Haringey Council

Children and Young People's Scrutiny Panel

WEDNESDAY, 18TH MARCH, 2015 at 6.30 pm HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Akwasi-Ayisi, Berryman, M Blake, Hare, Hearn (Chair), Ibrahim and Morris

Co-Optees: Ms Y. Denny (Church of England representative), Mr C. Ekeowa (Catholic Diocese representative), Mr L. Collier (Parent Governor), and Mr. K. Taye (Parent Governor).

AGENDA

1. WELCOME AND INTRODUCTIONS

2. APOLOGIES FOR ABSENCE

3. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business (late items will be considered under the agenda item where they appear. New items will be dealt with at item 13 below).

4. DECLARATIONS OF INTEREST

A Member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:
(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Members' Register of Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure. Disclosable pecuniary interests, personal interests and prejudicial interest are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

5. DEPUTATIONS/PETITIONS/PRESENTATIONS/QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

6. JOINT MENTAL HEALTH AND WELLBEING FRAMEWORK (PAGES 1 - 50)

This report outlines the priorities and outcomes of the Joint Mental Health and Wellbeing Framework. It details the process for development of the Framework, summarises consultation feedback and highlights how the recommendations from Overview and Scrutiny reviews have been incorporated into the Framework. It also proposes a governance structure for delivering the Framework. The Panel are asked to consider the draft Framework prior to its publication.

(To be jointly considered with the Adults and Health Scrutiny Panel)

7. TRANSITION FROM CHILD MENTAL HEALTH SERVICES TO ADULT MENTAL HEALTH SERVICES: ADULTS AND HEALTH SCRUTINY PANEL PROJECT REPORT (PAGES 51 - 94)

To consider the report of the Adults and Health Scrutiny Panel regarding the transition process from child to adult mental health services.

(To be jointly considered with the Adults and Health Scrutiny Panel)

8. MINUTES (PAGES 95 - 102)

To approve the minutes of the meeting 22 January 2015 (attached).

9. YOUNG PEOPLE IN THE YOUTH JUSTICE SYSTEM (PAGES 103 - 110)

To report on the work of the Youth Offending Service with particular regard to the young people in the youth justice system, including outcome and performance measures, service user profile, types of intervention and restorative justice processes.

10. SUPPORT FOR CHILDREN AND YOUNG PEOPLE WITH DISABILITIES/SEN REFORM (PAGES 111 - 124)

To consider the issue of inclusive education in Haringey and the impact of the Special Educational Needs and Disabilities (SEND) Reforms covered in Part 3 of the Children and Families Act 2014.

11. BULLYING AND HATE CRIME IN SCHOOLS (PAGES 125 - 130)

To report on action to address bullying and hate crime in schools, including reference to exclusions, parents and carers and monitoring data.

12. WORKPLAN (PAGES 131 - 132)

To note the future workplan for the Panel.

13. NEW ITEMS OF URGENT BUSINESS

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Tuesday, 10 March 2015

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Agenda Item 6

Haringey Council

Report for:	**Joint Children and Young People and Adults Health Scrutiny Panel, 18th March 2015**	**Item Number:**	

Title:	**Joint Mental Health and Wellbeing Framework**

Report Authorised by:	**Tamara Djuretic, Assistant Director of Public Health**

Lead Officer:	**Tamara Djuretic, Assistant Director of Public Health** **Tim Deeprose, Assistant Director, Mental Health Commissioning, Haringey CCG**

Ward(s) affected: All	**Report for Non Key Decisions:**

1. Describe the issue under consideration

1.1 Haringey's Overview & Scrutiny Committee function has commissioned a series of reviews on mental health over the last eighteen months. Recommendations from completed reviews are being incorporated into the Haringey CCG and Haringey Council Joint Mental Health and Wellbeing Framework due to be approved by the Health and Wellbeing Board on the 24th March.

1.2 This paper outlines the priorities and outcomes of the Framework, details the process for development of the Framework, summarises consultation feedback and highlights how the recommendations from Overview &Scrutiny reviews are incorporated into the Framework. It also proposes a governance structure for delivering the Framework.

1.3 The Joint Adults and Health Scrutiny Panel and the Children and Young People's Scrutiny Panel are asked to consider the draft Framework prior to its publication.

2. Cabinet Member introduction

N/A

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3. Recommendations

3.1 To consider the draft Framework prior to its approval by the Health and Wellbeing Board.

4. Alternative options considered

N/A

5. Background information

5.1 The proposed Framework is being developed with a range of stakeholders and experts across local health and social care economy (Mental Health Expert Reference Group) and it sets out an high level vision for mental health and wellbeing in Haringey, defines a set of outcomes, principles and specific priorities that would underpin implementation of the vision (Appendix I).

5.2 Recommendations from previous Overview and Scrutiny Panels related to mental health have been incorporated into the overall Framework and priorities were shaped in line with the recommendations:

- Priority 2: Improving the mental health outcomes for children and young people by commissioning and delivering effective, integrated interventions and treatments and, by focusing on transition, is incorporating recommendations from Children and Young People Scrutiny Panel

- Priority 3: Improving mental health outcomes of adults and older people by focusing on three main areas: meeting the needs of those most at risk; improving care for people in mental health crisis and improving mental and physical health is incorporating recommendations from the review focusing on mental health and community safety and mental health and physical health;

- Priority 4: Focusing on enablement is incorporating recommendations from the review on the accommodation and mental health.

5.3 Online consultation of the Framework yielded eighteen individual responses from residents, voluntary sector and Barnet, Enfield & Haringey Mental Health Trust. In addition, the Framework was also presented at various forums such as GP Clinical Cabinet, Local Medical Committee, GP Collaboratives and focus groups of service users and carers. Consultation feedback is being incorporated into the final report that will be published in the week commencing 16th March for the Health & Wellbeing Board meeting on the 24th March. The version enclosed in Appendix I has not incorporated any consultation comments yet due to tight timescales.

5.4 In summary, consultation feedback was generally positive and clearly articulated strategic focus on mental health for the borough was welcomed. Four priorities were seen as the right direction of travel and in line with the overall strategic direction of

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the Barnet, Enfield & Haringey Mental Health Trust. Suggestions for improvement consisted of the following:

- Inclusion of a more explicit link between mental health and domestic violence;
- Reference to the mental health specialist services commissioned by NHS England specifically in relation to mental health and offending;
- Concerns were raised on the extent of actions specified in the delivery plan and ability to deliver those in full over the next three years. This was acknowledged by the Health and Wellbeing Board Mental Health and Wellbeing Delivery Group and the Mental Health Expert Reference Group and suggested that task and finish groups, underneath each priority, conduct a prioritisation exercise to streamline the actions going forward;
- Constructive feedback from users on housing related issues, more focus on information and advice that would enable health professionals, as well as users, to be aware on the availability of a range of initiatives available locally, and more focus on physical health, food and nutrition advice. These suggestions will be taken forward in the implementation of the Framework.

5.5 The Framework will be finalised for the Health and Wellbeing Board meeting on the 24th March. Implementation governance for the Framework will be established underneath the Heath and Wellbeing Board Mental Health and Wellbeing Delivery Group and will be organised around four priorities. Task and finish groups will be established across health and care economy and will be reporting regularly to the Mental Health Reference Group that sits underneath the Adult Partnership Board.

5.6 The Panel is asked to consider the Framework prior its final publication.

6. Comments of the Chief Finance Officer and financial implications

N/A

7. Comments of the Assistant Director of Corporate Governance and legal implications

N/A

8. Equalities and Community Cohesion Comments

N/A

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9. Head of Procurement Comments

N/A

10. Policy Implication

10.1 The Framework will be incorporated into the refreshed Health and Wellbeing Strategy 2015-18 under Priority 3: Mental health and wellbeing.

11. Reasons for Decision

11.1 Considering the extensive work on mental health conducted by the Children and Young People's Scrutiny Panel and the Adults and Health Scrutiny Panel over the last 18 months, it was felt crucial that the Panels consider development of the Framework prior to final publication.

12. Use of Appendices

Appendix I – Joint Mental Health and Wellbeing Framework

13. Local Government (Access to Information) Act 1985

Mental Health and Wellbeing Framework in Haringey

CONSULTATION DOCUMENT

NHS
Haringey Clinical Commissioning Group

Haringey Council

Haringey's Mental Health and Wellbeing Framework

Consultation on the draft Framework – tell us your views

We value your feedback and we are interested to hear your thoughts on the following questions:

1. **What do you think of the overall vision? Does it capture balanced focus on the whole population as well as those most at risk and those with mental ill health?**

2. **What do you think of the outcomes? Do you agree with proposed key measures in Appendix II? Is there anything else that we are missing?**

3. **Do you agree with our priorities? Is there anything else that we need to focus on over the next three years?**

4. **We would welcome your views on how could you contribute, as a resident, in achieving each of these priorities?**

5. **For organisations: How could the support and services of your organisations contribute to meeting each of the priorities?**

6. **Have we captured, in a balanced way, the described needs of our diverse population?**
   ☐ Yes ☐ No

7. **Have we represented currently provided services and interventions in a comprehensive and balanced way?**
   ☐ Yes ☐ No

8. **Is there any significant information missing that would better inform the Framework and proposed action plan?**

THANK YOU FOR TAKING TIME TO ENGAGE IN SHAPING MENTAL HEALTH AND WELLBEING SERVICES AND INTERVENTIONS FOR HARINGEY RESIDENTS.

Please send your viewsby **20th February 2015** to **publichealth@haringey.gov.uk**

CONTENT

1 EXECUTIVE SUMMARY

Joint Mental Health and Wellbeing Framework – Plan on a page

Our vision:	All residents in Haringey are able to fulfil their mental health and wellbeing potential
Context:	Haringey's Health and Wellbeing Strategy focuses on improving the mental health and wellbeing of our residents. Over recent years, there has been a greater emphasis on improving services, tackling stigma and discrimination, and a focus on prevention to improve the overall mental health state of the people living in the borough. We now need to scale up our ambition and work together to transform mental health and wellbeing services locally. This will require a cross-partnership response which seeks to address the causes of poor mental health, promote positive mental health and resilience, tackle stigma and discrimination, offer early help and engage fully with those affected by mental ill-health, their families and communities.
Our priorities:	1. Promoting mental health and wellbeing and preventing mental ill health across all ages; 2. Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments and by focusing on transition into adulthood; 3. Improving mental health outcomes of adults and older people by focusing on the three main areas: meeting the needs of those most at risk; improving care for people in mental health crisis; improving the physical health of those with mental-ill health and vice versa; 4. Commissioning and delivering an integrated enablement model which uses individuals, families and communities' assets as an approach to support those living with mental illness to lead fulfilling lives.
What would success look like?	➔ More people will have good mental health ➔ More people with mental health problems will recover ➔ More people with mental health problems will have good physical health ➔ More people will have a positive experience of care and support ➔ Fewer people will suffer avoidable harm and die by suicide ➔ Fewer people will experience stigma and discrimination
Principles:	➔ Working together in partnership to co-design services with residents ➔ Offer person-centred services based on individual choice that is reflected in commissioning ➔ Promote asset based approach that builds individual, family and community strengths ➔ Strive for quality and right services at the right time ➔ Commission and deliver efficient and effective services based on robust evidence Integrate commissioning and delivery of services, whenever possible, where those with mental ill health, their families and carers feel supported
Enablers:	Health and social care integration, Value Based Commissioning, Working with communities National and local policies, Effective monitoring and evaluation

2 INTRODUCTION

Our mental health and wellbeing has a great impact on our ability to live happy and fulfilling lives, to achieve our goals, have good social relationships and to contribute positively to society. However 1 in 4 people will experience some form of mental health problems during their lives ranging from mild anxiety and depression to severe mental illness. Those who experience poverty, unemployment, social isolation, poor quality housing and lower levels of education, are exposed to crime, violence or substance misuse, are at greater risk of developing mental illness.

What is mental health?

Good mental health is not just the absence of a mental health condition but the foundation for the wellbeing and effective functioning of individuals and communities. It is defined as 'a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'. (World Health Organisation).

What is wellbeing?

The Care Act 2014 defines the wellbeing of an individual in relation to all of the following:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional well-being;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
- participation in work, education, training or recreation;
- social and economic well-being;
- domestic, family and personal relationships;
- suitability of living accommodation;
- the individual's contribution to society.

What is mental ill health?

Mental illness is generally categorised in Common Mental Disorders (CMD) and Severe Mental Illness (SMI).

Common mental disorders are those which tend to occur most often. People with CMD have more severe reactions to emotional experiences than the average person. For example, this may mean developing depression rather than feeling low, or having panic attacks rather than experiencing feelings of mild anxiety.

CMD includes conditions such as depression, anxiety disorders, obsessive compulsive disorders and post traumatic stress disorder.

Severe mental illness is less common. It disrupts person's perception of reality, their thoughts and judgement, and affects their ability to think clearly. People affected may see, hear, smell or feel things that nobody else can. This includes conditions such as schizophrenia and bipolar disorder. Severe mental health illness may be referred to as psychotic conditions.

Haringey's Health and Wellbeing Board, Haringey CCG and the London Borough of Haringey (LBH) identified mental health and wellbeing as one of three priorities for the next three years. This Framework sets out our vision, ambition and joint commitment for improving the outcomes for residents starting from early years, through adulthood and into older age. The Framework articulates commissioning intentions and calls on effective partnership working to transform mental health services, tackle stigma and discrimination, promote mental health, offer early help and engage fully with those affected by mental ill health, their families and communities.

As we are developing the Framework, it is important to reflect on the current Health and Wellbeing Strategy, evaluate its progress and identify further challenges. The success achieved in these areas should encourage us to achieve our greater ambitions through this Mental Health Framework. Here are just a few main achievements of the 2012 – 2015 HWB Strategy, Outcome 3: Improving mental health and wellbeing:

- **Reduced risk factors** for mental ill health such as the number of young people not in education, employment or training (NEET), crime by 40% and helped 320 adults and 100 young people to find jobs (third of them maintained job after six months);
- Commissioned a range of interventions on mental health awareness raising, **mental health promotion and mental ill health prevention** in a range of settings including schools, voluntary sector, Tottenham Hotspur Foundation etc.;
- The Clarendon Recovery College has been established as a **community based initiative** which, working with a range of partners, assist people with mental ill health to find employment, pursue education and training and improve social life;
- **Service improvements:** commissioned Recovery House run by Rethink, developed value based commissioning approach to mental ill health, re-commissioned 185 mental health units by Housing Related Support, re-commissioned drugs and alcohol services informed by the needs of the local population;

- Four **Overview and Scrutiny** reviews, recently completed, focused on mental health and physical health, mental health and accommodation, Children's and Young People Mental Health Services in transition, and mental health and community safety. Recommendations of these reviews can be found at http://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=128&MId=6266

Further challenges are ahead of us as we seek to transform mental health care to person-centred and seamless provision of integrated services based in and within the communities. Over the last couple of years we have seen real improvements locally in how we support people with mental ill health to access adequate interventions and treatments. We now need to reach more people and scale up our offer for recovery and enablement. By recovery and enablement we mean supporting people to meet their potential to live independently, to have meaningful social relationships, maintain good quality housing, find and/or maintain employment and live a satisfying life.

The scope of the Framework will include: the importance of promoting wellbeing and developing community assets; a life course approach to mental health from early years to older age; a cohort of people with dual diagnoses needs such us those with mental health problems who also have dementia, substance misuse, learning disabilities or autism.

Due to their specific and complex needs the following groups of people and the services they require will be excluded from the Framework:

- Older people with dementia and frailty;
- People with learning disabilities;
- Adults with autism

Separate strategic and commissioning approaches are taken for these services.

To inform the development of the Framework, we have set up an Expert Reference Group with a range of stakeholders that met in a series of workshops over the last six months. Details on the process of the Framework development are set out in Appendix I.

3 VISION AND OUTCOMES

Haringey's Mental Health and Wellbeing Framework Expert Reference Group proposed the following vision:

> *All residents in Haringey are able to fulfil their mental health and wellbeing potential*

This articulates the need to focus on prevention and mental health promotion. It also recognises that there is a wide range of mental health and wellbeing experiences within Haringey's communities, and encompasses principles of services being flexible and tailored for a range of individual needs.

In Haringey, by 2018, we would like good mental health and wellbeing to be a main focus of all frontline services. Certainly, there will be a group of people that would need extensive multi-disciplinary service support and for those, we would work towards commissioning and providing care that will be wrapped up around their individual, their family and their carer's needs. There will be equal partnership between services and individuals and intervention models will be designed together.

Emphasis on the importance of good mental health will start from early years. Families will be supported, whenever needed, to access a range of community interventions to help and support when there is an emotional or behavioural concern for any member of the family. There will be greater focus on improving maternal mental health. Schools will aspire to mainstream emotional literacy and emphasis on resilience in curricula, fully and consistently. They will also be able either to offer or signpost to appropriate support, those pupils who may be at risk of developing mental or emotional problems.

Focus on mental health promotion will be integrated and delivered from a range of community settings: libraries, schools, GPs, pharmacies, third sector. A large proportion of frontline staff will be trained to raise awareness, offer prevention advice and advocacy and spot early signs of mental and emotional problems, where appropriate. The model of prevention will be based on building community capacity and strengths and focusing on asset based community development to enable residents to actively improve their mental wellbeing and learn essential coping skills.

Case study: John: 45 year old male

John suffered with depression and anxiety along with a history of alcohol misuse. He also had financial issues with mounting debts. He was seen and assessed by the community mental health team who discovered John walking around at night, sometimes shouting and causing disturbances resulting in unhappiness within the local community.

At first John reluctantly engaged with the services. Joint visits held by the Community Mental Health team and a Community Psychiatric Nurse were helpful and treatment with medication proved successful. John was also assessed by the Dual Diagnosis team who referred him onwards to the Primary Care Alcohol Mental Health Counsellor based at his local surgery. On completion of this programme, he engaged with the Substance Misuse recovery service run by St Mungos. Regular support from his key worker has seen him getting back into employment starting with voluntary work. His debt has now cleared and he is currently in receipt of disability living allowance. As John's life became stable, he had a support and recovery plan that set out the support he needed over 18 months. Currently John continues to receive peer support from BUBIC (Bringing Unity Back into the Community – community organisation).

We would like to see a whole system approach in enabling people to be supported in the community to live independently. This will be achieved by designing innovative models for enablement in the community (including support for obtaining and maintaining employment, appropriate housing with care wrapped around individual needs, a focus on assets and individual resilience, and promoting social connections). Also, by partnership working with a range of stakeholders including residents, primary care, NHS, local authority, housing associations, police and the third sector.

Given the current financial climate, it is really important to reduce inefficiencies and duplication, and provide services based on robust evidence. We will strive to integrate at both levels, commissioning and provision of services, whenever possible. We will modernise current models of care to be delivered in line with the national and regional guidelines. We recognise that successful examples of mental health service modernisation did not happen overnight and we will reflect this in a phased approach over the next three years in the Framework Delivery Plan. This Plan will be aligned to the North Central London (NCL) 5-year strategy, the CCG's 5-year strategy, Haringey's Health and Wellbeing Strategy 2015-2018 and Haringey's Corporate Plan.

In achieving the proposed vision, we commit to improve mental health and wellbeing outcomes for all residents and, in particular, those with mental ill health. Below is a set of locally defined outcomes aligned to the national mental health strategy. Further details of on how we will measure these outcomes are included in Appendix II.

Haringey's Mental Health and Wellbeing Outcomes

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support, including carers
- Fewer people will suffer avoidable harm or die by suicide
- Fewer people will experience stigma and discrimination

4 NATIONAL AND LOCAL POLICY CONTEXT

4.1 National policy context

The national mental health strategy: **'No Health Without Mental Health[1]'** was published in 2011. It sets out six main objectives and emphasises the role of the individual and that of the community, in strengthening and managing their own mental health, with appropriate support provided by statutory services. The strategy also describes a life course, outcomes based preventative approach to responding to mental illness and notes the importance of significantly increasing the involvement of primary care, education, employment and housing in the prevention of and recovery from mental health problems.

In January 2014 the Department of Health (DoH) published **'Closing the GAP[2]'** which aims to bridge the gap between long-term ambition and shorter term action in mental health. The strategy sets out four priority areas focused on increasing access to mental health services, integrating physical and mental health care, starting early to promote mental wellbeing and prevent mental health problems, and on improving the quality of life of people with mental health problems.

Launched in February 2014, the **'Mental Health Crisis Care Concordat[3]'** seeks to improve outcomes for people experiencing mental health crises by ensuring services are working with a shared commitment to provide the proper level of care in the right environment. Haringey CCG and LBH will be working with partners from Barnet, Enfield and Haringey Mental Health Trust (BEH MHT), the Police, the London Ambulance Service and the Voluntary and Community Sector (VCS) to ensure there is a local action plan to support this national policy.

The Care Act, which received Royal assent on 14 May 2014, places a range of new duties on local authorities. The aim of the Care Act is to put people and their carers in control of their care and support, and to change the way in which people are cared for with the concept of 'wellbeing' being central to the act. This means local authorities have a duty to consider the physical, mental and emotional wellbeing of the individual needing care.

The new **'National Tariff Payment System'** has been implemented from April 2014. This new way of commissioning mental health services based on 'tariff payments' rather than activities and processes will assist in commissioning services across the whole pathway and focusing on the outcomes. In preparation for the implementation of Mental Health Tariffs, each Trust has been clustering patients under 21 groupings. Patient clusters are determined through the use of specified clinical tools and protocols and are based on specific diagnostic, severity and risk characteristics, which will inform the basis of treatment and payment mechanisms.

The Mental Health Promotion, Mental Health Prevention: Economic Case[4] and the **Chief Medical Officer's Annual Report on Public Mental Health[5]** clearly describe a range of low-cost, evidence-based prevention services that could be implemented across life course pathways to promote mental health, prevent mental ill-health, detect mental health problems early, improve outcomes and subsequently reduce high care costs further along the pathway[6].

Plans from NHS England such as the 'Five Year Forward View' and the CCGs Operating Plan propose additional funding for mental health. Additionally, the Autumn Statement announced national investment in eating disorder services for children and adolescents of £150 million.

Work is being undertaken locally to look at how these national policies will be implemented in Haringey to better achieve balanced investment across the whole pathway and implementation of this Framework.

Children and Young People's Mental Health Services are starting to attract significant national attention. **The Health Select Committee Report** published in November 2014 on Children and Adolescent Mental Health Services (CAMHS) articulates concerns about commissioning and provision of CAMHS across the country. A DoH and NHS England Taskforce will be developing plans on how to support local commissioning and provision over the coming months.

4.2 Local policy context

The draft **Haringey Council Corporate Plan 2015-2018** and the draft **Health and Wellbeing Strategy 2015-2018** are currently out for consultation. The importance of mental health and emotional wellbeing has been

1 Department of Health 2011: No Health Without Mental Health https://www.gov.uk/government/publications/the-mental-health-strategy-for-england
2 Department of Health 2014: Closing the Gap
3 HM Government 2014: Crisis Care Concordat http://www.crisiscareconcordat.org.uk/
4 Department of Health 2011: The Mental Health Promotion, Mental Health Prevention: Economic Case
5 Department of Health 2014: Chief Medical Officer Report on Public Mental Health
6 Department of Health 2011: Mental health promotion and mental illness prevention: The economic case https://www.gov.uk/government/publications/mental-health-promotion-and-mental-illness-prevention-the-economic-case

articulated throughout the Corporate Plan with a specific focus in Priorities 1 and 2 and it is defined as one of the three priorities in the Health and Wellbeing Strategy. Additionally, one of the proposed cross-cutting themes for the Corporate Plan is 'Working with Communities' – an approach to strengthen communities and support them to lead positive change and be more involved in service re-design and delivery.

The vision of **Haringey's Community Safety Partnership (CSP) Strategy 2013-17** is to make Haringey one of the safest boroughs in London. The CSP works closely with health and safeguarding partners to address alcohol, drugs and mental disabilities as critical drivers of offending, disorder and ill health across all crime types.

Tottenham is the most deprived area in the borough and has a high prevalence of mental ill health. **Tottenham's Strategic Regeneration Framework** – a landmark 20-year vision for the future of Tottenham – sets out how local people's priorities could be achieved through long-term regeneration including creating more opportunities for employment, affordable housing and making the place safe and pleasant to walk, cycle and play.

The Haringey Clinical Commissioning Group Five-Year Plan focuses on partnership working to deliver a major shift from provision of services from hospitals to primary and community care, whenever possible. Better management of people with mental ill health is dependent on strong primary care that takes an active part in early detection of cases but also management of those living with severe mental illness in the community. Haringey CCG, with their role in improving the quality of primary care, has been supporting practices to work together 'at scale' to run services more effectively, and organise themselves in a federation model. This might include seeing each other's patients, running call centres or sharing back office functions. These models encourage a mixing of skills and professionals to work together in one place or as part of one network e.g. welfare advice, nurses, health care assistants. This model could, in the future, include hubs with multidisciplinary primary care mental health teams in areas of greatest need.

The NHS North Central London (NCL) five-year strategic plan aligns the plans across Barnet, Camden, Enfield, Haringey and Islington Clinical Commissioning Groups and proposes stronger partnership with local authorities. The vision is to develop an integrated care network between organisations focused on outcomes with patients taking greater responsibility for their own health and accessing care appropriately. One of the focuses in the plan is supporting people with mental health needs.

Across North Central London, there are areas of excellent practice and some trusts (including BEH) are piloting these approaches. However, pathways and indicators used to monitor how 'good' services are delivered, need to be strengthened. There is a significant investment imbalance between preventative services and services for those in crisis, with the majority of resource directed at inpatient acute services and more generally at the higher end of need. Furthermore, the pattern of provision is not best equipped to respond to service user and carer wishes to ensure that their care is co-produced, personalised and responds to individual preferences and needs. As tariff, choice and personal budgets are being introduced locally; we need a reshaping of pathways to ensure these policies have positive and meaningful outcomes for people with mental health needs in Haringey.

NHS England and Clinical Commissioning Groups have a statutory duty[7] to work with local authorities to promote integrated health and social care, making person-centred coordinated health and social care the norm for people with multiple health problems, including mental ill-health. The London Borough of Haringey and Haringey CCG are progressing a structured approach to development and provision of integrated services. This work is led by the newly-established **Health and Social Care Integration Programme Board**. It will enable Haringey to achieve better outcomes for local people, improve the experience of service users and deliver efficiencies and value for money. Mental health and wellbeing is one of the main priorities identified for the integration, especially with a focus on commissioning and providing integrated enablement model and the integration of mental health and wellbeing services for children and young people.

Under the **Public Services (Social Value) Act**, all public bodies in England and Wales are required to consider how the services they commission and procure can improve the economic, social and environmental wellbeing of the area. 'Social value' is a way of adding further benefit to contracts where resources are being directed towards improving people's lives, opportunities and the environment. Commissioning and procuring for social value can help join up all the strategic aims of public services. Haringey Council, in partnership with the CCG is part of the national programme that aims to use the implementation of the Public Services (Social Value) Act 2012 as a catalyst for maximising social value through a cross sector partnership approach to health and care commissioning and delivery. We will pilot this approach on future commissioning and procurement of mental health and wellbeing services.

7 http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf, para 14Zi

5 LOCAL NEEDS AND SERVICE LANDSCAPE

This section summarises the mental health needs of Haringey's residents from various sources such as local Joint Strategic Needs Assessment on mental health in children, young people, adults and older people; Mental Health HaringeyStat; Public Health England's mental health profiles; NHS Benchmarking tools; Healthcare Information System (HCIS); local adult social care; Community Mental Health Profile 2014 and the CCG's and the Council's financial information. Full details are enclosed in Appendix III.

5.1 Local needs

Children and young people

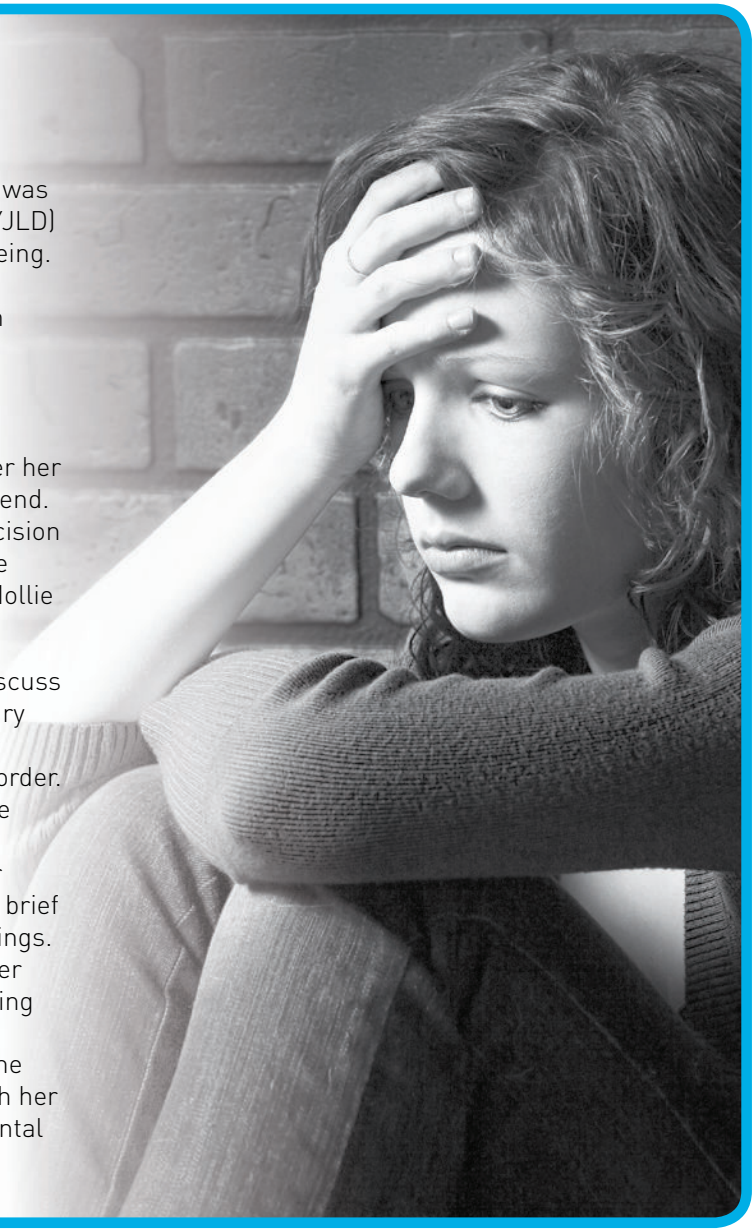
Some children and young people in Haringey may be at greater risk of developing mental health problems than those living elsewhere in London and nationally. This is attributed to the number of factors impacting on mental health such as lack of education, rates of offending, levels of deprivation, unemployment and children living in lone parent households. Mental health needs of children and young people are greater in the east part of the borough. The pyramid diagram below summarises the estimated prevalence and current service utilisation by children and young people in Haringey with mental ill health.

Case study: Mollie, 15 year old girl

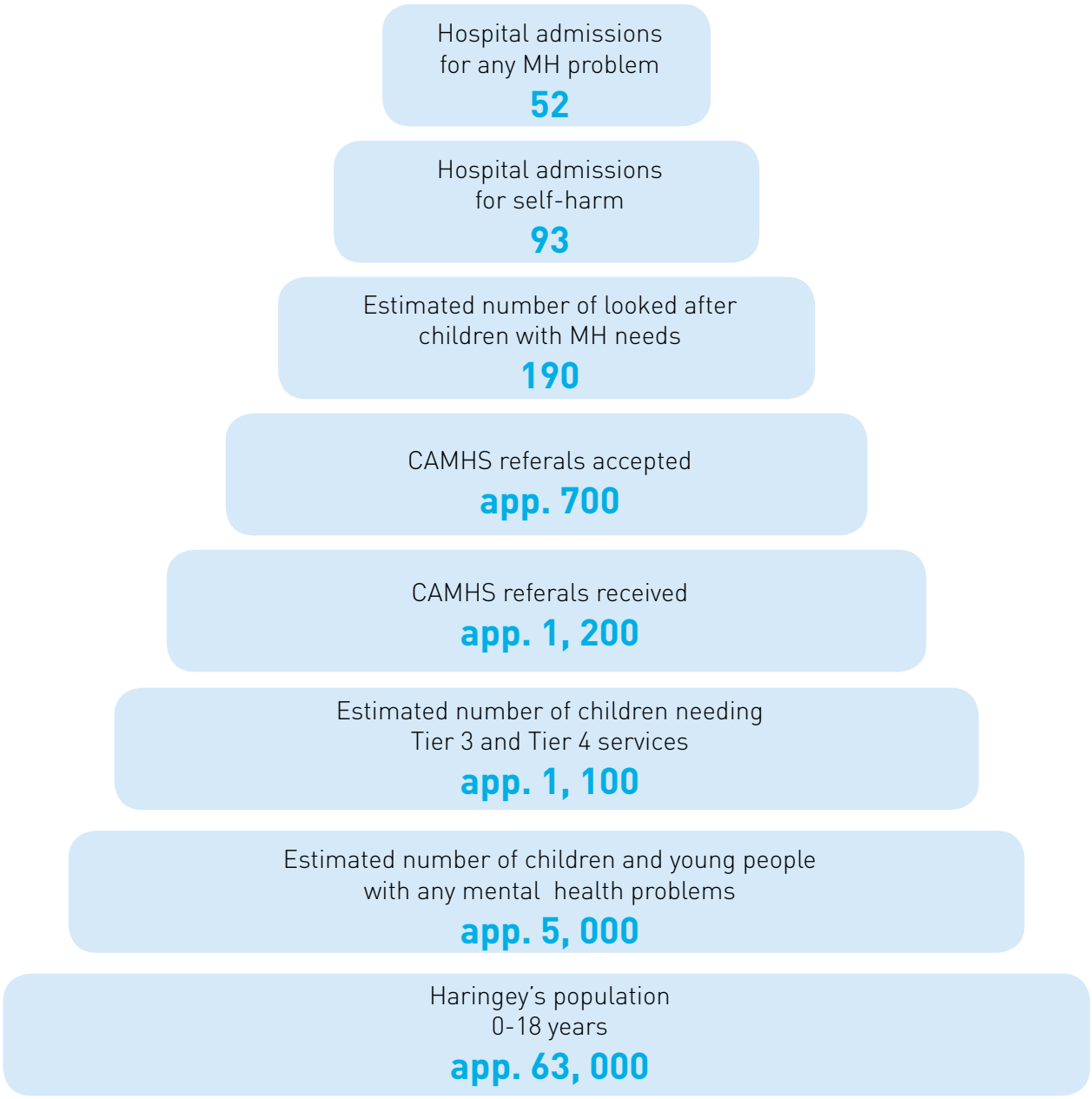
Mollie was arrested for common assault. She was triaged under Youth Crime Action Plan (YCAP) and was referred to a Youth Justice Liaison and Diversion (YJLD) worker for her mental health and emotional wellbeing. Through her interviews it was revealed Mollie had self harmed in the past and was having difficulty in managing her anger.

Mollie's grandfather passed away a year ago. She was very close to him, as she has never had any meaningful contact with her father. Quite soon after her grandfather's death Mollie was raped by her boyfriend. Even though police were involved at the time, a decision was made not to pursue the matter further and the assailant was subsequently only given a caution. Mollie is still very angry about the outcome.

The YJLD worker offered a series of sessions to discuss her issues and offer a way forward. An initial enquiry questionnaire was completed to establish whether Mollie was suffering with posttraumatic stress disorder. Mollie scored very high in this and has agreed to be referred on further for specialist help within Tier 2 service at the St Ann's Hospital to help her recover from her trauma. The YLJD worker also organised brief therapeutic sessions to explore her mood and feelings. She has learnt non-violent strategies to manage her anger. Mollie has kept herself out of trouble following the YJLD intervention. She completed her work experience last summer and is now back in full time education. The YJLD worker continues to meet with her fortnightly to monitor the situation and provide mental support when she needs.



Children and young people in Haringey with any mental health problems, 2013/14*



*Information used from different sources including Public Health England, CHiMAT, Haringey's JSNA, Census 2011 and children's social care.

Local data suggests that we have a higher number of referrals to CAMHS but a lower number of those seen by Tier 3 and Tier 4 services it is estimated by Public Health England (PHE).

PHE also estimated a higher prevalence of mental ill health in children and young people compared to England, in particular conduct disorders. Almost 50% of children with conduct disorders engage in crime activities by the age of 20 and are at higher risk of suicide and substance misuse[8].

Our local information on self-harm referrals in children and young people seems much lower than that reported anecdotally by schools, general practitioners and accident and emergency departments. It is therefore important to understand real need in local communities and focus on prevention, particularly in school settings.

Adults and older people

The risks to mental ill health in adults and older people vary by age, sex and ethnicity. The borough has high levels of factors impacting on mental ill health such as large proportion of ethnic minorities, deprivation, low levels of education, unemployment, substance misuse, violence and crime, social isolation and homelessness. These risk factors and mental health needs are greater in the east part of the borough.

The pyramid diagram below provides details of the estimated prevalence of mental ill health in adults and

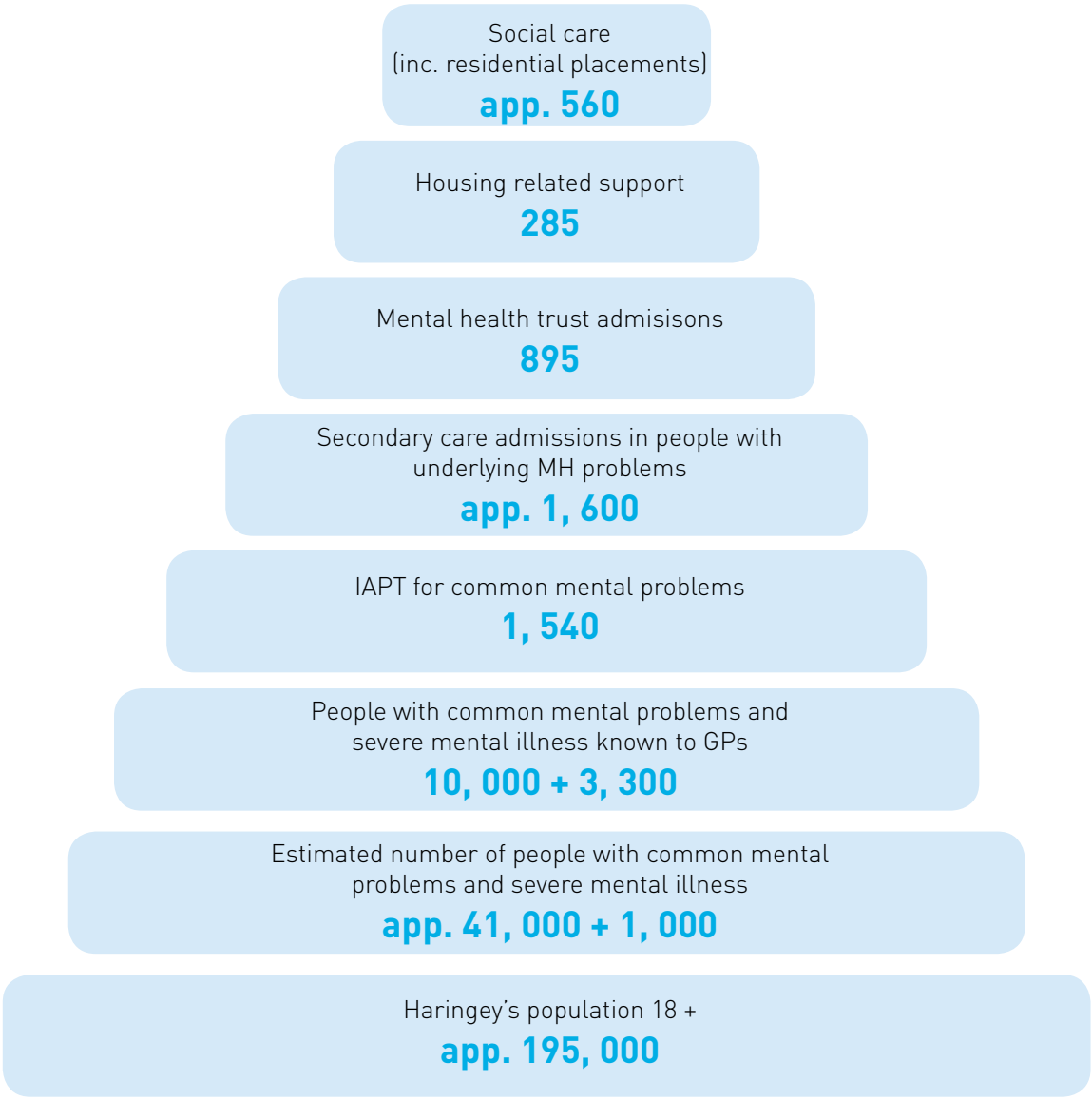
8 Friedli L and Parsonage M (2007): Mental health promotion: building an economic case

older people and their utilisation of services. Only one third of people living with mental ill health are known to health services. This is possibly due to the stigma and discrimination surrounding mental illness coupled with a lack of trust and understanding of how statutory health services work.

Undiagnosed depression is one of the main risk factors for suicide; these people are more likely to live in the east and central part of the borough. Haringey's suicide rates are higher than London and England, especially in men 30 to 45 years of age. About 26 Haringey residents commit suicide each year. The highest numbers of deaths by suicide are in men aged 25-44, living in east part of the borough.

Public Health England estimated that common mental disorders will be increasing over the next ten years by 25-30%. This is probably due to people living longer and in a more challenging economic climate.

Adults and older people with mental ill health in Haringey, 2013/14*



*Information used from different sources including Public Health England, Haringey's JSNA, Census 2011, adult social care and supported living activity data

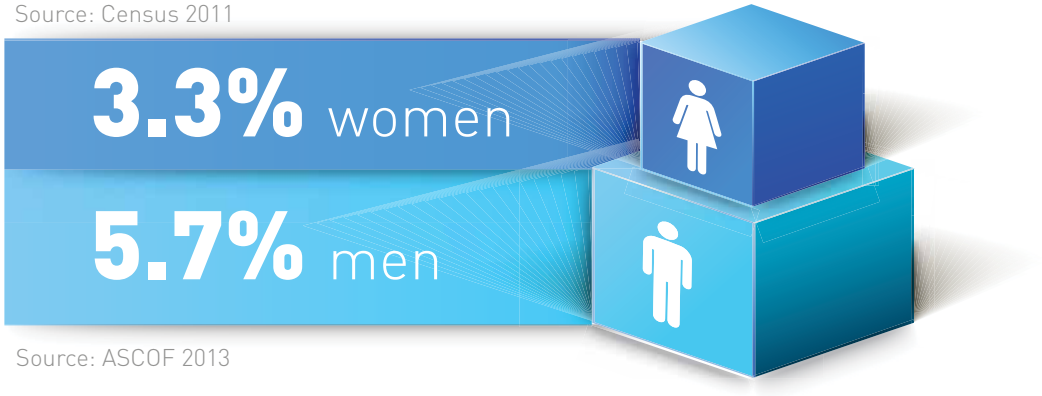
Local data from GP registers suggest that there are three times more people living with SMI than estimated; the 6th highest prevalence of SMI in London. People with SMI have complex care needs often requiring a number of different services at some point on their care pathway. They are at higher risk of dying earlier and are affected by lifestyle risk factors that often cause long term physical conditions. Local primary care information suggests that over 20% of people with SMI have diabetes, 44% are smokers and 34% are obese. This is coupled to a high number of admissions to the acute trusts for people with underlying mental ill health seeking care for their physical conditions.

In terms of understanding how people known to mental health services live in the community, it is important to note that only 65 per cent of people with care programme approaches were in settled accommodation and overall 3.9 per cent in employment in 2012/13.

People with severe mental illness known to mental health services and in employment

Haringey overall employment rate **69.1%**

Source: Census 2011



Source: ASCOF 2013

HaringeyStat on mental health identified a number of unmet mental health needs in high risk groups such as offenders, those of Black Caribbean and Black African origin, those with mental ill health and substance misuse, and young men.

Mental health and substance misuse problems are major public health and social issues. Studies suggest that dual diagnosis may affect between 30 and 70 per cent of those presenting to health and social care settings.

In Haringey, 28% of people who access mental health services also access drug misuse services, compared to 17% for England. This suggests higher prevalence of dual diagnosis locally.

It is important to note that one in three offenders on probation have either mental ill health, substance misuse or both. These cohorts of people are more likely to have late diagnosis of mental illness that often comes to light after the offence.

Case study: Esther, 27 year old woman

Esther was diagnosed with schizoaffective disorder following referral and assessment by the Community Forensic Mental Health Team. She had been under forensics due to offences pertaining to a series of assaults mostly on her mother and on some occasions, involving members of the public.

Due to her illness, her physical health was also affected and was monitored by her GP. Over the course of treatment, she put on 5 stones in weight and her thyroid and asthma started to become affected. It was very difficult for her to find the right medication that worked for her.

Working with a Community Psychiatric Nurse, Esther has now found the right medication and is slowly reducing it. In consultation with her GP, Esther developed weight management programme, she is now looking after her physical health and has lost 2 stones. Esther has gone through cognitive behavioural therapy (CBT) which was very positive. It enabled her to go back to university, where she is now in her final year. Currently Esther has a support plan along with wellness and recovery action plans that help her identify the early warning signs of poor mental health as well the plans and advise she can implement to prevent any deterioration or worsening of her condition.

5.2 Current service landscape

Our current local offer of services for people with mental ill health is based upon highly specialised hospitalised services, a few beds for recovery and rehabilitation, and high cost care packages and residential care. This offer does not always result in long-term improvement of health outcomes and it creates a community that is highly dependent on the services. Individuals are seldom supported to move on and have a fulfilling, independent life.

Furthermore, the current emphasis on the treatment at the severe end of illness rather than prevention and early help results in costly and inefficient commissioning of services that are often reactive and have limited impact on health outcomes.

Mental health services in Haringey are commissioned by Haringey CCG, NHS England (specialist services) and Haringey Council. Services are provided by a range of providers including Haringey Council, NHS Trusts, primary care, VCS and the independent sector.

The main provider of mental health services for Haringey is Barnet, Enfield and Haringey Mental Health Trust. Most of the current activity is commissioned in a block contract making it challenging to support the shift of resources to prevention and early help, or to develop further community based services.

Barnet Enfield and Haringey Mental Health NHS Trust (BEH MHT) provides a range of mental health services principally to the London Boroughs of Barnet, Enfield and Haringey. They provide a comprehensive range of services for children and young people working closely with the local authority (public health, education, youth justice and social care departments) and the voluntary and community sector.

BEH MHT Children and Adolescent Mental Health Services (CAMHS) are provided in the four-tier framework (Appendix I) and there is a single point of referral[9] for all children. Most referrals to CAMHS are from GPs, followed by schools and social services.

There is a variety of services provided in Tier 1 and Tier 2 ranging from interventions in the community, schools, and primary care and parenting initiatives provided by the Council. However, at present, there is no system in place to monitor comprehensively the referrals to Tier 1 and 2 and follow children and young people along the whole pathway. Appropriateness of referrals depends on the information being disseminated to all stakeholders and the communities. Commissioning arrangements for Tier 1 and Tier 2 services could also be better integrated to reduce duplication and improve efficiency. At present, over 40 services and interventions are being commissioned by schools, the Council, the CCG, the Public Health Department and a number of external agencies (Appendix I). Some of these services are general and include a component of mental health and wellbeing such as health visiting and school nursing. Other services provide a more targeted approach such as Open Door, a charity that provides counselling and psychotherapy to young people age 12-24. At present, there is no single directory of Tier 1 and Tier 2 services in Haringey that would enable full utilisation of this diverse offer. Also, fragmented provision arrangements make it challenging to consistently apply quality standards for commissioned services across the whole borough and in line with the national evidence and best practice.

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) is the main provider of nearly all specialist adults and older people mental health services in Haringey, including forensic services. The Trust services operate from over 30 locations across Barnet, Enfield and Haringey, some of them large hospital sites but most are small units in the community. Haringey's main site is at St. Ann's Hospital. The services available from the Trust in Haringey are described in more details in Appendix III. There were over 6,000 outpatient contacts and over 90,000 community contacts last year. Only a small proportion of these contacts are new patients suggesting that the Trust has a significant demand from patients with severe and enduring mental health problems that need a lot of support, coupled with a lack of capacity to discharge these patients safely into a variety of community settings, including adequate supported housing.

The Trust also provides substance misuse services and dual diagnosis services for Haringey residents while talking therapies in Haringey are provided by the Whittington Hospital.

The second largest provider of mental health services in the borough is Haringey Council which provides social worker input to Community Mental Health Services and day services. It also provides social care to people with severe mental illness such as domiciliary care, supported living, day care centres, home care, direct payments, personal budgets and adaptation equipment.

The Council also provides Clarendon Recovery College (CRC) aimed at assisting the recovery process for people with severe mental illness. There are currently 230 enrolled students who are seen by secondary mental health services. This service has been recently evaluated by Middlesex University and has been shown to be very effective in assisting people to move on, find appropriate employment and pursue further education.

Residential accommodation and supported housing is provided by a range of independent providers and some VCS, the majority of which are in east of the borough. A large proportion of residential care placements (40%) are being utilised by people living outside the borough although this figure has been decreasing recently. The independent sector and VCS also provide supported accommodation, floating support and domiciliary care.

Haringey has a number of supported living providers (mostly independent providers and some VCS), working with people with mental ill health that do not reach a threshold for social care support, including those funded through the Council's Housing Related Support.

9 Emotional wellbeing and mental health for children and young people in Haringey Needs Assessment 2011

It typically provides the service user with a flat or shared housing within a warden controlled scheme. Schemes vary in terms of the level of support provided to cater for a wide ranging level of user need. Including Supporting People funded schemes; there are 13 main providers of supported living, offering around 285 places.

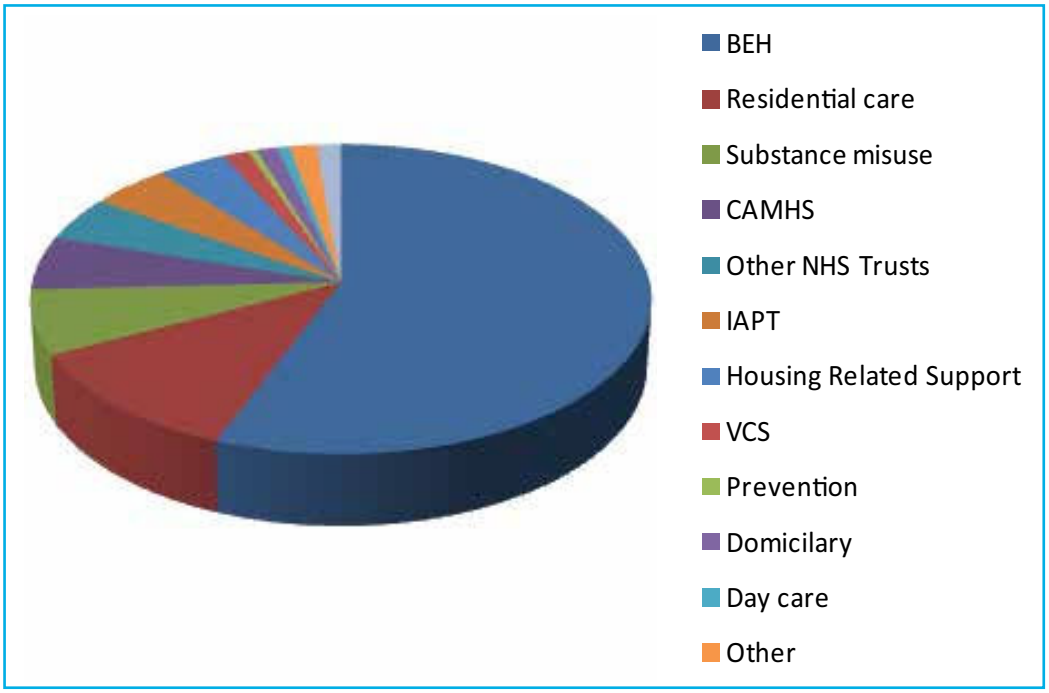
Mental Health and Wellbeing prevention and promotion interventions are largely commissioned by Council's Public Health team. These include awareness raising and training in schools, tackling stigma and discrimination in the community (such as interventions targeting specific risk groups such as Turkish and Kurdish men) and digital peer support for mild to moderate anxiety and depression.

Information and advocacy services are provided by a range of VCS in the borough. These arrangements will be reviewed in the near future to align this offer with Care Act 2014 requirements.

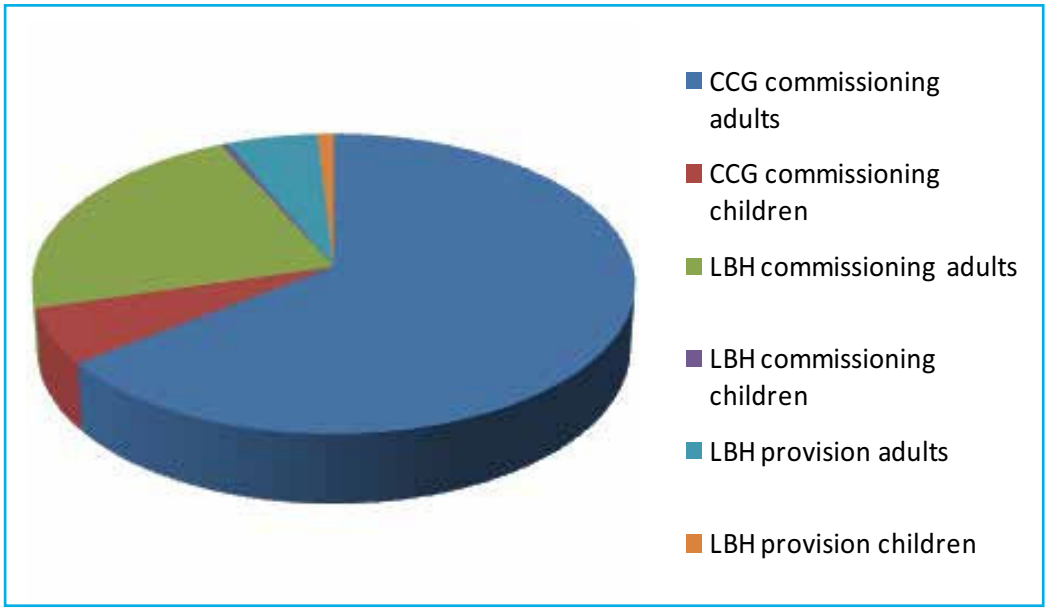
5.3 Total spend on mental health services

Total spend on mental health in Haringey (including substance misuse) for 2013-14 was over £51m. This equates to 11% of the total CCG budget and 6% of the Council's budget. Below is a chart describing total spend by services and total budgets by commissioners.

Total spend on mental health in Haringey in 2013/14 by services



Total spend on mental health in Haringey 2013/14 for the CCG and L



Benchmarking data from various sources suggests that spend on residential care, housing related support, children's and young people mental health, specialist adult mental health services (forensic services), prescribing on psychosis in primary care and the overall spend on secondary mental health per head of population is higher in Haringey compared to England.

Expenditure on community mental health teams and outreach services per head of the population is lower than England's average. This information should be treated with caution as the quality of data depends on accurate and complete returns. However, the overall trend analyses suggest that local spend is highest at the severe top end of the pathway (secondary care, residential placement and supported housing) while there is underinvestment in outreach and community services. Furthermore, lower spend in secondary care for people with psychosis coupled with high spend in primary care for the same cohort of patients suggest that, probably due to high demand, these people are more likely to be cared for in the community.

Considering that the Council's and other partners investments' are indirectly related to tackling root causes of mental ill health (such as employment, affordable housing, community safety and clean and safe environment), it is likely that the overall spend on tackling mental ill health in Haringey is much higher than could be easily quantified.

6 WHAT GOOD LOOKS LIKE?

National evidence suggests that access to effective care for people with mental illnesses is only available to approximately 30 per cent of those that need it, and that standards of care across the country vary greatly[10]. Even though 50% of all mental illness starts before age of 14, investment in prevention and early identification and in children and young people's services is limited .

Effective mental health services should represent a continuum from prevention, promotion and early help through primary care, secondary care and highly specialised services. It should ideally be delivered through an enablement model in collaboration with a range of partners and service users. The model should be based on individual, family and community assets and designed to promote social connectivity and reduce isolation. However, currently the pathways, often being very complex, are delivered disjointedly, resulting in fragmentation of care for patients and carers. Patients, GPs and other professionals have found access to services difficult and management across interfaces and boundaries unachievable.

Over the last few years, there has been a focus on building a body of evidence on what integrated and modern mental health and wellbeing services should look like. The Joint Commissioning Panel for Mental Health, the London Strategic Mental Health Network and the National Institute of Clinical Excellence have published a series of commissioning guides, quality standards and guidelines to assist commissioners and providers at the local level in transforming mental health services across the life course. Brief summary of wealth of national evidence is enclosed in Appendix IV.

In Haringey, we are committed to using robust evidence to transform services to be more effective, to improving quality and outcomes and to offer best value for money.

Based on the evidence, it is proposed that Haringey's whole system mental health and wellbeing model contains the following components:

- **A better start in life** – ensuring that services for 0-5 year olds support lifelong mental health and wellbeing, by promoting emotional and social resilience and strong and positive parental attachment;
- **Promotion of mental health and wellbeing for all children and young people**, working with schools and other parts of the community to ensure there is early intervention as well as support for ongoing emotional and social development;
- **A prevention and early help offer based on working with communities** to build emotional resilience, to tackle root causes of mental illness such as unemployment, low levels of education and reduce social isolation, stigma and discrimination;
- **Integration of mental health and wellbeing aims** into the delivery of major regeneration and development in the borough – particularly through ensuring that more residents are able to live in good quality accommodation, access stable employment and to have attractive places for walking, cycling and children's play;
- **Effective, evidence based primary care mental health services** - models focusing on multidisciplinary teams based in communities and arranged as 'hubs'. The aim of these teams would be to manage people with stable and ongoing mental ill health holistically as a part of their social system and network to support enablement and independent life. One of the leading roles of primary care mental health is to support people with long-term conditions to manage their mental ill health and also for those with mental ill health to manage their physical health effectively.
- **Secondary and specialist services** that are

10 Joint Commissioning Panel for Mental Health: Practical Mental Health Commissioning (2011)

commissioned based on the outcomes, with co-ordinated single point of entry with information about services, waiting times and support to access services readily available to service users, carers and professionals. Referral and treatment pathways should be clear and transparent and arranged around nationally defined clustered funded by Mental Health Tariff.

- **A whole system approach to integration and enablement** that include:
  - Integrated commissioning and service provision of Child and Adolescent Mental Health Services across all tiers;
  - Integrated commissioning which supports integrated delivery, through value based commissioning and by exploring whole system approaches to creating a more joined up system;
  - Integrated service provision between the mental health trust, social care, residential care, housing related support and primary care, including through multi-disciplinary hubs, to support a more seamless service for users;
  - Effective pathways into employment and housing for those with mental ill health, based on the evidence;

7 PROPOSED PRINCIPLES AND PRIORITIES FOR ACTION

The aim of the Framework is to mobilise effective, whole system partnership working to deliver integrated pathways for mental health and wellbeing that will improve the outcomes of our residents. We recognise that such an ambitious task is complex and will take time. We therefore set principles that we would embed in our work while we are approaching major transformation of services:

Proposed Principles

- Working together in partnership to co-design services with residents;
- Offer person-centred services based on individual choice that is reflected in commissioning
- Promote assets based approach and interventions that build on individual, families and community strengths at every level
- Strive for quality and right services at right time
- Commission and deliver efficient and effective services based on robust evidence on what works
- Integrate commissioning and delivery of services, whenever possible, where those with mental ill health, their families and carers feel supported

This set of principles will underpin our approach to the delivery of the four main priorities that we are focusing on over the next three years. These priorities are informed by the national and local policy context, evidence review, needs of our population and local expertise. Below is a brief rationale for these priorities. Detailed recommendations for actions are enclosed in Appendix V.

Priority 1: Promoting mental health and wellbeing and preventing mental ill health across all ages

Why is this priority?

Current resources are locally directed towards the higher end severe mental health needs. This model of care is not sustainable and it does not improve outcomes. There is a strong financial case for shifting some of the resources towards prevention and tackling root causes of mental ill health on a universal basis. This would include access to good housing, work and leisure facilities, and for children and young people, particularly through schools. Additionally, there is a significant number of children, young people and adults living with mental ill health in the community who are not accessing services. We need to tackle stigma, provide better information on the existing interventions and promote benefits of early access to services.

What are we going to do about it?

We will establish a baseline on mental health and wellbeing in Haringey by commissioning a community based survey. This would give us a good basis for monitoring the effectiveness of any interventions over the life of the Framework. We will also work on raising awareness, by providing better information on existing services and tackling stigma through working together with community leaders. This priority will focus on developing resilience at the individual, family and community level. This priority will also include interventions aimed to prevent suicide in Haringey.

Priority 2: Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments, by focusing on transition into adulthood

Why is this priority?

Good mental health and wellbeing starts from conception and continues into early years. Given that Haringey is a borough with stark inequalities and many risk factors for developing mental ill health, it is important to focus on giving children the best start in life and then support those who have emotional or mental health concerns as early as possible. It is estimated that we have a higher number of children with mental ill health and a high number of children at risk, including children in care. Our services are fragmented and not necessarily co-ordinated in best possible way.

What are we going to do about it?

We will use evidence from the recent Overview and Scrutiny review to inform planning on the transition pathways between adolescent and adult services. By working in partnership with other family services in the community, we will develop quality standards based on the evidence to support commissioning of children and young people mental and emotional wellbeing interventions by schools and other organisations and develop clear pathways across Tier 1 to Tier 4.

Priority 3: Improving mental health outcomes of adults and older people by focusing on the three main areas:

- ➔ meeting the needs of those most at risk;
- ➔ improving care for people in mental health crisis;
- ➔ improving the physical health of those with mental-ill health and vice versa;

Why is this priority?

Haringey has a large number of those at highest risk of developing mental ill health such as offenders, children in care, young people and adults with substance misuse, a large proportion of BMEs, homeless, older people and those who are socially isolated. These groups of people are often accessing services late when they are acutely ill and have worse outcomes.

It is a national priority to strengthen services for those who are in crisis and work has started to implement Crisis Care Concordat locally. Both LBH and the CCG have signed the local concordat.

Finally, people with serious mental illness are more likely to die early and have poor physical health. We are committed to tackle those inequalities and work on parity of esteem.

What are we going to do about it?

We will explore how to improve access to people who are at high risk of mental ill health by strengthening pathways between primary care and mental health services and establish fast-track for those most at risk, including people in crisis.

We will develop a Crisis Concordat action plan in partnership with a wide range of stakeholders and also develop suicide post-vention interventions to help individuals, communities and families to deal with aftermath of suicides/attempted suicides.

We will strive to further improve relationships between mental health service users, primary care (especially GPs) and secondary care services and ensure that people with mental ill health are followed up more regularly in primary care. Care co-ordinators can play important role in promoting physical health in those with mental ill health.

Priority 4: Commissioning and delivering an integrated enablement model which uses individuals, families and communities' assets as an approach to support those living with mental illness to lead fulfilling lives

Why is this priority?

At present, the mental health care model focuses on high cost secondary and residential care with under-investment in community mental health teams and outreach services. People stay longer in hospital even if they are clinically fit to be discharged due to complex pathways for securing accommodation and care support. We need to radically change the way we care for people with mental ill health in the community, help individuals to be able to achieve their goals and provide opportunities for adequate employment, affordable housing and timely care packages. We also need to reconnect people into communities to better achieve their potential.

What are we going to do about it?

We will integrate at both levels, commissioning and provision of services to develop an enablement model where people will receive seamless holistic care that focuses on their social problems at the same time as providing ongoing and stable clinical treatment. GPs and care co-ordinators will be at the centre of this model supported by a range of providers such as housing associations, jobcentre plus, VCS and independent sector. We will link this work with Tottenham regeneration to create safer environments in the community as part of wellbeing and work on reducing stigma and discrimination.

8 RECOMMENDATIONS FOR ACTIONS, TIMESCALES AND MONITORING ARRANGEMENTS

Governance for ensuring implementation of the Framework will be via the Health and Wellbeing Board Delivery Group for Mental Health and Wellbeing Outcome Three. Support will be provided by both the Mental Health Expert Reference Group and the Children's Partnership Board.

The impact of the proposed outcomes and priorities will be monitored regularly. A draft National Mental Health Services Dashboard illustrating a set of indicators aimed at monitoring six outcomes is enclosed in Appendix II.

Appendices

Appendix I: Development process and governance framework

This Appendix sets out the process for developing the Mental Health and Wellbeing Framework and how the process will be governed. The final framework will be approved by the Health and Wellbeing (HWB) Board which has senior representation from the council, Clinical Commissioning Group (CCG), Healthwatch and the voluntary sector. Before the final framework is sent to the Health and Wellbeing Board, we are planning the following process:

1. A draft framework will be co-produced by an expert reference group. The expert group will consist of one or two representatives from the following groups:

- Users of mental health service and carers of people with mental health needs (representatives drawn from the Adult Partnership Board and its sub-groups).
- Local voluntary sector organisations that specialise in mental health care
- Local providers from independent sector
- Clinicians from the Barnet, Enfield and Haringey Mental Health Trust
- GPs or other primary care practitioners as providers of primary care and GPs as commissioners
- Public health
- Senior council officers managing social workers in the Mental Health Teams
- Commissioning managers from the council
- Commissioning managers from the CCG

The expert group is expected to meet 2-3 times to develop the draft framework.

2. The draft framework will then be consulted on more widely in the following ways:

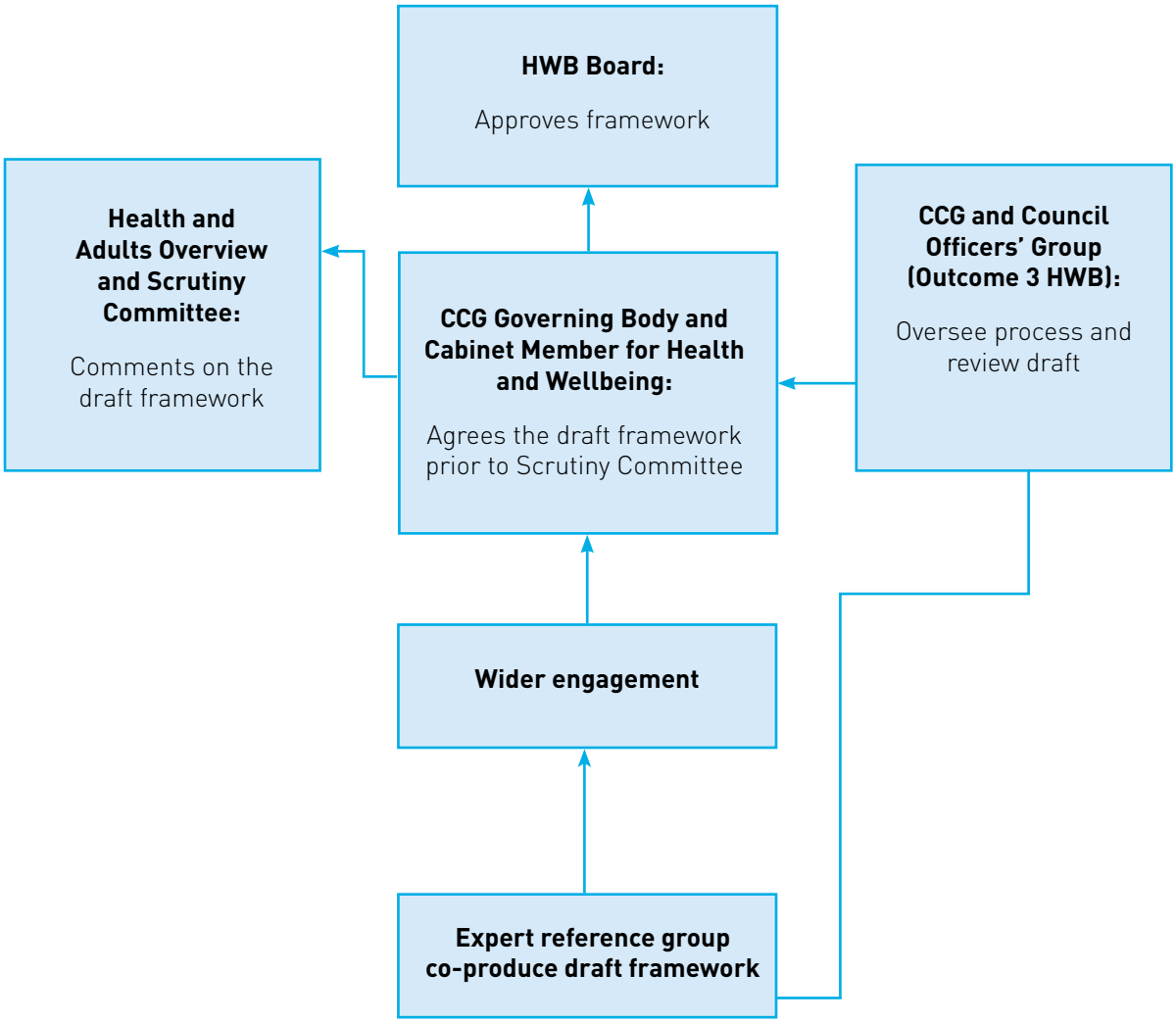
- Commissioners will write to all local providers of mental health services and other services commonly used by people with mental health needs and ask them to comment on the framework;
- Commissioners will meet with wider groups of carers and service users to get their comments;
- The draft framework will be taken to the CCG's Governing Body, GP Collaboratives and Cabinet Member for Health and Adult Services for agreement that the document can be taken to Adults and Health Overview and Scrutiny Committee;
- The draft framework will then be discussed at Scrutiny before being sent to the HWB Board for final approval.

3. The process will be overseen by a Council and CCG officers' group (called the Health and Wellbeing Outcome Three Group) chaired by the Director of Commissioning at the CCG. The role of this group is to:

- Ensure that the process described above is followed;
- Review the draft framework to ensure that it is aligned with existing council and CCG strategic priorities and deliverable within available resources.

The process and governance is shown as a diagram below:

Governance of the development of the Haringey Mental Health and Wellbeing Framework



Appendix II: National Mental Health Dashboard

PHOF-Public Health Outcomes Framework; MHMDS-Mental Health Minimum Data Set; NHSOF – NHS Outcomes Framework; ASCOF-Adult Social Care Outcomes Framework

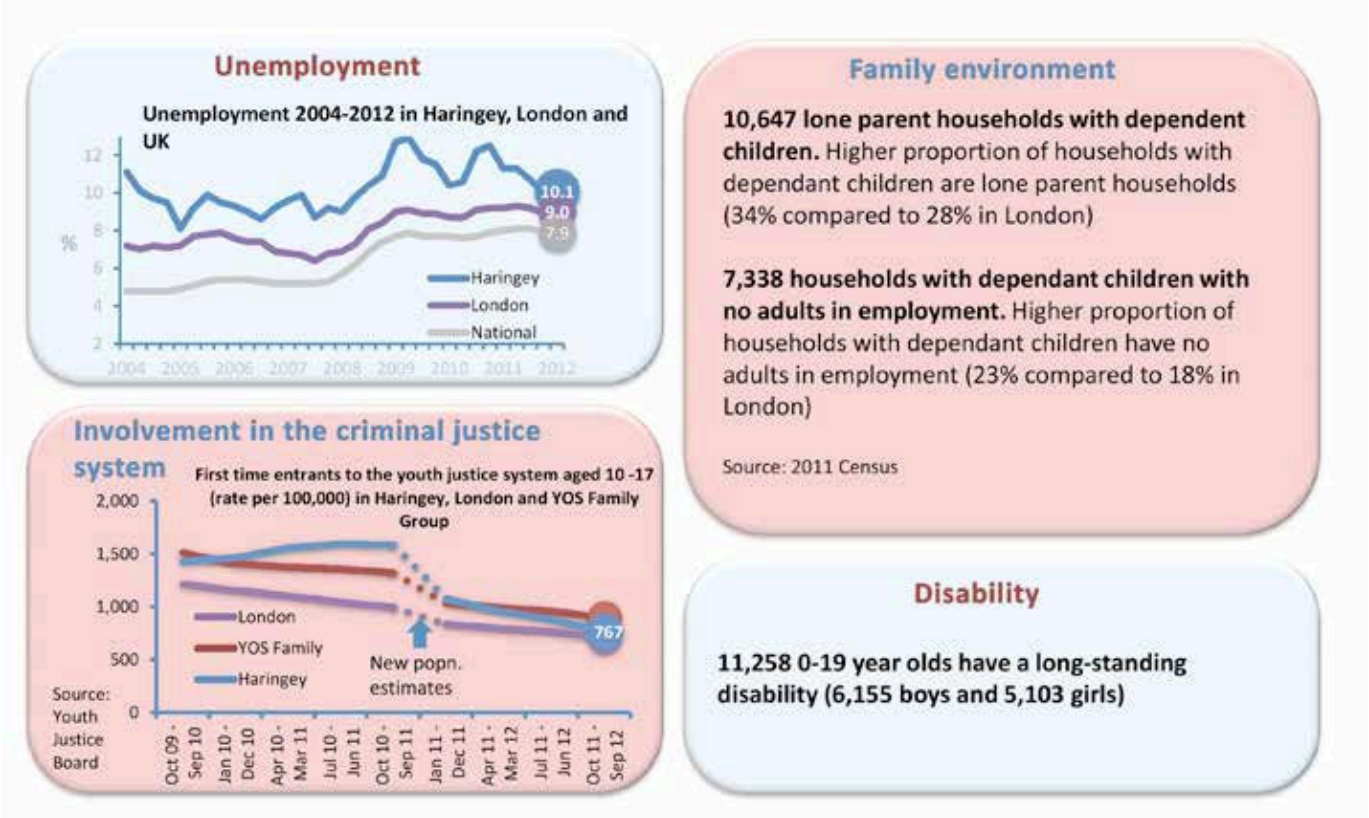
More people have better mental health	More people with mental health problems will recover	Better physical health
WHOLE POPULATION **Self-reported wellbeing (PHOF)** **Self-reported of children and young people** **Prevalence of MH problems** Possible mental health problems (HSE) Long-term mental health problems (HSE) Days lost due to common mental illness (LFS) WIDER DETERMINANT **Homelessness (PHOF)** **Absolute low income (HBAI)** Illicit drug use Social isolation Child development at 2, 2.5 years (PHOF, Placeholder)	CARE AND TREATMENT Improving access to psychological therapies (IAPT, NHS OF) Access to IAPT Recovery rates Patient outcomes following Children and Adolescent Mental Health Services (CAMHS) Treatment outcomes for people with severe mental illness RECOVERY AND QUALITY OF LIFE Employment of people with mental Illness (NHS OF) People with mental illness or disability in settled accommodation (PHOF). The proportion of people who use services who have control over their daily life (ASCOF) IAPT Recovery Rate (IAPT Programme)	Excess under 75 mortality rate in adults with severe mental illness (NHS QF & PHOF, Placeholder).
More people have positive experience of care and support	**Fewer people will suffer avoidable harm**	**Fewer people will experience stigma and discrimination**
Patient experience of community mental health service (NHS OF). Overall satisfaction of people who use services with their care and support (ASCOF). The proportion of people who use series who say that those services have made them feel safe and secure (ASCOF) Proportion of people feeling supported to manage their condition (NHS OF). Indicator to be derived from Children's Patient Experience questionnaire.	Safety incidents reported. (NHS OF) Safety incidents involving severe harm or death (NHS OF) Hospital admissions are a result of self harm (PHOF). Suicide (PHOF) Absence without leave of detained patients (MHMDS)	National Attitudes to Mental Health survey (Time to Change) Press cutting and broadcast media analysis of stigma (Time To Change) National Viewpoint Survey – discrimination experienced by people with MH problems (Time To Change)

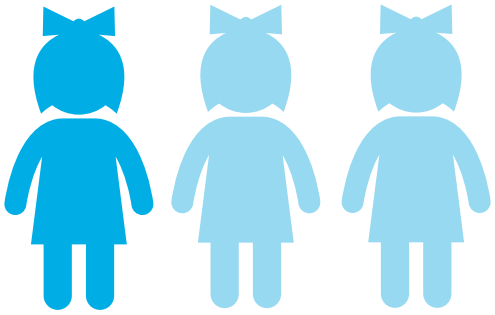
Appendix III – Mental Health Needs and Service Landscape

This section summarises the mental health needs of Haringey's residents from various sources such as local Joint Strategic Needs Assessment on mental ill health in children, young people, adults and older people; Mental Health HaringeyStat; Public Health England's mental health profiles; NHS Benchmarking tools; Healthcare Information System (HCIS); local adult social care; Community Mental Health Profile 2014 and the CCG's and the Council's financial information.

Children and Young People

Factors influencing mental health and wellbeing





One child in **three** live in poverty

Mental ill health

It is estimated that approximately 4, 600 children and young people 5-16 years of age have mental health concerns locally. Below is table that summarises various conditions.

Estimated prevalence of any mental health concerns in children and young people 5-16 years of age

Condition	Prevalence	Estimate
Emotional disorder	3.9%	1463
Conduct disorder	6.6%	2288
Hyperkinetic disorder (ADHD)	1.6%	600
Less common disorder	0.7%	262

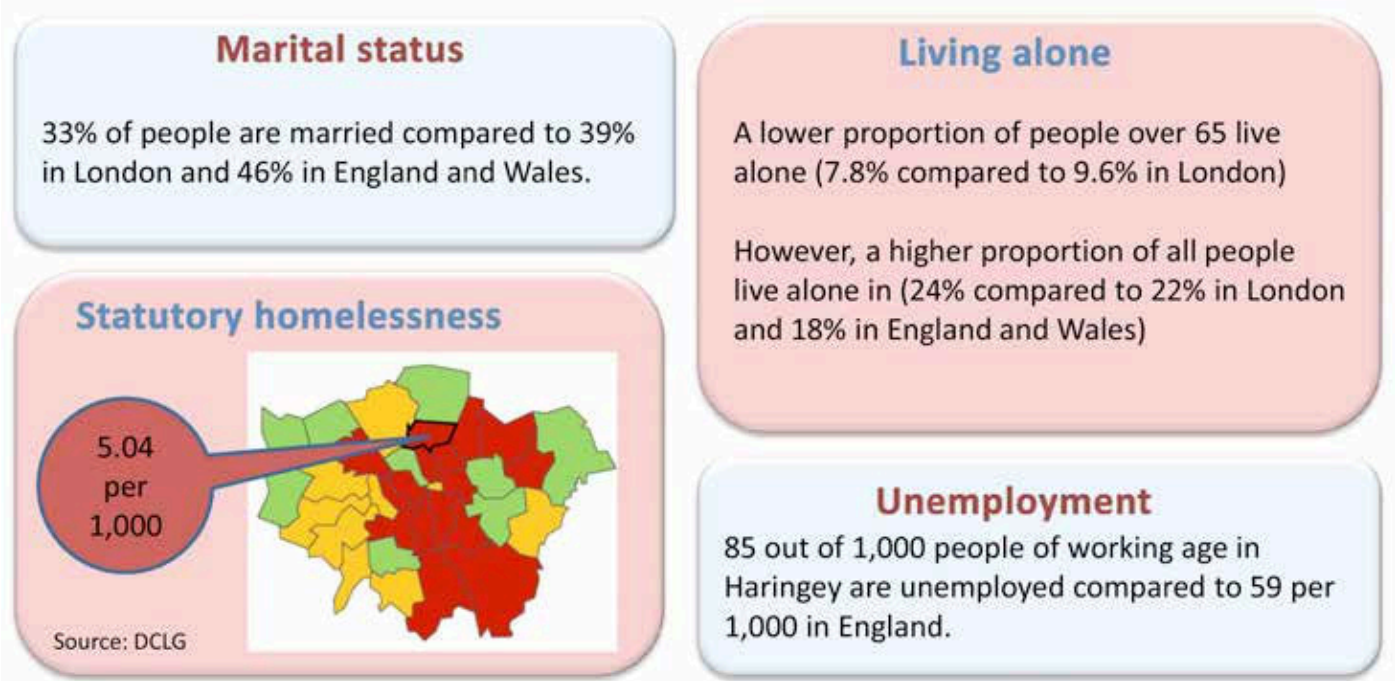
Source: Public Health England CYP Profile and 2011 Census

Children in the care of local authorities are at particular risk of mental ill health. At the end of March 2014, there were 511 looked after children. Of those 50% were without any concerns, 13% had borderline mental health concerns and 37% had mental health concerns, as identified by the Strengths and Difficulties Questionnaire (SDQ) screening tool.

Young offenders are at high risk of suffering mental ill health. It is estimated that up to 40 per cent of young people in the youth justice system have mental ill health. The rate for first time entrants to the youth justice system in Haringey (417 per 100,000) was similar to London and England.

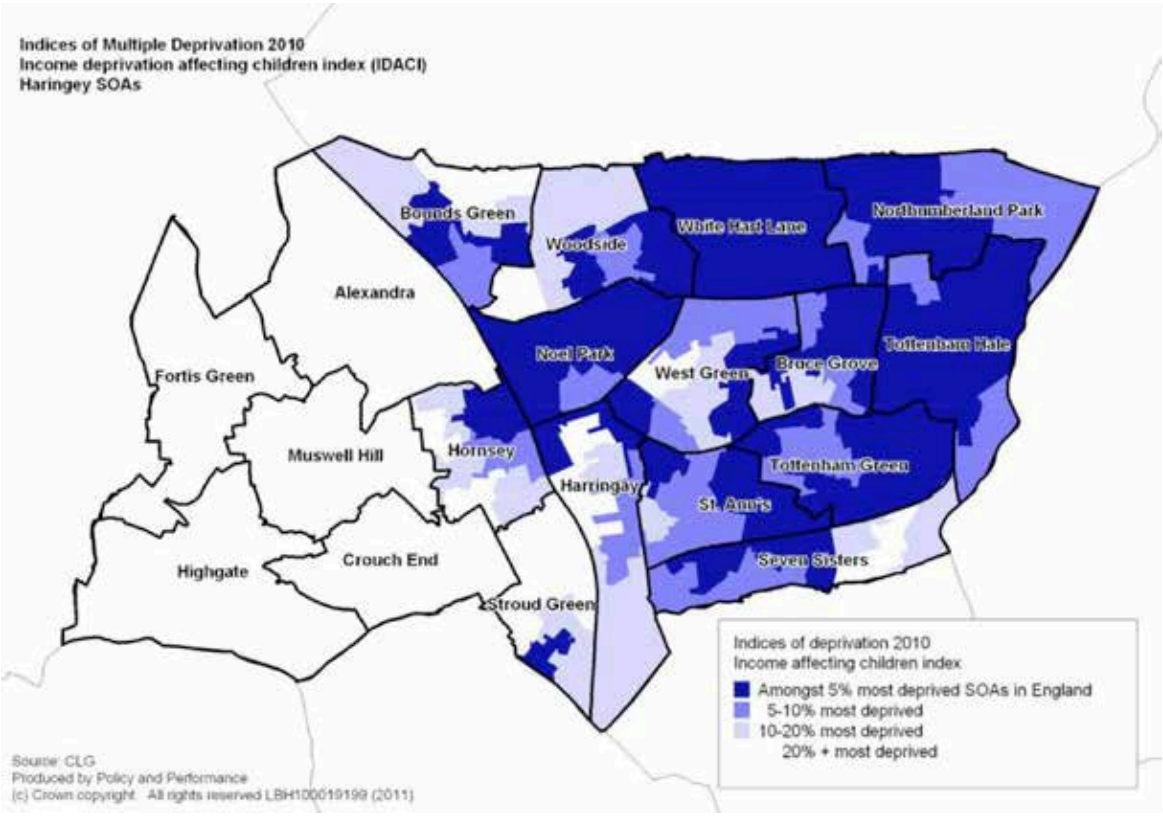
Adults and older people

Factors influencing mental health and wellbeing

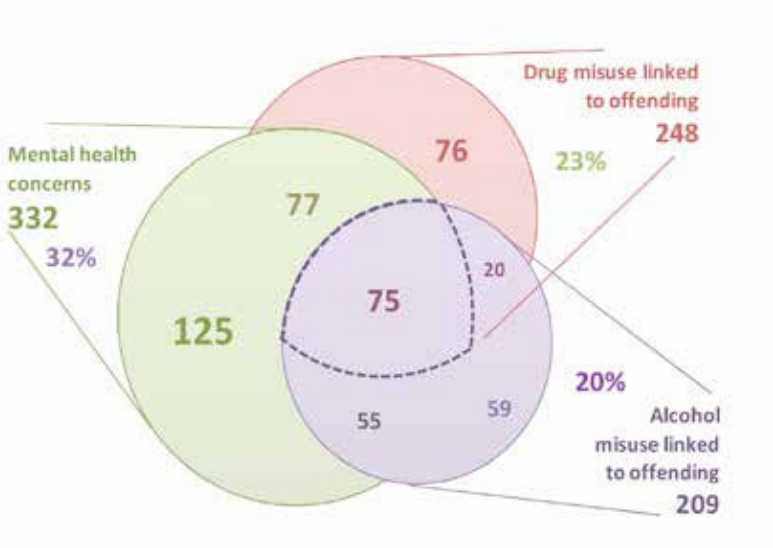


Haringey is 4th most deprived borough in London and unemployment rates are still high, especially in younger age groups. Almost 2,000 adults are claiming job seekers allowance and 48% of those have mental health behavioural disorders. Estimated 27 per cent adults have no qualification or level one qualifications and a high proportion of those under 65 years of age live alone. On the other hand, borough has significantly higher household crowding (16.3%) and households living in rented accommodation (58.2%) compared to London and national figures. Five in every 1,000 residents are homeless and statutory homelessness (5.8%) is significantly higher than London (3.9%) and nationally (2.3%).

Employment and support allowance claimants in Haringey whose condition in mental and behavioural disorders



Key issues linked to offending (Of the 1062 statutory offenders commencing probation Sept - Aug 2011/12

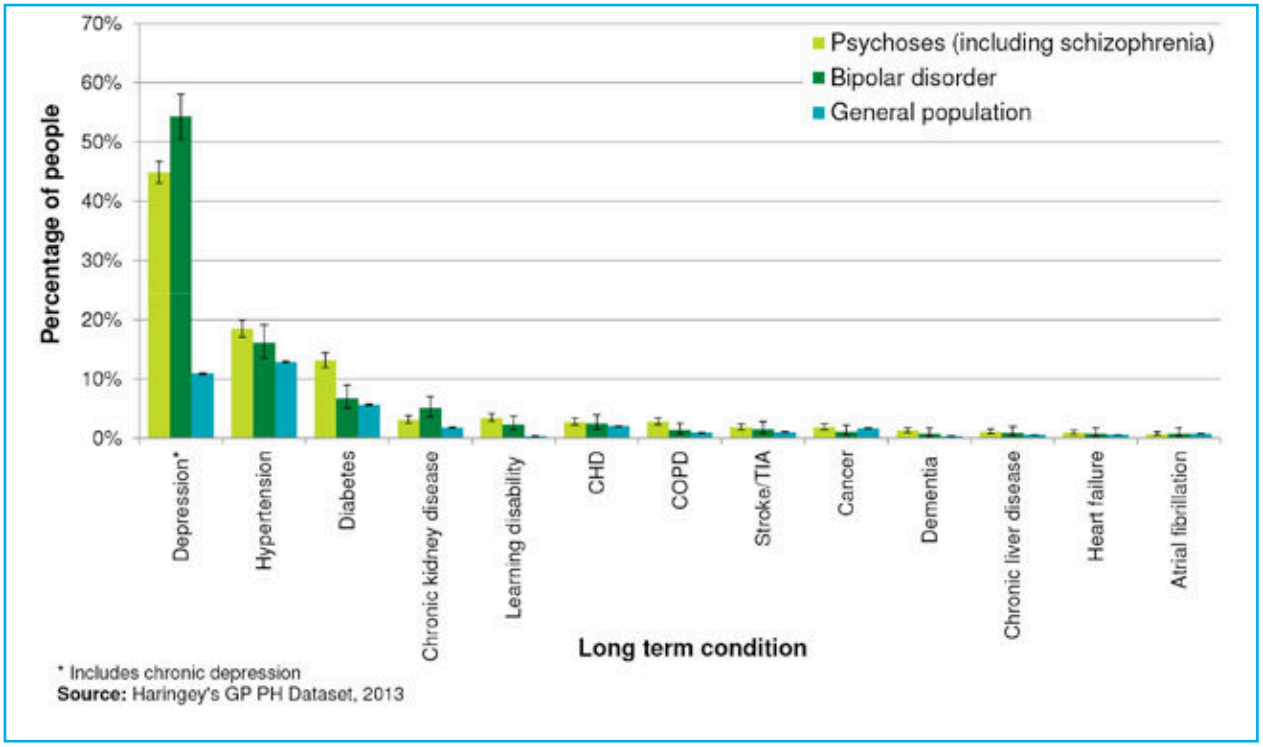


207 offenders (19.5%) had mental health problems and substance misuse problems

In Haringey, 28% of people who access mental health services also access drug misuse services compared to 17% in England. This suggests higher prevalence of dual diagnosis locally.

Mental health problems are associated with long term physical conditions. Graph below suggests that a large proportion of people with SMI have one or more long-term conditions.

Prevalence of long term conditions among people diagnosed with serious mental illness compared to Haringey's registered population

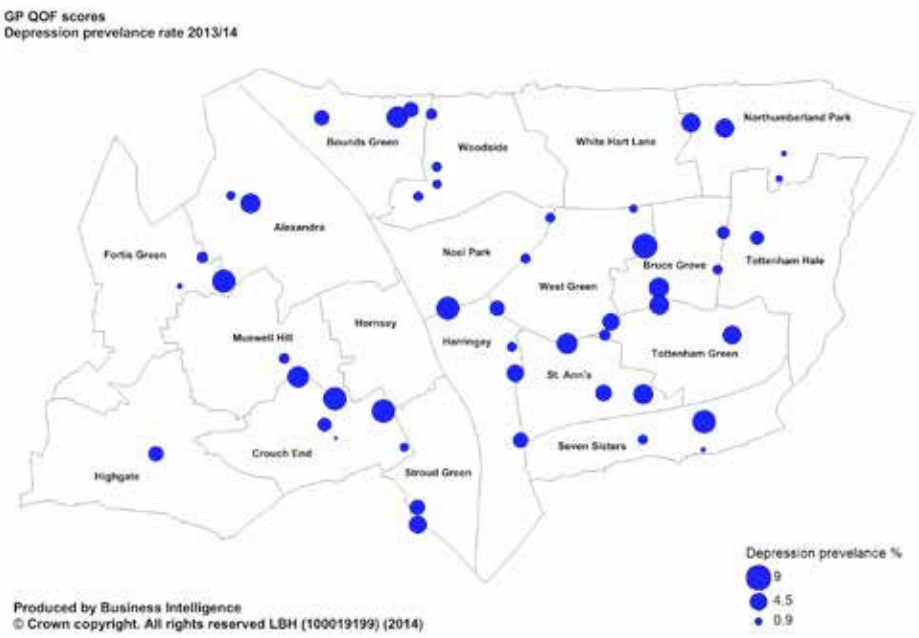


Source: Camden and Islington Public Health Intelligence

Mental ill health

Locally there are over 41, 000 adults (16-74 year olds) who are estimated to have a common mental health disorder. Of those, only 9,452 adults with depression known to Haringey GPs and 1,184 adults have a new diagnosis of depression (QOF 2013-14) . It is estimated that this will rise by 26% in 2021.

Diagnosis of depression by Haringey GPs



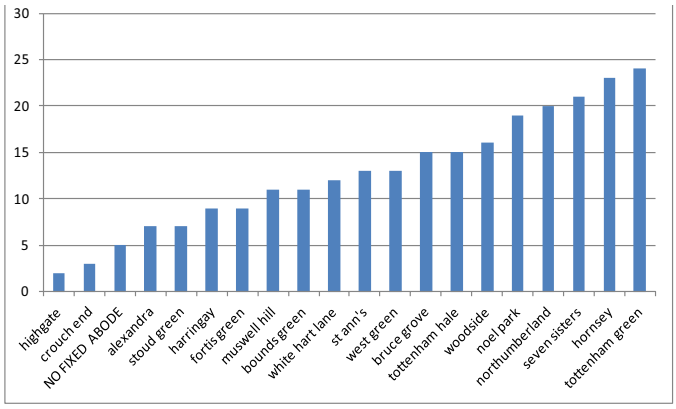
Source: Haringey JSNA

In March 2014, 10.4 per cent (300) people entered Improved Access to Psychological Therapies (IAPT) services as a proportion of those estimated to have anxiety and/or depression and 39.4 per cent (65) have completed IAPT treatment and 'moving to recovery[11]' . This figure is lower than expected national standard and particularly low for people over 64 years of age.

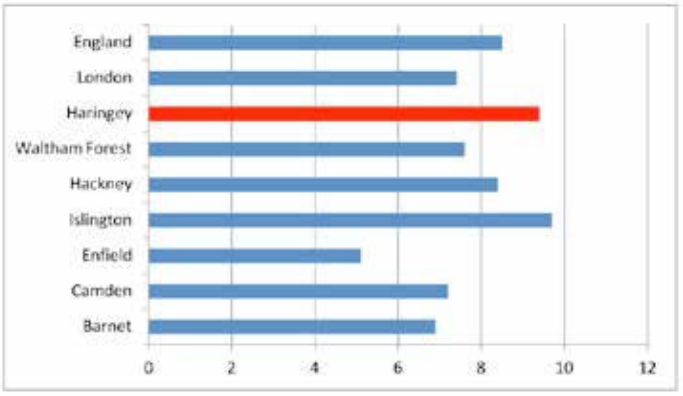
Haringey's suicide rates are higher than London and England, especially in men 30 to 45 years of age. About 26 Haringey residents commit suicide each year. The highest numbers of deaths by suicide are in men aged 25-44. In the last 10 years, 62% of suicides were people born in the UK compared to 34% born abroad (Haringey's Suicide Audit).

11 Health and Social Care Information Centre: Quality and Outcomes Framework, October 2014

Suicides by ward 2002-2012



Suicide rates by 100, 000 population, by borough



Clustering Outcome - Haringey Ccg (Based On Current Caseload As At 2 Dec 2014)

		Number of Registered Service Users			Proportion of Registered Service Users	
		Services Users on CPA	Services Users Not on CPA	Total Service Users	% Services Users with CPA	% Services Users Without CPA
CCG - HARINGEY						
1	Common mental health problems (low severity)		5	5	0%	100%
2	Common mental health problems		10	10	0%	100%
3	Non-psychotic (moderate severity)	12	57	69	17%	83%
4	Non-psychotic (severe)	13	68	81	16%	84%
5	Non-psychotic (very severe)	34	113	147	23%	77%
6	Non-psychotic disorders of overvalued Ideas	9	50	59	15%	85%
7	Enduring non-psychotic disorders (high disability)	72	275	347	21%	79%
8	Non-psychotic chaotic and challenging disorders	22	68	90	24%	76%
10	First episode in psychosis	131	15	146	90%	10%
11	Ongoing recurrent psychosis (low symptoms)	378	179	557	68%	32%
12	Ongoing or recurrent psychosis (high disability)	318	48	366	87%	13%
13	Ongoing or recurrent psychosis (high symptom and disability)	258	127	385	67%	33%
14	Psychotic crisis	14	10	24	58%	42%
15	Severe psychotic depression	1	3	4	25%	75%
16	Dual diagnosis (substance abuse and mental illness)	5	6	11	45%	55%
17	Psychosis and affective disorder difficult to engage	24	8	32	75%	25%
18	Cognitive impairment (low need)	7	329	336	2%	98%
19	Cognitive impairment or dementia (moderate need)	18	135	153	12%	88%
20	Cognitive impairment or dementia (high need)	14	44	58	24%	76%
21	Cognitive impairment or dementia (high physical or engagement)	6	9	15	40%	60%
Sub Total		**1336**	**1559**	**2895**	**46%**	**54%**

Haringey has high levels of severe and enduring mental illness, the 6th highest prevalence (1.3%) of serious mental illness (SMI) in London; 82 per cent (2,900) are diagnosed with psychoses and 18 per cent (650) with bipolar disorders[12] . Men have higher prevalence than women and men from Black and Ethnic Minority Groups (BME) have the higher prevalence of SMI. The borough has estimated 1,000 living with severe mental health problems against actual 3,381 patients registered with GPs who have a diagnosis of a psychotic disorder; 917 in the west and 2,462 in the east. Of those with SMI, 2,959 people had a comprehensive care plan in primary care[13] . In 2014, nine GP practices administer antipsychotic injections for their patients and those practices are scattered around the borough.

There were 65 new cases of psychosis serviced by Early Intervention teams and it is significantly higher in Haringey compared to national figures suggesting higher demand and good access to services[14] . The rate of people

12 Camden and Islington Public Health Intelligence: Serious mental illness in Haringey: The facts

13 Serious Mental Illness profiles, Public Health England, 2014
14 Severe Mental Illness profiles: Public Health England, 2014

receiving assertive outreach services in Haringey (12%) was significantly lower than London (40.9%) and England (25.7%). Given such a high need locally, this information would suggest concerns with access to outreach teams.

Below is table with details on people seen by BEH MHT (as of December 2014) and their conditions split by Clusters. In total, BEH MHT have seen 2, 895 patients compared to 2, 972 in Enfield and 3, 033 in Barnet. Majority of Haringey's patients had severe psychosis followed by those with cognitive impairment and non-psychotic severe illness.

The rate of social care mental health clients receiving services was significantly low in Haringey (189) compared to London (419) and England (404) per 100,000 population. This may be a result of service reduction over the recent years where social care is only accessible to those at the highest end of needs. Also significantly low was the rate of social care mental health clients aged 18-64 receiving home care (28.2 per 100, 000 population) in comparison to London (46.6) and England (47.6).

Current service landscape

Our current local offer of services for people with mental ill health focuses on highly specialised hospitalised services, few beds for recovery and rehabilitation, and high cost care packages and residential care. This offer does not always result in long-term improvement of health outcomes and it creates a community that is highly dependent on the services and individuals that are seldom supported to move on and have fulfilling, independent life.

Furthermore, the current emphasis on the treatment at the severe end of illness rather than prevention and early help results in costly and inefficient commissioning of services that are often reactive and have limited impact on health outcomes.

Mental health services in Haringey are commissioned by Haringey CCG, NHS England (specialist services) and Haringey Council. Services are provided by a range of providers including Haringey Council, NHS Trusts, primary care, VCS and independent sector.

Main provider of mental health services for Haringey is Barnet, Enfield and Haringey Mental Health Trust. Most of the current activity is commissioned in a block contracts making it challenging to support shift of resources to prevention and early help and develop further community based services.

Barnet Enfield and Haringey Mental Health NHS Trust (BEH MHT) provides a range of mental health services principally to the London Boroughs of Barnet, Enfield and Haringey. They provide a comprehensive range of services for children and young people working closely with the local authority (public health, education, youth justice and social care departments) and voluntary and community sector.

BEH MHT Children and Adolescent Mental Health Services (CAMHS) are provided in the four-tier framework and there is a single point of referral[15] for all children. Most referrals to CAMHS are from GPs, followed by schools and social services.

15 Emotional wellbeing and mental health for children and young people in Haringey Needs Assessment 2011

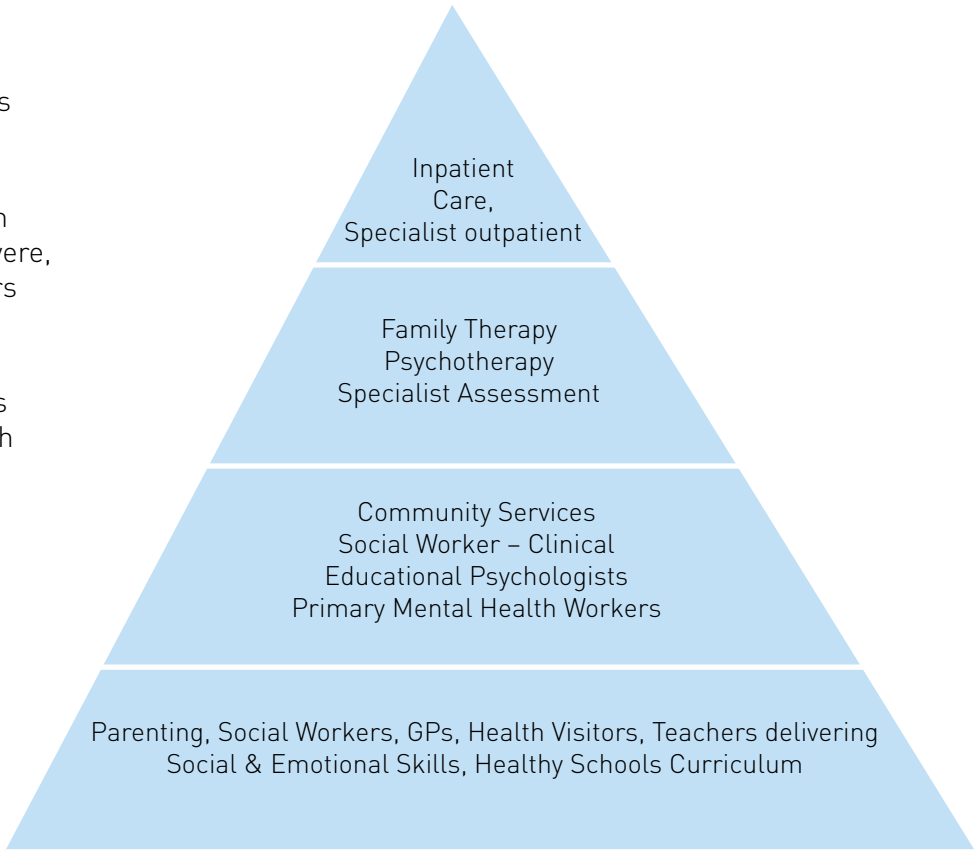
Mental health services for Haringey's Children and Young People

Tier 4 - Inpatient and highly specialist mental health services

Tier 3 – Specialist mental health services for those with more severe, complex and persistent disorders

Tier 2 – consultation for families and other practitioners, outreach to identify complex needs, and assessments and training to practitioners at Tier 1

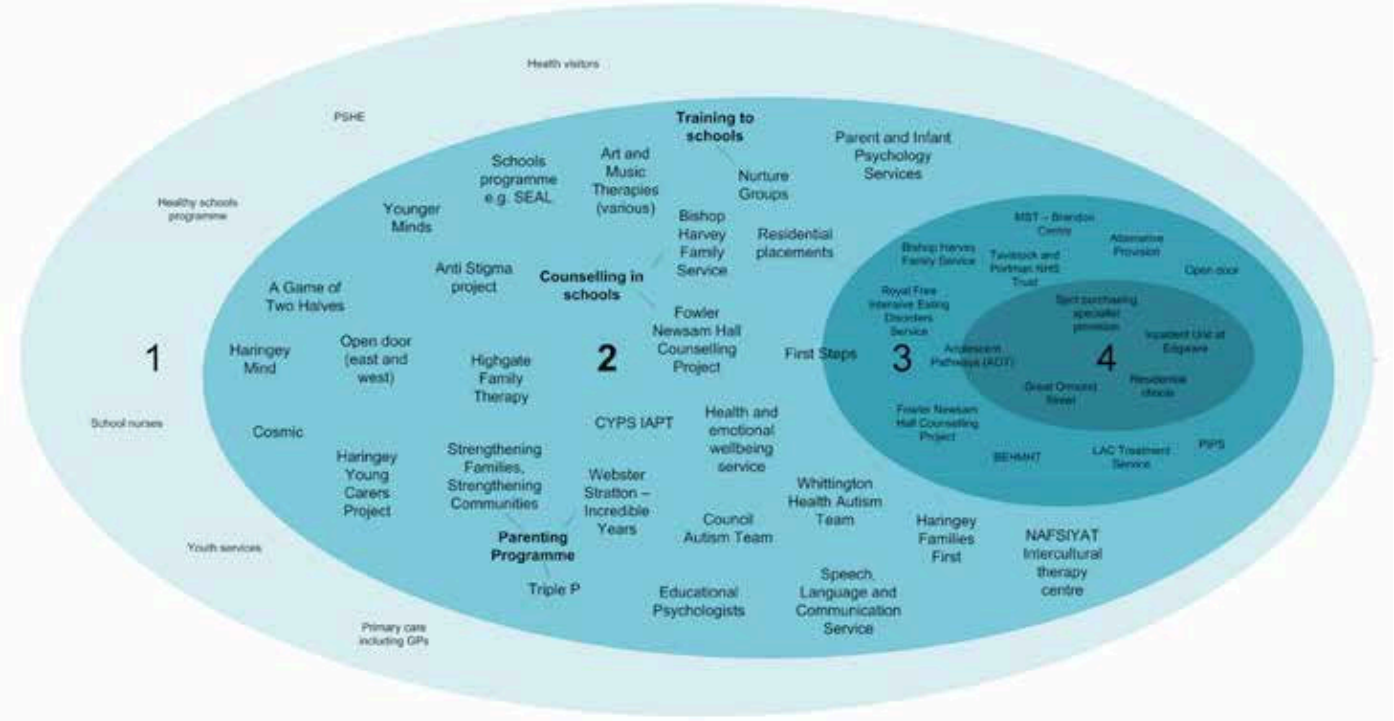
Tier 1- promote mental health, early identification of problems and refer to more specialist services



Source: National Service Framework for Children, Young People and Maternity Services, 2004

There is a variety of services provided in Tier 1 and Tier 2 ranging from interventions in the community, schools, and primary care and parenting initiatives provided by the Council however, at present, there is no system in place to monitor comprehensively the referrals to Tier 1 and 2 and follow children and young people along the whole pathway. Appropriateness of referrals depends on the information being disseminated to all stakeholders and the communities. Commissioning arrangements for Tier 1 and Tier 2 services could also be better integrated to reduce duplication and improve efficiency. At present, over 40 services and interventions are being commissioned by the schools, Council, CCG, Public Health Department and a number of external agencies. Some of these services are general and include a component of mental health and wellbeing such as health visiting and school nursing. Other services provide more targeted approach such as Open Door, a charity that provides counselling and psychotherapy to young people age 12-24. At present, there is no single directory of Tier 1 and Tier 2 services in Haringey that would enable full utilisation of this diverse offer. Also, fragmented provision arrangements make it challenging to consistently apply quality standards for commissioned services across the whole borough and in line with the national evidence and best practice.

Children and young people services currently commissioned in Haringey



Specialist Children and Adolescent Mental Health Services (CAMHS) are NHS services offering assessment and treatment when children and young people have emotional, behavioural or mental health difficulties. In 2012, there were 1,080 children in Haringey who required Tier 3 and 45 for Tier 4 CAMHS services (Public Health England 2014. Current data (March 2014) from CAMHS shows 40% of children referred into CAMHS tier 3 were 10-14 years old. About one in five referrals were made for children age 5-9 years and nearly a third (31%) were referred into CAMHS among the 15-18 year age range. The greatest numbers of referrals were from General Practitioners, equating to 45%. Local Authority referrals were mainly from Education (24%) and Social Services (14%).

In 2012-13, inpatient admission rate (89 per 100,000) for mental health disorders for 0-17 year olds was similar to London and England. Young people's hospital admission rate for self harm (191.7 per 100,000 directly standardised) was lower than London and England figures (Public Health England 2014).

Adults And Older People Services

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) is the main provider of nearly all specialist adults and older people mental health services in Haringey including forensic services. The Trust services operate from over 30 locations across Barnet, Enfield and Haringey, some of them large hospital sites but most are small units in the community. Haringey's main site is at St. Ann's Hospital. The services available from the Trust in Haringey are described in more details in Appendix I. There were over 6,000 outpatient contacts and over 90,000 community contacts last year. Only a small proportion of these contacts are new patients suggesting that the Trust has a significant demand from patients with severe and enduring mental health problems that need a lot of support, coupled with a lack of capacity to discharge these patients safely into a variety of community settings, including adequate supported housing.

The NHS Benchmarking assessment suggests that BEH MHT has the overall slightly lower number of adult beds (22 vs. 23[16] national average), with significant variation across the Boroughs - lowest in Barnet (14), followed by Enfield (21.5) and Haringey (32.5). There has been an overall 25% reduction in adult beds over the last five years.

The overall availability of inpatient beds in the Trust is aggravated by a slow throughput, especially in Enfield and Haringey. Evidence suggests that service users in these two boroughs tend to stay longer than clinically required (Delayed Transfers of Care or DTOC) mostly due to their more complex social needs (e.g. unemployed, homeless, history of offending). Organising adequate support in the community for this cohort of people is a very challenging process due to a lack of integration and communication between the Trust and other key stakeholders locally. This issue was also highlighted in the service users' survey[17] where concerns were raised with the level of advice and support given to carers and service users on getting back to employment, accessing benefits and securing suitable accommodation.

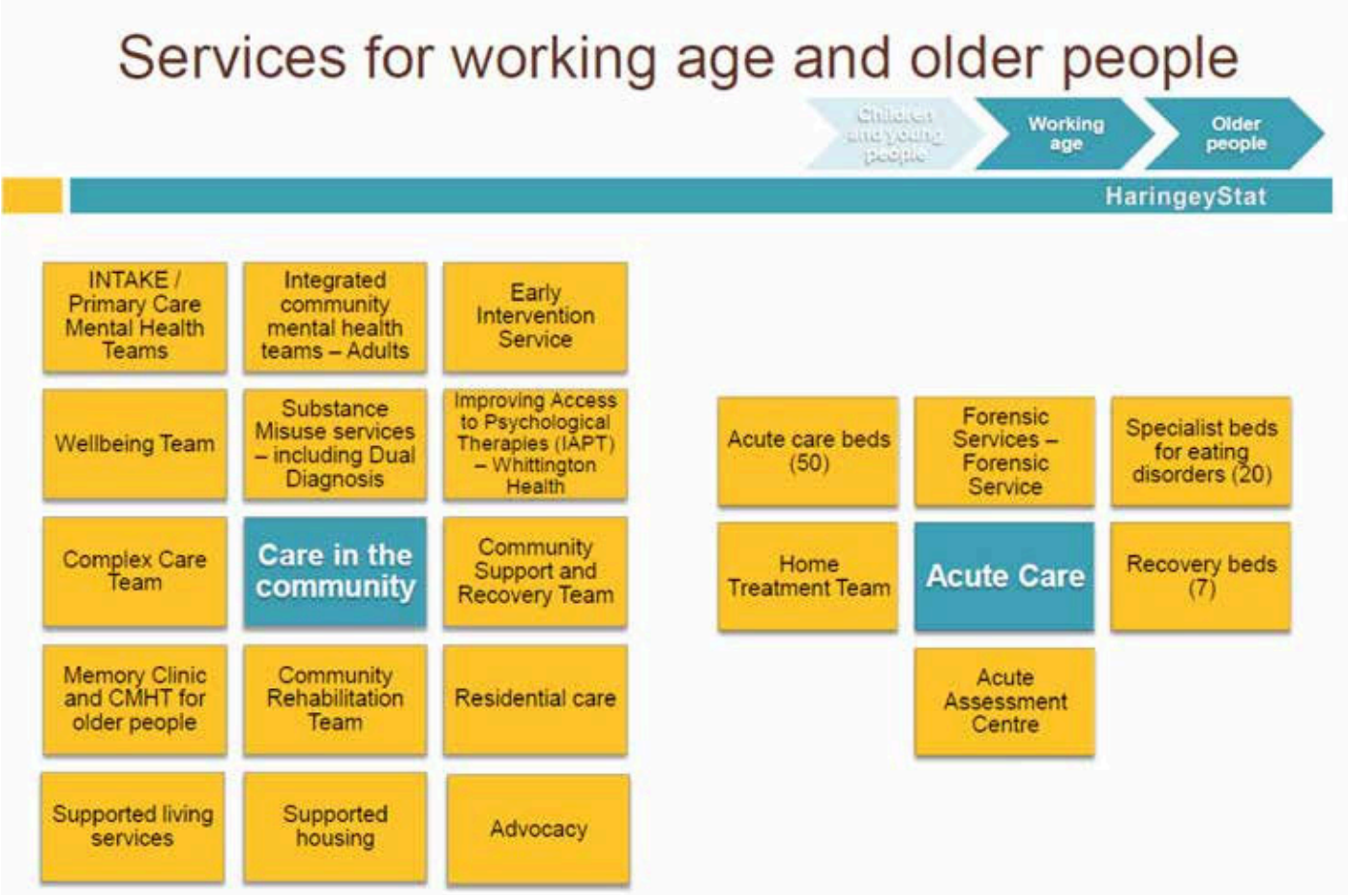
NHS Benchmarking data also suggests that BEH MHT has relatively lower reference cost which, at 87, are the lowest

16 Number of beds are per 100, 000 population so it would equate to app. 3.2x for Barnet, 3x for Enfield and 2.6x for Haringey to get the total number

17 Care Quality Commission: Patient Survey on BEH Mental Health Trust, April 2014

of any London NHS mental health inpatient provider and are considerably lower than those of neighbouring Camden and Islington NHS Foundation Trust (at 107) and Central and North West London NHS Foundation Trust (at 112).

The Trust also provides substance misuse services and dual diagnosis services for Haringey residents while talking therapies in Haringey are provided by the Whittington Hospital.



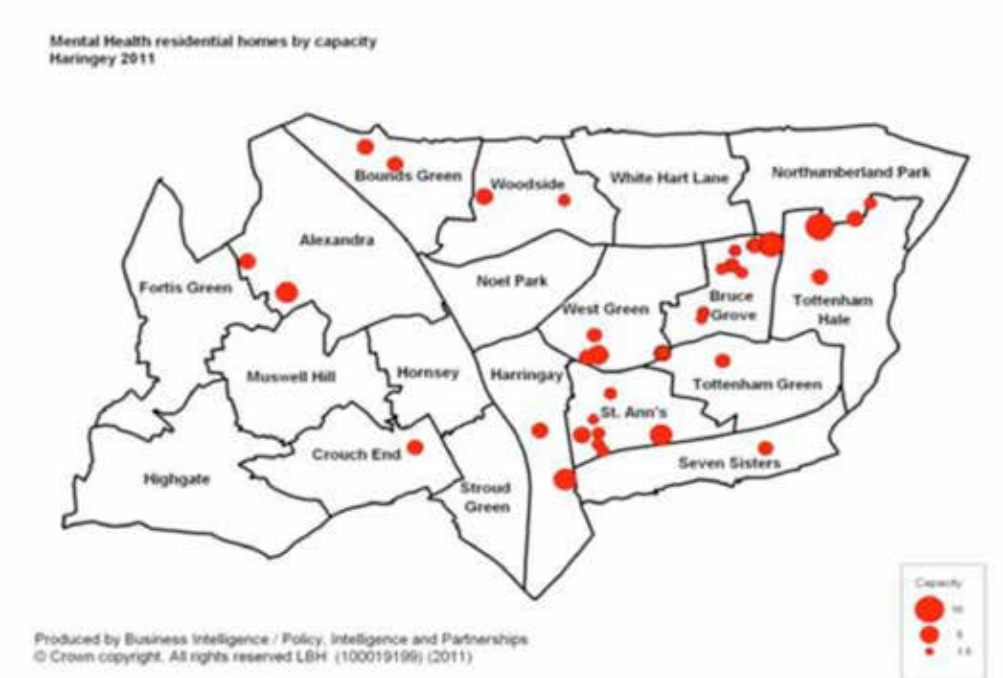
Second largest provider of mental health services in the borough is Haringey Council that provides social worker input to Community Mental Health Services and day services. It also provides social care to people with severe mental illness such as domiciliary care, supported living, day care centres, home care, direct payments, personal budgets and adaptation equipment.

The rate of social care mental health clients receiving services was significantly low in Haringey (189) compared to London (419) and England (404) per 100,000. Also significantly low was the rate of social care mental health clients aged 18-64 receiving home care (28.2) in comparison to London (46.6) and England (47.6) per 100,000 population. In 2012-13 there were 389 people with mental health condition who were provided a care package from the Council. In total 529 adults (18-64 year olds) had a service brought to them through a mental health budget code. Between April 1, 2013 and January 2014 566 people 65 per cent patients aged 18-69 years of age on CPA were in settled accommodation and 3.9 per cent in employment[18].

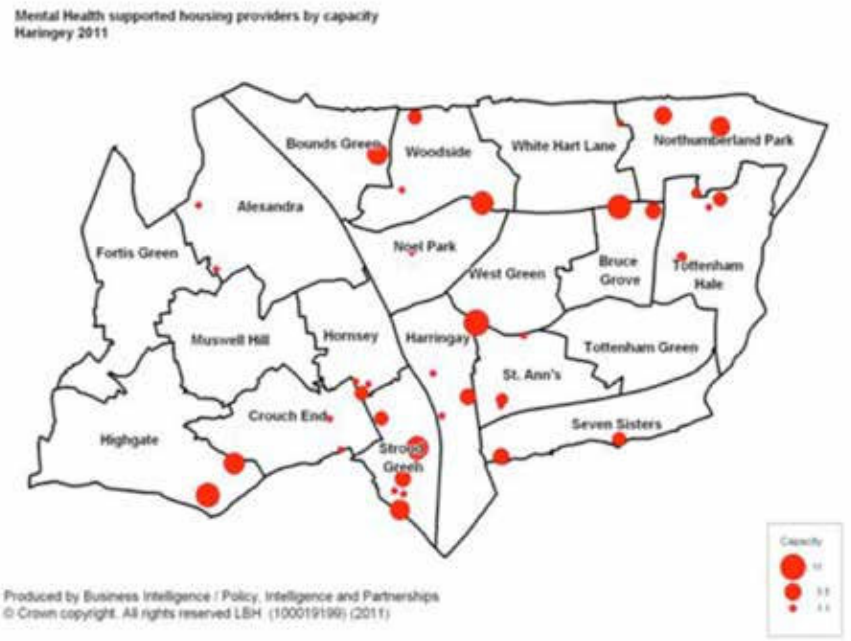
The Council also provides Clarendon Recovery College (CRC) aimed at assisting recovery process for people with severe mental illness. There are currently 230 enrolled students who are seen by secondary mental health services. This service has been recently evaluated by Middlesex University and it is showing to be very effective in assisting people to move on, find appropriate employment and pursue further education.

Residential accommodation and supported housing is provided by a range of independent providers and some VCS, the majority of which are in east of the borough. A large proportion of residential care placements (40%) are being utilised by people living outside the borough although this figure has been decreasing recently. Independent sector and VCS also provide supported accommodation, floating support and domiciliary care.

18 Mental Health Minimum Dataset 2014



Haringey has a number of supported living providers (mostly independent providers and some VCS), working with people with mental ill health that do not reach a threshold for social care support, including those funded through the Council's Housing Related Support. It typically provides the service user with a flat or shared housing within a warden controlled scheme. Schemes vary in terms of the level of support provided to cater for a wide ranging level of user need. Including Supporting People funded schemes; there are 13 main providers of supported living, offering around 285 places.



Mental Health and Wellbeing prevention and promotion interventions are largely commissioned by Council's Public Health team ranging from awareness raising and training in schools, tackling stigma and discrimination in the community ranging from interventions targeting specific risk groups such as Turkish and Kurdish men to digital peer support for mild to moderate anxiety and depression.

Information and advocacy services are provided by a range of VCS in the borough. These arrangements will be reviewed in the near future to align this offer with Care Act 2014 requirements.

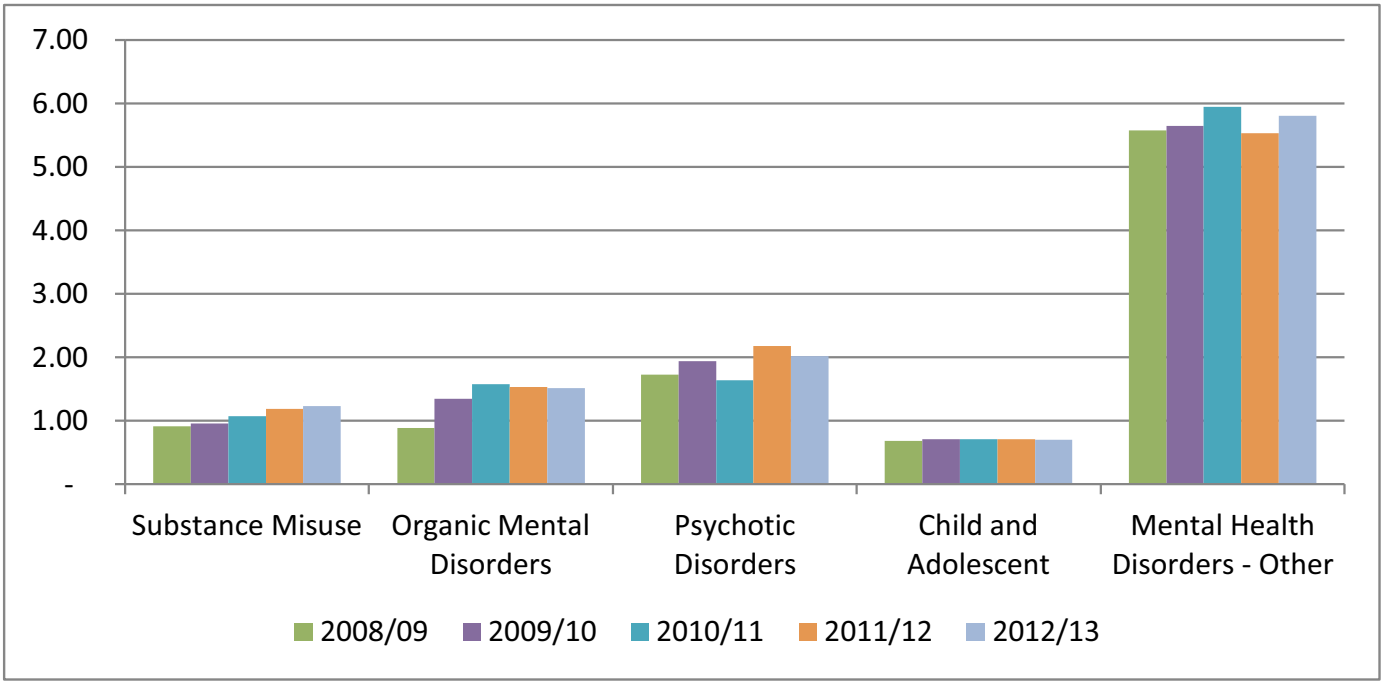
Total spend on mental health services

Total spend on mental health in Haringey (including substance misuse) for 2013-14 was over £51m. This equates to 11% of the total CCG budget and 6% of the Council's budget. Table below provides breakdown, by main commissioners.

Total spend on mental health in Haringey in 2013/14 by services

	LA	CCG
BEH MHT	1m (Section 75)	28.3m
Other NHS Trusts		2.9m
CAMHS		2m
IAPT		2.36m
VCS	600k	188k
Adult social care (including residential homes)	11m	
DAAT	3.5m	
Prevention and promotion	260k	
Other services		260k

Mental Health Gross Expenditure in last 5 years



Source: 2012-13 Benchmarking tool

Benchmarking data from various sources suggest that spend on residential care, housing related support, children's and young people mental health, specialist adult mental health services (phorensic services), prescribing on psychosis in primary care and the overall spend on secondary mental health per head of population is higher in Haringey compared to England.

Secondary care spend on psychosis, community care and outreach services care spend on mental health per head of the population is lower than England's average (Table below). These information should e treated with caution as the quality of data depends on accurate and complete returns. However the overall trend analyses suggest that local spend is highest at the severe top end of the pathway (secondary care, residential placement and supported housing) while there is underinvestment in outreach and community services. Furthermore, lower spend in secondary care for people with psychosis coupled with high spend in primary care for the same cohort of patients suggest that, probably due to high demand, these people are more likely to be cared for in primary care settings. Considering that the Council's and other partners investments are indirectly related to tackling root causes of mental ill health such as employment, affordable housing, community safety and clean and safe environment (open spaces etc.), it is likely that the overall spend on tackling mental ill health in Haringey is much higher than what could be easily quantified.

Haringey's expenditure on adults mental health for 2012-13, compared to England and based on the population size

High Low

Indicator	Haringey	England
Specialist mental health services spend (per 100,000 population) (rates are calculated for PCT and then mapped to CCG)	£33,167	£26,756
Primary care prescribing spend on mental health (rate (£000s) per 100,000 18+ population)	£1,791	£2,021
Primary care prescribing spend on psychosis (rate (£000s) per 100,000 18+ population)	£934	£541
Cost of GP prescribing for psychoses and related disorders (net ingredient cost per 1,000 population)	£713 (quarter 4)	£657
Secondary care spend on mental health (rate (£000s) per 100,000 18+ population)	£18,8480	£12,518
Secondary care spend on psychosis (rate (£000s) per 100,000 18+ population)	£1,356	£3,051
Community care spend on mental health (rate (£000s) per 100,000 18+ population)	£1,974	£5,094
Spend on psychosis services (rate (£000s) per 100,000 18+ population) (rates are calculated for PCT and then mapped to CCG)	£3,712	£4,789
Spend on psychological therapy services (IAPT and non IAPT) (rate (£000s) per 100,000 18+ population) (rates are calculated for PCT and then mapped to CCG)	£1,069	£1,021

Source: Mental Health Dementia and Neurology Intelligence Network, Public Health England, 2014

Appendix IV – Summary of evidence on best practice for mental health services

National evidence suggests that access to effective care for people with mental illnesses is only available to approximately 30 per cent of those that need it, and standards of care across the country vary greatly[19]. Even though 50% of all mental illness starts before age of 14, investment in prevention and early identification and children and young people's services is limited[20].

Effective mental health services should be integrated and include the whole pathway from prevention and early help through primary care, secondary care, highly specialised services and enablement model delivered in collaboration with a range of partners and service users.

Recent years have seen an increase in the body of evidence for investment in prevention of mental ill health and promotion of mental and emotional wellbeing that result in long-term cost savings and improve the outcomes. Some of the interventions cited having most impact across life course are parenting interventions for preventing conduct disorders, school-based emotional wellbeing learning programmes to prevent conduct problems, workplace initiatives for improving wellbeing and screening for anxiety and depression, befriending for older adults etc[21].

The effectiveness of current services for children and young people or Children and Adolescent Mental Health Services (CAMHS) has been debated nationally and the evidence is emerging that focus on four tier services actually lead to service fragmentation. Tavistock is proposing to replace the tiered model with a conceptualisation that is aligned to emerging thinking on payment systems, quality improvement and performance management, observed for adult mental health services. The THRIVE[22] model below conceptualises four clusters (or groupings) for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of preven¬tion and promotion initiatives in the community.

Current commissioning arrangements for adults and older people services are based usually on block contracts with mental health trusts and do not allow for an approach where multiple providers are supported and encouraged to provide integrated services based on the outcomes[23]. Value Based Commissioning has become a recent focus in health care as commissioners seek to ensure more innovation and integration in services and across providers in order to improve patient outcomes and quality of services. The Joint Commissioning Panel for Mental Health (JCPMH), published a guidance for implementing values based commissioning in mental health noting that the approach will achieve higher levels of patient and carer engagement than in traditional managerial or medical approaches.

19 Joint Commissioning Panel for Mental Health: Practical Mental Health Commissioning (2011)
20 NHS England, 2014, A Call to Action
21 Department of Health 2011: The Mental Health Promotion, Mental Health Prevention: Economic Case

22 The Tavistock and Portman NHS Foundation Trust and Ana Freud Centre, 2014: Thrive: The AFC-Tavistock Model for CAMHS
23 Joint Commissioning Panel for Mental Health 2014, Guidance for implementing values-based commissioning in mental health

JCPMH has published a series of commissioning guides to assist commissioners at CCGs and Local Authorities in transforming the overall mental health services[24]. Their website provide a wealth of information on different services aimed to support local commissioners in the CCG and Local Authorities. Furthermore, recent Kings Fund publication[25] identified some underpinning principles for the overall effective mental health provision:

- A collaborative or integration strategy to the delivery of mental health care,
- Equality and equity, ensuring a parity of esteem between physical and mental health,
- Involvement and engagement of patients and clinicians is central to all aspects of mental health service design, delivery and monitoring,
- Patient centred in order to improve patient experience and enable staff deliver high quality care,
- Embedded within the community taking account of the holistic needs of the individual and the interaction between health and other areas of people's lives,
- Holistic with a shift of focus from ill health to one that offers support to enable people maintain their health and wellbeing,
- Prevention focussed,
- Recovery/enablement oriented care supporting people to take an active role in determining their needs and goals and supporting them to achieve this.

One of the main pillars in transforming mental health services is effective primary care mental health. One in four of the population will need treatment for mental health problems at some time in their lifetime and the majority of these will be managed in primary care. There are pockets of good practice in primary care regionally, nationally and internationally however the level of mental health support and training in primary care in general does not often reflect the level of need and responsibility. London Strategic Clinical Network[26] produced guide for commissioners based on a summary of over 60 case studies collated across the country and internationally. Primary care mental health models proposed are focusing on multidisciplinary teams based in communities and often arranged as 'hubs'. Those teams aim is to manage people with stable and ongoing mental ill health holistically as a part of their social system and network to support enablement and independent life. One of the leading roles of primary care mental health is to support people with long-term conditions to manage their mental ill health and also those with mental ill health to manage their physical health effectively.

The ultimate outcome of any effective system is to enable people to recover and to help them better manage their own health and care needs. This is best supported by timely evidence based interventions using an integrated care model that assist people to regain hope and motivation, control over their own life while providing opportunities to participate in a wider society by having adequate employment, decent housing and socially fulfilling life. 'Recovery is For All'[27] publication describes integrated models of care and challenges current mental health services to radically change the way people with mental illness are perceived and treated. Their proposed model is based on enablement and 'social recovery'. The benefits of the proposed model include improving employment outcomes based on the best evidence of Individual Placement and Support (IPS) model[28]; users involvement in decision making about their treatment and management; peer support by those with lived experience helping others with similar problems; and self management that aims to enable people to develop practical tools of everyday living.

Evidence suggests that housing issues are more common in people with mental illness in terms of maintaining adequate tenancy and the overall satisfaction with housing conditions[29]. Housing support is therefore an essential part of a good enablement model. National and international reviews that looked at the best model of housing support for people with mental illness are however inconclusive but do suggest that best outcomes are achieved where housing solution is secured first followed by adequate care wrapped around a person that is flexible and changing with needs over time[30].

Holistic enablement model in current commissioning landscape can only be achieved by integrated commissioning and provision of a range of services that are working across organisational boundaries. This could be achieved effectively by focusing on the Value Based Commissioning.

24 Joint Commissioning Panel for Mental Health access @ http://www.jcpmh.info/
25 Kings Fund 2014, Transforming Mental Health- A Plan of Action for London
26 London Strategic Clinical Network: A commissioner's guide to primary care mental health. July 2014
27 South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust (2010) Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists. London: SLAM/SWLSTG.
28 Sainsbury Centre for Mental Health (2009c) commissioning what Works: The economic and financial case for supported employment. Briefing paper 41. London: The Sainsbury Centre for Mental Health
29 Johnson R, Griffiths C, Nottingham T (2006). At home? Mental health issues arising in social housing. London: NIMHE. www.socialinclusion.org.uk/publications/GNHFullReport.doc
30 Crisis UK and University of York: Staircases, elevators and cycles of change, 2010

Appendix V – Proposed recommendations for actions with timescales for delivery

	2015/16	2016/17	2017/18
Priority 1: Promoting mental health and wellbeing			
Conduct mental health and wellbeing survey to establish the baseline locally	✓		
Work with schools to include/commission emotional and mental wellbeing training as part of their standard curriculum	✓		
With Health Visiting services being commissioned from the Council from 2015, explore opportunities to deliver specific programmes for early years on promoting positive attachment and good parenting		✓	
Capitalise on the opportunities with Tottenham regeneration re. employment, affordable housing, built environment			✓
Integrate, whenever possible, prevention and awareness raising within a wide range of frontline services;		✓	
Re-commission mental health awareness raising for frontline staff			
Review information, advice and advocacy services to provide single web-base information portal and to integrate commissioning and delivery of the eservices in line with Care Act 2014		✓	
Prevention of mental ill health and promotion of good mental health to be delivered in and by the communities – retender prevention and promotion contracts to focus on community development;	✓		
Tackling social isolation – some services existing for older people, important to broaden out to all people who are at risk of mental illness (e.g. people with LTCs). Innovative models e.g. Family Mosaic projects;	✓		
Commission prevention of self harm training and education for schools;	✓		
Suicide prevention – training on suicide prevention for primary care professionals and provision of bereavement services and lessons learnt from incidents (recent suicides);	✓		
Tackling mental ill health amongst offenders and gang members (MAC-UK)		✓	
Develop joint pathways for women and their families affected by perinatal mental ill health;		✓	
Include prevention element in contracts with all service providers			
Evidence-based prevention interventions for families with children at risk of conduct disorders;			✓

	2015/16	2016/17	2017/18
Commission interventions based on assets in the community (e.g. time bank)	✓		
Priority 2: Improving mental health outcomes of children and young people			
Review all CYP mental health services in order to focus on prevention and early help and strengthen referral pathways, avoid duplication and commission care model based on the evidence;	✓		
Strengthen Tier 2 services with targeted youth offending teams and provide targeted interventions at schools for those children at risk in line with quality standards and best evidence;		✓	
Implement NICE guidelines for severe mental illness in CYP, in particular review Early Intervention in Psychosis (14-35 years of age);		✓	
Review transition from CAMHS to adults, subject to Children's O&S Panel;	✓		
Review of mental health services offer for Looked After Children (LAC). Also, pilot jointly with Enfield and Haringey swifter completion of care proceedings where LBH applied for care order. Work towards 26 weeks against average of 56 weeks. Mental and emotional wellbeing assessment is a crucial part of this process.	✓		
Priority 3: Improve mental health outcomes for adults and older people			
Improving care for people in mental health crisis			
Develop Crisis Concordat Action Plan and implement London Mental Health Strategic Clinical Network commissioning standards;	✓		
S136 – Implement London MH Partnership Board guidelines and refresh local joint protocols in line with the new standards.	✓		
Including crisis plan in CPA on discharge with specific guidelines on how to recognise early signs of worsening conditions and mechanisms to prevent crisis occurring		✓	
Provision of crisis houses with psychiatric care and support		✓	
Dedicated areas for mental health assessment in A&E and 24 hours psychiatric liaison service	✓		
Mental health crisis care training for GPs, practice nurses and community care staff	✓		
Commission a place of safety for children		✓	
Improving physical health of those with mental-ill health and vice versa			
Implement the NHS Five Year Forward View standards in relation to access to mental health services (Actions included in the 5-year NCL plan);			✓

	2015/16	2016/17	2017/18
There should be greater focus on smoking cessation, weight management and physical activities interventions and referrals to these pathways for people with mental ill health;		✓	
Increase awareness of services offering behavioural change support such as Health Trainers and Health Champions amongst people with mental ill health;		✓	
Review current pathways between primary and secondary care referrals and update to strengthen management of physical and mental health;	✓		
Agree and establish role of pharmacies in relation to mental and physical health;	✓		
Review current model of liaison psychiatric service (Rapid Assessment and Interface Discharge scheme) in order to improve the outcomes and impact on the wider system and agree a standardised performance framework based on the outcomes;	✓		
Primary care is currently performing well on recording physical illness in people with severe mental illness, review if this is the case for people with long term conditions (LTCs);	✓		
Audit a random sample or Trust-wide of care plans to understand if those with co-morbidity have clear plans on how to manage their physical illness;	✓		
Develop strong relationships between those working with people with mental illness and primary care staff	✓		
Meeting the needs of those most at risk			
Improve waiting times for referrals in people in contact with Criminal Justice who have mental health problems.	✓		
Establish more effective liaison between mental health services in the criminal justice sector to achieve a seamless treatment pathways		✓	
Ensure that all mental health services are culturally appropriate for Haringey's diverse communities by developing minimum standards for training frontline services	✓		
Focus on mental health and wellbeing in 'Violence against women and girls' Council's workstream	✓		
Improve information sharing between Integrated Offender Management Unit, primary care, accident and emergency department and primary care		✓	
Link mental health prevention with antisocial behaviour initiatives based on the best practice		✓	
Forge links with Serious Youth Violence Strategy	✓		
Promote mental health and wellbeing for homeless people within 'Homeless Health and Wellbeing Charter		✓	

	2015/16	2016/17	2017/18
Priority 4: Commission and deliver integrated enablement model			
Explore possibilities of further integration between adult social care, housing related support and prevention public health programmes;	✓		
Develop service specification for enablement model that improves the outcomes such as good housing, employment, social relationships) and tailored to individual needs;	✓		
Strengthening role of primary care in management of mental illness (implement Joint Commissioning Panel for Mental Health guidelines: Commissioning primary care mental health services);	✓		
Strengthen pathways between Community Mental Health Teams, Home Treatment teams and primary care;	✓		
Provide local evidence on needs and service effectiveness to support BEH MH Trust to develop enablement model;	✓		
Support third sector to deliver enablement model in collaboration with mental health trust, LBH and other stakeholders;	✓		
Commission and implement housing based solution for people with mental ill health;	✓		
Develop flexible pathways for accommodation that promote choice;	✓		
Develop jointly between the CCG, MHT and LBH care packages in line with the mental health tariff care clusters;	✓		
For those who are known to have experienced crisis, include crisis management plan in their CPAs;	✓		
Enable people with mental ill health to enter employment market and maintain their job;			✓
Promote 'Time to Change' model for all local employees;		✓	
Develop asset based community approach that promotes independence, self-reliance and resilience in partnership with voluntary and community sector;	✓		
Review care-coordination against minimum standards in terms of capacity and competencies; offer training on welfare benefits, housing pathways and the importance of physical and mental health (Manchester model).	✓		

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Haringey Council

Report for:	Children and Young People's Scrutiny Panel – 18 March 2015	**Item Number:**	

Title:	Transition from Child Mental Health Services to Adult Mental Health Services: Adults and Health Scrutiny Panel Project Report

Report Authorised by:	Cllr Pippa Connor, Chair, Adults & Health Scrutiny Panel

Lead Officer:	Christian Scade Interim Principal Scrutiny Officer Christian.Scade@Haringey.gov.uk 0208 489 2933

Ward(s) affected: All	**Report for Key/Non Key Decisions:** N/A

1. Describe the issue under consideration

1.1.1 Under the agreed terms of reference[1], the Adults and Health Scrutiny Panel can assist the Council and the Cabinet in its budgetary and policy framework through conducting in depth analysis of local policy issues.

1.1.2 In this context, the Panel may:

- Review the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas;

- Conduct research, community and other consultation in the analysis of policy issues and possible options;

- Make reports and recommendations on any issue affecting the authority's area, to Full Council, its Committees or Sub-Committees, the Executive, or to other appropriate external bodies.

1.1.3 Cabinet Members, senior officers and other stakeholders were consulted in the development of an outline work programme for the Overview & Scrutiny Committee. Project work undertaken by the Adults and Health Scrutiny Panel on the transition from child mental health services to adult mental health services was agreed as part of this work programme by the Committee in July 2014.

2. Cabinet Member introduction

[1] Overview and Scrutiny Protocol, 2012, Haringey Council

N/A

3. Recommendations

3.1.1 That the Adults and Health Scrutiny Panel:

(a) Agree the report and recommendations; and

(b) Agree that the final report be considered for approval by the Overview and Scrutiny Committee on 26 March 2015.

4. Alternative options considered

4.1 The options considered during the course of this scrutiny project are outlined in the body of the report.

5. Background information

5.1.1 The Terms of Reference for the project were to review the Child and Adolescent Mental Health Service (CAMHS) transition pathway from child to adult mental health services in order to make recommendations to improve the transition pathway and experience for young people.

5.1.2 The objectives of the project were:

- To gain an understanding of the CAMHS transition pathway process from child to adult mental health services including commissioning and budgetary arrangements

- To gain an understanding of the CAMHS transition pathway from the perspective of young people and their families

- To compare local practice with identified areas of good practice and national guidance.

- To make evidence based recommendations to improve the pathway.

5.1.3 The Panel heard from a range of stakeholders, both in project meetings and externally. These included Barnet, Enfield and Haringey Mental Health NHS Trust, Haringey Clinical Commissioning Group (CCG), Mind, Mental Health Support Association, Public Health, Open Door, Young Minds, First Step, Camden and Islington Mental Health Trust, Adult Services and Children's Services.

5.1.4 A number of themes emerged from the project, which are outlined in more detail in the main body of the report.

6 Comments of the Chief Finance Officer and Financial Implications

6.1.1 The Panel has put forward a number of recommendations for consideration. At this stage, the recommendations are fairly high level and further work will be required to fully assess their financial implications.

6.1.2 Recommendations should only be adopted if there is a robust business case that demonstrates they offer value for money and resources have been identified. As the Panel are already aware from their research that funding for Mental Health is limited and there is little new funding available to support these recommendations and so their implementation may require redirection of existing resources. In particular the Heads Up For Haringey model may require additional investment in the short term. These costs would mostly fall to the Health service rather than the Council but there may be implications across a number of agencies.

7 Assistant Director of Corporate Governance Comments

7.1.1 The Assistant Director Corporate Governance has been consulted on the contents of this report.

7.1.2 The legal context to transition planning for children to adult services has been dealt with in the Project Report. The recommendations arising from the Project Report are within the terms of reference of Adults and Health Scrutiny Review Panel.

7.1.3 Under Section 9F Local Government Act 2000 ("LGA"), Overview and Scrutiny Committee have the powers to review or scrutinise decisions made or other action taken in connection with the discharge of any of Cabinet's functions and to make reports or recommendations to Cabinet with respect to the discharge of those functions. Overview and Scrutiny also have the powers to make reports or recommendations to Cabinet on matters which affect the Council's area or the inhabitants of its area. The Constitution provides that the Scrutiny Review Panels must refer their findings/recommendations in the form of a written report to the Overview and Scrutiny Committee for approval and afterwards, final reports and recommendations will be presented to the next available Cabinet meeting together with an officer report where appropriate.

7.1.4 Under Section 9FE of the LGA, there is a duty on Cabinet to consider and respond to the recommendations indicating what if any action Cabinet proposes to take and to publish its response. The Constitution provides that Cabinet will consider the reports and formally agree their decisions.

8 Equalities and Community Cohesion Comments

8.1.1 Overview and scrutiny has a strong community engagement role and aims to regularly involve local stakeholders, including residents, in its work. It seeks to do this through:

- Helping to articulate the views of members of the local community and their representatives on issues of local concern

- Bringing local concerns to the attention of decision makers and incorporating them into policies and strategies

- Identifying and engaging with hard to reach groups

- Helping to develop consensus by seeking to reconcile differing views and developing a shared view of the way forward

8.1.2 The evidence generated by scrutiny reviews help to identify the kind of services wanted by local people. It also promotes openness and transparency as meetings are held in public and documents are available to local people.

9 **Head of Procurement Comments**

N/A

10 **Policy Implication**

10.1.1 Work carried out by the Adults and Health Scrutiny Panel during 2014/15 should contribute and add value to the work of the Council and its partners in meeting locally agreed priorities. In this context, the work of the Panel, and the terms of reference for this project, will contribute to improved policy and practice for the following corporate priorities:

- **Haringey Corporate Plan 2013-15**

  - Outcome – Outstanding for all: Enabling all Haringey children to thrive
  - *Priority* – Enable every child and young person to thrive and achieve their potential

  - Outcome – Safety and wellbeing for all: A place where everyone feels safe and has a good quality of life
  - *Priority* – Reduce health inequalities and improve wellbeing for all

  - Outcome – A better council: Delivering responsive, high quality services and encouraging residents who are able to help themselves to do so
  - *Priority* – Get the basics right for everyone

10.1.2 In addition, recommendations within this report, if accepted, would contribute to:

- **Haringey's Health and Wellbeing Strategy 2015-2018**
  - Outcome 3 – Improved mental health and wellbeing

- **Haringey's Joint Mental Health and Wellbeing Framework**
  - Priority 2: Improving mental health outcomes of children and young people

11 **Reasons for Decision**

11.1 The evidence behind the recommendations are outlined in the main body of the report.

12 **Use of Appendices**

12.1 As laid out in the main body of this report.

13 **Local Government (Access to Information) Act 1985**

13.1 External web links have been provided in the main body of the report. Haringey Council is not responsible for the contents or reliability of linked websites and does not necessarily endorse any views expressed within them. Listings should not be taken as an endorsement of any kind. It is your responsibility to check the terms and conditions of any other web sites you may visit. We cannot guarantee that these links will work all of the time and we have no control over the availability of the linked pages.

Haringey Council

Project Report:

Transition from Child Mental Health Services to Adult Mental Health Services

A PROJECT BY THE ADULTS AND HEALTH SCRUTINY PANEL

March 2015

www.haringey.gov.uk

Chair's Foreword

Young people with mental health problems need the support they receive to be seamless as they progress through their adolescence into young adulthood. The current situation involves a 'cliff edge' in this support which occurs when a young person reaches the age of 18 and leaves the Children's Service to transition into the Adult Mental Health Service. At this point of transition, young people often don't meet the higher Adult threshold criteria for care, resulting in their support being withdrawn. This leaves vulnerable young people without support at a critical time and can often lead to a young person ending up in crisis and needing a much higher level of support as their mental health worsens.

At a workshop run by the Council which was attended by outside agencies from support services in mental health, it was clear that the current system not only allowed young people to drop through the net in terms of support for their mental health condition, it was also strongly felt that this current system of transition should end and that young people should be supported right through from the age 0-25, to prevent this cliff edge scenario.

The Adult Health Panel took evidence from a variety of stakeholders including; BEH Mental Health Trust, the CCG, Mind in Haringey, Open Door, Young Minds, First Step, Camden and Islington Mental Health Service and most importantly Haringey's front line staff in Children's and Adult Mental Health Services. From these experts the problems were identified and a new service was proposed which took shape under Dr Nick Barnes guidance, who as the Young Peoples Consultant Psychiatrist working within the BEH Mental Health trust, created the new proposed service 'Heads up for Haringey'.

This new model would be run as a pilot initially and be headed up by Dr Nick Barnes. Heads up for Haringey would remove the variation in funding and support young people currently experience and instead provide a service that continues through the young person's life up to age of 25. This would provide a joined up service that wraps care around an individual to support them with their mental health problems. The aim being to reduce any escalation in a persons mental health problems and allow all the services to be based in one hub with communication shared between all staff, from housing through to education. This will allow individualised care without the young person being passed from one service to another. Current national guidelines also recommends this more joined up approach; including the Care Act 2014, the Children's and Families Act 2014, 'Closing the Gap' a national policy document 2014 and NHS England's recent advice regarding providing a cross-service approach.

The new Joint and Mental Health Wellbeing Framework, which this new initiative would sit within, is an opportunity to transform our local mental health services and improve the mental health and wellbeing outcomes for our residents by allowing young people to access appropriate care and support, in order to remain within their own communities. I hope the panel's recommendations are taken forward and take advantage of the governance arrangements for implementing this new framework.

I would like to extend my heartfelt thanks to everyone who came and gave their time and expertise to develop this new Heads Up For Haringey service, in particular Melanie

Ponomarenko who arranged all the meetings and was instrumental in putting this report together.

Cllr Pippa Connor
Chair, Adults & Health Scrutiny Panel

Panel Members:

Cllr Gina Adamou
Cllr David Beacham
Cllr Gideon Bull
Cllr Jennifer Mann
Cllr James Patterson
Cllr Anne Stennett
Helena Kania (co-optee)

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Contents

Recommendations

RECOMMENDATION (1)

In view of the absence of a shared electronic client record system across mental health and social care, the panel recommends that a clear process for information sharing across agencies is developed.

RECOMMENDATION (2)

The panel recommends that a piece of work is undertaken to look at what data is available, and is required, across health and social care agencies. This could be used to analyse trends, understand why young people drop out of services, and to identify the most appropriate ways to support discharge planning. This information could help tailor the help offer to prevent escalation of need and re-entry at a later point.

RECOMMENDATION (3)

The panel recommends that a coordinating and overseeing role is identified at the commissioning and operational level to ensure that no young people fall through the gap due to their housing needs and situation and to prevent young people from becoming homeless.

RECOMMENDATION (4)

The panel recommends that:

(a) The "Heads up for Haringey" model should be adopted for young people in Haringey on a partnership basis. In the first instance this should be on a pilot basis working with young people. This pilot could then be built on and expanded taking into account lessons learnt and feedback from young people and their parents and carers. *(Dr Nick Barnes, BEH Mental Health NHS Trust, has offered to oversee this)*

(b) A scoping exercise should be completed by CAMHS providers to understand the number of children and young people approaching transition.

(c) A multi-agency workshop should examine how the pilot would be resourced, implemented and evaluated.

(d) Intelligence from the pilot should be used to inform future commissioning intentions and service developments.

RECOMMENDATION (5)

The panel recommends that a "Heads up for Haringey" guide be developed and presented to young people as they are referred to this mental health service. This guide should be developed with input from young people and carers and include:

- **Information on local services which may be accessible to the young person**
- **Referral forms**
- **Pages for useful information which the young person can add to**
- **Information on useful websites and Apps**

RECOMMENDATION (6)

The panel recommends that there is a multi-disciplinary and multi-agency meeting a minimum of once per month to discuss the cases of young people who are due to move across into the Heads up for Haringey service and those who are in the new Heads up for Haringey service to ensure the needs of young people are being met.

RECOMMENDATION (7)

The panel recommends that consideration is given to the merit of placing an adult trained mental health social worker in the young adult service and a social worker with child mental health experience in the adult mental health team.

Introduction

1. Why did the Panel choose this project?

The process for identifying a work programme for the Adults and Health Scrutiny Panel included a 'Scrutiny Café' consultation, meetings with Cabinet Members and Senior Officers, input from partners, and a discussion by Members of the Panel. The issue of transition from child to adult mental health services was identified from this process for a number of reasons, which are best summarised by a written submission to the project from Dr Nick Barnes, Young People's Psychiatrist, Barnet, Enfield and Haringey Mental Health NHS Trust, as below:

"Transition within mental health services at the age of 18yrs can be problematic for many reasons;

- *It can be problematic for young people as they make the transition from childhood to adulthood in many other areas of life.*

- *There is a marked difference in provision between adolescent and adult services.*

- *It is often a time of distress and disengagement for those that do need transfer from adolescent mental health services to adults mental health services.*

- *The arbitrary age of 18yrs doesn't fit with a developmental model of adolescence – up to 25yrs*

Most services working with young people up to the age of 18yrs often do their best to discharge young people rather than seek for them to be transferred on to adult services. In most cases this is about the young person making steps forwards in their life and not needing to be dependent upon adult services, but this decision can also be driven by higher thresholds for accessing care being set out by the adult mental health teams.

Many other services are developing provision for up to 25yrs, as shown by the development of the Education, Health and Social Care Plans (replacing SEN statements) offering support up to 25yrs as well as the youth justice system exploring the extending of support through the Youth Offending Services to an older client group. The Government has shown clear commitment to developing services for children and young people to be extended through to 25yrs." (Dr Nick Barnes)

Policy Context

2. National context

2.1 One in four people on average experience a mental health problem, with the majority of these beginning in childhood. A report by the Chief Medical Officer in 2014 found that 50 per cent of adult mental health problems start before age 15 and 75 per cent before the age of 18.

2.2 The Government has committed to improving mental health provision and services for children and young people. The information below provides a summary of commitments relevant to this review.

2.3 The Government's 2011 Mental Health strategy, **No Health without Mental Health**, pledged to provide early support for mental health problems, and set out the Government's plan to improve mental health outcomes for people of all ages.

2.4 The strategy states "*Care and support should be appropriate for the age and developmental stage of children and young people...Careful planning of the transfer of care between services will prevent arbitrary discontinuities in care as people reach key transition ages."*

2.5 The strategy sets shared objectives to improve people's mental health and wellbeing and improve services for people with mental health problems. The strategy highlights that services can improve transitions, including from child and adolescent mental health services (CAMHS) into adult mental health services, by:

- planning for transition early, listening to young people and improving their self-efficacy;
- providing appropriate and accessible information and advice so that young people can exercise choice effectively and participate in decisions about which adult and other services they receive; and
- focusing on outcomes and improving joint commissioning, to promote flexible services based on developmental needs.

2.6 The **Health and Social Act of 2012** put a responsibility on the Health Secretary to secure improvement "in the physical and mental health of the people of England".

2.7 The **Children and Families Act 2014** reforms the system of support across education, health and social care. It creates a new 'birth-to-25 years' Education, Health and Care Plan (EHC) for children and young people with special educational needs and offers families personal budgets so that they have more control over the type of support they get.

2.8 In some cases, where a person is over 18, the "Care" part of the EHC plan will be provided for by adult care and support, under the Care Act. For children and young people with special educational needs, the Act aims to:

- Get education, health care and social care services working together

- Make sure children, young people and families know what help they can get when a child or young person has special educational needs or a disability

- Make sure that different organisations work together to help children and young people with special educational needs

- Set up one overall assessment to look at what special help a child or young person needs with their education, and their health and social care needs, all at the same time

- Give a child or young person just one plan for meeting their education, health and social care needs, which can run from birth to age 25 if councils agree that a young person needs more time to get ready for adulthood

- Reform the system of support across education, health and social care to ensure that services are organised with the needs and preferences of the child and their family firmly at the centre, from birth to the transition to adulthood.

2.9 **The Care Act 2014** introduces new responsibilities for local authorities. It also has major implications for adult care and support providers, people who use services, carers and advocates[2]. The Care Act states if a child, young carer or an adult caring for a child is likely to have needs when they turn 18, the local authority must assess them if it considers there is "significant benefit" to the individual in doing so.

2.10 When a local authority assesses a child who is receiving support under legislation relating to children's services, the Act requires them to continue providing him or her with that support through the assessment process. This will continue until adult care and support is in place to take over.

2.11 These changes should mean there is no "cliff-edge" where someone reaching the age of 18 who is already receiving support will suddenly find themselves without the care and support they need at the point of becoming an adult. This is regardless of whether the child or individual currently receives any services.

2.12 The assessment should give information about eligibility, what can be done to meet or reduce their needs and an indication of the support they will get and requires local authorities to work to promote the integration of adult care and support with health services. The Act does not say that the child or young person has to be a certain age to be able to ask for an assessment. It says that local authorities must consider, in all cases, whether there would be a "significant benefit" to the individual in doing an assessment.

Ensuring there is no gap in services

2.13 When a local authority assesses a child (including a young carer) who is receiving support under legislation relating to children's services, the Act requires them to continue providing him or her with that support through the assessment process.

[2] http://www.scie.org.uk/care-act-2014/

2.14 This will continue until adult care and support is in place to take over – or until it is clear after the assessment that adult care and support does not need to be provided. Again, these changes will help ensure there is no "cliff-edge".

2.15 The Care Act (and the special educational needs provisions in the Children and Families Act) requires that there is cooperation within, and between, local authorities to ensure that the necessary people cooperate, that the right information and advice are available and that assessments can be carried out jointly.

2.16 The Deputy Prime Minister's 2014 policy paper, **Closing the Gap: priorities for essential change in mental health**, includes twenty five priorities for action to improve mental health services. Most relevant to this piece of work is:

"We will end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18..."

2.17 The document goes on to say *"...it has long been recognised that far too many young people who rely on mental health services are 'lost' to the system when they reach adulthood. From a point where they receive regular, focused support for their mental health needs, they find themselves on their own, unprepared for the abrupt cultural shift from a child-centred developmental approach to an adult care model. They may disengage, in many cases dropping through the care gap between the two services and losing much needed continuity of care. Those affected are often the most vulnerable and disadvantaged; getting lost in transition only adds to this – and makes them more likely to end up out of work and not in education or training. It can also mean their physical health deteriorates. For a significant number therefore, transition is poorly planned, poorly executed and poorly experienced. For so many reasons, this "cliff-edge" situation must end."*

Model specification for Children and Adolescent Mental Health Services (CAMHS)

2.18 NHS England has published a new model specification for Children and Adolescent Mental Health Services (CAMHS) targeted at specialist services (tiers 2 and 3) which treat patients with a range of emotional and behavioural difficulties such as behavioural problems, depression and eating disorders, to help improve the standards of care being given to vulnerable youngsters. It was developed by professionals working in the NHS and Local Authorities and young people and their parents were consulted.

2.19 The service specification includes a range of quality indicators such as personalised transition plans that include, for those young people who do need to transfer to adult services, joint meetings with CAMHS and adult mental health services. For those who do not, it will include information on how to access services if they become unwell.

2.20 Monitoring the outcomes of transitions from CAMHS to adult mental health services, or to other services such as the voluntary sector or primary care, is neither universal nor robust. CCGs and Local Authorities will be able to use the specification to build on best practice and the evidence from a range of service models to commission high quality, measurable person-centred services that take into account the developmental needs of the young person as well as the

need for age appropriate services. This will need a cross-service approach, involving housing, employment services and social workers – and not least, the young person themselves – to ensure they get the support they need.

2.21 The Panel were able to access a draft copy of the specification which was used to inform the recommendations contained in this report.

Funding for services

2.22 Concerns have been raised about levels of funding for CAMHS services and such issues were discussed in 2014 during a House of Commons Health Select Committee inquiry[3].

2.23 In December 2014, the Deputy Prime Minister announced a five year investment of £150m for eating disorder and self-harm services for children and young people[4]. Part of the intention is to channel money from expensive inpatient services to local provision, and foster the development of waiting time and access standards for eating disorders for 2016.

Scoping Study 15-24 year old services

2.24 In addition to the information above, the panel was made aware of a forthcoming publication highlighted in the policy paper "Closing the Gap: priorities for essential change in mental health" –

> "NHS England will undertake a high-level scoping study to examine evidence for both physical and mental health services focused on the 15-24 year age group and the implications this might have for care pathways, social workers and health professionals in the UK."

[3] http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/cmh-2014/

[4] https://www.gov.uk/government/news/deputy-pm-announces-150m-investment-to-transform-treatment-for-eating-disorders

3. Local context[5]

3.1 Some children and young people in Haringey may be at greater risk of developing mental health problems than those living elsewhere in London and nationally. This is attributed to the number of factors impacting on mental health such as lack of education, rates of offending, levels of deprivation, unemployment and children living in lone parent households. Mental health needs of children and young people are greater in the east part of the borough.

3.2 Local data suggests that we have a higher number of referrals to CAMHS but a lower number of those seen by Tier 3 and Tier 4 services than is estimated by Public Health England (PHE). PHE also estimated a higher prevalence of mental ill health in children and young people compared to England, in particular conduct disorders. Almost 50% of children with conduct disorders engage in crime activities by the age of 20 and are at higher risk of suicide and substance misuse.[6]

3.3 Children in the care of local authorities are at particular risk of mental ill health. During their investigation the Panel was informed that at the end of March 2014, there were 511 looked after children. Of those, 50% were without any concerns, 13% had borderline mental health concerns and 37% had mental health concerns, as identified by the Strengths and Difficulties Questionnaire (SDQ) screening tool. It should be noted that as of February 2015 the number of looked after children had reduced to 462. In addition, children placed from other local authorities in Haringey will also need to access local services.

3.4 Young offenders are at high risk of suffering mental ill health. It is estimated that up to 40% of young people in the youth justice system have mental ill health. The rate for first time entrants to the youth justice system in Haringey (417 per 100,000) was similar to London and England.

3.5 Our local information on self-harm referrals in children and young people seems much lower than that reported anecdotally by schools, general practitioners and accident and emergency departments. It is therefore important to understand real need in local communities and focus on prevention, particularly in school settings.

Service landscape[7]

3.6 Mental health services in Haringey are commissioned by Haringey CCG, NHS England (specialist services) and Haringey Council. Services are provided by a range of providers including Haringey Council, NHS Trusts, primary care, VCS and independent sector.

3.7 The main provider of mental health services for Haringey is Barnet, Enfield and Haringey Mental Health Trust. Most of the current activity is commissioned in a block contract making it challenging to support the shift of resources to prevention and early help, or to develop further community based services.

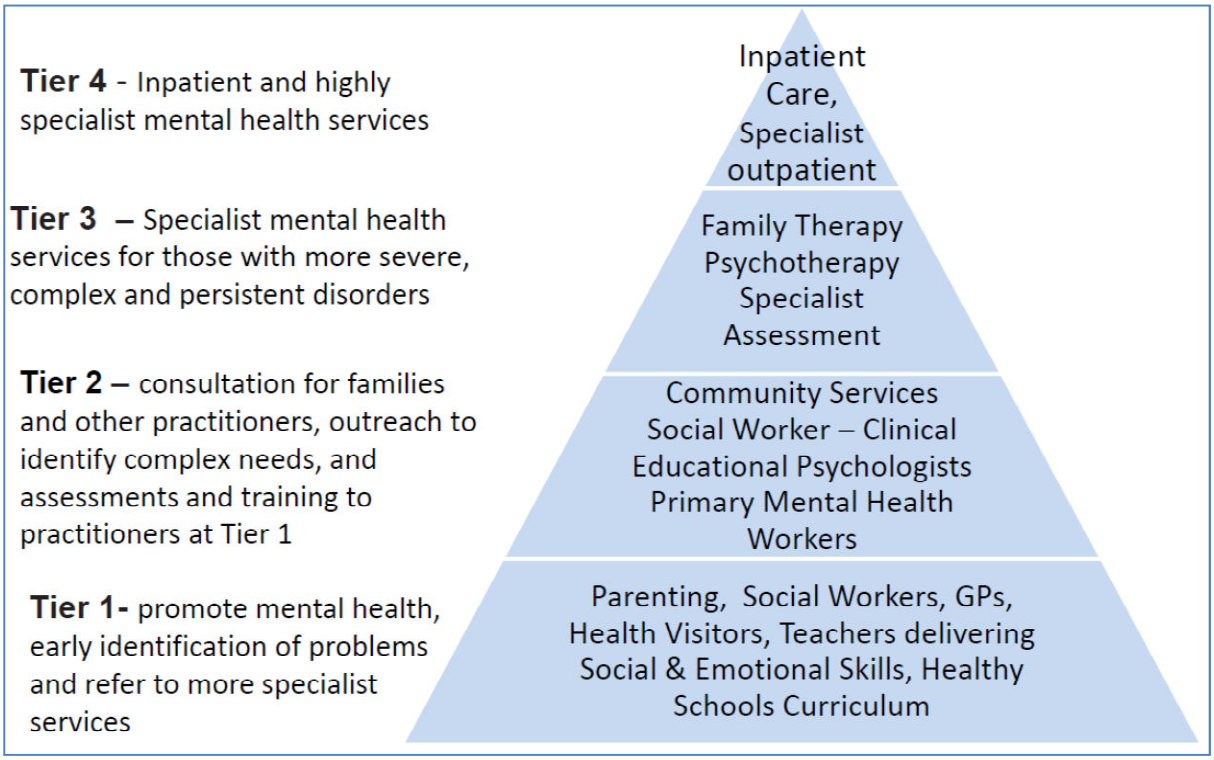
3.8 Barnet Enfield and Haringey Mental Health NHS Trust (BEH MHT) provides a range of mental health services principally to the London Boroughs of Barnet,

[5] Information taken from Mental Health & Wellbeing Framework in Haringey – Consultation Doc (2015)
[6] Friedli L and Parsonage M (2007): Mental health promotion: building an economic case
[7] Information taken from Mental Health & Wellbeing Framework in Haringey – Consultation Doc (2015)

Enfield and Haringey. They provide a comprehensive range of services for children and young people working closely with the local authority (public health, education, youth justice and social care departments) and voluntary and community sector.

3.9 BEH MHT Children and Adolescent Mental Health Services (CAMHS) are provided in the four-tier framework and there is a single point of referral[8] for all children. Most referrals to CAMHS are from GPs, followed by schools and social services.

Mental health services for Haringey's Children and young people



Source: National Service Framework for Children, Young People and Maternity Services, 2004

3.10 There is a variety of services provided in Tier 1 and Tier 2 ranging from interventions in the community, schools, and primary care and parenting initiatives provided by the Council. However, at present, there is no system in place to monitor comprehensively the referrals to Tier 1 and 2 and follow children and young people along the whole pathway. Appropriateness of referrals depends on the information being disseminated to all stakeholders and the communities. Commissioning arrangements for Tier 1 and Tier 2 services could also be better integrated to reduce duplication and improve efficiency. At present, over 40 services and interventions are being commissioned by the schools, Council, CCG, Public Health Department and a number of external agencies. Some of these services are general and include a component of mental health and wellbeing such as health visiting and school nursing. Other services provide more targeted approach such as Open Door, a charity that provides counselling and psychotherapy to young people aged 12-24. At present, there is no single directory of Tier 1 and Tier 2 services in Haringey that would enable full utilisation of this diverse offer. Also, fragmented provision arrangements make it

[8] [8] Emotional wellbeing and mental health for children and young people in Haringey Needs Assessment 2011

challenging to consistently apply quality standards for commissioned services across the whole borough and in line with the national evidence and best practice.

3.11 Specialist Children and Adolescent Mental Health Services (CAMHS) are NHS services offering assessment and treatment when children and young people have emotional, behavioural or mental health difficulties. In 2012, there were 1,080 children in Haringey who required Tier 3 and 45 for Tier 4 CAMHS services (Public Health England 2014). Current data (March 2014) from CAMHS shows 40% of children referred into CAMHS tier 3 were 10-14 years old. About one in five referrals were made for children aged 5-9 years and nearly a third (31%) were referred into CAMHS among the 15-18 year age range. The greatest numbers of referrals were from General Practitioners, equating to 45%. Local Authority referrals were mainly from Education (24%) and Social Services (14%).

3.12 In 2012-13, the inpatient admission rate (89 per 100,000) for mental health disorders for 0-17 year olds was similar to London and England. Young people's hospital admission rate for self harm (191.7 per 100,000 directly standardised) was lower than London and England figures (Public Health England 2014).

4. Introduction

4.1 "There is a clear appreciation across all services working with Children and Young people within the London Borough of Haringey that the issue of "Transition" – and more particularly the moving between adolescent mental health services and adult mental health services at the age of 18yrs - proves enormously problematic for many young people and their families/carers." (Dr Nick Barnes).[9]

4.2 During the review the Panel, with input and assistance from a range of stakeholders looked at the various issues and considered what recommendations could be made to improve the transition pathway for young people.

5. Survey

5.1 The Panel felt that it was important to get the views of young people who had experienced or were experiencing transition as well as the views of both parents and carers of those young people. The Panel had initially planned to set up a focus group to hear views and input with the support of BEH MHT. However none of the young people who were contacted felt able to talk about their experiences, and so the Panel felt that an on-line survey would be beneficial.

5.2 Two surveys were developed in order to gain input from young people and their parents/carers. The Panel gratefully received comments and amendments on the survey from a number of professionals involved in the project to ensure that the questions were the right ones to be asking, as well as being useful in developing the transition service.

5.3 Hard copies of the survey were distributed by partners at their reception centres and the online survey link was sent out to relevant mailing lists, however the response rate was low, even with an extension. The total number of responses was just 20 people. Therefore whilst the results of the survey are in no way statistically proportional of the population they may provide a useful snap shot of views.

5.4 Further analysis of the parent/career survey can be found at **Appendix A**. In addition, there were some suggestions from young people that may be useful to commissioners. These are noted below:

- *When asked about their current mental health, one respondent said that it was 'ok', one 'very bad' and one 'very good'.*

- *Respondents were asked whether there were any experiences they wished to share around their mental health. One respondent noted that sometimes a young person just needs someone to talk to and this should not be classed as a mental health issue. This may relate to stigma, something the Public Health*

[9] Dr Nick Barnes, 'Suggestions for CAMHS transition project', submission to Panel, Nov '14

Team are currently doing some work on. Another respondent indicated that it was better not to talk about your experiences.

- *Some respondents did not feel involved in planning and making decisions about their move from child to adult services.*

- *Some respondents were not aware that there might be a time which they could no longer access some services due to their age.*

- *When asked the question on the best way for young people to get information on services, one respondent felt that their support worker/key worker/personal adviser was the best source of information, one felt that drop-in sessions would be best and one felt that an email may be helpful.*

- *When asked what could be done to improve transition one respondent responded "give them the heads up…"*

5.5 The Panel felt strongly that further input was needed from young people in order to improve the service. This is something which is also stated as extremely important in the NHS England CAMHS specification.

6. Fair Access to Care

6.1 Whilst recently legislation and policy has focused on ensuring that information, advice and guidance is available to those who require it, and on a greater integration of services, the legislation has not addressed the differing eligibility criteria between adult and children services. These legislative issues are around a young person's need, as set out by national criteria, at the point at which a young person becomes 18 years of age. The clear gaps in what a young person of 17 years of age can access and what a young person can access at the point at which they turn 18 years of age, present what has been termed a 'cliff-edge' and can be a difficult time for a young person.

6.2 The Panel heard that in adult services a person must have 'severe and enduring' mental health needs in order to meet the eligibility criteria for access to services. However, there are adult mental health services that are available to those with less complex needs such as counselling and Improving Access to Psychological Therapies (IAPT). These provide a different service offer and this can mean that a young person can be shocked at the difference in provision and access, at a time when they are already vulnerable.

6.3 Whilst the Panel is aware that it is out of its remit to make recommendations on nationally set criteria, it felt that it is extremely important that this 'cliff-edge' is as cushioned as possible, in order to try and prevent the development of more severe mental health needs in the future. The Panel also felt that there is a need to prepare young people and their parents/carers for this change, this includes making it clear to young people what is available at each stage of the pathway.

7. Transition point

7.1 The Panel heard from a range of stakeholders about issues at the point of transition between child mental health services and adult mental health services, when a young person turns 18 years of age.

7.2 The Panel noted that there are some areas which work well, for example if a young person was referred to CAMHS with psychosis at 17, they would seamlessly move to the Early Intervention Service (EIS) at 18. In this instance the Panel heard that the move tends to work well, as the staff know each other, work well together and also communicate effectively. This is also aided by the EIS being quite an intensive package and so a young person would still have intensive support on reaching the age of 18 years, for the completion of the 3 year treatment programme (as outlined in the National Service Framework and NICE). After 3 years the person would generally transfer back to primary care or the Support and Recovery Service, which uses an enablement model to help young people move forward with their lives.

7.3 However in the instance of a young person accessing CAMHS for first episode psychosis at 14 years of age, the majority would be discharged back to primary care at the end of three years, assuming they had stabilised sufficiently. If they then required a service after they were 18 they would go straight into adult mental health services which are quite different from what they would have previously received. The Early Intervention Service (EIS) is currently being reviewed, and transition issues will be examined as part of this.

7.4 The Panel heard that those working with young people try to look at services such as Improving Access to Psychological Therapies, GP management, Open Door etc. to fill gaps/cover patches for young people who are not eligible for secondary care mental health services. However, those working with young people felt that there was a need for a much more seamless service for young people with a higher level of support across the board to prevent them experiencing the above mentioned ‘cliff-edge’. Panel Members agreed with this view.

8. Communication with young people and their families/carers

8.1 The Panel were informed that overall young people in Haringey are not currently very well prepared for transition. This includes ensuring young people have the relevant information on what is happening, including changes to their service provision (e.g. when a service would no longer be available due to age) and also ensuring that the correct staff are engaged early enough, from all relevant services (both adults and children’s services). There was acknowledgement that this is an area which needs some further work and improvement, and suggestions such as merging services more so that a young person does not feel lost or bereft at the point which they transition to adult services were discussed as a good way forward by both the Panel and project participants.

8.2 The Panel felt that it would be beneficial to provide young people with a booklet or folder of information, possibly which they could add to as and when they are given new information. The Panel and attendees felt that it would be important for this information to be presented in a professional format to ensure that young people feel that the information is valid and important.

8.3 A recommendation to develop a guide book to improve communication with young people and their families/carers has been put forward by the panel. This is included under section 13 as this provides further information on pathways / service models.

9. Data

Data on those who are due to transition

9.1 The Panel heard that at present there is no consistently updated list of young people who may need adult services at the point at which they turn 18 years of age. The Adult Mental Health Service has a list at present[10], which has ten young people who may need to transition to adult services in the near future and require services/funding. However the young people on the list have been added due to relationships and contacts across the services as opposed to any clear process by which a young person could be added. The Panel felt that this would not only make it difficult for adult services to properly plan for those who may be transitioning into the service, but also meant that the risk of a young person falling through a gap and being lost from services was greater.

9.2 The Panel agreed that there was a need to identify those who may need adult services at the right time. This should be early enough to enable sufficient planning and transition.

RECOMMENDATION (1)

In view of the absence of a shared electronic client record system across mental health and social care, the panel recommends that a clear process for information sharing across agencies is developed.

Data on young people who come back into services at a later date

9.3 The Panel heard evidence relating to young people who are not eligible for adult services when they turn 18 years of age, however do then come back into contact with services a few years down the line, often in crisis. This can be into adult mental health services, but it can also be into services such as homelessness.

9.4 There is currently no data collected on those who come back into contact with services and who may have been in contact as a young person. The Panel heard that there may be challenges in getting this kind of information, for example a person may not disclose that they were in contact with children's services and BEH MHT have anecdotal evidence but no statistics. However, Panel Members felt it would be useful for a piece of work to be done looking at those who do come back into contact with services, what their needs are, and whether there are particular groups who are most likely to come back into contact at some point. The Panel felt that this would be a valuable piece of work which could help with early intervention, prevention and planning e.g. to assist with

[10] As per October 2014

targeted work with those of higher risk of re-entering services. The Panel felt that this would also link into the Council's wider work on early intervention.

RECOMMENDATION (2)

The panel recommends that a piece of work is undertaken to look at what data is available, and is required, across health and social care agencies. This could be used to analyse trends, understand why young people drop out of services, and to identify the most appropriate ways to support discharge planning. This information could help tailor the help offer to prevent escalation of need and re-entry at a later point.

10. IT

10.1 The Panel was made aware that there is currently no interface between RIO (mental health IT system) and Framework-i (Social care records system). This means that staff working across services, and organisations, have to physically request information as the systems do not link. This process can take time.

10.2 The national charity, Young Minds, informed the Panel that data sharing is often cited as a barrier by organisations nationally (often with reference to data protection rules). However Young Minds directed the Panel to Caldicott 2, an independent review, requested by the Secretary of State for Health, on how information is shared across the health and care system. This includes information sharing guidelines and places an emphasis on there being an obligation to share information.

11. Young Adult Service

11.1 The Panel heard the status underpinning the Young Adult Service is slightly different – a young person is classed as 'leaving care' up until the age of 21, or 25 years of age if they are in education. Looked after children often have very complex needs and young people rarely present with one clear need, rather these young people often require very significant support. There is a lot of unmet need, however there is also a lot of work being done to try and address this e.g. with Open Doors and Young Minds.

11.2 The Panel was made aware of the work being carried out by First Step, a service provided by Tavistock and Portman NHS Trust, who undertake a multi-disciplinary screening and assessment in the first instance. This ensures that Looked After Children (LAC) are screened to identify any mental health needs, then more extensive screening takes place to consider the level of the needs (where identified). A young person would then be referred appropriately should they need to be. This is specific to leaving care due to the increased prevalence of mental health needs within this group of young people. There are often added complexities, for example unaccompanied minors can often have substance and alcohol misuse needs.

Transition

11.3 As with young people across mental health services, at the point of transition young people can often not meet the adult diagnosis threshold, but they will often meet this threshold later in life as their mental health needs deteriorate. They therefore often come back into mental health or other services at the point of crisis, at which point they meet the eligibility threshold.

11.4 During their investigation, and as noted earlier in the report, the Panel heard there were over 500 young people in care in Haringey, with approximately 330 placed out of borough. Following the panel's research however, and as noted in par 3.3, the number of looked after children, at February 2015, had reduced to 462 – with 101 placed in borough and 299 placed out of borough (62 placement details suppressed due to confidentiality). Given that different boroughs have different pathways, and young people often have to move often, this again adds to the complexities.

11.5 Many young people come back to the borough at 18 years of age as this is where they are eligible for housing. The Young Adult Service works with the Vulnerable Adults Team on housing issues, however due to the leaving care status this housing is often only available up until the age of 21 or 25 years, again adding a complexity for young people who have been in care.

11.6 The Vulnerable Adults Team is the main housing link, however it is difficult to find suitable housing for these young people and the Panel heard that only 60 care leavers will have housing in the borough. The Panel felt that there should be an overseeing role within mental health services to ensure that young people do not fall through the gap between children and adult services at this point.

RECOMMENDATION (3)

The panel recommends that a coordinating and overseeing role is identified at the commissioning and operational level to ensure that no young people fall through the gap due to their housing needs and situation and to prevent young people from becoming homeless.

12. Young people appropriate services

12.1 There was a great deal of discussion on ensuring that services for young people are appropriate to meet their needs, as opposed to being rigidly constrained by an age. The Panel heard that a young person may have arrested development, for example when a young person has been in care and/or been through a difficult time their development can be on hold/'arrested' until later. In these instances a young person turning 18 years of age is a false view of when a young person becomes an adult. The Panel agreed with stakeholders that in order to bridge this gap and ensure young people in the borough have the support that they need a strong integrated model which spanned a larger age range e.g. 15-25 years of age would be the most appropriate form of service provision.

12.2 An age appropriate service was again discussed and explored further at the pathway workshop, which is outlined below. It has also been identified as best practice in a number of authorities in the UK, as well as in other countries. Examples of these are included in the written submission by Dr Nick Barnes, which can be found further in this report.

13. Pathway workshop

Current Pathway

13.1 The Panel ran a workshop with staff who work with young people across adult services, children's services, BEH MHT and the voluntary sector. This included social workers, personal advisers and a young people's psychiatrist. The objectives of the workshop were:

- To understand the pathway between child and adult mental health services.
- To understand how different agencies fit into the pathway.
- To identify issues/challenges/blockages along the current pathway and opportunities to improve these pathways.
- To identify an improved pathway.

13.2 It was evident from the workshop that the current pathway from child to adult mental health services is very ad hoc, and the Panel felt that it was very dependent on who a young person happens to be in contact with, for example Open Door runs a service for young people aged 12-25 years of age and therefore a young person is unlikely to fall between the gap, and Psychosis also works on a more seamless pathway. However, if a young person is assessed by adult services and does not meet the threshold then they are likely to fall between the gap.

A more effective pathway

13.3 As part of the workshop, two groups were set up to consider what a more effective pathway would look like for young people. The first group felt that a multi-agency hub, which could be accessed by young people up to the age of 25 years, would be a more effective pathway for young people.

13.4 The second group 2 came up with two options:

- Multi-agency transition service for young people up to the age of 25 years
- A multi-agency formulation meeting at the point of discharge from children's mental health services to discuss, with involvement from the young person, the most appropriate care package moving forward, including involvement from voluntary organisations.

A new service model?

13.5 The Panel heard evidence from the national charity, Young Minds, who made the following points:

- There is no point tweaking processes around the edges, you have to change the whole system to make improvements.
- There is a need to remember that there are young people who will have needs that 'don't quite fit' into structures and therefore there needs to be flexibility.
- Any transition service must be holistic – and a one stop shop.
- This approach may be expensive but the evidence is there to demonstrate that it is cost-effective.
- Engagement with the young people is much easier when it is in a hub which covers a variety of services, and is also therefore non-stigmatising.
- Young people must be involved.

13.6 The Panel felt that in order to provide an effective transition pathway for young people, as well as ensuring Haringey is in line with best practice, the borough should move towards an integrated service model for young people from 13-25 years of age.

13.7 The Panel was very grateful for the support and assistant of Dr Nick Barnes and Dr Virginia Valle, Young People's Psychiatrists from the Adolescent Outreach Team, BEH MHT, throughout the project. Dr Nick Barnes made a written submission to the Panel which he presented at the final meeting. The Panel felt that the points made in Dr Barnes' submission, and the proposed model were in line with the conclusions which the Panel were discussing. The Panel and project attendees also felt that the model which was suggested by Dr Barnes was also in line with the NHS England Model Specification for Child and Adolescent Mental Health Services which the panel had early sight of whilst in draft form. In particular the Panel and attendees felt that the proposed model would address the model specifications outlined in the document[11].

13.8 The extract below is from a statement submitted to the Panel by Dr Barnes:

"*There is scope and need for a wider provision at a Tier 2 level in community which could link with schools/education, social care and other services. There are 2 very strongly favoured models of support that seek to address this integration of care;*

[11] http://www.england.nhs.uk/resources/resources-for-ccgs/#camhs

The Sandwell Model[12] *– delivered in Sandwell and Dudley, this is a service that offers a widely integrated service that seeks to address "wellbeing" in a far wider sense, rather than focus specifically on mental health. Hence it has had significant impact on levels of violence within the local population, as well as seek to raise levels of resilience. A key feature of this service has been the desire to reduce the threshold of accessing support. This service appreciates that offering work at an earlier stage reduces the risk of further escalation of need, and so invests in an earlier intervention and more preventative approach.*

Headspace[13] *(in Australia) – Effectively seen as a One Stop Shop for addressing the wellbeing of young people (12 – 25yrs). This approach is more about a reconfiguration of current services, rather than necessarily commissioning more services (seeking an integration of – Childrens Services, Education, Sexual health, Employment, Youth Offending service, Youth services, drug and alcohol services as well as mental health services) so that a young person may approach the service without specifically believing they are looking to address their mental health needs first and foremost.*

Models of good practice for (Tier 3/4) mental health services – there are many models of good practice, and within our own borough, there are areas where transition is addressed in a well-coordinated manner. This is particularly so in the **Early Intervention Services** (linking across the Adolescent Outreach Team and the adult EIS services that work with young people with psychosis). The bridging of care across both teams works well within the borough but is only for a very small and select number of young people, with the EIS intervention only being available for a maximum of 3 years[14].

Orygen Youth Health[15] *- Orygen Youth Health Clinical Program (OYHCP) is a world-leading youth mental health program based in Melbourne, Australia. OYHCP has two main components: a specialised youth mental health clinical service; and an integrated training and communications program……..*

The Enablement Initiative within BEH-MHT and local authorities – The Network – *The development of enablement approach by BEH-MHT and local*

[12] http://www.bcpft.nhs.uk/services/for-children-and-young-people-and-families/84-camhs/250-specialist-camhs
[13] http://www.headspace.org.au/
[14] This is in-line with NICE and the National Service Framework for Mental Health
[15] http://oyh.org.au/

authorities has also opened up opportunities for exploring the issues of transition, perhaps best exemplified by the model developed within Barnet – the Network. The Network is an enablement service that provides support and interventions which enhance and promote recovery, social inclusion, and community integration to maximise resilience and independence. (See attachment). As BEH-MHT are looking to expand the enablement approach across all services, it is clear that there could be some very positive collaborative work between the local authority and the trust, involving the third sector/Community and Voluntary sector organisations, that would allow for us to address transition, accessibility, integration and enablement. See model below. Currently the trust is exploring setting up a pilot for addressing transition concerns through this enablement approach.

Other important local developments *-*

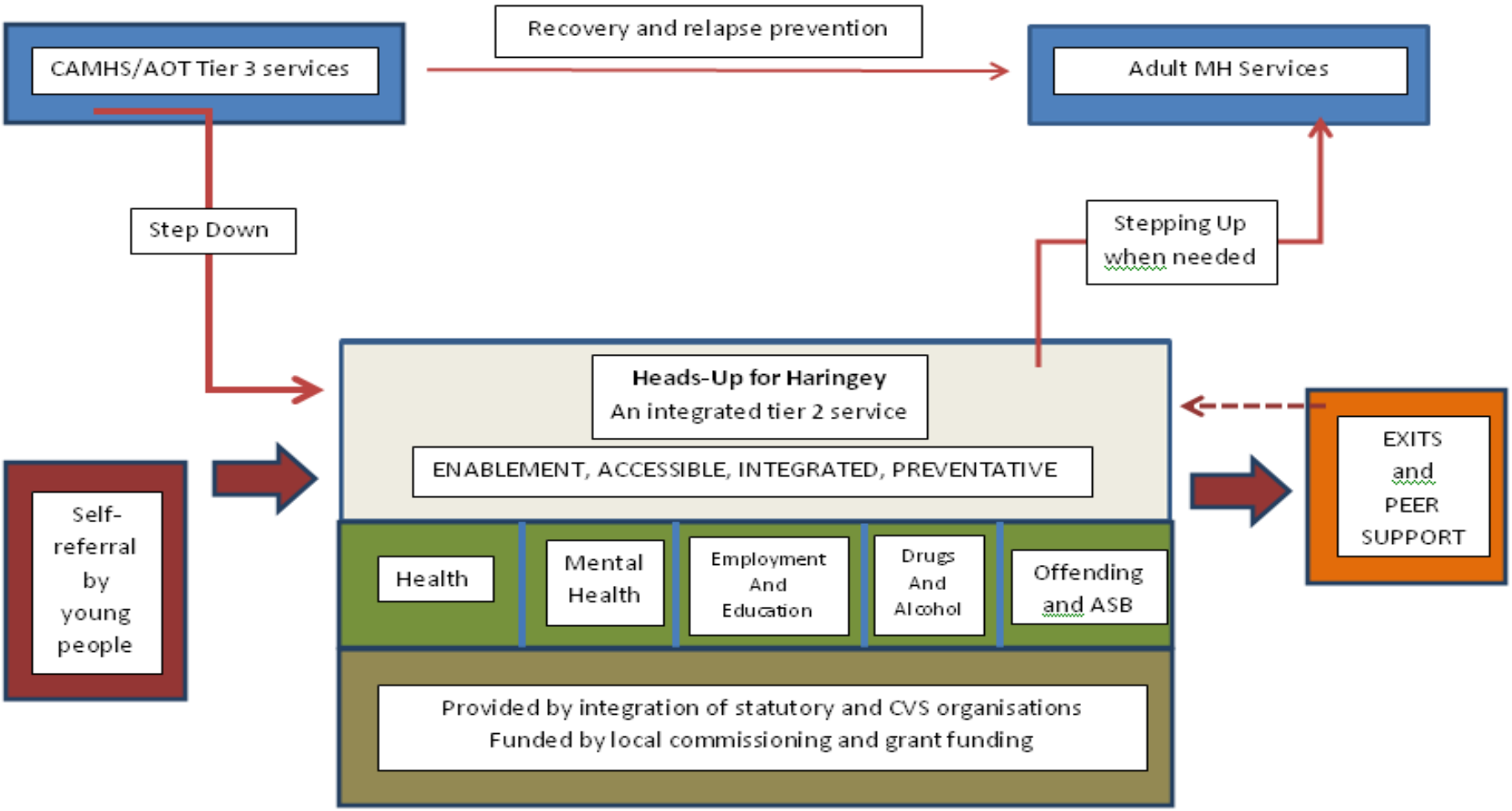
- ***Integrate Haringey*** *– the involvement of MAC-UK within the borough, seeking to set up an integrate project with the local authority and BEH-MHT offers a real opportunity for young people who would never normally access mental health services find a less stigmatising way of addressing their needs – often in a much more integrated perspective. To offer a Headspace type service for these young people to move on to would reinforce that perspective of inclusion and participation*
- ***Early Help*** *offer from local authority – Establishing the role of the Early Help coordinators, with a clear emphasis on earlier intervention and more preventative work would also fit well with a headspace type model for the borough's young people*
- ***Tottenham Regeneration*** *– within a climate of regeneration, surely this is also the time to then think about how to regenerate services so that they meet the needs of the young people; that the services are accessible, integrated, about enablement and focus on working sooner rather than later.*

Proposal – Heads Up for Haringey *– If we are seeking to address Transition, then to best achieve this, we also need to think about accessibility (and unmet need), integration of services, early help and prevention, promoting enablement (and not dependency) and fundamentally seeking to provide the most appropriate support for young people in Haringey.*

The model (overleaf) seeks to build on the information provided above. It seeks to allow for a clear pathway from adolescent services to adults services where needed, but that for the majority of young people this could occur through a "step-down" – more integrated, community service that would allow for young people that doesn't reinforce dependence, but seeks to promote enablement and empowerment. This service could be an integration of support at a tier 2 level, from statutory and CVS organisations (promoting wellbeing and building resilience rather) and then gradually evolve to become an open access, self-referral provision for all young people within the borough".

- **Dr Nick Barnes, Young People's Psychiatrist, BEH Mental Health NHS Trust**

Haringey CAMHS Transition project



Nick Barnes, Haringey Adolescent Outreach Team

13.9 Given the consensus amongst the Panel and attendees (including representation from Haringey CCG and the Commissioning team) that the proposed model was a positive way forward the Panel made the following recommendations:

RECOMMENDATION (4)

The panel recommends that:

(a) The "Heads up for Haringey" model should be adopted for young people in Haringey on a partnership basis. In the first instance this should be on a pilot basis working with young people. This pilot could then be built on and expanded taking into account lessons learnt and feedback from young people and their parents and carers. *(Dr Nick Barnes, BEH Mental Health NHS Trust, has offered to oversee this)*

(b) A scoping exercise should be completed by CAMHS providers to understand the number of children and young people approaching transition.

(c) A multi-agency workshop should examine how the pilot would be resourced, implemented and evaluated.

(d) Intelligence from the pilot should be used to inform future commissioning intentions and service developments.

RECOMMENDATION (5)

The panel recommends that a "Heads up for Haringey" guide be developed and presented to young people as they are referred to this mental health service. This guide should be developed with input from young people and carers and include:

- **Information on local services which may be accessible to the young person**
- **Referral forms**
- **Pages for useful information which the young person can add to**
- **Information on useful websites and Apps**

14. Staff awareness

14.1 As mentioned above the pathway workshop engaged with a range of professionals who have first-hand experience of working with young people with mental health needs including social workers, personal advisers, a young people's psychiatrist and staff from local voluntary organisations (Open Door, First Step and Mind in Haringey).

14.2 Throughout discussions at the workshop participants were sharing ideas and learning more about what each service and/or organisation provided, what the referral routes were and how the different services/organisations fitted together. Participants also shared contact details. The Panel felt that this demonstrated a potential for much greater partnership working to enable professionals to learn more about what is available across the borough and where they could refer or signpost young people and/or their parents and carers to.

14.3 The Panel heard that there is no Approved Mental Health practitioner with a childcare background in the adult service and no adult trained social worker in the Young Adult Service. The Panel felt that the inclusion of a social worker trained in children/adult service would be beneficial across the services.

14.4 The Panel gathered evidence from Camden's mental health services concerning their new model for transition of young people with mental health needs as an example of best practice. Camden have two aspects to their service, one of which is 'age alignment' where meetings are held every 2 weeks and attended by decision makers from across adult and children mental health services. At these meetings cases are looked at individually with discussion on what needs to change to assist the young person. The attendance of staff from children's and adult services encourages a focus on how the departments operate differently and what needs to be done to bridge this gap. An advantage of this approach has been that more information has been shared across children's and adult services and has also enabled working practices to be shared. Another advantage includes sharing knowledge on what services are available for young people e.g. projects that an adult team may know about that a children's team does not.

14.5 The Camden model also involves 'transition champions' in each team in adult services – this assists with sensible thinking about what will help a young person even when they do not meet the transition threshold.

14.6 The Panel felt that there were lessons which could be learned from the Camden model which would benefit young people in Haringey. Whilst the Panel's main recommendation centres on the new service model it felt that improved communication and working across the services and partnership would benefit young people in the interim and until the new model was fully operational (subject to agreement of the recommendation).

RECOMMENDATION (6)

The panel recommends that there is a multi-disciplinary and multi-agency meeting a minimum of once per month to discuss the cases of young people who are due to move across into the Heads up for Haringey service and those who are in the new Heads up for Haringey service to ensure the needs of young people are being met.

RECOMMENDATION (7)

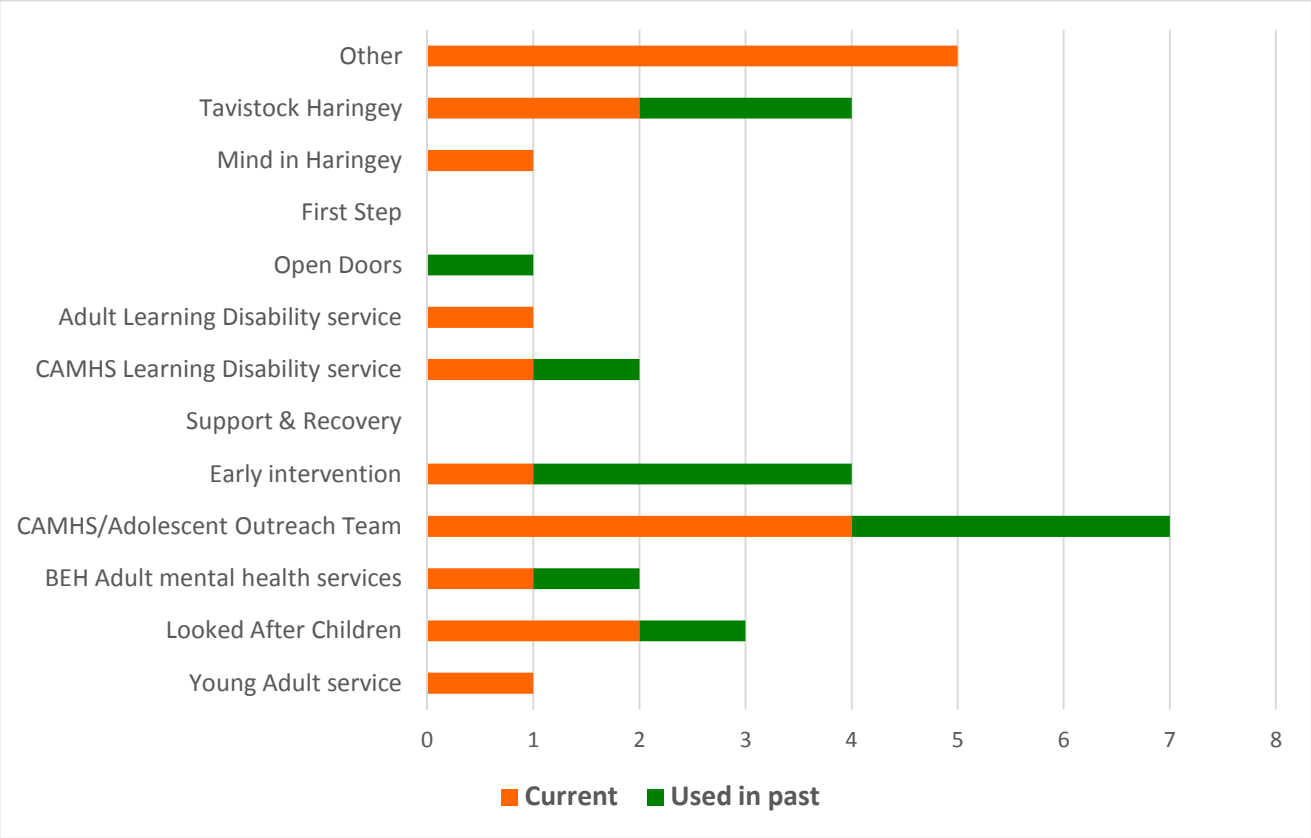
The panel recommends that consideration is given to the merit of placing an adult trained mental health social worker in the young adult service and a social worker with child mental health experience in the adult mental health team.

APPENDICES

Appendix A – Parent/Carer Survey

Q1. Has your young person ever used or is currently using any of the following services?

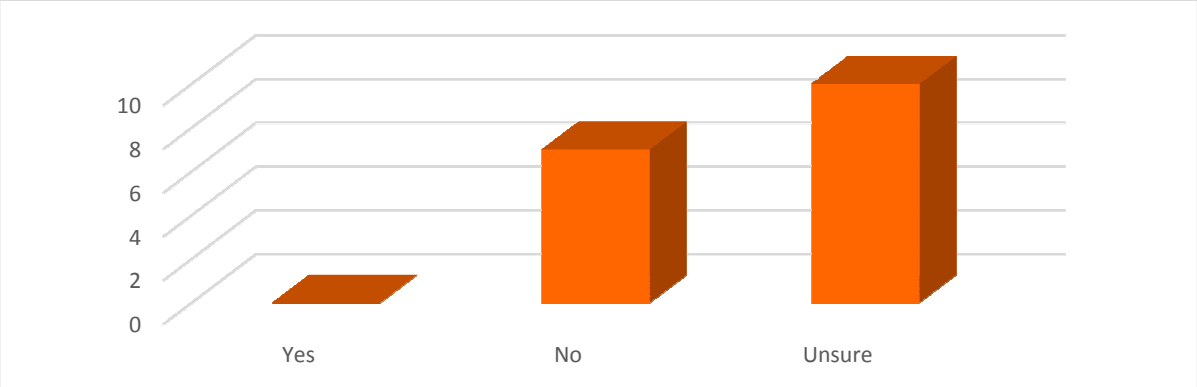
As can be seen from the chart below survey respondents had come into contact with a range of services across the young person's mental health services.



Q2. Do you feel that the children and young people's services and adult services communicate well with each other?

There were no responses to this question.

Q3. Do you think that the transition between children and young people services and adult services works well?



Respondents were also asked to give an example of when transition has worked well, or where it could be improved. There were three responses to this part of the question, two of which centred on delays in transition – one on a young person experiencing a service transition and one on a delay in the transition assessment until the young person was 19 years of age:

"*The transition for my daughter with autism, from school to college was very difficult. I had to employ solicitors at great cost to me. The outcome was a delay of 3 weeks from the start of the term. This was a residential college and the delay for a young person with problems with social skills was very difficult for her. Friendships had already been formed and she felt very isolated for some weeks at the start. This led her to say she wanted to die. Though this relates to Education the delay was caused by Social Care as opposed to the Special Educational Needs department*."

"*Transitions assessments should be done before the child turns 18yrs old. My son did not get a transitions assessment until age 19*"

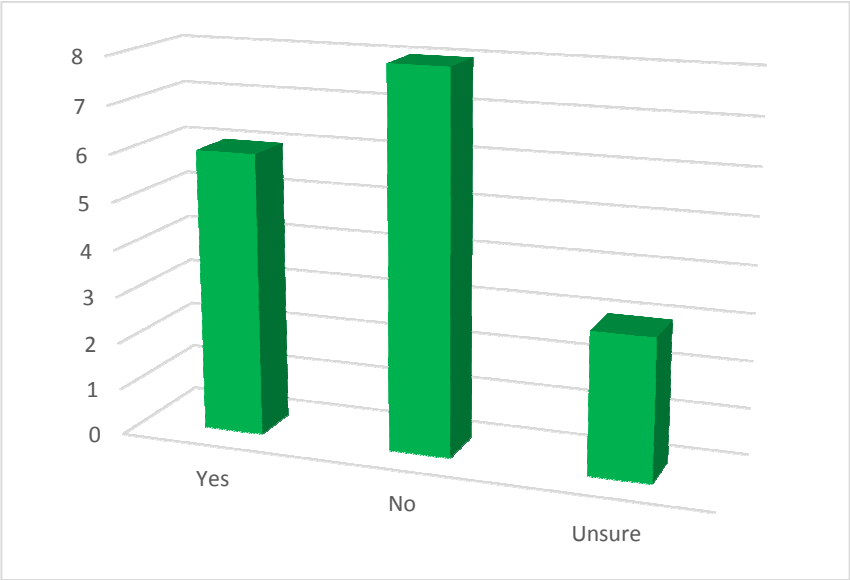
The third respondent talks about the changes or 'cliff-edge' when a young person transitions from child to adult mental health services and which was part of a recurring theme through the course of the project:

"*Most of the time I think it takes a bit of time for the transition to settle into place. The young people need to be made aware of how the boundaries change and the responsibilities that they will have to take on. I'm unsure as to whether or not they are prepared for this but at the same time there is some apathy amongst the young people as they are used to getting everything handed to them on a plate and then suddenly everything changes and they have to become much more responsible and manage their emotions at the same time."*

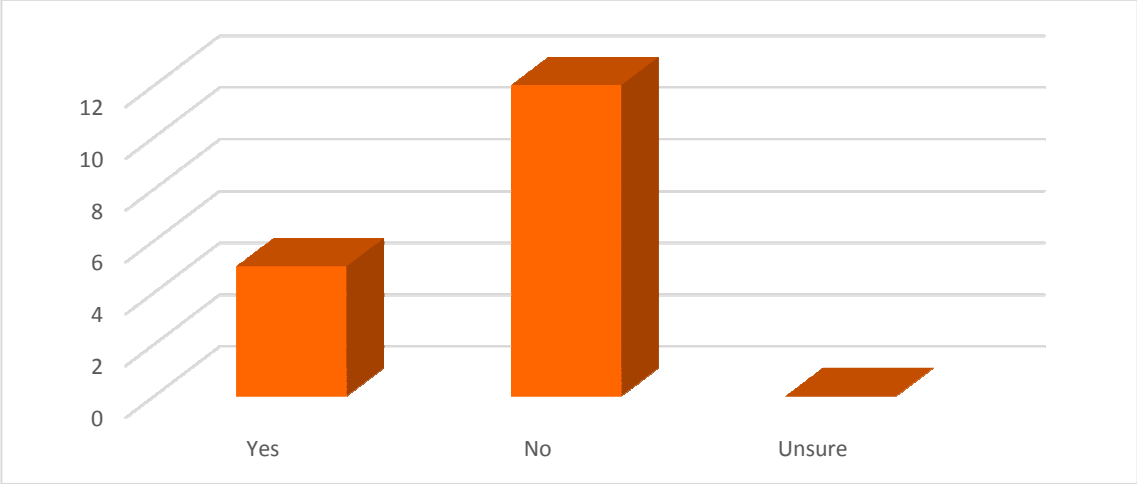
Questions 4, 5, 6 and 7

Based on the responses to these questions there may be merit in considering how information can be better shared with parents and carers of young people with mental health needs in order to ensure that they are personally prepared for the different role and responsibilities they are likely to have in their young person's life when that young person transitions and also how they can best support their young person at this critical time. Whilst the Panel is aware of the parent/carer counselling services offered by Open Door the Panel understood from project participants that information on this valuable service may not be widely known. The Panel also felt that the Open Door projects were an example of best practice and should they be more widely expanded and/or built on then it could ensure that parents and carers are better informed, as well as their young people.

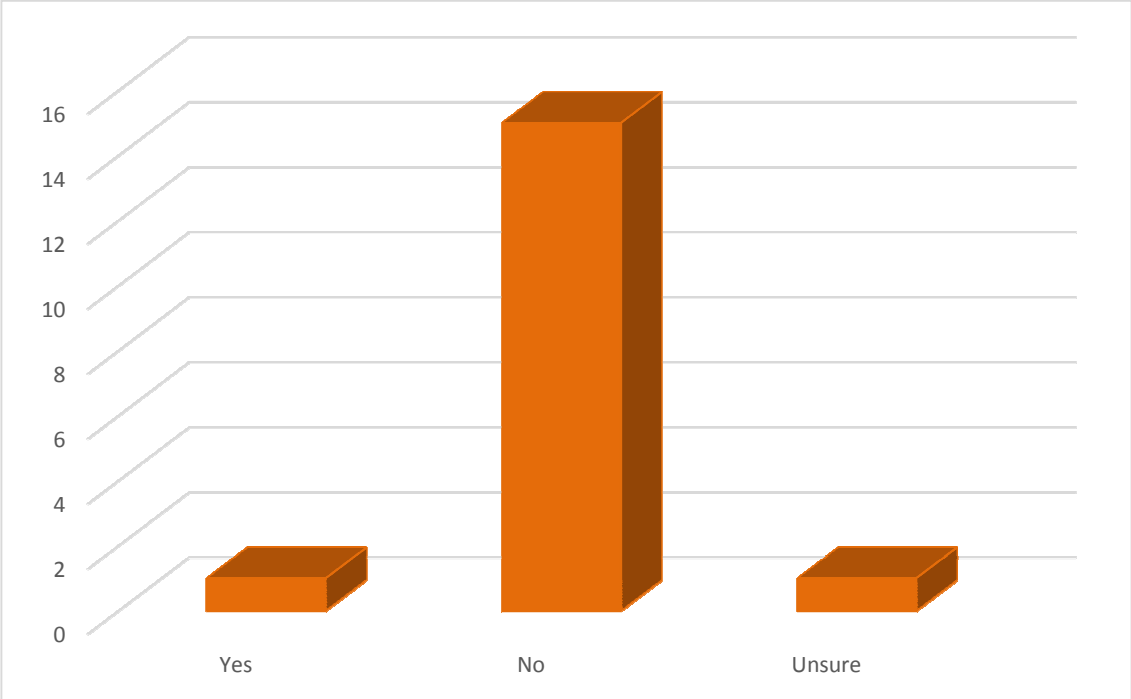
Q4. Were you aware that there would be some services that your young person might not be able to access based on their age?



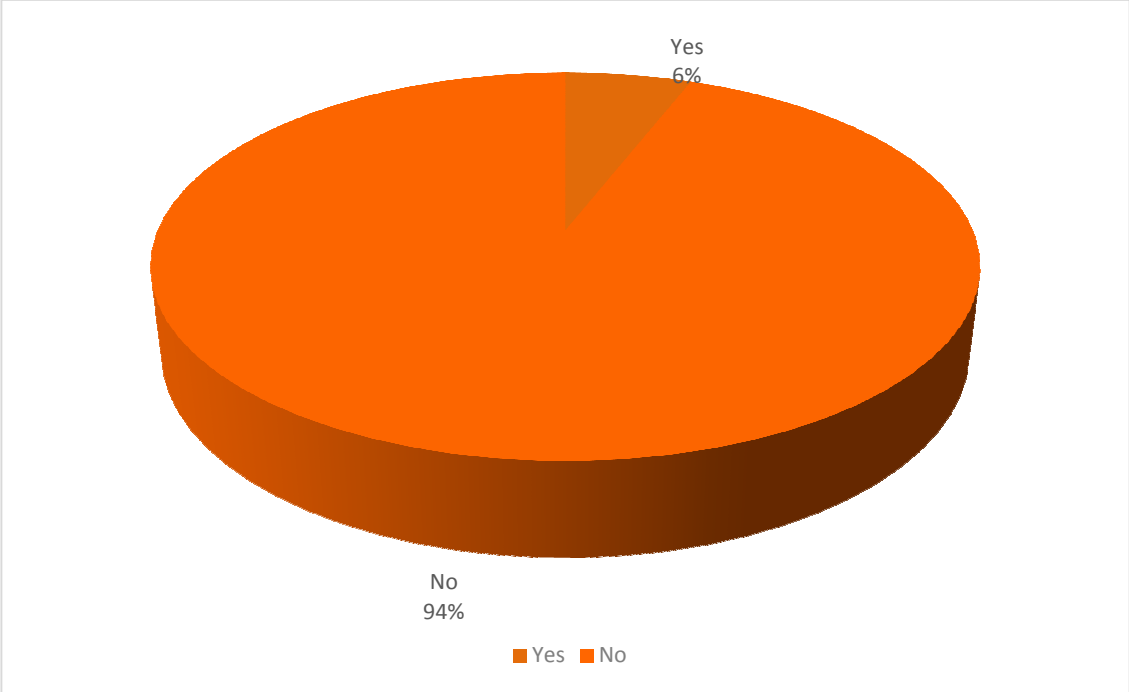
Q5. Has anyone told you that your involvement in your young person's care may change depending on their age?



Q6. Have you been offered any guidance to help you support your young person as they transition between services?



Q7. Have you been offered any personal support to manage the impact on YOU that may result from the service transition of your young person (e.g. counselling)?



Q8. Is there anything you think should be done to help <u>YOU</u> understand and prepare for your young person when they transition between services (e.g. peer support)?

The majority of respondents to this question felt that it would be beneficial for them to have more information on transition. Commissioners may wish to consider how best these needs can be met.

- *"A standard pack containing a timeline of what to do when etc, details of services available all downloadable from Haringey website.*

- *It would be very helpful to have at least one discussion on the subject of transition, rather than spend all that valuable time simply fighting for the right placement*

- *Yes - I think even basic information would be useful. I've not been told anything about transition eg he is finishing Year 11 this year - what happens next? Does it matter if he goes to college outside Haringey?*

- *I would like a designated person to talk me through the process of transitioning to higher education for my child*

- *Yes. There needs to be more dialogue about expectations, proactivity and outcomes that are there leading up to and beyond the transition period.*

- *Workshops*

- *More and clearer information and access to social work advice*

- *Support from local agencies. Ease of access to information through either web app or direct mail.*

- *One to one meetings or group forums about the changes*

- *Yes, peer support might be helpful.*

- *We get no support at all"*

Q9. Is there anything you think should be done to improve the transition process for young people?

Responses to this questions included ensuring the young people have the information they needed to be prepared for transition, improved communication and a more seamless pathway. Should the recommendations of this project be agreed then the Panel hopes that these issues will be resolved as part of the new model.

- *"More talk about it at school and college from about age 15 so they see it as something that will definitely happen and is positive and so they feel prepared.*

- *Give quicker response to the agreement of next placement so that transition could be managed much more calmly*

- *Better information and earlier - maybe a basic transition information pack and then a meeting with the young person and carer to discuss the process with them*

- *I always have to fight hard for help with every transition. Haringey council are never pro active in helping*

- *Only experienced this so far with regard to education transition. Young people are 17 years.*

- *Professionals talk to each other*

- *Consultation with parents and parent groups*

- *Support from local agencies. Ease of access to information on services through either web app or direct mail.*

- *Make the transitions team properly resourced. Ensure that all sencos in schools & colleges understand the system and what is on offer*

- *Communication*

- *Yes. They need to be made fully aware of what their responsibilities are to themselves and how to manage these."*

Appendix B – Review contributors

Name	Job Title/Role	Organisation
Cllr Pippa Connor	Chair	Haringey Council
Cllr Gina Adamou	Panel Member	Haringey Council
Cllr Jennifer Mann	Panel Member	Haringey Council
Cllr Gideon Bull	Panel Member	Haringey Council
Cllr Anne Stennett	Panel Member	Haringey Council
Cllr James Patterson	Panel Member	Haringey Council
Cllr David Beacham	Panel Member	Haringey Council
Helena Kania	Panel Co-Optee	Haringey Forum for Older People
Melanie Ponomarenko	Senior Policy Officer (Scrutiny)	Haringey Council
Diane Arthur	Advocacy Services Manager	Mind in Haringey
Ewan Flack	Director	Mental Health Support Association
Nuala Kiely		Mental Health Support Association
Mike Wilson	Director	Haringey Healthwatch
Tim Deeprose	Assistant Director, Mental Health Commissioning	Haringey Clinical Commissioning Group
Dr Virginia Valle	Young People's Psychiatrist	Haringey Adolescent Outreach Team, BEH MHT
Dr Nick Barnes	Young People's Psychiatrist	Haringey Adolescent Outreach Team, BEH MHT
Lynette Charles	Operations Manager	Mind in Haringey
Wendy Lobotto	Service Manager	First Steps
Julia Britton	Director	Open Door
Michael Murphy	Head of Learning Disabilities	Haringey Council
Jennifer Plummer	Team Manager, Mental Health Services	Haringey Council
Emma Cummergen	Deputy Head of Young Adult Service	Haringey Council
Charlotte Pomery	Assistant Director for Commissioning	Haringey Council
Paul Quinn	Social Worker / AMHP	Haringey Early Intervention Service
Sally Hodges	Associate Clinical Director and PPI Lead	Tavistock Portman
Andrew Wright	Director of Strategic Development	BEH MHT
Shaun Collins	CAMHS	BEH MHT
Janet Blair	Interim Project Manager	Camden & Islington Mental Health

Name	Job Title/Role	Organisation
		Foundation Trust
Lysanne Wilson	Director of Operations	Young Minds
Daniel Palmer	Personal Adviser, Young Adult Service	Haringey Council
Andrea Melis	Personal Advisor	Haringey Council
Sally Morley		BEH MHT
Sara Perry		BEH MHT

MINUTES OF THE CHILDREN AND YOUNG PEOPLE'S SCRUTINY PANEL
THURSDAY, 22 JANUARY 2015

Councillors Berryman, M Blake, Hearn (Chair), Ibrahim and Morris

CYPS22. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Akwasi-Ayisi, Mr Collier and Mr Taye.

CYPS23. DECLARATIONS OF INTEREST

None.

CYPS24. DEPUTATIONS/ PETITIONS/ PRESENTATIONS/ QUESTIONS

None.

CYPS25. MINUTES

AGREED:

1. That the minutes of the meeting of 3 November 2014 be approved;

2. That, subject to the following amendment:

   Item CYP21 (Scrutiny of the Draft Medium Term Financial Strategy) Reference 2; Services for Young People Including Young Offenders -
   (i). Recommendation 4, line 3: Delete all after the word "statutory"; and
   (ii). Add recommendation 5: "That the proposal be withdrawn";

   the minutes of the meeting of 15 December 2014 be approved.

CYPS26. BUDGET UPDATE

The Chair expressed concern at the late receipt of the further information that had been requested by the Panel in respect of the savings proposed for Services for Young People, including Young Offenders (Ref. 2). She stated that, in the future, she was minded to not accept any late documentation that was received by the Scrutiny Support Officer for circulation less than 48 hours before the meeting.

The Panel noted that 90% of work undertaken by the Youth Offending Service was statutory. 10% of clients were non statutory but work with this group was focussed on prevention. The services associated with the Youth and Community Participation Service were non statutory. Although the budget reductions in the Youth Offending Service were more than 10%, it was considered that the Council's statutory responsibilities could still be achieved by addressing staffing ratios and caseload allocation.

One of the Council's key strategic priorities was early help and it was anticipated that this would perform a preventative role in respect of youth offending. In particular, more support could be provided through universal services. One current key issue was that individuals at risk were being identified far too late. It was proposed to undertake engagement with young people in a more flexible way through outreach work and this would ensure that young people who were not in the education system continued to be accessed.

Concern was expressed by Panel Members at the move away from direct provision of services for young people. The remaining funds within the budget were for the commissioning of services and it was felt that the community sector were less effective in addressing the needs of the full range of young people as they tended to target specific groups. Directly provided services were also good at monitoring young people. The Assistant Director for Children's Services (Quality Assurance, Early Help and Prevention) stated that work needed to be undertaken with providers to ensure that these issues were addressed. In addition, quality levels needed to be maintained. The Interim Director of Children's Services commented that the challenge would be to define what the universal offer should be.

In respect of the proposals for Public Health (Reference 3), the Interim Director of Children's Services stated that the Council could not dictate to schools how they spent the Pupil Premium. The Cabinet Member for Children and Families commented that the suggestion was that schools could spend some of the funding on public health related areas that impacted on school performance.

In respect of Special Educational Needs and Disabilities (Reference 7), it was noted that there were two particular areas where it was intended to make savings. These were contracting and transport. One particular objective was to promote greater independence amongst service users and developing their skills and confidence could reduce their reliance on transport. There had been little feedback in respect of the future of Haslemere so far but engagement would be arranged with service users. The recruitment of more foster carers would also enable greater flexibility in respect of the provision of respite care.

Panel Members commented that transport was of particular benefit to families of children with special educational needs and disabilities that had other children who went to different schools as it provided them with some respite. In addition, children got to know the bus drivers, which could reduce stress levels for them.

AGREED:

That the Panel's recommendations in respect of the Medium Term Financial Strategy, as recorded in the amended minutes of the meeting of 15 December 2014, be confirmed.

**MINUTES OF THE CHILDREN AND YOUNG PEOPLE'S SCRUTINY PANEL
THURSDAY, 22 JANUARY 2015**

CYPS27. OPTIONS AFFECTING FUTURE TRADING ACTIVITY AT THE COUNCIL'S OUTDOOR EDUCATION CENTRE, PENDARREN HOUSE IN POWYS, WALES

The Interim Assistant Director for Schools and Learning reported that the subsidy for Pendarren was a particular issue that needed to be addressed particularly as schools already received funding that was intended to cover such activities. It could be argued that the service was effectively receiving a double subsidy. It was intended to undertake some market testing in due course. Price levels were normally nominally increased each year.

Panel Members questioned whether children from black and minority ethnic communities were now taking full advantage of the facilities. It had been the case that girls from several communities were often not allowed to participate by their parents for cultural reasons. The Interim Assistant Director stated that she would endeavour to find out the demographic of children who remained at school whilst trips were taking place.

It was noted that the asset management report had yet to be received. The buildings were nevertheless now very old and likely to require work. The results of the asset management report would be a key determinant of the viability of the Council retaining the property. There was a need for the facility to be better marketed and for opportunities to be exploited. Panel Members were of the view that outside organisations and other boroughs could be targeted.

The Panel expressed their support for the development of the facility along the lines outlined in option one of the three alternative management options for the Council, as referred to in the summary of the feasibility study. However, should it not be possible for the Council to afford to continue funding the facility, the Panel would wish to consider the matter further. They felt that Pendarren was an immensely useful facility that the Council should seek to maintain.

AGREED:

1. That option one of the three alternative management options for the Council outlined in the summary of the feasibility study be supported;

(Councillor Ibrahim requested that her dissent in respect of this be recorded).

2. That in the event of it being determined that it was no longer feasible for the Council to continue funding the Centre, a further report be submitted to the Panel; and

3. That the Interim Assistant Director for Schools be requested to determine the demographic of children who remain at school whilst trips to the Centre are taking place and to share this information with the Panel.

CYPS28. 2014 TEST AND EXAMINATION RESULTS

The Head of School Performance (Standards and Provision), reported that recent test results had been overwhelmingly positive. Results now showed performance in Haringey to be either in line or above the England average. In addition, the gap between Haringey and rest of London had narrowed. In Key

Stage (KS) 4, the Council was now in the second quartile of authorities. The borough was now rated as either A or B in the Department for Education (DfE) ratings for all categories except KS2 progress with reading and writing. Other areas of note were the improvement in performance in KS1 above level 3, where there had been particularly notable improvement amongst black pupils. It was likely that projections for 2015 would be met. However, the Council was not complacent.

A Panel Member reported that a DfE press release regarding improvements in GCSE performance had shown Haringey to be the third most improved authority rather than first, as stated by the Council. The Panel noted that this had been looked at by officers and it appeared that the benchmarking used by the DfE had used different parameters, particularly in respect of qualifications that were considered equivalent to GCSE. As far as the Council was concerned, its data was correct.

The Panel noted that relevant data had been used to ensure that there was a strong level of accountability and to identify risk effectively, which enabled effective early intervention. There had also been a real will to succeed and effective collaboration. The Cabinet Member for Children and Families commented that school governors were becoming more effective in their role. There had been a need for them to gain a better understanding of how schools worked and this was now happening.

In respect of academies, the Interim Assistant Director for Schools and Learning reported that approximately half of secondary schools had now converted. The conversion of primary schools was influenced by different criteria to that of secondary schools and this was based on performance. All were nevertheless regarded as part of the family of schools, irrespective of their status. There was a rota of visits to schools and all were visited at least three times per year. Challenged schools were visited more frequently. Some academies were very easy to work with but they could be challenged robustly if the need arose.

The Panel noted that the performance of black pupils overall was improving very well and the gap with other pupils was narrowing. There was key data available on all ethnic groups. The Interim Director reported that data for groups of schools was shared with Network Learning Communities and they were encouraged to identify specific challenges within it.

A Panel Member highlighted the recent considerable improvement in the rating given by Ofsted to some of the new academies with the borough. The Interim Director reported that schools that were supported by the local authority had shown equal or better levels of improvement. The improvements were likely to be indicative of a number of issues.

In respect of performance levels for KS2 in reading, a working party was looking at how these could be improved. Early progress was very important as it gave children and better chance of success later on.

AGREED:

That a report outlining comparative performance data in respect of the attainment of children and young people with special educational needs be submitted to a future meeting of the Panel.

CYPS29. PANEL PROJECT ON YOUTH TRANSITION

The Interim Head of Youth, Community and Participation provided an overview of the challenges relating to young people who were not in education, employment or training (NEET) and how these could be best addressed.

Although unemployment was dropping, there were still too many young people not transferring from school into further education or training. One additional issue nationally involved young people who disappeared off the statistics. There had been comparatively high levels of NEETs and not knowns in Haringey in recent years but these had diminished. Not knowns began at a high level in September/October but reduced as information came through about the destinations of young people. The local authority was dependent on schools and colleges for data and it was important that there were good relationships. The figures for not knowns and NEETs showed a downward trajectory but there were still issues that needed to be addressed.

Young people in certain ethnic groups and wards were more likely to become NEETs. In addition, children of offenders or young mothers were also at greater risk. For some young people, if they were unable to get on the right pathways, involvement in gangs could become an option.

There had been an increase in employment in London. Of particular note was the growing demand for people with high levels of qualifications. There had been decreases in the level of graduate unemployment as well as a very large increase (400%) in the number of apprenticeships. However, the rate of unemployment in London was higher than that of the UK as a whole and much higher than that for the south east.

There were risks arising from being a NEET. For instance, 15% of long term NEETs were dead within 10 years. In addition, there were high rates of depression, poor physical health, drug use, homelessness and crime. The economic cost had been estimated as being £10,800 per NEET per year with an overall cost for all NEETs of £2.6m.

It was the responsibility of the local authority to identify NEETs and target resources on those who needed support. They were also expected to take the lead role with the September Guarantee, which required local authorities to find education and training places for 16 and 17-year-olds.

The Council's Corporate Delivery Unit had undertaken specific work on post 16 outcomes and found that there four areas which required specific attention;

- Tracking and data sharing;
- Careers education, advice and guidance, which was variable. An Ofsted report on the position nationally had found provision to be poor overall;
- Education, training and employment provision was also variable and could be much improved;

- Early help and support. It appeared that the crucial ages were between 12 and 14, where a lot of significant decisions were taken by young people.

It was important that young people had the right skills and qualities to be accepted in the work environment, such as resilience and confidence, and character education had an important part to play in this. There appeared to be fewer job opportunities within the borough than elsewhere. It was estimated that there 41 jobs per 100 population whereas other boroughs had figures of between 70 and 80. In addition, there was no single major employer within the borough. There were a lot of micro businesses which employed between 1 and 5 people and they tended not to have the infrastructure to support training and development effectively due to their size. The information that young people received was often not good and this could cause them to get on courses that were not right for them. There was a particular issue with choices not being clear. The key issue that needed to be considered was how young people could be supported effectively from the age of 14 upwards, including the development of employability.

The issue of access to the creative industries was referred to. It was noted that there were a number of opportunities within the borough for young people in these. They included Unity Radio, Jacksons Lane Community Centre, the Chocolate Factory and Mountview Theatre School.

Panel Members commented that schools could be driven by market forces and this could cause them to channel young people in directions that were not always suitable for them. In addition, young people could be influenced by their surroundings and home life and there were equalities issues that needed to be considered.

The Panel stated that, as part of their work on this issue, they would like to look at what other authorities were doing. In addition, the work could provide a framework for further scrutiny. Further work would be undertaken on the specific questions to be asked of young people as part of the engagement process that would take place as part of the piece of work on the issue.

AGREED:

1. That the scope and terms of reference for the project be approved; and

2. That comparative employment figures for Haringey and information on how other London boroughs were addressing the issue of NEETs be shared with the Panel as part of evidence gathering for the project.

CYPS30. WORKPLAN

In respect of the agenda items for the next meeting of the Panel on bullying/hate crime in schools and children and young people in the justice system, it was agreed that Panel Members would e-mail the Scrutiny Support Officer with any specific issues that they wished to raise under this item.

AGREED:

That the report be noted.

CYPS31. ESTABLISHMENT OF YOUTH TRUST - ON LINE SURVEY

Panel Members expressed concern that an on line survey had been taking place on the possible establishment of a Youth Trust. Although this had been suggested as a possible future option, further discussion and advice needed to be acquired before the matter was progressed. The Assistant Director for Commissioning reported that the survey had not been designed as a consultation and was instead focussed on developing interest from the community sector as further work was needed on the potential model.

Cllr Kirsten Hearn
Chair

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Agenda Item 9

Haringey Council

Report for:	Children and Young People's Scrutiny Panel 18 March 2015	**Item Number:**	

Title:	**Young People in the Youth Justice System**

Report Authorised by:	 **Jon Abbey** Interim Director

Lead Officer:	**Simon Stone** Acting Head of Service, Haringey Youth Offending Service

Ward(s) affected: All	**Report for information**

1. Describe the issue under consideration

1.1 This report outlines the work of the Youth Offending Service with particular regard to the young people in the youth justice system. It includes information in respect of outcome and performance measures, service user profile, types of intervention and restorative justice processes.

2. Cabinet Member introduction

2.1 Haringey's Youth Offending Service (YOS) was set up following the introduction of the Crime and Disorder Act 1998. This act defined the role of the youth justice system as having the principal aim of preventing offending by children and young people and required all local authorities to establish a youth offending team in order to meet this aim. The Act requires the provision of a multi agency team that must include at least one of the following; probation officer, social worker, police officer, health and education professionals.

3. Recommendations

Members are asked to note the report.

Haringey Council

4. Alternative options considered

Not applicable – report is for information.

5. Background Information

5.1 Haringey's Youth Offending Service (YOS)

5.2 Haringey's Youth Offending Service works with children and young people between the ages of 8 and 18 and consists of approximately 50 staff arranged within four teams and subsidiaries. There is a Restorative Justice and Prevention Team (whose main aim is to prevent young people entering the formal youth justice system), and three Intervention teams (managing statutory community and custodial orders in addition to servicing the criminal courts in relation to reports and remand services). The teams vary in makeup according to need but include social workers, probation officers and a range of specialists. In addition to these teams, the Youth Offending Service has a data analyst and number of administrators.

5.3 The YOS utilises a range of interventions to engage children, young people and families including one to one sessions, group work and parenting support. We work closely with a range of partner agencies including Probation, Police and the third sector.

5.4 All work is carried out in accordance with Youth Justice Board (YJB) National Standards for Youth Justice, with quarterly reporting to the YJB who monitor performance against three identified outcome measures. The three measures are as detailed below in the performance section and success is determined in relation to the direction of travel rather than any hard targets.

5.5 Performance

5.5.1 **Reducing the number of first time entrants to the Youth Justice System**
This measure is in relation to the number of young people entering the youth justice system that have not had prior involvement with the formal criminal justice system. The data for this measure is taken from the Police National Computer (PNC) on a rolling, 12 month, basis.

5.5.2 **Reducing the use of custody** (as a means of sentence);
This target is in relation to the number of Haringey young people receiving a custodial sentence in a 12 month period.

5.5.3 **Preventing Reoffending**
Reoffending data is calculated via the Police National computer and measured in relation to a cohort of young people in a, rolling, 12 month period. As this data is collected from the PNC it includes young people that are not necessarily known to

Haringey Council

the Youth Offending Service and some who may not, in reality, be from Haringey beyond the date of arrest. Data in relation to the number of young people that have reoffended and the number of offences committed. Within this report the data given is the percentage of young people that have reoffended in the measured period for 12 months.

5.6 Performance Data

5.6.1 The Youth Offending Service submits quarterly returns in relation to the above performance measures on a quarterly basis. Haringey's YOS compares our own performance with our Family (areas with a similar demographic) and also the London average. The most recent data is for Quarter 3 - December 2014. The data below compares the latest figures with the equivalent data set in Quarter 3 of 2013, 2012, and 2011.

5.6.2 **First Time Entrants**

There were 95 first time entrants at Q3 of 2014 compared to 120 in 2013, 182 in 2012 and 268 in 2011. This performance is better than both our family and the London averages and highlights strong local performance in relation to diverting young people from the formal youth justice system and preventing offending.

5.6.3 **Use of Custody**

37 young people were sentenced to a custodial sentence at quarter 3 of 2014. This compares with 48 in the same period for 2013, 52 in 2012 and 60 in 2011. The current performance data, despite being comparatively high in relation to the family and London averages, represents the lowest number of Haringey young people entering custody in a 12 month period since this measure has been collated.

5.6.4 **Reoffending**

The latest reoffending rate for Haringey's young people stands at 40.9 %. This is the lowest that it has been since 2011 with the comparative data for the same periods being 47.2% in 2013, 47.1 in 2012 and 40.1 in 2011. This represents a dramatic reduction of 6.3% in the last 12 months after a lengthy period of increased reoffending.

5.6.5 **Active Caseload**

- The above reduction in relation to first time entrants and success in relation to reoffending and preventative measures has led to a dramatic reduction in the numbers of young people being worked with by the Youth Offending Service. In December 2014 there were 173 young people actively engaged with the Youth Offending Service in relation to preventative work and criminal orders. The comparative figure for June 2014 was 195, June 2013, 333 and in June 2012 it was 396.

- Whilst we have seen a marked decrease in the numbers of young people being worked with by the Youth Offending Service there has been a noticeable increase in terms of the complexity of the issues affecting the young people and the levels of assessed need. All young people are assessed using ASSET,

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the Youth Justice Board's National Assessment Tool, that focuses on assessing young people in relation to range of areas leading that may or may not contribute to the risks posed in relation to their likelihood of reoffending, the risk of serious harm posed to the public and their own vulnerability.

- If we compare the assessed risks in each of these areas amongst the current caseload with those in 2012, we can detect a clear increase in relation to the risks posed and draw conclusions that, whilst taking account of improvements in assessment skills by practitioners, indicate an increased level of complexity.

- In 2012 the percentages of young people assessed as presenting a high risk of serious harm to others was 4% with 43% medium and 53% assessed as low. The current caseload is assessed as presenting a high risk in 26% (an increase of 22%), 37% medium and 37% low.

- In relation to vulnerability we see a similar shift with high risk being assessed in 21% as opposed to 5%, medium 41% from 35% and low vulnerability moving form 60% to 39%.

- The figures in both of these areas indicate that whilst the Youth Offending Service is working with fewer young people the needs of the young people and risks posed to others and themselves are more acute requiring more intensive intervention.

5.7 Profile of Young Offenders

5.7.1 The Youth Offending Service works with young people from a range of backgrounds and identities. Data is collated in order that we can identify who we are working with and understand changes in trends and respond accordingly to identified need. The current ethnicity make up of our case load includes 47% black, 37% white, 11% dual heritage, 3% Asian with 2% other. This represents a minus 9% disparity for the white population and a plus 19% disparity for the black population when compared with the Haringey census data.

5.7.2 The issue of disproportional representation of young black people in the youth justice system has been an issue for a considerable amount of time both locally and nationally due to a myriad of contributing factors. We are committed to addressing this issue where we can and have delivered a number of specific interventions in attempts to better meet the needs of young black people in the system. These have included group work programmes aimed at equipping young people with the knowledge and skills to achieve their potential to specific interventions targeting issues of gang membership and serious youth violence that have affected this group in the borough.

5.7.3 The Roma young people that we have worked with have been disproportionately affected by punitive sentencing in the Courts and have suffered levels of coercion from older community members leading to offending. The stereotypes within society that affect this group heavily influence how they are dealt with by agencies

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and Haringey Youth Offending Service has been determined to ensure that discrimination is addressed wherever possible by providing appropriate services.

5.7.4 Girls make up 12% of the current YOS caseload down from 29% in June 2012. This reduction is, in large part, due to the reduction in numbers of Roma young people that were involved in theft offences at that time. A recent Her Majesty's Inspectorate of Probation Report (HMIP) into girls in the Youth Justice System highlighted the safeguarding concerns present in working with girls in this context. Their involvement in offending, particularly when related to gangs, massively increases vulnerability issue and in turn the vulnerability issues increase the likelihood of reoffending. We are embarking on further analysis in relation to the girls that we work with in relation to this area and will be developing a strategy for addressing the identity related issues for females involved in the Youth Justice System when complete.

5.8 Why do young people offend?

5.8.1 The ASSET assessment tool focuses on a range of areas within a young person's life in order to determine which areas are most influential in terms of increasing the likelihood of them reoffending. These include family and personal relationships, lifestyle, substance misuse and education, to name a few. From an analysis of the assessments in place during December 2014, we can conclude that the most influential areas were thinking, behaviour and Lifestyle as these sections were rated as having a high correlation in most cases. These areas of assessment focus on the young person thinking skills and how they impact upon their behaviour, for example impulsivity and their daily routines and associations. A lack of structure and absence of positive activities are important factors in terms of risk of repeat offending and definable targets for intervention in order to reduce the levels of risk. Involvement with gangs or offending peer groups is a major risk factor for young people in relation to their offending. Girls involved in such groups are at heightened risk of offending linked to their vulnerability and issues of sexual exploitation amongst peers.

5.8.2 Other areas that are rated consistently as problematic are family and personal relationships and difficulties in education. The absence of caring and consistent significant others is often a factor and under achievement or lack of appropriate education often contributes toward a complex situation and increased level of risk. All of these issues are compounded by issues of poverty and neglect suffered by the most disadvantaged in our borough, as they are nationally.

5.9 Preventing offending and reoffending

5.9.1 The Youth Offending Service utilises a range of interventions to address offending and reoffending including one to one supervision, group work and referral to specialists both within and outside of the service.

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5.9.2 Triage is a service aimed at reducing the number of first time entrants. This involves liaison with the Police at the point that a young person is arrested for a relatively low level offence. Where agreed, the young person is made subject to bail whilst they are assessed by a Youth Offending Service Triage Officer who then targets interventions in order to address any concerns. An example of this may be a young person arrested for possession of cannabis receiving a short substance misuse intervention or referral to the parenting worker in order to address boundary setting issues. If the young person cooperates with the intervention, the charges are discontinued and the young person diverted from the formal criminal justice system.

5.9.3 In addition to triage, the Youth Offending Service currently has prevention staff that receive referrals from a range of sources where a young person is believed to be at risk of becoming involved in offending. The Prevention Team will work with the young person and parent/carer to address the concerns and reduce the risk to the young person. This may involve working with schools and other community resources to ensure that the young person is linked into positive activities within the community.

5.9.4 Youth Offending Service staff are involved in delivering programmes in selected schools to prevent future offending and are developing programmes for parents in order that they can better identify issues in relation to substance misuse that increase the likelihood of offending.

5.9.5 Young people subject to Court Orders receive a range of interventions aimed at addressing the levels of risk posed and identified needs. This may involve one to one supervision utilising a range of techniques from motivational interviewing to group work programmes specifically for young black men involved in serious youth violence. Programmes are designed to address need and evaluated utilising a tool that measures attitudinal and behavioural change. The Youth Offending Service has recently completed a reoffending toolkit which identifies the groups of young people that are more likely to reoffend and is embarking on the use of a 'real time' toolkit in order that we can measure outcomes in order to address need with currently active cases.

6. Third Sector involvement

6.1 The Youth Offending Service works with a range of organisations in order to deliver services to young people. These include Catch 22 who provide an Appropriate Adult Service to young people in Police custody and Working Links who work with young people in custody in order to reintegrate them to education or work upon release form custody. We have strong links with Tottenham Hotspur who provide a range of mentoring programmes for young people as well as Safer London who work with girls at risk of sexual exploitation through gangs.

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6.2 The Youth Offending Service has worked in partnership with the Red Cross for a number of years providing a weapons awareness course to young people both at the YOS and within schools. This programme provides young people with an insight into the dangers of knife crime and training in First Aid for which they receive a certificate. This intervention was first targeted at young people that had been arrested for knife related crime and has been broadened out due to its success.

6.3 In 2013/14, the Youth Offending Service worked closely with the Roma Support Group to develop a programme for Roma girls who were appearing before the Courts repeatedly. This programme taught life skills such as dress making whilst enabling us to build stronger trusting relationships with a cohort of young people that had previously found it difficult to engage with statutory services.

6.4 We are currently in discussion with Lift, a creative arts organisation committed to working in Tottenham over the next six years, in order to develop a programme for young people who are either not in employment, education or training (NEET) or at risk of offending. This project will work with young people to develop their own stories in a creative context whilst building interpersonal and social skills.

7. Restorative Justice

7.1 Restorative Justice places the victim and community at the centre of the youth justice system with the aim of reparative interventions being undertaken that both empowers individuals and make amends for crime committed.

7.2 The Youth Offending Service has two support workers tasked with victim contact and engagement and also staff involved in reparation projects within the community. We have had difficulties over many years in engaging victims in formal RJ processes which have been influenced by restrictive procedures. However we have recently made amendments to our internal processes with great effect and recently held our first RJ conference for some time with both the victim and perpetrator of a robbery offence. This process brought the victim and offender face to face in order that they could discuss and understand what had happened and the impact of the crime. This was extremely beneficial for both parties as the victim was able to have their voice heard and the offender was confronted with the very real consequences of their crime.

7.3 Reparation projects that are undertaken by young people aim to pay back to the community in a way that is visible and beneficial to the community. Young people have been involved in contributing to the Holocaust Memorial as well as a range of other duties such as gardening, assisting at community events, construction and clearing up around the borough.

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8. **Comments of the Chief Finance Officer and financial implications**
N/A

9. **Comments of the Assistant Director of Corporate Governance and legal implications**
N/A

10. **Equalities and Community Cohesion Comments**

11. **Head of Procurement Comments**
N/A

12. **Policy Implication**
N/A

13. **Reasons for Decision**
N/A

14. **Use of Appendices**
NA

15. **Local Government (Access to Information) Act 1985**
NA

Agenda Item 10

Haringey Council

Report for:	**CYPS Scrutiny Panel 18 March 2015**	**Item Number:**	

Title:	**Support for Children and Young People with Disabilities / SEN Reform**

Report Authorised by:	 Jon Abbey – Interim Director of Children's Services

Lead Officer:	Vikki Monk Meyer – Head of Integrated Service for children with Special Educational Needs and Disabilities.

Ward(s) affected: All	**Non Key**

1. Describe the issue under consideration

1.1 This paper considers the issue of inclusive education in Haringey. The major impact on this area is the Special Educational Needs and Disabilities (SEND) Reforms covered in Part 3 of the Children and Families Act 2014.

1.2 The Scrutiny Panel has requested evidence about the following issues with regards to children and young people with disabilities:

- The proportionate population of children and Young People with SEN and Disability in Haringey
- Haringey's policy on Inclusion
- Attendance in mainstream and special educational settings
- The support Disabled learners receive in Haringey schools
- Accessibility in Haringey's mainstream schools.
- Curriculum access
- Workforce development
- Achievements of Disabled learners in Haringey.

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1.3 The SEND reforms 2014 have not changed the way that identification and support for Children and Young People with SEN and Disability is provided, however it has change the legislation over duties to provide support to children from multiple agencies. This strengthens the requirement to jointly commission services with Health, and between Education and Social Care in the Local Authority. It also requires individual schools to clearly articulate their 'offer' to children with SEN and Disabilities. Detail discussion around the SEND Reforms are outside the scope of this paper, however the key features are:

- a requirement for the Authority and local Schools to publish their 'Special Educational Needs Offer' for Families and Young People with SEN and Disabilities on their websites
- joint Commissioning between Health, Education and Social Care
- Education, Health and Social Care Plans to replace statements, but the threshold to remain as the child's significant learning need.
- extension of the EHC plan to 25 years for Young People in Education
- a requirement for a policy on managing children's medical needs in school.
- the use of a personal budget for services within the Education, Health and Care Plan.

2. Scrutiny introduction

2.1 The needs of the Children and Young People with SEN and Disability are wide ranging and can challenge their learning in very different ways. A disabilities is defined by the Disability Discrimination Act 1995 as

"....a physical or mental impairment which has substantial and long-term adverse effect on (the person's) ability to carry out normal day to day functions"

2.2 Whereas a child is described as having a Special Educational Need (Section 312 Education Act 1996) if they have:

"a learning difficulty which calls for a special educational provision to be made for them. Children have a learning difficulty if they:

a) Have a significant greater difficulty in learning then the majority of children of the same age: or
b) Have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for children of the same age in schools within the area of the local education authority
c) Are under compulsory school age and fall within the definition at (a) or (b) above and would do so if special educational provision is not made for them".

2.3 Special Educational Needs are often primarily as a result of a cognitive difficulty or difference in learning from the 'average' learning style. This can mean that a person with a Special Educational Need, such as a specific literacy difficulty, may require

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adjustments and support in school. They may not experience this challenge as a long term disability however, if able to use effective and appropriate strategies.

2.4 A young person with a significant physical disability may need adjustments and support in their physical environment to enable them to access the curriculum, but may not have a Special Education Need in terms of their ability to learn, once access has been successfully arranged.

3. Background information

3.1 The Population of Young People in Haringey with Special Educational Needs and Disabilities

3.1.1 Haringey has 1414 children and young people with Statements of SEN and 499 Young People with Learning Difficulty Assessments. All of the children's statements will be converted into Education Health and Care plans over the next three years, and most of the Young People's Learning Difficulty Assessments (LDD). The conversion of the LDD will depend on whether the Young Person is choosing to stay in Education until 25 years, and their request for a conversion as the SEND code is clear that the request for an Education, Health and Care Plan is required from the Young Person themselves. For Young People who require less adjustment they may choose not to have their LDD converted, however it is expected that most will request a conversion or have a conversion requested by an advocate.

3.1.2 The Young People with Statements of SEN have identified on their statement the following primary needs:

- Autism - 525 children and young people
- Moderate learning difficulties - 309 children and young people
- Communication Difficulties -184 children and young people
- Emotional and Behavioural difficulties - 161 children and young people
- Physical Disabilities - 87 children and young people
- Severe learning difficulties (e.g. associated with Down Syndrome, William's Syndrome, epilepsy) - 36 children and young people
- Profound and Multiple Learning difficulties – 34 children and young people
- Profound Hearing impairment - 33 children and young people
- Specific literacy difficulties – 30 children and young people
- Visual Impairment - 22 children and young people.

3.1.3 Two children and young people have medical needs without a special educational need. Some children have more than one diagnosis.

3.1.4 The majority of statements are issued as a result of a significant cognitive difficulty as a result of Autism, general learning difficulty and/or behaviour or language difficulty. The numbers given above are as a result of primary diagnosis, however many children may have a co-occurring need.

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3.1.5 Planning for the needs of a borough by the numbers of children can be slightly misleading as incidence and prevalence of need may be different. Incidence is the number of people born into the borough with a particular need, where as the prevalence is the number of people who live in the borough with a need e.g. they may move here from other boroughs or from abroad for a particular reason. The incidence of the above types of difficulty are increasing over time for all Boroughs, with Autism and general learning difficulty being highly prevalent in Haringey. The incidence of children and young people with physical disabilities has remained the same but anecdotally appears to be reducing slightly for the profound and multiple learning difficulties group. This is likely to be as a result of changed medical approaches both pre birth, in utero and at birth e.g. changed practice for highly premature babies, which reduces their acquired visual and hearing impairment long term. It may not be able to prevent more moderate learning difficulties however.

3.1.6 Certainly people with profound physical needs, who once might have been thought of as life limited, are surviving longer. There are key groups in the borough, including a group of children with hearing impairment that require adaptations made but may not need a statement of special educational needs. 113 children in the borough are hearing aid wearers and 14 are fitted with FM systems. The use of cochlear implants for children and young people with hearing impairment is also increasing. This is encouraging many young people who in the past may have attended a special school and predominantly used signing such as British Sign Language, to choose to use more spoken language or sign supported English.

3.1.7 Incidence is an area that needs more detailed analysis outside the scope of this paper in order to better predict children's longer term learning needs dependent on their medical history and experiences.

3.2 Schools and School Support for Children and Young People with SEN and Disabilities

3.2.1 Of the Young People with statements, 974 are in mainstream schools in and out of borough, with 440 in Specialist provision. Of those young people in Specialist Provision 309 are in borough and 131 are out of borough. For those young people who attend specialist provision out borough, 52 Young People are children in care who predominantly have a Special Educational Need related to social communication and behaviour.

3.2.2 Nationally the age at which statements (now Education Health and Social Care Plans) is initiated is reducing. Ten years ago the average age of initiation was 10 years old, now due to better identification, and joint working with health, more children are identified early who may have and SEN or Disability. More recently National Strategies such as "Aiming High for Disabled Children" 2012 initiated the Early Support principals. Early Support is a national initiative to ensure children likely to require long term support are identified early, often at birth for some conditions, and therefore Statements are often initiated when children are due to

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start school at 4- 5 years old. The SEND reforms emphasises the duty to provide nursery experience for children with SEN and disabilities from the age of 2 years old with the result that many boroughs who were pathfinders for the reforms have issued EHC plans for children as young as 2 years old.

3.2.3 Haringey has an Early Years Inclusion Team who work with agencies in health and social care to ensure that children experience an inclusive start to their school experience. The team work in Private and Voluntary settings, Children's Centres and Nurseries with children who have SEN and Disabilities.

3.2.4 The choice of mainstream or special school for a child is lead through parental choice, with the understanding that mainstream education for a child is preferable where ever possible. The teams working with the parents/carers, children and young people would be evaluating the children and young people's progress looking at a number of factors when considering where the child will achieve at their best including:

- Success of the strategies and differentiations available for the child to maintain the child's progress
- Emotional impact on the child and their experience of social integration and feelings of inclusion e.g. are they able to identify with their peer groups and participate as independently as possible with the right support
- If the child has a recognised diagnosis, what is known about their likely pattern of development e.g. will they develop their skills along normal lines but later, achieve as their peer group but need different strategies, or is their condition known to be one that causes deterioration in their cognitive skills over time.

3.2.5 The majority of children with SEN and disability remain in main stream school over their school life time, however there is an increased demand for specialist provision at secondary school, often requested by the child and family. This is because the secondary curriculum places additional cognitive and organisational challenges on the child, and they are often more conscious of attention from adults if they require additional support. There is less willingness from the child at this age and stage to have additional adult support or experience teaching which is in any way 'different' from the norm.

3.3 Continuum of Support

3.3.1 The children who have statements of special educational need access support from the following professional directly:

- Speech and Language Therapy
- Occupational Therapy
- Advisory Teachers of the Deaf, Blind and Visually Impaired
- Advisory Teachers of Autism
- Language Support Teachers

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- Educational Psychology
- Specialist teaching
- Special Needs Assistants
- Meal time supervisors.

3.3.2 The schools themselves have additional funding from the pupil premium which can be used to support children with high incidence, low need special educational needs, such as language, literacy or handwriting difficulties. Many of the services described above are available to children in schools without the requirement for a statement of special educational need, however if a child has an enduring need then the statement may also being additional support or outlines of differentiation which needs to be delivered as a statutory duty.

3.3.3 The types of support outlined in children's statements is as follows:

- 42 children have specialist teaching hours
- 300 children have 20 hours or under of special needs assistant time, with 285 of these with 15 hours or similar
- 265 have over 20 hours or support
- 270 have 32 hours of support.
- 218 have meal time assistant time

15 hours of support is equal to 3 hours per day of direct support during teaching time.

3.4 **Specialist Provision within Haringey**

3.4.1 Haringey has four Special Schools which are all co-located with mainstream schools. These are:

- The Brook Primary School - school for children with Profound and Multiple Learning Difficulties, Severe learning difficulties and Autism.

- Riverside Secondary School - school for children with Profound and Multiple Learning Difficulties, Severe learning difficulties and Autism.

- The Vale Special School – School for children with Physical Disabilities both specific and co-occurring with other needs

- Blanche Nevile School for the Deaf – School for children who are severe to profoundly Deaf or Hearing Impaired. This school has a signed bilingual policy.

3.4.2 Haringey also has the Primary aged Mulberry Autism provision, the Primary aged Language unit at West Green, and an Autism resource base at Heartlands Secondary School.

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3.4.3 The specialist provision for young people with emotional and behavioural needs is the Octagon, now managed by an organisation called TBAP. This facility has 54 spaces for learners, or which 12 have statements of special educational need. The provision can be accessed on a short or long term basis in that children can be referred by their mainstream school for a short time period, or they can be placed there for the duration of their schooling. Much of the work is done in small groups with high levels of adult to child ratio in the staffing.

3.4.4 In addition there is the Haringey 6th Form College which has over a 110 learners aged 16 who have statements of special educational need. 54 of these young people are based in the resource base at the centre, and the majority of the other learners access the wider college offer with support or fully independently.

3.4.5 Discussions with the head teachers of these school indicated that the many factors which would influence the amount of time a learner chooses to be included in mainstream sessions or remain within the special school. In the main the more specific the learning difficulty or physical disability, the more likely the young person was to be fully accessing the mainstream curriculum.

3.5 **Integration**

3.5.1 In mainstream schools the support should allow the child or young person to access the curriculum and integrate as fully as possible. Barriers are often more emotional and cognitive than physical, with children more likely to be taught a more highly differentiated curriculum if they have more learning difficulties. Diagnosis is not necessarily a predictor of outcome e.g. Riverside secondary special school often has young people who go onto complete a GCSE in maths, as this is often a particular interest for Young People with Autism.

3.5.2 Strategies for access, not exhaustive, include:

- Personal equipment - such as hearing aids and body worn FM systems, adaptive technology such as laptops and software to support access such as ‘dragon’.

- Use of communication aids to support access for people with physical disabilities. We have 35 high level technology communication aid users in Haringey. Currently 176 children with hearing impairment attending mainstream schools. 113 are hearing aid wearers and 14 are fitted with FM systems.

- Classroom organisation such as workstations for people with Autism, or quiet areas for those more likely to find concentration difficult when all day in a busy classroom.

- Use of symbols, pictures and signing to support access, or for delivery of lessons by a signing interpreter.

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- Peer buddying for children and young people
- Social skills groups
- Personal support to use strategies e.g. a trained Special Needs Assistant to assist in differentiation.
- All schools are supported to differentiate their learning for children with Disabilities and Special Educational Needs, including learning difficulties and emotional and behavioural difficulties. The role of the Advisory Teacher and Educational Psychologist are key in ensuring that schools are able to adapt their practice as efficiently as possible. The learning outcomes for children with SEN and Disability are monitored quarterly by the school improvement advisors, with a risk tracker for schools who are not making expected or better than expected progress, and the strategies in place to support their development. We are currently extending the use of this risk tracker to include the monitoring of a schools ability to identify and monitor the use of effective strategies for groups of children with particular types of difficulty. E.g. the quality of the schools special educational needs offer, and their ability to effectively implement it.

3.6 **Training and Workforce development in Schools**

Training is provided to schools directly, and through the Professional Development Centre to schools and school staff. Training includes specific teaching approaches, information and advice regarding Autism, literacy difficulties, communication, maths programmes. It also includes training on specific needs e.g. Down Syndrome.

3.7 **Achievements**

The following is an extract of data from the pupil progress tracker held by the school improvement team**.**

- At Key Stage 2, this data is for 2 Levels of Progress (Expected Progress) and 3 levels of Progress (Better than Expected Progress) in Reading, Writing and Maths
- At Key Stage 4, this data is for 3 Levels of Progress (new, best entry) in English and Maths and 4 Levels of Progress (new, best entry) in English and Maths

Key Stage Two

School Action Pupils (413):

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- Attainment: Average Point Score (APS) for Reading, Writing and Maths was 25.3, which is above the National Average. The % of pupils achieving L4+ in Reading, Writing and Maths was 47%, which is above the National Average which was 43%

School Action Plus Pupils (193):

- Attainment: Average Point Score (APS) for Reading, Writing and Maths was 23.8 which is in line with the National Average. The % of pupils achieving L4+ in Reading, Writing and Maths is 36%, above the National Average which is 32%

- Key Stage Four

- **School Action Pupils (397):**

- English:
- 73% pupils at School Action made 3 levels of progress from their starting points (plus on the FFT Aspire dashboard)*)*
- 35% pupils at School Action made 4 levels of progress from their starting points (plus on the FFT Aspire dashboard)
- Maths:
- 67% pupils at School Action made 3 levels of progress from their starting points (plus on the FFT Aspire dashboard)
- 32% pupils at School Action made 4 levels of progress from their starting points (plus on the FFT Aspire dashboard)

- **School Action Plus Pupils (153):**

- English:
- 66% pupils at School Action Plus made 3 levels of progress from their starting points (plus on the FFT Aspire dashboard)
- 33% pupils at School Action Plus made 4 levels of progress from their starting points (plus on the FFT Aspire dashboard)
- Maths:
- 63% pupils at School Action Plus made 3 levels of progress from their starting points (plus on the FFT Aspire dashboard)
- 33% pupils at School Action Plus made 4 levels of progress from their starting points (plus on the FFT Aspire dashboard)

- **Statemented Pupils:**

- English:

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- 38% pupils with a Statement made 3 levels of progress from their starting points
- 20% pupils with a Statement made 4 levels of progress from their starting points (plus on the FFT Aspire dashboard)
- Maths:
- 32% pupils with a Statement made 3 levels of progress from their starting points (plus on the FFT Aspire dashboard)
- 14% pupils with a Statement made 4 levels of progress from their starting points

All children made progress in line or better than the national average. This data does not include children attending special schools, which was not available at the time of writing.

3.8 **Post 16 Destinations**

3.8.1 The destinations known for the 1018 young people over the age of 16 years with SEN and disabilities are as follows:

- 474 young people are still in some form of further education
- 56 young people are at University
- 20 Young People are employed with no training as part of their employment
- 6 Young People are employed and expecting to gain an NVQ2 as part of the training with their employment
- 9 young people are employed with another form of training
- 12 young people are in an apprenticeship (3 with Job Centre training)
- 8 Young People are in a vocational setting e.g. the Harrington's scheme.

3.8.1 Unfortunately there are also four Young People over the age of 18 years in custody and five are deceased.. 114 Young People remain not in education, employment or training.

3.8.2 There were not specific patterns in those young people who went on to access higher education or employment in terms of physical disabilities, although those young people who went on to develop mental health difficulties did less well than those who maintained their emotional wellbeing, suggesting this is a significant factor in young people with SEN and disabilities that requires further investigation.

3.9 **Physical Accessibility in Schools**

There is not an overarching report available on this area. Many of the school buildings are old and differentiations have been made when a child starts according to the child's specific needs e.g. accessible toilets are available in all schools, however some schools have also had some minor building adjustments to accommodate hoists and through floor lifts. Ramps and stair rails have been added

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as and when needed by a child. The newer buildings are all fully compliant with the regulations for disabled access.

4. Funding for Children and Young People with Special Educational Needs and Disabilities in schools

4.1 Schools received an age weighted pupil premium (AWPU) of approximately 2,000K per child for each child attending their school. This is element 1 funding. In addition to this schools can claim a pupil premium of a further 4,000K per pupil which is based on a deprivation index e.g. a child requiring free school meals. This is the schools Element 2 funding. In addition to other school services, the funding for Element 1 and Element 2 should be used by the schools to commission services for children with high incidence low need special educational needs e.g. specific literacy difficulties. Schools now need to publish the services and interventions that they provide for children and young people with SEN and Disabilities, as a result of this funding, in their 'schools offer'.

4.2 For children and young people with disabilities and special educational needs that are likely to be complex and enduring, an education, health and social care plan (EHSC) can written. The plan should be co-produced with children and families and outline their needs across all aspects of their school. It will include equipment required aswell as short breaks and leisure activities. A completed EHSC plan will draw down support from services commissioned through the High Needs Block budget. This is a combination of schools funding (dedicated schools grant) and local authority funding known as Element 3 funding. In addition to the High Needs Block funding from Education, the EHSC plans also outline care and support requirements for a child or young person outside of their school time. This funding is known as a personal budget within the EHSC plan, and can be held by the local authority for the child or young person (a nominal budget) or accessed directly by the child or family in the form of a direct payment. At this stage transport, Continuing Care from Health and short breaks moneys can be accessed in the form of a direct payment.

4.3 Current Challenges in Implementing the SEND reforms:

- The move to a personalised, co-produced EHSC plan in a shorter timescale
- The workforce transformation needed with the introduction of the 'Education, Health and Care Plan Co-ordinator' as a new profession.
- Introducing, monitoring and assisting families with the personal budget and as a result introduction of brokerage.
- The identification of appropriate services to offer as a personal budget, with agreed outcomes in education, health and social care. De-commissioning some services commissioned on block may mean the value for money element is lost
- Conflict resolution for families and children where legislation is currently based on separate services e.g. mediation, tribunals,for the Local Authority, complaints policies, patient advice and liaison services and health watch for health services

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- The Local Offer is required to include voluntary and private schools out of area. There is a risk here in terms of increased pressure on the High Needs Block.
- The broadened offer of the EHSC plan pre-school, and onto 25 years will require increased commissioning and development of services in education in this wider age group. This may create increased pressure on the high needs block as a result of plans starting later and lasting longer. It is, however, an opportunity to improve a child and families experience of transition into school and into adult services.

5. Summary

The offer for children and young people with SEN and Disability is quite comprehensive in Haringey, however there are areas of development required in terms of reducing transitions between services, and further involvement of families and children in raising awareness, planning and developing services for children and young people with disabilities.

6. Comments of the Chief Finance Officer and financial implications

6.1 Potential pressure on the high needs block in terms of school place planning and element 3 top up funding for pre and post 16 years. Implications for commissioning of short breaks services if more direct payments are requested by families. Local offer and early help offer need to be clearly articulated so that the element 2 funding is used effectively.

7. Comments of the Assistant Director of Corporate Governance and legal implications

NA

8. Equalities and Community Cohesion Comments

NA

9. Head of Procurement Comments

NA

10. Policy Implication

NA

11. Reasons for Decision

NA

12. Use of Appendices

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NA

13. Local Government (Access to Information) Act 1985

NA

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Agenda Item 11

Haringey Council

Report for:	CYPS Scrutiny Panel 18 March 2015	Item Number:	

Title:	Bullying and Hate Crime in Schools

Report Authorised by:	 Jon Abbey, Interim Director of Children's Services

Lead Officer:	Anji Phillips, Interim Assistant Director, Schools and Learning

Ward(s) affected: All	Report for Key/Non Key Decision: NA

1. Describe the issue under consideration

The CYPS Scrutiny Panel requested a report on Bullying and Hate Crime in Schools including reference to exclusions, parents and carers and monitoring data.

2. Cabinet Member introduction

NA

3. Recommendations

Members of Scrutiny Panel note and comment on the report.

4. Alternative options considered

NA

5. Background information

5.1 Introduction

The school system is changing rapidly with the advent of University Technical Colleges, Academies, Studio Schools and Free Schools joining the wide family of schools. The world our young children and students are being brought up in is

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changing fundamentally, with the pressures of radicalisation and the ongoing Child Sexual Exploitation (CSE) agenda prevailing. The Department of Education published a revised, detailed Governors' Handbook in January 2015, reflecting the way school governance is changing to provide a robust system of accountability. The Ofsted inspection framework is shining a light on the effectiveness and impact of governing bodies to reflect the change in the balance of power, duties and accountability from Local Authorities to school governing bodies. This paper demonstrates how those changes no longer require or enable Local Authorities to collect or have insight into detailed information on bullying and hate crime in schools. However, the LA are engaged in the wider safeguarding agenda and raising the awareness of schools in the Prevent agenda and CSE dynamics and challenges. Haringey has launched a campaign to raise the profile of the CSE agenda in order to strengthen our responsibility for safeguarding children and young people. Not losing sight of vulnerable young people is a priority and joining up intelligence of those who go missing from home, education and care remains an absolute focus.

In Haringey, the robust school improvement strategy and strong partnership with schools enable the Local Authority to continue to retain some insight and knowledge of the educational provision, including bullying and hate crime. This is exemplified in the examples set out below.

5.2 Governance

Governing body responsibilities include:

- ensuring clarity of vision, ethos and direction and a responsibility to set and safeguard high expectations of everyone in the school community.
- making sure that their school has policies designed to promote good behaviour and discipline among pupils. These policies must include the school's approach to the use of reasonable force to control or restrain pupils.
- drafting and periodically reviewing, a written statement of principles to help the headteacher determine the measures that make up the school's behaviour policy. The statement must be published on the website. In Haringey, the Local Authority has been proactive in monitoring all school websites to secure 100% compliance.
- reviewing headteachers' exclusion decisions. The school must arrange suitable full-time education for excluded pupils from the sixth school day of a fixed-period exclusion. Governing bodies have a wider role to hold headteachers to account for the lawful use of exclusion. For the period April to December 2014 there were no governor hearings.
- making arrangements to ensure that their functions are carried out with a view to safeguarding and promoting the welfare of children and their general duty to eliminate discrimination. As such there is an expectation that schools should have a child protection policy in place, reviewed annually and ratified by the full governing body. The governing body will monitor bullying and hate crime in schools as part of this duty.

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5.3 The Role of the Local Authority

The Education and Inspections Act 2006 and the Education Act 2011 outline the Local Authority's role for interviewing in schools that are underperforming. The four main functions for the Local Authority are to:

- challenge and support schools to improve, and intervene more formally where necessary, to ensure high standards of pupil achievement;
- make appropriate provision for excluded pupils and children with special educational needs and disabilities to ensure they make good progress;
- ensure there are sufficient good quality school places for every child;
- deliver fair access to appropriate education for each child;

Haringey's Standing Advisory Council for Religious Education (SACRE) has produced detailed guidance for schools which includes significant information on the challenging national context, the ethical dilemmas that arise from different beliefs, practices and ways life. The guidance focuses particularly on Ofsted, promoting British Values in schools, collective worship and the impact of the Trojan Horse Affair in Birmingham. This provides invaluable support and advice for schools and their governing bodies.

5.4 Complaints

The volume of parents and carer complaints is a key indicator of issues surrounding bullying or hate crime. The DfE has updated the Governors' Toolkit for handling complaints which no longer involves a referral to the Local Authority. Complaints Panels are held in schools and escalated to the DfE if appropriate.

5.5 Exclusions

Schools inform the local authority once a term of the number of Fixed Term Exclusions they assign to pupils. Permanent Exclusions must be reported immediately. The information provided by the school will include a summary of the nature of the offence that lead to exclusion. This is collated by the local authority and it informs a annual report. The categories of exclusion are as follows

- Verbal abuse/threatening behaviour towards an adult
- Verbal abuse/threatening behaviour towards a pupil
- Physical assault against a pupil
- Physical assault against an adult
- Other
- Theft
- Sexual misconduct
- Persistent disruption
- Drug Related Offence
- Bullying
- Racist abuse

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Last year 379 fixed term exclusions were reported to the local authority, 254 from secondary schools and 125 from primary schools. Defining the incidents by the categories given above, 16 or 4.2% of the 379 fixed term exclusions were categorised as either Bullying or as Racist Abuse. 3 of these incidents were in primary schools and 13 in secondary. In the same year there were 41 permanent exclusions. None of these exclusions were categorised as either Bullying or as Racist Abuse. It remains a challenge to ensure there is clear oversight and visibility of young people who are excluded by schools on a day to day basis, so that they do not become a missing statistic and re-introduction back to school must remain a priority.

5.6 Safeguarding

The establishment of Local Children Safeguarding Boards in all Local Authorities provides the challenge to all key agencies and partners to safeguard and protect children from harm. This, of course, involves the issues of bullying, cyber bullying, racist, disability, homophobic abuse and those children who could be exploited sexually. It also focuses on all aspects of radicalisation and extremist behaviour (Haringey is a PREVENT priority Borough). In this context, Ofsted make the judgements on how well the school and the governing body are discharging their duties.

The Acting Director of Children's Services presented a paper to Haringey's Local Children's Safeguarding Board collating the Ofsted judgements on safeguarding for all schools. This presents a very positive picture and gives reassurance that safeguarding practice is good or outstanding in all but two schools.

Swift action was taken to address the aspects of safeguarding highlighted by Ofsted as requiring improvement in the 2 schools. The issues focused on vetting procedures for staff and 'e' safety.

The full report on 'Safeguarding - A picture of our schools', is available from the clerk to this committee.

5.7 Prevent work with Schools and Education

'Prevent' is the government's strategy to stop people being involved with extremist organisations or being radicalised and participating in criminal acts.
Haringey has been assessed as a priority authority and delivery of *Prevent* is funded in Haringey until March 2016. Prevent seeks to achieve the following:

- Ideological challenge to extremism and radicalisation
- Preventing people from being drawn into extremist groups
- Working with sectors and institutions where there are risks of radicalisation which we need to address

Prevent in Schools

Haringey Council

Schools are a focus for the Prevent Priorities in 2014-2015. The programme includes, delivering Prevent awareness training to frontline professionals, engagement with schools to meet Ofsted framework standards in relation to Prevent, and embedding Prevent into existing early intervention referral pathways for children and young people.

In relation to Ofsted, schools need to demonstrate engagement with their community on the Prevent agenda. The Community Safety team has produced a package of support for schools which facilitates discussion to challenge extremist views and promote tolerance and critical thinking skills.

So far training has been delivered to seven secondary schools in the borough and further training sessions are planned over the rest of 2015. All headteachers and governors have been briefed, building upon their existing safeguarding capabilities to identify, challenge and refer concerns around extremism and radicalisation. Case work in individual schools has been supported with curriculum resources for use in the classroom.

The Prevent Co-ordinator had been involved in national policy development around embedding British Values, which is another key duty for schools.

5.8 British Values

The Governing Body has a duty to ensure the school's ethos promotes the fundamental British Values of democracy, the rule of law, individual liberty and mutual respect and tolerance. Children must be encouraged to respect other people with particular regard to the protected characteristics set out in the Equality Act 2010. In Haringey, this presents a particular challenge for Islamic schools to meet the Ofsted inspection criteria. We are working closely with them to provide challenge and support on the way these values are demonstrably evidenced within the teaching and learning, whilst retaining a strong faith ethos.

Schools have been working together and sharing best practice on British Values through the Early Years Forum, Haringey Governors Association, Headteacher meetings and school to school support. Children are taught and understand the impact of name calling, bullying and hate crime on their peers. The impact of this is evidenced by the exemplary reports on safeguarding in schools, levels of exclusion and few complaints from parents and carers. However, some elements of under reporting and of children's behaviour out of school cannot be underestimated in the drive to improve the impact of education.

The Local Authority promotes and encourages schools to participate in local and national initiatives, such as Anti Bullying Week which is held annually in November. Anecdotal evidence shows that schools embrace and embed these initiatives as part of their wider curriculum.

6. Comments of the Chief Finance Officer and financial implications

NA

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7. Comments of the Assistant Director of Corporate Governance and legal implications
NA

8. Equalities and Community Cohesion Comments
NA

9. Head of Procurement Comments
NA

10. Policy Implication

The national policy framework is referenced within the report.

11. Reasons for Decision
NA

12. Use of Appendices
NA

13. Local Government (Access to Information) Act 1985

Children and Young People's Scrutiny Panel

Work Plan B/F

Project;

1. Transition for young people: The journey for young people from adolescence to adulthood with aim of gaining an understanding of what it is like to be a young person in Haringey at the moment.

2. Childhood Obesity

TBA

Haringey 54000

Comparative performance levels of children and young people with special educational needs

Recruitment of in-house foster carers, including retention rates

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