Camden Community Mental Health Core Teams Learning Programme

Implementing the Community Mental Health Framework: An Evaluation of the Camden Mental Health Core Teams

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Executive Summary

The Community Mental Health Framework, published in 2019, sets out a vision for how mental health services can deliver a collaborative and accessible model of community mental health care. Our evaluation of its implementation within the Camden Community Mental Health Core Teams shows that there is a lot to celebrate about work that has happened in the community thus far. However, there are also challenges and improvements that can be made.

The Core Teams is successfully implementing the framework in the areas of:

- Being community based
- Receiving positive service user feedback
- Providing a unique offer that flexibly meets community need

Meanwhile, challenges are apparent in:

- Information sharing
- Collaboration
- Coproduction

The Core Team's work is often of a high quality and there is a clear understanding amongst staff on how to implement the framework, however the realities of the work, or systemic limitations, make it hard to consistently work in a community-based way.

Introduction

The Community Mental Health Framework

NHS England published the Community Mental Health Framework in 2019 outlining a transformative vision of community mental health services[1]. The framework critiques "siloed, hard-to-reach" services and calls for "fundamental transformation" of the community mental health system.

The framework places a strong emphasis on ending exclusion and addressing inequalities. It sets out a vision to improve access to care for people with long-term and 'severe mental illnesses,' with an emphasis on timely and accessible NICE-recommended psychological therapies. It advocates for reducing gaps between IAPT thresholds (now Talking Therapies) and secondary care for people with eating disorders and people with complex difficulties, associated with 'personality disorder' diagnoses.

It proposed solutions include: maximising the continuity of care by removal of service-thresholds based upon diagnosis, complexity or severity: to 'eliminate exclusions' and avoid 'unnecessary repeat assessments.'

It outlines a vision of collaboratively commissioned care, breaking down the barriers between:

1. Mental health and physical health
2. Health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and
3. Primary and secondary care.

It outlines a vision of 'place-based' care that brings mental health services closer to people's homes and aligns them with GP Primary Care Networks.

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1 *The framework is published across four key documents. Each can be accessed here: https://www.rcpsych.ac.uk/improving-care/nccmh/service-design-and-development/community-framework*

The framework outlines the following six key principles[2]:

1

Promote mental and physical health, and prevent ill health.

2

Treat mental health problems effectively through evidence-based psychological and/or pharmacological approaches that maximise benefits and minimise the likelihood of inflicting harm, and use a collaborative approach that:

- Builds on strengths and supports choice; and
- Is underpinned by a single care plan accessible to all involved in the person's care.

3

Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities, and create or fulfil hopes and aspirations in line with their individual wishes.

4

Maximise continuity of care and ensure no "cliff-edge" of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs.

5

Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.

6

Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation.

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2 *The community mental health framework for adults and older adults, NHS England: https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/*

Local Context: Community Mental Health in Camden

The origins of the Core Teams and community mental health work in Camden can be traced back to before the COVID-19 pandemic. Prior to this, there was a well-expressed desire across the care system for greater collaboration to exist. The pandemic expedited this process by making way for the founding of the Resilience Network, the predecessor to the Core Teams. Like the Core Teams, this was a collaboration between various professions and organisations, both NHS and VCSE.

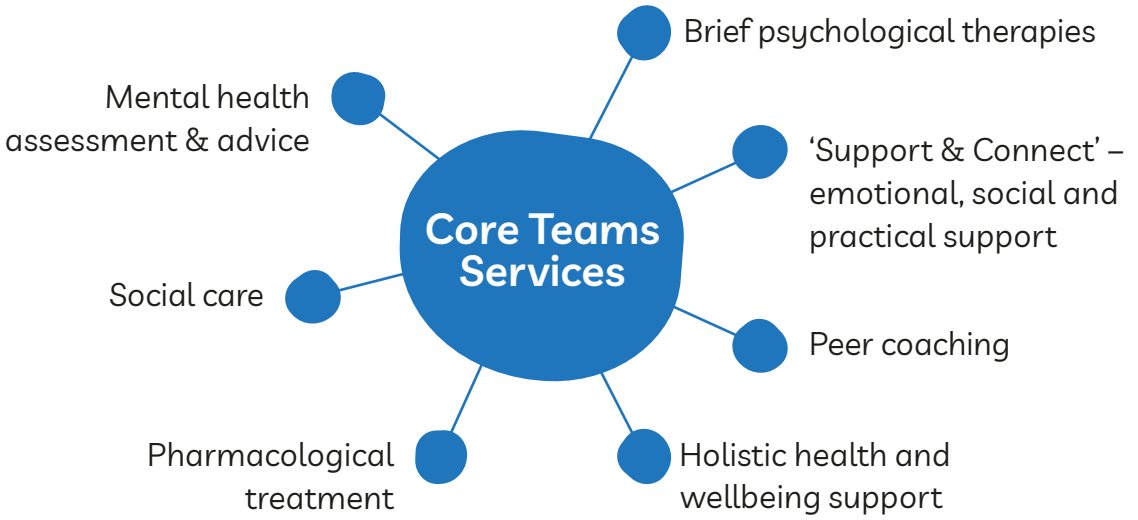
The Community Mental Health Framework was launched parallel to this by NHS England and it has been commented by those working in the system in Camden at the time that this provided the language and impetus for a pre-existing desire. This demonstrates that the drive for closer collaboration and a greater community presence has been long standing within Camden. The framework is useful in allowing us to assess how this desire has implemented and the successes and challenges of collaboration within Camden.

The Camden Community Mental Health Core Teams

The Camden Core Teams are a partnership between North London NHS Foundation Trust, Mind in Camden, Likewise and Hillside Clubhouse.

The teams comprise NHS, social care and voluntary sector experts from a variety of backgrounds and training. The team is split into three 'Core Teams' across the borough of Camden: North-West, Kentish Town and South.

Core Teams services include:



Staff groups include:

Location of each locality Core Team and associated GP practices within Camden:

The Camden Core Teams Learning Programme

This report was written and produced by The Camden Core Teams Learning Programme. The vision for this programme was set out by Camden Council, North London NHS Foundation Trust, Likewise and Mind in Camden to support the implementation of partnership working and service transformation in Camden mental health services. At the inception, the programme proposed the following aims:

- Building a 'learning culture' of reflective conversations and practices within the Camden Community Mental Health Core Teams.
- Working towards 'genuinely coproduced' service design and delivery with service users and their carers.
- Supporting the linking and interfacing between different services within Camden to create a person-centred mental health system in the borough through partnership working.

In 2023, two members of staff were recruited by Mind in Camden and Likewise to design and implement this work in practice – the authors of this report. To support our work, we recruited a Service User Reference Group, formed of current and recent service users of the Camden Core Community Mental Health Teams.

Learning Into Action: Intended Use

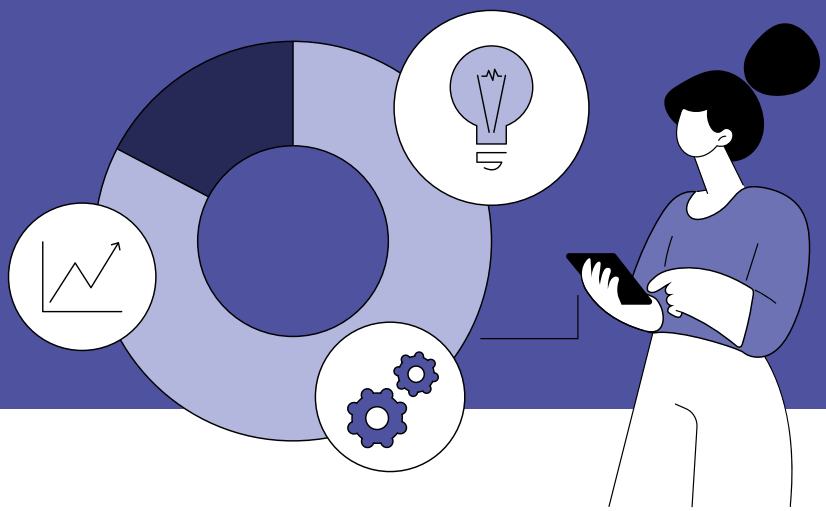
This report is intended as a learning tool: not just to be read - but to be presented, discussed and, ultimately, to guide informed-decision making in future service and system design.

While our roles and perspectives centre around the Camden Core Community Mental Health Teams, the learnings in this report are intended to speak to the wider system of mental health services in Camden. We encourage readers to get in touch with us, the authors, if you'd like us to present our work or speak to our service user reference group. You can find our contact details on page 48.

Glossary

- **North London NHS Foundation Trust (NLFT):** The new name of the mental health Trust in Camden (previously, Camden and Islington NHS Foundation Trust (C&I)). We have utilised NLFT as the Trust name in this report. However, during data collection services were operating under the name of C&I.
- **Mind in Camden:** A mental health charity located in Camden Town. Delivers the Support and Connect service (in partnership with Likewise) as part of the Core Teams.
- **Likewise:** A wellbeing charity located in Swiss Cottage. Delivers the Support and Connect service (in partnership with Mind in Camden) as part of the Core Teams.
- **Regis Road:** the site of the Kentish Town Core Team (and currently the North West Core Team)
- **Margarete Centre:** The location of the South Camden Core Team
- **St Pancras Hospital:** The site of the previous Camden Primary Care Mental Health Network (the predecessor to the Core Teams service). Previously the site of both the South Camden and North West Camden Core Teams.
- **Support and Connect:** is a VCSE service run by Mind in Camden and Likewise, embedded into the Core Teams, providing one-to-one support work and community development expertise.
- **iCope:** The Talking Therapies service (previously IAPT) in Camden.
- **FOCUS:** A mental health team providing assertive outreach to the homeless population in Camden.
- **Kentish Town Big Room:** A quality improvement initiative focused on improving the discharge process in the Kentish Town neighbourhood, bringing together staff from the Core Teams and the Rehabilitation and Recovery team.
- **Camden Core Teams Reference Group:** A group of comprised of Learning Programme staff (the authors) and current or recent service users of the Camden Core Teams services.

Method



Vision

The scope and goals of this report were envisioned in January 2024 with the involvement of Learning Programme staff (the authors), Head of Service for the Camden Core Teams (Tom Costley), Director of Likewise (Hugo Reggiani), Camden Core Teams Service Manager (Clare Church), Senior Manager at Mind in Camden (Elina Marques) and Quality Improvement Advisor for Camden (Emma Scott).

Camden Council's Head of Learning Disability, Autism and Mental Health Commissioning, Jonathon Horn, provided oversite and advice throughout the research process.

The aims of this service evaluation were outlined as:

- Creating an 'assessment framework' for the implementation of the CMHF.
- Speaking to staff to understand their views on keys themes of 'change' and 'collaboration.'
- Giving staff a space to reflect, speak openly and acknowledge the difficulties of working in community mental health services.
- Building an understanding of what supports and undermines the process of change.
- Understanding service-user experiences of accessing Core Teams services.
- Highlighting best practice in what makes a difference for service users.
- Learning from service user feedback and generating learning from this.
- Telling the story of CMHF transformation in Camden to help engage staff in the vision.
- Producing a report on the outcomes of the work.
- Producing recommendations to inform decision making for future investment and resource allocation.

Literature Review

Supported by the Whittington Health Library, we conducted a literature search of research on the impact of the implementation of the Community Mental Health Framework across the UK[3]. This search produced only four results. While there has been significant writing on the ambitions and implications of the framework, there is minimal reporting on the impact of its implementation.

Rethink Mental Illness produced a report in 2022, Getting started: Lessons from the first year of implementing the Community Mental Health Framework. This report offers – to our knowledge – the only published evaluation of the implementation of the CMHF. Their report focuses on early implementation of the framework, with an emphasis on commissioning and partnership-working between NHS, VCSE, and co-production partners.

Given the minimal literature on the implementation of the CMHF, we believe this report offers a unique perspective on how the framework is being implemented in practice. While it is intended to inform the leadership of mental health services in Camden, it may have wider relevance. Current literature about implementation focuses on high-level commissioning and partnership building. We hope this report offers a different perspective, by gathering data from service users who are currently (or recently) in Core Teams services and the frontline staff that support them – we offer a 'bottom-up' account of the Community Mental Health Framework from the perspective of the people who best know the successes and challenges of its implementation.

Data Collection

We conducted a series of interviews with staff across all three Core Teams. All staff were offered the opportunity to be interviewed. We aimed to conduct at least two interviews with staff members from each discipline.

We approached other primary and secondary mental health services in Camden, GP practices, housing services, drug and alcohol services and wider VCSE services to offer their views via an option of surveys, interviews, and group discussions.

- We conducted 21 one-to-one interviews with staff
- We conducted 4 group discussions that involved service users
- We conducted 4 group discussions that involved staff
- We conducted 3 staff surveys:
  - A survey for GP practices
  - A survey for workers in the drug and alcohol service
  - A survey for other employees with the NHS Trust

[3] *Literature review was conducted in August 2024*

Those who shared their views included[4]:

- Service users and involvement groups
- Core Teams Staff, including NHS and Voluntary Sector
- Primary and Secondary Care Services NHS Staff
- Council Services and VCSE Organisation staff

We also reviewed secondary data including staff survey results, focus group minutes, and demographic data using SHAPE Atlas (Department of Health and Social Care).

Evaluation framework

We developed an Evaluation Framework to inform our data collection and analysis. We reviewed the CMHF documents (NHS England) and cross-referenced these with the Operational Policy of the Camden Core Teams alongside Camden's Clinical Strategy.

We developed three key evaluation criteria and thirteen sub-criteria:

Evaluation Framework for assessing the implementation of the Community Mental Health Framework in Camden

Evaluation criteria	Models of practice	Accessibility and Holistic Care	Collaboration
What this means	**The key principles underlying the care we provide**	**Taking a wider view of mental health in the community**	**How effectively we work within the wider Camden mental health ecosystem**
Sub-criteria	• Evidence-based care • Trauma-informed care • Personalised, strength-based & recovery-oriented care • Healthy work practiced (staff wellbeing)	• Accessible and preventable care • Health inequalities • Place-based care • Access for those with co-occurring substance use and mental health need • Addressing social determinants of mental health	• Collaboration with people who use Core Teams services • Collaborations with primary care, secondary care, and social care • Collaboration with GP practices • Collaboration with local council services and VCSE partners

[4] *We were unable to collect feedback from social workers or the employment service. We did not interview senior leadership in the NLFT or VCSE organisations.*

Learning Approach

Positionality

Throughout our time working on this report, we have been situated as staff within the Core Teams, working alongside the colleagues and service users we interviewed. Alongside this report, we have worked on several evaluation, learning and service design projects across different disciplines and neighbourhood teams. Given that mental health services are complex systems that often work differently in practice than how they are envision in design and policy - our positioning has given us unique insight into the day-to-day practices of staff and experiences of service-users. Our relationship with staff and service-users informed its design. For instance, the presentation of findings according to a binary framework - 'what's working well' and 'what's challenging' - is informed by our desire to ensure that we made no criticism without also recognising successes. We also recognised that leaders and managers need on clear, concise information to make decisions: we hope this structure aids easy navigation of the report and supports effective decision making.

Method of Analysis

We utilised a process of rapid thematic analysis to identify areas of success and challenge across each of the 13 evaluation criteria. Interviews transcriptions were coded according to the evaluation criteria using the qualitative analytics Dedoose software. Data collection and analysis was an iterative process undertaken across two months. Following initial data collection, we reached out to key staff to supplement gaps in our understanding of certain areas of the Evaluation Framework.

Service User Reference Group

Throughout the design and delivery of this report, we have been advised by our Camden Core Teams Reference Group, formed of service users who have used Core Teams services. We presented initial findings to this group and gathered their reflections. Their celebrations and concerns based on these findings are outlined throughout and summarised at the end of this report.

> **Service user voice:** *Throughout this report, feedback that is provided by our Service User Reference Group appears in this shaded style.*

Contributors

In addition to our service user reference group, this report had input from Alice Ormerod (Mind in Camden) who conducted a thematic analysis of service user feedback data and contributed to the literature review. Henry Langford (East Camden Integrated Neighbourhood Team) offered valuable feedback on our initial analysis and Jonathon Horn (Camden Council) contributed significantly through his feedback on the first full draft of this report.

Findings and Analysis: Model of Practice

The community mental health framework sets out key principles underlying the provision of community mental health care.

These include:

- **Providing evidence-based interventions:** this refers to NICE recommended treatments for mental ill health including psychological therapies and pharmaceutical treatment.
- **Person-centred care:** this refers to the provision of care that is adaptable to the individual needs and situation of each service user.
- **Trauma-informed care[5]:** this refers to the recognition of trauma and how it impacts people and communities. Principles of trauma informed care include safety, choice and empowerment.
- **Staff wellbeing:** related to trauma-informed care, this relates to staff having a safe and supportive working environment.

Below we explore the implementation of these core principles and how this is viewed by staff and service users in Camden Core Teams.

Evidence-Based Care

The Community Mental Health Framework outlines evidence-based treatment as a key aim - in particular, psychological therapies and pharmacological interventions.

> *"We want to ensure that the provision of NICE-recommended critical in ensuring that adults and older adults with severe mental illnesses can access evidence-based care in a timely manner within this new community-based mental health offer, to give them the best chance to get better and to stay well – as service users have so often told us they would like." (Community Mental Health Framework)*

5 https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

It places an emphasis on ensuring those with complex (those with a personality disorder diagnoses) or severe mental health issues (those with psychosis or bipolar diagnoses) are able to access psychological therapies.[6]

What's working well

In terms of pharmacological care, patients can access medication reviews with a psychiatrist within a reasonable timeframe: "I know that generally within a month they should have an appointment" (GP) Beyond initial review, pharmacological intervention requires minimal resource from the Core Teams, in terms of staff time, and is therefore widely accessible to patients.

Where there were established relationships between GP practices and Core Teams, GPs reported access to timely and expert psychiatric consultation: "Gina is so helpful and responsive on email - if something is urgent, we know we can email her." As such, Core Team psychiatrists are providing indirect consultation for the wider Camden population.

In terms of psychological care, there are a wide range of interventions – including one-to-one and group work – and a rich, flexible offer of expertise, including, CBT, DBT, Systemic, and Trauma Stabilisation modalities. There was recognition that Core Team psychology is successfully addressing a previously unmet need within the Camden mental health system: straddling the gap between primary care provision within iCope (Talking Therapies) and specialist services such as CDAT or the Personality Disorder service. This is a key criteria set out in the CHMF.

Providing evidence-based care for people with complex mental health issues (i.e. diagnoses of personality disorder) is a key aim in the framework. Staff across the Core Teams viewed multi-disciplinary working as highly positive. This was seen as a particular strength in managing complexity: integrating psychiatric and psychological expertise alongside nursing, social care, and values-based and social approaches by VCSE and Peer workforce.

What's challenging

The CMHF outlines a vision in which "Interventions for mental health problems are readily available and accessible" (emphasis ours). A key barrier in achieving this aim is capacity to meet demand. In particular, psychological intervention

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6 *The CMHF places an emphasis on psychological interventions for people with 'Severe Mental Illness.' Currently, the Camden Recovery and Rehabilitation Team (R&R) operates separately to the Core Teams and provides specialist care to people with psychosis or bipolar diagnoses. However, upcoming Transformation will see this team merged with the Core Teams.*

within the Core Teams necessitate a wait of well-above 6 months. Lack of psychological intervention capacity was associated with a number of issues.

A psychiatrist explained that many people presenting with "mild to moderate" anxiety and depression should first be treated with a talking therapy intervention. In practice, "the waiting time for Step 3 [Talking Therapies] is a year. So often people get stuck." As such, patients lack meaningful choice of recommended treatment. Medication is "easier to provide" and can be accessed within a week.

Where service-users are able to access psychological care within the Core Teams, it is short-term (up to 8 sessions). One staff member highlighted this was less than evidence-based recommendation for some mental health diagnoses. Further, staff told us that clients identified as needing psychological intervention are often referred to a different service-offer, such as Peer Coaches or VCSE Support Workers and Social Prescribers as a 'meanwhile' offer. This can have negative impact on the client – such as confusion or frustration – where it's not their desired outcome. This was also associated concerns about staff qualification to meet a psychological need.

> **Service user voice: "***Waiting times are a big concern. People need support while they wait and clear communication while they wait."*

Notably, this issue is not unique to the Core Teams. Interviewees across primary and secondary services identified significant gaps in the provision of psychological therapies at all levels of care. Many practitioners raised concerns with the acceptance criteria of Core Teams, iCope (Talking Therapies), and secondary services. Relatedly, service-users raised concern that wider social or health factors – such as housing issues, substance use and or issues associated with 'complexity' – often prevented access to psychological intervention. While it is clear the Core Teams has expanded access to psychological treatment for many, staff and service user feedback indicates are still gaps in access to evidence-based interventions.

Summary

Key challenge

The systemic lack of psychological therapies across primary and secondary care is a key area of challenge in providing evidence-based care

Recommendations

- Improved offer for people waiting for care (on waiting lists), including:
- Improved communication – those on waiting lists should receive regular communication, to update on wait times and ensure they know they haven't been forgotten.
- Check-ins with staff members, where possible.

- Sharing of community support offers (such as those offered by Likewise) while people wait.
- Where new funding becomes available, expanding the psychologist workforce should be prioritised.

Links to current work

The Landing Space Co-Design Project has generated a service blueprint that offers support for people on waiting lists.

Person-Centred Care

> *"Sometimes it's not about receiving help, it's about finding someone who's going to listen and not judge you" (Service user)*

The CMHF lays out a vision of person-centred care that is personalised, strength-based and recovery-oriented:

> *"Person-centred care is flexible care based on the need of the person rather than the service. People are: treated with dignity, compassion and respect; offered coordinated and personalised support, care or treatment; and supported to recognise and develop their strengths and abilities, to enable them to live as independent and fulfilling a life as possible."*

The CMHF also places a strong emphasis on the 'co-production' of Care Plans, that are designed with involvement from the service user themselves, as well as carers and family members, and staff.

What's working well

Staff described the passion and commitment of their colleagues to provide flexible care that centres on patient needs. At the beginning stages of the Core Teams: "everyone was quite committed to meeting people in a way that isn't rigid and it's quite warm" (Quality Improvement Advisor).

The implementation of the CMHF in Camden involved the introduction of Peer Coaches and VCSE Support Workers into the clinical teams. Staff in both roles were seen as key facilitators of person-centred care: "This part of the service [personalised care] is also working fairly well, mainly due to the input from associated services like Social Prescribing, Support and Connect[7] and Peer Coaching" (Psychiatrist).

Clients who had worked with Support Workers and Peers put particular emphasis on being given choice over their care, such as where they met or what they worked on together. For instance, a Peer Coaching client described their experience: "I had loads of flexibility, encouraged to diversify and try new places. I felt I was given some agency."

[7] *Support and Connect is the VCSE offer in the Core Teams, delivered by Mind in Camden and Likewise.*

A key emphasis was also placed on staff ability to form strongly relationships with clients: "Getting to know Toni, she asked me what makes me feel safe and what makes me feel comfortable, she's getting to know my method of communication. I tell her and she listens and takes that on board, I'm then more open to speak to her about things" (Service user).

> **Service user voice: "***We recognise staff love their work and appreciate all the ways they help people."*

What's not working well

The DIALOG+ survey is the model of Care Planning used within the service. There were differing views regarding DIALOG+ and its value. One staff member raised concern that Key Performance Indictors (KPIs) provide too narrow of a view of the care provided by Core Teams. By emphasising DIALOG scores or appointment numbers as indicators of quality care, we risk devaluing the unmeasured aspects of staff work that is equally as important.

Another staff member challenged this view, emphasising the need for DIALOG+ to be further integrated into staff practice to fully realise its benefits:

> *Targets are there to reflect what's important to the clients. Letting something being labelled as 'target' changes how its seen. The team need to see that targets are useful and meaningful… People see [DIALOG+] as separate to their work. DIALOG+ is a way to ensure we do what we should be doing. It's another way of working with the client – brining in the client into decisions."*

Rethink Mental Illness' report, Getting started: Lessons from the first year of implementing the Community Mental Health Framework, highlights how NHS England targets emphasise quantity over quality. They quote an NHS England Policy Lead who states: "If we were in an ideal world, it would be all about measuring the quality of transformation, but we're not. So, the quantity is the thing that we can measure most easily and consistently… but the quality aspect is absolutely where I think most of the work is happening." This neatly summarises a key challenge for services in Camden: services must ensure they meet nationally mandated targets while recognising that meeting a target in itself does not constitute a quality service. In the realm of personalised care, outputs risk being reduced to 'tick-box' exercises that come at the expense of meaningful personalisation. Where a Core Teams intervention has been successful, staff

and service users referenced the need for longer-term, one-to-one support for people discharged from short-term interventions services. We were told that this kind of support is rare across the mental health system in Camden. This contributes to a sense of unmet need that arose from many of our conversations across the sector.

Summary

Key challenge

The Camden Core Teams have successfully established a number of short-term, person-centred interventions. However, options for further mental health support are limited.

Recommendations

- Ensure availability of medium-term and long-term mental health support in Camden. This includes both 'step-up' into more intensive clinical services and 'step-down' into community mental health offers.
- Where these pathways are available, ensuring they are well advertised and easy to refer into.

Trauma-Informed Care

The provision of trauma-informed care is central to the Community Mental Health Framework. The framework makes reference to the Centre for Mental Health's 'Engaging with Complexity' publication.[8]

Engaging with Complexity states that "trauma-informed care is most usefully defined in terms of ongoing processes, approaches and values, rather than fixed procedures." It outlines four processes that are 'fundamental' to trauma-informed care:

- **Listening:** Enabling [people] to tell their stories in their own words.
- **Understanding:** Receiving [people] and their stories with insight and empathy.
- **Responding:** Offering [people] support that is timely, holistic and tailored to their individual needs.
- **Checking:** Ensuring that services are listening, understanding and responding in a meaningful way.

In many senses, this definition of trauma-informed care is similar to that of person-centred care discussed above. However, it stems from recognition of how trauma has wide ranging impacts on people and communities and how this impacts interactions with services.

8 https://www.centreformentalhealth.org.uk/wp-content/uploads/2019/05/CentreforMH_EngagingWithComplexity.pdf

Trauma-informed care places a particular emphasis on generating physical and psychological safety and prevention of re-traumatisation:

> *"Aspects of a situation that may seem benign to someone with no history of trauma can trigger overwhelming feelings of distress in a trauma survivor, leading the individual to behave in ways that might be labelled as, for example, 'oppositional', 'non-compliant', 'delinquent' or 'hostile'. If an organisation reacts to these behaviours with seclusion, exclusion, restraint or force, further trauma may result. Trauma-informed care is actively mindful that, in these ways and others, service design and delivery have the potential to perpetuate distress and disengagement in traumatised people."*

What's working well

Staff told us there is widespread understanding across Core Teams of how traumatic experiences impact people's mental health. Indicators of trauma are regularly highlighted during initial assessment by doctors and nurses. In terms of treatment, psychological interventions were highlighted as a key success: offering emotional containment, coping strategies, and space to explore traumatic experiences. Further, there is a specific psychological group intervention for trauma stabilisation.

For service users, the ability to build a trusting relationship with staff member was highlighted as a key factor in generating feelings of safety. Service users highlighted VCSE support workers as skilled in building safe, trusting relationships.

Physical environment is a key factor in trauma informed service design. Likewise was celebrated by service users as a welcoming space: "Likewise is a nice space… very warm and welcoming." Interactions with staff on reception and the garden outside were highlighted as particular features that made the space feel welcoming.

What's challenging

> *"It takes a while to get to know someone, you need to be even more conscious in this sector" (Service user)*

Service users highlighted that initial contact, such as arriving at reception, was a crucial point in building trust and safety. This relates to both their experience of the physical environment and contact with staff. Service users described some reception areas as impersonal and unwelcoming, with unclear entry and exit routes. One staff member told us: "It's not… a warm therapeutic space, which I think is what people want."

We also heard from staff across the system about an increasing pressure to discharge people from services quickly due to high demand and limited capacity to meet it.

One service user mentioned that "it takes a while to get to know someone, you need to be even more conscious in this sector." Pressures to effectively discharge people rapidly can lead to less safety and trust being built with service users which is integral to delivering trauma-informed care.

Finally, some staff and service-users highlighted system-design as failing to be trauma-informed. One service-user spoke to us passionately about her frustration with attending numerous initial assessments, only to be passed onto another service: "It feels so frustrating, you start believing there's no point, I'm never going to get the help." Our findings indicate that many people are bounced between different services as they seek support with their mental health. As a result, service users are compelled to disclose psychological distress and experiences to multiple staff members. See chapter on 'Collaboration between Primary and Secondary Care' for a further exploration on service bouncing in Camden.

Summary

Key challenge

Service users first contact with services, especially when entering buildings, can be perceived as hostile and unwelcoming.

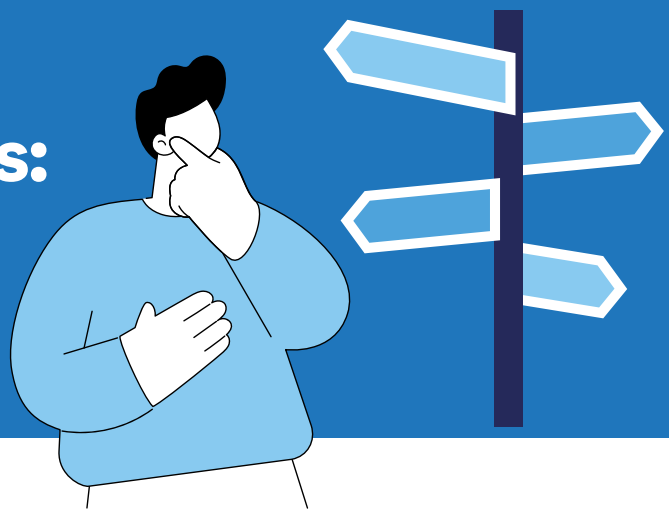
Recommendation

Conduct trauma-informed audit of all mental health sites with a focus on building entry, reception areas and clinic rooms.

Links to current work

Core Teams staff and Learning Programme staff are in the process of establishing working groups to improve physical environment at Regis Road and Margarete Centre. If you would like to conduct a similar audit at another site, please get in contact.

Findings and Analysis: Accessibility and Holistic Care



In this section, we explore the wider factors surrounding community mental health care.

Holistic care refers to our wider approach to health in the Camden community. If we are successfully providing holistic care, we are engaging with the wider picture around someone's mental health. This can include working in a preventative way to reach people before their challenges become serious, supporting those with physical health challenges and also working directly on the social determinants of mental health.

> *"See the person holistically and see their mental health in the context of their life." (CMHF)*

Accessibility refers to how easy it is for people in Camden to access appropriate care, a key improvement aim in the Community Mental Health Framework. The framework acknowledges that referrals into community mental health services across England involves "complex" processes that act as barriers to accessing care:

> *"When people's care moves between teams, typically over 20% of them do not reach the new team. This may be due to complicated referral and transition processes, or a lack of the most appropriate support in one place to address multiple needs." (CMHF)*

The framework proposes a system that enables services users to "access mental health care where and when they need it, and be able to move through the system easily, so that people who need intensive input receive it in the appropriate place, rather than face being discharged to no support."

The following discussion explores how the Core Teams has responded to these challenges to improve access to timely mental health care and the provision of holistic care.

Ease of Access and Preventative Care

> *"I think mental health services like putting up gates and fences so they can keep control."*

A responsive service that can reach people early and easily is an important part of the Community Mental Health Framework. This is because it means people are supported before their wellbeing declines further and their support needs become greater. People can be referred to the Core Teams via their GP, other NHS mental health teams or through safeguarding referrals to mental health social care.

What's going well

There are clear areas of preventive care occurring within the Core Team. In particularly the Population Health Nurses, Peer Support Workers, and Social Prescribers have been cited as examples of this. One of the positives of our work when talking to external partners was the volume of options the Core Teams offers for someone to be referred into. This means that Core Teams is able to offer a range of interventions to meet individual and unique circumstances and enable earlier access.

> **Service user voice: "***We've come a long way in terms of stigma and taboo around mental health – we should celebrate this."*

Similarly, GPs highlighted how first contacts after referral happen within a reasonable timeframe, usually within a month, and that responses to their questions and queries are picked up promptly and reliably. This means not only is there a range of options available to enable preventative care, but GPs are able to easily access Core Team staff and service users hear back from their initial referral quickly. Together this means that we can reach people early and easily by establishing early contact and being able to tailor the service to their needs.

> *The ability to provide practical options rather than just talking therapy is really helpful."*

Further to this, supporting access and early care, Community Development Workers have done much work reaching out to specific community group, supporting the Core Teams to have better access within the community and inform people about services at a much earlier point,

> *Personally, the offer from Peer Coaches and Support and Connect has been really welcome." iCope (Talking Therapies)*

There is widespread acknowledgement that there are large gaps in service provision between primary and secondary care (see above section on Collaboration Between Primary and Secondary Care). As outlined in the CMHF, people defined as having 'complex' needs are often more

at risk of being excluded from care. There is evidence that the Core Teams can bridge this gap successfully. A Core Teams psychiatrist outlined the role of the VCSE Support and Connect service, in particular, in addressing this gap:

> *"The Support and Connect services is probably one of the kind of bright exemption[s]. There [is] really this ability to work with really complex patients and supporting them for this sort of time limited Intervention without... this pressure on changing something" (Psychiatrist)*

More widely, the Core Teams are not a diagnostic-specific service which differentiates it's offer from both iCope (Talking Therapies) and many secondary services. As such, there is a wide pool of interventions on offer to service users, regardless of diagnosis or complexity (although not without exception). Multiple staff emphasised to us the significant effort staff make to meet the need of people referred into the service, even when they believe Core Team intervention is not appropriate: "We hardly ever reject a referral – even when we feel we're not the right service, we generally do the assessment anyway." This sentiment was echoed by colleagues within the iCope service (Talking Therapies).

What's challenging

In terms of challenges, there are four clear themes: the referral pathway, wait times, collaboration, and communication.

The referral pathway

There are no self-referral routes into the Core Teams. As such, people can only access mental health support through their GP. In itself, this creates a barrier to timely access to support where people struggle to access GP appointments or have a difficult relationship with their GP.

> *"The fact that someone can't self-referral can be a barrier. Some kind of drop in where people can be assessed, and self-referral, would be a good way to achieve this" (Team Manager)*

Additionally, this means that less preventative care be provided as the requirement to go through GPs can create another layer of difficulty in reaching people. Our service user reference group discussed how relationships with GPs in many cases can be mixed and act as a barrier to access

Wait times

> *"Frustrations with wait times are preventing us doing truly preventative work" (Psychologist)*

Once someone has been referred into the Core Teams, the wait times to see certain professionals appeared frequently as a source of concern in terms of preventative working. If someone has been able to seek early support with their challenges, they are likely to end up on waiting list to see one of our professionals, particularly to see psychologists where the wait times are

well over 6 months on average. This means by the time someone has been seen, their situation may have worsened and the work is no longer preventative.

A common suggestion to combat this in our interviews was to provide a phase of checking in or signposting between referral and starting support so someone can receive support or can have an understanding of the referral journey.

> *"Someone I know was told to wait 6 months before being re-referred. What are they supposed to do in that time" (Service User)*

Collaboration

In some areas, we observed an information gap or lack of understanding about the Core Team offer, which may cause service users to fall through the gaps. For instance, in our conversations with the Camden Housing Team there was a lack of understanding of the Core Team. Improved communication with wider community teams could be impactful as they work with many people who are early in their experience of mental health challenge.

> *"There's an opportunity for prevention being missed" (Housing Team)*

Our survey of GPs in Camden also reflected something similar. Whilst there were positive responses present, a lack of understanding and information appeared once again in our results. It's clear that where there is understanding in the system we are able to work earlier with people in their journey and where there's less understanding there's a higher risk of people falling through the cracks.

Communication

While the Core Teams is praised for its flexibility, it was also criticised by both internal and external staff for having an unclear service offer, remit, and acceptance criteria. One staff member told us, "It has been difficult trying to get answers from the core team regarding suitability of referrals."

Many of the discussed issues are seen as broader challenges within the Camden system. A staff member told us, "[for] GPs and patients is really difficult to know which service offers what." A service user told us, "accessing services is so complicated." Discussing difficulties in onward referrals, a Core Teams manager told us, "I think mental health services like putting up gates and fences so they can keep control."

The impact of rigid service boundaries and unclear referral pathways is the phenomenon of 'bouncing.' The phenomenon of bouncing describes the process in which someone is referred to multiple services, often undergoing multiple assessments, but failing to access intervention due to service criteria.

The below discussions on substance and alcohol use and health inequalities explore this phenomenon further.

Summary

Key challenge

There is a lack of accessible information regarding mental health services for both residents and professionals in Camden. GP-only referral bottleneck creates a barrier to access for many.

Recommendations

- Ensure clear, up-to-date information is available regarding service offers, aimed at external professionals, particularly those who may work with people early in their challenges e.g. housing.
- Expand and formalise liaison to offer consultation for wider community services to share expertise and reduce siloed working.

Best-practice outside of Camden

Rethink Mental Illness's *"Getting started: Lessons from the first year of implementing the Community Mental Health Framework"* highlights two common solutions to accessibly issues:

- 'One-stop-shop' community hubs or Single Points of Access, commonly delivered by local VCSE organisations – were successful in creating accessible services.
- Local websites which act as contact points (self-referral) and sharing of events and services, with a website manager employed to maintain this.

Health Inequalities

The Community Mental Health Framework states that there is "a strong legal, economic and ethical case for combating [health] inequalities." It highlights "racial disparities" and the "life expectancy of people with severe mental health problems" as key inequities in community mental health services. People with 'severe mental illness' (SMI) typically refers to people with a diagnosis of psychosis or bipolar, although some definitions are wider.

The Community Mental Health Framework specifically mentions the link between diagnoses of severe mental illness, lower life expectancy and physical health conditions: "By 2023/24, the NHS Long Term Plan commits that at least 390,000 people with severe mental health problems will have their physical health needs met."

The framework indicates that "strengthening relationships with local community groups and the VCSE" is key to addressing health inequalities. The framework indicates that a "rights-based care based on greater choice" and "engaging early with communities to address inequalities" are the means to addressing inequalities in community mental health. Finally, it highlights the need to make "reasonable adjustments" for "those with disabilities or complex needs" to access services.

What's working well

> **Service user voice: "***We want to celebrate the diversity of people working in mental health services and accessing mental health services in Camden, in terms of nationality and culture.***"**

There is a clear understanding among staff of the physical health inequalities faced by people with mental health conditions. Core Team population health nurses are delivering physical health clinics across the borough in both GP practices and community locations. These clinics were referenced in multiple discussions across the team as an area of success.

The interventions are specifically targeted towards the SMI population, to tackle health inequalities in the borough:

> *Another good example is SMI clinics that Ophelia leads... they happen in GPs by Core Teams nurses... People with SMI are more likely to suffer from avoidable physical health conditions. These people need different support. The idea is that the clinics are set up sympathetic to the needs of people with SMI – food, blood pressure, exercise, interventions to reduce" (Team Manager)*

Staff highlighted the role of population health nursing alongside VCSE Community Development Workers as key to addressing inequalities. The provision of Community Development Workers as dedicated resource to reaching out into communities means there are mental health staff "genuinely listening" to community needs.

Many stakeholders highlighted that those people with complex needs or social contexts often receive an inequitable outcome in mental health care. The Core Teams received praise for capacity to work with complexity effectively. An iCope (Talking Therapies) practitioner highlighted how the Core Teams were "accommodating... to [a] patient" who was "particularly emotionally dysregulated and had a lot of behavioural difficulties."

Further, the expanded offer of interventions to include peer coaching and support work is credited with improving accessibility of services to a wider population. A Core Team psychiatrist highlighted the ability of the VCSE Support and Connect service to manage complex needs effectively: "there [is] really this ability to work with really complex patients."

A note on complexity

The term 'complexity' came up frequently in our interviews with staff. While usage varied depending on the context, the term tended to refer to the multiplicity of difficulties: i.e., homelessness or substance use alongside mental health.[9] The term also referred to complexity in presentation, including emotional regulation, relational difficulties, or risky behaviours.[10] Complexity was associated with difficulty in effective engagement between staff and service users.

What's challenging

A key barrier to wider implementation of physical health interventions is the capacity of staff. Nursing staff told us that competing demands on their time, it has been difficult to find time to focus on physical health interventions.

Two key barriers appeared in the Community Development work. Staff often do not have capacity to engage in the outreach work which can limit its impact and integration into broader clinical work. Additionally, in the case of the Core Teams, there are not direct referral routes which means getting someone support requires a GP's intervention rather than being held by the Community Development Worker in the first instance.

It was also reported that supporting people with complex needs can be challenging as not all staff are equally equipped to support those with higher need. Additionally, we were told of some people with complex needs falling through the net of mental health services with one GP reporting that "it often feels that the fallback position is GP care and not Core Teams".

Homelessness was highlighted as key realm of inequality across services in Camden: "The Core Team at a previous meeting said they don't take people who experiencing homelessness... but other people [were] more open on how people could access." Further, service users and staff told us there was significant gap between remit of services. For instance, some referrals were declined by both the Core Teams and FOCUS (assertive homeless outreach team) leading to a lack of mental health intervention for some patients facing economic adversity.

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9 *See this NICE publication for a definition of complexity that emphasises multiplicity of needs: https://www.nice.org.uk/guidance/ng216/documents/final-scope*

10 *See this Mind report – referenced by The Community Mental Health Framework – for an account of complexity that focuses on 'personality disorder' diagnoses:* https://www.mind.org.uk/media-a/4408/consensus-statement-final.pdf

Community Development workers mentioned that NHS mental health services have had challenges engaging with Somali community groups. This was attributed to negative experiences of prior care shaping people's willingness to engage with services and having a concern about hospitalisation.

We reviewed data from a focus group conducted by Reach Out Camden in 2024 which asked Black British residents in Camden about their experiences of mental health services.

This data was not specific to the Core Teams or community mental health teams. However, findings indicated that:

- Black people experience racism in mental health services: there is a lack of cultural competence in staff and service users experience hostility and judgement.
- Lack of knowledge about services is a key barrier to access: GPs don't know about services and more could be done to share information in community spaces.
- Mental health services are strongly associated with the police and being placed under section.

> *"Showing kindness and love is important. I will never forget the professional who showed that." (Service user)*

Summary

Key challenge

Service demand limits effective integration between statutory mental health services and voluntary and community organisations.

Recommendations

- Ensure staff time is ringfenced for outreach or community development opportunities.
- Improve ethnicity data for incoming referrals to mental health services to understand who is (and is not) accessing services. Targeted engagement should follow, based on outcome of this analysis.

Address Social Determinants of Mental Health

The Core Teams working with social determinants means that we are directly engaging with the socio-economic factors that we know have an impact on someone's mental health outcomes. These include challenges like social isolation, housing, and benefits access.

"[Social determinants] have a direct bearing on the level of mental health problems in a community. A key aspect of effective mental health care is ensuring that all communities can maximise the support they provide to people who need it and therefore address local population needs." Community Mental Health Framework.

What's going well

> **Service user voice:** *"We've come a long way in terms of treating mental health problems in a holistic way – it's not just about medication. We want to celebrate the variety of offers to support mental health – and health more widely – taking a holistic approach to care in Camden."*

From our conversations with staff, service users and stakeholders, Social Proscribing, Support and Connect, and Peer Coaching frequently came up in the conversations when discussing this area of work.

There was recognition that we do have an offer for those experiencing social isolation both through our social prescribers and groups like the weekly Kentish Town Coffee morning. Although there was a sense that this offer could be better advertised, those who worked with people on this side of our offer had positive feedback to give. Indeed, specific reference was made to instances of successful work liaising with housing officers.

What's challenging

Through attending the Homelessness Delivery Group, we were able to hear about staff's experiences with referring clients who are experiencing homelessness. There was mention of people turned down due to a lack of stable address or different guidance around whether someone experiencing homelessness can access Core Team services. Additionally, GP access for people sleeping rough is often lacking, meaning navigating the Core Team referral system can be daunting. This demonstrates a group where there has been less consistent working with social determinants.

Additionally, frustrations were voiced by Core Team staff around the general challenges of working with issues like housing and the lack of expertise present. This is due to it creating a sense in service users that the service is not able to meet their most pressing needs.

> *We're not experts and we're having to plug gaps, there's few experts available" (Support & Connect Staff)*

Staff report that they are doing their best to plug gaps and provide service users with support on a range of issues but there is a limit on effectiveness if not working alongside experts or those with a depth of knowledge and experience in working on a particular issue. These frustrations can also be shared by clients who want support with something practical that there isn't available expertise in.

> **Service user voice:** *"We are concerned about failure of services to support people facing additional social issues – such as housing. Issues like this make mental health difficulties worse – and yet people are made to wait longer for support as a result. This should not be the case."*

Summary

Key challenges

Housing issues are a significant cause of mental health issues in Camden

Recommendation

Mental health team staff should have access to specialist housing staff. This could involve:

- An in-house housing rights advisor
- Improved liaison with housing teams within Camden Council

Mental health teams need a clearer, improved offer for people rough sleeping. This could involve:

- Flexible criteria regarding address, where someone has no fixed address.
- Involve all 'front door' mental health teams in creating clear referral pathways for homeless people with mental health needs. Including, Core Teams, FOCUS and iCope, to ensure there are no gaps between the remit of each service.

Place-Based Care

The CMHF sets out a vision in which mental health care is brought closer into people's local community. The framework offers a holistic definition of community as: "a geographical location, or a group in which people find or place themselves."

The framework aims to achieve this by aligned community teams with Primary Care Networks (PCNs): "a significant proportion of community mental health staff [will] become integrated within primary care, to provide better support to patients and the primary care workforce." The framework also offers approximate population sizes for 'local' level services - 30,000 to 50,000 people (aligned with PCNs) – and 'place' level services - 250,000 to 500,000 people.

The framework also proposes a collaborative approach to provision of services, involving VCSE organisations, local authorities, and social care providers. Overall, it outlines a vision in which services are physically located closer to the communities they serve, link into the community assets of that community, and are designed to meet the specific needs of the communities they serve.

What's working well

In terms of building locations, two of the three NHS Core Team sites are located in the neighbourhoods they serve, South Camden and Kentish Town. In addition, Mind in Camden is located centrally in

Camden Town and Likewise in the west of the borough. Hillside Clubhouse sits just outside of the borough, east of the Kentish Town neighbourhood. As such, each neighbourhood has a least one Core Team building located within the local community.

We heard praise from some GP practices about Core Teams presence in local surgeries, including Core Team consultants regularly attending MDTs and hosting clinics at the practice. Core Team nursing staff are also regularly conducting physical health clinics at GP surgeries. Both peer coaching and VCSE staff are regularly visiting service users out in the community at locations of their choosing – such as cafés, parks and their homes. This is a significant step in making care more accessible to people who may struggle to travel to appointments. One person told us, "[I was] encouraged to diversify and try new places. I felt I was given some agency."

Finally, community development workers and nursing staff are also conducting proactive outreach into local communities, building on the needs of specific neighbourhoods.

What's challenging

A key premise of the CMHF is that mental health services need to better facilitate links into community assets. However, the Mental Health Social Prescribing team described incidents in which community centres are turning away referrals and walk-in, due to issues in meeting the needs of people with mental health difficulties:

> *"People are just saying, please don't send people to us because we don't have the capacity to support the communities that you think that we are holding."*

Community development work conducted by VCSE staff and nursing staff was recognised as an important part of the new Core Teams model. However, many staff expressed frustration that community-based presence of the Core Teams was often limited. One team manager told us, "I'm not sure we are maximising community-based presence more widely."

Another person said, "I wish we could have days going to community centres, saying what we do, doing some of our work out in the community, spreading the word." Staff attributed these difficulties to service demand outpacing capacity, "The culture in the core team is overwhelmed, always making room for the next [patient]. There's not enough staff to fulfil what's been suggested in the framework."

Summary

Key challenge

Non-statutory community services are not well equipped to work with people with mental health difficulties.

Recommendations

- Improve liaison between clinical mental health teams and local community organisations, to ensure community locations are confident in working with people with mental health needs.

Links to current work

- The Learning Programme have supported the Camden Mental Health Social Prescribing service to develop a 'Camden Hidden Gems' offer. In its second cycle of 'test and learn', the initiative aims to link the local population into community spaces.

Co-occurring Substance Use and Mental Health Needs

> *"Service users regularly feedback that they just feel like no one wants to take responsibility"*

The Community Mental Health Framework highlights substance misuse services as an area in which "changes in commissioning structures have led to fragmentation between services." The framework aims to address issues in which "People whose care is transferred from drug and alcohol misuse services to a community mental health service or primary care can... experience discontinuities in their care."

The CMHF states that people with 'co-occurring' mental health and substance use issues should have access to community mental health services. It highlights a Public Health England report[11] which reports that: "mental health problems are experienced by the majority of drug (70%) and alcohol (86%) of alcohol users in community substance misuse treatment."

The report offers guidance on what an effective system for co-occurring substance and mental health needs should look like:

> **Everyone's job.** *Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.*
>
> **No wrong door.** *Providers in alcohol and drug, mental health and other services have an open door policy for individuals with co-occurring conditions, and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point."*

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

Local context

The local drug and alcohol service in Camden is provided by Change Grow Live (CGL). This follows a change in commissioning and a move away from the previous NLFT service run from the Margarete Centre in Euston. When speaking with staff at the CGL, they told us: "It's only in the last probably four or five months that we've had capacity to start really focusing on our relationships with mental health teams in the borough." As such, the relationship between mental health and substance use services in the borough is in a state of change and the situation described below is likely to change significantly over the coming months.

What's working well

Evidence indicates the Core Teams are taking a holistic view in triage decisions regarding substance use. Core Teams managers emphasised that there is no outright policy of rejecting referrals for people with substance use issues: "It's not a full exclusion, each case is looked individually, there's a lot of thinking about what's gone on before." Expanding further, they explain: "We work on the principle of what's the primary problem, if it's substance misuse then that needs to be addressed first for any meaningful intervention."

There was recognition by both Core Teams and CGL staff that joint working between both services would achieve the best outcome. Speaking with a Lead member of the CGL Camden service, they outlined a clear vision of what effective joint working should look like: interface meetings, Information sharing, and a substance use worker placed in mental health teams.

At time of data collection, these initiatives were not in place. Though CGL staff noted that Likewise stood out in their willingness to collaborate and liaise with the substance use service, arranging a joint meeting to explain the Core Teams service offer. Further, since initial data collection, a Dual-Diagnosis CGL staff member has been recruited and placed within the Core Teams – a significant step in collaboration between both services. We have also been informed of introduction of joint working protocols, and liaison between mental health services and the substance use services in Camden.

What's challenging

One of the key issues raised was of service gaps in service provision. This was identified as a wider systems issue – not specific to the Core Teams. Speaking with a group of service users, they emphasised their frustration that they have been denied mental health support due to their substance use, even when they were confident it was an appropriate time for them to engage in mental health support.

Many had examples of being denied support by multiple mental health services due to their substance use. A GP practice highlighted similar concerns that people with substance use issues are often denied mental health support.

While drug services do not exclude this population, a CGL worker explained they have difficulty addressing mental health need, "The drug services have a feeling that, you know, [if] there's this unaddressed mental health need… it's difficult for us to support this person to reduce their substance use when they're hearing voices." The impact of this is unmet need: where people are not able to access full support for their situation: "Service users regularly feedback is that they just feel like no one wants to take responsibility [for their care.]"

A difficultly faced by Core Teams staff is the lack of onward referrals options for people who use drugs and alcohol. Where service-users need more intensive, specialist, or long-term support, this necessitates an onward referral. However, we are told that intensive services in Camden still operate on the basis on abstinence. As such, service users cannot access longer-term mental health support if they are a current substance user.

> *"Another issue is that we can't refer onwards – intensive services require abstinence. But we can't keep people long term as we are a short-term service."*

Speaking with professionals that refer into the Core Teams – such as GPs, CGL, FOCUS (Homelessness Outreach Mental Health) - all highlighted issues with communication, information, and liaison. Having a named contact to liaise within the Core Teams was a key request from these groups. They also highlighted a lack of information about how and when to refer to the Core Teams.

> *"I feel that they are too many barriers for [people who use substances] to access [mental health] support. This is especially true for the many individuals facing co-occurring conditions… It is also very hard to liaise with the Camden Core teams around specific cases as there is no point of contact for that."*

However, these are wider system issues not specific to the Core Teams. There is a lack of clear information regarding who is best placed to work with people who use substances and no clear agreement between Camden NHS services.

As such, referrals are often bounced between Core Teams and FOCUS with neither accepting. iCope (Talking Therapies) was understood to reject any referrals indicating substance use. Specialist teams do not typically consider referrals from agencies outside other NHS teams. Consequently, referrers struggle to navigate this landscape with lack of clear information about determining appropriate service referral. Service users themselves feel rejected and frustrated.

Summary

Key challenge

Ensuring collaboration between substance use and mental health services to close any gaps in the provision of care

Recommendation

Move beyond liaison to establish joint-working practices between staff in both mental health and substance use service: to ensure service users can access both mental health and substance use support simultaneously.

Links to current work

We note that there is a recent appointment of a dual-diagnosis CGL worker placed with the Core Teams. We have also been notified that a regular interface meeting with CGL and senior staff across the North London Trust's Camden Division has been initiated and a joint working protocol has been drafted. As such, the context is likely to change rapidly in coming months.

Findings and Analysis: Collaboration

The Community Mental Health Framework highlights that a shared vision across the service users, carers, and staff is integral to running an effective community mental health service:

> *"Perhaps the greatest challenge for commissioning mental health services is to ensure that the key stakeholders in the process – people with mental health problems, their families and carers, general practitioners, and other primary care staff (including those working in physical health care) and staff from secondary care mental health services – have a clear understanding of the overall aims and objectives of an integrated community mental health service. They should have a key role in developing and shaping the service, which is collaborative in nature, and all participants should feel that they have had a significant say in its production."*

The framework emphasises the importance of co-production in ensuring that services are aligned with local needs and ensuring that staff work together towards a shared vision.

Below, we explore how service users and staff are involved in the Core Teams design and implementation and highlight key successes and barriers. This section, while oriented around the Core Teams, also offers wider perspective of Community Mental Health service in Camden and highlights both success and challenges in system design across services.

Collaboration within the Core Teams

To deliver the ambitions of joined-up care, the CMHF outlines an expansive multidisciplinary team that operates at a partnership level across NHS, social care and VCSE organisations.

> *"The starting point for this workforce would be staff currently working in secondary care community mental health services. To realise the joined-up approach this Framework sets out, these teams would fully*

integrate their working with other local services, including Primary Care Networks, employment and housing support staff, key VCSE organisations in the area and social support services. Care will be planned and delivered across this wider partnership." (Community Mental Health Framework)

Rethink Mental Illness' report Getting started: Lessons from the first year of implementing the Community Mental Health Framework explores in depth the successes and difficulties of partnership commissioning.

It highlights the differing "priorities, pressures and funding models" between NHS and VCSE organisations and explores how "The movement toward a more equal status and shared decision-making across stakeholders can be uncomfortable."

In Camden, the Core Teams developed out of the Camden Primary Care Mental Health Network: a small team of professionals providing assessment, advice and onward referrals. Today the Core Teams are far larger teams, which include case-holding staff offering brief interventions and based across multiple sites, disciplines, and organisations. In particular, the Core Teams saw the introduction of Peer Coaches and the integration of VCSE workers into NHS teams.

What's working well

The Core Teams operate within weekly multi-disciplinary meetings in which staff consult and discuss appropriate interventions for patients. Staff widely praised the value of these spaces in which multiple expertise can be accessed across a number of disciplines:

> *"I think in a lot of ways [the MDT] creates a more holistic approach to the work... in a lot of ways, safer. You've got larger teams, you've got more eyes, you've got more professionals, you've got more perspectives. You've got lots of different ideas." (Social Prescriber)*

Especially where people are deemed 'complex' in their presentation, staff value the expertise of MDT spaces in making decisions about someone's care. Staff trust one another's judgement and support one another: "When I've had difficult cases people have checked in with me... There is this feeling of 'we want to help and support you'" (Support Worker).

What's challenging

Service transformation in Camden – a process through which mental health teams are redesigned and staff jobs roles are changed – was highlighted as a key challenge. The scale of change can generate stress or uncertainty for staff and can be perceived as a top-down. This

was seen to undermine frontline staff capacity to collaborate effectively: "The pace and scale of change for these teams and these staff has been huge. So I think those will create quite difficult context to do improvement work, particularly when that's about kind of empowering bottom up frontline change" (Quality Improvement Advisor).

Summary

Key challenge

Pace and scale of service transformation risks undermining staff capacity and willingness to work collaboratively.

Recommendations

Establish formalised learning and improvement structures for each Core Team:

- Service transformation should be monitored and reviewed by those delivering the services.
- Frontline teams should have access to service data and data analysts to aid understanding.
- Learning and improvement processes should feed into wider service Transformation efforts.

Collaboration with Services Users

The CMHF sets out a vision in which "new services should be introduced using genuine co-production."

Within the framework, 'co-production' refers to two key areas. Firstly, the co-production of care plans, with service users and carers. Secondly, the co-production of service design and delivery. This section focuses on the latter – how service users are involved in the design of the Core Teams. (For a discussion of co-produced care plans, see the chapter on Personalised Care).

> *"People with mental health problems [and] their families and carers... should have a key role in developing and shaping the service, which is collaborative in nature, and all participants should feel that they have had a significant say in its production."*

In the process of gathering data for this report, we sought out information regarding the involvement of service users in the initial design of the Core Teams. Staff told us that service users are often consulted regarding changes to services.

Nationally, Rethink Mental Illness' Getting started: Lessons from the first year of implementing the Community Mental Health Framework report highlights the process of co-production as an aspect of transformation that is yet to produce clear results: "It appears that almost

everyone grasps the idea of co-production, but not many have translated this into a set of concrete structures, processes and everyday actions."

What's working well

> **Service user voice:** *"We want to celebrate groups like the Core Teams Reference Group and the intention to listen and learn."*

Staff highlighted that there is investment at a strategic level to co-produce within the Core Team: "There is a clear investment in something, both financially and strategically" (Peer Coach). Coproduction features within the goals of the Trust's Community Strategy. Funds are allocated to pay for service users to be involved. Indeed, the Community Mental Health Framework itself involved experts by experience in its design.

Staff highlighted a Quality Improvement 'Big Room' project in the Kentish Town Core Team as an example of co-production. The project is focused on creating a person-centred discharge process. "I genuinely believe that the Big Room has been a positive example of co-production, um, both with service user involvement but also different stakeholders across the pathway and across the community" (Quality Improvement Advisor).

The introduction of Peer Coaching roles within the Core Teams was also highlighted as evidence of working towards co-production. Of the two Peer Coaches interviewed, there were different views on whether their position in the team constituted co-production in itself. However, both agreed that the involvement of people with lived experience within clinical MDT spaces was a significant change.

The Camden Mental Health Social Prescribing team based at Mind in Camden highlighted a new initiative 'Camden Hidden Gem Visits' as a "overwhelmingly positive" experience of coproduction.

With support from the Core Teams Learning Programme (this report's authors), they worked with service users to design the event and design the poster, receiving positive feedback from the service users involved.

> *And it's been quite helpful to have [Community Practice Lead] as a middleman, otherwise I don't think we would have known... how to do that. Having kind of someone that's familiar with... processes... that also knows us and has been... in between the VCS and NHS... has been quite beneficial." (Social Prescriber)*

What's challenging

Discussion with both staff and service users engaged in involvement activities highlighted how important it is to have a shared vision and definition of what co-production means. Both groups told us that mental health services in Camden have struggled to articulate a shared vision of co-production in the borough, leading to confusion and frustration.

Secondly, service users and staff involved in coproduction questioned whether coproduction initiatives lead to meaningful action or impact. For instance, we spoke to members of the Kentish Town 'Big Room'.

Members of this group told us that, although there were positive intentions, there was minimal impact in terms of changes to service delivery: "impact isn't happening yet." Staff also highlighted that what is termed 'coproduction' often becomes 'consultation' – i.e., a far lower level of involvement in meaningful decision making.

In summary, there is regular consultation and engagement with service users, however many stakeholders are sceptical of whether this is leading to meaningful impact.

Summary

Key challenge

Ensuring that consultation with services users leads to meaningful impact and change in services.

Recommendations

- Generate shared definition and understanding of what coproduction means in Camden community mental health services.
  - This should focus on 'localised' coproduction. I.e., what coproduction looks like in systems where many decisions are made centrally (at national, ICB, or Trust level).
- Leaders should utilise the Core Teams Reference Group – and similar groups – to facilitate and input into the co-design of new services. Service transformation offers an opportunity to bring services users into meaningful decision-making at a system level.
- Improve mechanisms to capture and learn from service-user perspectives: ensure that service user voice is regularly reviewed in team meetings.

Links to current work

The Camden Core Teams Reference Group, run by the Learning Programme, is open to any staff across Camden to attend and seek input into service design and delivery. Please get in contact if you'd like to work with this group.

Collaboration with GP practices

> *"This Framework proposes a core community mental health service, which will bring together what is currently provided in primary care for people with less complex as well as complex needs... It should be built around existing GP practices, neighbourhoods and community hubs" (Community Mental Health Framework)*

Relationship with GPs form an integral part of the Core Teams as the main source of referrals into the team. To understand perspectives on how the collaboration operates, we spoke to staff within the team and GPs, as well as sending out a survey to GP surgeries across Camden.

What's working well

In general, we were able to hear many responses pointing to positive relationships being developed between Core Team and GP surgeries. Particular reference was made to strong attendance at GP MDT meetings, as well as the clinics being held by the Population Health Nurses.

> *"This part of the service seems to be working fairly well and my impression is that the GP practices I have regular contact with are fairly comfortable holding complex patients with repeated referrals to us as needed" (Psychiatrist)*

In terms of what is important to a good GP-Core Team relationship, having a named contact who is present and available came up as being important to rapport. GPs mentioned wanting to feel that the Core Team was there to support their work and that having a specific person they can speak to reinforces this. Many of our teams are seeing successes in this, but this success relies on individual relationships.

What's challenging

Distant staff relationships and the information available to GPs appeared as challenges to collaborating effectively. Where GPs felt that they had a good relationship with a named person, they provided positive feedback and where this wasn't the case, feedback was more negative. Similarly, a GP pointed out that the CCG GP directory, the main source of service information for GPs, was not up to date with Core Team information. This meant they were less able to make referrals and understand the services available.

Collaboration with GPs is one of the areas of our research which saw the largest amount of variation between teams and patches. We have been able to locate presence and familiarity as integral to the relationships we hold, as well as the information shared, and these should be prioritised as a means of creating more consistency across the board.

Summary

Key challenge

Lack of consistent liaison with Camden GPs, unclear referral routes and lack of up-to-date information.

Recommendation

- Ensuring that the information about mental health services in clinical directories used by GPs is up-to-date so that they understand service offer.
- All GPs should have a named contact within service they collaborate with – we know this is effective in supporting warm and responsive relationships between the Core Team and GPs.
  - In particular, this relationship could be further strengthened by formalising liaison and consultation, ensuring that teams have regular contact points with each other.

Collaboration with VCSE, Substance Use, Local Authority, Housing Teams

> *Strengthening relationships with local community groups and the VCSE will support the adoption of more rights-based care based on greater choice and engaging early with communities to address inequalities." (Community Mental Health Framework)*

As part of our research, we spoke to a range of VCSE organisations, staff in the council and Core Team staff to get a sense of how the Core Teams in interacting with different council and VCSE services.

What's working well

The Core Team has been able to signpost people to the right places. Internally, there is a strong base of knowledge on what's available for people or what may be more appropriate for someone's needs.

> *I've found talking to the Core Team's pretty good, I always get an acknowledgment and my questions get answered" (VCSE Staff)*

What's challenging

We consistently heard about a lack of understanding and information about mental health services. This was highlighted to us by the Camden Housing team who made specific reference to not being sure who they needed to contact to navigate the Core Teams. More promotion and engagement around pathways to services and what they can provide would be helpful to remedying some of this.

> *It's difficult to know who we should be contacting, it's hard to navigate" (Camden Housing Team)*

Finally, there was also mentioned of how the strength of collaboration with the Core Team, VCSE and Council, relied on

individuals (similarly to collaboration with GPs). Organisations can build relationships with particular Core Team staff, when these staff leave, sometimes these relationships can go with them.

> *"Sometimes we'll have quite a good contact in a particular team and then they more on and you're on your own" (VCSE Staff)*

Summary

Key challenge

Lack of understanding about service offers. Lack of consistency of relationships as staff leave.

Recommendations

- Clear and up-to-date information about all mental health service offers need to be available and accessible to organisations across Camden.
- Ensure external relationships are included in staff handovers to maintain communications after someone leaves.

Collaboration Between Primary and Secondary Care

> *"[Transformation] won't work if people keep putting up barriers. They need to pay more attention to the gaps than the teams themselves."*

The collaboration and integration of primary, secondary, and social care is a key aim of the Community Mental Health Framework:

> *"This Framework provides an historic opportunity to address this gap and achieve radical change in the design of community mental health care by moving away from siloed, hard-to-reach services towards joined up care and whole population approaches."*

The aim is to improve user experience of services and reduce barriers to accessing care:

> *"Close working between professionals in local communities is intended to eliminate exclusions based on a person's diagnosis or level of complexity and avoid unnecessary repeat assessments and referrals... care will be centred around an individual's needs and will be stepped up or down based on need and complexity."*

As such, collaboration is a key criterion to understand to what degree the Core Teams is aligning with the vision set out in the CMHF.

What's working well

We have seen evidence of strong collaborative relationships with primary care partners in GPs and iCope (Talking Therapies) (see section on GP Practices for a fuller discussion). Communication and liaison were particular strengths.

iCope staff regularly attend meetings in each Core Team neighbourhood. There is also regular consultation via email outside of MDT spaces. Core Teams were praised in particular for their speed and clarity of communication. Core Teams were also acknowledged as a supportive and flexible team, able to take on 'complex' patients where it was felt inappropriate for iCope. Core Teams staff echoed this sentiment, emphasising staff willingness to be flexible and adaptable to patient need.

> *"Often when I send referrals of patients we've already assessed who clearly aren't suitable for us, the Core Team is very supportive and responsive. I had a case of a patient who was particularly emotionally dysregulated and had a lot of behavioural difficulties and they were quite accommodating not only to me but to the patient as well" (Staff, iCope)*

iCope staff also highlighted an increased trend in consultation prior to referral to iCope, for Core Team staff to determine whether a person would be suitable for iCope intervention. This was highlighted as a key success in terms of thinking collaboratively across clinical teams. This practice also aligns with the CMHF aims of reducing unnecessary referrals and repeated assessments.

> *"We've also had a number of times we get contacted directly as clinical coordinators... just inquiries about whether or not a referral would be suitable, which is fantastic, which really means that we're thinking together about the patients. So that really helps" (Staff, iCope)*

One CDAT staff member highlighted the joint delivery of the Trauma Stabilisation psychology group intervention as a key success. The R&R team was highlighted as a service that enabled easy referrals and consultation.

What's challenging

Across the majority of interviewees, both within the Core Teams and external staff in primary and secondary care, there were common frustrations: predominantly these focused on poor communication, issues with acceptance criteria, and people falling through the gaps between service. Communication was a key issue raised by many staff, for instance, timely response to referrals and email communication.

Queries for the Core Teams are coordinated through a centralised inbox whereas referring teams preferred to have a named contact for liaison. Finally, there was a lack of published information about what the new Core Teams services offer – i.e., on the website.

Notably, frustrations with communication is common across mental health teams: "I think [Core Teams] can feel frustrated at us [iCope] turning down referrals and we can feel the same way about them!" This was also the case for secondary care services: "There are referral criteria that sometimes are quite strict... Like the personality disorders or psychodynamic therapy service[s] where the criteria [are] sometimes a bit more, kind of, obscure".

Frustration with acceptance criteria was a particularly emotive topic for staff, emphasising the emotional burden of failing to navigate someone into appropriate treatment: "It's not realistic... This brings out a lot of stress sometimes on a professional, you know, feeling like we need to have something to offer to everyone."

Finally, there was significant concern across primary and secondary care staff about gaps in the provision of mental health services: gaps in provision of care often focused on complexity and system incapacity to meet the needs of 'complex' presentations. For instance, if someone has multiple mental health conditions: "it can be tricky to access... secondary care... because it doesn't meet the exact criteria and that's why these patients are... still not getting... interventions or input." Gaps were also highlighted for service users who had social issues, for instance housing or substance use: "It's very challenging. If it's not in Focus's remit, other services like CDAT [or] Traumatic Stress [Clinic] won't accept people".

The impact of gaps in provision is the 'bouncing' of service users across different services without being able to access care: "So essentially you just get a bunch of people that are bounced around because they don't quite fit all of the different criteria." This is a concerning pattern in that it directly contradicts the aims set out by the CMHF, namely the intention "to eliminate exclusions based on a person's diagnosis or level of complexity and avoid unnecessary repeat assessments and referrals."

Speaking to service users who had accessed the Core Teams, as well as a group of service users who had experienced homeless and substance use, this was a key concern: there was widespread perception that mental health services are difficult to access and that referral rejections were often ill-reasoned.

> *"I've been through so many professionals and assessments – they have all explained I need long term therapy, for someone with my issues. You're working with people who are messed up and are messing them up even more." (Service User)*

Summary

Key challenge

Many service users face multiple referrals, assessments and rejections before accessing care.

Recommendations

Community mental health transformation offers a unique opportunity to re-define service to create a person-centred system in Camden. We suggest the following:

- Change of service design away from 'referral criteria' towards 'best place for someone to be supported' across all services – to eliminate gaps in care.
- Increase liaison between referrers – prior to referrals – to reduce multiple assessments.
- Generate a clear mental health services 'pathway' that outlines routes into mental health services. Pathways should be accessible within NHS, as well as for wider system partners (Council & VCSE services) and publicly for service users. This is particularly important for 'front door' services (I.e., iCope, Core Teams, Focus).

Appendix

Authors' reflections on the delivery of a learning and coproduction programme

This report was produced as a central piece of work from The Camden Core Teams Learning Programme. The vision for this programme was set out by Camden Council, North London NHS Foundation Trust, Likewise and Mind in Camden. At the inception, the programme proposed the following aims:

- Building a 'learning culture' of reflective conversations and practices within the Camden Community Mental Health Core Teams.
- Working towards 'genuinely coproduced' service design and delivery with service users and their carers.
- Supporting the linking and interfacing between different services within Camden to create a person-centred mental health system in the borough through partnership working.

This report constitutes a key output of our work within Camden community mental health. Below, we outline our personal reflections on our wider roles within the Core Teams, both as authors of this report and more widely regarding the delivery of the Learning Programme. We include reflections on both successes and difficulties in the roles, alongside recommendations for future commissioning and implementation of learning and community involvement work in Camden.

Community Linking

Firstly, we believe the intention of the roles was well envisioned: there is, indeed, a need for improved links and collaboration between different service offers in Camden.

Our roles – accountable to the local council, delivered by the VCSE, and placed with the local Trust – enabled us to work effectively across different services. We have built strong relationships both within and beyond the Core Teams and many colleagues have appreciated our ability to usefully link them with other organisations to make their work more effective. While there are some barriers in terms of scaling this linking work – ultimately, we see it as a real success of our roles.

Service user engagement and co-production

To effectively support our roles, each organisation had funding set aside for staff training and service user involvement costs. We have found this budget to be sufficient to widely involve service users in monthly advisory meetings to guide and input on our work.

We setup and recruited for a Service User Reference Group that runs monthly. Alongside this, we conducted one intensive co-design process and a number of ad-hoc meetings to address different initiatives.

When speaking with our Camden Core Teams Reference Group, members highlighted the positive atmosphere and open discussions we held as valuable.

We are proud of our work in designing this group and immensely grateful to those members who are part of it. Having designated staff to support in the facilitation and implementation of co-production is certainly essential and our roles enabled us to provide this facilitation to engage staff and service users in reflective and productive conversations. Again, we see this as a real success of our work.

Key challenge: from learning to action

A challenge we often face in working with services users is ensuring that our conversations lead to meaningful change.

We were located alongside frontline colleagues which meant we lacked access to the strategic direction of services in Camden, which is integral for coproduction to affect change. As such, we were often a learning resource working alongside transformation work rather than as part of it. Whilst the relative independence of our roles allowed us to use an organic, bottom-up approach that helped us genuinely capture lived experience of staff and service users - how this type of work is meaningfully integrated is a challenge for the system.

Both frontline staff and our reference groups members echoed this, discussing doubts around the impact of their involvement in Learning Programme work on the wider mental health system in Camden.

Acknowledgements

Mind in Camden
Mind in Camden is a mental health charity based in Camden Town and affiliated with National Mind. We work alongside people of all ages who are experiencing distress through voices, visions, unusual beliefs, anxiety, hopelessness and extremes of mood. Find out more: https://www.mindincamden.org.uk/

Likewise
Likewise is a charity and community centre in Swiss Cottage, Camden, with a history rooted in supporting the wellbeing of marginalised and isolated people and communities. We work with people from diverse backgrounds and circumstances, meeting them where they are in their lives to support their sense of wellbeing, belonging, and community. Our vision is a society where everyone can thrive and feel safe to be themselves through supportive relationships, genuine connections, and inclusive environments.

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