CAMHS:
A TIME TO TRANSFORM

A discussion note on child and adolescent mental health services
by Maggie Atkinson and Debbie Owen

iMPOWER

INTRODUCTION

Society is deeply uncomfortable with the notion that our children and young people could be mentally ill. We therefore find it impossible to avoid the stigma that accompanies mental ill health. That stigma affects adults, but perhaps still more so those children and young people who are anxious, depressed, suffer eating disorders or self-harm, or harbour harmful thoughts or impulses.

The population of affected under-18s is more evenly spread across genders, and more socially diverse, than those in the care or youth justice system. However, there is a correlation between a child being in those systems and suffering anxiety, attachment issues, low self-esteem and the translation of any of these into destructive, including self-destructive illness. In forensic and secure adolescent psychiatric units, staff indicate more than 80% have had experience of being in care. In youth justice, between a quarter and a third have been in care. Given there are 12 million under-18s in England and at any one time only 70,000 of them are in care, this over representation should worry us all.

The research evidence is clear that over 60% of those who go on to have lifelong mental health issue see its first manifestations aged under 14. The figure directly challenges our dislike or reluctance to acknowledge mental ill health in some of our children. The corollary is what we don't acknowledge, we choose to under-fund.

At least 1 in 10 under-18s has a diagnosable mental health difficulty, translating to 3 in a class of 30 in an ordinary school, any day of the week. In a medium sized secondary school's 7 forms of entry (210 children) that's almost a form's worth given the standard 30 in a form. There will be children in every classroom who need and are unlikely to be receiving enough help. The numbers are rising. Headteachers report rising levels self-harm, eating disorders, anxiety, fear of failure not amenable to staff reassurance or support.

Adolescents in particular report being assailed by unfiltered assaults from tech-based sources including cyber-bullying and the influence of online pornography. This is before we count the 1 in 4 – in some places 1 in 3 – living with the relentless stigma and worry of family poverty, or the hundreds of thousands carrying primary carer duties at home. Parents of troubled children often relate being told their child has a behavioural rather than a mental health issue. The blame, not "the responsibility" passes back to the family.

Medical experts, charities and those working with children and young people all report that access to therapies to avert crisis and restore a child's equilibrium remains patchy. Help is too often available too late (meaning it is expensive), and it seems to be given reluctantly, relying on complex, threshold-guarded and gate-kept referrals that neither enable continuity nor empower agile, flexible interventions much further up-stream at the start of the child's problems. The system seems unable to appreciate that a month's wait for help in a child's life is a far longer period than it is in an adult's.

We currently have a tiered system of services. On the ground the presence of these layers creates boundaries that behave as barriers between the tiers, and children wait in long queues for short services, or are passed to somebody else.

On paper the system makes sense, but in reality children and young people are poorly served. As people devise their new CAMHS strategies we need to acknowledge the dysfunctions in the way we commission and collaborate around children and adolescents with mental health issues.

HOW IS IT MEANT TO WORK?

To highlight the dysfunction in the way CAMHS services are commissioned and delivered we first must establish the conceit of how it is supposed to work. In some parts of the country, work at the boundaries between crucial CAMHS Tiers is good. Triage works. Children are assessed by nursing and other staff, signposted as to where to look for support, or assigned to somebody who can help. Referral routes are smoothed out and professional jealousies are set aside to place the child at the centre of staff's concerns. The work relies on blended teams featuring social workers, school staff, counsellors, nurses, Education and Clinical Psychologists and Child Psychiatrists. Some places have forged together their learning difficulties and disabilities (LDD) services and CAMHS, where Tier 1 to 3 services are available at home, rather than just at a clinic. Nationally, investment is underway in the Children and Young People's Improving Access to Psychological Therapies Programme. Some localities have waiting times down to a matter of weeks. There are good programmes available for staff development, like the MindEd suite which anybody can access and professionals can sign use to follow an ascending accredited training pathway.

Services at Tiers 1 and 2 are universal, preventative and should be provided where a child is likeliest to be: their schools, youth and other young people's services, first-call "somebody to talk to" interveners, many of them positioned in those places, with open door policies so a child can go and talk. Staff at Tier 1, and most at Tier 2, are in universal services and often ill-trained to do what children need. They are keenly aware of this. Too often, they don't know how to get help. That unavailability and poor profession to profession support has become, by default, a way of managing demand, especially given budget cuts.

Tier 2 services begin to provide help beyond simple day to day common sense, for example through a school counsellor, a family intervener who can come to and support you at home.

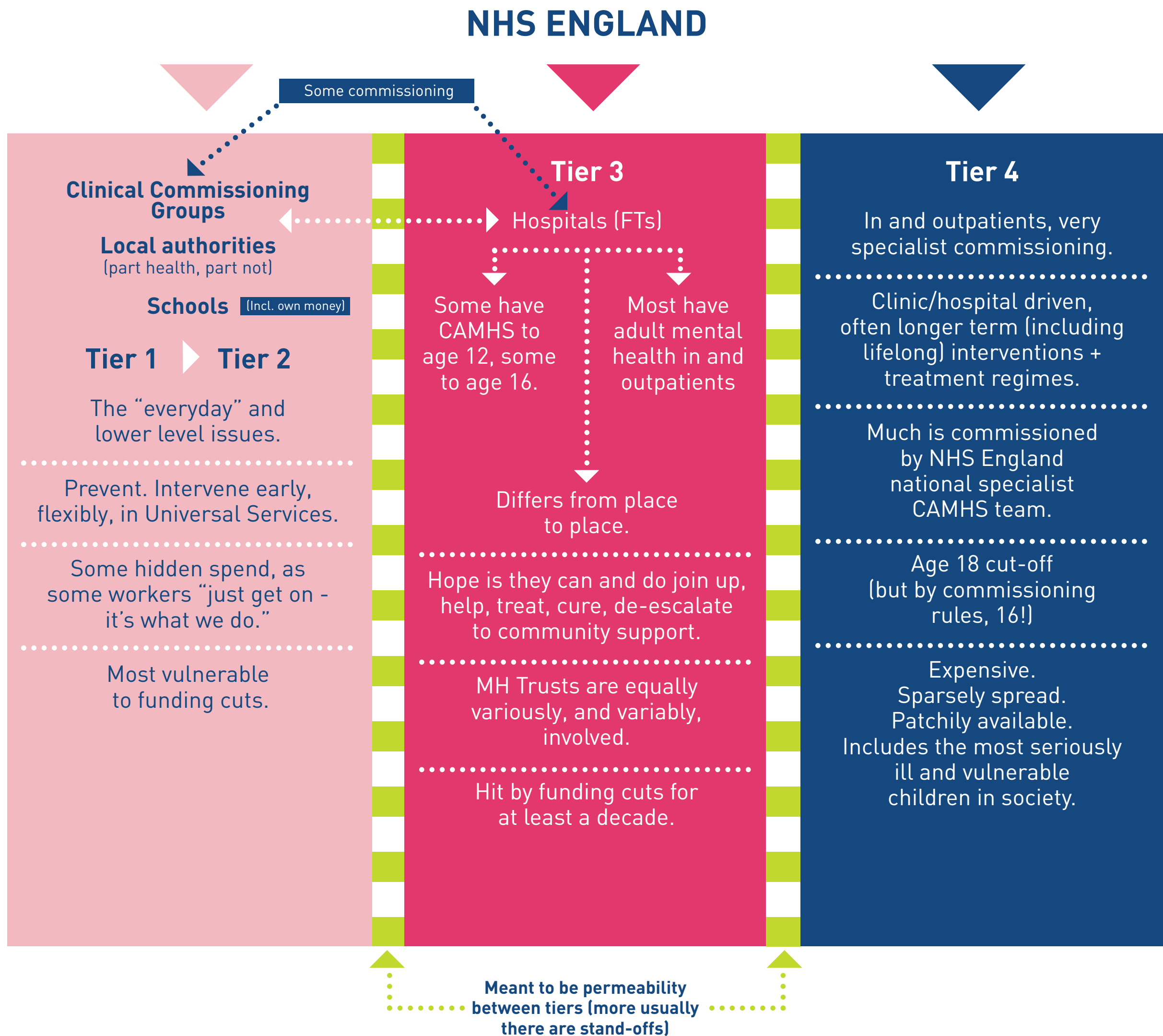
The step between Tiers 2 and 3 is crucial. Tier 3 is the start point for specialist mental health teams. They are not necessarily clinic-based but undertake more specialist interventions than Tier 1 or Tier 2, offering therapeutic treatment by qualified staff. A Tier 3 patient is likely to have a diagnosed problem. They may receive both talking therapies and medication.

Tier 3 is variously commissioned: CCGs commission in some areas, Mental Health Trusts in others. Some support goes up to age 16, some to 18. Some is sourced through general hospitals. At the moment the picture is confusing. Of course it is not "lean" or agile, because it involves negotiation, and inevitable passing to and fro, case by case, child by child.

BUT THE PROBLEMS BEGIN WITH HOW CAMHS IS FUNDED AND COMMISSIONED

The commissioning and funding system of CAMHS is built upon a presumption of permeability between the tiers of services offered. This means not just inter-team work within a single organisation but for the most part inter-agency work between schools, the NHS and local government. Unsurprisingly this permeability often manifests itself as a series of stand offs in the journey of the child or young person through support services. These cross agency, structural and cultural issues are common to all who work in public services. With the commissioning system so fragmented however, it serves only to exacerbate the tensions between agencies, not reduce them, by forcing different funding streams at different tiers and different agencies.

HOW ARE CAMHS CURRENTLY COMMISSIONED AND FUNDED?

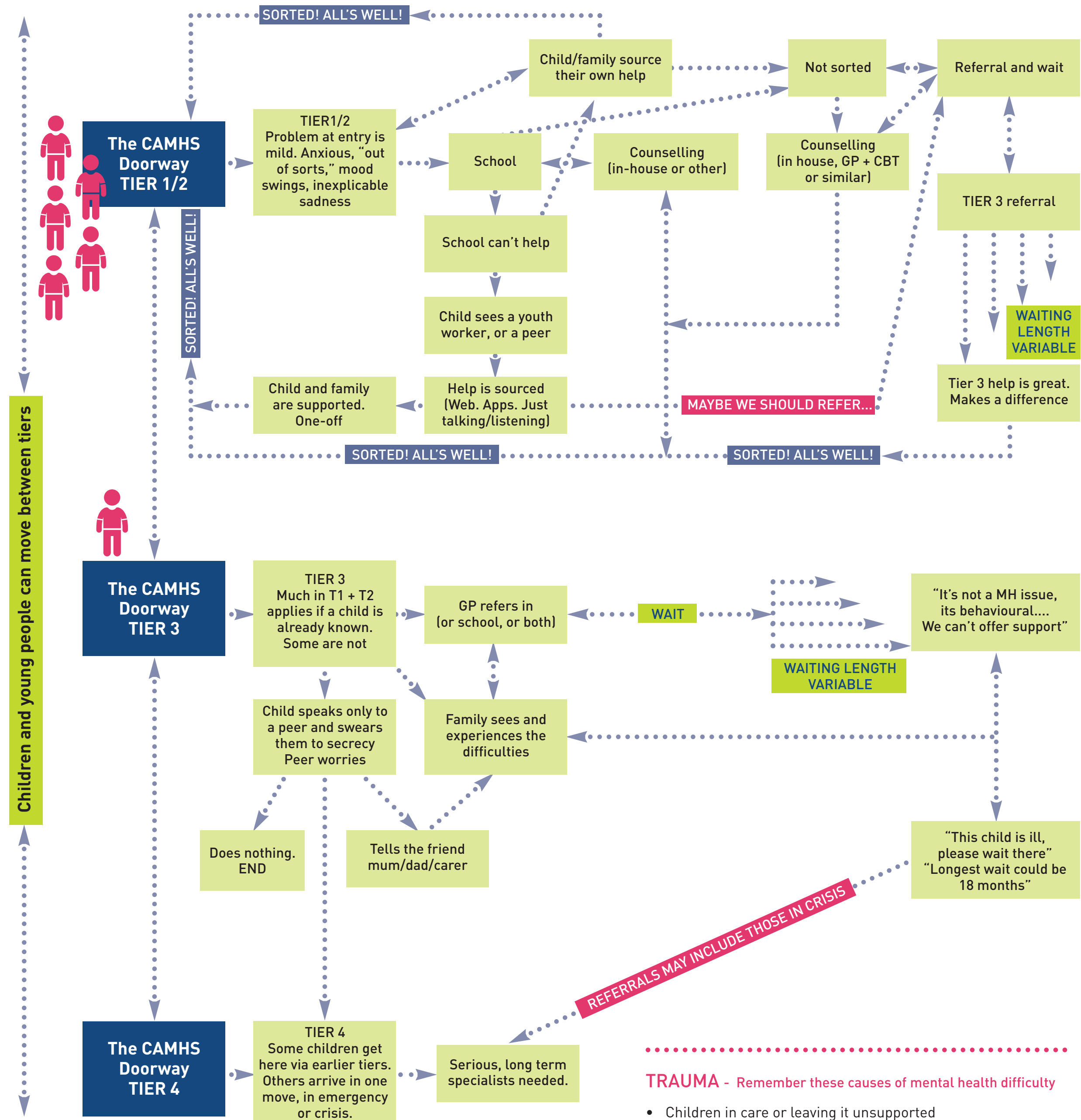


At age 18 (16) the service user will likely be referred/passed to Adult Mental Health Services where cultures, regimes, support and ways of working are **ALL** different.

HOW DOES THE SYSTEM ACTUALLY WORK IN REALITY

(A HUGE LEVEL OF COMPLEXITY FOR SERVICE USERS AND PRACTITIONERS)

AS CAMHS IS EXPERIENCED NOW:



TRAUMA - Remember these causes of mental health difficulty

- Children in care or leaving it unsupported
- Those abused, neglected and damaged by their childhoods
- PTSD suffering asylum seekers or victims of war, cataclysm, disasters
- Those who have been exploited, trafficked, used and abused by others, including CSE
- Witnesses of violence, including at home
- Children with learning difficulties and mental health issues combined.

The level of complexity in how the system operates creates a number of challenges:

Challenges	Notes
1: Difficult to access the system without delays	Users experience significant delays on receiving support because the permeability between tiers too often acts a barrier
2: Who actually owns the co-ordination of support provided	Tiers 1 and 2 can feel like the user is being passed around a range of professional until they 'stick'. In many places Tiers 1 and 2 are also patchy with some professionals perhaps unaware of their roles and responsibilities
3: Permeability between the tiers of services offered just is not there, and where it does work it does so in spite of the system because the people make it happen	The experience of professionals surveyed for this report is that services breakdown and agencies turn on each other
4: Commissioning engrains divisions	The way we commission CAMHS doesn't encourage professionals from different agencies to see themselves as part of a single continuum of support
5: There are major issues with Tier 4	Because of the level of specialist and intensive interventions this is commissioned by NHS England which adds to the complexity. The transition between CAMHS into adult services can often be traumatic and messy. Demand is also increasing with scarce supply available

Our diagnosis is that we need a model based on a shared understanding that mental ill health problems are far more commonplace issues than we think for our children and young people. We need that system to cut through the complexity. Demand management, new service models, and multi-agency work and support offer unique opportunities to change the way we commission and deliver CAMHS services.

THE SECTOR RECOGNISES THE SAME ISSUES ITSELF

RESPONSES TO AN IMPOWER SURVEY ON CAMHS TRANSFORMATION – OUR SURVEY SAID:

Respondents want the resources to follow the ambition. Where inter-agency defensiveness & suspicion are dropped and staff have seen the problems & deliberately co-worked & co-constructed, there are now early signs of progress. (Survey conducted August 2015)

Survey respondents' common themes echo our analysis in this paper. They spoke of:

- Early intervention, in universal settings, is the predominant wish of those working with children and young people who might otherwise become more troubled and ill. However, whilst in a small number of places such early intervention both works and pays dividends, in many neither applies. This means that dedicated professionals' ambitions are confounded, not by the will to act, but the cumulative effects of the systems currently in place.
- Complex commissioning is a key issue in this regard: it creates conflicts and complexities in relationships between localities and the centre, but also between different bodies in localities. Navigation has been made more rather than less difficult in a reformed NHS

- Workforce issues are considerable. Barriers to joint working, shared language and plans too often remain in place between services, and between the different layers of services within organisations. This causes both frustration and professional concerns among staff who wish to do the best possible job in often under-resourced and pressurised circumstances. Where the will to work together is already (or has the potential to be) strong, there is considerable joint working towards common goals for children. But even there, difficulties and differences in resourcing, accountabilities and governance, boundaries and barriers between elements of the system, a lack of shared offices, supervision, information and data are all considerable and get in the way of steering change.
- Waiting lists remain problematic in a system struggling to both make ends meet and meet rising demand from an ever more aware under-18 population, with evidence that its needs are increasing rather than diminishing. Pressure on resources compromises both the appetite for change, and the ability to deliver it.
- Lack of transparency plagues the system; it is difficult to know who to ask for help, how the referral or escalation mechanisms work, who is accountable to whom, how patients and families are signposted and supported.
- Tensions continue to exist between schools as universal services (education psychology as a first call service for them) and bodies in the local health economy. These tensions are exacerbated by the current frameworks in place for a 4-tiered CAMHS system. Tiers 3 and 4 services in particular are unevenly distributed and operate differently from place to place.
- There are echoing, and reinforcing, tensions, misunderstandings and potential conflicts between commissioners and providers.

It is clear that the signs of change are there. Some places – as reported by survey respondents – have embarked on whole system co-redesign and co-construction. There, staff and patients are seeing practical and very real signs of progress. Even in places moving forward with positive plans to address the challenges we have outlined in this report, there are concerns about the fragility (and therefore sustainability of) partnerships, future funding and other resources, and the strategic will of parent organisations to maintain momentum. It is clear from our research and survey that there is a will but questions remain about the means to ensure that will bear fruit.

WHAT IS CHANGING, OR WHAT IS HOPED FOR?

In the second half of 2014, the government set up a Children and Young People's Emotional and Mental Health and Wellbeing Taskforce, peopled by specialists and non-specialists which published "Future in Mind" in March 2015. It recognised: over complex, multi-strand commissioning and provision, issues over access, funding and cuts, the low priority given to children and young people rather than adults, poor access to crisis and specialist care.

The Children and Young People's Mental Health and Wellbeing Taskforce 2014-15 considered how to make it easier for children, young people, parents and carers to access help and how and to improve children and young people's mental health services' organisation, commissioning and provision. The Taskforce's report "Future in Mind" makes five key recommendations for change:

Theme	Action required
Promoting resilience, prevention, early intervention	Requires a shared understanding and proven willingness to act on ensuring clarity for service users seeking help; understanding demand in a locality and how to manage it; determined joint working and barriers being broken with the child at the centre of all concerns. Requires that you capture what you save if you intervene earlier, rather than what you would spend if you intervened later, or not at all
Improving access to effective support – a system without tiers	You have to mean it in order to do it. Understand the demand patterns. Deliberately simplify structures to improve access. Dismantle artificial barriers between services. Ensure those who plan and pay for services work together, so children and young people have proven, visible access to the right services at the right time. Signpost them to help more clearly. Commission different ways of communicating including using ICT. Be there when you say you will. Divert cash from upper tiers to do all this, then track where early intervention is better than late, financially.
Care for the most vulnerable	Deliver a clear, determinedly joined up approach: link services so mental health care pathways are easier to navigate for all children and young people, including the most vulnerable (this includes Children in Care, young carers, those both suffering and recovering from neglect, abuse, violence or exploitation, those with a learning or other disability). The job is to ensure people do not fall into gaps and go on falling.
Accountability and transparency	Harness the power of information. SHARE IT if the child's needs require that everybody involved needs to know. Share information to drive improvements in both the delivery of care, and shared standards of performance. An improved understanding of how to get both the best outcomes for children, young people and families/carers, and the best value from the promised investment. Remember the child is the centre of the service, and staff ARE expected to share.
Developing the workforce	Create and sustain a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience. Make CAMHS basic knowledge and understanding an expected part of teachers' and other professionals' expertise. Review how the workforce is placed, deployed and rewarded, to create blended and multi-professional teams.

The Children and Young People's Mental Health and Wellbeing Taskforce have clearly indicated that it is time for change.

The review concentrated on these needs for action, all of them relying on taking seriously the voices, views and interests of young patients and potential patients. We gauge localities could use help and support in any and all of these, or at least in the analysis and planning of how to get there. They all have to have plans in place now, but having a plan is not the same as "been there, done that."

In terms of demands on the system and society, by 2020:

- Better societal awareness and understanding of mental health issues difficulties and challenges for children and young people, helping remove stigma by reducing ignorance and challenging prejudice
- Timely access for all children and young people, all over the country, to the services they need when they need them and close to home
- Services built not on a tiered system basis but that are built around the needs of the child or young person and family, joining up services and challenging CCGs and national commissioners to de-clutter, simplify and clarify how commissioning happens, how signposts and pathways are provided and ensured, and how information is used so that services improve and investment is made in accordance with proven need, including in the workforce.

Since the new government came to power, several developments have taken place. This means that there ARE resources in the system, though they remain scarce and in many places, increases in demand for services remain impossible to manage. Our analysis is that CCGs, local authorities, schools in clusters or singly, and primary and secondary care, all do need each other's – and potentially iMPOWER's – support to manage the changes they wish to make.

- £150 million has been pledged to work on self harm and eating disorders, out of a £2.95 billion pledge in March 2015 for mental health resources of which £1.25 billion was for CAMHS by 2020.
- £7 million has been pledged for new inpatient beds. £33 million has been awarded for cutting waiting times for psychological treatment. Children and Young People's Improving Access to Psychological Therapies Programme (CYP IAPT) expansion has been awarded £54 million. These are real, positive signs of change.
- Every locality has been issued an expectation that by mid-September they will have created and submitted an implementation plan based on the findings of and emerging demands on the system in "Future in Mind".
- The professional learning and development platform MindEd has been taken up by professionals from teachers to specialists in mental health.
- The consciousness of everybody in the system has been raised and that seems unlikely to go away, but people do not necessarily see what to do, or how to do it, in localities.

There is now professional and policymaking momentum behind making changes for the better:

- There is both a national recognition that neither CAMHS commissioning nor delivery has been done well and correspondingly there is a will to do it better in future.
- The wealth of reports and research available, including from children and young people themselves through the British Youth Council's Select Committee, Young Minds and other organisations, all add to the voices in favour of, and suggest workable models for, ensuring positive change.
- The imperatives remain pressing: the system remains and is likely to continue to be short of money and other resources. Doing less of the same with shrinking resources is not sustainable. The problems with how things are done now, the propensity of the difficulties children and young people face, and the need to change, are all known. New thinking is needed.
- There is some resource now arising from policy promises made by both previous Coalition Ministers and the current government. Money for eating disorder services is a start. Holding the government account to the promises made as "Future in Mind" was published will now be vital.

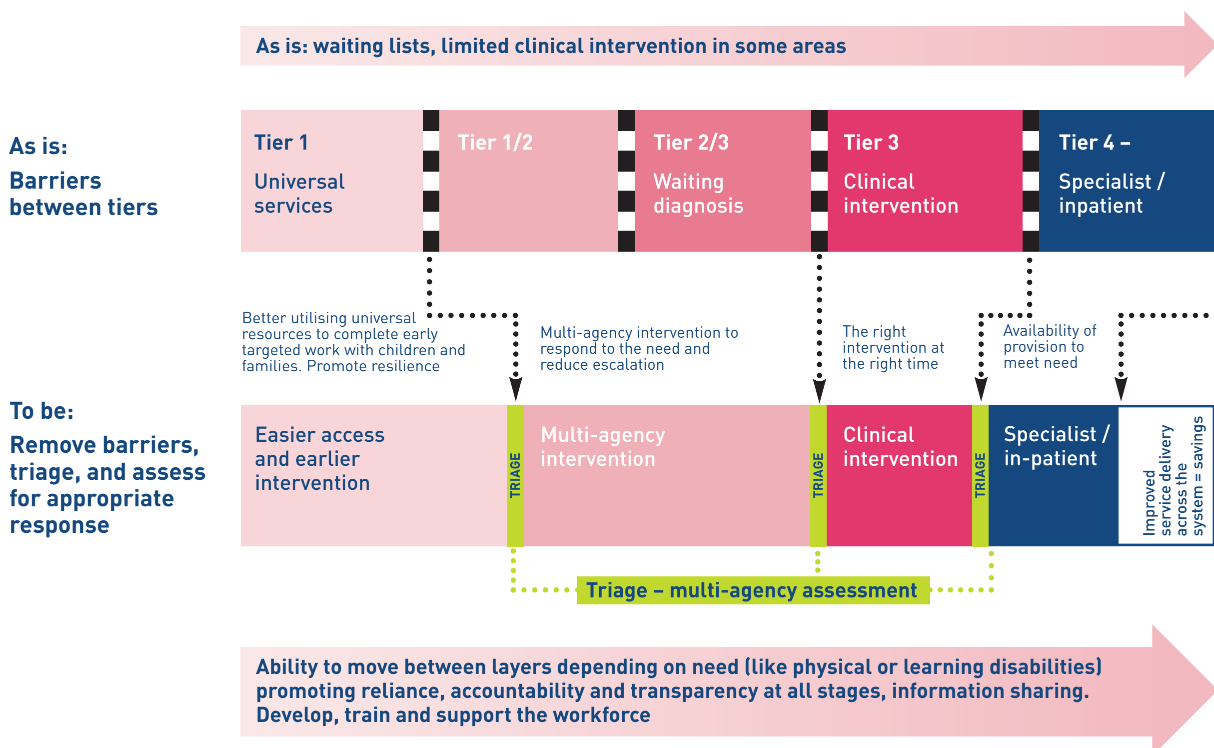
- There is a clear and imperative requirement on all localities to publish implementation plans arising from "Future in Mind," and these plans should lead to and feed the appetite to act, not simply to write the plans concerned.
- We have a national framework available for reaching high to find a real, shared solution to problems that even a year ago might have been considered intractable.

WHAT WE NEED TO DO NEXT

We consider every agency and partnership needs to work out where the demand for mental health services is coming from and how they could manage it differently. Earlier interventions will then become possible as practitioners can better spot trends and red flags that point to new issues emerging. It is possible to reimagine a different CAMHS system.

WHAT A REIMAGINED CAMHS SYSTEM COULD LOOK LIKE

What would good CAMHS look like? A system based on prevention and early intervention for the most vulnerable including Children in Care



What a reimagined CAMHS system could look like

Delivery of this change will require:

- Earlier intervention when a child's difficulties first arise
- Focus on the lower tiers in the system, in the hope that escalation to the higher ones will not be needed
- Breaking down the barriers between services as a deliberate, focused, planned action for all concerned
- Good information sharing and a mind-set that expects to share, not to withhold
- Triage as a way of assessing children's needs at each stage, not creating barriers but means of ensuring the child "lands" with the next stage of help and support
- Multi-agency working as a foregone conclusion, including during the transition to adults' services, or out of intensive help and support and back into communities and lower level interventions after a period of specialist treatment
- Developing the workforce: an expectation that in every professional's initial and CPD development and training, if they are to work with children and young people they are given at least a basis of knowledge, understanding and expertise in mental and emotional health, wellbeing and development.

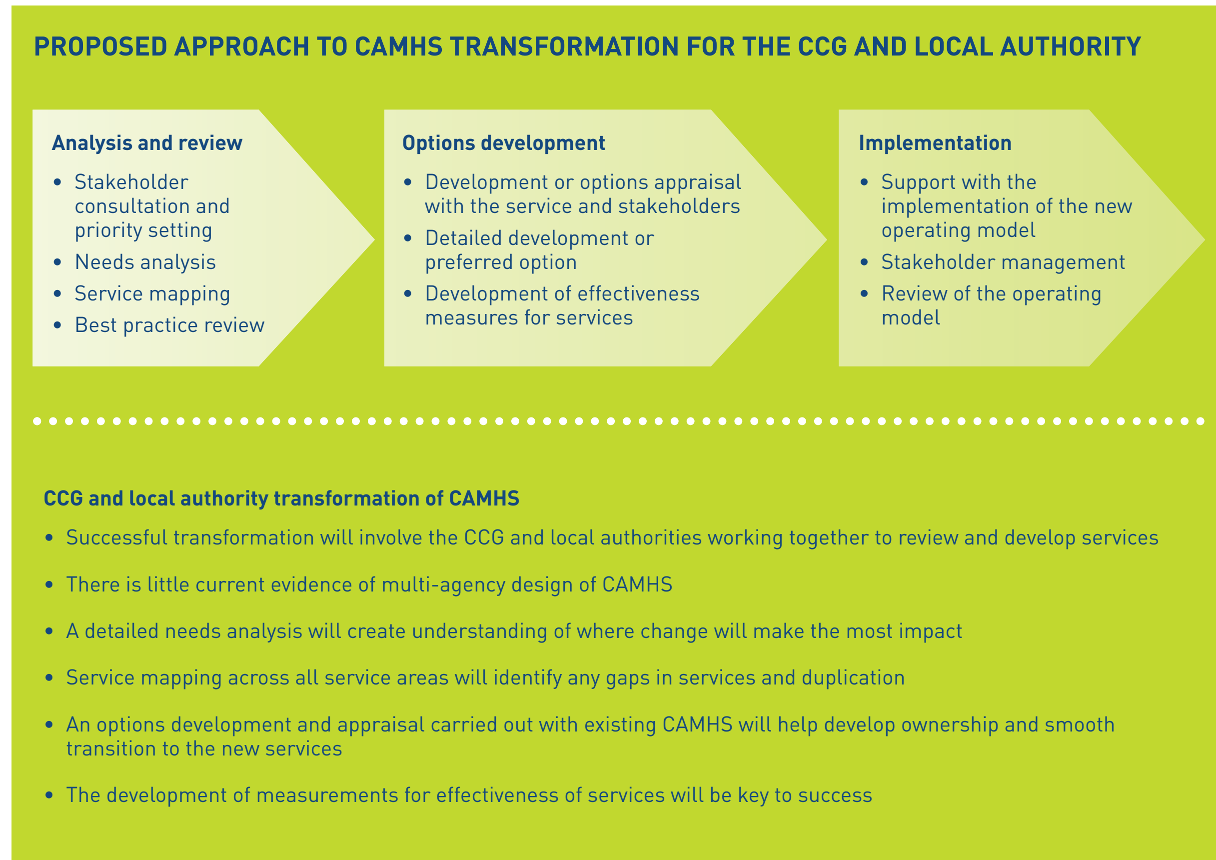
Our work and approach is based on:

- "Future in Mind" as a framework of problem analysis and demands on the system
- iMPOWER's previous publication on children's services "Breaking the Lock" and its core principles focused on doing what's right
- iMPOWER's "Inflection Point" and its core argument that innovative change is needed in all areas of public service, including CAMHS.

We offer to help find ways for all agencies to meet in safe spaces to reflect on what is being done and to challenge each other on what is needed; what conventional thinking says "can't be done" but is nonetheless necessary if children and young people are to be treated as they deserve and we are to stop problems piling up with needs remaining unmet (at who knows what cost).

We help confront Implementation Plan issues – everybody has to have a plan, what does it look like in reality and how can it be made to live in practice for children and young people?

WE CAN HELP YOU TO MOVE YOUR PLANS INTO PRACTICE



CCG and local authority transformation of CAMHS

- Successful transformation will involve the CCG and local authorities working together to review and develop services
- There is little current evidence of multi-agency design of CAMHS
- A detailed needs analysis will create understanding of where change will make the most impact
- Service mapping across all service areas will identify any gaps in services and duplication
- An options development and appraisal carried out with existing CAMHS will help develop ownership and smooth transition to the new services
- The development of measurements for effectiveness of services will be key to success

APPENDIX

DOCUMENTS, WEBSITES AND REFERENCE POINTS

Please note this is nowhere near an exhaustive list of available materials or sources. It supports this publication's lines of argument. Statistics quoted in the main body of the text are largely from the first paper referenced below.

- Department of Health/NHS England: "Future In Mind" March 2015, from the Ministerial taskforce on Children's and Young People's Emotional and Mental Health and Wellbeing **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf**

- iMPOWER: "The Inflection Point" (2015) on squaring the circle of rising demand versus shrinking resources by changing behaviours, expectations and thinking. Free download at **www.impower.co.uk**

- iMPOWER: "Breaking the Lock" on breaking free from the relentless drivers brought to children's services by an inspection regime that does not look at the whole picture, or give a steer on how to do things differently, earlier, and more holistically. Free download at **www.impower.co.uk**

- Department of Health: Reports of the Children and Young People's Health Outcomes Forum (CYPHOF,) established 2011 and reporting annually. Details available at **https://www.gov.uk/government/groups/children-and-young-peoples-health-outcomes-forum**

- Department of Health: Regular updates from CHIMAT (Child and Maternity statistics). These materials are available online (**www.chimat.org.uk**). CHIMAT is now part of Public Health England.

- Atlas of Variations in Child Health **http://www.rightcare.nhs.uk/index.php/atlas/children-and-young-adults/**

- UCL's Centre for Health Equity **www.instituteofhealthequity.org**

- Public Health Profiles published and updated by LA area online by Public Health England. These profiles include PH prevalence surveys, research, trend and data analysis: **https://www.gov.uk/government/organisations/public-health-england**

- The Chief Medical Officer's annual reports on the state of the nation's health: for 2012 (published autumn 2013) and 2013 (published in 2014.) **https://www.gov.uk/government/news/chief-medical-officer-publishes-annual-report-on-state-of-the-publics-health**

- NHS England: Five Year Forward View, references a move towards prevention, earlier intervention, and new models of delivery.

- Department for Communities and Local Government: Troubled Families Programme **www.gov.uk**

- Early Intervention Foundation (EIF) **www.eif.org.uk**

- MindEd: Training and development resources, from general/entry level of generalist or universal services like school, to accredited pathways for specialists **www.minded.org.uk**
- Websites from campaigning and educational bodies, including:
  - The Mental Health Foundation
  - Child Abuse Prevention, Child Abuse and Neglect: BASPCAN
  - British Psychological Society
  - King's Fund
  - Online resources from:
    - Howard League for Penal Reform
    - Prison Reform Trust
    - The Who Cares? Trust
    - Barnardo's
    - NSPCC
    - The Children's Society
    - Action For Children
    - MIND
    - Mental Health Foundation
    - Children and Young People's Mental Health Coalition
    - Time to Change
    - Young Minds
- British Youth Council (BYC) 2015 Select Committee inquiry: on Children and young people's mental health issues. Publication expected 2015 **www.byc.org.uk**
- Office of the Children's Commissioner: **www.childrenscommissioner.gov.uk**
  - I Must Have Been Born Bad (2011) on commissioning and provision of mental health services in secure youth justice settings
  - We want to make a change (2013) on better involvement of children and young people in commissioning and evaluation of health services
  - It takes a lot of courage (2013) on how young people seeking to complain about mental health services are heard. Led to system-wide work on child-friendly complaints processes later published as follow-up.
  - Nobody Made the Connection (2013) with Exeter and Birmingham Universities, on under or ill-diagnosed LDD, SLD and attendant or related mental health issues in youth justice settings. Companion document to Barrow Cadbury's report on similar issues, also 2013.
  - Reports on two year inquiry on child sexual exploitation: key findings are in I thought I was the only one: the only one in the world (2013) and If only someone had listened (2014).
- Launched September 2015: Commons Education Select Committee inquiry into the emotional and mental health and wellbeing of children in the care system. Ongoing. Expect publication of findings and recommendations during 2016.

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