Vulnerable Groups and Inequalities Task and Finish group Report

Children and Young People's Mental Health and Wellbeing Taskforce

This report summarises proposals from the "Vulnerable Groups and Inequalities" Task and Finish Group of the Children and Young People's Mental Health and Wellbeing Taskforce and has informed the report *Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing.* **It is not a statement of Government policy.** A full list of members and contributors is included at the end of the report.

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Introduction

This Task and Finish group brought together professionals drawn from numerous sectors and services with considerable expertise and experience of working with children, young people, and families with a range of different vulnerabilities. Following extensive discussions between group members and consultations with a wider constituency, agreement was reached on a vision for the future, the challenges needing to be overcome and proposals for change.

This Task and Finish group report addresses two key issues concerning children and young people with vulnerabilities. The first is that there are groups of children and young people in our society with multiple difficulties and complex needs which significantly impede their access to, engagement with, and outcomes from services; this report therefore considers factors which contribute to this impediment and solutions for overcoming them. The second is that the majority of children and young people who need mental healthcare do have multiple vulnerabilities which often contribute to their reasons for needing mental health support; as such, whilst this report makes particular reference to 'vulnerable groups', it is framed by the overarching principle that many of the proposals made within this report can be applied across the whole system of child and adolescent mental health services.

The Vision

1. Children and young people with vulnerabilities that predispose them to mental health problems due to their biological or social history should be able to access and receive high quality support at an early enough stage to prevent entrenchment and escalation of existing problems. This means making changes to referral and access routes where these are known to exclude those with vulnerabilities. Services should take steps to increase access for vulnerable individuals who might not reach the current threshold for support.

2. Children and young people with multiple difficulties and complex needs should be able to access and receive integrated support from a range of professionals across health, education, social care, youth justice, the police and the voluntary sector to ensure that their needs are met in a co-ordinated way.

3. Children, young people and their families who have vulnerabilities and complex needs should not have to fight for services. Services should take steps to increase access for vulnerable individuals who might otherwise fail to be identified. The vision is to empower staff who are already working with vulnerable children and young people by providing support from mental health practitioners when and where they are needed, provide co-ordinated services that make children feel safe, build resilience, and offer interventions and care that draw on the expertise and engagement of all the key agencies involved.

4. All the principles described in the CYP IAPT (Children and Young People's Improving Access to Psychological Therapies) programme should be actively implemented to ensure that all children and young people feel empowered, welcomed and able to engage in services. This means that services need to be more accommodating of the range and complexity of the needs with which children and young people present.

Key challenges

"I have considerable experience of children and families caught up in the care system as a consequence of sexual abuse, sexual exploitation, learning disabilities, domestic violence, drug and alcohol abuse, neglect or offending behaviour. So many of these children and young people are damaged and suffer from any number of mental health problems… but there are so few services now and those that do exist have very rigid referral criteria… basically there is nowhere for them to go. I remind you again that these depressed and unhappy children are our adults and parents of the future. These are the same people I know I will be assessing in 5 or 10 years time when their own children, too, are removed from their care."

A psychologist who took part in the Taskforce engagement exercises

5. The challenges involved in meeting the mental health needs of children and young people with vulnerabilities are addressed below under the following headings:

- Eligibility and Access
- Engagement and Experience
- Systemic Issues

6. Eligibility and Access

- Greater exposure to adverse life events and other determinants of poor mental health render some children and young people more vulnerable than others. These are children and young people who are impacted by multiple difficulties, each of which confer vulnerability to mental health problems. For those who accumulate multiple risks, their life chances may be weighted down, not by a single mental health difficulty, but by the accumulation of multiple biological and contextual factors conferring vulnerability, which *taken individually* may not meet the eligibility for services designed for children and young people who meet a diagnostic threshold.

- It is frequently difficult for children and young people to meet the threshold for specialist mental health services. Currently, services are unlikely to make allowances for how these multiple difficulties interact with each other, and therefore assess the child or young person on only one aspect of the picture they present with. These children and young people are frequently precluded from accessing specialist services due to their sub-clinical levels of symptomatology.

- Given a narrow definition of mental health problems and rigidity of eligibility criteria, the presenting problems of children and young people with vulnerabilities may also lack clarity, so children and young people who have experienced significant adversity will only meet the criteria for existing services if the presenting mental health problem is clear, whereas it may not emerge or reach clinical significance for some time.

"When CAMHS thresholds are so high many of these vulnerable and sometimes labelled young people slip through the net. If funding was made available to develop specialist services and teams, with the resources and expertise to "grow" established relationships with some of the most vulnerable groups, a multi treatment model approach could be provided which in my experience has been most successful."

A child and adolescent psychotherapist who took part in the Taskforce engagement exercises

7. Engagement and Experience

- The complexities of access to mental health services for children and young people with multiple vulnerabilities can lead to a marked delay before they become eligible for services, resulting in an escalation of their difficulties and increased distress while they wait for support. At this point, they frequently present with problems that have increased in severity and complexity.

- Children and young people with certain vulnerabilities are not always willing to access conventional services – they may experience the setting as alienating and punitive, or may have a lifestyle that is not conducive to meeting regular appointments. Appointments based in clinic settings are not the most suitable for vulnerable groups and their families, who may – at least in the first instance until they are engaged with services – be better served by outreach and home-based services.

- Vulnerable children and young people are likely to feel particularly disempowered and may have less support due to their social and family context. This means that simple and straightforward information and explanation about what to expect in the services will be particularly important along with person-centred and compassionate engagement by staff. Children, young people and their families need to understand what to expect from services, what choices they have and how they can be involved in sharing decisions about their care. Services need to ensure that this information is written in an accessible way – including 'Easy Read' – and that treatment programmes are constructed in such a way as to take into account any vulnerabilities which might act as obstacle to continued engagement.

- The existing evidence base, including NICE guidance, gives important pointers to what works effectively with some vulnerable children and their families, including Looked After Children and children with conduct disorder. Other guidance is under development, including on attachment and child maltreatment. However for some vulnerable children and young people whose problems are complex and may not fit a specific diagnosis, practitioners may be unclear how best to intervene.

8. Systemic Issues

- The current lack of capacity in services means that the needs of highly vulnerable and complex children and young people may not be given the priority or provision that they need.

- Many vulnerable children and young people experience extreme versions of the common issues that other children and young people face, such as being in touch with a number of agencies who do not always share information or co-ordinate care for them effectively.

- Vulnerability becomes greater as co-existing problems increase; when separate problems cut across different spheres of functioning (mental health, social relationships, conduct and behaviour, education, substance misuse etc.), intervention requires specialist input from many different agencies.

- Children and young people who experience multiple health, social, and educational difficulties are in particular need of an integrated response from services across health, social care, and education. These services are currently fragmented and may struggle to provide the co-ordinated response needed by these children and young people, who then must navigate a disjointed system. The more services they are in need of, the more likely it is that they must deal with the impact of the lack of co-ordination between those services.

- There is a lack of joined-up commissioning; the large number of agencies involved with vulnerable children and young people do not always co-ordinate effectively. Often there is no lead agency or individual accountable for the child or young person, despite the large number involved in providing services (sometimes in more than one geographical area for example in the case of some looked-after or adopted children).

- There is a failure to keep the child or young person and their families informed as to what is happening; the lack of information sharing between agencies concerned with a vulnerable child or young person may have a significant impact and reduce the quality of care and of the experience of services. The confusion of not being informed as to what information had been shared, as well as the frustration of having to repeat information, was one of the most frequently raised points amongst both young people and their parents in the Engagement Surveys conducted by YoungMinds.

Proposals for change

9. The proposals set out below apply equally to all children and young people, irrespective of their vulnerabilities, as general good practice. Specific vulnerable groups of children and young people have been referred to in order to illustrate and exemplify the issues under consideration. The examples used were not intended to represent the full range of vulnerabilities, but to illuminate the particular needs and inequalities that are commonly experienced by most vulnerable children, young people and their families.

The proposals are grouped under the following themes:

- Better and clearer routes of access to services and support
- Trauma-focused care
- Different delivery models including more accessible and engaging settings
- Increased participation
- Co-ordinated services
- Tackling inequalities and promoting equalities

10. Better and clearer routes of access to services and support

All children and young people who require specialised services need significantly improved access to assessment and treatment. For specified vulnerable groups, a clear offer for the route into specialist services is needed - for instance, learning

disabled children with behavioural problems who need an easier referral mechanism and earlier identification and intervention, where appropriate. The existing evidence base should be used to clarify what specialist mental health services and other services should provide for vulnerable groups, and where the threshold should be set for the interface with universal services.

Acceptance for specialist input should not be based solely on clinical diagnosis, but also on the presenting needs of the child or young person and the level of professional or family concern. The first point of contact following referral needs to be a telephone or face-to-face consultation with a skilled professional who can rapidly ascertain whether or not bringing the local network together can meet the needs of the children or young person or whether referral to specialist mental health services is needed, and where a comprehensive assessment will take place. Specialist services will need to be far more flexible in the acceptance criteria and avoid diagnostic rigidity. This will depend partly on increased capacity and additional training.

Specific groups need to be highlighted and understood, for instance, with children and young people with a learning disability, alerts would include those below (though these would vary across different types of vulnerability):

- Behaviours that are self-injurious, aggressive and destructive, hyperactive and impulsive, socially odd or sexually inappropriate
- Severe parental stress in managing the child
- Significant concerns from school or social care environments.

Safeguarding and child protection should be at the forefront of all professionals' consideration of young people belonging to vulnerable groups who may present with apparent mental health needs.

11. To ensure better and clearer routes of access to services and support this Task and Finish group proposes the development of care pathways for vulnerable groups:

a) Commissioners should lead the development and implementation of a range of multi-disciplinary and multi-agency care pathways that incorporate new models of providing effective support to children and young people who are vulnerable to mental health problems. Development of the pathways should be inclusive with the active involvement of a range of providers, children, young people, parents and carers and led by the lead professional.

b) Where possible, these should align to existing structures where agencies are already working with the child – for instance, looked after children care review meetings, or youth justice sentence review meetings and interventions. The Common Assessment Framework may also be a useful tool. Each care pathway should include a comprehensive assessment – drawing on available information from all involved agencies and highlighting all vulnerabilities shown or expressed by children and young people – so that services in contact with them will know when and where to refer onwards for further expert assessment. This might include what to look out for and where to refer if there are concerns about:

i) **General health, growth, nutritional status**
ii) **Behaviour**
iii) **Possible neurodevelopmental disorder such as autism spectrum disorder, attention deficit hyperactivity disorder, etc.**
iv) **Learning abilities**
v) **Domestic violence – witnessing or experiencing**
vi) **Bereavement**
vii) **Risk of and actual sexual exploitation**
viii) **Risk of and actual gang involvement or involvement in serious youth violence**
ix) **Emotions, mood, behaviours or mental health**
x) **Current or past history of substance misuse**
xi) **Historical or current exposure to a range of adverse childhood experiences which are likely to increase the risk of mental health difficulties.**

c) **Pathways need to be developed in such a way as to align with and support any relevant Education, Health, and Care planning for children and young people.**

12. Trauma-focused care

"There are not enough professionals trained to work therapeutically with children who have experienced trauma, abuse (especially sexual abuse), attachment difficulties. CAMHS staff often don't have the skills to work with the levels of trauma and attachment difficulties and just seem to offer whatever they have rather than what the young people actually need. The truth is that these are more complex children and they question the 'helper' identity role that professionals often have - if professionals feel less able to help because they haven't had the training or skills to best manage it, then they are more likely to exclude these children from services."

A psychologist who took part in the Taskforce engagement exercises

There is clear evidence that experiencing neglect and experiencing or witnessing violence or abuse have a major impact on the growing child. A great many mental health service users of all ages have problems directly attributable to these kinds of trauma in the early years. Some children and young people – including those who are adopted, Looked After Children or those on the edge of care, those in contact with the youth justice system and substance misusing young people - are more likely to have experienced trauma, both in early years and by cumulative exposure during childhood and adolescence. Whilst this is widely known and the procedures for dealing with the resulting safeguarding issues are clear, the traumatic impact of violence and abuse is not always taken into account nor fully reflected in the case management or therapeutic process. Young people with serious behaviour issues, for example, may be inappropriately referred for anger management rather than therapy for underlying trauma and loss.

Some staff find it difficult to make enquiries about the possibility of violence or abuse in the child's history although it is essential information which helps to assess the likelihood of children and young people developing mental health, physical health and social problems across the life course. Work by the Home Office around recognising gangs and youth violence as an issue affecting mental health has highlighted that mental health professionals are not consistently asking questions about risk arising from gangs and serious youth violence. Furthermore, substance misuse by young people is linked to poor emotional wellbeing as well as more severe psychiatric morbidity. The

Office of the Children's Commissioner's inquiry into child sexual exploitation in gangs and groups showed a connection between alcohol and drug use and child sexual exploitation. Staff in both community settings and specialist mental health services should be skilled in how to enquire sensitively about substance misuse in all cases when they are concerned about an adolescent's mental health.

Enquiry about the possibility of a child or young person having been exposed to violence or abuse needs to be done in a sensitive and appropriate way, once the clinician has established trust with the child or young person which can take some time. This may be particularly so in cases of child sexual abuse, including child sexual exploitation, where a young person may not always see themselves as a victim and therefore not report abusive experiences. Further research is needed into the possible benefits of introducing routine enquiry about such violence or abuse into mental health assessments of children and young people.

13. For services to become more trauma-focused, this Task and Finish group proposes:

a. Staff offering support and services for children and young people's mental health should become more aware of the impact of trauma so that people working with children and young people understand the impact of violence, abuse and neglect on a child or young person's development and behaviour. Assessments carried out in specialist services should include sensitive enquiry about neglect, violence and physical, sexual or emotional abuse; this is likely to have training implications for specialist and wider children's services.

b. All children and young people should receive education to raise their awareness on keeping safe. Those children and young people who have been sexually abused and/or exploited should receive a comprehensive specialist initial assessment, and referral to appropriate multiagency services providing evidence-based interventions according to their need. There will be a smaller group who are suffering from a mental health disorder, who would benefit from referral for intervention by a specialist mental health service. This should take account of guidance issued by the Crown Prosecution Service on pre-trial therapy.

c. Specialist mental health services should be actively represented on Multi-Agency Safeguarding Hubs or other similar local information sharing arrangements which should be used more extensively to identify those at high risk who would benefit from referral at an earlier stage.

14. Different delivery models

"Make it meaningful for them - we currently try and make them fit within "specialist" services. I think most vulnerable young people would rather have someone that talks to them like they want to be spoken to, and listened when they want to speak… the engagement is more important and needs to happen first, not sit someone down and decide "they aren't appropriate for therapy" - a line I have heard an awful lot over the last 6 years which just leads me to the conclusion that it's the therapy that isn't appropriate, not the other way round."

A mental health services commissioner who took part in the Taskforce engagement exercises

There is currently a lack of capacity in the system to meet the needs of all children and young people with diagnosable mental health problems. There is no doubt that increased capacity and resources are needed. However, it is unlikely that all vulnerable children with mental health problems will need to receive direct interventions from specialist mental health services. Instead, specialist mental health services should in the new remodelled system be used as a source of stepped intervention offering advice, formal professional consultation and, where appropriate, assessment and intervention so that front line workers who are concerned about children and young people for whom they are responsible can access support commensurate with the young person's needs. This model would enable initial contact with specialist mental health services without the need for a formal referral. Only when, after initial discussion, it becomes clear that further input (professional consultation or assessment/intervention) is required would more formal referral be required; even then, case management advice only may be sufficient to manage any risks, rather than the need for automatic assessment in all cases. Alternatively, the mental health professional may become aware of other more appropriate or pressing needs which should be first attended to, or supported, and will make such recommendations to the appropriate agency.

The aim will be for children and young people's mental health services to offer such a stepped approach in response to family or professional concern. Such a model requires an experienced practitioner or experienced practitioners who is/are credible and authoritative and is/are accessible. Such a model is only successful if the service provided is meaningful to referrers and not seen as a means of deflecting complex clinical presentations. In addition to the clinical role, there should also be an emphasis on training professionals working in other agencies so that they are better able to support young people with emerging mental health problems. Such a model could apply to a wide range of children and young people with vulnerabilities, including those who are involved with the youth justice system, those involved in high risk behaviours towards others, those involved in gangs, those who are missing education, looked after children, those with substance misuse issues, and those displaying sexually harmful behaviour**.**

It is also recognised that there are changes that have little or no cost and which could be implemented straightaway. Examples include:

- A warm and encouraging welcome for children and young people and families when they walk through the door.

- Enabling and encouraging the involvement of children and young people in their own treatment plans and reviews.

- Having a positive attitude and culture within services for children, young people and families.

- Providing simple and straightforward information on what to expect.

- Promoting effective participation in all aspects.

Young people have reported that these interactions make an enormous difference to how they feel, to their confidence in participating, and to counteracting the stigma associated with accessing mental health services.

"The first professional I contacted - after I built the courage to speak up about my mental health - dismissed me and looked really bored. I never went back and now I suffer alone as I will not put myself in a position like that again"

A young person who took part in the Taskforce engagement exercises

Case study: The Brandon Centre for Counselling and Psychotherapy for Young People

The Brandon Centre is the charitable organisation which offers confidential help, advice and therapy for young people aged 12 to 21 year olds and also family and parenting work.

The Centre offers an accessible and non-stigmatising service by providing comfortable and welcoming premises in the local community. Some services are also offered on an outreach basis in schools or young people's homes. Young people and their families can refer themselves for support, as well as services being open to referrals from health, social care, education and youth offending agencies.

The Centre also has strong links with academic institutions and a good reputation for using evidence-based interventions and for involvement in research and audit. Its services include:

- Counselling and psychological therapy services for young people, including both individual and group work and Cognitive Behavioural Therapy, working with young people with a wide range of emotional difficulties, including anxiety, depression, self-harm and relationship difficulties. Where appropriate, the Centre works closely with local CAMHS teams.

- Parenting work, including evidence-based group work for parents of adolescents.

- Multisystemic Therapy (MST): This is a NICE-recommended programme for young people with conduct disorder and their families. The Centre ran the first randomised controlled trial of MST in the UK in partnership with Camden and Haringey Youth Offending Services, funded by the Tudor Trust, Atlantic Philanthropies and Department of Health (DH), and results from this research trial indicate positive outcomes and cost savings as a result of this intervention (Butler et al 2011).

- The first UK pilot of MST for young people with problem sexual behaviour (MST PSB)

which works intensively with young people aged 10 to 17 years with problematic sexual behaviour and their families for 5 to 7 months. This pilot is part of a randomised controlled trial of MST PSB http://www.ucl.ac.uk/steps-b/mst-psb.php

- There is a contraception and sexual health service based at the Centre and also an outreach service to schools, offering sex and relationship education. This service aims to reduce unwanted pregnancy and sexually transmitted diseases but is able to pick up young people's emotional and relationship difficulties at an early age.

Funding: The Centre receives funding from a number of sources, including charitable foundations and local commissioning from CCGs and local authorities.

15. More accessible and engaging settings for vulnerable children and young people to receive support

"[We should be] Working with a more assertive outreach approach and taking services to those children rather than expecting them to attend clinics when it is known those groups have a history of poor engagement with services generally."

A community nurse who took part in the Taskforce engagement exercises

Some children and young people find the formal setting of a clinic off-putting and are unwilling to attend even when offered a convenient appointment. This is particularly the case for some highly vulnerable groups of children and young people such as those involved with gangs and those who have been sexually exploited. There are many services that are available that are not offered in clinic settings - including those delivered in schools, colleges and early years settings, by voluntary organisations aimed at vulnerable young people (such as Youth Information Advice and Counselling Services, services run specifically for children who have been sexually exploited and some innovative interventions delivered through youth services) and this is widely welcomed by young people. It is also important that the needs of children and young people not in school, including those missing education, are taken into account in providing more accessible settings.

Some mental health practitioners and other staff such as youth workers delivering interventions have made great efforts to see children and young people in public places, for example, café's and fast food restaurants which are seen as neutral territory. Whilst this may take up more of the health care professional's time, it is likely to lead to a better result than young people failing to attend and receiving no support.

16. This Task and Finish group proposes new delivery models:

a. Liaison Mental Health Model.

Based on a stepped liaison approach to handling concerns about mental health or neurodevelopmental difficulties, a liaison mental health model could be introduced, which is already best practice in some areas. Specifically, this would include children and young people with highly complex needs which include mental health difficulties, such as those who have been adopted and have additional mental health or developmental needs or those who exhibit harmful sexual behaviour, as well as those at risk of being, or in contact with the youth justice system, or those presenting elsewhere with a range of high risk

behaviours, about whom there are mental health or neurodevelopmental concerns. There should be particular awareness of young people in a range of settings where liberty is restricted; such settings are not limited to the children and young people's secure estate, but also include secure mental health in-patient units, residential educational schools and other residential provision.

This model could be implemented at a sub-regional level with co-ordination between clusters of CCGs and local authorities as it would not be needed in every local area. The role of such services would be to offer advice, troubleshooting, formal consultation and care planning where appropriate, working closely with local service providers, or assessment and intervention where this is required, if local cross-agency provision, including specialist mental health services, is not able to meet the needs identified.

The model requires an identified specialist point of reference, including senior clinical input with specific expertise to evaluate the referrer's or family's concerns, make authoritative and informed judgments and able to undertake/facilitate assessments/interventions where these are required. Consultative input, could be provided to colleagues from other agencies across the whole children and young people's system, particularly in the case of children or young people with complex or multiple needs not requiring specific mental health interventions.

The model includes both direct and indirect casework as well as the development of strong inter-agency working relationships (rather than reliance on protocols). A similar model is already working well in some areas as part of the Early Help approach as well as the existing tested model of regional community forensic CAMHS.

There is already a similar approach in adoption services, though it is considered that this should be expanded if more adopted children and their families are to be reached. Joint commissioning across the three sectors would enhance this element of a local offer of which all adoptive families and looked-after children and their carers would be aware.

b. Better follow up for those who did not attend (DNA).

Missed appointments should be actively investigated to establish why the young person or parents did not attend, to ensure that the child or young person is safe and to offer services the young person or parents are willing to engage with. Not attending appointments should not lead to the families or young people being rejected from services and should be considered as an indicator of need or risk in itself.

c. Treatment away from NHS settings.

Building on existing good practice and evidence of effectiveness, all children and young people should have the choice of receiving treatment away from traditional NHS mental health settings – this might be in schools or universal settings, but may also be away from any services and would include home-based treatment for some children, young people and families. This will take time to achieve so, in the first instance, should be rolled out to vulnerable groups such as those who have been sexually exploited and those who are involved in gangs.

d. Mental health practitioners embedded in teams responsible for groups of

vulnerable children and young people.

Young people who are amongst the most excluded need to be able to work with people they trust. This includes those who may have been sexually exploited or abused including, for example, children in the care system or in contact with the youth justice system and those involved in gangs who are not in contact with professional services, other than the police. These are a very small number of young people, who very often do not recognise that they have a mental health problem and need sustained engagement. A mental health practitioner can be embedded in teams that have relationships with, and responsibility for, these groups such as a youth club, a voluntary sector drop-in facility or a specialist substance misuse service.

The embedded worker can then develop a relationship with the young people concerned so that, as and when needs arise, they are able to respond as the familiar, trusted adult, rather than another new face. Frontline staff working with vulnerable young people should be trained in mental health, e.g. encouraged to use MindEd, and in basic therapeutic techniques, and encouraged to develop confidence around mental health, so that they are able to prevent excess referrals to specialist mental health services. This will include awareness and understanding of the evidence for resilience building and competence in working alongside children, young people, families and colleagues to develop a sense of belonging, and skills in coping and managing. The mental health practitioner can support the non-mental health workers to identify and meet the needs of children and young people who are in some way hard to reach.

Case Study: Jay's story

Jay was a 17 year old cannabis dealer associated with a known gang in London. He had a Youth Offending Team (YOT) worker and a social worker, but didn't talk much to either – he didn't feel safe going to their offices because of gang rivalry, and he worried that the other members of his gang would call him a snitch. Jay's YOT worker referred him to a substance misuse worker for his cannabis use and a psychologist for anger issues, but Jay didn't want to talk to people he didn't know or trust; he worried that all of these professionals wanted to find reasons to put him in prison. Jay didn't turn up to meet either professional and eventually the referrals were closed. Jay gradually became more drawn into gang activity and serious youth violence, and his mental health deteriorated as he witnessed several stabbings in his area.

Jay's YOT worker undertook a training in MAC-UK's INTEGRATE model, which emphasises the importance of delivering support in a flexible way that is adaptive to the needs of the young person rather than to the traditional structures of public services. Jay's YOT worker identified a youth worker in the community that knew Jay and his family well, and who had already worked with him in the past. The youth worker started to meet Jay in places where Jay felt safe and comfortable, like his favourite fish and chip shop or the playground on his estate. In time, the YOT worker met Jay together with the youth worker at events of Jay's choosing, such as local football matches.

After one match, whilst walking Jay back to his home, they gently explored the pros and cons of Jay's cannabis dealing and smoking. The YOT worker met with the team clinical psychologist and asked for support to address Jay's possible cannabis dependence. They acknowledged that it would not help Jay to introduce another professional into his life, but

instead made an arrangement whereby the team psychologist supervised the YOT worker to complete some basic CBT with Jay. Sometimes Jay found this hard and didn't turn up to sessions, but the YOT worker kept in touch with Jay to let him know that the sessions were there for him to attend at his pace whenever he felt up to it. After a year of meeting and making progress, the YOT worker asked for Jay's help to think about how he could support the substance misuse service by using his experience as a recovered user. Jay was offered a part-time employment role in the service as a peer support worker, which gave him an alternative to drug dealing as a way to make a living.

17. Increased participation

"Talk to young people about the barriers to accessing services - and put their suggestions into action. This authentic participation is a fundamental principle of the CYP-IAPT programme."

A psychologist who took part in the Taskforce engagement exercises

Services for children and young people should be framed within the United Nations Convention on the rights of the child (UNCRC), with particular reference to Article 12 (respect for the views of the child) and Article 13 (freedom of expression). Young people with vulnerabilities may struggle to participate in traditional engagement activities and events due to their needs. Services need to think specifically about how they seek out, listen and respond to the voices of vulnerable children and young people.

18. This Task and Finish group proposes that, in order to increase participation:

Children, young people and their families should have an active role, both in their own treatment or care and in shaping the services they are involved in, through consultation, feedback and active participation. The Children and Young People's improving Access to Psychological Therapies (CYP IAPT) programme provides for the involvement of children and young people in their own care, by engaging them in setting goals for their treatment and then in checking their progress by the use of Routine Outcome Monitoring (ROM). Additionally children, young people, their parents and carers should be involved more widely in service planning, delivery and monitoring. CYP IAPT has promoted the embedding of participation in everyday practice and this needs to be built upon and sustained.

19. Co-ordinated services

"Multiple services involved but a complete lack of communication between CAMHS, social services, school, and - most importantly - me"

A young person who took part in the Taskforce engagement exercises

"The way that many vulnerable children are 'passed around' from one professional to another is like a form of abuse in itself. Key workers with a commitment to work with children for longer periods but with access to support from other professionals and a clear understanding that the child's perspective of the support is vital to the process might be helpful. Secure relationships are very important to vulnerable children"

A counsellor who took part in the Taskforce engagement exercises

Children and young people in vulnerable groups are amongst the most complex that will be seen in specialist services. As a consequence, they will frequently come into contact with a range of different agencies, with information poorly shared, a lack of co-ordination and the need for the child, young person or carer to repeat their story time and time again. The feedback from children and young people, their parents and carers – including through the engagement exercise carried out for the Taskforce - emphasises the need for consistency and continuity in their experience of services. For some, such as those in contact with youth justice system or Looked After Children and those on the 'edge of care', this may span geographical and commissioning boundaries, causing additional complications.

Children whose parents have mental health problems, or a learning disability, have a higher than average incidence of such difficulties themselves, with many young carers looking after a family member with a mental disorder. When families come to the attention of children's services because of safeguarding and child protection issues the rate of parental problems is considerably higher than found in the general population. These same children have increased vulnerability to poor mental health. The learning from the Troubled Families Programme is that vulnerability to mental health problems often arises within the family and needs to be considered in that family context. This supports the need for strengthening services which tackle both children's and adults' problems, as well as the need for improved co-ordination between adults' and children's services.

Co-ordination of services is vital where a child with a learning disability needs an Education, Health and Care Plan, with an integrated assessment and any mental health provision needed being set out in the plan. The consequent duty for that provision to be secured by the responsible commissioner means that mental health and learning disabilities services have to be fully integrated with statutory local joint commissioning arrangements for special educational needs and disability (SEND) and included in the Local Offer.

It is essential that the appointment of lead professionals for mental health is designed to fit with and complement existing lead professional arrangements particularly those applied in social care, through the Troubled Families Programme or the youth justice system. For the more complex and vulnerable young people, there is a clear need to strengthen the lead professional approach to co-ordinate support and services and to prevent them falling between services. This role could be allocated through multi-agency processes such as the Common Assessment Framework or Team Around the Child or Family or – for those with more severe mental health difficulties – it may be appropriate to use the Care Programme Approach.

Part of the lead professional role will be to ensure that information sharing is made much clearer for vulnerable groups; difficulties in sharing information cause particular problems for children and young people involved with a number of agencies. Clarification of the ability to share information with consent of child and/or parent/carers would overcome many of the problems of confidentiality that professionals perceive as a barrier to sharing.

In some areas, young people within the CYP IAPT programme have developed a passport for the young person or parent/carer to complete together with a professional.

The aim is that young people own their information and decide when they wish to share the information with other professionals they are or come into contact with (a passport template will be published on www.cypiapt.org in April 2015).

Case Study: Alice's story

Alice was a 17 year old who was abusing drugs and was increasingly involved in aggressive confrontations with authority figures and other young people. Significant trauma coloured her past and she had experienced recent periods of homelessness. Her placement at a local supported hostel was now at risk, and sadly she could not rely on her family for support as many members were in prison. Alice had a history of very poor relationships with professionals – screaming at them and refusing to see them, often for no apparent reason. Alice had been involved with a number of services including the Youth Offending Service, a Pupil Referral Unit, and an inpatient unit.

Although she had been referred to a psychiatrist, Alice refused to meet with one. The services working with Alice applied the AMBIT (Adolescent Mentalisation-Based Integrated Treatment) approach in order to reduce the number of professionals that Alice had to interact with. Rather than requiring Alice to meet with various professionals and repeat her story, her services created a "team around the worker" - 'the worker' was the staff member who Alice had identified as the one that "gets me best" and the effort by the team was to avoid insisting that too many other workers are granted direct access to Alice, forcing her to have to make multiple intimate relationships with different people at a time when she was struggling to make even one.

Alice's key worker offered to meet her wherever she chose – in McDonalds, in the park, at her hostel, etc – and at a time that suited her. This allowed Alice to feel safe and to start trusting her key worker. Over time, Alice eventually agreed to see a psychiatrist on the condition that her key-worker accompanied her and that the meeting was not in a clinic.

20. To improve co-ordination between services and make the experience more seamless for vulnerable children, young people and their families, this Task and Finish group proposes appointment of a lead professional:

A lead professional should be appointed from one of a range of agencies for the most complex vulnerable children and young people. The lead professional role is to co-ordinate support and services to meet needs, for example, of children and young people in contact with the youth justice system, or those with both mental health and substance misuse problems, or those with a learning disability who are otherwise likely to fall between several different agencies. An essential aspect of co-ordination is information sharing across agencies, which will require the shared commitment of all agencies and the informed consent of the child or young person and their family.

For the lead professional role to be effective, all partner agencies need to commit to the expectation that identified needs will be responded to and that referrals will not be rejected unless there is an alternative for that child or young person. In the case of children and young people with learning disabilities and mental health needs, a joint response is needed across the education, health and social care sectors, bringing with it flexibility about how the different parts interact, and their thresholds for considering and/or participating in the care.

Case study: Multisystemic Therapy for Problem Sexual Behaviour (MST-PSB)

- **MST-PSB is an evidence-based multisystemic intervention for young people and their families when young people aged 10 to 17 years who have sexually harmful behaviour and may also be having other difficulties in school, at home or in the community. The intervention lasts for between five and seven months and involves the young person and his/her parents or carers. A therapist works with the family two or three times a week at home or in the community, over a period of 5 to 7 months and an on-call service is provided 24/7 to respond to families on urgent issues.**
- **MST-PSB works by tackling the range of factors which led to the problem sexual behaviour in the young person, providing parents and carers with advice, skills and strategies for managing future difficulties. Therapists use structural family therapy, parenting interventions, cognitive behavioural therapy and social skills building to support young people and their families. The team also work closely with other key agencies, including schools, social care, the police and Youth Offending Services in relation to both individual young people and to support planning for wider services for young people with problematic sexual behaviour.**
- **Three areas are currently delivering this model (the Brandon Centre in London, Cambridgeshire and Sheffield) and a Randomised Controlled Trial is under way at University College London (http://www.ucl.ac.uk/steps-b/mst-psb.php)**

21. Tackling inequalities and promoting equality

Children and young people with vulnerabilities experience inequality in at least two ways – both as a cause of their increased vulnerability and potentially as a consequence of it, in creating issues of access to appropriate support and services. For example, children and young people from Black and Asian Minority Ethnic (BAME) groups are under-represented in children and young people's mental health services, but over-represented in adult mental health services, and there may be issues of 'cultural competence' across the workforce. The experience of stigma is often much greater due to faith or traditional cultural dynamics. It is therefore important that commissioners and providers consider how to tackle inequalities and promote equality as they plan and deliver services, ensuring support and services take account of need, not just demand.

Linked to this, dedicated research is needed to build the evidence base around all vulnerable groups and particularly groups where little is known about how to intervene effectively, such as young people affected by cyber-bullying, young people from some BAME communities that experience higher levels of adult diagnosable conditions, gang-involved behaviour and child sexual exploitation. This research will need to be carried out across services and sectors, including interventions that address mental health needs. but also young people's social and educational functioning and should build on the existing evidence base for multisystemic interventions in the community (such as Multisystemic Therapy and Functional Family Therapy) referred to in existing NICE Guidance (March 2013).

As well as dedicated research, consistent methods of evaluating services, innovations and initiatives are needed, to begin to build strong evidence of ways of supporting vulnerable children and young people, not only in what is clinically effective, but also in the methods of engagement that are appropriate, culturally sensitive and acceptable to these groups. The resultant evidence will be the basis for commissioning what works with vulnerable groups**.**

22. So that inequalities are better addressed, this Task and Finish group proposes improved awareness of Equality and Health Inequalities Duties.

It is understood that health inequalities result from social inequalities and that action is needed to address the social determinants of health. However, we also know that there are inequalities in both access and outcomes from the support and treatment people receive. Reducing health inequalities in children and young people from vulnerable groups should be a focus both for commissioners and providers of health care. The Health and Social Care Act 2012 places a legal duty on clinical commissioning groups (CCGs), NHS England and the Department of Health to have regard to tackling health inequalities and this includes children and young people vulnerable to mental health problems.

Additionally, the Equality Act 2010 sets out equality duties for both the public and voluntary sector in respect of protected characteristics. Awareness is needed that those in vulnerable groups may have protected characteristics, such as disabilities caused by both physical and mental health difficulties, complex medical conditions, race, faith, sexual orientation, or gender reassignment. There may be a need for more training across all agencies working with children and young people, in recognising protected characteristics as a potential vulnerability to mental health problems. Children and young people – such as those with learning disabilities – should not be turned away from specialist services because of their disability.

An example of a protected characteristic that could easily be missed is LGBT children and young people who are more vulnerable to mental health difficulties, particularly those who are just coming to terms with their sexual orientation or gender identity. In addition, many LGBT young people experience homophobic bullying and the impact on their mental health is profound. This is made worse if they have not come out to family and friends and consequently feel they have no one to turn to.

Annex A: Table to illustrate the proposals applicability to some particular vulnerable groups

The following table is intended to exemplify some of the proposals in this report that apply to particular vulnerable groups and is not a comprehensive summary of different vulnerable groups. The groups and examples in this list are in addition to the statutory duties all public sector and voluntary organisations must fulfil under the Public Sector Equality Duty. They are also additional to the statutory health inequalities duties on the Secretary of State for Health, NHS England and Clinical Commissioning Groups:

Some examples of vulnerable groups [1]	**Existing processes**	**Examples of what could change**	**Who needs to consider nationally**	**Who needs to consider locally**
Adopted children	LAC health assessments Child health assessment	Improved professional awareness of the signs and impact of neglect, abuse and exploitation Introduction of sub-regional centres to provide specialised expertise and advice/assessment	Department for Education (DfE): adoption legislation and statutory guidance DfE: Adoption Leadership Board NHS England	Local Authorities (LAs) CCGs and NHS England Specialised providers of adoption support services Mental health service providers
Looked After Children (LAC) and Care Leavers	Annual LAC health assessments and health plans – part of LAC care plans	Improved professional awareness of the impact of neglect, abuse and exploitation Mental health service engagement is	DfE: Children Acts, care planning regulations and statutory guidance	LAs Clinical Commissioning Groups (CCGs) and NHS England

[1] These are not necessarily distinct and may well overlap

	Personal advisers for care leavers	triggered by level of professional concern rather than clinical diagnosis. This principle will be supported if the consultation and liaison model is adopted enabling local areas to access expertise and advice on children and young people with highly complex needs.	NHS England Royal Colleges Inspectorates	Mental health service providers
Children in contact with youth justice system	Comprehensive Health Assessment Tool (CHAT) secure and community versions, ASSET *e*tc. Youth Offending Teams (YOTs) are responsible for developing and overseeing delivery of sentence plans for those sentenced by the courts. Local multi-agency YOT Management Boards bring together statutory partners in the delivery of youth justice services, including health. Mental health provision by NHS England in custodial settings Liaison and diversion services (commissioned by NHS England)	Care-co-ordinator may be appointed to improve care and support and co-ordination of services - and those leaving the youth justice system subject to YOTs' statutory responsibilities for co-ordination of services for those in the youth justice system. Introduction of sub-regional centres to provide specialised expertise and advice/ assessment for children and young people with highly complex needs. Wider roll-out of consultation and liaison model so that Youth Offending Teams are able to access expertise and advice on children and young people with highly complex needs and with referrals based on level of professional concern rather than diagnostic criteria alone. The sharing of local data highlighting young people linked to gangs, violence and vulnerability	Youth Justice Board (YJB) Ministry of Justice (MoJ) DfE: Secure Children's Homes CCGs Local Safeguarding Children Boards (LSCBs) NHS England Inspectorates Her Majesty's Courts and Tribunals (HMCTs) National Crime Agency	YOTs/YOT Management Boards Community Safety Partnerships LA Children's Services Police/Police and Crime Commissioners (PCCs) CCGs Public Health England (PHE) responsible for the commissioning of substance misuse services NHS England Voluntary organisations working with young people in the youth justice system. Courts Local policing response

Children who are abused (including those who are sexually exploited), neglected or victims of trauma	Children in need and child protection assessments LSCBs	Improved professional awareness of the impact of exploitation, neglect and abuse. Introduction of routine enquiry for those aged 16 and above in mental health assessments. Use of sensitive enquiry about neglect and abuse in all children and young people with follow-up for those who respond positively. Comprehensive assessment and referral to evidence-based services. For those found to be more symptomatic and suffering from a mental health disorder, referral to a specialist service.	DfE: Children Acts, statutory guidance on safeguarding children NHS England: safeguarding accountability and assurance framework) Royal Colleges and professional associations: guidance on roles & competences of health staff dealing with safeguarding children Inspectorates	Local authorities LSCBs CCGs and NHS England Local organisations working with abused and/or exploited children Mental health service providers Police
Young people who are the most excluded including those who are involved in gangs	Voluntary sector provision	Embedding mental health professionals in teams and services working with gang-involved young people. Offering appointments away from the clinical environment – in cafes, schools, community settings.	National Crime Agency	Youth Services working with Mental Health Services Local gang multi-agency partnerships
Children and young people YP with Learning Disabilities/Autistic Spectrum Disorder	Education Health and Care (EHC) plans Special Educational Needs and Disability (SEND) support	The Special Educational Need and Disability (SEND) Code of Practice emphasises the importance of seeking to identify underlying mental health issues for pupils with SEND.	DfE Department of Health (DH) NHS England	LAs: including commissioners, SEND lead, educational psychology provision CCGs

	in schools and colleges For EHC plans, there are already requirements for relevant people across education, health and social care to be engaged, for plans to encompass the range of needs including mental health and for the plan to be jointly commissioned.	Single points of contact within schools and CAMHS would help to inform mental health assessments and to secure appropriate and accessible evidence-based interventions - for those with SEND but no EHC plan.		LA Children's Services SENCOs

Please note that a number of the vulnerable groups identified above may also be included in the local Troubled Families Programmes. This will involve a whole range of local public services. The Troubled Families Programme has been expanded to reach up to an additional 400,000 families from 2015-16. It is building on the success of the current programme to reach families with a broader range of multiple problems – including those with younger children, those affected by domestic violence, and families where mental and physical health problems are prevalent.

Annex B

Members of the Vulnerable Groups and Inequalities Task and Finish Group

Name	Title
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