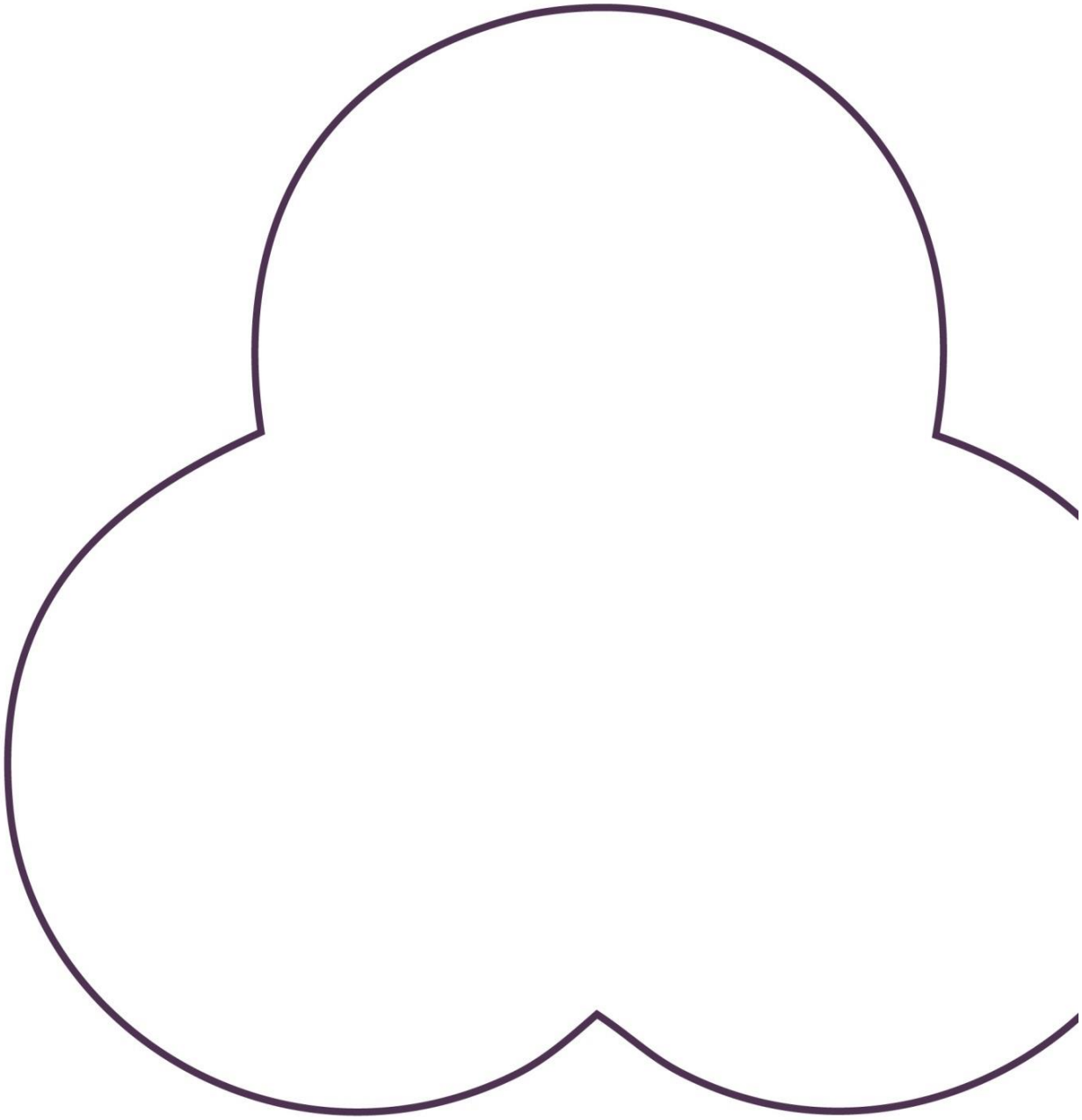

Children and Young People's Emotional Health and Wellbeing in Bromley

Insights from 2016 Summer-Autumn Co-Production process

October 2016

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Introduction

Childhood and teenage years are a time of rapid change. Challenges such as relationships, exams and unfamiliar situations can be tough to manage. Three children in every classroom and 45% of children in care live with diagnosable mental health issues.

Bromley CCG is leading a Bromley CAMHS Transformation Plan (2015-2020) with schools, GPs and Bromley Council. The strategy aims to transform the experience of accessing mental health support and treatment in Bromley but also to raise the level of mental health and wellbeing across the Borough. This includes helping adolescents learn how to cope with difficult emotional issues as they come up and build their personal resilience. The programme is aligned with a national movement, flagged by the Government's *Future in Mind*[1] report in 2015 that is pushing for more integrated support offered across schools, carers, VCSO providers and clinical specialists.

In recent years engagements with young people in Bromley have revealed that the existing structure and design of Child and Adolescent Mental Health Services (CAMHS) could meet their needs better. For example, the 2014 Healthwatch Bromley survey highlighted that young people did not feel listened to and would be better served by addition of drop-in services rather than access by appointment only.

Bromley CCG and partners commissioned NEF Consulting to engage young people and other stakeholders in co-designing the transformation of services. A co-production approach was pursued in order to enable young people and their families to be partners in shaping how services for mental wellbeing and emotional health for children and young people (CYP) should be delivered in Bromley.

Methodology

It is important to note that the project we undertook was not a process evaluation or service review. The main focus of the work has been to draw out elements of how the services and system could be in the future, and as a part of this, we do reflect the experiences of how the system is working for CYP at the moment.

Stakeholder driven outcomes

In considering the redesign of services, our preliminary step was to identify and define the outcomes desired. An outcomes framework can open up space for and direct providers and citizens to innovate and co-design, creating together the activities that might best meet the aims. We co-designed these outcomes with CYP by focussing on the **change** that should occur as a result of particular activities and interventions. An outcomes framework was then drafted to provide a system which promotes, values and measures the change that matters to CYP, rather than being overly focused on tightly defined and highly specified services.

[1] *Future in Mind* was published by the Government's Children and Young People's Mental Health taskforce

Running co-design focus groups with CYP to understand which outcomes are important to them and their families is essential. This is because outcomes cannot be done **to** a child or young person; they must have ownership over them for the outcomes to have a chance of being achieved.

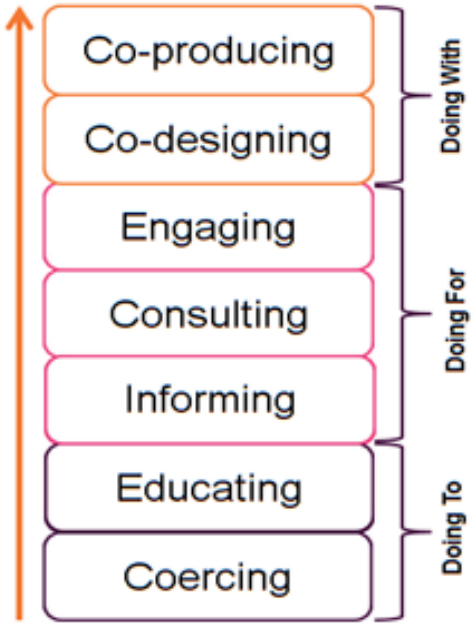
It was also important that other stakeholders involved in the system were involved in the co-design stages including commissioners, frontline staff, third sector partners and the health sector. In this way, every aspect of the system that matters can be identified and incorporated into future provision and systems. The reach of outcomes can go beyond services and siloes and should be used to support other areas of the community and society.

Co-design

The research was undertaken through a co-productive approach. Co-production, meaning equal partnerships between people and professionals, is well suited to mental health services. The people who most rely on mental health services tend to be those who have the most difficulty in being heard and involved and transforming services by applying the key features of co-production offers the prospect of substantially improving outcomes for them.

The nature of engagement with service users is a key distinguishing feature of co-production and its foundations are built on co-designing services. As shown in the ladder below in Figure 1 traditional service models are designed in a way that can be described as **'doing to'** and providers view the services as a way of educating or curing. Other service models may be described as **'doing for'** and professionals only engage with users in tokenistic ways or within clearly set parameters by the experts.

Figure 1: The ladder of participation showing the depth of engagement suggested needed to achieve co-production.



On the other hand the deepest form of participation, where outcomes are most owned by residents is known as **'doing with'.** This approach recognises that even with the best of information, positive outcomes cannot be delivered 'to' or 'for' people. An equal and reciprocal power-sharing relationship is established whereby people's voices are heard,

valued and debated on their own terms; then agencies and service users act together by sharing roles and responsibilities.

NEF Consulting therefore ran a co-design process with children, young people, parents and professionals. An open-ended questioning approach was taken to allow participants to lead researchers towards outcomes and service qualities which matter most to them. This process should build young people and other stakeholder's interest, willingness and their capacity to contribute. Building this foundational level of ownership will put the Transformation Plan in good stead for deeper integration of the capacity and roles of the young people, families, schools and professionals.

Appreciative Inquiry

The outcomes and principles were developed with stakeholders using an Appreciative Inquiry approach so that all conversations were based on identifying what is currently working well, 'what does the best look like' and how can issues be reframed differently for the future.

Appreciative Inquiry (AI) is a particular way of asking questions and thinking of the future that fosters positive relationships and builds on the basic goodness in a person, a situation, or an organisation. It can be used to enlist all stakeholders (commissioners, staff, providers, parents/carers and young people) in conversations to rethink service provision.

The basic idea is to develop outcomes and build organisations around what works, rather than trying to fix what doesn't. It is the opposite of problem solving. Instead of focusing your energy on fixing the small part that is wrong, this approach focuses on how to create more of what's already working. Importantly it acknowledges the contribution of individuals and increases trust and collaboration.

Focusing on what works gives clues for future changes. Few organisations or individuals enjoy being criticised, and many respond by becoming defensive. Encouraging them to do more of what they do well is more productive than trying to stop them doing what they do badly.

The approach is very flexible and aids capacity building due to the following attributes;

- story-telling format is easy to grasp and use
- participants can learn the skills while taking part
- its flexibility means that it can be used almost everywhere: community; school; family; voluntary group; etc.

In this project, the AI approach was used to shape conversations with all the stakeholders from the initial engagement event with practitioners and staff to the focus groups with children, young people and parents.

Analysis

As illustrated in Appendix A mixed methods were used to gather data including co-production discussion, idea stations, questionnaires and workshops. The outputs of these were largely qualitative including words, pictures and summary flipcharts and post-it notes. These in turn were analysed thematically. An integrative approach was used by comparing results from different sessions and methods alongside each other. As the co-production

sessions advanced a less open and more purposive inquiry was made whereby themes which emerged in earlier sessions were raised for comment and verification.

Sample

The Bromley Emotional Wellbeing Steering group was the core group who led and facilitated the project and helped to create the space for conversations with many of the stakeholders. This steering group has been recently formed to bring together practitioners, commissioners and managers who have a particular interest or remit in the emotional wellbeing of CYP. Appreciative questions were used throughout the stakeholder engagement and Appendix X has further detail on how these discussion guides were framed.

Practitioners

Forty-five practitioners from across the children/young people sector attended the stakeholder engagement event held on 19th July. This lay the ground for the subsequent conversations held with other practitioners and children, young people and parents as it provided a clear set of themes from which to start the analysis.

In addition to the formal stakeholder event, a series of interviews were undertaken with key practitioners in the borough. These were:

- Jacob Pereira – Lead advisor for inclusive education, Bromley Council
- Andrea Blair – Inclusion support advisory teacher, Bromley Council
- Dr Mark O'Leary – Lead consultant community paediatrician, Phoenix Children's Resource Centre
- Ramanjit Janack – Communication and engagement manager, Bromley Healthcare
- Matt Beavis – Interim designated nurse, Safeguarding Children and LAC

Focus groups were also held with staff at:

- CAMHS
- Bromley Y

Children, young people and parents

Focus groups were facilitated with parents and young people using the appreciative questionnaire and they were held through the following organisations and projects:

- Bromley Challenge
- Newstead Wood School
- Coopers School
- Wickham Primary School
- Bromley Beacon Academy
- Vision - Sensory support service
- Youth Council
- Bromley CAMHS service user group
- Bromley Y
- CASPA
- Parent Voice
- Cotmandene Children and Family Centre
- Charles Darwin School

Table 1 below shows a breakdown of how many CYP were involved, their gender and their ages:

Table 1: total number of participants involved in the co-production process and breakdown

Total number of participants	**347**
Girls	92
Boys	42
Under 11 years old	23
11-14 year olds	40
15-17 year olds	58
18 year olds and over	5
Idea station & online surveys (mix of ages and gender)	66
CAMHs professionals	21

The same questionnaire was used by some practitioners who 'interviewed' CYP as part of their day-to-day interaction. The following projects undertook these interviews:

- Youth Offending Service
- Bromley Y
- Mencap

An online survey was created which was distributed through the following settings:

- Libraries
- Wickham Primary School
- Virtual school
- Children in care
- Young carers

Ideas stations were used at the following settings:

- Phoenix Children's Resource Centre
- Libraries
- Youth Offending Service

As the engagement period came to an end, the conversations were analysed and key themes drawn out. These findings were presented to the Emotional Health and Mental Wellbeing Steering Group and participants from this group played a central role in agreeing and shaping the final set of outcomes and service principles for the sector.

Key findings

The responses from CYP, parents and practitioners during the insight phase were analysed thematically to build a picture of what is important to CYP and the current service. There is widespread parity between the views of the practitioners and those of the CYP providing a strong base from which the outcomes and service qualities could be developed.

What is important to young people for their mental health?

Sense of autonomy, anonymity and choice

A desire for more autonomy, having a sense of control and choice resonated across most of the conversations with CYP. Currently, once the young person had raised an issue about their emotional health, they felt they were given little control about who they could talk to, where and how. This was especially relevant in the case of the school counsellor's role. In some schools, the school counsellor was well known by the students and was a integral part of the fabric of the community. Many of the young people at these schools, spoke highly of the role. However, many other young people said they would not go the school counsellor because they did not know who they were, they were worried about who would know they were visiting them and they did not want anyone at the school to be aware of their situation. In fact, nearly all the young people agreed that they worried about the stigma attached to visiting the school counsellor and their friends or peers finding out that they needed their help.

If a young person has reached the situation where they feel they need external help, they often do not feel able to speak to their peers or family so retaining confidentiality is fundamental to them.

> *We need to be sure that they won't just go and tell your parents what you've told them.* –Girl, 15

This was played out by the experiences of some who had met with their school counsellors in offices which were located in areas of the school frequented by students and not anonymous, so that peers could see what they were doing and who was visiting. Furthermore, there is usually only one school counsellor so that if the young person did not make a good relationship with them, they had no other options for support. Some students talked about the frustrations of this and how it seemed the importance of the relationship was not taken seriously enough by professionals.

> *I didn't get on with my counsellor; she decided I wasn't ready for CBT because I wouldn't open up to her so I stopped seeing her.*
>
> *I saw someone for 18 months but I never liked her so it was a waste of time.*

Additionally, young people seemed not to have a choice of suitable times to visit external support and they were usually expected to travel to attend appointments at the clinic or service. Parents voiced their concern about this approach as their sons/daughters often failed to attend because they had difficulty remembering their appointment or did not prioritise it over other aspects of their lives.

Directing negative thoughts and feelings

Almost all CYP recognize the value of talking about difficult times, however many young people also choose to be alone if they are feeling sad, upset or angry and often preferred to divert their attention away from their feelings rather than face them or speak about them to friends or family. Their choice of distraction included sport, video games, listening to music and watching TV. For example when asking how children would advise others who needed cheering up responses included:

You could do things with them to help them forget about things, -Boy aged 9

Go watch a bit of TV and relax, watch a movie – Girl aged 9

Sometimes I bash out my anger on my drum kit – Boy aged 12

Others who chose to face their feelings, would do so alone, listening to music, playing a musical instrument or writing poetry. Many young people questioned the efficacy of talking to a professional, and some recognized they found it difficult to talk about their feelings per se. Alternative channels to sharing thoughts and feelings with other people included enacting their inner worlds through games, writing in diaries or records they can then destroy or conversing with those who can guarantee confidentiality:

Sometimes I talk to my dog. He can't hurt your feelings. He won't judge. – Girl aged 10

I feel comfortable around animals, more comfortable than around people – boy aged 14

Options and choice regarding the approaches to supporting them were considered very limited and young people and parents agreed that more creative approaches should be explored to develop a more inclusive offer.

When I have problems I like to write them down…I don't always like talking face to face to someone. This would let me get everything that I want to say down without getting interrupted or side tracked – Girl aged 19

As shown in Figure X below, CYP feel at their best doing a wide range of activities or spending time with friends and family whom they feel close to. Many of the activities which make CYP happy were also used to direct and channel negative feelings.

Figure 2: Drawings from co-production sessions: showing CYP's sources of happiness including time with family and friends, relaxation, amusement activities and contact with nature.

Participation in service delivery

Giving young people a voice – peer led (theme from stakeholder event)

There was a resounding agreement across the board from children to parents that they should and would like to be involved in shaping the future service provision in Bromley.

> *I've seen lots of people involved with charities in my school and lots of people passionate about campaigning for mental health*. – Boy aged 16
>
> *I'm equally qualified to run mindfulness trainings to the head of pastoral care at my school* – Boy aged 15.

Some of the parents from Parents Voice are already creating their own solutions by connecting with other parents and organising group events and days out. The Bromley Youth Council is also in the process of setting up a champions network and publishing a set of self-help books. Bromley Y has developed an emotional wellbeing awareness programme with some of the young people they have supported and they are voluntarily taking this into schools and facilitating classroom learning.

One group of girls agreed they could create a better PHSE programme for themselves and the quality of their current one was considered so poor, that they believed the school did not really care about their wellbeing and simply wanted to tick a box.

> *We had loads of ideas about what we'd like to talk about in our lessons but the list was taken away and we've not heard anything since* -Girl aged 15

Involving the children, young people and parents through co-production might open up the type of provision available, and include other interventions and opportunities which go beyond medicalised approaches and talking therapies.

Relationships, trust and connections

The importance of a trusting and open relationship with the person providing the support was highlighted by all the CYP engaged with. In their words, they talked about adults who took the time to understand them, someone who accepts them and doesn't judge. Many of the young people who had attended a mental health service found the assessment process very difficult:

> *She asked me so many ridiculous questions* – Girl aged 14
>
> *Her assessment said I had depression; I don't have depression – I've got anger issues* –Girl aged 17

And some of them talked about how difficult it was to respond to their questions when they'd only just met the practitioner and did not feel ready to open up.

> *She expected me to tell her all about it but I didn't know her. Why couldn't she spend some time getting to know me first.* -Girl aged 15

There was a recognition from the young people and some of the practitioners that a relationship can take time to build and how vital the quality of the relationship is to the success of the intervention. Many of the young people had spent time with counsellors and practitioners who they did not want to talk to and many months and years were potentially wasted.

> *I went through three counsellors over 3 years before I finally found the person I could really trust and talk to* -Girl 19 years old
>
> *I would not be comfortable with other members of the community [other than family or people within the school], because I don't know them as well B*oy aged 14
>
> *I would be more likely to approach someone if they thought they knew what they were doing, like if they were an expert, rather than just a normal person or teacher, someone who could give you real advice* -Girl aged 15

There was a point of consternation regarding the number of sessions on offer from Bromley Y and CAMHS which at present stand at 6-8. The young people who had experienced this number felt they should have had more choice about the length of time they received support. They felt that this number of sessions did not take into consideration the amount of time it takes to build that vital relationship and they all agreed there should be flexibility around length of intervention.

> *I have my six sessions so I feel better, and then I start to go downhill again and have to be referred back into CAMHS for more help.* - Girl aged 14 years old

Practitioners were unsure whether they should be given longer, some stating that they were concerned about the young person growing a dependency on the service, while others felt it was not long enough.

Issues around relationships also has an impact on who the young person should be expected to talk to. The role of the school counsellor and the efficacy of having this type of provision in schools has already been questioned. However, it also questions the use of teachers as PHSE facilitators; many students highlighted the need to have a separate external 'teacher' who they could open up to in PHSE lessons rather than discussing these issues with someone who they would see everyday at school. They felt these conversations should be kept confidential from school staff.

> *I've only met you for an hour but I feel able to talk to you more about this stuff than one of my teachers* - Girl aged 15
>
> *Sometimes you need to talk to someone, but it can be hard to find the right person, a resource to help identify who to talk to would help, but you would need confidence to actually talk to them about it, some people may not talk about stuff because they think they will be judged, so just bottle it up and it deal with it* –Girl aged 16

Competency and education

Empowering young people to identify and use their skills and capabilities to find their own solutions and coping mechanisms – allowing them some control in a safe, supportive, creative space (theme from stakeholder event)

The conversations with young people highlighted a serious lack of knowledge and understanding about emotional wellbeing, in particular how the mind works, aspects of brain functioning and signs and symptoms of mental ill-health. Many of them were keen to learn more about this aspect of their lives and wished to understand strategies to help them cope with their emotional responses including stress and anxiety.

> *You don't know what you don't know* -Boy aged 18

> *Need confidence to be able to say what health issue they have, have to be able to tell people what you need* -Boy aged 16

Those young people who had learnt strategies such as breathing techniques and cognitive behaviourial therapy spoke highly of their ability to self manage and found them vital to maintaining their well-ness. Additionally, many CYP needed help to understand when their mental health was affected and when they should take action and talk to someone about it.

> *I taught myself CBT from the internet and it has been the best thing (boy aged 17)*
>
> *I learnt about CBT through CAMHS and it is really helpful in stopping me get so stressed* -Girl aged 15
>
> *We were taught breathing techniques at school to help us with exam stress and I still use them now* -Girl aged 17

In the particular example of self-harm, young people talked about the lack of knowledge they had about the consequences of using this as a coping strategy; they had little idea that it could be deeply addictive and unlike the use of drugs/alcohol, there is little information available to young people warning them of the dangers.

> *I learnt about self-harming from my friends but I had no idea what I was doing. I had no idea it was really addictive* -Boy aged 18

Competency was also highlighted by parents; they wanted the knowledge and ability to manage their children's behaviour better. They also felt their competency and knowledge was underplayed by professionals so that they felt as if they were perceived to be part of the problem rather than the solution.

> *While we were waiting for help from professionals the problems are getting worse and worse and nobody seems able to help us cope with them* - Parent

A programme of mindfulness is being rolled out across Bromley secondary schools; it is important that the quality of these programmes is monitored to ensure CYP receive the best instruction and support; without this, the full impact of mindfulness might not be achieved and CYP may be less likely to maintain the practice beyond the lessons.

Self-help, self-management and greater awareness of mental health are also connected to a young person's ability to feel autonomous. It is important to remember that CYP have less lived experience and often don't have examples in their lives to compare their current situation with. For this reason, they may not know what would help them because every strategy is untried and untested and they might not know whether they will recover because this is the first time they have felt like this. It seems vital to help them self-manage by giving them the knowledge and skills to make appropriate choices about how to cope and introducing them to people with shared experiences.

These coping strategies should be available to everyone, including those CYP already living with behavioural issues including ADHD and autism. There are methods which young people can be given to help self-manage but these do not seem to be taught to them or their parents at present.

Having competency related to their mental health may also help CYP to allow themselves to feel and not be ashamed of their more negative emotions. From discussing this issue with them, it became clear that there is some stigma attached to feeling sadness or crying and

some of the young people spoke about how they prevented themselves from expressing this:

> *I turn my sadness into anger. It feels better that way* -Boy aged 15
>
> *I never let myself cry – I only cry if I hurt myself – the last time I cried was when I broke my ankle* -Girl aged 14

This is something that might need further investigation because it is unclear where the stigma originates and whether it is expounded by social media and the culture of high achievement which seems to be present in Bromley. There was a range of reasons put forward by young people as to why they felt affected by stress and anxiety or anger and these included difficulties at home and school stress but it might be necessary to unpick some of the other reasons to establish whether 'bottling up' their feelings was adding to their stress levels.

Self-esteem

Many CYP thought their wellbeing was closely connected to their own self-esteem. Believing in the importance of their own opinions and experiences is critical to being able to function effectively. Low self-esteem appears to be closely linked to social anxiety and a fear of being judged and negatively regarded by peers.

> *Confidence. At school, if you are not confident, you are basically not heard. I find it hard sometimes just to raise my hand and answer a question. All of the confident people are popular, they do not care what other people think about them as they already have their friends…* - Online survey respondent

The interpersonal element of self-esteem means many young people do not know where to seek appropriate help. Friends provide some solace but often friendship groups are isolated from, and therefore have limited influence over, those who are the source of the social anxiety: peers who are considered to have a higher social status.

Self-esteem is an aspect of wellbeing which appears to be particularly low for CYP across Bromley and should therefore be a focus for interventions along with peer awareness on how to be inclusive and treat each other with respect.

Connectedness

Developing a local community where every child and young person feels valued and that they belong (theme from stakeholder event)

It is well documented that increasing connectedness between people has a direct positive impact on their wellbeing. This theme goes beyond the role of trusted relationships and focuses on the need to help young people to connect with a different range of people, including peers, adults but also members of their communities.

Some of the young people talked about the difficulties they faced in meeting new friends because friendship groups were already established and if they were feeling unconfident or anxious, it became an impossible task. Additionally, there seem to be few opportunities to meet new people outside school unless they were involved in sport. Many of the young people highlighted the lack of extra-curricular activities and some said they did not have the time due to homework.

Having opportunities for CYP to connect with different people from different schools and outside their family environment may prove to give them more informal support if their situation starts to become unmanageable.

Proposals from Sensory Impaired CYP:

A program that would match certain happy children with those facing difficulties to ask each other how to deal with different situations

A program for people with vision problems, talking about how to get through life generally, talking about vision problems and talking to each other

Online resources are there, but having face to face contact is good with someone who Is not a parent or teacher, to talk to in confidence, peer mentoring

A group to talk to before a minor issue becomes a major issue

Often young people do not want to talk to parents or school friends as they are the source of the difficulties, so equipping them with other relationships and helping them to feel valued within their local communities may help to build their resilience.

Relaxed therapeutic environment

The setting where young people were expected to receive professional help for their mental health issues seemed to have a significant impact on how effective the interventions were. Many spoke about the difficulty of trying to talk about their issues with someone within a clinical setting where they felt intimidated by the sparse, medical environment. Furthermore, many of the young people who had met with the school counsellor talked about the setting being unrelaxed and uninviting – often a school office – and not being offered any form of refreshment.

When asked, young people wished for a therapeutic environment which felt homely and comfortable, where attention was given to helping them feel relaxed and at ease. In this case, Bromley Y was highlighted as a good example where the setting is a house rather than a medical environment.

Many young people did not wish to meet a professional at a hospital or somewhere with an obvious mental-health related remit. The word mental health was considered to be frightening and associated with 'mental hospitals' and madness.

Somewhere you're not ashamed to go to. You might be apprehensive to go somewhere because you're worried about what people will think. -Boy aged 15

Services provided within school are good, because location is important, however at school other people are listening, so either spread message and advice to everybody, or anonymously. -Girl aged 15

Some of the practitioners agreed that children services unlike adult services try very hard not to label and instead attempt to contextualise issues with the experiences the child has had so that there is a fluid view of children and mental health issues. However, there remains a stigma linked to the language around mental health but generally an understanding that attitudes need to be changed not terminology. Many of the young people were keen to be

involved in helping to challenge the language and culture to break down the shame and embarrassment associated with having problems with their mental health.

> *Yesterday I told my mum where I was going (Bromley Mind) and she said "that's the place for mad people". I don't think the people that come here are mad.* -Girl aged 16

Nature of existing system

> *The perfect road is so narrow it is really easy to fall off and once this happens, you have to fight to get back on.* -Parent of child with autism

> *The child follows the services, rather than services following the child* - Practitioner

Parents, CYP and practitioners were asked about the current system of provision for mental health and wellbeing and there were some common elements highlighted across them all.

There appears to be too little early intervention and prevention within the community or third sector settings so that professional help often comes too late, when the child, young person or family have reached a crisis.

> *A child's development is fluid so having to say 'you are not bad enough yet' and waiting until they are is very detrimental* -Practitioner

> *The best support we have had is from the police – there has been so little support for us that by the time we get help it's because my son has become a teenager is now a threat to me*. -Parent of child with ADHD

There are four youth hubs in Bromley and a range of other extracurricular activities and uniformed groups but we found it difficult to engage with staff and young people attending these, so this should be an area of further investigation. In particular, the youth hubs should be brought into the conversation as they may have a vital role to play if the system shifts towards early intervention.

The services provided by Bromley Y were favoured by young people but young people and parents alike mentioned the inflexibility of the appointment system, the need for young people to travel to their appointment and the short period for any intervention (6-8 sessions). Bromley Y acts as the single point of entry into the system and it may be that this entry point is too high up-stream so that a range of other more community, diversionary and peer based options are available on entry.

> *We should move away from a tier system and instead base help around CYP's needs. It should adapt to the young people themselves* -Practitioner

Some practitioners and young people felt that services related to emotional wellbeing were too medicalised and restricted in Bromley and the interventions were locked into NICE evidence based treatment which doesn't always provide the flexibility and creativity that young people respond well to. It was proposed by some practitioners that this may due to the way the services are commissioned with tightly defined specifications so that providers feel unable to branch out into activities which they believe would be beneficial. Additionally, the issue may be exacerbated by the culture of some of the parents in Bromley who feel a sense of shame about the mental health issues of their children and reach out for a quick fix rather than a longer term intervention.

There is a relatively long waiting list for CAMHS and families were keen to receive some sort of support while they were waiting, especially strategies to help them manage better. CAMHS was seen as the redeemer by many:

> *Once we got to CAMHS it felt as if at last something would be done to help us* - Parent

> *I knew that once I was seen by CAMHS I could get some medication and then I could start sorting myself out* –Boy aged 17

> *Getting referred to a councillor takes so much time, the waiting list makes it pointless as by the time you get to talk you are in a worse state* -Boy aged 16

But the threshold for CAMHS is high and this indicates that families and young people need to have severe issues before they are accepted. Apart from support from Bromley Y, there seemed to be little or no effective intervention during the years when the issues were first starting. Most of the young people interviewed from CAMHS and Bromley Y had met with their school counsellor but had not had a positive experience either because they were unable to form a good relationship with them or their symptoms were already too serious for the school counsellor to deal with.

Parents and practitioners highlighted the lack of intervention for families as a whole and believed that supporting the family unit to manage better together should be an accessible option for many rather than a few. Similarly teachers suggested that many families failed to engage because parent focused interventions were run far from places where they naturally congregate and at inconvenient times. For example sessions are offered in the centre of Bromley at 9am when parents need to drop children off at school. Instead a session or service could be offered in schools themselves at this time to fit into their agendas.

There was a strong feeling from many that the system is fragmented and disjointed and despite the number of forums for practitioners, these seemed not to be linked. With a lack of resources, specialist services are more likely to tightly define their boundaries and thresholds so that those marginal or borderline cases may not be seen. Furthermore, practitioners believe the 'silo' thinking between services i.e. mental health, education, social care, is largely due to the funding structure, so that an internal market is created with the same children and same families being supported, but little incentive to work in partnership or openly because they feel they need to protect their own budget.

CYP have little knowledge or awareness of the services that exist and the majority said they would not know where to go if they needed help, outside school. Additionally, CYP are siloed according to their symptoms (e.g. anorexia, self harming) which might exacerbate the fragmentation. Some practitioners recommended joining the responses according to the causes of the behaviour rather than categorizing the young person's response.

Within the school sector, practitioners highlighted the lack of acknowledgement and commitment from head teachers to address the wellbeing of their students.

> *There's a concern that if you 'do' mental health well in school, then your school will become labelled as the place for young people with those sorts of difficulties.* - Practitioner

Many of the schools are academically high achieving and they appear to be keen to uphold good reputations. Although we were unable to speak to students in schools in more deprived

areas of the borough, such as Penge, there is an opinion among some practitioners that these schools were more upfront about the challenges and open to working with their students on issues related to mental health.

Assets accessible to young people in the community

Friendships

Almost all CYP described turning to their friends as the first and often primary source of support. Friends provide understanding and familiarity for the CYP as they can contextualise any difficulties which arise. They also offer trust, the promise that they will act in the young person's best interest making it easy for young people to open up.

> *I always turn to my best friend – we talk through stuff and see what happens.*- Girl aged 13.

Siblings and cousins

Many CYP said they would talk to their siblings if they needed help or solace, especially older siblings who were perceived to have experienced similar anxieties and situations.

> *I would talk to my sister because she is older than me and she has normally had similar experiences* – Girl aged 10

> *I would go talk to my brother if I needed help – he's six years older* – Boy aged 9

Parents

Parents remain many CYP's first port of call for difficult mental health issues. This can sometimes be a poisoned asset if parents are also the source of worry or upset.

> *Definitely my parents. They always know what to do.* – Online survey respondent

> [When I want to feel better about something I…] *give my mum a big hug* [because…] *that makes me happy* – Idea station respondent

Internal resources

Most CYP seemed to have skills in diverting their mind from sources of concern and most were happy to spend time with themselves. Young people choose to spend time alone, relaxing etc. Almost everyone talked about wanting to be alone, possibly writing poetry, playing games or listening to songs

> *Drawing, singing and playing are all expressions of myself and make me feel good about myself and my unique-ness* – Idea station respondent

Optimism and hope were a theme for many CYP when exploring their inner resources. They suggested contextualising the difficult patches and focussing on a more positive future.

> *I'm fairly determined and persevere when like gets tough. I also always try to be positive and look for the pros in my situation.* – Online survey respondent

> *There is always hope. My life has given me so many more opportunities than others, and it is never the end of the world, just keep your chin up and believe it will get better.* –Online survey respondent

Out of school clubs

Although some after school clubs were critical to CYP's social support network, this seemed to be an under used resource within our sample. Attendance and the relationship with leaders could both be maximised.

> *I'm in a few clubs but I don't know the leaders well enough.* –Girl aged 13

> *Lots of people have never heard of a youth club. Cadets and explorers are the two biggest. Really good ones for those who are shy at school.* -Practitioner

> *Some wouldn't go to youth clubs because of gangs and territory.* -Practitioner

Churches and religious associations

Church attendance did not appear to be very high in our sample, but for those who do attend religious groups they found the leaders and community to be a useful sources of advice and support.

> *The other day I went to a Bible study and this guy was talking about when sadness attacks you is when you're hungry, isolated and ….something else. It was really good, I recommend it, it cleared my mind…* - Girl aged 17

Apps and self-help resources

The use of apps to manage mental health such as the mindshift app is common amongst those who are seeking help. One group of high school students was particularly enthusiastic about 'Mindful', a text-based group chat platform which operated in the school which anonymously matched up students with other student who were trained to deal with issues. If an issue was too serious for the student to deal with, it could be escalated to a trained professional, who acted as group moderator and overseer. Unfortunately this service was stopped due to funding shortages just a few months after initiation, and regret at this was expressed by almost all of the people involved in one way or another.

The platform, once built, seemed to fulfil a number of needs at presumably a relatively modest cost of the expert advisor's time. It created space to connect students with their peers, it allowed for anonymous communication, as the students said they were more comfortable using a text based service over other formats and it gave access to more expert advice if needed. Importantly it provided a simple, easy to use, anonymous space to talk with someone as a first step, and to seek more formal help if need be.

> *I keep to myself, but do talk to people once in a while, to friends, though I normally figure things out by myself, I could use online as a source of information, google searching, but it does take time* – Boy aged 14

> *There's a lot of online support: we would suggest young minds and NSPCC* - Practitioner

Self-help techniques

Some young people, especially those who had formal help from a counsellor effectively use self-help techniques such as writing things down that bother them and then throwing the paper away. This shows that school and community level interventions can travel a long way in the future.

Mindfulness calms me down and slows down my thoughts. I take deep breaths… - Girl aged 17

I pass on the tips from my therapist. A pressure point you can tap and it releases a calming hormone. –Girl aged 13

Sports

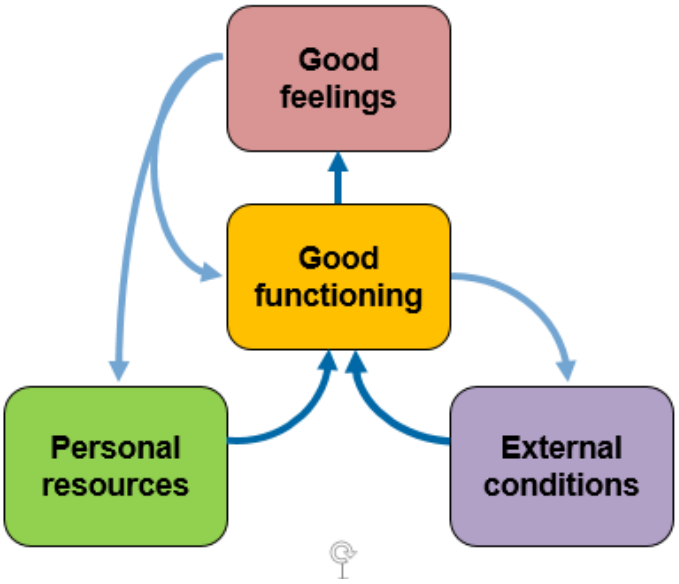
I advise people to try sport. I play in a benchball team with friends… I like to run it makes me happy –Girl aged 15

Outcomes

The key findings raise a set of core themes which can be used to determine the ideal outcomes for CYP. As the findings map closely to wellbeing theory, we have analysed them in relation to the Dynamic Model of wellbeing. The Dynamic Model of wellbeing was developed by NEF's Centre for Wellbeing after a major review of the theoretical approaches to understanding and measuring wellbeing. It is unique in that it brings together two of the major theories of wellbeing – the hedonic and the eudemonic theories – into one framework of subjective wellbeing[2].

The Dynamic Model of wellbeing posits that subjective wellbeing is made up of both good feelings (the hedonic understanding of wellbeing) and functionings (the eudemonic approach to wellbeing). It shows how our good feelings are in fact dependent on how well we function in society, which in turn is shaped largely by the interaction between our personal resources and external conditions.

Figure 3: The Dynamic Model of wellbeing



[2] Abdallah, S. Michaelson, J. Seaford, C. & Stoll, L. (2011). Measuring our progress: The power of wellbeing. London: New Economics Foundation

The notion of functioning well (the middle amber box) is best explained by the psychological theory known as self-determination theory (SDT). Developed by Richard Ryan and Edward Deci[3] the SDT argues that we all have a set of core psychological needs. These needs, which, if satisfied, enable people to flourish in society, are:

- autonomy: a feeling of choice and authenticity about your thoughts and behaviour
- competence: a sense of efficacy and skill, and a belief that you can have a meaningful impact on the world around you
- relatedness: the feeling that people care about you, and that you are close to others.

Functioning well and thriving in society will, it is suggested by this model, increase people's chances of feeling good on a day-to-day basis.

The Dynamic Model of wellbeing is completed by two further elements that shape people's subjective wellbeing: external conditions and personal resources. External conditions describe the material and social conditions in which people live. These include factors such as employment, working hours and conditions, income, crime rates, housing quality, access to green space and the like. Personal resources are "assumed to be relatively stable characteristics of the person – though not necessarily fixed – that are likely to influence their behaviour"[4], including their health, optimism and self-esteem. It is important to note that these two elements of the model are not part of the model's definition of wellbeing. They are drivers influencing wellbeing, interacting with wellbeing in a dynamic way.

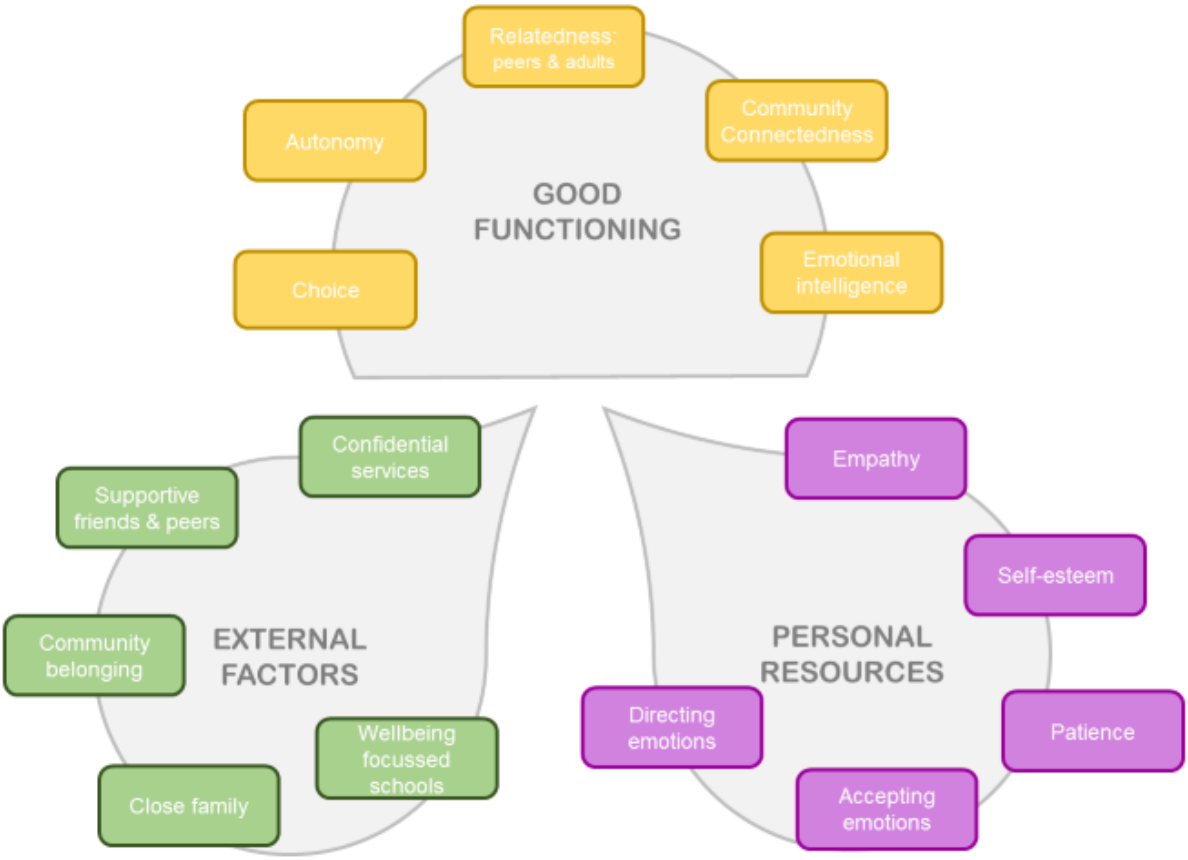
This model is dynamic in that it posits a number of feedback loops, which may be positively or negatively reinforcing. If we are functioning well, we are better able to improve our external conditions (this is shown by the light blue arrows in the diagram above).

From our experience with other commissioners, we have found the dynamic model of wellbeing useful in developing outcomes and measurement frameworks. The model suggests that commissioners should aim to commission for, and measure outcomes relating to, all four of the model's elements if they are to achieve wellbeing for all.

We have used our findings from the co-production sessions to populate a bespoke version of the Dynamic Model. The focus is on outcomes which are unique to Bromley CYP and so the hedonic areas of emotions is not presented. Instead we have picked the most material outcomes which we heard are important for the CYP to support their own wellbeing.

[3] Ryan, R & Deci, M. (2000). 'Self-determination theory and the facilitation of intrinsic motivation, social development, and wellbeing'. American Psychologist. 55, (1): PP. 68–78
[4] Abdallah, S. Michaelson, J. Seaford, C. & Stoll, L. (2011). op cit. p. 14

Figure 4: Bromley CYP's outcomes framework for mental health services



Service Qualities

A range of different characteristics emerged during the co-design sessions and these should be taken as guiding principles for the roll out of future services. Service qualities are not outcomes in themselves, they are a key component against which services are commissioned and evaluated. Alongside the outcomes which define what will be delivered, the service qualities define how they are delivered. They are intended to ensure that we are not just delivering good outcomes for CYP, but that we are doing so in the best way possible.

Table 2: desired service qualities identified during this project

Quality	Description
Co-production	All service models should involve co-production so that children, young people and parents work in equal partnership with commissioners and providers to design and deliver future delivery.
Early intervention and prevention	Services prioritise early intervention and prevention as part of their core offer to prevent CYP requiring more specialist intervention and to keep CYP well after they have received interventions
Appreciative and asset-based	Promote and strengthen the factors that support good mental health and wellbeing, protect against poor mental health and foster communities and networks that sustain mental health. In this way, CYP are assessed for their skills, capabilities, experience and knowledge and these are mobilised and strengthened as a core part of any therapeutic intervention.
Learning and reflection	A culture which encourages learning, prototyping and flexibility and enables the system to change and adapt over time in response.
Diverse and accessible	CYP have access to a range of different types of support from specialist, clinical interventions to more informal options including: diversionary activities; support groups and peer-to-peer self-help. Services and activities are able to adapt according to the needs of the child or young person and in response to the learning and reflection of the system.
Connected	Services which build bridges between individual young people, their friends and family and their wider community.
System view of CYP's wellbeing	Building the resilience of the support system that surrounds the CYP including family members, peers and community.
Person-centric	Consistent provision for each individual based on contact with professionals and supporters they trust and feel understand them. Services should be based on each individual's context rather than their diagnosis.
Private	Services should facilitate confidentiality and anonymity for CYP. In practice this might mean separating pastoral roles from other responsibilities teachers might have towards CYP or giving support options that protect user's identity.

Welcoming	Services are based around environments and contexts that CYP feel comfortable in such as buildings with informal, comfortable furnishings or activities which feel relatable to young people such as cooking.

Potential service models

The models and examples detailed below have been singled out because they may provide Bromley CCG with opportunities to change the current system. In particular they provide commissioners with examples of how to:

- Incorporate the children/young people and parents' skills and abilities in the redesign and delivery of mental health provision
- Deliberately push resource downstream away from specialist provision to improve early intervention and prevention
- Create a collaborative culture across the sector to prevent fragmentation and encourage integration
- Change the way services provide support to children, young people and families
- Provide a different response to students' emotional wellbeing within a school environment.

Co-production

Co-production refers to an approach to service delivery that radically reimagines the traditional dynamic of expert service-deliverer working on behalf of the passive end-user. Instead, the design and delivery of services are undertaken by both professionals and service-users/citizens. Table X above distinguishes co-production from other approaches:

A co-production approach envisages a relationship of mutuality between agencies and service user, at all stages of a service's life: from design, to planning and delivery. It recognises that both parties have vital contributions to make to improve the quality of life for people and communities.

Table 3: Models of service design and delivery

		Who designs services		
		Professionals	Professionals and citizens (Service-users)	Citizens (Service- users)
Who delivers services	Professionals	Traditional service model	Co-designed services	N/A
	Professionals and citizens (Service-users)	Co-delivered services	**Co-production**	N/A

	Citizens (Service users)	People trained to deliver services	N/A	Self-organised community provision

Future services for mental health and wellbeing should move towards an integration or collaboration of young people, communities, voluntary sector and clinical professionals. Increased participation and a growing feeling of co-responsibility among young people and families will mean more power can be shared between agencies and their service users.

The movement towards co-production can be conceptualized as a shift from 'public services FOR the public' towards 'public services WITH the public', within the framework of a public sector which continues to represent the public interest, not simply the interests of 'consumers' of public services. Public sector co-production activity has until recently been most prevalent in the adult social care sector and this is now reflected by the new Care Act (2014) which recommends that Councils treat commissioning as a shared endeavour with commissioners, support providers and citizens working together to co-produce the entire commissioning process.

The vision of a coproduced mental health provision will not be achieved overnight. Coproduction requires a genuine culture change, and this can take time to come about even for the most dedicated practitioners. Nor is it desirable to move directly from a state of not coproducing to one of transformative coproduction. It is more helpful to think of a transition towards coproduction, with everyone working from where they are now towards the goal of coproduction.

It is also important to distinguish between **substitutive co-production** and **additive co-production**. The former is where public sector inputs are replaced with inputs that come from users and/or communities; this can become an excuse to remove or withdraw service provision completely, leaving people to sink or swim. The latter involves combining the new and often overlooked resources of citizens, service users and community members with the professional/public resources. While One Ilfracombe aims to remove duplications, it is dedicated to providing for people's needs. The work of One Ilfracombe intends to be additive: integrating the voluntary and public sectors along with deeper service user involvement.

Asset based approaches

Assets can be considered as the "the collective resources which individuals and communities have at their disposal, which protect against negative health outcomes and promote health status"[5]. The skills, knowledge and connections inherent within individuals and communities are often not accessed or drawn upon purposefully, and so asset based approaches aim to make these collective resources visible and to utilise them.

Salutogenesis is a key theory underlining asset based work and provides an evidence base to help identify health promoting factors. It is an approach that focuses on examining what resources help people to maintain good mental and physical health, and seeks to

[5] Glasgow Centre for Population Health (2011) *Asset based approaches for health improvement: redressing the balance*

understand why some individuals fare better under stress and hardship than others. Antonovsky, the key theorist behind this approach, identified two health supporting factors[6]:

- Generalised resistance resources (GRRs) are the genetic, psychosocial and material resources that help people to understand and shape their lives. These resources can include financial assets, knowledge, intelligence, social support, traditions and religion.
- Sense of coherence (SOC) refers to an individual's overall outlook on life, and the extent to which life is perceived to make sense cognitively, have meaning and feel manageable with the skills, resources and capacities available to an individual.

A systemic review of the evidence[7]found that sense of coherence is a mediator and a predictor of health, for example an individual with a low SOC score is likely to also experience poor mental or physical health. Salutogenic approaches help us to understand how people can be supported to feel emotionally and physically well, and the role that resilience plays in health.

Asset based approaches fundamentally change the nature of the relationship between the individual and the State. It moves from a dynamic that focuses primarily on deficits and fixing problems to one that focuses on supporting and empowering communities. Deficit approaches that focus on identifying problems need not be completely abandoned, they offer some value in identifying priorities for State resources and locating inequalities. However the research evidence suggests that redressing the balance between asset approaches and deficit approaches can lead to a more resourceful and effective way of tackling health inequalities[8] and helping individuals stay well.

Dunraven school – an asset based approach to a school community

Since September 2013, the Student Engagement Department (SED) at Dunraven secondary school have pioneered an asset based approach to engaging their more challenging students and families in response to the ever-increasing need to prevent them from permanent exclusion.

The asset based community development (ABCD) approach has been used to develop tools and language that assess and identify the existing strengths and potential of students and their families that can then be mobilised within the school community. This demanded a change in focus from a traditional deficit system and it also required a change in the mindset of teachers, students and their families to view the entire school community differently; schools are often seen as separate 'fortresses' where children are the recipients of education from 'experts' and their school and community life are juxta positioned but aren't expected to mix. The new approach views the school as a community in its own right, with relationships and assets at the very heart and each and every community member (students, teachers, families) as an untapped resource with something to contribute. Where

[6] Hopkins, T and Rippon, S. (2015) *Head, hands and heart: asset-based approaches in health care: a review of the conceptual evidence and case studies of asset-based approaches in health, care and wellbeing*. Health Foundation

[7] Eriksson M, Lindström B. (2006) *Antonovsky's sense of coherence scale and the relation with health: a systematic review*. Journal of Epidemiology and Community Health 60 (5):376-381.

[8] Morgan, A. and Ziglio, E. *Revitalising the evidence base for public health: an assets model*. Promotion & Education 2007; Suppl 2:17-22

traditionally, money and staffing had been relied upon to improve student outcomes, now relationships are the key resource and these are not limited by budget cuts and staff shortages.

Now students referred into the SED are offered a range of opportunities including group work, peer-to-peer support and co-production. Teachers are trained and mentored by the SED staff in appreciative inquiry and are encouraged to share their own talents beyond those related to teaching.

The approach has been embraced positively by the whole school and the everyday language is becoming more appreciative as a result. Co-production and the asset based approach has improved both academic outcomes and commitment to learning from some of their most challenging students at risk of permanent exclusion. Over the last two years, their GCSE outcomes have vastly exceeded both local and national averages.

Whole system approaches

Building alliances to create integration and prevention

An alliance is, in effect, a virtual organisation consisting of a number of different organisations working towards a common vision and outcomes. The members of an alliance drive the synergy whereby the benefits of acting together are greater than those obtained by acting individually. Collective ownership of opportunities and responsibilities combines with shared decision-making. Alliancing can be applied to the delivery of services, co-design, research and development, innovation and change programmes. All alliances have the following outcomes in common:

- Formalises collaboration to accelerate and strengthen shared goals
- Drives innovation and fresh thinking
- Values parties equally however big or small
- Maintains each party's unique identity
- Uses whole system outcomes to align success for each party.[9]

The commissioner will contract 'the alliance' as a whole, rather than the separate members of that alliance and this single contract creates a collaborative environment without the need for new organisational forms. The contract is based on the outcomes to be achieved so that there is freedom for providers to come up with innovative ways to deliver these. The providers are not constrained by a detailed service specification.

The basis for working in this way is that the owners recognise that putting together different people with different perspectives provides a rich source of ideas. They are signalling that they want collaboration, innovation and continuous improvement.

All those involved in delivering the service work together to make sure the whole service is successful. They know they will not be judged on their individual contribution but on the performance overall. They are collectively responsible for success and collectively at risk for failure. This collective responsibility means that everyone has a vested interest in each other. It creates the sense of 'your problem is my problem, your success is my success'.

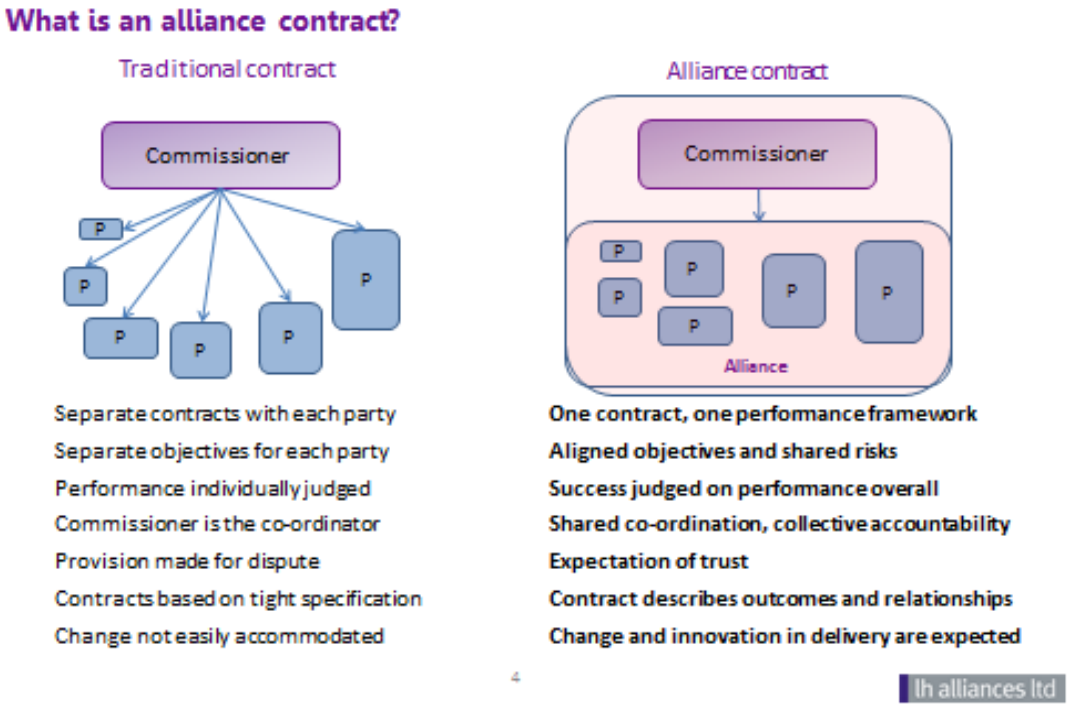
[9] www.LHAlliances.org.uk

Working together in a spirit of openness, mutual benefit and with a desire to achieve the best outcomes possible has led to people in alliances elsewhere achieving outstanding results.

There is usually a 'gainshare / painshare' approach – a reward and penalty type of arrangement. This means that when there is above expected performance then the parties share in additional monies. However if there is less than expected performance, some monies are held back. The precise form of agreement is specific to every situation and would be negotiated openly with all parties.

The use of alliances is being seen increasingly as a viable option across the public sector, especially as a mechanism to integrate services and sectors within the parameters of reduced budgets and greater demand. There are many examples of alliancing in the UK although they are fairly new developments and have yet to be tested over a prolonged period of time. See also 'Lambeth Living Well Collaborative' for an example of alliance contracting.

Figure 5: Alliance Contracts



Stockport Targeted Prevention Alliance (TPA)

Stockport Council had over 60 separate contracts and grants with charities and other organisations, which were providing services for those who needed additional support but who did not meet eligibility criteria. Faced with an impending severe reduction to budgets and frustration that there was little collaboration across these 'label' specific services, the council put all suppliers on notice and put out a tender for an alliance of providers to deliver a generic service. The winning bid included six providers: a mix of local and nationals. These now run a completely integrated offer on a funding envelope well below the combined previous total, with service focused on outcomes and 'style of delivery' as set by the Council. One of the outcome areas is to build community assets and social action.

The TPA is formed of Threshold, Age UK Stockport, FRAG, NACRO, Relate and Stockport Homes. The staff structure of the alliance has been purposely integrated so that although each employee is employed by the parent organisation, the line management falls to the alliance manager. Additionally, the expertise of the staff is amalgamated so that each worker holds a specialism but also delivers generic work. While it is too early to be able to demonstrate clear improvements in outcomes, early indications are that the alliance relationships are more open and transparent as each member has a joint vested interest in the performance of the contract. A wealth of resources and expertise arise from each provider organisation so that the delivery grows and adapts more quickly than a single traditional contract. Alliance beneficiaries may also have more choice, as there is a larger pool of workers and resource for them to draw on.

Lambeth Clinical Commissioning Group (CCG) – Living Well Collaborative

A period of diagnostic investigation was undertaken within the Lambeth adult mental health system and it was discovered that most of the people who were referred to the specialist South London and Maudsley (SLaM) services were presenting in crisis. However, many of them had to wait weeks to be seen and some did not reach the threshold of need, and so were not seen. This led to commissioners redesigning the approach to mental health services using a process of co-production that involved all stakeholders, including: SLaM, third sector and service users.

A prototype was developed in the north end of the borough. Funding was diverted from specialist provision and used to create a multi-agency team known as the Lambeth Living Well Collaborative (LWC). It combined SLaM, primary care, peer support and third sector agencies. This team was trained to implement asset-based approaches as its core offering. All GPs in the area changed their referral procedures so that instead of referring patients to SLaM, they 'introduced' them to the LWC. This introduction prevents people being drawn immediately into the referral/assess pathway and becoming a 'case'; instead the person can be offered a range of different support following a simple conversation. This prototype has since gone mainstream and encompasses the south of the borough as well.

Some of the results of the early help approach are:

- SLaM now receives more appropriate referrals, which reduces their caseload and saves time and resource
- More people are supported more quickly, and earlier – the LWC is a doorway to a range of different provision from third sector to peer support. These services are able to support people within a few days and are flexible to the person's needs.
- There has been a reduction in the demand on specialist SLaM services – in 2013, there were 125 referrals to SLaM; in 2015 the number of referrals was 25. The remaining 100 are being supported through the LWC.

The LWC is now being formalised. There will be a single alliance contract to tie the providers into a common set of principles and outcomes. The terms should enhance the collaboration between organisations and enable commissioners to further embed their asset-based approaches. Additionally, commissioners are working towards the inclusion of other services into the collaborative approach, such as supported housing – in order to further integrate support across the sector and combine resources.

One of the difficulties faced by commissioners is the instance of different monitoring and evaluation systems used by each provider. This has made the collation of performance data and evidence complicated. Despite the clear positive outcomes, there are still some sceptical senior managers who are keen to see robust data.

Early Help models

There are a number of early help models that have been developed and implemented across the UK, each with different strategic and operational elements but all generated from similar origins (such as reduced budgets, increased service demand and a need to integrate key sectors) and with some clear similarities.

A couple of examples of these have been included in this report because they demonstrate approaches to overall systems change and purposefully shifting resource downstream.

Kent County Council

The Kent 'Early Help' model integrates a wide range of services for children, young people and families: children's centres, youth work, targeted youth work and NEET support, the Troubled Families programme, youth offending service, family support, attendance and inclusion and pupil referral units. These services had not previously been integrated so this was the first time it had be attempted. The service does not include statutory children's social care services. The integration happened over a very short period of time (approximately 18 months) from conceiving and making the business case to completing service delivery and planning sustainability.

The model was informed by extensive analysis, workforce and stakeholder engagement and a systemic family practice approach, adapted from a model which had previously been tried and tested in the London Borough of Hackney on a much smaller scale.

The main focus of the service model stems from Early Help Units delivering intensive level family work including Troubled Family interventions, alongside more specialist youth justice work, attendance and inclusion work, and delivery of universal services and additional support from youth hubs and children's centred across the county. Early Help units and universal and additional provision are located according to the demographics of the area so that more deprived areas have more units. A significant level of diagnostic work was undertaken at the outset to establish a strong baseline for the achievement of families' outcomes, before the new model was introduced. Since the new approach was embedded, the diagnostics have been used to examine the social care data, comparing those who have had early help with those who have not.

In order to create the new Early Help service, all staff posts within the existing services, were deleted and workers were required to apply for the newly created posts. Voluntary redundancy was offered and taken up by some staff. The important factor to note about this restructure was that everyone was given the opportunity to apply for a promotion for posts for which they were eligible to apply. The budgets for each service strand were consolidated and combined so that the newly designed Early Help and Preventative model would be commissioned from one cross-cutting budget. This approach enabled the efficiency savings to be allocated from the budget before the services were designed.

Engaging and communicating with staff at the beginning of the change process was vital and a significant amount of staff resource was invested in this lead-in period. Managers led staff

roadshows and maintained contact with staff on a range of levels throughout. All staff, from managers to front-facing workers, were given the opportunity to become part of a 'task and finish group' which was brought together to help design the new service provision. This enabled workers to they were feel part of the process and, as a result, less resistant to the changes taking place. The results of the task and finish group were then piloted in a *sandbox* in one area over a few months to enable processes, delivery and monitoring dashboards to be tested out and tweaked where necessary.

Each unit is a 'collaborative' and there are distinctive differences in this type of approach compared to the previous traditional 'team' approach:

- Each unit is supported by a *leader* rather than a manager who also carries a case load (albeit a smaller one).
- The staff within each unit are co-located so that there are no isolated workers.
- The different levels of support, provided by the units, are spread out across the staff. There are two basic levels of support provided by unit staff, these are *open access* and *casework*. Staff with a remit of casework will undertake 80% casework and 20% open access. For those staff who are primarily open access workers, the reverse is true so that 20% of their time is spent on more targeted casework.
- Casework is time-limited to prevent waiting lists; each case is supported for approximately 20 weeks and the open access services are then used to provide ongoing support.
- Each unit holds a weekly case review meeting, which provides the staff with peer support and supervision and enables them to discuss more complex cases where necessary.

The service delivery is monitored through the use of two dashboards which were co-designed with the front-facing staff. One focuses on the efficiency of the unit and staff and has clear performance indicators and targets (for example, the number of cases held or number of cases closed per month). The second dashboard tracks the outcomes achieved by the families over time; every case that is closed without achieving the outcomes is audited to establish why. These dashboards work on many levels so that results can be monitored on a service basis as well as county wide.

Kirklees Council

Kirklees early intervention and prevention model is still in its infancy but the framework of the model has been established and the implementation has started. This model is quite unique as it is embedding early help across children and adult services simultaneously. Early Help is one of two strategic priorities for the council, so it is being driven by very strong political influence. Two key budgets have been amalgamated from Children Centres and Youth and this overall allocation is being used primarily for the implementation of the model.

The model comprises of the development of locality-based provision which focuses on a relationship-based approach, whereby one person acts as the chief navigator for each family through the system. This person does not necessarily need to be a professional; in some family situations this key position could be held by a peer.

Each locality will be served by a community 'hub'. The hub will be intelligence-driven and data-driven and will not be based around any one particular building. All existing resources within the community will be viewed as potential opportunities that could help in the

progression of the family, including schools, GPs, children centres, housing teams and so on. The primary delivery from each locality will be asset-based, promoting independence and value with the community. The support system is divided into three categories:

- *Community Plus* – which is universal
- *Targeted* – families with additional needs
- *Complex* – children in need, possibly in need of child protection

Unlike the existing system, all families within the *complex* category will also be offered resources and support from both the *community plus*, and *targeted* sectors, to provide them with an all-round package of support and opportunity.

The Early Intervention and Prevention team are currently developing a set of person and community-centred outcomes with a focus on wellbeing and resilience. These will be included in an Early Intervention and Prevention test (EIP test). The test will set out the criteria which all external services need to reach in order to be commissioned in the future. A range of pilots are being developed and implemented to test delivery and start to measure performance against the outcomes. These will include the creation of a number of community connectors and initiators in each of the localities.

A certain amount of stakeholder engagement has taken place before and throughout the implementation of the model to date, especially with key partners such as health, housing, schools and the third sector. However, commissioners are aware that much more needs to be done and different stakeholders need to be involved to ensure a rounded response to the development.

Key findings and recommendations for the implementation of Early Help models

- All the models created locality-based, multi-agency or disciplinary teams which prevented duplication – and enabled families and individuals to have a single point of contact for a diverse range of provision. Within some of these teams, the staff were expected to retain their specialism *as well as* deliver more generic work, as part of their role. Additionally, the multi-disciplinary teams were located together in local, community-based services and in the case of the Living Well Collective, also included the provision of peer support.
- Engagement with stakeholders at the beginning of the process was seen as crucial and much time and resource was spent by commissioners as they built relationships with internal colleagues, statutory and third sector – as well as community groups and service users. This helped to develop a positive momentum about the changes and to enable people to feel valued and to take ownership over some of the design of the new provision.
- Developing a positive, trusting interface with clinical and social care providers was highlighted as an important factor for the continued success and investment of an early help model. There can be tension between early help provision and clinicians. As budgets become more restricted, it may be too easy for strategic leads to prioritise specialist provision over early help.
- Each Early Help model was funded through a central budget pool, which broke down the siloes between the services and helped to create a common vision and outcome. In some cases, budgets were combined from existing services whilst in others, funding was diverted from other provision.

- Each model had the opportunity to test out and prototype the approach on a smaller scale before mainstreaming it. This allowed commissioners and providers to build their confidence in the programme and, where necessary, 'fail safely' and learn from those mistakes. In addition, it is useful for commissioners to organise the new model so that there can be some early wins. Again, this enables stakeholders to build their confidence while, at the same time, helping to influence strategic leads early on, so that the model is a good investment.
- Leadership was highlighted as an important factor in two ways. Firstly, collaborative leadership was the dominant style throughout the case studies, whether through leadership of the frontline staff or when created within an alliance contract. Secondly, system leadership needs to be strong in order to maintain the momentum of the transformation and bring people along with the changes.
- Strong political buy-in is essential and goes hand-in-hand with robust system leadership. This will protect the model as it develops and prevent influence from sceptics, of which there may be many.
- Each model has a common vision and outcomes. In most cases, these have been developed or influenced by all the stakeholders involved. It was suggested that when people are committed to working towards a set of common outcomes, this jointly vested interest can help to create open, honest and transparent relationships between people.
- The Early Help model requires rigorous and robust monitoring and evaluation. This is vital, in order to collate evidence that can be used to convince strategic leads that early help should be invested in as a future priority. In some cases, the system was designed with staff, which was viewed as important, because the staff was then less resistant to embedding the measuring tools into their everyday work.

Discrete service level approaches

MAC-UK – the Integrate Model

MAC-UK have developed a model in partnership with young people which supports others with mental health issues through diversionary activities, leadership training and co-production. They start by asking the young people for their help, rather than offering help and this builds trust. They treat them as experts, placing them at the heart of the design and delivery of services. They move from seeing the young people as the object of their care and make them architects of their own support. The young people are an early reality check on any initiative and MAC-UK harness the expertise that springs from their lived experience as young people, in their communities, on the street to learn what would work for them and their peers. Then they adapt their NHS practice. This co-production is not necessarily efficient in the traditional sense of the word. It takes a lot longer because people come with different experiences, not standard job training. It's more meaningful but slower, as trust takes time to build. It helps to build the capacity of the community, so the process is, in reality, also a form of prevention work.

One of their pioneering projects - the Integrate Model works intensively for 2 to 4 years with up to 50 young people per year. These young people are among the 5% that commit 50% of youth crime and have a history of non-engagement with existing services. By giving them the opportunity to create and own a project they find interesting, whether that might be setting up a boxing club or DJ-ing, young people successfully engage.

The MAC-UK team works collaboratively with the young people on their chosen project, helping them to develop leadership and employment skills and build trusting relationships with MAC-UK staff. Young people peel off into 'streetherapy©' at their own pace and wherever and whenever they feel comfortable.
Streetherapy helps to deliver conventional therapy but in a highly flexible way i.e. 'whatever, wherever to whoever'. It is about bringing psychological thinking into everyday interactions. Streetherapy can therefore range from having conversations on a park bench or in a café to helping a young person write their CV or accompanying them to an appointment. It is not the activity that is important but the conversations that you can have whilst completing the task at hand. By completing an activity or task, it takes the focus off the young person's mental health and relieves the pressure of formal talking. Most of the young people MAC-UK work alongside have little experience of talking as a therapeutic intervention, so asking direct questions like 'do you want to talk about that?' or 'how did that make you feel?' can be off-putting for them.
Streetherapy is very informal 'therapy' in which you can draw upon psychological models (e.g. CBT, systemic, psychodynamic models etc); however, using such models is not a requirement when conducting sessions. Streetherapy may be planned e.g. you have arranged to meet a young person in a café or it may be accidental e.g. you 'bump into them' whilst walking around Rowley Way.
Integrate also trains existing services (e.g. housing providers, the police) using a youth-led approach to enhance professionals' understanding of young people's mental health needs.

Wellington College – teaching happiness

Wellington College is an independent school in Somerset. In September 2006, they made the decision to launch a course in happiness and wellbeing for their 4th and 5th form students. This decision sparked enormous - and unexpected - interest nationally and internationally, which several years on has yet to die away.
At face value, deciding to teach happiness and wellbeing seems bold, but in many senses, it is an obvious and some might argue fundamental requirement in a school's educational provision. Their course has a very simple aim: to promote the flourishing and excellence of the young people at Wellington. Instead of focusing on disaster prevention, they educate about how their students might capitalise upon their human resources and make the best of their potential.
Wellbeing is defined by the Government Office for Science Foresight Report as
'a *dynamic* state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in their society.'
There is a growing body of scientific evidence on the causal factors around happiness and wellbeing, which can then be applied in work with individuals and institutions. Having a better understanding of how to increase the likelihood of happiness with life, and how to channel the emotional pains of set-backs en route, are the sort of skills that can substantially improve an individual's progress.
Previous research has shown, for example, that becoming involved in challenging and absorbing activities is important to people's ability to cope better with life. As an independent boarding and day school which focuses on an 'all-round' education, Wellington already offers its pupils a wide range of such activities.

Their course is based on six elements which serve to promote wellbeing:

1. Physical health
2. Positive relationships
3. Perspective (developing a psychological immune system)
4. Engagement
5. The world (living sustainably)
6. Meaning and purpose

All students in the first 4 years of the school receive the equivalent of 1 hour per fortnight of wellbeing lessons which also cover all PSHE requirements. Each lesson presents a skill that students can employ to enhance their wellbeing from advice on getting to sleep to more complex cognitive methods for dealing with adversity. Everything that is taught is based on reliable research conducted by some of the most eminent academics in the field. The Lower 6th also enjoys a series of lectures given by inspiring speakers designed to help their students reflect on the potential for making the most of their lives.

Conclusions and recommendations

The outcomes framework

The outcomes framework co-designed by the children, young people, parents and practitioners in Bromley provides a unique insight for commissioners into what they believe matters when it comes to mental health. Interestingly, the over-arching message seems to be to focus on wellbeing and the different components that this includes, for example, connectedness, contributing, feeling valued, and learning. It is particularly noteworthy that the principle agreed to be most important by practitioners and echoed throughout the engagement period, was the need for every child and young person to feel valued and part of their community. We would call this a community level outcome which should be included in all service contractual agreements because it asks the provider to think outside their walls and consider how to help the child, young person or family to feel connected with their community. It also asks providers to create ways in which they too can become more embedded within the local community.

The outcomes that resonated most with CYP were:

- An increased sense of autonomy – particularly in terms of anonymity, choice of intervention and opportunities to contribute to their own and other's mental wellbeing.
- Emotional intelligence – their need and wish to learn about their own mental health, the nature of emotions and thinking processes and ability to self-manage
- Relatedness – that a good, trusting relationship with the person helping them is fundamental to the efficacy of the intervention and that this should precede or be a priority over other service requirements.
- Wellbeing focused schools – that the school environment may be too focused on academic achievement to the detriment of the students' wellbeing. If there is a shift towards prioritising students' wellbeing, then a supportive learning environment should follow hand-in-hand. Happier students are likely to achieve more both academically and emotionally.

The outcomes framework should provide a solid basis from which to commission services with the service principles shaping the delivery. In the case of the dynamic model of wellbeing, it is advised that services work towards at least three outcomes, but that each outcome originates from each category – functioning, personal resources and external factors. In this way, each aspect affecting a young person's wellbeing is being affected, creating a whole person approach.

Commissioning against an outcomes framework is a relatively new concept and requires a degree of confidence and leadership from commissioners. It leaves space for providers to innovate and design activities with CYP which focus on achieving their outcomes and enables commissioners to focus on the change they wish to see. This report does not go into the detail of how to commission for outcomes but we advise commissioners to become familiar with the approach by reading NEF's *Commissioning for Outcomes and Co-production*[10] which provides a step-by-step practical guide to the concept.

The report draws insights from a range of projects we have worked on, and from the lead commissioners in these sites, to develop some starting points, intended to help you begin to put this commissioning approach into practice, whichever part of the cycle you are currently in. These include:

- **Senior leader engagement and support is vital**. Senior leaders need to be involved throughout, to provide commitment to both the process and the outcomes that arise.
- **Always strive to have an even balance of people using services and professionals.** Changing the default setting of meetings can be one of the most challenging parts of co-production. Continually developing new relationships with different groups of people is an essential part of co-production. Don't just invite people 'in' to your meetings, but get out into spaces where they go about their daily lives, and start the conversations there.
- **Thinking about outcomes and developing shared outcomes.** Talking about outcomes from the start helps to move away from 'services' and gets people thinking about and discussing change, opening up the space for innovation and co-production.
- **Changing the professional methods that are used in commissioning is just as (if not more) important than changing the service specifications.** Commissioners we worked with said that appreciative enquiry, coaching, and creative forms of facilitation were key skills they and their teams needed to learn, and which are now central to the way they work.
- **Less is more.** Do not over-specify detail within the services' specifications; leave as much space as possible to prevent limiting providers and allowing them to innovate and test out approaches that they and their young people believe will work.
- **Measure what matters.** Be mindful of what you measure because this might have an impact on the delivery of a service. For example, if they have a target for numbers coming into the service, the drive of the service maybe more about that rather than the quality of the provision and the outcomes for the service user.
- **Think long term.** Remember that this change is a long-term strategy. Incremental change will happen, but the big wins are likely to emerge in the medium to long-term

[10] http://b.3cdn.net/nefoundation/974bfd0fd635a9ffcd_j2m6b04bs.pdf

as relationships are developed and strengthened, and providers and the people they support are encouraged to take positive risks, and innovate together.

Systems change

Along with commissioning for outcomes we have the current experience of CYP in using mental health services and broader community provision to support their mental health. We have also presented a number of models to look to for reforming Bromley's system. Table 4 summarises some of our recommendations based on these alternative systems. We encourage Bromley CCG and partners to also reflect on which of these recommendations are most relevant or supportive of what is already going well for Bromley CAMHs. To preserve the strengths in the existing model, reduce harmful practice and direct future transformation towards these system qualities.

Table 4: summary and recommendations for CAMHs system level change

Co-production		
Key features	**Comparison with Bromley**	**Recommendations**
Services are designed and delivered in partnership with service users and the wider system.	Services are designed and delivered by practitioners. Service user groups are active but do not affect core service delivery	• Begin to reframe the system with training and workshops to enable all stakeholders to understand the new co-productive approach and to create a local definition which providers are clear about. • Involve a range of children, young people and parents in the design and delivery of future service models • Begin to develop a local map of assets and resources available within the system and community which can contribute to the wellbeing of CYP • Commission all service provision with co-production as a core service principle
Considers all the resources in the system and local area to go beyond commissioned services and include community assets and other resources	Current system focuses on commissioned services, practitioners and schools	
Asset based approaches		
CYP are assessed according to their skills, abilities and talents in balance with the problems they are coping with	Some of the current system is based on a deficit model which focuses on what is wrong with the child or young person without balancing it with their assets	• Begin to reframe the system with training events and workshops on asset based working and how it will impact future service provision

Their existing assets are mobilised as part of their recovery so that their 'treatment' includes enabling them to contribute to their community	The system is currently focused on specialist services so that providing access for CYP to more informal support within their local communities is not mobilised	• Refocus policy and procedure to enable asset based working to thrive • Hold regular learning and reflection sessions for all practitioners to enable them to build their approach together
Alliance contracting		
Key features	**Comparison with Bromley**	**Recommendations**
Collaborative working across tiers including universal, specialist and schools	Services disjointed and fragmented with varying degrees of quality	• Draw in the universal sector and other stakeholders to begin integrating them into the system. • Facilitate the process of collaboration and alliancing all the partners and developing shared aims and outcomes • Pool the budgets across the alliance and facilitate allocation across the alliance members
Single contract across all providers with shared aims and outcomes	Individual contracts with CAMHS and Bromley Y. Schools currently employ their own provision	
Single budget distributed between providers by alliance according to alliance outcomes	Budget allocated by CCG rather than by alliance	
Single point of contact much lower in the system so that CYP have access to universal and peer support on entry	Single point of contact midstream in the system and provision does not include universal or peer support	
Early Help models		
Pooled budget across the sector	Separate budgets for individual contracts	• Draw in the universal sector and other stakeholders to begin integrating them into the system. • Facilitate the process of collaboration with all the partners and develop shared aims and outcomes • Identify a discrete locality or project which could act as a prototype and commission service provision accordingly • Pool the budgets across the system and allocate resource within the new system
Approach tested out and prototyped on a small scale to enable learning and reflection		
All stakeholders including service users, involved in developing the approach to ensure buy-in and collaboration	Reshaping service model has started with all stakeholders involved in developing common outcomes	
Locality based multi-agency or disciplinary teams to enable access to wide range of provision at point of contact	Separate services with different remits and located according to their organisation. Universal provision not currently included in the system so less generic skill sets mobilised	

Common aims and outcomes across system	Individual contracts with CAMHS and Bromley Y. Schools currently employ their own provision	
Strong collaborative systems leadership		

Common themes across all models
Strong, collaborative systems leadership
Engaging with all the stakeholders including children, young people, parents, communities and the universal sector throughout the design, delivery and monitoring/evaluation of provision
Encouraging collaboration across the sector with common aims and outcomes that everyone is signed up to and being confident about limiting access to those providers who do not wish to work in this way
Pool budgets so that the system is managed through a single fund to prevent siloes and encourage collaboration
Spend time reframing the system and bringing practitioners and other stakeholders on board so that everyone is working to the same approach
Lower the entry point to provision so that the starting point is less about assessment and more about a conversation, including access to a broader range of provision such as local diversionary activity and peer-to-peer interventions and support

Appendix A: Co-production research tools

1. Discussion guides

Below are appreciative inquiry questions developed to explore what supports the emotional wellbeing of CYP in Bromley, and how to create more of this. The questions were designed to capture what they valued most about services, and what elements they would change. One of the most important aspects of these questions was to understand why the person has responded in this way. Understanding why would help us to connect themes and distinguish the broader motivations behind people's actions and values.

These questions were used across the entire spectrum of engagement, including focus groups, survey monkey and one-to-one interviews undertaken by practitioners. This maintained a level of consistency which enabled us to effectively analyse and compare the responses.

Children and young people

1. When are you happiest and why? *Prompts: Where are you? Who are you with? What are you doing? Why do these things make you feel happy?*
2. Who do you turn to or rely on and why? Which people do you value and why? *Prompt: apart from family/friends, who else in the community?*
3. What resources have you got inside you that help you manage and cope with the ups and downs of life? *Prompt: If you feel down about something – how do you make yourself feel better?*
4. What other resources do you think you need inside you to help you manage and cope with the ups and downs of life?

Additional questions for children and young people accessing services

1. Can you tell me about any services you may have experienced? How useful/successful have they been and why?
2. What do you value most about the service and/or the workers?
3. Considering what we have already talked about, what three changes would you suggest for the future of the service?

Parents/carers

1. When is your child happiest? *Prompts: Who is with them? What are they doing? Why do these things make them feel happy?*
2. Apart from their family and friends, which people in the community does your child value and why? *Note: this is asking them to consider their community and its role in the wellbeing of the child*.
3. We'd like to find out a bit more about what's made a difference in your child's life. Can you tell us about any support or strategies that have been successful in helping them manage or cope? Can you give specific examples?
4. Now we'd like to ask you about your experience of services that have been involved in the care of your child. What aspects of services – or access into or pathway through services – have worked well and why? Can you give specific examples?

5. Looking back over the years, what do you wish you had known about the care/wellbeing of your child that you know now? *Prompt: What piece of advice would you have given yourself?*
6. Considering what we have already talked about, what three changes would you suggest for the future?

2. Workshop guides

Participants at the stakeholder event were invited to tell each other stories in pairs using the following script:

'Tell a story about a time when you felt you and/or your organisation really helped a child or young person improve their emotional health and wellbeing; a time when you felt inspired and motivated.'

The pairs were then combined into groups of four and then eight, to discuss their stories and identify and collate themes from the conversations. The event ended with participants 'voting' on the themes they felt were most important to them.

3. Idea station questions

Idea stations

Idea stations are fixed areas within a setting where people are naturally waiting for appointments, queuing or gathered for an event. The ideas stations will provide ways of capturing the voices of young people, either anonymously through a piece of paper placed in a 'post box' or more publicly via posters and post-it notes.

I feel happy when…….because…….

When I want to feel better about something I…….
because……

The one thing I rely on in myself is……
because……..……

Ideally, the receptionist at each ideas station would coordinate the handing out of the questionnaire and where the children are young, parents are encouraged to help them complete it.

4. Online survey questions

An online survey was circulated through services and partners to CYP. The questionnaire was intentionally short and designed around appreciative inquiry questions in a similar manner to general discussion guides. The questions were:

1. When are you happiest and why? Please think about where are you, who are you with and what are you doing.
2. Who or what do you turn to or rely on when life is difficult?
3. What personal strengths have you got inside you that help you manage and cope with the ups and downs of life?

4. What other resources do you think you need inside you to help you manage and cope with the ups and downs of life?