaboration with providers)	➢ All delivery is evidence-based and patient & clinician reported outcomes measures are routinely collected	➢ Assurance that all interventions from parenting support to intense community based crisis work and inpatient care is evidence-based	➢ Audits and data demonstrate compliance with evidence based interventions and routine outcomes measurement
2		➢ Commissioners consider the enhancement of crisis intervention and home treatment as *invest-to-save* in order to reduce the number of admissions to hospital. Consideration could also be given to this as a *CQUIN* target	➢ No young person is admitted to hospital with mental disorder because of lack of resource in community settings	➢ Young people experience the best possible care in the least restrictive environment	➢ Further reductions in inpatient episodes and out of area treatments
3		➢ Commissioners promote access to *MindEd* and work with providers to develop support and education toolkits similar to the Toolkit for Social Care – for example a Toolkit for Primary Care, and a Toolkit for Schools. Consider a countywide Healthy Minds worker to support implementation.	➢ More staff in universal settings are educated and supported in recognising and responding to mental health needs of CYP	➢ CYP will experience staff who understand their needs and who can respond and refer appropriately	➢ Annual survey reveals improvements in basic knowledge of all staff about mental health
4		➢ Commissioners work with NHSE Taskforce and begin Shadow Tier 4	➢ Planning for transition of Tier 4 commissioning responsibilities begins	➢ Patients experience is seamless and the local services are	➢ A written transition plan which sets out the arrangements for

		commissioning planning		more responsive to need	handing over commissioning responsibilities for specialist inpatient care
	1 YEAR				
1		➢ Commissioners complete the Tier 4 transition	➢ A seamless transition with all risks managed	➢ As above	➢ As above
2		➢ Service specifications, data and outcomes are reviewed	➢ Observations are fed back to the CAMHS Strategic Partnership, JCB and HWB; providers are engaged in co-producing new priorities and workforce development needs responding to the priorities set in CAMHS Strategy	➢ CYP and parents are engaged in the review and have the opportunity to contribute	➢ New specifications, data requirements and outcomes measures are published as necessary and built into the review cycle
		➢ Strengthen Psychiatric/paediatric and A&E liaison to ensure children and young people are admitted to appropriate settings. Consider the development of a liaison post for paediatric and Targeted/Looked After Children teams.	➢ A clear and well publicised care pathway including psychiatric liaison to A&E and paediatric departments supports all professionals involved in supporting, assessing and treating children and young people out of hours. Strengthen and improve liaison so that numbers of young people admitted via A&E are reduced by increasing capability of staff through support, education and consultation by specialist CAMHS. Improve the throughput and reduce numbers of children and young people in paediatric beds over weekends and bank holidays	➢ Strengthen Psychiatric/paediatric and A&E liaison to ensure children and young people are admitted to appropriate settings. Consider the development of a liaison post	➢ A clear and well publicised care pathway including psychiatric liaison to A&E and paediatric departments supports all professionals involved in supporting, assessing and treating children and young people out of hours. ➢ numbers of young people admitted via A&E are reduced by increasing capability of staff through support, education and consultation by specialist CAMHS. ➢ Improved throughput and reduced numbers of children and young

					people in paediatric beds over weekends and bank holidays
		Co-produce a model which ensures the involvement of the voluntary and community sector in delivering non-specialist emotional health, wellbeing and mental health services over the full CAMHS strategy period	➢ Increase the range of easily accessible non stigmatising services and enables self-referral	➢ Children and families tell us they are able to directly access services without the need for a referral and that they improve outcomes	➢ The voluntary sector is directly and consistently involved through clear commissioning model providing opportunities for mixed methods of accessible delivery
		Consider feasibility of CAMHS support through multi agency hubs with increased outreach working	➢	➢ More attractive and convenient support venues ➢ Improved multi agency working	➢ Greater satisfaction from CYP and parents ➢ Lower non attendances ➢ Less duplication ➢ Improved access to help
	YEAR 2				
1		Service specifications, data and outcomes are reviewed	Observations are fed back to the CAMHS Strategic Partnership, JCB and HWB; providers are engaged in co-producing new priorities and workforce development needs responding to the priorities set in CAMHS Strategy	CYP and parents are engaged in the review and have the opportunity to contribute	New specifications, data requirements and outcomes measures are published as necessary and built into the review cycle
2		A full perinatal and infant mental health service is commissioned to allow early intervention and support, strengthen knowledge and practice	Improve liaison between primary care, midwifery, adult mental health, CAMHS and children's services; identify vulnerable families; reduce puerperal psychosis; reduce post-natal depression	Reduced antenatal and perinatal mortality; mothers vulnerable to mental health problems are identified and supported; vulnerable families receive support, are more resilient; infant attachment is promoted.	Perinatal and infant mental health is included in the CAMHS Strategy and in published commissioning priorities Parents tell us they know about these services and can access them.

Appendix: Current levers in the system

This appendix summarises currently available system levers that should support the development of a new CAMHS strategy in Hertfordshire.

The CAMHS Taskforce

The CAMHS Taskforce has provided an opportunity for transformation through articulating a Universal National Ambition spelling out what the system needs to offer and the responsibilities of everyone within the system towards shared outcomes. The requirement of local transformation plans offers an opportunity for Hertfordshire to set out its approach and commissioning priorities in its CAMHS strategy which could then either be a stand alone strategy or become the Transformation Plan.

In March 2015, the Children and Young People's Mental Health Taskforce published its report *Future in Mind,* which recommended that CCGs should lead local Transformation Plans to improve and modernise child and adolescent mental health services and commissioning. It recommended a shift away from the tiered schematic model toward a model that would reduce the likelihood of organisational barriers, artificial divisions and threshold criteria preventing a child or young person getting the right service at the right time and in the right place.

It confirmed further investment in CYP IAPT, including an extension of its reach into non-clinical settings, identified additional money for eating disorder services, and presaged clear waiting time targets. It also signalled further funding for the Time to Change anti-stigma campaign and to promote positive mental health and emotional wellbeing.

Public health transition

In October 2015, local authorities will take over responsibility from NHS England for planning and paying for public health services for babies and children up to 5 years old. These services include health visiting and the Family Nurse Partnerships.

Funding

£1.25bn had been made available over five years by the Coalition Government which will be directed towards helping children and new mothers with mental health issues. The money is designed to help treat 110,000 more children over a five year period and provide rapid access to mental health treatment for new mothers.

As part of the package, the first ever access and waiting time standards for children's mental health will be introduced and specialists in children's talking therapy will be available in

every part of the country by 2018. The funding will also extend access to services for children under five and those with autism and learning disabilities.

Additional money has also already been identified for eating disorder services from April 2015. And targeted investment is being put into liaison psychiatry services in hospitals as part of the Department of Health's *Achieving Better Access to Mental Health Services by 2020* programme.

Other funding opportunities

The national Taskforce report identifies opportunities to support children's emotional health through grants available via the Social Care Innovation Fund and the Department for Education's Voluntary and Community Sector Fund (DH, 2015 48).

The Department for Education has also announced a National Prospectus Grant Award https://www.gov.uk/government/news/25-million-injection-to-help-life-changing-childrens-services, which includes £4.8 million for CYP mental health projects

Anti-stigma campaign

The Taskforce recommends more investment in a national movement to dispel stigma and promote awareness of positive mental health and emotional wellbeing, as well as a better understanding of mental health problems, what support is available and how to access it. This may involve an extension and expansion of Time to Change activity and allow greater coverage across the county of some of the pastoral support activity already taking place in one area of Hertfordshire.

National activity to support children and young people's mental health

Education

In 2014 the Department for Education published guidance for schools that set out the important role schools play in building resilience and in recognising and responding to distress. It set out how and when to refer to CAMHS, gave advice about how to support children with emotional and behavioural difficulties and how to strengthen pupil resilience and provided practical tools to help identify the pupils likely to need extra support.

Ofsted's schools' inspection framework is a lever for encouraging schools to promote mental health and wellbeing. The new Ofsted Inspection Framework, which is currently in development, includes a judgement on personal development, behaviour and welfare, with elements that are relevant to mental health and wellbeing (Department of Health, 2015). The new framework will become operational in September 2015.

The Department of Education announced that it will be developing a blueprint for schools to use when delivering counselling services, and will be working with the PSHE Association to

help schools know how to teach pupils about mental health (Department of Health, 2015). This will link to the Department's developmental work on 'character' and resilience.

Recently enacted Special Educational Needs and Disability legislation introduced a co-ordinated assessment process to determine a child or young person's needs across education, health and care; it replaced statements of special needs and learning difficulty assessments with an Education, Health and Care (EHC) plan for children and young people with complex needs. It also introduced the option of personal budgets for those with an EHC plan.

Health Select Committee inquiry report

The Health Select Committee's child and adolescent mental health report 2014 reiterated many of the concerns expressed by the CMO and NHS England, however it emphasised the impact that poverty has on mental health, the impact of budget cuts on local services and the importance of targeting services at those most in need, including early intervention and prevention.

Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat which focuses on four main areas:

1. Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
2. Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
3. Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
4. Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

The Hertfordshire Mental Health Crisis Care Concordat Action Plan sets out its priorities for ensuring compliance with the Concordat.

The Government's Mental Health Act Review

In 2015 the Department of Health published amendments to the Mental Health Act Code of Practice which strengthened the section relating to children and young people. It also published a green paper consulting on proposals to outlaw the use of police cells as places of safety for under-18s, among other suggested changes to the Act.

NHS England

The NHS England Five Year Forward View plan has committed to 'a **radical upgrade in prevention and public health'.**

As part of the Government's introduction of new access standards, £120 million has been set aside to improve mental health service waiting times. This includes £33 million set aside to make sure young people with psychosis get prompt treatment. Further funds from this pot will be focused on patients needing talking therapies for conditions like depression. This will include women with perinatal mental health problems. New waiting time targets should guarantee the treatment they need in as little as 6 weeks, with a maximum wait of 18 weeks.

The Chief Medical Officer's Annual Report of 2013 was the first to focus on mental health, exploring ways in which investment should be maximised in areas of highest impact. An important message was that the NHS and Public Health services should not commission services under the descriptor 'promoting wellbeing' but instead commission on the basis of evidence based interventions to promote mental health, prevent mental ill health and support recovery from mental illness.

NHS England's planning guidance for 2015-16 encourages CCGs to work with other local commissioners to invest in children and young people's community mental health provision. They are seeking to ensure mental health spending will rise in real terms in every CCG. It says NHS England will make a specific contribution by prioritising the further investment in children and young people's mental health announced in the Autumn Statement 2014 and the 2015 Budget in areas that can demonstrate robust action planning through the publication of local Transformation Plans (Department of Health, 2015) that accord with the principles and ambitions set out in the Taskforce Report.

There is specific work under way through the CYP IAPT Integrated Services Group to develop a child or young person's passport as a way of facilitating information-sharing to improve care management in relation to individual cases. A specific question to capture children and young people's views on the use of their NHS number to link information for the purposes of delivering more joined up care was included in the engagement work commissioned by the Taskforce.

NHS England's review of child and adolescent mental health inpatient care found significant gaps between the services offered by community based teams and the inpatient estate with a lack of consistent step-up and step-down services and crisis assessment and treatment teams. It recommended increasing the number of inpatient beds and the appointment of case managers. It highlighted the poor connection between local commissioners and the national specialised commissioning board, and the distances at which children and young people are placed from their homes.

East of England strategic clinical network activity

The Maternity, Newborn, Children and Young People Strategic Clinical Network (East of England) has identified priorities for 2014-16 and these include:

'Following the development of an integrated commissioning toolkit for the healthy child programme we are piloting this in 5 sites across the East looking at 3 aspects; the handover between health visitors and midwives, perinatal mental health and developing a set of outcome indicators. There are also a number of other projects looking at child and adolescent mental health, including supporting commissioners to review CAMHs across the east of England.'

Commissioners need to ensure that they are linked in with the developments across the East of England being led by the Strategic Clinical Network to ensure that there is no duplication of projects and that learning can be shared across Hertfordshire.

The Youth Well Being Directory

The Youth Well Being Directory has been identified by the National Taskforce as a potential resource to improve the quality of local whole system CAMHS activity. Those registering can be part of a network of accredited organisations supporting children's wellbeing. The resource can also be used by children, young people and families to identify what is available in a local area. Hertfordshire should ensure that local support services are registered and work towards accreditation via the Youth Well Being Directory (http://www.youthwellbeingdirectory.co.uk/).

Data

Public Health England has led the development of a new Mental Health Intelligence Network (MHIN). This is intended to be a comprehensive one-stop shop for data and intelligence enabling providers, commissioners and policy makers to understand and improve system performance – which includes a children and young people's mental health strand. The usefulness of this tool relies on good quality local data collection.

From January 2016, the CAMHS Minimum Data Set will be implemented. It is likely that early data will be flawed and it will take time for data completeness and quality to be such that conclusions can be drawn about access and waiting times. The Minimum Data Set does not cover investment levels. The implementation in 2015 and central flow of data through the Health and Social Care Information Centre (HSCIC) must be a key priority for implementation at a national and local level. This includes ensuring that commissioners are placing into contracts the requirements for meaningful data collection, including outcomes monitoring. The CYP IAPT programme is collecting outcome and activity data and working with services to drive up the quality of data collection.

Activity is likely to build on current work developing payment systems in CAMHS. This work is reaching a conclusion: advice to the Department of Health was due to be completed by

March 2015. The work is showing that young people coming to services have needs that can be segmented into four groups based on the number of hours of help they receive.

The DH announced in its national Taskforce report that it has commissioned an updated national prevalence study on infant, children and youth mental health.

Commissioning levers

We advise that Commissioners:

- Use the payment incentive Commissioning for Quality and Innovation framework (CQUIN), which makes full payment of the contract conditional on meeting quality and innovation improvements – for example, more staff using outcome measures in their practice to improve children and young people's participation in their own treatment.
- Use approaches such as CAPA and Lean Thinking to support system change and targeted and specialist CAMHS transformation.
  Invest to save. Although out of county treatments are rare in Hertfordshire, the numbers nationally are rising. Pressures on the system, particularly in light of heralded further public sector funding cuts should make commissioners aware that preparing for 'bulges' in the low volume high cost system are likely and are significantly affected by the 'flow' of patients through the pathways of care.