# Our perspectives…

## Read our stories about young people and mental health

### From our young people

### From our families

### From our practitioners

The stories within this report are taken from people living or working in the City of Westminster, The Royal Borough of Kensington and Chelsea and the London Borough of Hammersmith and Fulham.

**July 2015**

healthwatch Central West London

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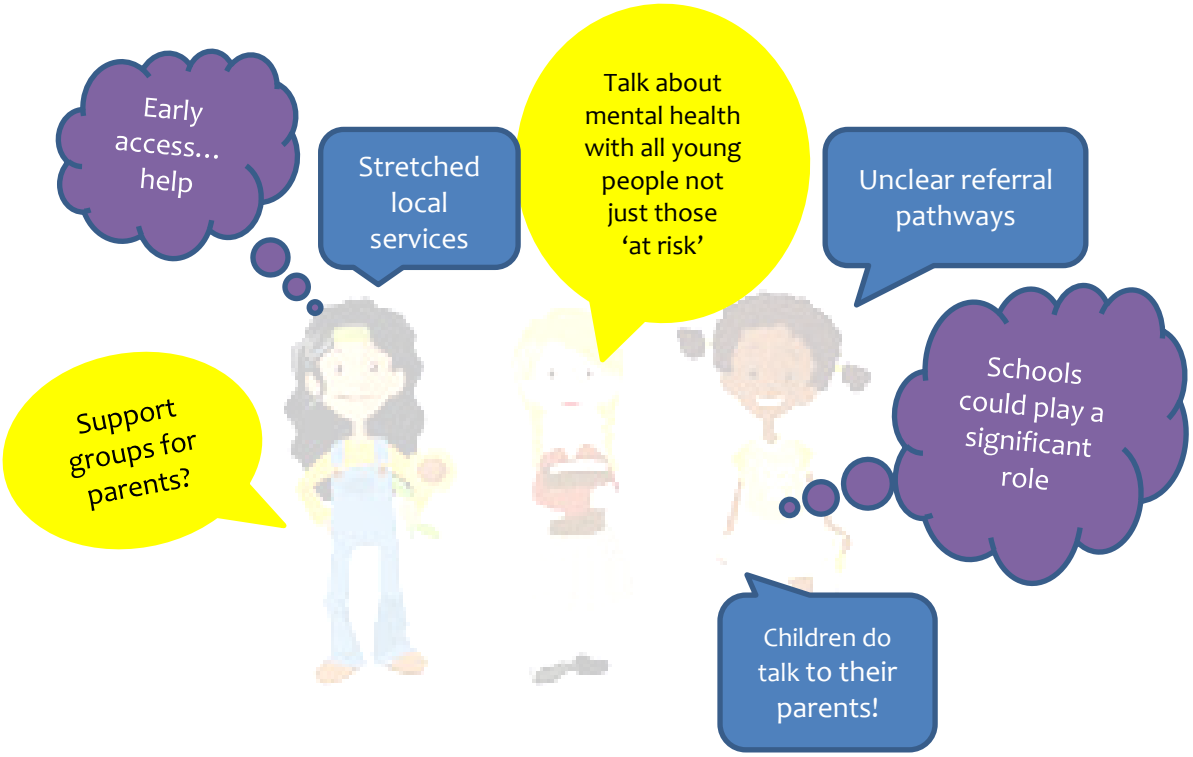
## 1. Executive summary

This report tells the stories of how our local young people, our families and our practitioners have experienced our mental health services.

The findings introduce us to key overarching questions about how we can work together to address the pressures and the contributing factors affecting the mental health needs of our young people locally.

The graphic below outlines key themes emerging from this report




In developing this report, we found there was a significant contrast in perceived roles and responsibilities. Practitioners frequently highlighted the impact of poor parenting skills whilst in contrast, parents reported feeling isolated (even after referral) and disempowered when seeking to support their child through the system(s).

Voluntary services were viewed by practitioners as Tier 1 (low level) support yet the sector reported difficulties in accessing pathways and even had difficulty referring young people through the main gatekeeper, the GP.

However the vast majority of people we spoke with were in agreement that there was a definite concern with the significant number of young people whom do not appear (DNA) for appointments and are lost in/out of the system. Most people also reported particularly poor experiences of the transition between child and adult mental health services.

## Who is Healthwatch Central West London?

Established under the Health and Social Care Act 2012, Healthwatch Central West London is an independent charity, governed by local people on a Board of Trustees. We work to ensure our voice counts when it comes to shaping and improving local health and care services. We support over 6,000 local patients, residents and stakeholders in:

- Hammersmith and Fulham
- Kensington and Chelsea
- Westminster.

Our work programme is determined by our membership and is based on local needs. Mental health has been a key work priority for Healthwatch for several years[1]. Following on from our important report on Sex and Relationship Education[2] in local schools and on School Nursing[3], we gleaned significant anecdotal evidence relating to mental health services and layers of holistic care needs which were not being met. We issued our interim report on local experiences of CAMHS in 2014[4] and made recommendations on public health messaging; simpler referral pathways; the need for analysis of DNAs; greater support for school and the need for professional to adopt a 'whole family' approach.'

All of these recommendations still apply and in this report we add further user experience from the last twelve months.

For further information on how Healthwatch Central West London is effectively influencing services in your area, please see our website: www.healthwatchcwl.co.uk

[1] http://healthwatchcwl.co.uk/about/our-work/mental-health/
[2] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/SRE-report-FINAL.pdf
[3] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/school-nursing-report-FINAL.pdf
[4] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/From-the-mouths-of-interim-Final.pdf

## 2. The Local Picture

### *What is happening locally with Child and Adolescent Mental Health Services (CAMHS)?*

In our boroughs, CAMHS NHS services are provided by two NHS trusts namely; Central North West London NHS Foundation Trust (CNWL) working across Westminster and Kensington and Chelsea, and the West London Mental Health NHS Trust (WLMHT) providing services in Hammersmith and Fulham.

The key to referral or getting a young person in to these services is usually through primary care (the GP) and in a smaller number of cases via social services.

However, another crucial level of service provision is provided by the voluntary and community sector in all boroughs. Local charities and groups provide many different types of low level support services for families and young people in need of early intervention. More targeted support at the higher end can also be provided.

Local CAMHS are based on national design and has 4 levels (known as 'Tiers') with the higher number reflecting the higher level of need provided for.

**Tier 1**
CAMHS at this level are provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies.

Practitioners will be able to offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

**Tier 2**
Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services).

For example, this can include primary mental health workers,

psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services.

Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1.

**Tier 3**
This is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.

**Tier 4**
These are essential tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams (e.g. for children who have been sexually abused), usually serving more than one district or region.

In our locality, the Health and Wellbeing Boards have produced a very interesting report about our local CAMHS provision, on what is working and what is not, our earlier work[5] informing that report and has formed a baseline for this work.

As of the end of August 2014, the number of children and young people reported to be in the CAMHS stood at:

- Kensington and Chelsea 690
- Westminster 437
- Hammersmith and Fulham 491

[5] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/From-the-mouths-of-interim-Final.pdf

According to official definitions (2013), over a quarter of children in Kensington and Chelsea are living in poverty (24%) with more than a third (39%) are living in poverty in Westminster, with 29% in poverty in Hammersmith and Fulham[6].

The national programme for 'Troubled families' recognises that the mental health of children in families as a significant issue. The amount of local families currently on that programme is:

- 516 families in Westminster
- 336 families in Kensington and Chelsea
- 509 families in Hammersmith and Fulham.

It is important to note that these are families are 'known' to the system. An important focus for our report was capturing the experiences of people who are not necessarily included in the above statistics.

## 3. Methodology

This aim of our work was to engage with a wide cross-section of local communities in Hammersmith and Fulham, Westminster and Kensington and Chelsea to find out what people knew about child and adolescent mental health. We posed the same basic questions (in age appropriate formats) to the following people:

1. Young people, 8 – 12 and 13 – 18
2. Parents, carers, family
3. Practitioners, anyone who works with young people/families were invited to fill out our surveys.

We also hosted two events engaging approx. a further 150 local, young people and we visited the in-patient unit, the Collingham Children's Centre near Earl's Court.

### 3.1 Engaging young people

To start with, we spoke with young people about their understanding of their feelings. We first held a focus group with children and young

[6] http://www.jsna.info/local-health-profiles

people in a local secondary school in Year 7 (aged 11-12) to co-design an age appropriate methodology.

During this session, there was a lively debate about some of the terminology used and the connotations. Everyone agreed that it would be easy, for all ages to understand, if we asked people about feeling 'happy' and 'sad.'

More than 100 young people filled in our initial questionnaire online or through face-to-face outreach work at the following places;

- School
- Youth groups
- Local parks
- Skate park
- Parkour wall park.

Young people who attended focus groups were incentivised with a gift voucher of £5 and entered in to a raffle at the events.

### 3.2 Engaging parents, family and carers

We held face to face interviews with parents whose child had used mental health services or had been referred to mental health services within the past three years. In total, we spoke to 26 local parents about their experiences. This included:

- 6 parents whom stated their child was their official carer
- 4 parents who self-identified their own mental health condition as being at the root of their children's mental health needs
- 2 parents who felt that their migrant status had impacted on their children
- 3 parents whose children had now left CAMHS and transitioned to an adult service
- 2 parents who were helping other families and have built up local peer support help networks partly using online resources
- 4 parents whose children attend the CAMHS inpatient unit
- 5 parents who were worried about their child's mental health but were falling between services.

## 3.3 Engaging practitioners

We asked practitioners to fill out our survey online or face to face. The vast majority of respondents fell within Tier 1 provision and included:

- Teachers
- Social workers
- Support workers/key workers
- NHS nurses
- Psychiatrists
- Commissioners
- Youth workers
- Mentors and teaching assistants.

The practitioner survey asked people about their experience of referring; their expectations of the service; what improvements could be made; and how things could be done differently.

## 3.4 Engaging the services (In-patient visit)

At our visit to the Collingham Centre, we heard from:

- Parents via a focus group
- Young people through informal discussions
- Staff through informal discussions and by
- Observing the unit, the interactions and the general atmosphere.

We also met with people informally in the CAMHS service in H&F.

## 3.5 Events

During the course of our work, our team also held two events;

In October 2014, we held an event at St Ann's Church, Soho. It was an open access event where we invited any interested local people to come along to find out about the following:

- Kick It (Smoking cessation)
- The Alcohol and Education Trust
- CAMHS and Me

- Turning Point
- Alcohol Education Trust
- Body Gossip

The event had over 40 people in attendance and was particularly supported by young people from local hostels.

In March 2015, we hosted an event for young people at Westminster College. This event was hosted in partnership with Youth Projects International[7].

We created a space for young people to find out more about sexual health and mental health issues and provided a forum to share experiences and thoughts on services. 94 young people took part in the event and 7 services engaged with young people on the day[8].

## 4. Findings

We have structured our findings around the main themes emerging from the personal stories people so generously shared with us over the last year and as outlined above. To illustrate the real experiences of people affected by the services, we have chosen a small number of stories that best illustrate the wider issues emerging from our research.

### 4.1 Mental health – People do not share the same understanding of what this term means

**Young people told us:**

Our 'fact finding' focus group with young people asked what the words 'mental health' meant. Most young people present referenced a type of incoherent behaviour, whilst other young people talked about people who would be locked away in a special hospital. The young people however clearly agreed on what depression was but overall they wanted us to use simple words, such as 'happy' and 'sad.'

[7] http://www.ypint.org/contact-us.php

[8] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/True-Talk-Event-Report-March-2015-Final.pdf

During our event at Westminster College, young people discussed mental health and spoke about labelling and stigma;

***'I don't want to be labelled with a mental illness when I need someone to speak to'*** (aged 17)
***'I would be scared of being locked up if I said I was unwell'*** (aged 16)

During a visit to a youth club we spoke to two boys about mental health, interestingly they spoke about a classmate who had jumped from a nearby block of flats. They knew this fall was not fatal but neither of them knew what had then happened to him. After the incident the school held intensive discussions about mental health, but the boys went on to tell us that he couldn't have gone back to school with everyone knowing what he did, as the other kids would have mocked him. They felt the stigma associated with the suicide attempt was very real.

**Families told us:**
A parent we spoke with discussed her daughter who is self-harming. The parent was unsure about what many of the words meant in meetings. This parent said she considers herself to be quite intelligent and works in finance but the words (/jargon) are really hard to understand. She told us how she briefs her ex-husband before he attends meetings as the NHS staff use ***'really sad words'*** in reference to her daughter. This used to make her husband quite angry.

Nearly all of the parents whom we spoke with, told us that they are often worried leaving meetings about their child and do not fully understand what has been said.

**Practitioners told us:**
Only one provider told us that they felt uncomfortable with the 'jargon' used in the sector. He didn't like the 'labelling' of a lot of the young people attending his youth club. He recognised that for some it is necessary (so as to get extra help) but felt that often the label given by health or social services professionals is not fully

understood by the family and little thought is given to the future impact on the child involved.

This youth worker also described how he needs 'labelled' young people to attend his club so as to 'prove' his work and to ensure funding. However, he felt this was not a healthy thing for society. He worried about how some behaviour is over-analysed.

An outreach youth worker tasked with engaging disaffected young people said that he thought young people understood the words 'mental health' but that they do not always associate the term with related topics such as smoking or drugs. He felt the words 'mental health' still had much stigma attached. He suggested losing the term 'mental health' and being forthright and using terms such as self-harm, drugs and addiction and how in his experience young people have generally engaged positively.

As illustrated above, whilst we did not proactively query people's understanding of the term 'mental health,' often respondents sought to clarify this term and it created a communication barrier. The majority sought to define their perceptions of the term 'mental health' and recognise the difficulties in doing so before answering further. These perceptions map to the findings of the Young Minds report; 'Stigma a review of the evidence' (2010) which outlined three definitions within the label:

- Public stigma – where large social groups endorse stereotypes about mental illness
- Self-stigma – where people internalise public stigma, which results in a loss of self-esteem and self-efficacy.
- Label avoidance – where people don't seek help to avoid being labelled with a stigmatising mental health problem.[9]

## 4.2 What is the parental role?

### Families told us:

[9] http://www.youngminds.org.uk/assets/0000/1324/stigma-review.pdf

***'We all speak to him but it does no good'*** *(Mum, son aged 15 uses drugs)*

This Mum has a recognised disability; her sister cares for her and her son comes home from school early to pick up his younger sibling and to do the shopping. This young person would be known as a 'hidden' carer, he has been referred to get help for his addictions. His mum told us that he has some good teachers at his school ***'looking out for him'*** but the service that he has been referred to (for his addiction problem) is too far away and he won't go. All the responsibility has been left to him to get to the clinic and it's been left to his family to make sure he goes. The GP did write a letter asking him to go in to the surgery.

One of the young people who answered our survey explained that drinking relaxes her Mum and helps her Mum when she is getting stressed out.

Another parent we spoke to explained the sense of relief she felt when she attended the CAMHS clinic and how (for the first time) she did not feel judged as a bad parent because of her daughter's mental health troubles.

A Somalian Mum that we spoke to explained that it was her belief that children of immigrants have a really hard time fitting in and then they are labelled as being naughty and get a 'black mark' against their name. She explained that when she first moved to Britain (her children had already been here for a year), her son had to do most of the interpreting and it was hard for him (and her). He now mainly hangs around with his peers but spends a lot of time smoking and is 'out of control.'

Her son is 17 years old, she explained that (in the UK) there is much pressure on him to behave a particular 'culturally acceptable' way and it is really restricting for him. She also explained that their housing situation is another pressure point as he has to share a room with two younger siblings.

This mum spoke to us in the company of her friend who felt young people in London live next to rich people and think of their lives as 'rubbish' in comparison. This lady had come from Swansea to visit her friend. She went on to explain that even though there wasn't such a big Somalian community (in Swansea), the kids did not have the pressure of London life such as gangs and living on the same street as multi-millionaires.

A youth worker told us that parents are too often blamed for their children's issues. He told us that many parents are depressed surmising that housing and money are at the root of the problem. He went on to explain the different pathways to get help for the young people that attend his club, all of which he said were 'a joke.' He explained that it is absolutely useless telling a parent to phone social services or that their child should see a GP because then the kids wouldn't come back to the club. He told us that the stigma around what social services will do is still 'ridiculous' in English families. In his opinion, newly migrant families were more open to social services, or any intervention but he wasn't sure why.

We asked young people where they would go to if they were experiencing difficulties. The overwhelming majority (across all age groups) told us that they would go and talk to their parents (78%).

However in our survey of practitioner's only one teacher (of 14) identified parents as their first port of call when worried about a young person. An NHS practitioner told us;

***'A lot of the mental health symptoms in young people are often a symptom of being with parents who are disturbed or unable to parent successfully. The parents do not want to access help, and the child is struggling to cope in that environment'.***

The experiences outlined above show the fragmented view of the parental role in supporting young people with mental health needs.

The majority of parents we spoke with held teachers in high esteem, and recognised that it wasn't necessarily their job to get help for their child. However, most cited the school environment as somewhere that

could provide help and how different methods of teaching could better support children with needs.

One parent explained how the transition from primary to secondary meant her son went from being one of a few (known to everyone) to being one of hundreds (known to very few). This mum said that whilst the school were patient with her son, they could not afford to support her son. She felt really trapped and went online to find out what she could do.

### 4.3 How can parents find help?

During a mapping exercise task that we carried out in conjunction with the local Health and Wellbeing Board Task and Finish Group on CaMHS[10], Healthwatch was tasked with finding out about what local services were accessible for parents and their children.

We tested the environment from a parent's point of view by using the following terms to help us explore what the internet has on offer:

***'My child is sad – what can I do?'***
***'How do I help my child if he is feeling down?'***
***Who can I contact in Westminster to get help with my son/daughter?'***
***'How can I cheer up my son/daughter?'***
***'Who can help if I have a problem with my son in Westminster?'***

Both internet and phone research identified social services as the place to go for 'local' help. However, local resources were incredibly patchy; we found that online directories were a good source of information only if they had been kept updated. Most listings of local activities were outdated (as confirmed by 12+ phone calls).

Overall, national providers tended to have greater capacity to update websites with real time information and advice in an accessible and usable manner.

[10] http://committees.westminster.gov.uk/documents/s8631/Item%204%20-%20Appendix%20B%20-%20HWB%20presentation.pdf

## *4.4 Transition and GP's*

**Families told us:**

A parent told us that her older brother committed suicide eleven years ago and that her son (now 19 years old) was still affected by his death. Her son has been in and out of mental health wards/services for the past 3 years. Initially she had asked the school for help as her son's dad was not around. She felt that a male figure would have been useful. This mum continues to support other people who are going through similar problems.

She is one of four mums whom we spoke to whose child had straddled the 'transition' between child and adult mental health services. Her son is now an adult in the eyes of the NHS. She felt that this was wholly unfair because of his under met needs from childhood. She feels he still requires the intense personal attention that he had received in children's services.

All of the mum's we spoke with described how they themselves were suffering greatly as a result of their son's experiences.

In 2014, the CQC published 'From the Pond to the Sea- Children's transition to adult services'[11] which echoes the harsh reality of what local parents told us:

- Parents caught up in arguments with Child and Adult Mental Health Services about the care their child should receive
- No named 'lead' for the transition phase
- Transition should be appropriate to the individual and planned for from an earlier age.

Another of the key recommendations stated the NHS Trusts should work with GP's to enable a smoother transition phase. When we surveyed parents about GP's we received a mixed reaction.

One mother told us that her GP ***'could do no wrong and has worked her socks off'*** for her son.

[11] https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report.pdf

However several told us that it wasn't easy to see the same GP each time at their surgery, and another told us that she felt her GP had no time to listen and just wanted to give her son medication.

**Practitioners told us:**
A support worker explained that it would be much easier for her to be able to pick up a phone and ring in a referral. She said many adult services can by-pass the GP and she did not think the GP should have to be the gatekeeper. The support worker explained that this is especially true for families who do not have a GP, such as the high risk families on her caseload. These families might come in to the borough from elsewhere and it takes time for them to sign-up at their local GP practices.

**Young people told us:**
We heard different perspectives about the role of the GP, one person (a young carer) told us that her GP has always helped her and that she can always go in and have a chat to her GP or to the receptionist.

Another young person (in-patient) explained that the GP tried to talk to him (when his mum took him to see the GP) but that he would not ever talk to a GP about his problems because they might then just tell his mum. When we asked who he would talk to he was happy to reel off a list of the adults who worked at Collingham, we asked who he spoke to before he was at Collingham and he said that his friends mum was the first person to be worried about him and that she asked him to talk to his mum and he did.

When we asked the young people at Collingham about their plans for the future most of them had the same intentions as any young person of a similar age. However we did talk (separately) to two young people, the first explained that she will probably 'just be in hospital' when this was explored further she knew that when she is ill again that she wouldn't be able to go back to Collingham (because of her age) but did not know where she might go and that worried her.

The second young person (under the age of 10) told us that he is too angry and too naughty to live out of hospital so if he doesn't get better then he will be in hospital or prison.

## 4.5 What are the pressure points?

**Families told us:**
A parent we spoke to whose child has a serious eating disorder (currently in Year 7) told us that the schools are too big, that they are daunting and incredibly isolating for some children. During the same focus group, a father (whose son has ADHD) explained that he found that the support offered was well meaning but that the support assistant was minimally qualified to assist his son to settle in to the school. This father spoke of the great, specialist work that was on offer once in the 'CaMHS system' in comparison with the initial support that the school had tried to put in place.

**Practitioners told us:**
***'Family dynamics have been the key factor in my case load (such as)domestic violence, parental mental health, going into care, being long term unemployed in the 16 - 18 age range'*** *(Practitioner who supports families)*

We had a mixed response when we asked about the pressures on males and females. Pressures are clearly unique to the individual; however, one of our local psychologists told us that females were overly represented in her work:

***'Females, aged 15-18, are the group I see above all others. 15 is an age where mental health problems seem to emerge in both genders, but girls are more likely to overdose or self-harm, which brings them to the CaMHS services. There are enormous pressures on this age group'.***

**Young people told us:**

During our visit to Collingham, two of the young people told us about their frustration at not being able to access their phones or tablets whilst on the Unit.

One young person told us that it is his life and that adults do not understand. He explained that staff think children are addicted but in fact it is 'where everything is' and that adults do not understand how technology is essential to being young.

One of the key workers who was sitting near us told us that social media or being 'connected' can cause so many more problems for young people.

In contrast, a youth worker said he feels the cyber world is a great thing for young people. He surmised that he thinks society is putting up too many barriers and 'scaring' young people about keeping safe and that this should not over ride or make people anxious about using the internet. He did know of cases where young people had experienced bullying but he felt that those young people just needed to build up their resilience. He said a lot of the mental health work should be aimed at skilling up young people to be ***'confident in their own skin'***.

A young person (aged 12), told us about the problems he was experiencing with people living near to his home. He felt they judged him because he was different. This young person went on to talk to us about fashion, the tattoo's he wanted and the lifestyle he dreamed of. He also told us about his anxiety and pulling his eyebrows out to relieve the pain and pressure in his head.

A teacher told us that the pressure on girls is too much; particularly to look perfect. This teacher was in her first year of work. She told us that although she is not much older than some of her pupils, she didn't experience the same pressure. She wondered if it is a London thing?

***'Parents, family, school, friends, the internet, societal pressures, social media the media, online pornography, culture (East v West), identity, academic success/failure, drink/drugs, the future (homes/jobs/uni/debt), parental mental health, parental substance mis-use, family debt, overcrowded accommodation, lack of places to go, gangs, physical health problems and learning disabilities.'***
(NHS practitioner )

As highlighted above, there is not one particular 'pressure point' but there are often layers of needs which can have several contributory factors.

A recent survey commissioned by Young Minds entitled 'State of Minds' outlined findings which showed that teenagers are under extreme pressure from exam stress, social media, bullying and body image.[12]

***'I teach history, but I spend lots of time with students who are aged 14+, particularly with GCSE students. There is enormous change for kids at that age. Different stuff for boys and girls…. the kids I knew early on in the school sometimes become a shell of themselves….their faces are pressured, life can become all too much… I am never sure if this is home or peers or school…'***

Many of the practitioners we spoke with also wanted to emphasise that young people do change and that it should not always be seen as anything other than normal.

### 4.6 Getting in to services

Whilst most of the parents, carers and practitioners all agreed that early intervention is a key component, we found clear evidence that, at times an intervention has not taken place even after a referral.

Practitioners told us that they did not receive any communication about whether or not the young person whom they had referred had attended the appointment, how they were getting nor what the outcome was (good or bad).

Another teacher felt that too much, of what should be parental; responsibility is put on teachers who already have enough pressure to produce mini-academics out of all children. This teacher also emphasised that there are so few solutions for children whom are 'failing academically' but yet may be talented in other areas. The school, largely, has to take them down a path of academia.

In contrast an educational psychologist felt that things are getting better: ***'Information sharing with school staff is improving, but still needs work (from the schools' perceptions)'.***

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12 http://www.youngminds.org.uk/news/blog/2347_survey_reveals_teenagers_facing_constant_onslaught_of_stress

Another psychologist informed us that social workers are only generally concerned with the younger children in a troubled family, which means that there are many teenagers who are in need of help to build up their emotional resilience. As this is not perceived as the most pressing concern for the family it is often not catered for, therefore leaving young people storing up many problems for later in their lives.

A CaMHS professional spoke about the excellent service she felt was provided in an environment which has been slowly depleted; ***'We have no in-patient beds. We have no secondary services. We work alongside a stretched and cut social services. We have people coming to check our services when we are chasing our tails trying to provide good care'.***

## 4.7 Do Not Attend (DNA)

Many professionals felt compelled to tell us about the cases where they had successfully referred a family for help but the family had decided, for whatever reason, not to attend the appointment. For teachers in particular, this was a sore point as there is often the will to get the young person help but the teacher has limited ability to do so because the follow-up is focussed so heavily on parental support, and as one teacher told us – ***'not all parent's want or have the ability to acknowledge that there is a problem'.***

Another teacher and youth worker echoed this sentiment, explaining that it should not be possible to ***close a case after a DNA***. An educational psychologist added ***'Don't close cases after a DNA. This is often the parents fault - not the young person'*** *and a* social worker also explained ***'there are a lot of DNA's as people find the services inaccessible. The skill mix tends to be of highly qualified specialists, rather than of generic workers whom can offer brief therapies.'***

The national NHS CAMHS Benchmarking[13] report (2013) claims DNAs in Tier 1-3 CAMHS are an average of 11%. Whilst the report notes this is an improvement, there are still a significant number of young people

[13] http://www.rcpsych.ac.uk/pdf/CAMHS%20Report%20Dec%202013%20v1(1).pdf

slipping through the net. If we apply the average locally, this would mean that 176 young people every year are slipping through the net.

### 4.8 Early intervention please!

Parents continually told us that had more help or assistance been available at an earlier point; their child's problem might not have escalated.

A young carer we spoke to recognised that because of her 'young carer' label, she was able to get help with issues. However, some of her friends at school do need support but they don't have anyone (apart from their family) to speak with because they are not in an identified group such as young carers.

A social worker told us that there should be many more keyworkers in place to deal with drug and alcohol needs at an early stage and that school mentors should be better skilled in these areas.

Our survey asked parents if they felt there should have been an earlier intervention for their child, 88% of parents agreed there should have been. Parents said they wished this had occurred either at the school or with their GP/nurse (at the GP's).

We also noted that 'early intervention' means different things to different people in the sector. For some, this came in the guise of services that could be accessed through extended provision in secondary school.

A young person told us his school has an isolation unit that he sometimes goes to when he is naughty. He thinks it works well because he has been violent in the past.

An educational psychologist felt that an intervention could be in a 'whole school' approach to learning and understanding of mental health; ***'issues being discussed within the community (of school) without stigma, a common language around mental health'***.

During a focus group, a father said that sport, specifically team sports, are essential for all young people to learn how to be around other children, ***'how to take a joke and build up their confidence around***

***other kids'***.
This parent told us that his older son is more sensitive than the younger one (who has mental health problems), but the older one played football and this has helped him more emotionally.

A parent explained that she had raised 'access' to parts of her son's school after 3.3.0pm with the Head-teacher. She explained how this school was really close to their housing estate where children are ***'marooned in their little box flats with just a screen to keep them occupied'***.

An educational psychologist also aired the need to think about the geographical spread of services; ***'Access to counselling, therapy etc. should take place in environments they (young people) are already familiar with (e.g. schools, youth clubs, GP surgeries) rather than somewhere that involves a bus journey and the perceived risk of being seen going in.'***

A support worker (domestic violence) said she would like to see a phone line for referring the whole family, as opposed to the parent (usually the mother) in to one service and the child in to another. She pointed out that there is a misconception that families fleeing domestic violence will be linked with a social worker – most are not, and are therefore not seen as a whole unit. This worker also told us that it seems so obvious to her that help should be provided in the safety of the home setting and not in a ***'scary hospital'***.

*A social worker also offered a similar insight;* ***'Home based services or services that outreach are missing'***

Sadly, for many of the parents whom we spoke with the solutions seemed obvious. In their minds, the solutions were not medication or CBT or therapy or even parenting classes, they just would have wanted a little more help at an earlier stage and before their problem got 'out of control.'

Overwhelmingly the parents identified solutions that revolved around schools, not necessarily with the teachers but with what else the school and infrastructure could be offering.

The practitioners focussed more on the types of interventions available, the need for more workers and for further access to whole family therapies with elements of sport, drama, art and music.

## 5. Conclusions

Many parents we spoke to did not need us to pose the question of what they would change or do better, most of the parents had thought through solutions and their stories were littered with ideas.

Unfortunately, this motivation to talk was frequently due to their sense of systematic failure in the CAMHS process. The personal stories from parents and carers showed how they take on a lot of the blame themselves and almost all of them would have liked more effective early intervention(s).

Some parents said they felt judged, not just by professionals but by other parents which shows how important accessible language and services must be to ensure parents feel supported once they spot the signs of concern.

The cross-section of practitioners we spoke with gave us a candid insight in to what they felt works well and not so well. It would seem that some of our local schools do have the will to invest in mental health; however this is determined locally and dependent on governance structures, ethos, local resource, and capacity.

Whilst young people were very open and frank when speaking about mental health illnesses and the effect on their family life, we noted that they differentiate between mental health and mental illness. Their experience and knowledge of mental well-being may still need de-stigmatising.

## 6. Recommendations

### *For Professionals:*

1. Professionals (voluntary and statutory) should be given clear guidelines about their remit as a Tier 1 level of support including pathways for escalation.

2. Create a Tier 1 provider forum with representation from the wide range of Tier 1 professionals to share real time knowledge about local pressures and good practice to support children and young people.
3. Awareness training to spot potential early signs of needs appropriate to the setting in which the professional will come in contact with the young person and also pathways for support.
4. Training about the multi-agency 'whole family' approach, with a simple flow chart of how and who referrals can be made
5. An accessible referral route using phone or email and integrated systems
6. Training on effective communication to reduce the use of jargon/acronyms when engaging with parents and young people.
7. The organisation making the referral should be involved in the escalation and the further support, including the step down, of the young person
8. Allow for the development of a young adults service to mitigate for a gradual shift between children's and adult's support services
9. Improve liaison with schools to .

### For Parents/Carers:

10. Create parent support fora specific to young people and 'mental health'
11. Educate parents through brief interventions at schools, community and/or cultural group settings.
12. Offer early interventions which can be easily identified and accessed directly by a parent
13. Develop a local offer for parents whose young people are approaching a transitional arrangement

### For Young People:

14. Consider that the 'whole family approach' including the mental health of the older children in affected families, even if they do not present with a problem or meet the threshold for certain services e.g. older male children not eligible for a refuge)

15. Work creatively with young people and offer a range of early interventions disguised as anything but an 'intervention'
16. Use honest, accessible language with young people
17. Provide services at their homes
18. Create holistic well-being packages of support in schools.

## 7. Contact

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