Healthy London Partnership

Healthy London Partnership (HLP) Children and Young People's Mental Health Shared Learning Event

Prevention and early intervention presentations:

Greenwich approach including Headscape
Using CBT in early intervention with CYP
Sutton self-harm project
Violence Reduction in Trauma Care

Supported by and delivering for:

Public Health England

NHS

LONDON COUNCILS

SUPPORTED BY MAYOR OF LONDON

London's NHS organisations include all of London's CCGs, NHS England and Health Education England

CAMHS Prevention & Early Intervention

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NHS Greenwich Clinical Commissioning Group

ROYAL borough of GREENWICH

Oxleas NHS

We know…

- The majority of children receiving specialist CAMHS support see an improvement in outcomes
- Referrals to CAMHS are not representative of our community
- Children, parents and professionals don't always know what support is available (nationally or locally)
- The range of support available is much wider than CAMHS but needs co-ordination and unity

NHS Greenwich Clinical Commissioning Group

ROYAL borough of GREENWICH

Oxleas NHS

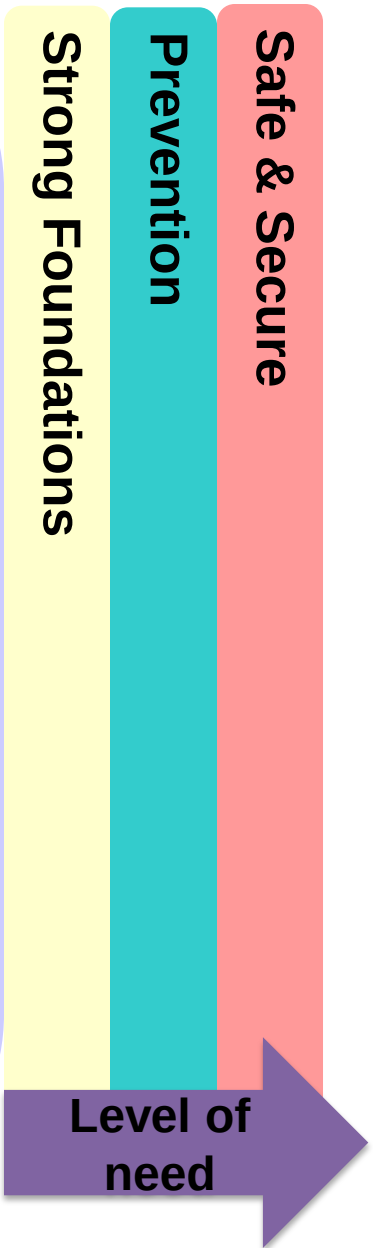
Our children would like to see more of…

ACE
Action | Change | Equality
Young people with disabilities in Royal Greenwich

ROYAL borough of GREENWICH

Resilience and Good Mental Health is important for all children

- Stigma is reduced and awareness of available support is increased amongst children, young people, parents and people working with children
- The children's workforce is confident and skilled in supporting children's mental wellbeing
- Parents' skills and confidence in supporting their child's mental wellbeing and health is improved
- Our understanding of new mothers' and children's mental health needs, assets and experiences is increased
- Children's needs are met by the appropriate service at the right time
- Effective specialist services are in place to meet needs
- Our understanding of impact of support for children's mental health is improved



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- Designed to provide self help tools for young people to manage their mental health and build community resilience
- ‘HeadScape’ has been designed for young people, by young service users, to give them a trusted website to use for information, to check how they feel and even take a test to find out if they need help with their emotions
- HeadScape is a ‘one stop’ source of self-help about a range of mental health issues and conditions for young people to browse at their leisure.

Oxleas NHS

- HeadScape offers young people the opportunity to independently undertake a mental health screening questionnaire, which provides individually tailored advice and information
- Depending on the results, the site can offer young people living in Bexley and Greenwich the option to self-refer directly into their local children and young people's mental health services.

The next 60 seconds could change your life

https://vimeo.com/143720646

Oxleas NHS

HeadScape

15 minutes

22 questions

The HeadScape Quiz

This quiz asks questions about your feelings and behaviour as well as the impact these have on your life. The results are not a formal diagnosis, but a quick assessment.

- HeadScape categorises specific mental health presentations into the following themes:

Behaviour	Feelings	Focus
Friendships	Physical	Self Harm

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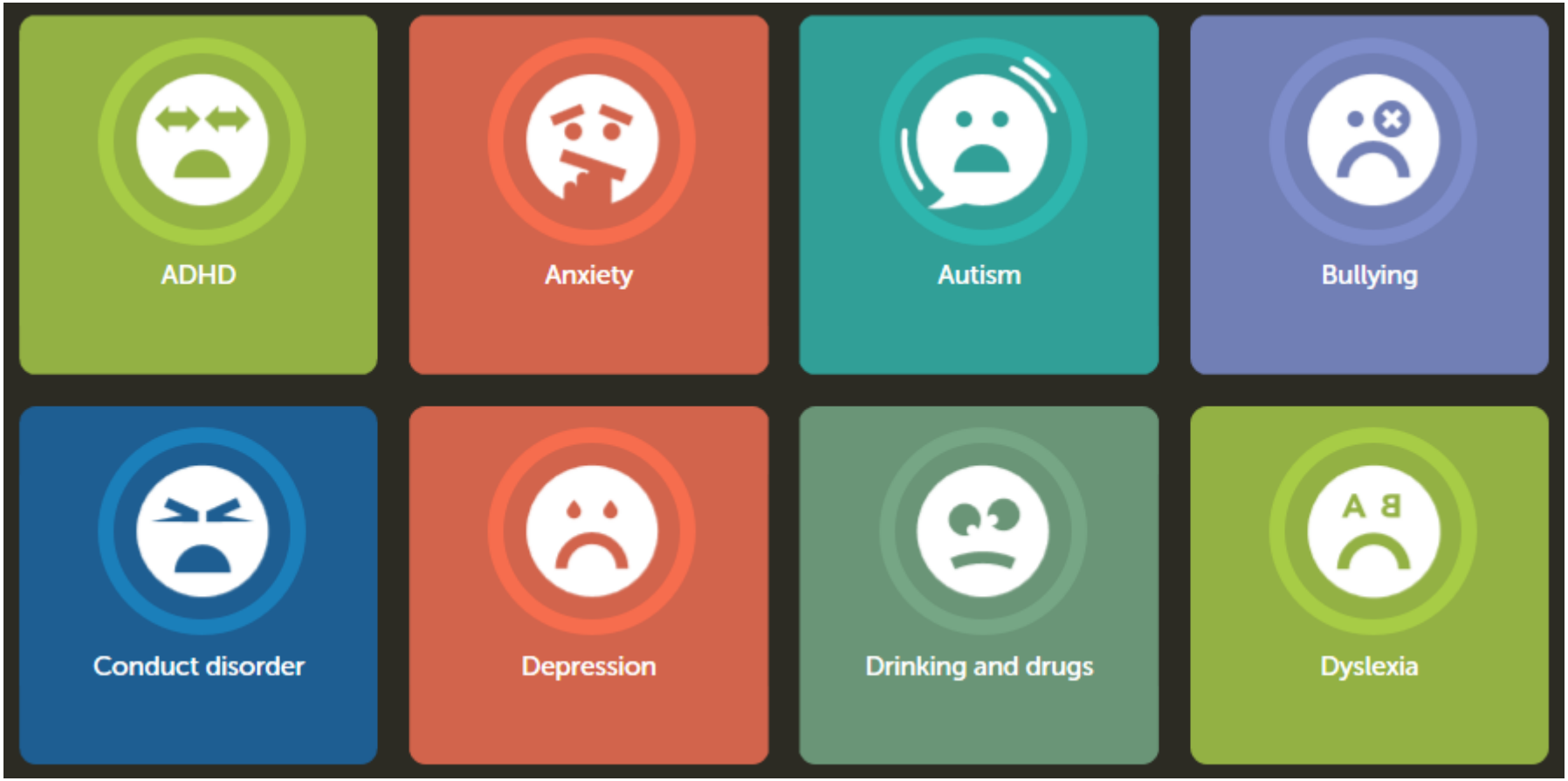
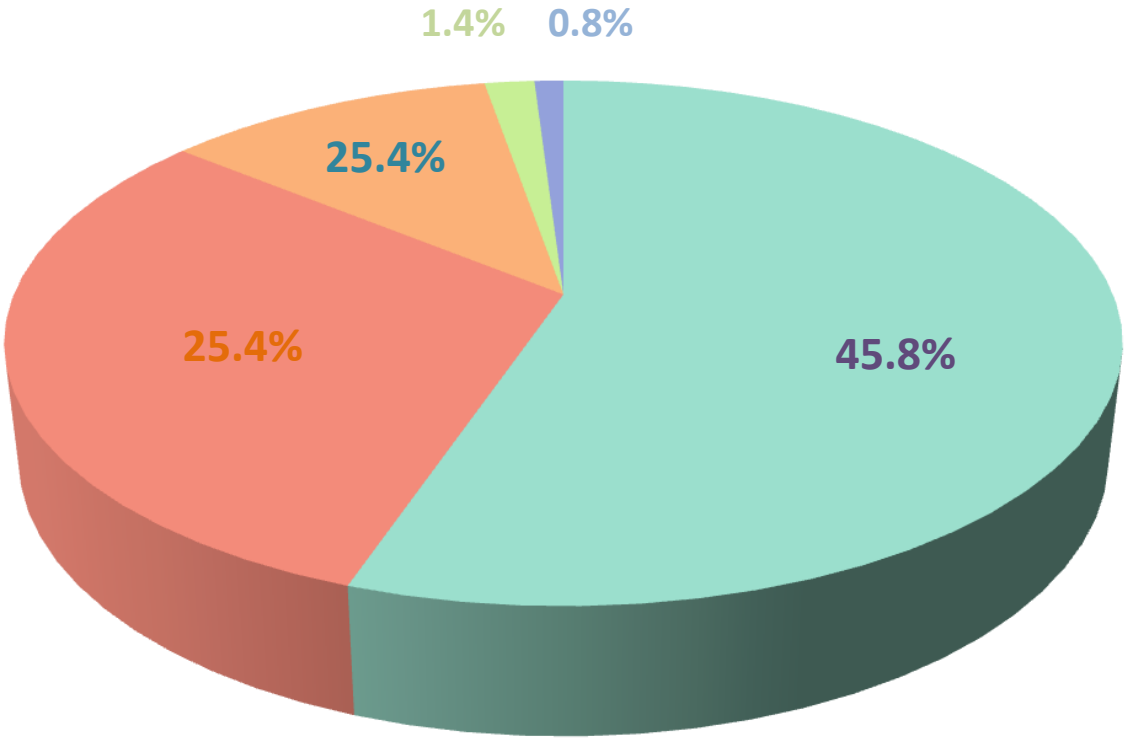
HeadScape



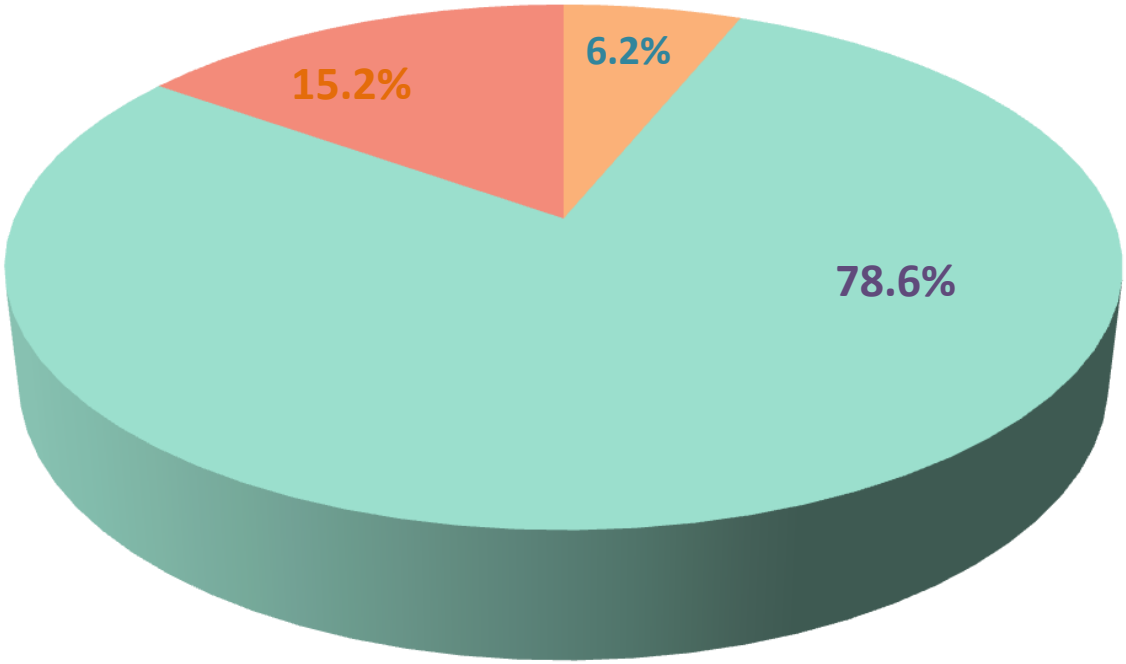
- In the last year (June 2018–June 2019) there were a total of **41,910 page views** (14,822 unique page views)
- A total of **2,581 individual users** were recorded during the same period – 86.22% new visitors, 13.78% returning visitors
- The majority of users visited the 'Behaviour' page (1,079 page views) of the website, followed by the 'Feelings' page (688 page views)
- From January–June 2019 **73 referrals** were accepted to Bexley and Greenwich CAMHS via HeadScape.

How People Are Referred



Direct Google Oxleas Website One's Website RBG Website

Website Age Profile



Aged 5-10

Aged 11-15

Aged 16-20

Further Support

- C&YP will be signposted to a range of local services as indicated by the questionnaire results, including CAMHS where necessary
- Those who are identified as displaying high risk mental state are advised to contact emergency services following completion of the questionnaire
- Professionals and family/friends are encouraged to support children and young people in completing the questionnaire if they have any concerns

Tele-Triage Pilot: Community CAMHS, Bexley

- Pilot established in the context of increased demand and increased waits
- Aimed to test whether high demand and long waits could be proactively managed by identifying needs and risks and streaming patients to the appropriate pathway early in the patient journey
- In the pilot, triage was undertaken first with those waiting longest, working back through the wait list
- Clinicians triaged patients, using a standard screening tool to identify needs and recommend next steps i.e. guided self help, signposting to alternative services, telephone support, face to face assessment, urgent help
- Set up with staff voluntarily working overtime
- Patients were contacted by telephone between 5 and 7pm weekdays with the average duration of calls being 45 minutes
- Triage was undertaken with parents / carers and young people
- Pilot operated over the course of 4 months

Tele-Triage Pilot: Community CAMHS, Bexley

- At the start of the pilot, 132 CYP were awaiting assessment, 63 of whom had waited over 13 weeks
- 150 patients were contacted; of these, 100 had two contacts with the service (triage/ screening call plus follow up)
- Of those contacted,
  - 2% were offered an urgent appointment (within 48 hours)
  - 19% were offered a sooner appointment (within 4 weeks)
  - 50% were offered a routine appointment
  - 21% did not need to be seen and were discharged
- All patients were offered a Support Plan with evidence based guidance relating to their presenting problems for self-management

Bexley tele-Triage pilot: Feedback from families and staff

- Families valued the contact from clinicians through tele-triage; they gained an understanding of their child's difficulties and how their care could be managed
- Those waiting longest said they felt cared for and kept in mind by the service
- The Support Plans were well received
- The tele-triage pilot had a positive impact on staff morale across the whole service. Clinicians felt relieved to know that the needs and risks of those waiting had been screened and managed
- Staff felt empowered and valued being able to reach out to families who had waited a long time. They linked this with their values and Duty of Candour, being able to apologise for long waits; and providing safe and effective care
- Making direct contact with families prior to face to face assessment, facilitated improved engagement and informed decision making at assessment

Bexley Tele-Triage Pilot : Learning

- Tele-triage improved responsiveness to patients' needs – identifying needs and providing appropriate follow-up action at an earlier stage rather than this taking place at or following assessment
- Triage prevented likely deterioration in the child's difficulties in some cases
- The screening function provided:

➢ A more realistic view of the child's risks as these are not always reflected clearly on referral forms

➢Clinically useful information which laid a good foundation for clinical formulation, care and treatment planning at assessment

➢Efficiencies in the use of clinical resources; it reduced the incidence of children being seen for assessment who did not then require follow on treatment. The screening enabled clinical information to be gathered and patients to be streamed (e.g. to an alternative provision) at an earlier stage without the need for initial face to face assessment

- Appropriate staffing levels and resources are required to deliver tele-triage sustainably
- Triage requires skilled clinicians and senior clinical oversight, to ensure robust decision making in complex cases; and administrative support
- There is a need to prevent the family having to tell their story twice - in triage and at assessment
- If tele-triage is embedded into the standard pathway for new referrals , triage calls need to be booked in advance with families at a time convenient to them, throughout the day and week
- There is a need for sufficient assessment appointments to be available following tele triage

Children & Young People's Mental Health Workforce Development Team

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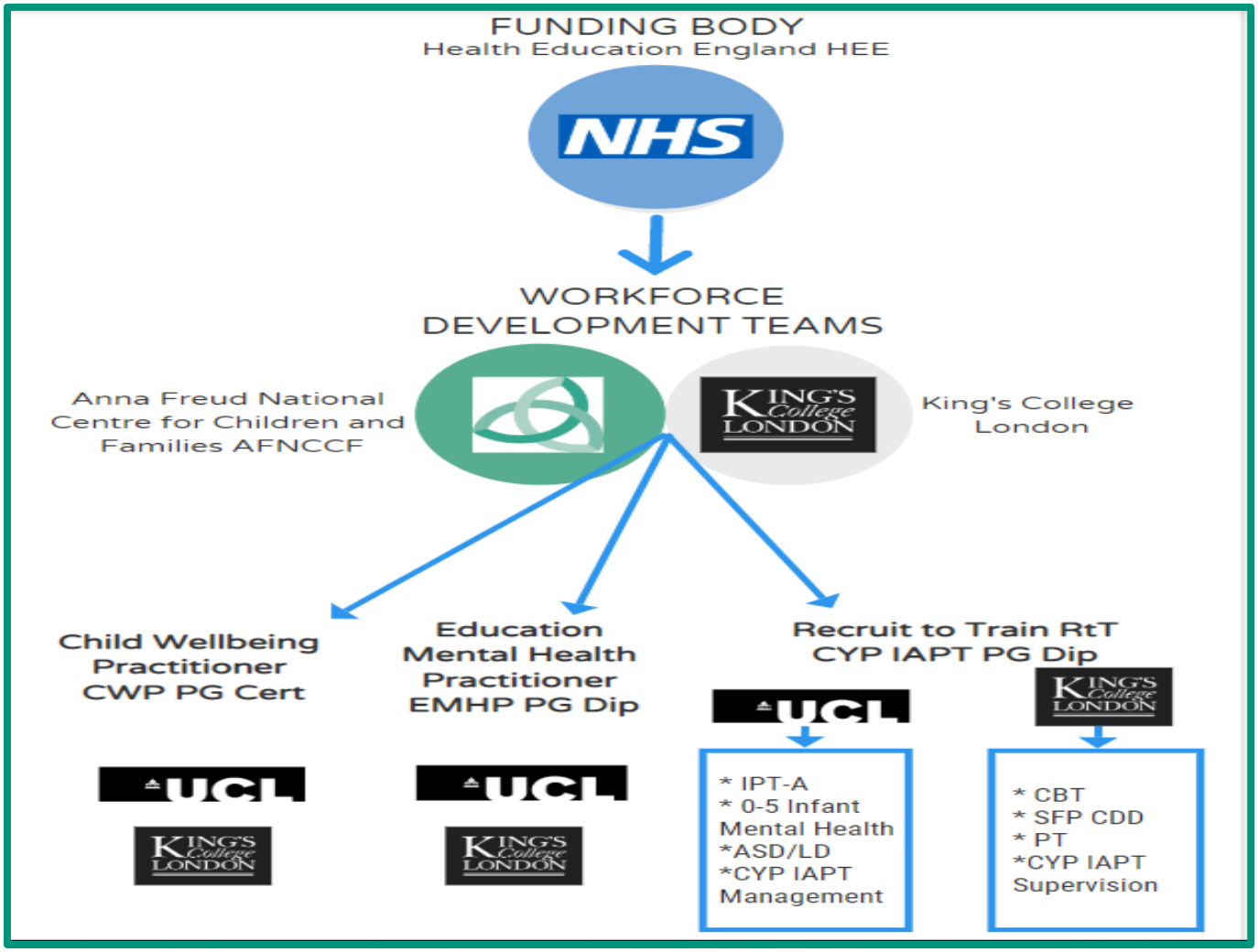
CYP MH WORKFORCE DEVELOPMENT TEAM

The CYP IAPT New Workforce is a response to the target for offering an evidence based intervention to 70,000 more children and young people annually by 2020

The aim is to train up 1700 new staff in evidence based treatments, outlined in *Implementing the Five Year Forward View for Mental Health*

- Increase capacity in services by increasing the workforce
- Further embed evidence based practice
- Have a role as change agents to accelerate transformation in services through use of feedback and outcomes tools, collaborative practice and participation with children, young people and families

CYP MH WORKFORCE DEVELOPMENT TEAM



THE CYP IAPT PRINCIPLES

Participation

- **Service users have an active role to play in the treatment they receive and in the services they use**

Accessibility

- **Actively working to improve access and engagement with services**

Evidence Based Practice

- **"The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and patient**

Awareness

- **Increase public understanding of the importance of emotional well-being and decrease stigma and discrimination .**

Accountability

- **Demonstrating the effectiveness of services and interventions through rigorous outcome monitoring**

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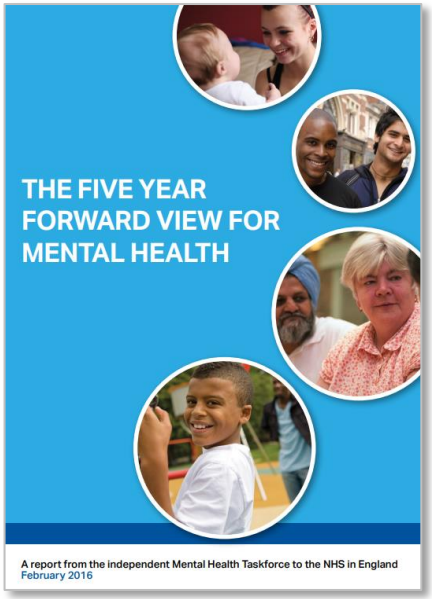
UCL

KING'S College LONDON

Children's Wellbeing Practitioner Programme (CWP)

Aims of the programme

- **Increase capacity by expanding the workforce** contribute to 1700 new staff target (5YFV) through creating a new sub-service with close links to local providers
- **Focus on prevention and early intervention** – diverting children and young people from specialist services through guided self-help for anxiety, low mood and common behavioural problems
- **Meet the gap in services** – increasing accessibility and seeing children and young people who might not meet the threshold for current services



Training

Brief, focused evidence- based interventions in the form of low intensity support and guided self-help to young people who demonstrate mild/moderate:

•Anxiety

- Parent-led CBT for child anxiety disorders (6 – 11 years)
- Guided self help for adolescent anxiety

Low mood

- Behaviour Activation GSH for adolescent depression

Common behavioural difficulties

- GSH Behavioural Parent-Training for Child Behaviour Problems (4-8 years)

Front loaded teaching – 3 days pw for the first term, 1 day pw second term, full time in service third term

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London and South East area to date

- 3 cohorts (May 2017, May 2018, Jan 2019)
- 182 CWPs (including current trainees)
- 31 different services including NHS, Voluntary Sector and Local Authority.

April 2019

CWP Outcomes for London and the South East

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National Centre for
Children and Families

Acknowledgements

This work is the result of a collaboration between:

- Wellbeing practitioners for Children
- Supervisors of the CWPs
- UCL and KCL teaching staff
- Collaborative/workforce team in London
- The POD developers
- National Analyser Developer

National Adviser report: Executive Summary

This report concerns cases seen by Children's Wellbeing Practitioner (CWP) sites across London & South East, South West, Midlands, during the period 30/01/2017 to 31/3/2018.

Primary outcome measures used for the CWP programme were the Goal Based Outcomes (GBOs), Revised Children's Anxiety and Depression Scale (RCADS), and Strengths and Difficulties Questionnaire (SDQ). GBOs and RCADS were completed by children and young people. SDQ was completed by parents.

Outcome measures were taken before (T1) and after (T2) treatment. 1820 children and young people were registered to the CWP programme across all sites. 1756 (96%) had T1 data for at least one outcome measure, the remaining 64 (4%) had no recorded outcomes. Of those with T1 data, 1488 (85%) also had T2 data (i.e. 'complete cases'). The current analysis uses data from complete cases only. The remaining 15% (268 cases) were either still in treatment or unavailable for data collection.

The number of complete cases for each outcome measure is listed as follows: GBO (N = 966, 90% of those with T1 data), SDQ (N = 271, 68% of those with T1 data), and RCADS (N = 851, 80% of T1 data).

GBOs Average Change. The average score across all three goals increased from 2.42 (1.54) at T1 to 6.68 (2.32) at T2. This increase was statistically significant ($t(294) = 29.51$, $p < .001$) and of a large effect size, g = 2.13 (1.87-2.38).

Reliable Change. 225 (76%) of the 295 cases who specified all three goals at T1 and T2 made a reliable improvement in achieving these.

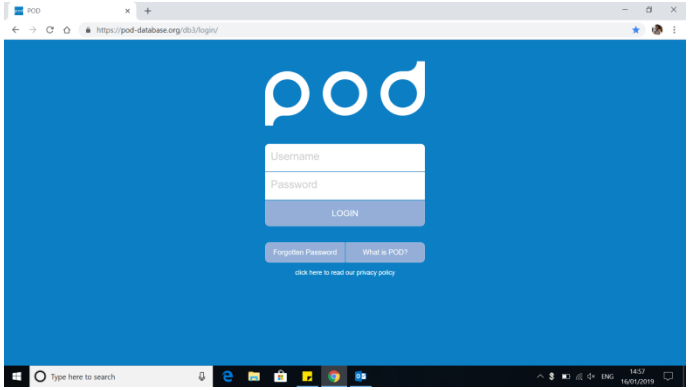
SDQ Average Change: The average total difficulties score decreased from 16.03 (6.71) at T1 to 12.35 (6.97) at T2. This decrease was statistically significant ($t(166) = 8.61$, $p < .001$) and of a medium effect size, g = 0.53 (0.40-0.67).

Reliable and Clinically Significant Change. 51 (38%) of the 136 cases who were above the clinical cut off for any SDQ subscale at T1 were no longer above the cut off at T2 (i.e. recovered). This decrease was statistically significant ($x2(1) = 33.38$, $p < .001$) and of a large effect size, OR = 7.29 (3.31-16.05). Furthermore, the number of cases showing reliable improvement was 22 (13%) on the total difficulties scale and 89 (38%) on the impact subscales.

RCADS Average Change. The average total anxiety and depression score decreased from 60.42 (15.72) at T1 to 48.90 (16.88) at T2. This decrease was significant ($t(635) = 19.93$, $p < .001$) and of a large effect size, g = 0.70 (0.63-0.78).

Reliable and Clinically Significant Change. 205 (46%) of the 443 cases who were above the clinical cut off for any RCADS subscale at T1 were no longer above the cut off at T2 (i.e. recovered). This decrease was statistically significant ($x2(1) = 147.53$, $p < .001$) and of a large effect size, OR = 9.32 (6.00-14.46). Furthermore, 197 (31%) cases showed reliable improvement on the total anxiety and depression scale.

CWP Outcomes system in London and South East



- Load Master Sheet
- SDQ Summary Sheet
- RCADS Summary Sheet
- GOALS Summary Sheet
- Sample Size Sheet
- Clear Sheets

What is POD

- A website that allows clients and clinicians to login and complete outcome measures.
- Calculates scores and subscales, generates graphs and tables.
- Data can be exported to Excel/SPSS.
- Accessible from any smartphone, tablet, or computer with access to the internet.

Sample

All cases registered on POD from both Cohort 1 and Cohort 2 for the London and South East CWP Programme between 30/01/2017 and 31/3/2019

Total cases with Time 1 data (100%):	2057
Cases with Time 1 and Time 2 data (84%):	1724
Cases still open (or unavailable) (16%):	333

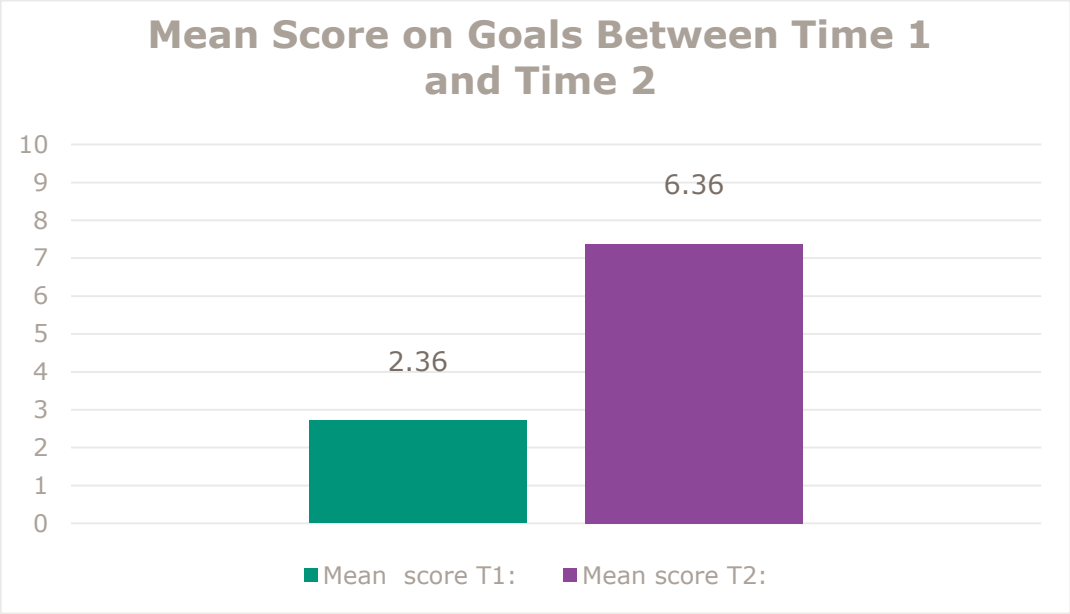
Number of registrations on POD

2057 cases

Group	Number
Goals based outcomes (GBO) (89%)	1521
SDQ (Parent) (52%)	483
RCADS (Child) (100%)	979

Goal Based Outcomes

1521 completions by all sites



Goal scores changed on average

4.00

points

73% achieved reliable positive change

Large effect size 1.92

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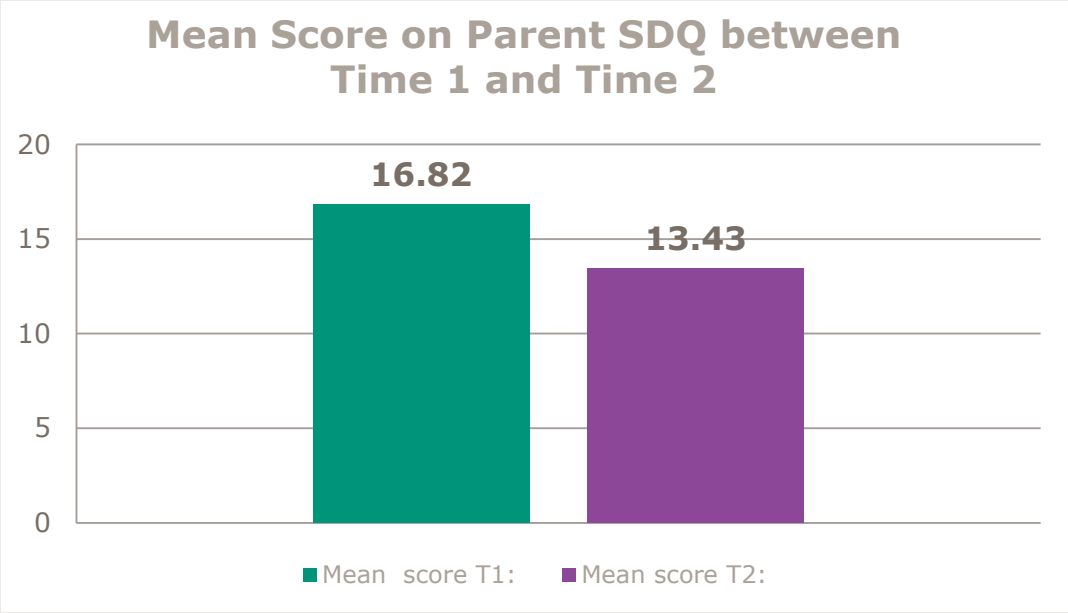
NB: 0 (Goal not at all met) to 10 (Goal Reached)

SDQ Outcomes

483 completions by all sites



SDQ scores reduced on average by

3.4

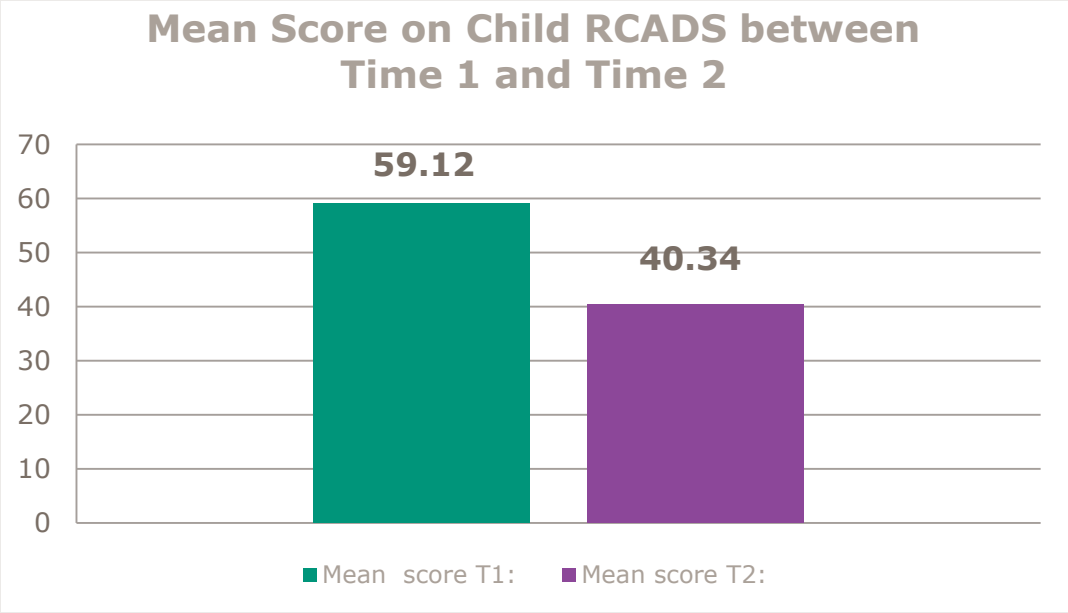
points

30% went from above to below threshold

Medium effect size 0.48

RCADS Outcomes

979 completions by all sites



RCADS scores reduced on average by

18.78

points

63% went from above to below threshold (recovered)

Medium to large effect size 0.75

Conclusions

1. CWPs provide effective for all three areas of need.
2. Medium to large effect sizes reported for goals and for the adolescent group.
3. Case selection and supervision are crucial to this approach and need to be recognised as part of the whole approach.
4. Highly effective addition to workforce working with children, young people and parents with mild, moderate levels of need.

Children & Young People's Mental Health Workforce Development Team

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Self Harm in Sutton

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Self Harm Trend

- Since 2001, higher rates of self harm in girls than boys – 37.4% per 10000 compared with 12.3 in boys
- Boys – figures around 2000 stayed the same in last 20 years
- More than a fifth of 14yo girls in the UK have self harmed

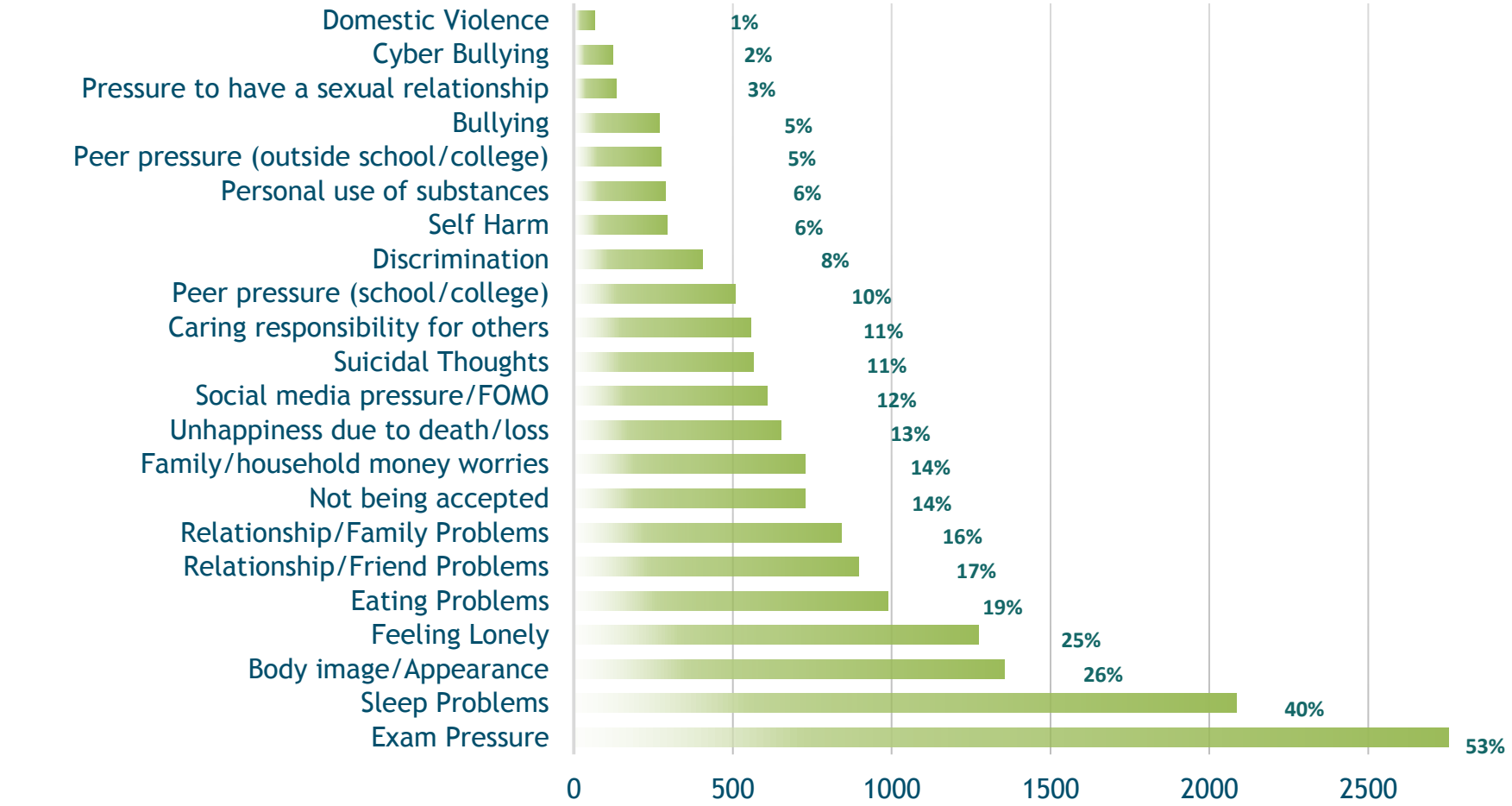
(NCPCC/BBC)

Sutton Population

- Sutton has a population of approximately 205,900 people, a quarter of whom are aged 19 years or younger.
- The population of children and young people (aged 0 to 19 years) is expected to increase by 10%.
- This is higher than London (7%) and England (5%). The wards estimated to have the highest increase of children and young people are Sutton North (22%), Wandle Valley (19%) and Sutton Central (16%).
- Our growing population of children and young people means that there will be increased demand for school places and children's services in Sutton.

	Persons		Males		Females	
	Number	%	Number	%	Number	%
0-4	14,100	7%	7,300	7%	6,800	6%
5-9	14,600	7%	7,500	7%	7,000	7%
10-14	12,800	6%	6,600	7%	6,300	6%
15-19	10,700	5%	5,600	6%	5,100	5%
0-19	52,200	25%	27,000	27%	25,200	24%
All ages	205,900	100%	100,500	100%	105,400	100%

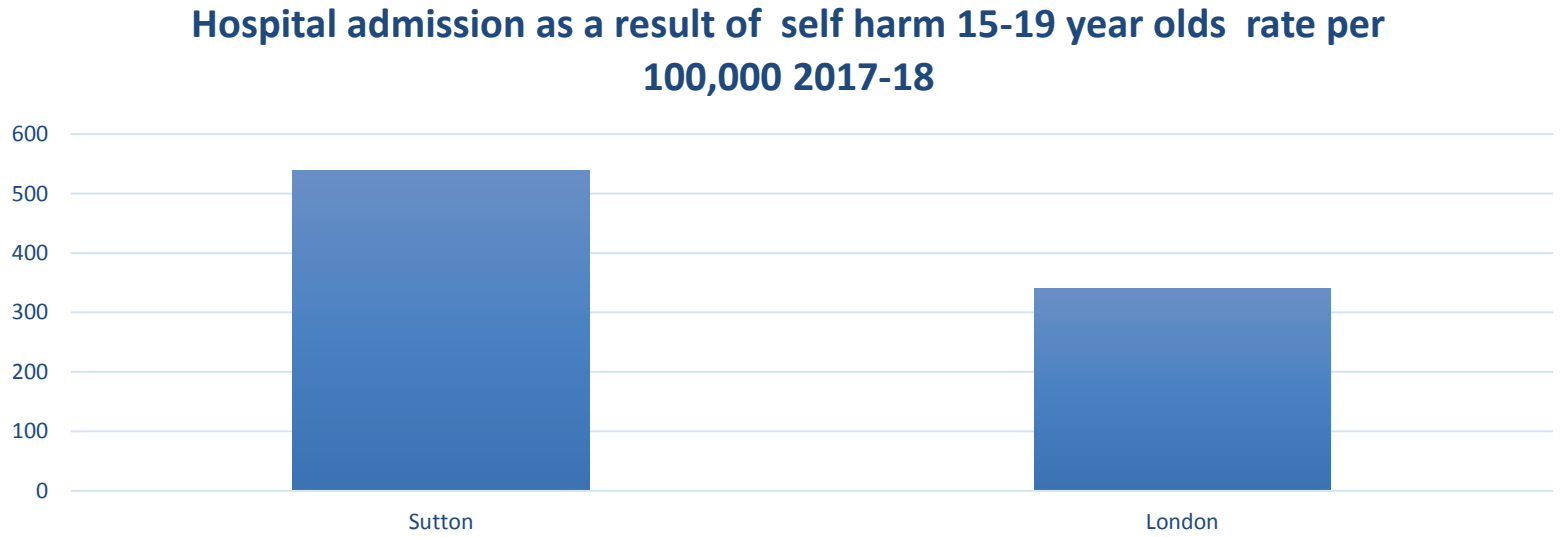
Key issues in Sutton



Healthwatch Sutton Survey

Sutton Self Harm

There is a high incidence of self-harm in children and young people (CYP) in Sutton



Suggested factors

The rate of admission is not linked to the estimated rate of mental illness in children and young people so other factors must be involved. Suggested factors that may be determining the higher rate of admissions for self-harm in Sutton include:

1)Accessibility and acceptability of a service

2) Barriers – real or perceived against usage of community services so that presentation is much later and in crisis

3) Differences in pathways and refer perception of risk, for example, young people are directed towards hospital based services and admission rather than community services.

4) Social and educational pressures in the borough e.g academic pressure

Achievements so far

- We developed a self-harm protocol and invested in additional support based in the single point of access and A&E. Interventions commissioned to support self-harm ensured there was a 40% decrease in children and young people presenting in A&E with self-harm in 17/18 compared to 16/17.
- Transformation programme services self-referral counselling, On-line self-referral counselling, drop in services consistently delivered positive measured outcomes for the children and young people they work with
- Identified exam stress as a major cause of increase in need of support, proactively created prevention leaflets with the voluntary sector and increased capacity of drop in services during exam time so young people could easily access the service

Achievements so far

- Increased the capacity of our single point of access to ensure timely triage to relevant pathways for children and young people
- Ensured that there were no children or young people with Autism or LD in inpatient settings, this was achieved through effective use of community Care Education and Treatment Reviews (CETRs)
- We increased access to services to ensure that we met operating plan target. We had an access rate for 18/19 of 38%.

Self Harm Nurse

- Implemented as of 8th May 2018
- Provide advice, assessment and treatment to the borough of Sutton. The role also consists of delivering training to social care, supervision to school nursing team and offering self-harm surgeries to schools (new development).
- To offer treatment and intervention to young people and families - informed integrative model is used, drawing on Cognitive Analytic Therapy (CAT) and Dialectical Behaviour Therapy (DBT).

Feedback

"I feel things would have been more of a struggle if we did not have this support in place"

"To really think about self harm with my young people and be more inquisitive and not be afraid to ask questions" – School Nurse

"I liked that Sam listened to my problems and didn't judge on how I dealt with them."

"The unpacking of the cause and the effects gave me a better understanding of my toll in finding solutions"

"I was so grateful for this service it has made a difference and I'm not sure what could of happened without it"

Self Harm Protocol

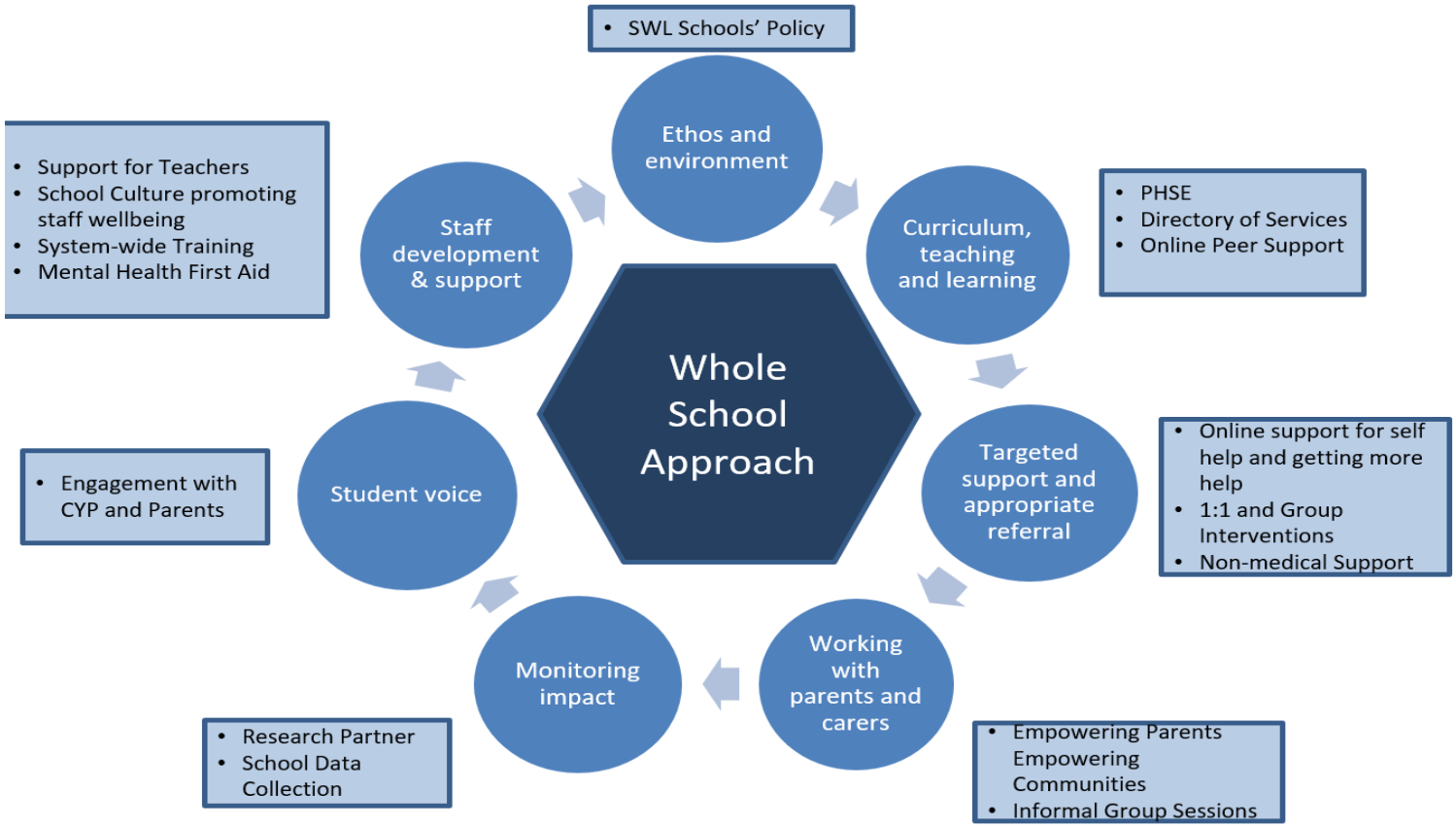
This protocol is a strategic document to strengthen partnership working when responding to self-harm. It relates to all professionals and volunteers working with children and young people (0 – 18), to support both them and young people to reduce the risk of self-harm incidents by:

- Supporting agencies to manage self-harm as it arises;
- Improving the response on presentation, disclosure, or suspected signs of self-harm;
- Improving the quality of support, advice, and guidance offered by all workers who work with young people.

Future priorities

- Deliver an increased support offer to schools to support emotional resilience of pupils and promote mental health understanding of staff.
- Build on the reduction in the number of children attending hospital with incidents of self-harm with a continued target of 25% reduction from the baseline
- Deliver operating plan access target
- Increase capacity of the CBT pathway to decrease waiting times for this service
- Strengthen the transition pathway between CAMHS and adult services.
- Enhanced delivery of the Liaison and Diversion Service for young people in the youth justice system and on the edge of offending behaviour

Prevention - Mental Health Support in Schools



Violence Reduction in Trauma Care

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NHS
Barts Health
NHS Trust

Serious Youth Violence – The Royal London Hospital

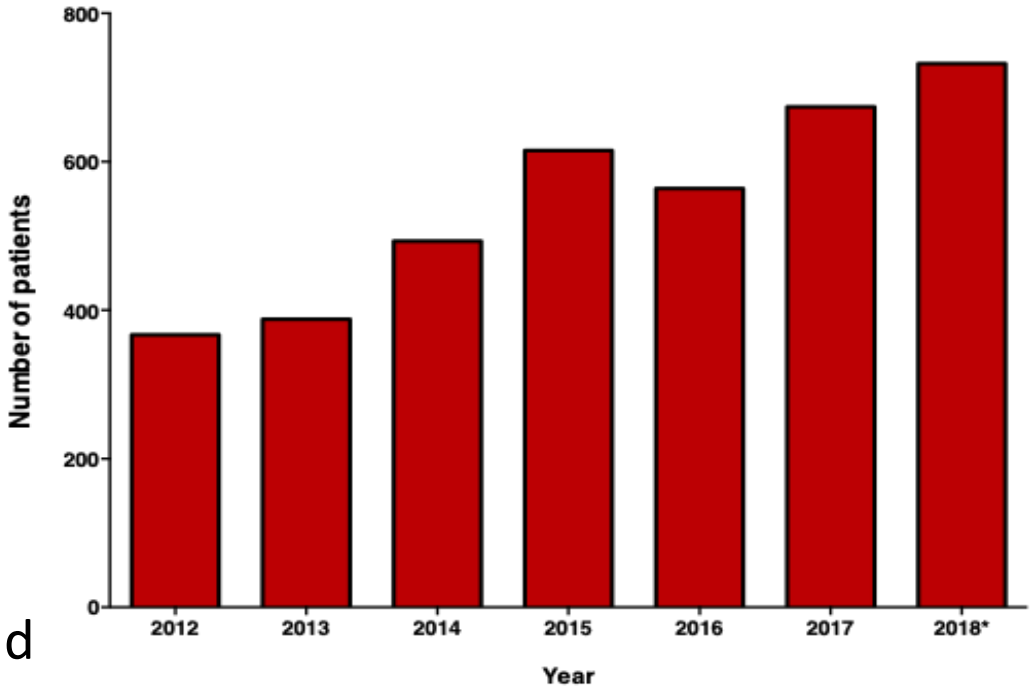
- 2017 - 712 knife and GSW
- 2017 – 418 under 25

- 2018 – 736 knife and GSW
- 2018 – 446 under 25

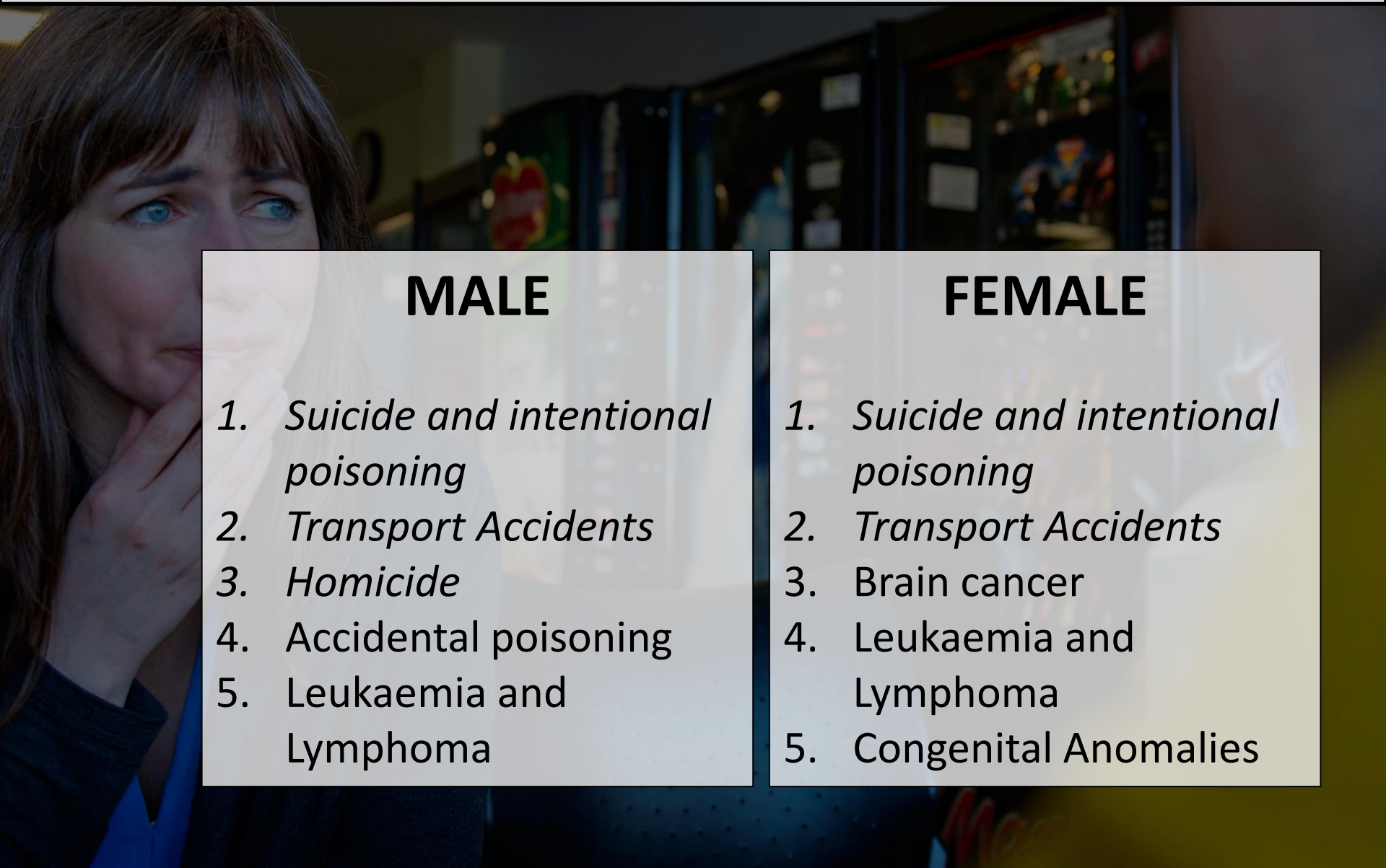
- 2017 - 110 homicides in London
- 2018 - 132 homicides in London

- Knife injuries in under 16s rose by 63% between 2011 and 2017 – 4x the rate of increase in the population as a whole.

Total cost of violence to NHS £2.9 billion per year

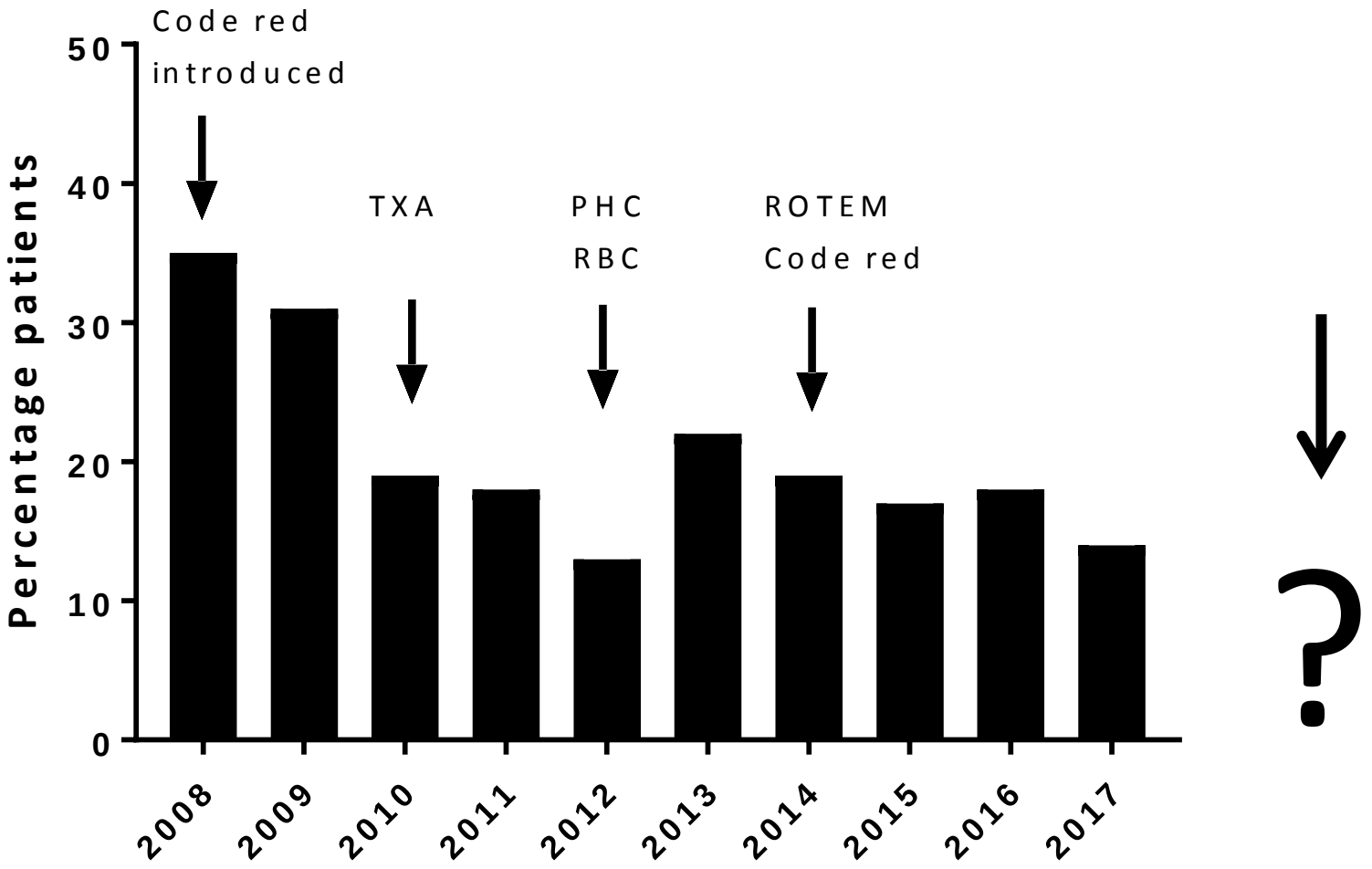


Leading Cause of Death for UK Under 19's



MALE	FEMALE
1. *Suicide and intentional poisoning*	1. *Suicide and intentional poisoning*
2. *Transport Accidents*	2. *Transport Accidents*
3. *Homicide*	3. Brain cancer
4. Accidental poisoning	4. Leukaemia and Lymphoma
5. Leukaemia and Lymphoma	5. Congenital Anomalies

Survival Rates in Code Red Trauma

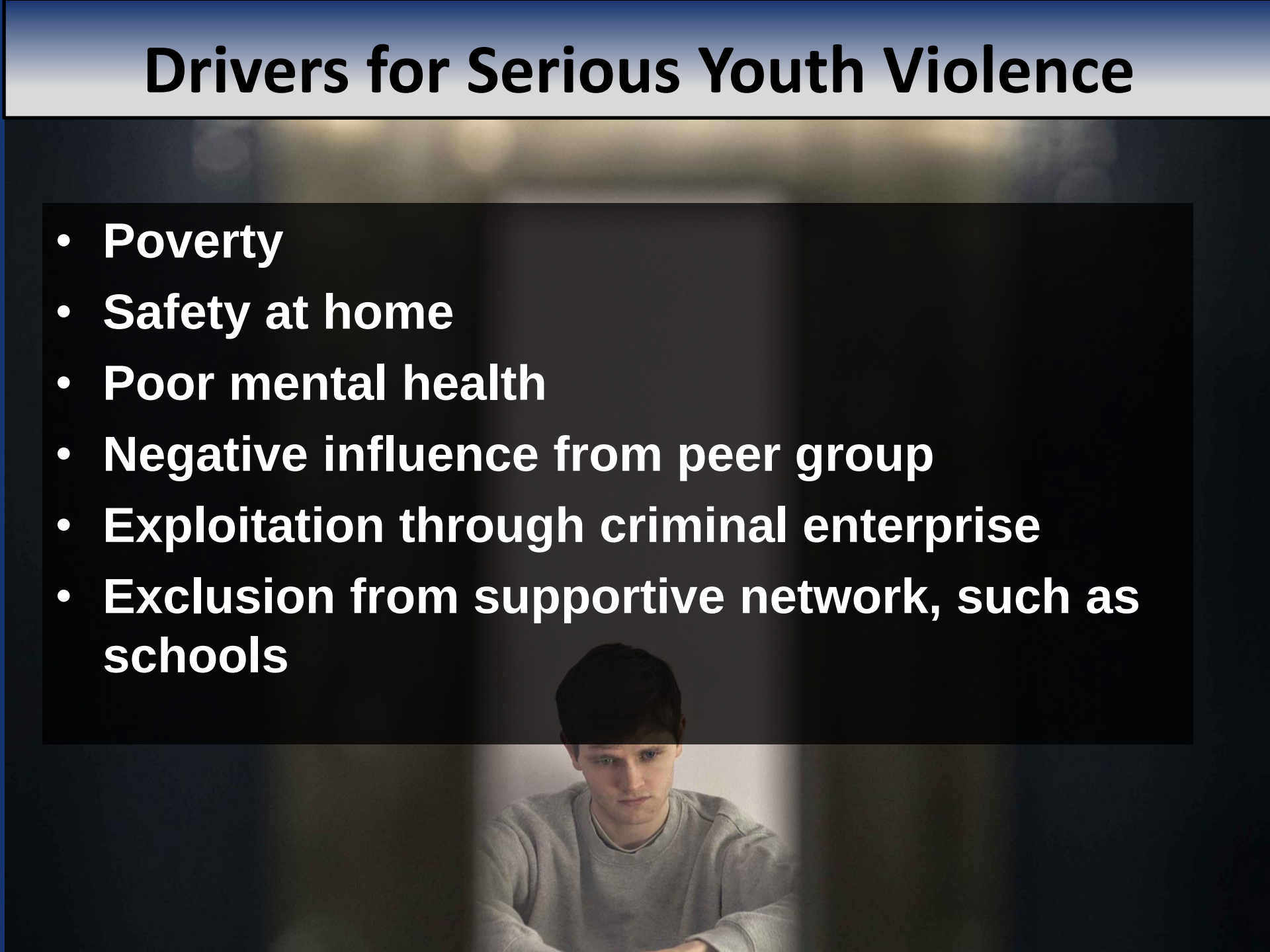


Troubled Lives, Tragic Consequences

- Tower Hamlets - highest rate of child poverty in England
- Ave. life expectancy is five years less than Kensington & Chelsea
- Children were known to CSS, youth offending services & CAMHS
- ‘If we want to address violence we need to consider the context in which it occurs.’

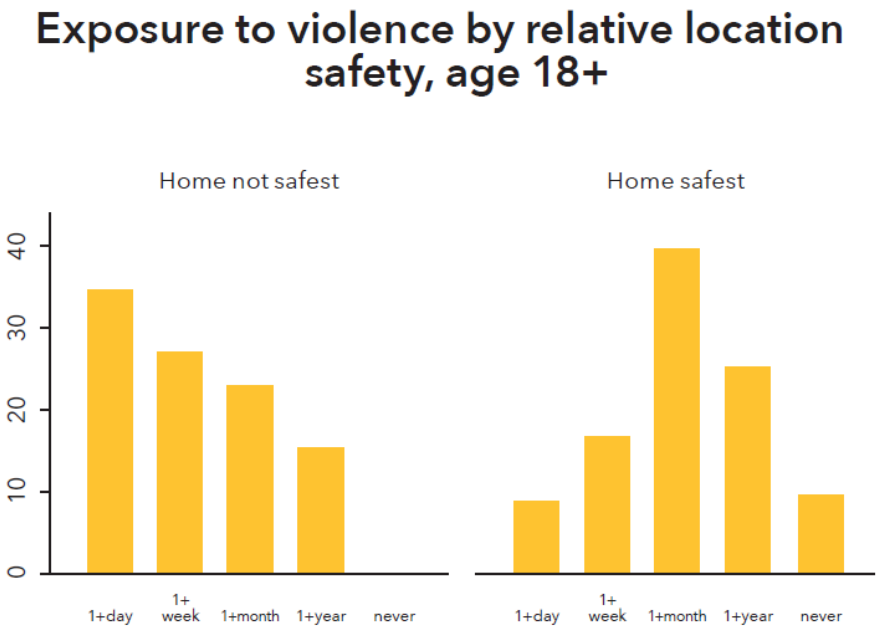
Drivers for Serious Youth Violence

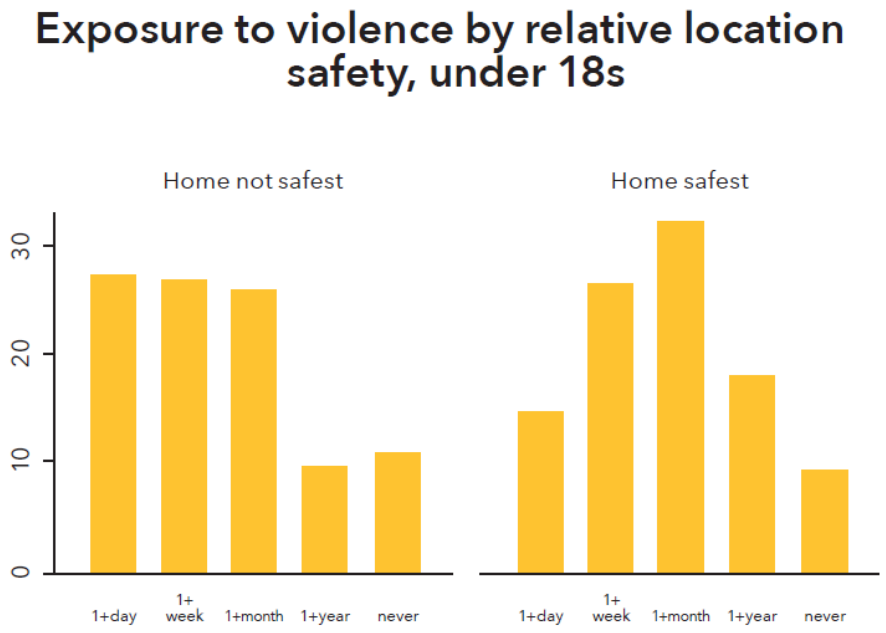
- Poverty
- Safety at home
- Poor mental health
- Negative influence from peer group
- Exploitation through criminal enterprise
- Exclusion from supportive network, such as schools



If we understand the context in which violence occurs, we can identify those at highest risk of harm.

- 70% of young people are exposed to violence at least once a month.
- 16% of young people do not feel safe in their own home.

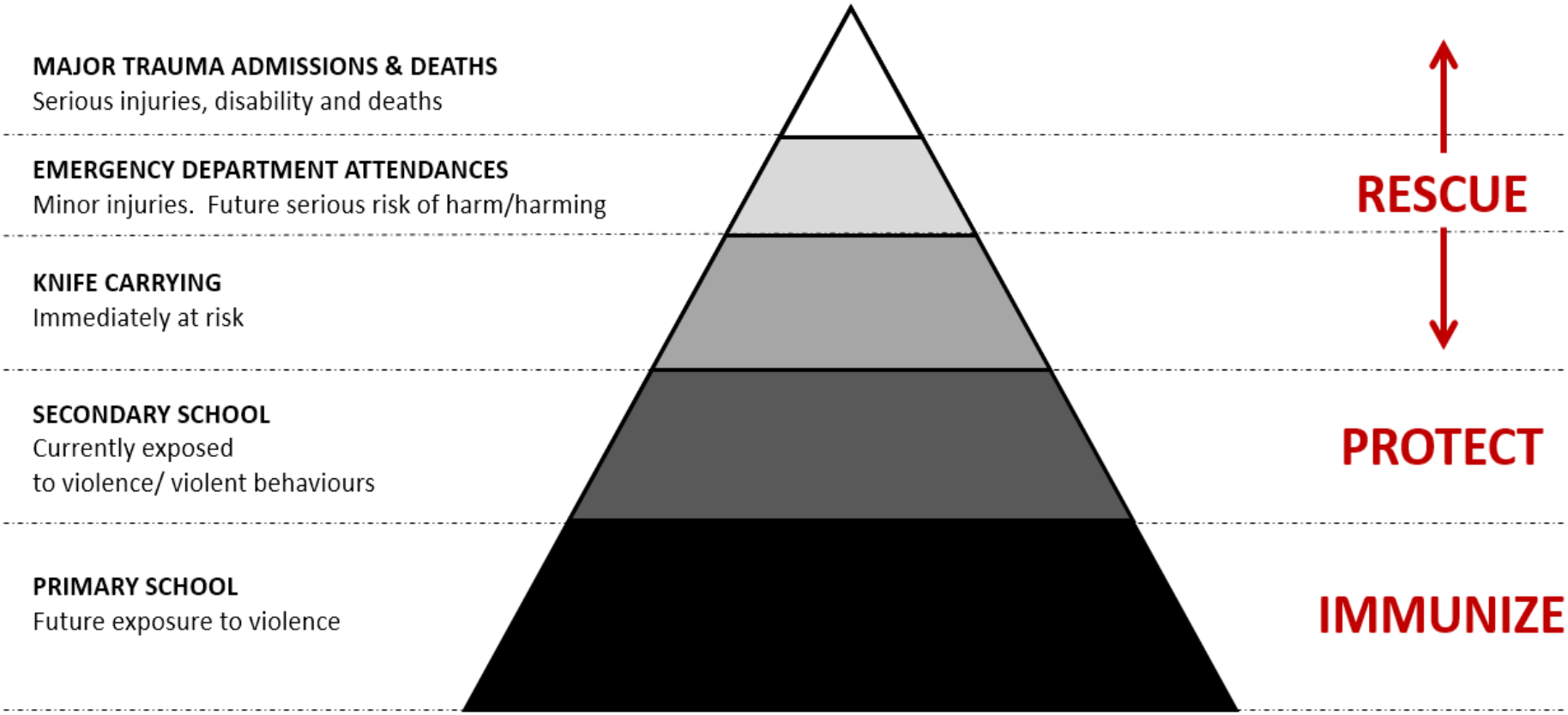




The London Major Trauma Network Public Health Approach to Knife Crime: Immunize, Protect, Rescue.

CENTRE FOR TRAUMA SCIENCES

London Major Trauma System



The St Giles Trust
Royal London Hospital SOS Project

What is the SOS Service?

- SOS is a service which offers intensive support to vulnerable young people to help those involved in the criminal justice system and carry out preventative work with those at risk.

- It works with young people exposed to or at risk of violence, vulnerability and exploitation. The work encompasses gangs work and family support as well as child exploitation.

Barts Health NHS Trust

What we do….

- There are two senior SOS caseworkers embedded in the Major Trauma Centre of Royal London Hospital who offer support to young people that are admitted as a result of serious youth violence and sexual violence. There is also one Support Worker who provides support around ETE, Housing, Benefits, job searching, CV's and support with accessing Education/Further Education.

- We work with young people between the ages of 11-25.

- When young people are referred to us, we assess their needs then support them whilst they are still in hospital, and offer follow up services in the community to help them stay safe and reduce the likelihood of future admissions.

- Usually, this involves helping the young person and their families to find a safe place to stay as returning to their local area can often have risks of reprisals. Once the young person's situation is stabilised, we will help them engage with services offering support around education, skills and training.

- This area of our work supports young people who are often in highly vulnerable, life-threatening situations.

Embedded Hospital Caseworkers

- Delivered to 4 London Major Trauma Centres.
- Delivered by SGT and Redthread
- Using the ‘reachable moment’ model.
- Over 600 patients, less than 1% readmission in 18 month study.

A young person is admitted to a Major Trauma Centre following violence

1. Young person identified as eligible and referred
2. Initial contact between caseworker and young person – *the Reachable Moment*
3. Further daily contact between the caseworker and young person to build support plan.
4. Referral to supporting agencies in the community that will help young person achieve their goals.
5. Long term support and engagement after discharge

Statistics....

- St Giles Case Workers engaged with a total number of 279 young people between April 2015 and March 2017 (127 in the first year and 152 in the second year).

Type of Need/Support	Detail about type of support	No. of service users supported in this area	Percentage of service users
Accommodation	Supported into temporary or permanent accommodation. Some needed relocating to reduce the risk of serious harm on discharge.	42	28%
Education, Training and Employment	Includes re-engagement with existing school, college applications, and university. Some were referred to St Giles' own 'Choices' programme for training and employment support	28	18%
Health	Service users with health issues such as PTSD, mental health, substance misuse were helped to access relevant services	8	5%
Finance	Assistance with debt issues, help to access relevant benefits	38	25%
Family relationships	Service users were helped with a variety of family relationship issues, including addressing any safeguarding concerns	30	20%
General support	Referred to external providers for ongoing community support, including referrals to Victim Support Services, London Gang Exit and statutory services. 13 service users were also referred to other St Giles Trust services	61	40%

Needs of the service users and how they were addressed, April 2016-March 2017