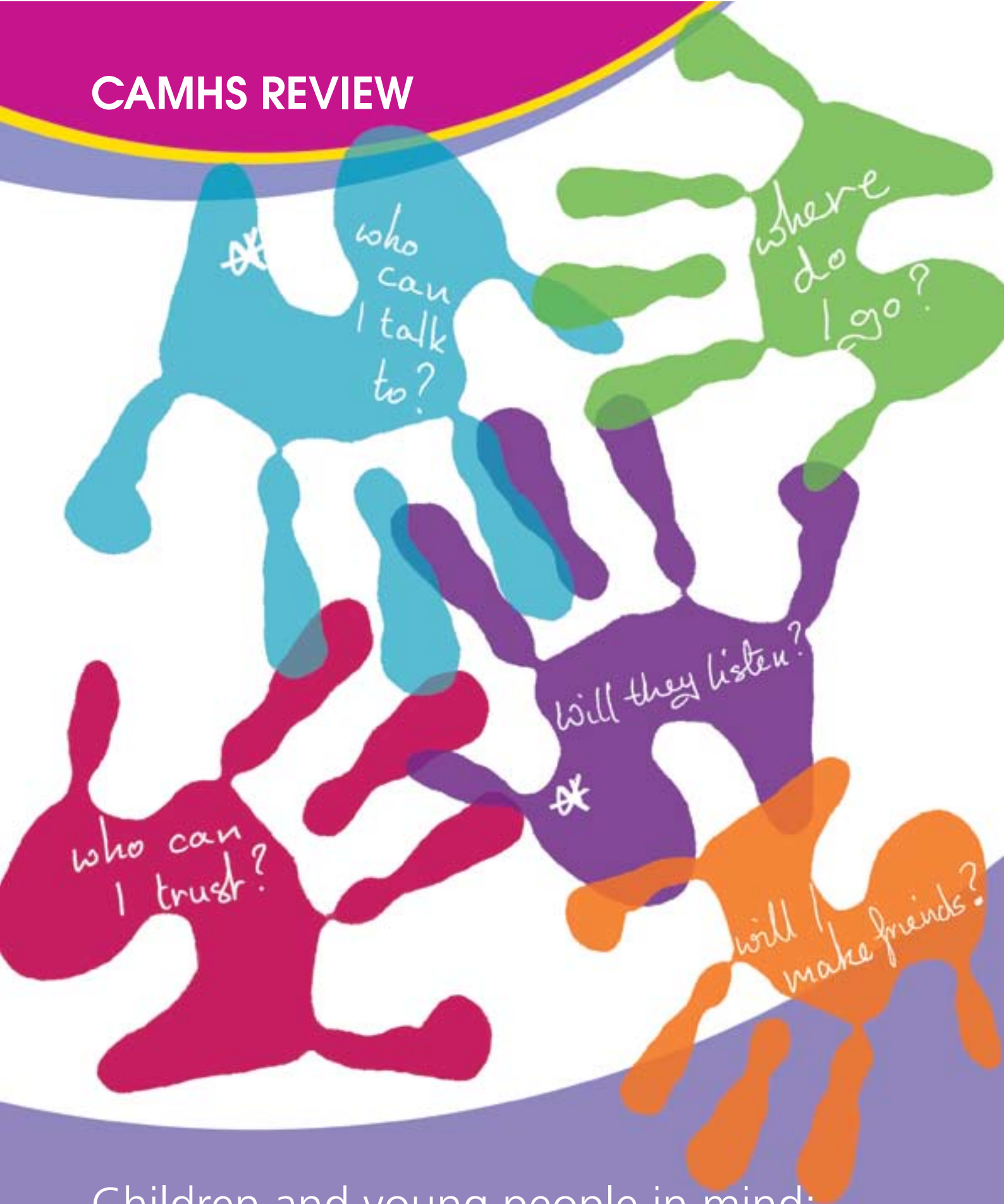


CAMHS REVIEW



Children and young people in mind:
**the final report of the
National CAMHS Review**

CAMHS REVIEW

Children and young people in mind:
**the final report of the
National CAMHS Review**



Contents

Foreword	5
Members of the Expert Group	7
Executive summary	8
Chapter 1 Setting the scene	14
Terms of reference	14
What difference do we hope to achieve?	18
What is the current picture?	19
Progress since 2004	24
Conclusion	26
Chapter 2 Everybody's business: leadership	27
Who's involved?	27
Strategic leadership	29
Chapter 3 Everybody's business: what children, young people and families want	35
Sources of support for children and young people	35
Attributes of effective services	35
Chapter 4 Everybody's business: promotion, prevention and early intervention	38
How different services are carrying out their roles	38
Developing capability and capacity in universal services	45
Chapter 5 Everybody's business: specialist help for children, young people and families	50
How different services are carrying out their roles	50
Chapter 6 Everybody's business: services working together	60
Integrated working	60
Care pathways	63
Flexibility and diversity of response	64
Language and professional perspectives	66

Chapter 7 A needs-led system	68
Commissioning	68
Joint strategic needs assessment	73
Resource deployment	76
Understanding individual needs, values and priorities	78
Chapter 8 Developing and supporting people who work with children	87
Training and development	87
Supervision and skills	89
Evidence and knowledge	90
Monitoring progress and evaluating outcomes	92
Conclusion	97
Notes and references	99
Annex A: The Review process	104
Annex B: Policy timeline	107
Annex C: Organisations contributing to the call for evidence	110
Annex D: Questions young people would like to ask about the services they receive	114
Annex E: Vulnerable groups	116
Annex F: Resources from the Review	117



Foreword

“If you do one thing, just get people who know what they are doing to work together better.” This was one father’s plea when he heard about this Review.

I was determined that our work would be strongly influenced by children and young people and their parents, carers and families. What would things look like from their perspective? Was there a meeting of minds between what they would like to see and what the thousands of people who work in children’s services would like? This report does not attempt to be an empirical academic report, to analyse different interventions or to revisit policy which continues to be relevant. It does, however, aim to capture the issues people are experiencing on a day-to-day basis and provide further impetus for change.

We had a tremendous response to the Review, and I would like to thank all those individuals and organisations who took the time to share their thoughts, their ideas and their experiences. The scale of the response has meant that we have not been able to address all the detailed issues that people raised. But where possible, information and evidence will be made available for further work.

Thank you, too, to people around the country who took time out from working with children, young people and their families and carers to show us what they are doing, and to the people who arranged this. They were honest about their trials and tribulations – and their triumphs, too. Thanks also to the Expert Group who have worked so hard over the past few months and been so forthright in their advice. Our group of young people have kept our feet firmly on the ground, and have told us how it is. Particular thanks go to my Vice-Chair, Bob Jezzard, who knows so much and to the support team who have been magnificent.

Undoubtedly there has been progress since 2004; it would be unfair of anyone to suggest otherwise. There is, though, a shared view, permeating the responses we received, that more can and should be achieved. People around the country recognised that children and young people are still often receiving fragmented and inconsistent support. People also recognised that support is still sometimes provided too late in a crisis, and information is not easy to come by.

What children, young people and their families and carers want is often quite simple. They told us they want consistent relationships with people who can help and to be treated with dignity and respect.

Mental health is as important as physical health. As one young person put it: "It doesn't mean being happy all the time but it does mean being able to cope with things." We all play a part in helping children and young people grow up. Mental health and psychological well-being are not the preserve of one profession or another, or of one government department or another. Children and young people need to be supported by professionals who help each other out and by a truly joint approach, that is child- and family-centred, from the Government at national level as well.

Anyone in contact with a child has an impact on that child's mental health and psychological well-being. The challenge for all of us is to remember that and to be able to respond if things start to go wrong. I hope the information and recommendations set out in this Review help all of us take some further steps forward, together.

Jo Davidson

Chair, National CAMHS Review
November 2008

Members of the Expert Group

Chair Jo Davidson – Group Director, Children and Young People’s Services, Gloucestershire County Council

Vice-Chair Dr Bob Jezzard – Child and Adolescent Psychiatrist (retired) and former Senior Policy Adviser for CAMHS at the Department of Health

Dr Cheryll Adams – Lead Professional Officer, Unite/Community Practitioners and Health Visitors Association

Dr James Brockbank – GP, Teddington. Clinical Lead, Mental Health, Richmond and Twickenham PCT.

Roger Catchpole – Principal Consultant, Young Minds

Barrie Chalmers – Headteacher, St Mary’s Church of England Junior and Infant School, Manchester

Dr Ted Cole – Executive Director, Social, Emotional and Behavioural Difficulties Association (SEBDA)

Dr Crispin Day – Clinical Psychologist, Child and Adolescent Mental Health Service Research Unit, Institute of Psychiatry, Kings College London, Centre for Parent and Child Support, South London and Maudsley NHS Foundation Trust. National Academy for Parenting Practitioners, UK.

Eustace de Sousa – Children’s Services Advisor, Government Office North West and Associate Director for Child and Maternal Health, NHS North West

Paul Elliott – Headteacher, Brockworth Enterprise School, Gloucestershire

Ricky Emanuel – Consultant Child and Adolescent Psychotherapist, Royal Free Hospital and Clinical Lead, Camden CAMHS. Children’s Commissioning, Camden PCT.

Janet Foster – Service Manager and Lead Nurse, Barnsley Metropolitan Borough Council

Dr Daphne Keen – Consultant in Neurodevelopmental Paediatrics, St George’s Hospital, South London

Gren Knight – Chief Educational Psychologist and Head of Social Inclusion, Wolverhampton City Council

Jan Leightley – Strategic Director of Children’s Services, Action for Children

Bruce Marr – Project Manager, Preventing Youth Offending Project, Portsmouth City Council

Gail McCarthy-Street – Senior Youth Worker, Somerset County Council

Philip Messent – Head of Family Therapy, East London NHS Foundation Trust

Jane Prashar – Divisional Manager, Children’s Resources, Directorate of Children’s Services, Dudley Metropolitan Borough Council

Dawn Rees – National Improvement Lead, National CAMHS Support Services (NCSS)

Janette Sherratt – Health Improvement Lead, Children’s Services, Sunderland

Professor Panos Vostanis – Child and Adolescent Psychiatrist, University of Leicester

Joanna Wainwright – Director of Commissioning (specialist services), Kent County Council

Stephen Whitmore – Director of CAMHS and Adult Learning Disability Services, Oxleas NHS Foundation Trust, South East London



Executive summary

Growing up can be great. It can also be hard, confusing and upsetting. The way in which a child or young person approaches and tackles these opportunities and challenges is a good indicator of their mental health and psychological well-being.

Mental health and psychological well-being is affected positively and negatively by a child's own make-up; the influence of their parents, carers, families and wider communities; and by their everyday experiences in places such as nurseries, schools and youth services. Unless a person is feeling mentally healthy, it is difficult for them to have optimum physical health and well-being.

In this independent Review, we have been charged with finding out how children's health, education and social care services are contributing to the mental health and psychological well-being of children and young people.

We have focused on progress since 2004, a period in which services have been working hard to realise the aspirations of the National Service Framework for Children, Young People and Maternity Services and Every Child Matters. We have also considered how services can be improved further to meet the educational, health and social care needs of all children and young people at risk of, or experiencing, mental health problems.

Our analysis

Since 2004 there has been significant progress within all services contributing to mental health and psychological well-being. In addition to positive trends in mapping data from child and adolescent mental health services (CAMHS) and inspection reports, we have found numerous examples of approaches that are making a real difference to children and young people of all ages all around the country. There are new programmes to support infant mental health, some improvements in waiting lists for CAMHS, new projects being developed for children who are particularly vulnerable, the introduction of the Behaviour and Attendance programme in schools, the Healthy Care programme for children in care, more positive developmental activities for young people and a range of approaches to divert young people from offending. Around the country, local organisations are developing innovative approaches to improve the skills of families and those who work with children and young people on a daily basis. Together, they are changing the way services are delivered. All these approaches make a vital contribution – either directly or indirectly – to improving mental health and psychological well-being.

But we have found that improvements in mental health and psychological well-being are still not as comprehensive, as consistent or as good as they could be, despite the detailed policy that exists. Our analysis is that this is because:

- Parents, carers and everyone in day-to-day contact with children and young people need a better understanding of child development, the causes of mental health problems and things they can do themselves to build resilience and deal with issues as they emerge, whatever age their child is.
- Children and young people say that services are not as well known, accessible, responsive or child-centred as they should be. Those who access specialist services do not always have the opportunity to develop trusting relationships with staff for the length of time they need.
- When problems arise, parents, carers, children and young people and the people who are working with them on a daily basis need swifter, more effective input from practitioners who are able to address the full range of needs, to ensure that a holistic approach is taken.
- Long-standing problems persist for some particularly vulnerable children and young people in accessing a full range of appropriate support, at whatever age. This is despite numerous national reports highlighting the problems and possible solutions.
- Administrative and legal processes, unhelpful thresholds for access to services and some entrenched professional views can 'parcel up' children into individual services and prevent their needs being met in a holistic, flexible and responsive way, or leave their needs unaddressed.
- Unacceptable variations in service provision exist between regions and within local areas, leading to inequalities in the level and type of support offered to children and young people with similar needs.

- Much of the research and evidence about risk and protective factors and effective interventions is not well understood or able to be accessed by very busy professionals.

Bleak though this appears, we feel there are a number of powerful forces available now, which create an environment in which there should be both the ability and the will to address these long-standing issues. In particular:

- Children's mental health and psychological well-being is now a priority concern for many people – and society as a whole – rather than just a specialist interest.
- The sea change brought about by Every Child Matters and the National Service Framework for Children, Young People and Maternity Services provides the vehicle to identify children's needs and reshape the way in which those needs are met, through organisations and professions working effectively together around children and families.
- There are numerous examples of good practice involving children and young people, parents, carers and workers that are literally transforming lives. These have relevance across the country.
- The evidence base for interventions and practice that improves mental health and psychological well-being is better than ever before.

The challenges identified by the Review are not all the responsibility of children's services. There are challenges with improving the collaboration between services for adults and children. There is also continuing stigma surrounding mental health, and a negative attitude towards some children and young people that reduces the likelihood of all our children and young people having strong mental health and psychological well-being.

To meet these challenges, we suggest that three fundamental changes need to take place.

1. Everybody needs to recognise and act upon the contribution they make to supporting children’s mental health and psychological well-being. And they need to recognise the contribution others make. For parents and carers, this means helping them to understand the importance of psychological well-being in their child’s life, and what they can do to promote this.

2. Local areas have to understand the needs of **all** their children and young people – at population and individual level – and engage effectively with children, young people and their families in developing approaches to meet those needs. For parents, carers, children and young people, this means being listened to, knowing what is available and being able to access help quickly and in places they choose to go to.

3. The whole of the children’s workforce needs to be appropriately trained and, along with the wider community, well informed. For practitioners, this involves having access to the best evidence and knowledge on improving outcomes for children and young people. For parents, carers, children and young people this means having the confidence that the people they are in daily contact with, as well as specialists, understand about mental health and psychological well-being and what works best if things go wrong.

To support these changes, the Government needs to emphasise its commitment by ensuring that there is a unified drive across all relevant departments to put a spotlight on mental health and psychological well-being.

These changes do not require substantial shifts in policy. They do, however, require the full implementation of existing policies, as well as shifts in thinking and behaviour within many services. They may also need focused resources – if not of money, then certainly of time and commitment.

This spotlight on mental health and psychological well-being will be especially important over the next three to five years to show how all the pieces of this complex jigsaw fit together and how everyone can play their part. This will be a challenge, given the other priorities that local areas have to address. Nonetheless, we believe this is a priority worth focusing on, given the impact that poor mental health has on children, their families, friends and also their communities.

Based on our findings, the recommendations that follow will support these changes. Some are about improvements we want parents, carers, children and young people to see in their day-to-day experiences. Others are about the ‘behind the scenes’ changes we want local services and regional and national bodies to make in order to build the country’s capacity to improve mental health and psychological well-being.

Our vision

Improving the mental health and psychological well-being of all children and young people can help realise the ambition set out in the Children’s Plan¹ “to make England the best place in the world to grow up in”.

Our vision is that the recommendations in this report will enable a number of important changes to take place over the next three to five years, to improve children and young people’s mental health and psychological well-being:

- Everybody will recognise the part they can play in helping children grow up, have a good understanding of what mental health and psychological well-being is and how they can promote resilience in children and young people, and know where to go if they need more information and help.
- Children's services will work effectively together to provide well integrated child- and family-centred services to improve mental health and psychological well-being. As part of this:
 - universal services will play a pivotal role in promotion, prevention and early intervention
 - specialist services will deliver support that is easy to access, readily available and based on the best evidence.
- Staff across these services will have a clear understanding of their roles and responsibilities and those of others, and will have an appropriate range of skills and competencies.

The implications of these changes for children, young people and their families are that:

1. All parents, carers, children and young people throughout the country should have:

- a more positive understanding of mental health and psychological well-being as a result of national media activity
- up-to-date information, in a range of formats, about mental health and psychological well-being and what services are available locally to help them
- good telephone and web-based help and advice
- confidence that staff in the services they use every day:
 - understand child development and mental health

- actively promote strong mental health and psychological well-being
- use language that they understand
- take them seriously
- can identify needs early
- can help their child and can draw on support from others to make sure needs are addressed.

2. Children and young people who need more specialised support, and their parents and carers, should have:

- a high-quality and purposeful assessment, which informs a clear plan of action and which includes, at the appropriate time, arrangements for support when more specialised input is no longer needed
- a lead person to be their main point of contact, making sure other sources of help play their part, and co-ordinating that support
- clearly signposted routes to specialist help and timely access to this, with help available during any wait
- clear information about what to do if things don't go according to plan.

3. Children and young people and their families who are vulnerable (such as children in care, children with disabilities and children with behavioural, emotional and social difficulties) should be confident that, in addition to the above:

- their mental health needs will be assessed alongside all their other needs, no matter where the need is initially identified
- an individualised package of care will be available to them so that their personal circumstances, and the particular settings in which they receive their primary support, appropriately influence the care and support they receive

- for those experiencing complex, severe and ongoing needs, these packages of care will be commissioned by the Children’s Trust and delivered, where possible, in the local area. Effective regional and national commissioning will occur for provision to meet rare needs.

4. Young adults who are **approaching 18** years of age and who are being supported by CAMHS should, along with their parents and carers:

- know well in advance what the arrangements will be for transfer to adult services of any type, following a planning meeting at least six months before their 18th birthday
- be able to access services that are based on best evidence of what works for young adults, and which have been informed by their views
- have a lead person who makes sure that the transition between services goes smoothly
- know what to do if things are not going according to plan
- have confidence that services will focus on need, rather than age, and will be flexible.

There are a number of changes that need to take place at local, regional and national levels to ensure that this happens. To facilitate this, we make a number of recommendations, which we summarise here and set out in greater detail in the main report:

1. A **National Advisory Council** should be established with a remit to ensure that:

- promoting mental health and psychological well-being remains a national priority
- the recommendations in this Review are effectively addressed

- the Government is held to account for its progress.

2. The Government’s **national support programme** should be strengthened to facilitate consistency, improvement and sustainability in service delivery. This should include the following elements:

- A national multi-agency support team, built upon existing service improvement teams, should be established to facilitate and support sustainable cultural change at national, regional and local levels.
- The Government should set out clear expectations for government offices and strategic health authorities to deliver a coherent performance management and ‘support and challenge’ role to local areas which promotes a consistent approach to service improvement and delivery. We also recommend that regional boards for mental health and psychological well-being are established to facilitate this role.
- Legislation should be strengthened to require Children’s Trusts to set out in their Children and Young People’s Plan how they will ensure the delivery of the full range of children’s services.
- Children’s Trusts should be encouraged to set up local boards (or other appropriate local arrangements) to ensure effective commissioning and delivery of the full range of services to support mental health and psychological well-being.

3. To support the **children’s workforce** in meeting these challenges, we recommend that:

- All bodies responsible for the initial training of members of the children’s workforce should provide basic training in child development and mental health and psychological well-being. This should be in place within two years.

- The children’s workforce development strategy should set out minimum standards in practice in relation to mental health and psychological well-being to cover both initial training and continuing professional development.
- The delivery of early intervention work in universal services should be supported through additional training, formal supervision and access to consultation from specialist services.
- The Government should ensure that those who need it should have access to the latest training in evidence-based therapies.

4. To deliver the highest **quality of practice** across children’s services, we recommend that:

- National work on outcome measures for services should continue.
- There should be a clear strategic approach – at national, regional and local level – to monitoring, outcomes-focused evaluation, service improvement and inspection across all children’s services.
- The body of knowledge about children’s mental health and psychological well-being should be made accessible to all professions in a way that is relevant to their role.

This drive and focus to improve the mental health and psychological well-being of our children and young people needs to be accompanied by reflection and change in all of us, as members of families, communities, services and organisations. It is not about other people or agencies shifting their perspectives or practice, but about how each of us thinks about the needs of children and young people and what we do to help them be resilient.

Setting the scene

Terms of reference

1.1 The Government asked us to carry out this independent review in January 2008 to investigate:

- **recent progress** in delivering services to meet the educational, health and social care needs of children and young people at risk of and experiencing mental health problems, including those with complex, severe and persistent needs
- **practical solutions** to address current challenges and deliver better outcomes for children and young people with mental health problems
- methods for **monitoring** these solutions.

1.2 Our approach to meeting these objectives has been highly collaborative, involving contributions from large numbers of individuals and organisations through a range of methods including a literature review; focus groups with children, young people, parents and carers; visits to nine areas across the country to review practice; and a national call for evidence to enable those from the third sector, professional groups and the public to identify key issues and solutions from their perspective. The main aim of our information collection and consultations was to obtain a comprehensive understanding of relevant issues rather than to conduct an empirical research study.

1.3 We established an Expert Group to consider this wide-ranging evidence. To bring a greater depth of analysis to

complex areas we also established three sub-groups comprising members of the Expert Group, along with additional experts from across the wide range of relevant professions. These sub-groups focused on: the organisation and delivery of services; monitoring, evaluation and accountability; and vulnerable groups. We also established a children and young people's reference group and web forum to ensure that their views and perspectives informed planning and decision-making throughout the process of the Review.

1.4 As well as 20 key recommendations, this report contains other recommendations that should also be taken into consideration. These are highlighted in italics throughout the report. Our specific objectives and the process we followed are described in more detail in **Annex A**. Throughout the report, we include a number of practice examples to illustrate the breadth of activity under way across the country. Many of these examples are drawn from our nine practice visits (see **Annex A**). We have indicated these with the use of the labels 'Area A' to 'Area I'.

What do we mean by mental health and psychological well-being?

1.5 We found there are many different ways of describing and understanding mental health and psychological well-being. Children and young people use terms such as 'feeling in control' or 'feeling balanced'. These descriptions are useful, because they highlight the fact that mental health and psychological well-being are not about feeling happy all the time. They are about having the

resilience, self-awareness, social skills and empathy required to form relationships, enjoy one's own company and deal constructively with the setbacks that everyone faces from time to time. All of us have mental health needs, and from time to time these may become problems that require support from others.

1.6 When a child or young person experiences significant problems – often related to their feelings, thoughts or behaviours being 'dysfunctional' in some way – there are four main statutory systems across education, health, social care and youth justice that are designed both to help the child or young person, and to protect others. The different theoretical perspectives, training routes and legal frameworks that shape each of these systems lead to different ways of describing and framing these problems. In this report, we refer to them as mental health and psychological well-being problems. However, a point we are keen to stress is that they are the same children and young people with the same problems and needs, whatever the terminology used.

1.7 In view of this complexity, no definition of mental health will satisfy everyone, but we found the World Health Organization's definition a positive and helpful one:

"A state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."²

We share the World Health Organization's view that mental health is the foundation for well-being and effective functioning, for an individual, for a community and for society as a whole. Any child or young person who is not in this state of well-being is at risk of poor mental health.

1.8 We use the term 'psychological well-being' to include emotional, behavioural, social and cognitive attributes of well-being.

1.9 Both terms are consistent with the terms used in the National Service Framework for Children, Young People and Maternity Services³ (Children's NSF). Further issues relating to terminology are discussed in more detail in paragraphs 6.20 to 6.26.

Which children and young people are we talking about?

1.10 The Review considered the needs of all children and young people from birth to age 19, and their families. We took this age range because it encompasses the responsibilities both of Children's Trusts and children's centres, early years settings, schools and colleges. However, this age range does not apply across all services. Child and adolescent mental health services (CAMHS), commissioned by primary care trusts (PCTs) and provided by other specialist health providers, are responsible for providing care for young people up until their 18th birthday but, as set out in the Children's NSF, some flexibility is required. Social care services have a responsibility for children and young people up to the age of 18, but have ongoing responsibilities where children have been in care. (Transition between child and adult services is a critical issue, which is covered in more detail in paragraphs 7.64 to 7.74.)

1.11 We also looked at all aspects of mental health and psychological well-being, ranging from the protective factors and activities that help all children and young people to develop resilience and strong psychological well-being, to intensive specialised therapeutic interventions for those who are experiencing severe mental illness.

1.12 A particular focus of this Review has been the mental health needs of vulnerable children and young people (see **Annex E**). We know that action must be targeted here if we are to make an impact on the mental health and psychological well-being of the overall population. These children and young people may be vulnerable for a number of reasons, including:

- because their problems are hidden from the system – for example, refugees, those seeking asylum, travellers, those who are homeless and young runaways
- because their problems are not recognised or addressed due to discrimination or lack of awareness – for example, children from black and minority ethnic communities
- because of the presence of other serious conditions – as may be the case for children with learning difficulties or disabilities
- because their mental health needs (defined as ‘behavioural, emotional and social difficulties’ or BESD) result in problems with their educational progress
- because they are experiencing difficulties through abuse or neglect
- because they have needs in a number of areas and are at risk of falling between services – for example, children in care, teenage mothers and fathers, those in contact with the youth justice system, those with complex needs or those with a chronic illness.

Which services are we talking about?

1.13 Our remit has been to review progress in CAMHS, but we found that this means different things to different people. We have considered the plethora of services that have an impact on children’s mental health and psychological well-being, because all these services must recognise and optimise the overall contribution they make. Therefore:

- We have included early years settings, schools, colleges and primary health care services such as those provided by GPs and health visitors.
- We have also included services for children and young people that exist to help address specific needs and problems – for example, social care, youth justice and CAMH services.

1.14 These services are provided by many organisations and agencies within the public, private and third sectors. The Children’s NSF uses the term ‘CAMHS’ to apply to this broad spectrum of services. However, we found that, in reality, many universal and targeted services do not include themselves in this definition of CAMHS, or see CAMHS policy as applying to them. There is also a strong perception that specialist mental health services are not well integrated with the rest of children’s services – and we found evidence of this too. In our view, this means that children and young people are not always getting the full benefit of the policy reforms that already exist and different services are not working together as effectively as they could by addressing underlying issues and needs.

1.15 Therefore, in this Review:

- We use the term ‘children’s services’ to refer to the whole family of services that have a role to play in this area. This includes universal, targeted and specialist services (see **Box 2**, page 18). **Figure 2** (page 28) shows the wide range of services included in this definition.
- We use the term ‘CAMHS’ when referring to those services that have a specific remit to provide specialist mental health care for children and young people, and their families. These are referred to as Tier 2, 3 and 4 CAMHS as set out in the Children’s NSF and preceding policy documents.

Conceptual models

1.16 Within CAMHS, the four-tiered model has been used for over a decade to conceptualise the planning and delivery of mental health services (see **Box 1**). We recognise that this model is well embedded within the culture and the systems of health services. Across children's services more widely, there has been a more recent move to the concept of universal, targeted and specialist services (see **Box 2**, page 18). Both models are subject to local interpretation and differences in understanding, although they share the basic aim of helping people understand which services are available to everyone and which are available to some. It is important to note that, whichever conceptual model is used, a child may be receiving services in one or more of these categories at any one time. They may be delivered by public, private or third sector providers.

1.17 Although there were calls from some for the four-tiered framework to be abandoned in order for there to be consistency across all children's services, the tiers were referred to frequently during the course of the Review. They are also embedded in a number of existing policy documents and guidelines, and we felt that a lack of reference to them at this stage would increase rather than decrease any confusion over terminology.

1.18 We have come to the conclusion that there is no single way of describing the needs of children and young people with reference to the spectrum of services available. It would be helpful if, over time, care was taken at a central level to reach a consensus across all children's services about the single best conceptual framework to use and the way that all children's services fit into that framework, in order that greater consistency and clarity is achieved. We welcome the steps already taken in some local areas to bring



Box 1: The four-tiered CAMHS framework

Tier 1: Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.

Tier 2: Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

Tier 3: Services usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.

Tier 4: Services for children and young people with the most serious problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one area.

the different models into line and to adapt them for local use. Therefore we recommend that all local areas discuss, clarify and develop terminology that puts the needs of children, young people and families at the centre of their considerations, and gives local families a better understanding of what is available (see key recommendation at paragraph 6.26).

Is it just about services?

1.19 Although services are important, parents and carers are key to their children's mental health and psychological well-being. Their capacity to nurture and promote it is affected by many personal, family, social and economic factors. It is also affected by the access they have to good, local information, advice and services, and by the way these services work with them to meet their needs and support their children. This is crucial in

determining how effectively their children's needs are met.

1.20 All parents and carers should be able to access the good advice and support that is currently available to some, in some parts of the country. Children and young people, too, need to be able to take responsibility for their own well-being and that of others, and to be supported to do this.

What difference do we hope to achieve?

1.21 Improving the mental health and psychological well-being of all children and young people can help realise the Children's Plan¹ ambition "to make England the best place in the world to grow up in". Our vision is that the recommendations in this report will enable a number of important changes to take place over the next three to five



Box 2: Universal, targeted and specialist

Universal services work with all children and young people. They promote and support mental health and psychological well-being through the environment they create and the relationships they have with children and young people. They include early years providers and settings such as childminders and nurseries, schools, colleges, youth services and primary health care services such as GPs, midwives and health visitors.

Targeted services are engaged to work with children and young people who have specific needs – for example, learning difficulties or disabilities, school attendance problems, family difficulties, physical illness or behaviour difficulties. Within this group of services we also include CAMHS delivered to targeted groups of children, such as those in care.

Specialist services work with children and young people with complex, severe and/or persistent needs, reflecting the needs rather than necessarily the 'specialist' skills required to meet those needs. This includes CAMHS at Tiers 3 and 4 of the conceptual framework (though there is overlap here as some Tier 3 services could also be included in the 'targeted' category). It also includes services across education, social care and youth offending that work with children and young people with the highest levels of need – for example, in pupil referral units (PRUs), special schools, children's homes, intensive foster care and other residential or secure settings.

years, to improve children and young people's mental health and psychological well-being:

- Everybody will recognise the part they can play in helping children grow up, have a good understanding of what mental health and psychological well-being is and how they can promote resilience in children and young people, and know where to go if they need more information and help.
- Children's services will work effectively together to provide well integrated child- and family-centred services that address mental health and psychological well-being. As part of this:
 - universal services will play a pivotal role in promotion, prevention and early intervention
 - specialist services will deliver support that is easy to access, readily available and based on the best evidence.
- Staff across these services will have a clear understanding of their roles and responsibilities and those of others, and have an appropriate range of skills and competencies.

1.22 Children and young people will say we are successful if:

- the places they go to every day – like schools, colleges and GP practices – recognise the importance of mental health and psychological well-being and are able to identify issues early and address them effectively
- they can access services before things reach crisis point
- they have the information, tools and support to 'navigate the system'
- we listen to them and involve them in any services provided

- they have the opportunity to develop trusting, ongoing relationships with one or two key individuals
- they are treated as individuals with a range of strengths and needs, and as members of their wider families.

What is the current picture?

The mental health of children and young people

1.23 There is mixed data on the well-being of children and young people in England compared with other industrialised countries. The World Health Organization asked 11, 13 and 15 year olds in Europe how satisfied they were with their lives, as this measure is seen as an important aspect of well-being.⁴ In line with the trend in other European countries, girls in England showed a decline in levels of life satisfaction between the ages of 11 and 15, while the ratings for boys remained broadly the same. Overall, satisfaction levels among English children and young people were around the average for Europe as a whole. A more wide-ranging study by UNICEF, which took into account economic, health and educational data as well as the responses of children and young people to questions about friendships, family, risk-taking behaviours, enjoyment of school and life satisfaction, found that child well-being in the UK was lower than in 20 other industrialised countries (most of them European, but also including the United States).⁵

1.24 In general, there is a lack of consistent national data on the overall psychological well-being of children and young people in England, and also on the prevalence of 'lower-level' mental health problems that do not meet the criteria for a clinical diagnosis. However, there is data on the prevalence of diagnosable mental health problems and disorders, and this shows that overall prevalence has increased since the 1970s.⁶

Between 1974 and 1999 there was evidence of a significant increase in conduct problems for both genders, with an increase in emotional problems between 1986 and 1999.

1.25 The most comprehensive statistical survey of the prevalence of mental disorders in Great Britain⁷ found that, in 2004, 10% of children and young people aged between five and 15 had a clinically diagnosable mental disorder that is associated with “considerable distress and substantial interference with personal functions” such as family and social relationships, their capacity to cope with day-to-day stresses and life challenges, and their learning. Prevalence rates varied according to a number of characteristics, in particular:

- gender, with problems more common in boys than girls
- age, with problems more common among 11 to 15 year olds than five to 10 year olds.

1.26 The majority of these fell into the categories of emotional, conduct or hyperkinetic disorder. One per cent had a variety of less common disorders such as autistic spectrum disorder or an eating disorder.

1.27 A sample of the children from this survey was followed up over the three-year period from 2004 to 2007, to find out more about the factors likely to be associated with the onset or persistence of disorders:⁸

- Children who face three or more stressful life events, such as family bereavement, divorce or serious illness, are three times more likely than other children to develop emotional and behavioural disorders.
- Some 3% of children who did not have an emotional or behavioural disorder in 2004 had developed one by 2007. The

factors most commonly associated with emotional disorders were serious physical illness, stressful family situations and their mother’s mental health.

- Nearly one third of children diagnosed as having emotional disorders in 2004 still had them in 2007, with family, household and social characteristics again strongly linked to persistence. Children who lived in rented accommodation were more likely to have a persisting emotional disorder than those who did not.
- Around 43% of children and young people who had been assessed with behavioural disorders in 2004 still had them in 2007, with persistence linked with household tenure, parents’ educational attainment and occupation, and number of children in the family.

1.28 Many children will have mental health problems that are less severe and more likely to be short-lived, but which may nonetheless affect their psychological well-being and be of concern to themselves, their families and their friends. Those who live in families with a low household income, with no parent working or with a lone parent are more prone to have a diagnosable disorder. It is important to emphasise that these are associations and not necessarily direct causes, as the majority of children and young people in these circumstances grow and develop without difficulties. There are similar associations between mental health outcomes and poor educational attainment, absence from school, exclusion from school and lack of friendship networks.

1.29 In addition, there are some children and young people who are significantly more likely to experience mental health difficulties than the general population:

- Nearly 50% of children in local authority care have a clinically diagnosable mental health disorder, compared with 10% in

the general population.⁹ This increases to nearly 70% among children living in residential care.

- Children in special schools for behavioural, emotional and social difficulties (BESD schools) or PRUs are significantly more likely to experience mental health difficulties than the general population.
- Over a third of children and young people with an identified learning disability also have a diagnosable psychiatric disorder.¹⁰
- A high proportion of children and young people in contact with the youth justice system have a mental health problem (approximately 40%).¹¹ This rises to more than 90% for those in custody.¹² These children and young people are vulnerable for many reasons. For example, they tend to be exposed to multiple risk factors; frequently have more than one disorder (including more 'stigmatised' disorders such as emerging personality disorder or inappropriate sexual behaviour); frequently miss out on universal promotion and preventive services; and engage with the system at a point that does not offer the most appropriate treatment and placement solutions for mental health problems.
- Children and young people with physical disabilities are twice as likely to develop psychological problems as those without,¹³ as are those who experience serious or chronic illness.⁸
- Teenage mothers are three times more likely than older mothers to suffer post-natal depression and mental health problems in the first three years of their baby's life.¹⁴

1.30 Our literature review found that the data in relation to children from black and minority ethnic groups is inconsistent and at times contradictory, though there appear to be differences in prevalence

rates between different minority ethnic groups. Factors such as discrimination, racism, stress, low self-esteem, socio-economic disadvantage and the experience of seeking refuge or asylum may all exacerbate mental health problems.¹⁵ Two risk factors relevant to some young people are academic failure and low self-esteem. For example, black young men are three times more likely to be excluded from schools than their white counterparts and are also five times less likely to be seen as gifted.¹⁶ Young people who are lesbian, gay or bisexual may be more vulnerable to self-harm, suicide and bullying, though there is currently a lack of robust evidence.¹⁷

1.31 The mental health needs of children and young people are different at different stages in the life cycle. As the Child Health Promotion programme¹⁸ notes, pregnancy and the first years of life are a critical stage, when the foundations of future health and well-being are laid down. While it has been acknowledged for some time that this phase strongly influences outcomes in later life, new information from neurological research reinforces the importance of early intervention to reduce the impact of stress in pregnancy and to promote attachment. This is particularly true for children who are born into disadvantaged circumstances. At the other end of the age spectrum, adolescence – a distinct developmental stage in its own right – is characterised by dramatic physical and neurological changes.

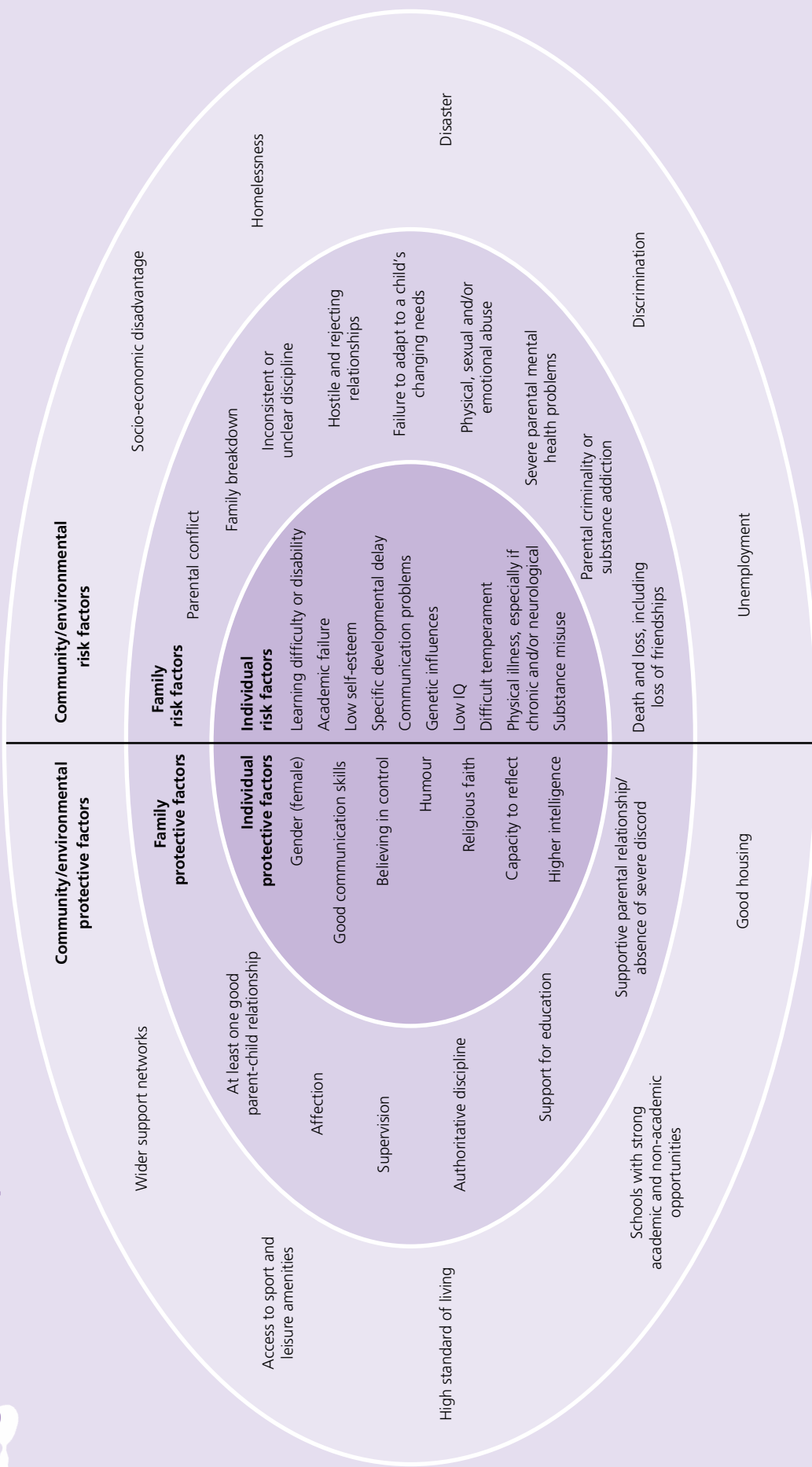
1.32 This important knowledge should be used across services, to help them remain alert to possible difficulties and to make appropriate provision, for example during the transition to adult services. It can also be useful for families who are looking for information and support to help them help their children.

Risk and resilience

1.33 Children and young people who contributed to the Review were asked to



Figure 1: Risk and protective factors



Sources: Audit Commission, 1999 and Mental Health Foundation, 1999¹⁹

describe what 'made them feel good inside' or what things they thought were important for children and young people's well-being. Three factors were consistently mentioned:

- having good support networks – across family, friends and school
- being able to do things they enjoy – ranging from sports and community-based activities, to having time with family and friends, and time to relax
- building self-esteem – in particular by having their achievements recognised and by having goals to work towards.

1.34 Conversely, difficulties or lack of opportunity in these areas can negatively affect the way that children and young people feel about themselves and their lives. This gives useful information to families, service planners and providers about the type of protective factors that children and young people themselves say are important to them.

1.35 In addition, research has given us a clear picture of a range of factors that are statistically associated with poor mental health outcomes ('risk factors'), as well as 'protective' factors that are associated with good outcomes (see **Figure 1**). These risk factors **increase** the likelihood of poor mental health outcomes. They do not necessarily **cause** them. The relationship between factors and outcomes is complex, and the two may influence each other. As the number of risk factors increases, so the likelihood of a child experiencing mental health problems increases dramatically – they have a far more adverse effect when they are combined.²⁰ However, not all children facing the same risk factors will develop problems; some will be more resilient than others because of other, protective factors in their life. Using this considerable body of knowledge can help to reduce the likelihood of problems arising and to both recognise and

accurately identify difficulties when they do occur.

Policy and funding

1.36 There is a broad policy framework in place for supporting mental health and psychological well-being across children's services. This is the result of numerous developments across health, education, social care and youth justice since 1995, when children's mental health issues were first directly addressed in *A Handbook on Child and Adolescent Mental Health*²¹ and *Together We Stand: The commissioning, role and management of child and adolescent mental health services*,²² with the proposal for a four-tiered framework as a basis for planning, commissioning and delivering CAMHS. The main policy driver at present is the Change for Children programme, as set out in Every Child Matters and the Children's NSF.

1.37 A short history of these and other policy developments is included in **Annex B**. It is notable, however, that policies have not always been developed on a joint basis nationally, or implemented on a joint basis locally, as the analysis in subsequent chapters will show. The implication of this is unhelpful tension between services, disjointed support for children, young people and families and missed opportunities.

1.38 These developments have been accompanied by significant growth in funding for CAMHS. According to the CAMHS mapping data,²³ spending on CAMHS increased by 62% between 2003/04 and 2006/07, from £322 million to £523 million. In 2007/08 the NHS received an additional £31 million for 17 projects to provide appropriate inpatient care for children and young people. There has been increased provision of CAMHS in young offender institutions, accompanied by additional annual funding of £1.5 million in 2007/08 and 2008/09. There has also been substantial investment in other initiatives – for example the Behaviour and

Attendance programme, the innovation projects for the Children's NSF, a range of parenting projects and the Targeted Mental Health in Schools programme – all of which contribute to improving aspects of mental health and psychological well-being.

Progress since 2004

1.39 The intention of the Change for Children programme is to achieve a broader ownership of all aspects of the lives of children and young people, including their social, educational and health needs, across all agencies and to improve outcomes through much earlier intervention. It is evident that a great deal has been achieved since 2004 as a result of this:

- some areas have very effective Children's Trusts in place, with full co-operation between education, health and social care
- an increasing number of areas have joint strategies and joint commissioning of services to support mental health and psychological well-being.

1.40 However, this is not the case everywhere across the country. Provision within and across local areas is variable, in part because there has been only a limited strategic emphasis on the way in which the whole agenda for children's services – across health, education, social care and youth justice – can jointly prioritise mental health and psychological well-being, and work together to achieve intended outcomes. The individual contributions that different services make to supporting mental health and psychological well-being are discussed in more detail in **Chapters 4, 5 and 6**. The following gives a brief overview of progress across the board.

Progress across children's services

1.41 There has been considerable progress in the development of a number of children's services that have an impact

on mental health and psychological well-being, including the significant expansion of Sure Start children's centres and a new universal entitlement to high-quality early years provision. The Child Health Promotion programme published in 2008 has also provided a new impetus to universal preventive services in the early years.

1.42 There has been a strong focus on helping parents develop their skills. Programmes designed to improve parenting are now a feature of children's services, often commissioned through the voluntary sector. The role of the recently established National Academy for Parenting Practitioners²⁴ is to enhance the level of training available and support the wider introduction of well-evidenced interventions.

1.43 For children of school age, there are many aspects of provision that have developed rapidly over recent years and which are making an important contribution to mental health and psychological well-being. Examples include extended schools, aspects of the Behaviour and Attendance programme (including Behaviour and Education Support Teams) and the Social and Emotional Aspects of Learning (SEAL) programme, which are becoming well established, although it is too early to demonstrate sustained impact. More than 95% of schools nationally are now involved in the National Healthy Schools Programme and over 60% of schools (covering around 3.7 million children and young people) have achieved National Healthy Schools Status. The Targeted Mental Health in Schools pathfinders have also been established, and the programme will be expanded over coming years. However, there is little consistency between schools, so parents, children and young people are finding that levels of support and understanding differ widely. This may be one of the factors behind the variation in exclusion rates between schools in similar circumstances. (See **Annex B** for more information on

these and other policies.) Special schools and PRUs have also benefited from these developments and have shown some improvement.

1.44 Since 2006, services for young people have become more closely integrated, in line with the broader Every Child Matters agenda. In particular, there has been a focus on the development of Targeted Youth Support in each local area. One of its stated aims is to address the risk factors that can result in poor outcomes, and to build young people's resilience. The programme is delivered collaboratively through a range of services, including education welfare, behaviour support, Connexions, youth services, social services, drugs and alcohol, sexual health, mental health, housing support, school nurses and youth offending services. They work in conjunction with the services that young people go to every day for their learning and work opportunities, for example further education and training providers.

1.45 There have been improvements in services for children in care and care leavers, including better planning arrangements, greater placement stability, fewer out-of-area placements and more effective health and well-being monitoring.²⁵ All of these aspects are important to the mental health and psychological well-being of this vulnerable group of children and young people. However, despite these overall improvements, inspectors have identified the need for further work in a number of areas and aspects of provision, for example placement choice and educational attainment.

1.46 Services to deal with substance misuse and associated problems have been strengthened, with a number of CAMHS consultants now being funded by substance misuse commissioners. In addition, areas are increasingly taking a joined-up approach to commissioning services, with some children's commissioners taking an overview of

CAMHS, substance misuse, youth offending and teenage pregnancy services.

Progress within CAMHS

1.47 Many areas now have multi-agency CAMHS partnerships, which have provided a more strategic focus on service developments. In the most successful examples, CAMHS are operating as an integral part of children's services provision, with straightforward assessment arrangements, better training for all staff to improve universal services, coherent access routes based on the priority of the child's need and the delivery of services in a way that makes most sense to children, young people and their families.

1.48 Some specific developments in local CAMHS provision between 2005 and 2007²⁶ have been:

- an increase in the number of local authorities reporting fully comprehensive provision for children and young people with complex needs (from 23% to 53%)
- a 14% fall in the number of children and young people waiting to be seen, with shorter waiting times as well
- a 20% increase in the number of targeted and dedicated worker teams with a focus on looked-after children and social care
- an increase in the provision of 24/7 on-call services with a CAMHS response (from 44% to 56%)
- an increase in the number of CAMHS reporting appropriate care for young people aged 16–17 (from 56% to 90%)
- an increase in CAMHS for children and young people with learning disabilities and mental health problems (with 87% of services now having this provision)
- overall increases in the size of the workforce and mental health being

identified as a focus of work by a broad range of universal and targeted services

- a slowdown in the development of services at Tiers 2 and 3, and a mixed pattern of both improvements and slight reductions in some services across the country
- more Tier 4 services providing alternatives to inpatient care on an intensive outreach basis, and more units providing secure inpatient mental health care for young people who have committed serious offences and who have a severe mental disorder.

1.49 As these figures show, there are still significant variations and inconsistencies across the country. An NSF progress report in 2006²⁷ highlighted the key areas that commissioners and service managers would need to focus on to achieve their 10-year objectives. These covered a number of aspects, including:

- early intervention, prevention and primary care
- bed provision
- paediatric liaison²⁸
- services for children with complex, severe and persistent conditions
- services for looked-after children
- CAMHS and youth justice
- delivering race equality
- workforce development.

Conclusion

1.50 Although there have been considerable service improvements and much progress in the collaboration between agencies across the country, unacceptable variations and gaps still need to be addressed. Children, young people and families are still waiting too long for interventions from more specialised children's services, including CAMHS. The documented differences between services at both local and regional level cannot be explained solely on the basis of differing levels of need, and the resulting inequalities in provision must be tackled at all levels and across the full spectrum of children's services.

1.51 Finally, it has not been possible to monitor improvements in outcomes for children and young people and to quantify the differences that services make to their lives. Reliable, routine outcome measurement and data collection is a complex task that is only just beginning to be undertaken by many services. Ultimately, improving outcomes for children and young people is what matters most, and we hope that the analysis and recommendations in this report will enable the Government and regional and local services to take the next steps toward achieving this.

Everybody's business: leadership

2.1 Everybody has a responsibility to make sure that children and young people have good mental health and psychological well-being as they grow up. Anyone working directly with children and families needs to ask themselves regularly 'what can I do to improve the mental health and well-being of this child?' If things go wrong, families need advice, help and support quickly. They need this from people who know what works or what can help, and who work as part of a united local effort to address problems early on. Underpinning this approach is a need for all practitioners to understand and respect each other's role and responsibilities and be able to rely on each other. There is also a need for the whole community to understand mental health issues, and to know they can be discussed without reinforcing stigma.

2.2 We have seen, and been given, many examples of people and programmes working in this way, with some success. These have formed the basis for our recommendations in this and subsequent chapters, which in turn will help to drive the cultural change necessary for achieving our vision for greater 'ownership' of mental health and psychological well-being issues and more responsive services for all children, young people and families.

Who's involved?

2.3 As the Children's Plan noted, **parents** bring up children, not governments or local services. This has been echoed throughout the Review. Many participants have emphasised the central role parents and carers play in nurturing and supporting their children's mental health

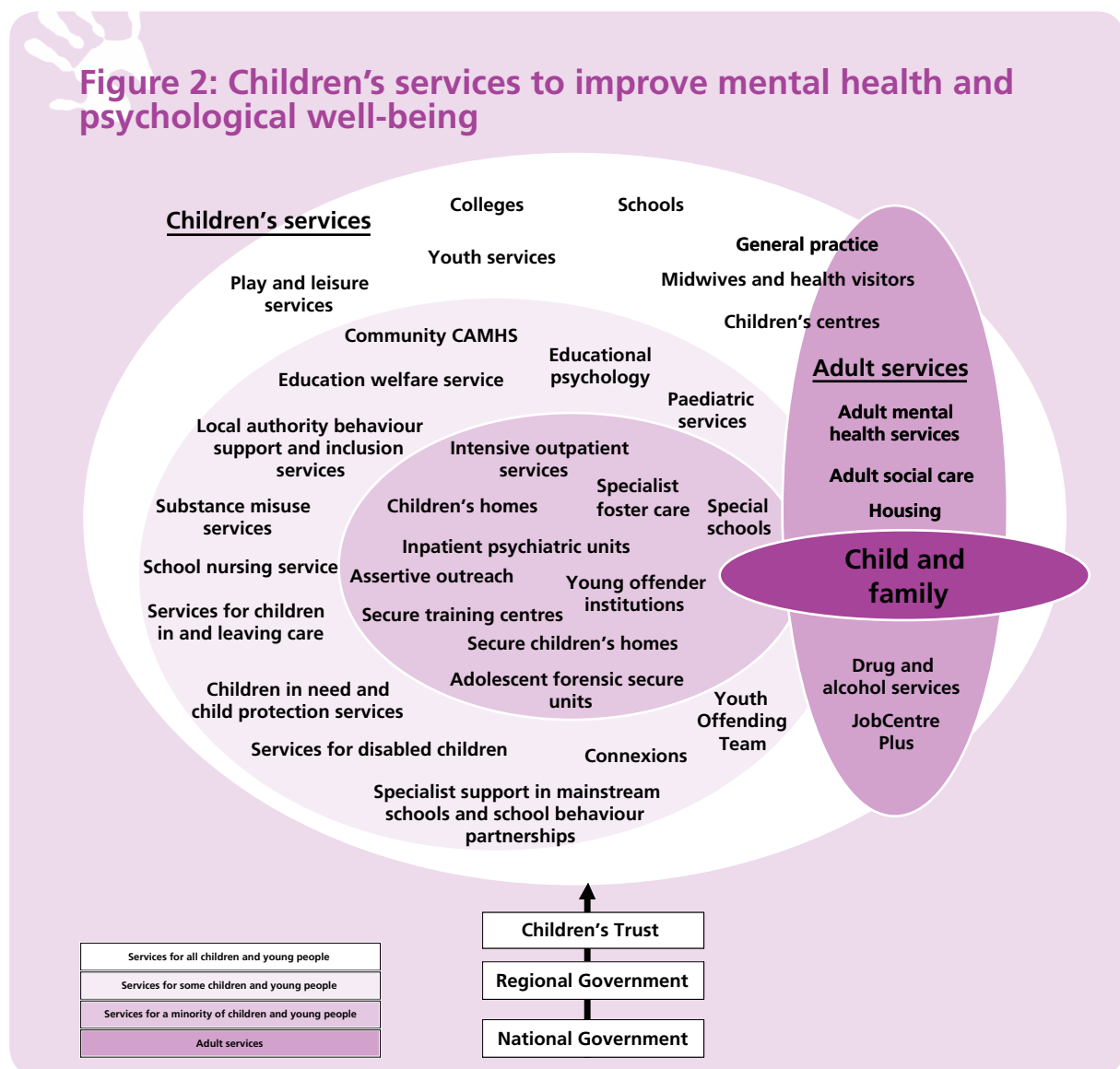
and psychological well-being. At the same time, the capacity of parents and carers to do this is influenced by their access to – and confidence in – local services.

2.4 The **community** and the **media** also play a role in improving children's mental health and psychological well-being. In recent years there have been a number of campaigns promoting greater awareness of mental health problems in adults, for example by the Royal College of Psychiatrists, the Mental Health Foundation and SANE. Most recently, the Time to Change campaign has been launched, billed as the most ambitious programme to end discrimination faced by people with mental health problems, and informed by international evidence on what works. Recent television documentaries have helped to tackle the stigma associated with adult mental illness and, periodically, soap operas address the challenges as well. However, action to promote awareness of children's mental health issues remains limited, and there has been little analysis of the role that the wider community – including the public and local amenities – can play in promoting mental health. At the same time, the young people that we spoke to expressed dismay at the negative stereotyping of young people in some areas of the media. *We would like to see the press in particular consider more carefully their responsibilities when reporting on stories of suicide, self-harm and young people with behavioural difficulties.*

2.5 In every area, a **diverse range of services** is involved in supporting the mental health and psychological well-being of children and young people (see **Figure 2**). These services are often involved in significant programmes of work to improve outcomes for children and young people in different priority areas. However, they may not always recognise the important contribution this work makes – or could make – to improving mental health and psychological well-being. And they may not be attuned to related work that other agencies are doing, often with the same children and young people.

2.6 The **Government**, at regional and national level, sets the legal and policy framework for delivering and monitoring all aspects of provision around mental health and psychological well-being.

2.7 **Figure 2** illustrates the breadth of provision available to support mental health and psychological well-being, and to highlight the scale of the challenge in getting all services to work more effectively together. It covers provision made by the private, voluntary and public sectors. This is not a definitive statement of where different services ‘fit’ in the jigsaw. That is a matter for local analysis and discussion.



Strategic leadership

What we found at local level

2.8 Our visits highlighted the developing role of the Children's Trust as a strong catalyst for change across children's services. All Children's Trusts are expected to produce a multi-agency CAMHS strategy, convene multi-agency steering groups and put in place joint commissioning arrangements. In the areas we visited, commissioners and senior managers felt that they were going in the right strategic direction but had not yet achieved their goals for delivering effective and comprehensive services to promote children's mental health and psychological well-being. Factors supporting the development of an effective strategic approach include:

- strong partnerships
- clear leadership that is respected across the full spectrum of services
- a commitment to a multi-agency approach
- good links to the wider Children's Trust agenda
- the close involvement of providers in developing strategy.

2.9 None of the areas we visited or which responded to our consultation would claim to have a fully comprehensive strategy in place for improving mental health and psychological well-being. However, a number of common features emerge in the areas that seem to be making a positive impact:

- involvement of universal services alongside CAMHS and other specialist services
- emphasis on promotion, prevention and early intervention
- mechanisms for multi-agency working at all levels
- plans for addressing all levels of need, including those children and young people with severe, complex and persisting mental health disorders
- a culture of involving children and families in service design and delivery.

2.10 In general, strategies focus on the mechanisms for delivering services. In many areas, accountability remains unclear, with parents in particular uncertain about who is responsible for ensuring that their children get the right support. Areas noted the importance – and the challenge – of moving to an outcomes-focused approach, structured around a strong needs assessment and



Practice example: Developing a local strategic approach

A multi-agency approach to the leadership and delivery of CAMHS in Area B is widely seen as a key supportive factor. Though, as in all multi-agency partnerships, there are tensions and challenges that need to be addressed from time to time, people reported a genuine commitment to working co-operatively and openly to share ownership of, and responsibility for, the mental health and psychological well-being of children and young people locally. But this has not happened overnight – it has taken a number of years to develop the strategic framework, based on several rounds of needs assessments, service mapping, stakeholder consultations and other joint exercises.

locally identified outcomes for children and families. This is covered in **Chapter 7**.

2.11 To improve leadership and accountability, there needs to be a clearer articulation of roles and responsibilities for all relevant people working in children's services at local, regional and national level. The three recommendations in this chapter aim to address this.

2.12 **Key recommendation:** The legislation on Children's Trusts should be strengthened so that each Trust is required to set out in its Children and Young People's Plan how it will ensure the delivery of the full range of children's services for mental health and psychological well-being across the full spectrum of need in its area. We would recommend that areas set up local multi-agency boards for children's mental health and psychological well-being, or other appropriate local arrangements to facilitate this.

Remit of the proposed local board

The remit of the proposed local board for children's mental health and psychological well-being (or equivalent) should be to inspire, lead and inform local efforts to improve children's mental health and psychological well-being. This should include ensuring effective commissioning of high quality services, improving access, overseeing implementation and service improvement, and monitoring practice and outcomes. The board should be responsible for ensuring that there is an assessment of the mental health and psychological well-being needs of local children for the Children and Young People's Plan. It should also oversee the impact of the strategic approach to improving outcomes for mental health and psychological well-being, as set out in the Children and Young People's Plan.

What we found at regional level

2.13 Strategic health authorities (SHAs) manage the performance of PCTs and are a key link between the Department of Health (DH) and the NHS. They have responsibility for planning service improvements and improving capacity within health services in their area. Government offices (GOs) represent 11 Whitehall departments in the regions, including the Department for Children, Schools and Families (DCSF). Their role is to interpret new policies at a regional level and inform national policy colleagues of the strategic and operational issues arising from their implementation. Performance management and support for youth offending teams (YOTs) are provided via eight Youth Justice Board (YJB) regional teams, whose role is to advise, support and monitor, as well as to share emerging practice. These teams have close working relationships with GOs.

2.14 In addition, there are several support and advisory teams whose work has an impact on mental health and psychological well-being. The remit of these teams varies from service development, support and quality improvement to performance management.

- Those with a direct remit to support the development of services for children's mental health and psychological well-being are the National CAMHS Support Service (NCSS)²⁹ located within the Care Services Improvement Partnership (CSIP) and regional co-ordinators who support the implementation of the National Healthy Schools Programme.³⁰
- Those with a contributory remit include consultants working for the National Strategies Behaviour and Attendance programme;³¹ children's services advisers;³² regional advisers from the Training and Development Agency for Schools (TDA), which supports the development of targeted youth support teams, extended schools and school

remodelling;³³ and Together for Children, which is supporting local authorities in their delivery of Sure Start children's centres.³⁴

2.15 Key recommendation: At regional level, the Government should set out clear expectations for GOs and SHAs to deliver a coherent performance management and 'support and challenge' role to local areas which promotes a consistent approach to service improvement and delivery across all areas. We recommend that regional boards for child health and well-being are set up to carry out this role. These should include regional directors of public health.

Remit of the proposed regional board

The remit of the proposed regional board for mental health and psychological well-being would be to deliver improvements against the performance measures for mental health and psychological well-being, and to ensure the coherent alignment of support arrangements for mental health and psychological well-being at a regional level.

What we found at national level

2.16 There is a strong policy framework for children's mental health and psychological well-being, with action being taken in numerous areas (see **Annex B**). The markers of good practice set out in the Children's NSF remain highly relevant – they are a central reference point for all aspects of mental health service provision for all Children's Trust partners, although they are not always recognised as such.

2.17 Policy responsibility for children's mental health and psychological well-being is shared primarily by two departments – DH and DCSF, which have joint ownership of the delivery of the public service agreement on children's

health and well-being (Public Service Agreement (PSA) 12). The Ministry of Justice has responsibility for policy on the mental health needs of children and young people in the youth justice system. Other departments such as Communities and Local Government and Culture, Media and Sport also play a contributory role.

2.18 This spread, and in some instances joint ownership, of responsibilities can ensure that mental health and psychological well-being are given detailed and appropriate consideration across a range of policy areas. However, it can also lead to a lack of clarity and accountability in some policy areas, as well as perpetuating an operational and cultural divide between services funded through DH and delivered to the NHS via PCTs and other health trusts, and services funded through DCSF and delivered primarily via local authorities.

2.19 **Table 1** (page 32) sets out the core policy responsibilities of DH and DCSF in relation to children's mental health and psychological well-being. The policy implementation and delivery approaches of the two departments are very different, and we were informed on a number of occasions of the tensions this creates for local areas that are seeking to work in a more integrated way.

2.20 In the course of the Review, we considered whether policy responsibility for all aspects of mental health and psychological well-being should be located within a single government department. Many people suggested it should be. On balance, our view is that this would have unintended consequences. A holistic approach to all aspects of children's mental health and psychological well-being – from mental health promotion to highly specialist care – cannot be provided by one department alone, because of the specialist knowledge necessary, and the interdependency with a range of other specialist areas across Government. *However, in taking forward work to improve mental health and psychological*

well-being, the Government needs to act as though this work is being led by a single department. This will involve meeting the challenges of good partnership working and co-ordinating all children's policy development more effectively. This will achieve greater consistency, be less confusing for those working at regional and local level and give better emphasis to the support Children's Trusts need for the challenges of implementation.

2.21 In addition, some core aspects of the Government's work are channelled through arm's-length organisations such as the TDA and the National Institute for

Health and Clinical Excellence (NICE). We would urge the Government to ensure that its policy messages and priorities regarding children's mental health and psychological well-being permeate these bodies with the same coherence and co-ordination that is expected across departments, regional government and local bodies.

2.22 There are also structural and policy changes, particularly in the NHS, that are likely to have an impact on the way in which services work together to improve children's mental health and psychological well-being. The greater freedoms for local health services as a result of foundation

Table 1: National policy responsibilities

PSA 12: Improving the health and well-being of children and young people

Co-ordinating the delivery of PSA 12 (to improve the health and well-being of children and young people) is the responsibility of the Secretary of State for Children, Schools and Families, with the Secretary of State for Health the key partner. DCSF and DH are each required to take action to prioritise child health and well-being, to reflect the contents of this and other relevant PSAs in their departmental planning and in the Operating Framework for the NHS, and to carry through these priorities into their discussions with local delivery partners. In practice, this responsibility is exercised through a jointly chaired PSA board and its sub-board on Child Psychological Well-being and Mental Health.

Department of Health

Department for Children, Schools and Families

- Joint responsibility for children and young people's mental health and psychological well-being policy, with particular responsibility for health services and public health.
- Other policy areas have a contributing interest, including NHS workforce and training, research and development, information sharing, offender health, children's physical health services and adult mental health.
- DH also has policy responsibility for arm's-length bodies such as NICE and the Medicines and Healthcare Products Regulatory Agency (MHRA).

- Joint responsibility for children and young people's mental health and psychological well-being, with particular responsibility for children's services.
- Other policy areas have a contributing interest, including early years provision, schools, safeguarding, children's workforce and training, the well-being of looked-after children, youth services and targeted youth support.
- DCSF also has policy responsibility for arm's-length bodies such as the TDA, the National Strategies and Together for Children.

trusts and practice-based commissioning³⁵ are intended to provide better quality and choice for service users, and to encourage more partnership working between foundation trusts, PCTs and local authorities, in line with local strategies for health and well-being. They will also put a greater focus on the measurement of outcomes. Some respondents have talked to us about the risk that some GP practices may still commission services independently, particularly when partnership working in this area can be so complex and time-consuming. Others are concerned that the move to foundation trust status will make it more difficult for mental health specialists in these trusts to provide consultation support to practitioners in other services. In addition to the recommendations we make in **Chapter 7**, *we advise the Government to ensure that all relevant aspects of the NHS contract work to secure effective integrated practice – in both commissioning and service delivery – in order that all areas can deliver the access to support for mental health.*

2.23 At national level, neither children and young people who have experienced mental health problems nor their parents or carers have a 'voice' (for example in the form of a service users' forum). This contrasts with the positive developments we have seen in recent years around young people's participation more generally, for example through the work of the National Children's Bureau and the establishment of bodies to provide a forum for certain groups, most notably children in care. This may be because of the stigma that continues to be associated with mental health problems. *We would like the Government to explore whether a national organisation, run by parents, carers and children and young people, could be established to represent the interests of children and young people with mental health and psychological well-being needs.*

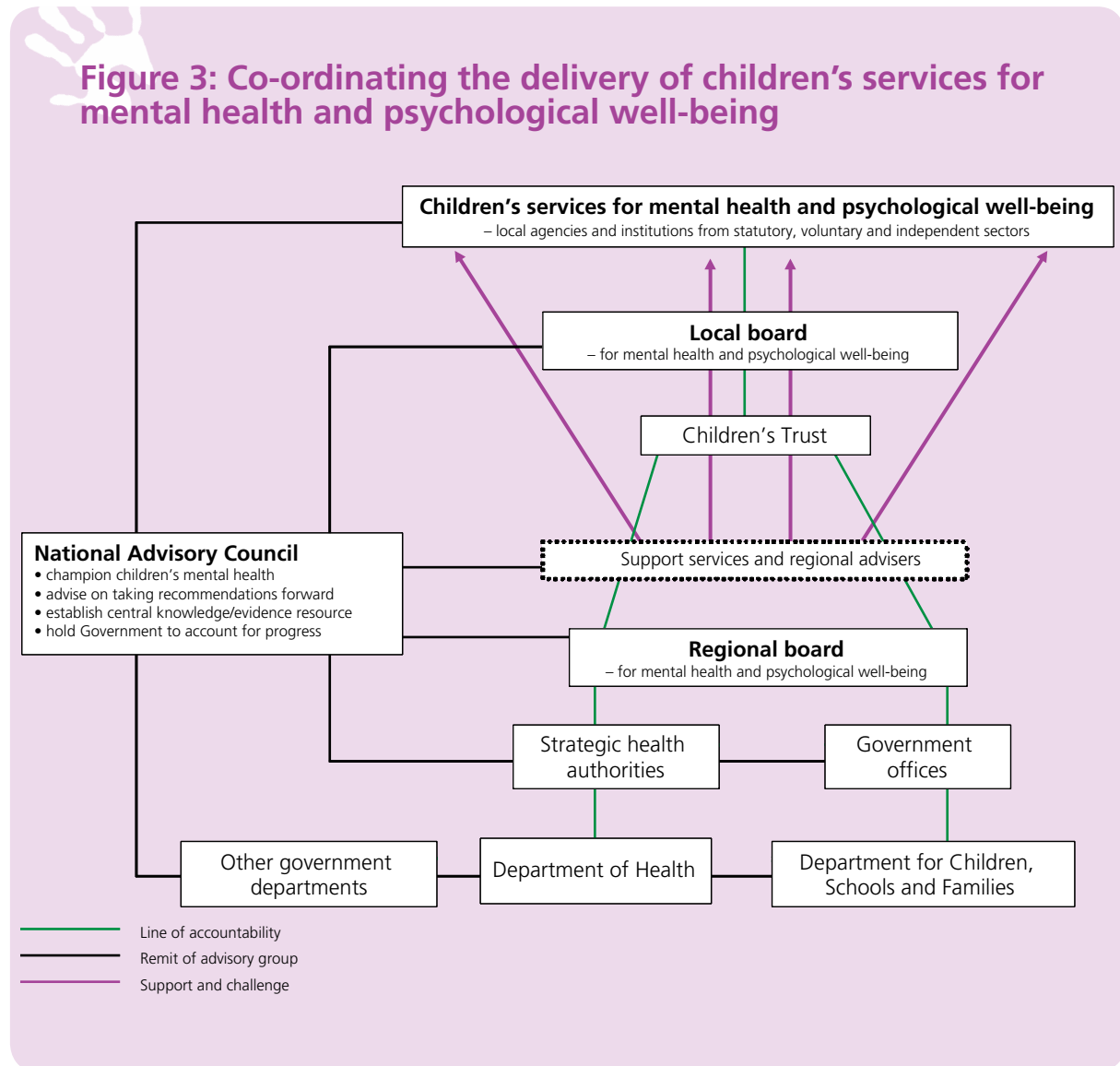


Practice example: Involving children and young people

In Area A, more than 500 children and young people have participated in a range of consultation and engagement activities to inform the development of children's services. Participation is sought at a range of levels. At strategic level, Voices in Action is a diverse group of 11 to 19 year olds who shadow the work of the Children's Trust. They have the opportunity to attend all key sub-groups and partnerships, including the CAMHS Partnership. When the executive group meets, the agenda is developed in order that any business that is unrelated to key decision-making about children and young people's services is dealt with first. Children and young people are then invited to attend the remainder of the meeting, in which they can be fully involved. At a locality-based level, all schools in the area now have a schools council. And at an individual level, children and young people using CAMHS are asked to provide feedback at the end of their experience of care. As is widely recognised, there are some inherent difficulties in involving this group, given that they may not be involved with services for long enough to develop the kind of relationship required to encourage effective feedback. Other barriers to getting feedback on mental health and psychological well-being issues include a lack of capacity to undertake research and evaluation exercises.

2.24 **Key recommendation:** At national level, DH and DCSF should clarify and publicise their roles and responsibilities, communicate consistently to stakeholders and secure effective commissioning and performance management frameworks across all children’s mental health and psychological well-being services.

2.25 **Figure 3** shows how the recommendations for leadership arrangement at local, regional and national level will provide a greater joint focus on mental health and psychological well-being at all levels.



Everybody's business: what children, young people and families want

3.1 Children, young people and families have clear views about how services are currently helping them, and the way they would like services to be delivered in future. The points they made to us during the Review have been echoed in other reports, which suggests that there are some common issues across the spectrum of services that have not yet been adequately addressed. We have been particularly struck by the importance of services that can support parents and carers and help them secure the best outcomes for their children, as they have the central role in nurturing their mental health and psychological well-being.

Sources of support for children and young people

3.2 The children and young people we spoke to are clear about who they will turn to when they need help (see **Figure 4**). The fact that teachers are included in the 'inner circle' suggests that they are valued and trusted by many children and young people and therefore play a significant role in supporting mental health and psychological well-being. So, they need support and knowledge to do this effectively.

Attributes of effective services

3.3 Children, young people, parents and carers all said that they wanted more information about mental health and psychological well-being and wanted to be better informed about the places they could go to seek advice and support – especially when they were first concerned.

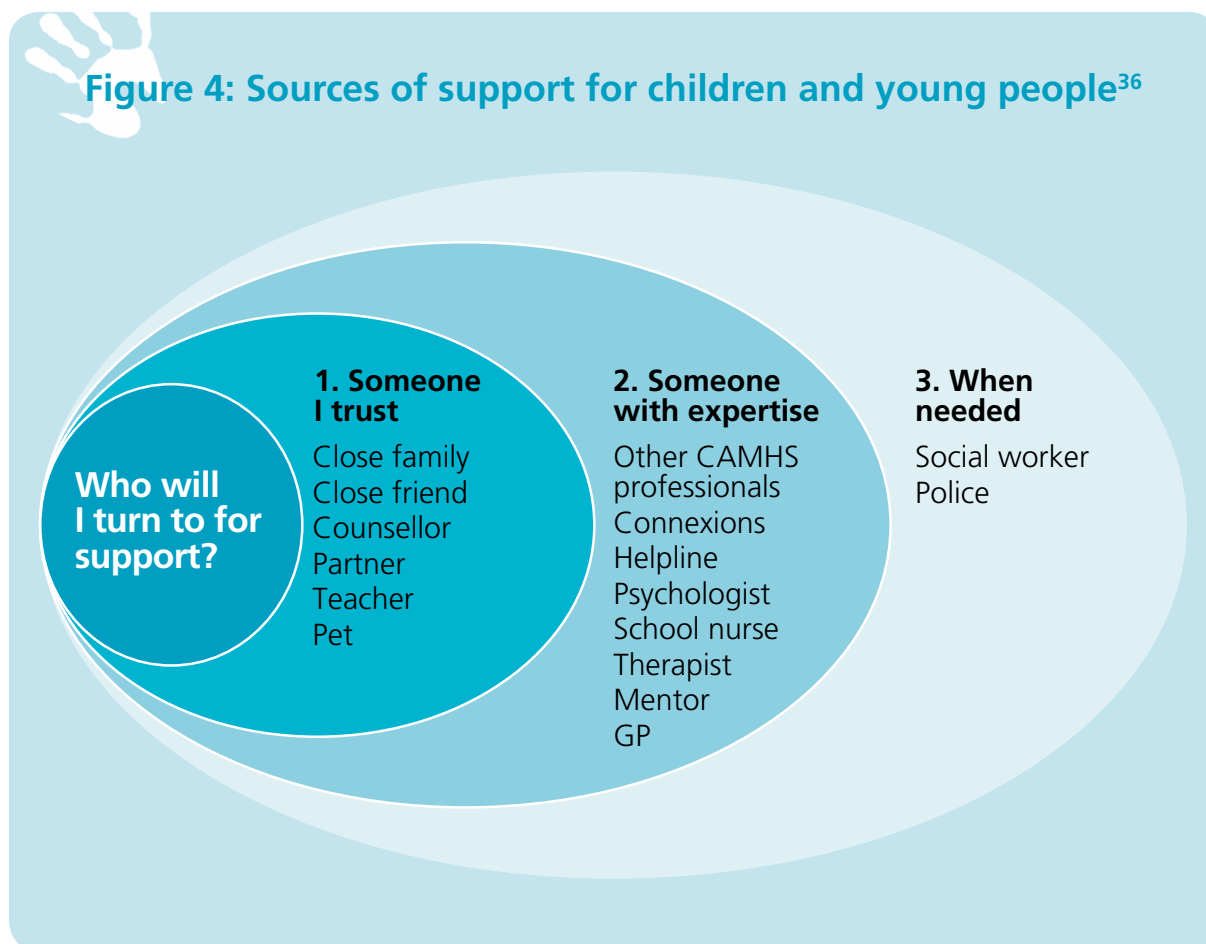
3.4 Parents and carers of children with mental health problems also told us they wanted to be able to support their child more effectively during their recovery and that they would benefit from help and advice to do this. This was seen as particularly important while the child or young person was waiting for treatment from specialist services, when the problem could be getting worse but no formal support could be accessed.

"Everything I got for my child I got on my own through me being pushy."
Parent/carer

3.5 Young people who are in vulnerable situations – for example, because they are in care or in custody – often have no constant adult in their life to provide emotional and practical support. They need and value information, advice and support in a number of areas. However, they want this to be provided in a co-ordinated way, because of the range of agencies potentially involved with them.

3.6 Children and young people were consistent about the qualities and features they would like to see across all services that promote mental health and psychological well-being. Their 'vision' for effective services is set out in **Table 2** on page 37, and is an integral part of the Review's vision for improving mental health and psychological well-being (see paragraph 1.22). In addition, children and young people contributed a range of questions to be asked of service providers during our

Figure 4: Sources of support for children and young people³⁶



area visits, and these could provide a useful starting point for local commissioners and managers of services (see **Annex D**).

3.7 These views are consistent with findings from wider research studies with children and young people, including recent ones such as the Good Childhood Enquiry.³⁷ The challenge for services lies in embedding these priorities in service design and provision, and in demonstrating to children and young people that their priorities have been taken seriously. The opportunity for all services lies in the relatively straightforward nature of the issues that children, young people, parents and carers would like to see addressed.

3.8 If the recommendations listed throughout this report are effectively addressed, all parents, carers, children and young people throughout the country should have:

- a more positive understanding of mental health and psychological well-being as a result of national media activity
- up-to-date information, in a range of formats, about mental health and psychological well-being and what services are available locally to help them
- good telephone and web-based help and advice
- confidence that staff in the services they use every day:
 - understand child development and mental health
 - actively promote strong mental health and psychological well-being
 - use language that they understand
 - take them seriously
 - can identify needs early
 - can help them and can draw on support from others to make sure that needs are addressed.

Table 2: Features of effective services – as defined by children, young people and their parents and carers

Awareness

- more awareness in children’s centres, schools, colleges and GP practices about mental health; how to promote it and how to deal sensitively with issues that arise

Trust

- opportunity to build a trusting relationship with a known member of staff in schools, so that problems can be shared and discussed
- regular contact with the same staff in targeted and specialist services
- clarity over confidentiality arrangements

Accessibility

- services in convenient places
- information and advice available in a range of relevant formats and media
- single point of entry to specialist mental health services
- age-appropriate services

Communication

- being listened to and given individual attention, whichever service you are dealing with
- being spoken to in a straightforward way, with no technical jargon

Involvement

- being valued for the insight and experience you bring
- opportunity to discuss what services and interventions are available

Support when it’s needed

- services that are available when the need first arises, not when things reach crisis point
- services that stay in touch after support or treatment has finished and follow up any problems

Holistic approach

- services that think about you as an individual; for example, providing help with practical issues and addressing your physical health as well as your mental health

Summary of key findings from *Focus groups and interviews with children, young people, parents and carers*, conducted specifically for the Independent CAMHS Review Expert Group.

Everybody's business: promotion, prevention and early intervention

4.1 Universal services work with all children, including children and families with complex needs, often on a daily basis (see middle circle of **Figure 4**, page 36). After parents and carers, they play the biggest role in promoting mental health and psychological well-being. This comes about through the skills these practitioners have in building relationships with children and young people. Many health visitors, nursery nurses, youth workers, learning mentors, teachers and doctors have a lasting impact on children and families, helping them to build resilience, work through problems and access extra support when necessary.

4.2 Since 2004, there has been a more systemic approach to promoting mental health and psychological well-being in universal services, through some of the new initiatives described in the sections that follow. However, these are not yet comprehensively available and, in many cases, universal services feel that they do not have sufficient input from CAMHS or other services such as parenting support, social care or substance misuse services, who can work with them to develop skills, knowledge and confidence around key aspects of mental health and psychological well-being, and who have a critical role in providing specific intervention and support themselves.

How different services are carrying out their roles

Midwives

4.3 Midwives are generally the first point of contact with universal services for mothers and fathers to be, helping to prepare them for parenthood, identifying at-risk families and promoting the health and well-being of mother and child. While the Review found limited evidence on their role in relation to mental health care generally, the national evaluation of Sure Start³⁸ found that midwives are involved in the work of local partnerships to develop mental health support for mothers and fathers, reflecting the Sure Start target to identify and support mothers with post-natal depression. Midwives have a key role within the Child Health Promotion programme, and in a few areas are working in children's centres to deliver post-natal clinics. These are new developments, so there is currently little research evidence on their impact or how they are operating.

Health visitors

4.4 Health visitors work with all children from birth to age five and their families. The recent review of their role³⁹ showed that health visitors are strongly supportive of new developments such as working in children's centres, and also that they need more up-to-date knowledge in mental health promotion, parenting and neurological development. *To deliver our aim of ensuring a common focus on mental health and psychological well-*

*being, we support the recommendations of the review of health visitors to make the focus on early intervention, prevention and health promotion one of their priority areas.*³⁹

Early years provision

4.5 The establishment of a children's centre in every community by 2010 should secure universal support at this critical stage. This is creating new demand at this level of provision, as children's needs are identified earlier. The children's centre model provides an important example of child- and family-centred, multi-agency working, and offers lessons for services working with older children and families. In the areas we visited, a number had good links with CAMHS – for example, Tier 2 CAMHS workers attached to

children's centres and an early years mental health service using children's centres as a base for delivering preventive services.

4.6 Parents, carers, children and young people access a wide range of other services delivered by the statutory, third and private sectors in a variety of settings. *These providers also need to be able to promote mental health and psychological well-being, and access support, including support for staff development. This includes provision that is led by parents, such as parent and toddler groups and childminding. These services need to have good links with children's centres to understand what other support and advice is available locally.*



Practice examples: Provision in the early years

Pre-school children with behavioural, emotional or social difficulties in Area E have access to a Play Development Service, which works with parents and carers, childcare providers and health and social care practitioners to develop play-based learning and care. It helps parents and providers to understand the child's specific needs, promotes healthy parent-child interaction and builds better relationships through play. The team consists of educational psychologists and play development workers who work directly with children and families at home and in the childcare setting.

Area C has created a number of infant mental health worker posts to deliver services for parents and infants within children's centres and other early years settings. They work closely with specialist midwives, family-focused substance misuse workers and health visitors.

In Area D, midwives and health visitors work closely together so that mothers with, or at risk of, mental health problems can be supported in a sustained way, both before and after the baby is born. This work is primarily focused on attachment, with the aim of preventing further issues developing later. Through the Child Health Promotion programme, nursery nurses in the area are being trained in offering ante-natal classes, which focus on attachment and which aim to help parents understand the importance of a baby's emotional development. At the same time, there was a concern that these promotion and preventive services were not backed up by more specialist services to support families with very young children where specific problems had been identified.

Schools

4.7 After the family, schools are the most important organisation in the lives of the vast majority of children and young people. Research shows that the school setting has a significant impact on children's mental health and psychological well-being. Exclusions, absenteeism, achievement at school and the existence of special educational needs (SEN) can all be linked to the onset and persistence of a mental disorder.⁸

"In our class we have a bubble book... if you're sad then you can write your name in it and the teacher checks it every week and she talks to you privately about what is wrong with you and sorts it out."

Child

4.8 The way that a school is structured and run, and the resources that it has at its disposal, all have a significant impact on its capacity to promote mental health and psychological well-being. Recent initiatives (see **Annex B**) such as the duty on schools to promote well-being, the National Healthy Schools Programme, aspects of the Behaviour and Attendance programme, extended schools, the SEAL programme and the Targeted Mental Health in Schools programme share a common aim of developing the capacity of schools to promote well-being and to play a pivotal role in prevention and early intervention.

4.9 At the same time, much can be achieved through the individual interactions between students and school staff – a theme highlighted by the children and young people in our focus groups. Younger children in particular valued the opportunity to share a problem or concern with a trusted adult, for example through school-based strategies such as circle time.

4.10 Our visits to areas across the country confirmed that most areas see schools as

central stakeholders in efforts to promote mental health and psychological well-being. Initiatives such as those described above are not yet established in all areas, but they are generally viewed as beneficial. A number of areas noted that schools are becoming more responsive to the well-being needs of their pupils, though others said it was still a challenge to involve them in preventive and early intervention work. Our literature review suggests that many schools have access to consultation and advice through CAMHS, although direct work with children, young people and their families is less widespread, as is provision in BESD schools, which is of particular concern, given the nature of the needs of the children supported by these schools.

4.11 From all of these sources a number of common themes emerged:

- There is a wide variation in the approaches taken to promote and support mental health across schools.
- There is a shortfall of staff with the skills and confidence to deal with mental health issues.
- School staff are receptive to developing greater awareness and understanding of mental health issues and good working relationships with CAMHS staff.
- Children and young people think that schools should be more aware of mental health issues, as this will help remove associated stigma.

4.12 We also identified three barriers that are preventing some schools from realising their potential to promote and support mental health and psychological well-being:

- Some schools still see their role in fairly narrow terms.
- There is a tension between the crucial emphasis on driving up educational

standards and the broader focus required of work to improve mental health and psychological well-being.

- The significant changes taking place for 14 to 19 year olds – for example, where young people may be studying at different institutions – are not always being approached strategically by the range of partners that may be involved.

“At my school it would have been good if they’d had a training day or something so that they knew more about my condition.”

Young person

4.13 *There are a number of levers available to schools, Children’s Trusts and the Government which we suggest should be used to address these issues:*

- Through initiatives such as extended schools and behaviour partnerships there is both the scope and the incentive for schools to develop provision that is beyond their traditional role. The active involvement of schools in Children’s Trust arrangements will help these changes to have the maximum impact, in terms of drawing input from a range of providers.
- The revision to the Ofsted framework and the duty on schools to promote well-being will go some way to addressing the tensions between standards and a broader focus on well-being.
- The joint commissioning of provision for 14 to 19 year olds and the establishment of behaviour partnerships between schools, colleges and local Children’s Trusts provide scope for a more comprehensive and integrated approach



Practice examples: Provision for school-aged children

A locality-based approach forms the basis of children’s service provision in Area E. Each local partnership is centred on a cluster of schools, and brings together school staff, social care professionals, educational welfare officers, educational psychologists, SEN caseworkers and primary mental health workers in a ‘virtual team’. The partnerships may also include representatives from youth services, children’s centres, the police, voluntary and community organisations. Within the clusters, the primary mental health workers work directly with children and also help school staff, such as teaching assistants, look at ways in which they can promote mental health and psychological well-being. The posts are well regarded, although it is not yet certain whether schools will commit funding to these posts in the longer term. However they are becoming increasingly aware of the importance of promoting mental health and psychological well-being – for example, nearly all primary schools are introducing the SEAL programme.

In Area F, there has been a strategic focus in the last two years on developing capacity in schools through community CAMHS. This service operates from two primary school sites, and has recently integrated the local children’s counselling service. The service works with staff in schools to help them play a more active role in promoting mental health and psychological well-being. They have helped schools develop group-based approaches like the Incredible Years programme and the FRIENDS programme for children with anxiety-based difficulties.

to service provision – including better support for mental health and psychological well-being to support vulnerable students and to help them engage with their educational provision.

Colleges

4.14 The move from school to further education has been identified as a stressful transition point. In addition, the population of students attending further education colleges may be more vulnerable than other groups to emotional and mental health problems.⁴⁰ This suggests that there is an important role for promotion and preventive work on mental health and psychological well-being across all aspects of college life. However, unlike guidance issued to schools, guidance issued to the further education sector has tended to focus on meeting the needs of students with identified problems, rather than on the need to adopt a ‘whole college’ approach. This is reflected in practice on the ground, with student support arrangements such as personal tutor systems, mentors and drop-ins being the most common way of supporting mental health.

4.15 However, an increasing number of colleges are taking a more systemic

approach to promoting mental health and psychological well-being. *The Government is currently developing a National Healthy Further Education Framework which we support. College staff need the same access to support, training and specialist advice as school staff in order to meet these ambitions.*

“You don’t have to be a formally trained mental health professional to be able to assess or have an opinion about or have an influence on children’s mental health.”

Local service provider

General practice

4.16 A range of primary care practitioners are brought together in GP practices, including GPs, nurses, health visitors and midwives.

4.17 Individual GPs commonly play a role in physical health promotion and in adult mental health. Often, they are an important first ‘port of call’ for parents and carers concerned about their children. A study in 2000⁴¹ found that GPs did not consistently recognise the signs of mental health problems, particularly lower-level



Practice example: The role of GPs

A commissioning priority in Area I is to increase the amount of consultation and direct work delivered in universal settings, including primary care. At a strategic level, links with primary care are facilitated by the inclusion of GPs on the multi-agency CAMHS implementation group, and also on the Children and Young People’s Partnership Board. At an operational level, CAMHS workers (psychologists and others) are located in cluster-based teams and deliver services in a range of universal settings, including sessions at GP surgeries. Getting GPs on board and more involved in the ‘cluster’ approach is therefore a priority area. They are being engaged in discussions about how services and pathways should work in each area. This partnership working is promoted and supported by the PCT, though there are logistical challenges because the cluster areas are based around school groupings and do not easily map onto GP practices, which have different boundaries.

problems which were likely to be more responsive to early intervention.

Recognition was more likely when the child or young person had a more severe problem or when they lived in a stressful family environment. In common with other practitioners, training will help to address this.

4.18 We found that GPs commonly work in collaboration with other health and social care practitioners, but their work with practitioners from education, youth justice and other children's services is less well developed. This means they are less likely to have information about the full range of services available to support mental health and psychological well-being. *This could be remedied through better information about what is available in local areas, and by greater involvement of other staff within the GP practice around mental health and psychological well-being and by better engagement of GP practices with Children's Trust arrangements.*

4.19 While GPs will be familiar with the Care Programme Approach, many will not be aware of the Common Assessment Framework (CAF). *These two frameworks need to be linked more effectively, given the importance of the role that GPs play in identifying children of adults who are ill.*

Police service

4.20 The police service comes into contact with young people who are at risk of offending, as well as with those who do offend, through their community work. Generally, the police do not have the training or the tools to identify mental health problems or learning disabilities or difficulties, unless these problems are very evident and severe. Often the duty staff working with the police (for example, a social worker or a forensic medical examiner) will not have experience of child mental health problems. Anecdotal evidence from the police suggests that, even where a child or young person has identified mental health or other problems, they find it difficult to access specialist support from social care or CAMHS.

4.21 It has been reported to us that some diversionary measures to keep young people out of the formal youth justice system are not available to young people with mental health problems or learning disabilities because they are not considered capable of understanding the process. *The new Youth Restorative Disposal, announced in the Children's Plan and currently being piloted,⁴² therefore needs to address this issue.*



Practice example: The role of the police

In one county council area, the police service is working with a national voluntary organisation to base independent youth workers at local police stations and take referrals from police officers about children and young people they believe to be at risk. The target children are those who have received a police reprimand, are engaged in offending behaviour while still at primary school, who live with domestic violence or who are at risk of school exclusion. The worker completes checks with relevant agencies and makes a home visit within 24 hours. Assessment and intervention is carried out in partnership with the family, and referrals to specialist services are made if necessary. Early evaluation findings show significant improvement in progress at school, an improvement in ways of coping with anger, a lack of return to contact with the police, and young people and parents reporting high levels of satisfaction with the help offered and received.

Youth services

4.22 Youth work provides rich opportunities for promotional work and proactive interventions. There are many examples of youth services making a positive contribution to young people's mental health and psychological well-being. The introduction of targeted youth support teams across the country provides opportunities for youth services to become more strategically involved, and to work in partnership with a range of services.

4.23 Inspection reports suggest that the relationships that youth workers develop with young people, and the informal settings in which the work takes place, lend themselves well to promoting healthy lifestyles. In some of the outstanding examples of practice that were identified, youth workers were directly addressing risky behaviours in areas such as drug misuse or sexual health. Youth workers are in a stronger position to respond to young people's concerns about their mental health where they have access to youth information and counselling services. Such provision continues to vary across the country.⁴³

4.24 These informal settings also include online communities, *and we would encourage further consideration to be given to the development of detached youth work approaches as part of the prevention and early intervention support available online.*

Play, leisure and community development services

4.25 Along with youth services, these services build 'social capital' by helping children and young people develop friendships, participate in clubs and groups, and feel safer in their neighbourhoods. These factors have all been shown in research to help prevent and alleviate mental health problems.⁸

"I go skateboarding... it's quite stress-relieving."

Young person

Practice example: The role of youth services

Young people in one county council area have benefited from an innovative youth work programme designed to help disabled young people aged between 16 and 25 who are experiencing mental health problems. Designed and run by a local voluntary sector organisation, the programme was based at two sports centres. Each week both sites offered an informal classroom session and an active sports session. The programme lasted for 12 weeks and ran three times. Each was led using youth work techniques, building trust, social awareness and individual development. A specialist youth lifeskills tutor was supported by sporting instructors, plus volunteer workers and a representative from the mental health service. Many of the young people involved had already had negative experiences of alternative provision. They had been asked to mix with older adults with long-term problems, or had had to return to school or college, where they felt they lacked support. In these programmes, they said they felt listened to and were given opportunities to develop skills and try new experiences, with appropriate support when ready.

4.26 Boys and young men in particular often prefer activity-focused interventions to help them, rather than 'talking therapies'. Although a lack of evidence means we are unable to provide a clear overview of the work that is under way among this disparate group of services, there are many examples of good practice. *We therefore recommend further development of these services as part of a comprehensive range of provision for mental health and psychological well-being.*

Developing capability and capacity in universal services

4.27 There are many causes of mental health and psychological well-being problems for children and young people. Consequently, there are a range of sources of mental health expertise available to universal services to help them develop capacity and capability in promoting mental health and dealing with difficulties. However, we have found regional variation in the way that these sources are used, and indeed in how they are co-ordinated with each other. A more integrated approach from these services should help universal services to take a more overarching view of the way in which they are supporting mental health and psychological well-being.

Support from CAMHS

4.28 CAMHS staff carry out a range of work in universal services – primarily in children's centres, schools and primary care. Our visits across the country found numerous examples:

- primary mental health workers providing consultation and training for primary care, early years and teaching staff
- teams of primary mental health workers working to support a cluster of schools
- training for nursery nurses to enable them to provide ante-natal support to mothers and promote attachment
- the involvement of CAMHS in parenting groups and youth service provision.

4.29 This represents a marked improvement since 1999, when the Audit Commission found that CAMHS professionals spent a very small proportion of their time on this area. However, there are still a number of barriers to effective collaboration:

- Schools and other universal services often say that they require more input from CAMHS than CAMHS is able to provide, due in part to the difference in the levels of need prioritised by the two services.



Practice example: Accessing CAMHS

Area G provides access to CAMHS through the Single Point of Access (SPA) system, which has operated since 2006. This is intended to make it easier for universal services across this large city to access CAMHS. There are four access points around the city, which are open to all agencies across the statutory and voluntary sectors, though not as yet to parents or children. The highest referrers are schools, and the vast majority of the remainder are GPs and community paediatricians. It took some time for awareness of the SPA system to filter through to different agencies, but it is now seen to be opening up access and, in particular, 'demystifying' CAMHS for schools and early years providers. An ongoing challenge for the system is ensuring consistency of approach in the way it is run across all four access points.

- The size of the CAMHS workforce is small compared to the number of children's centres, schools and colleges; this has significant implications for resourcing, as well as for working styles and practice.
- There are a number of other barriers common to multi-agency working – for example, a lack of consistency of terminology and its interpretation; different professional cultures; a perceived stigma in using specialist services; mismatching of expectations; and the understandable emphasis given in CAMHS to face-to-face clinical work, which reduces scope for consultation and training programmes.

4.30 Part of the solution to this lies in schools and other universal services doing more themselves to promote and support mental health, by improving the skills of their staff. There is also valuable input to be gained from practitioners from other sectors such as family support workers, who can work with staff and children and families as part of extended school arrangements. Most important is that the planning and development of capacity improvements in universal services takes place within an overall strategic framework locally, so that resources are deployed most effectively according to the needs identified.

Social care

4.31 Often, the underlying reasons for mental health problems can relate to problems at home or in the community, which means that social care practitioners have an important role to play in helping universal services. They can work with families to improve the environment at home, as well as working with staff in universal services to help them identify needs or risk factors. While some local areas have developed provision in this area, in other areas it is far less developed. This means that vulnerable children and families may have needs, but will be

turned away from services because they do not meet the threshold for intervention. The barriers – and solutions – to joint work between universal services and social care services are similar to those facing universal services and CAMHS.

Educational psychology

4.32 Educational psychologists are traditionally seen as supporting schools and families in identifying and addressing SEN. However, their role is much wider than this and can include therapeutic work, consultation and advice, parent training, staff training, support to schools on organisational issues such as behaviour management and specialist work with those in care and in contact with the youth justice system. As Children's Trusts develop, they are frequently to be found outside core education psychology services – for example, in 'community psychology services' which still work with schools but also engage in activity with other services. In a number of areas, educational psychologists are employed as members of multi-disciplinary teams.

4.33 There are wide variations in the way that educational psychology services are deployed and linked in with other agencies, and particular discrepancies in the way some educational psychology services work with clinical psychologists. This again highlights the need for a joint strategic approach to deploying resources in the most coherent and effective way to meet identified needs.

Behaviour support services

4.34 Behaviour support services employ specialist teachers and other staff to help schools improve their management of pupils with behavioural, emotional and social difficulties. They also help arrange and deliver alternative educational programmes for pupils who are excluded. Behaviour support services are sometimes managed alongside educational psychology services or PRUs. Staff work



Practice example: An integrated approach to specialist support

In Area F, an integrated service referral panel was established to prevent inappropriate referrals to CAMHS and offer a more needs-led approach to children and families. The panel has representation from: CAMHS, the behaviour support service, the autism service, language and learning, educational psychology and On Track (a service for young people at risk of offending). Any professional can refer to the panel using a tailored referral form. The panel considers each referral and allocates it to the appropriate service. This has challenged opinions by some that CAMHS is a 'magic bullet' and has allowed a more creative approach to support options for children and their families. Panel members have found that CAMHS is not always the most appropriate choice, particularly when a child or young person's mental health needs might be related to an environmental issue, a school management issue or a learning issue.

with parents and carers and assist with problems outside of school, but their focus is on engaging the children effectively in education.

4.35 In the last few years the DCSF initiative to encourage the development of behaviour partnerships has led to some centrally managed behaviour support services being reorganised to be managed by schools directly. In other places, operational management remains with the local authority, but schools are partners in the oversight of activity, strategic planning and funding. The potential of behaviour support services to contribute to strategic efforts to improve mental health and

well-being supports the view that behaviour partnerships should be developed on a multi-disciplinary basis, much like children's centres.

School nursing service

4.36 School nurses are specialist community public health nurses with responsibility for physical health and general health promotion. They often work as leaders of school health teams, alongside other practitioners such as health promotion specialists and trained support staff. Given the breadth of their role, it is unsurprising that there appears to be a wide variation in the emphasis



Practice example: The contribution of health services in early years and schools

In Area G, capacity is being built in schools through the use of school nurses (with a special interest in mental health) and a nurse specialist for children with attention deficit hyperactivity disorder, who works with the paediatrician and also goes into the school and home settings to work with the child and family. There is also a Healthy Schools co-ordinator who has focused on opportunities to link the Healthy Schools Programme with CAMHS objectives. The head of early years provision and the lead for Healthy Schools are both on the policy and strategy group for CAMHS.

placed on mental health and psychological well-being.

4.37 We are aware of many examples where the contribution of school nurses is significant and highly valued. A number of school nurses have received additional training on mental health, playing a key role within multi-agency teams to identify problems and provide prompt support and care. Some undertake direct work through activities like drop-in counselling. Indirect involvement includes strategic work to link activities around sex and relationships education and substance misuse education with activities to promote mental health and educational and social success. But overall the evidence is not available to provide a clear picture about the level and type of work being undertaken around mental health and psychological well-being. *We recommend that, along with the other services described above, school nursing services should be engaged fully in the local drive to improve mental health and psychological well-being.*

Youth support services and Connexions services

4.38 These are available to all young people. They are well placed to promote mental health and psychological well-being, and offer a particular blend of skills and approaches that, in some parts of the country, are being drawn on to enhance support arrangements for universal services such as school and colleges. In other areas, however, little use is made of the different yet complementary perspectives youth workers and Connexions personal advisers can bring.

Conclusion

4.39 It is our view that, because in many areas these services are currently still operating as separate services, the resource and expertise available within universal services is not being used as effectively as it could be. *For Children's Trusts and service providers to make a reality of prevention and early intervention in universal services, the individual services and specialisms as described above need to be considered together and deployed to better meet need.*

4.40 Our analysis of the current position in relation to promotion, prevention and early intervention is that:

- There are good examples of areas with well-established and carefully planned arrangements for promoting mental health and psychological well-being and intervening early.
- In general, however, staff in universal services need a better understanding of their role in promotion, prevention and early intervention; training to improve their skills and confidence to meet needs; access to information and advice about what is available; and awareness of the systems in place to access specialist support.
- Children, young people and families need ready access to specialist support when the issues they are facing go beyond the capacity and capability of staff in universal services.
- The huge diversity of services available, many of which are provided through the voluntary sector, enhance the opportunity for children and young people to access help when they need it. This can help to 'keep doors open' when a young person is in difficulty, rather than have them reject formal service provision altogether.

"I didn't even know a support service existed for people in my situation."

Young carer

4.41 To help this varied picture of service provision make sense to children and families, our Review suggests that services need to work and plan together so that even if they are provided by different organisations or sectors, they appear to operate as a unified service to children and families. The recommendations we make in this chapter will help to support this aim.

4.42 **Key recommendation:**

Forthcoming national media activity carried out by the Government and its partners to promote a positive understanding of mental health and psychological well-being should have a focus on children and young people as well as adults. This will help to improve everybody's understanding of mental health and psychological well-being; highlight what people can do to help build resilience in children and young people; and ensure that people know where they can go to seek support and help.

4.43 **Key recommendation:** To improve the access that children, young people and their families have to mental health and psychological well-being support, local areas should set out a clear description of the services that are available locally. These will include services to promote mental health and psychological well-being, early intervention support and high-quality, timely, responsive and appropriate specialist services which span the full spectrum of children's mental health and psychological needs.

Communicating what's available locally

The description of the services available locally should clearly reflect the priorities and needs of children, young people and their families, and should include arrangements for accessing services within the community. It should include the level and type of support and care to be available as a normal part of the provision made by universal services such as GP practices, children's centres, schools, youth services and colleges, as well as more specialised services.

Everybody's business: specialist help for children, young people and families

5.1 Children with mental health needs may receive interventions from a range of services across mental health, social care, education, youth justice, health and the voluntary sector. These services have developed in response to the needs that they are dealing with, and the perspectives from which they view these needs. Each of these services has their own purpose and focus and carries out important work with children, young people and families. Over time, however, this creation of specialised services with their own languages and processes has made it challenging for them to work together and to recognise that a child's needs may exist not just in their area but in other areas as well, and will often be inter-linked.

"The biggest thing I found was actually getting somebody to accept that there was a problem."

Young person

5.2 Achieving the vision of this Review requires a change in outlook so that services respond to the actual needs of the child or young person, with each service playing its part flexibly and responsively. Given the way that services have developed historically, such change will not happen overnight. Indeed, we have discovered that services across the country are at very different stages of development. What this means in practice is that there is not yet a consistent focus on organising and delivering more specialised services in a planned and

coherent way to improve mental health and psychological well-being.

5.3 This chapter sets out our analysis of the current situation, along with suggestions for improving organisation and delivery.

How different services are carrying out their roles

Mental health

5.4 In addition to their promotion, early intervention and prevention work (see paragraphs 4.28 to 4.30), CAMHS practitioners carry out direct work with children, young people and their families in universal service settings. This 'specialist in-reach' of mental health services into schools and primary care is a way of helping children and families with mental health problems to access services more quickly.

5.5 Primary mental health workers carry out a lot of this work. They provide a range of services, the most common being liaison, consultation, training, and direct and joint clinical work. GPs are less likely than teachers, school nurses or educational psychologists to receive liaison, consultation or training services from primary mental health workers.⁴⁴ Emerging evidence shows that primary mental health workers are having a positive impact on the functioning of the whole system of children's services for mental health and psychological well-being, by increasing the proportion of appropriate referrals to specialist mental health services and by reaching children

and young people with lower-level mental health problems who have traditionally had poor access to services. However, a large proportion of them do not believe that their training and development needs are being met.⁴⁴ In addition, some respondents to the Review were concerned that, in some cases, Tier 2 workers are having to deal with problems and challenges beyond their expertise and experience – particularly when working on challenging issues within schools and community settings. It is important to note the specialist skills that are required to undertake this work.

5.6 At Tier 3, evidence from practice visits suggests that a number of areas are feeling overstretched, either because they are being asked to carry out more work with universal services or because demand for their services is increasing. This was attributed to other services' increased awareness of mental health issues, generated by training and preventive work. It was also attributed to decreased investment in Tier 3 provision, as resource is shifted into prevention and early intervention work. A number of services noted they had a shortage of therapeutic staff – for example, those able to offer cognitive behavioural therapy (CBT) and other specific therapeutic approaches.

5.7 Some respondents to the Review noted that Tier 2 and 3 services could be located in different trusts within the same area, which could lead to overlap and duplication rather than a coherent approach grounded in the needs of children and young people. We also found a lack of comprehensive evidence on the provision of CAMHS through universal services and the effectiveness of this, although the evaluation of initiatives such as the Targeted Mental Health in Schools programme should provide new models for delivering CAMHS in community settings, and therefore help to fill this knowledge gap. This information needs to be shared widely to help local areas learn from and develop these sorts of approaches.

5.8 Tier 4 CAMHS is delivered through highly specialised multi-disciplinary mental health teams. Some of their services are commissioned on a regional or sub-regional basis, for example inpatient psychiatric units (including dedicated units for children as well as young people, and units for those with both a mental illness and a learning disability) and neuropsychiatric outpatient services. Other services are commissioned on a national basis through the National Commissioning Group, for example secure forensic mental health services for young people and mental health services for deaf children and young people.

5.9 The distribution of inpatient psychiatric services for children and young people throughout England remains uneven, as does access to these services.⁴⁵ Service users who are particularly affected are:

- children and young people with learning disabilities
- 16 and 17 year olds⁴⁶
- younger children whose access has been restricted through the closure of a number of units for the younger age range over the last few years.

“When I was at the hospital we were taken out for walks and given activities and stuff like that. It helps people cos if you’re stuck in a hospital day after day after day you feel lonely.”

Young person

5.10 Inpatient placements can be extremely expensive, ranging from £1,377 to more than £4,800 a week.⁴⁷ And there are individual cases where the costs are significantly higher, depending upon the need and the services provided. There is wide variation around the country, with costs tending to be higher in London. In our review visits, a number of areas said

that they found it difficult to access or provide beds in an emergency, reflecting the recent report from the Children's Commissioner for England.⁴⁸ This can have a number of consequences:

- Some young people may be inappropriately admitted to adult psychiatric wards and others to paediatric wards.
- Some young people may receive insufficient care to meet their needs within their community, or find themselves in other residential settings without access to appropriate mental health care.
- Young people who have committed an offence, who have a serious mental disorder and who are remanded to a custodial setting (such as a young offender institution) are particularly disadvantaged.

"They should really be able to try and help you out the first time, making sure you don't end up in there a second time, and then a third time. It doesn't help anyone."

Young person

5.11 There are notable examples of alternative and complementary services to inpatient care, which have been developed by local areas in order to provide services closer to home. These include:

- intensive treatment packages for children, young people and their families, for example to prevent family breakdown
- specialist care programmes for younger children with developmental disorders
- assertive outreach teams that provide intensive support for small caseloads on a 24-hour basis
- 'wraparound' services to help families to address their children's needs at home and at school.

However, the lack of systematic research into and audit of these alternatives currently limits effective planning and commissioning.⁴⁹

5.12 Social care and education services are central partners in the provision of high-quality inpatient care, although the extent to which this happens is variable. It remains difficult to ensure, for example, that children receive social care services when they need them and also continue their education while in hospital –



Practice example: Restructuring Tier 4 services

A review of Tier 4 CAMHS in Area F has focused on ensuring better access to inpatient services for young people with acute needs and the delivery of more locality-based services such as assertive outreach, specialist assessment, second opinion services and services for those children with complex behavioural, mental health and social care needs. This has involved expanding Tier 3 services to offer more local provision for those children and young people with higher levels of need. The Review has been motivated to provide a more holistic approach to meeting young people's needs and to offer more local and accessible services. At the same time, half of the total activity commissioned at these levels is specifically allocated to training and consultation, in order to meet the strategic priority of developing the skills of the whole children's workforce.

particularly when the inpatient setting is not in the same local authority area as their home. We support the view that there should be a national strategic approach to CAMHS that ensures a mixed economy of residential, outreach, community and home-based services,⁴⁷ from a range of providers. Our recommendations should assist this.

Social care

5.13 The guiding principles behind social care emphasise the importance of effective parenting for children and young people's mental health and psychological well-being. However, it was reported to us that the priority for most social care services is, understandably, child protection, and in particular protection from physical harm and sexual abuse. While this must have overriding importance, it has led to the view that social care services have more limited involvement in responding to the impaired emotional development or neglect that can put a child or young person at risk of, or exacerbate, mental health problems. This can in turn mean that mental health problems are seen solely as the remit of CAMHS. We believe that further development of CAMHS needs to be accompanied by developments in social care, as the two are often complementary.

5.14 Not all children and young people in the social care system have mental health needs. However, they are at greater risk of experiencing mental health problems, since the factors that cause a child to be received into care are frequently those that also cause them to be at risk from mental health problems. The recent review of safeguarding arrangements²⁵ noted that the monitoring of health and well-being had improved in nearly all areas and that arrangements for fast-tracking to CAMHS and therapeutic services were up and running in nearly all areas for those with higher levels of need, such as risk of self-harm. However, children and young people with lower levels of need, such as behavioural difficulties, often had to wait long periods before receiving assessment or treatment.

5.15 Although the evidence presented to the Review was limited, we found barriers that are hindering the delivery of effective mental health care for children in care:

- Rigidities in the system can mean that a child or young person who requires therapeutic input cannot be provided with it because they do not have a 'stable placement'. This in itself can lead to the breakdown of temporary placements and can exacerbate any problems.



Practice example: Restructuring social care services

In Area I, a new structure has been introduced for social care services. A number of small social work units have been established to enable those working directly with children and families to benefit from the support of a multi-agency unit structure. The units can provide assessments for children, young people and their families using the expertise of several disciplines. There are direct lines of communication to other specialist services if relevant needs are identified. Each of the units is led by a consultant social worker, who works alongside a social worker, a children's practitioner, a unit co-ordinator and a clinician (a clinical psychologist or systemic family therapist engaged on a part-time basis). The inclusion of non-social work practitioners changes the skill-set of the units and brings an additional dimension to addressing mental health and psychological well-being issues.

- The transient circumstances of many children in care mean that they may lose contact with services while they are waiting to be seen.
- Children and young people do not always receive the ongoing support and care they need after being discharged from services.⁵⁰

5.16 *It is our view that Children's Trusts need to identify the barriers that may exist locally to the provision and continuity of mental health care for children and young people who are in care and who are leaving care.* Improved care planning, involving all contributing services and professionals, is needed to ensure that these vulnerable children and young people are not disadvantaged by such unhelpful organisational barriers.

Education

5.17 A range of educational provision is in place for children and young people who exhibit disruptive, anti-social and aggressive behaviour; hyperactivity, attention and concentration problems; and emotional problems. Some of these issues will be associated with a physical or learning difficulty or disability. Many such children and young people are likely to have poor peer and family relationships and to have problems with attending or engaging in school. These problems all come under the broad term 'mental health needs'. As many respondents to the Review pointed out, the issue of whether these young people are also identified as having SEN (as a result of their behavioural, emotional and social difficulties) can depend more on local provision and attitudes than on an accurate assessment of a child or young person's underlying needs.

5.18 Some contributors to the Review were concerned about the variation in outcomes that can arise depending on whether a child's needs are met through the SEN system (which focuses on those

with learning needs, including those with behavioural, emotional and social difficulties) or through the pastoral support system (which focuses on behaviour and discipline). For example, at present a child with serious difficulties could have an SEN assessment, receive a Statement and be offered long-term help in a special school. Another child with similar difficulties could be excluded from school and attend a PRU or other alternative provision. This situation may be influenced by the availability of provision – for example, Ofsted found that in local authorities with no designated BESD school, all the pupils in PRUs had a Statement.⁵¹ Commonly, this meant that children and young people were admitted to PRUs without decisions being made about the length of their stay or their next placement, and they stayed indefinitely. This supports our view that the route that a child takes through the system is not always needs-led, and that assessments are not always adequate.

"Children with mental health needs, however severe these are, also have needs in relation to being healthy, staying safe and education. These are things that children's services need to be involved with. We don't need to build more and more specialist services around them."

Service provider

5.19 **Special schools** provide long-term education for around 13,000 pupils with behavioural, emotional and social difficulties in England. We have been unable to identify any comprehensive data on how access to support for mental health and psychological well-being is currently organised and delivered in these schools; however, the following issues emerged in our Review:

- The extent to which therapeutic work with children, young people and their families is undertaken as part of a co-ordinated programme is variable.

- A number of headteachers in BESD schools felt unable to offer adequate provision for young people with acute psychiatric disorders.⁵²
- The proportion of CAMHS teams providing support to specialist schools for pupils with educational and behavioural difficulties was lower than for mainstream secondary and primary schools.⁵³

5.20 **PRUs** are local authority-managed units providing short-term alternative education for more than 65,000 children and young people, a large proportion of whom have a variety of behavioural, emotional and social difficulties (although they may not have been assessed as such). Provision varies widely but they face similar barriers, such as:

- inadequate accommodation
- pupils of different ages with diverse needs arriving in an unplanned way
- limited numbers of specialist staff to provide a broad curriculum
- difficulties reintegrating pupils into mainstream schools
- underdeveloped links with CAMHS – for example, difficulties in gaining swift access to services (although a majority of PRUs thought the support they received from CAMHS was at least satisfactory).⁵²

5.21 Around another 65,000 children and young people are in a range of other alternative provision, including further education, private and voluntary sector provision.

5.22 *It is our view that special schools, PRUs and other alternative education providers need further support with specialist training in order to improve the skills mix within their staff. They also need better access to and involvement of specialist mental health staff, given the complexity of the needs that they are working with and supporting.*

5.23 Behaviour partnerships, operating within the context of a broader focus on mental health and psychological well-being, also offer opportunities to address these issues. They enable local areas to take an overview of all the provision available to address the range of difficulties described above. They also offer the scope to go back to first principles to look at what the needs are, and which services need to be available to meet those needs – including support for mental health and psychological well-being. At the moment, however, we are concerned that the partnerships tend to be focusing on the requirement for full-time education in mainstream schools, rather than on all provision for school-age children.

5.24 We welcome the Government's aim in the *White Paper Back on Track*⁵⁴ to achieve a step-change in the quality of



Practice example: Restructuring provision in alternative education settings

In Area F there are innovative working arrangements for children in alternative educational settings, many of whom have behavioural, emotional and social difficulties. A number of these settings employ specialist teachers, who are part of the wider community CAMHS team. These teachers can ensure that the right support is quickly available for children coming into the school with mental health problems. The teachers have also delivered training in CBT to other staff in the school.

provision in those PRUs where standards are poor. We also note the consideration the Government is giving to setting minimum standards on the length of time for the engagement of support services such as CAMHS. *However, we are of the view that a more fundamental change needs to take place, which is about the joint commissioning of an appropriate range of services to meet the needs of all children and young people – not just in PRUs but in special and mainstream schools as well.* It is not about one service passing the problem on to another. The commissioning changes proposed in *Back on Track* would, we believe, be a more appropriate lever for improving services, provided that all relevant stakeholders get involved and play their part.

Youth justice

5.25 Multi-disciplinary youth offending teams (YOTs) were established in 1998 with the aim of preventing offending by children and young people by providing a multi-agency response to meet the needs of those offending and at risk of offending. All YOTs should include a health practitioner, and in many cases they and other practitioners (for example, social care or behaviour support staff) will be able to provide input on mental health and psychological well-being issues. They work with young people at risk of offending and with young people who have received community sentences.

5.26 A 2006 inspection report¹¹ found that over 30% of YOTs did not have a mental health worker, even though 40% of the children and young people they work with have mental health needs. *Given the high level of need, we recommend that all youth offending services address this.* More positively, just over 80% of health workers reported good access to CAMHS, although 16 and 17 year olds were particularly disadvantaged by the gap in services for their age group. The Review also provided illustrations of good practice; for example,

in one case the YOT's health care worker was a mental health nurse who undertook promotion and early intervention work herself, while referring on to CAMHS for more specialised input.

5.27 When a young person receives a custodial sentence, this will be carried out in a young offender institution, a secure training centre or a secure children's home. The 2008 joint review of safeguarding arrangements²⁵ found that provision for young people in secure settings has improved since 2005, with more robust child protection procedures, better communication between YOTs and institutions and the introduction of social workers in young offender institutions. However, many concerns remain about how a young person's mental health and psychological well-being are cared for in these settings. This is particularly important given that the prevalence rate of mental health problems rises from 40% among all young people in contact with the youth justice system to over 90% among those in secure settings. On entry to custody, mental health can be affected in a number of ways:

- Basic procedural rigidities can leave a young person feeling vulnerable. For example if they arrive at an institution after casework staff have gone home, they may not have an opportunity to discuss any problems and to settle in properly. It also means that initial assessments may be deferred.
- Essential information such as vulnerability reports do not always accompany the young person, so staff are not always aware of issues that should be addressed.
- There is an expectation that prison officers act as personal officers or key workers, with the remit to provide an appropriate role model and be involved in all aspects of care planning. However, with some notable exceptions – for example in smaller girls' units – the latest

safeguarding inspection report found that this function was still “seriously underdeveloped”, with fewer than half of the young people reporting that they had met their personal officer in their first week.

It is our view that this should be addressed by more effective commissioning on a regional basis, which will give greater potential for the involvement of other children’s services within secure estate provision.

5.28 Mental health needs can be more effectively supported when procedures such as this are addressed within an overall ethos of care, and with timely access to CAMHS where necessary. This should help to ensure that young people with less severe mental health needs or with mild to moderate learning disabilities or learning difficulties do not find their problems exacerbated by the experience of custody.

5.30 Alternatives to custody in community settings can also make a difference to children and young people’s life chances – particularly if they are underpinned by a focus on mental health and psychological well-being, with CAMHS delivered proactively in ways that reach out to young people and their families. This includes outreach work in one-stop-shop venues and youth clubs, home visits and evening and weekend work.

5.29 In 2007, the Government published a framework¹² for promoting the needs of children and young people in secure settings. This recognises that meeting the needs of children in the secure estate presents significant challenges for the agencies involved, including commissioners, on a local, regional and national basis. This is due to many factors: different numbers of children coming from different areas; the size and nature of individual establishments and their geographical spread; movement of children between sites; variation in local CAMHS arrangements and resources; and the different responsibilities of health and social care commissioners and providers.

Child health and other health services

5.31 General and community paediatricians both play an important role in the mental health care of children and young people, much of it in relation to targeted services such as those for children and young people with disabilities and developmental problems, those with sensory impairments and those at risk of or experiencing abuse – all of whom are at a higher risk of developing mental health disorders. Other children may present primarily with physical symptoms that are subsequently found to be indicators of an underlying mental health problem. And some may have mental health problems



Practice examples: Mental health provision for young people in the youth justice system

In Area A, the youth offending service and the substance misuse mental health key workers are closely linked and are helping to deliver important CAMH services.

In Area B, services to children and young people who are at risk of offending or who have offended are provided through the YOT. There is a health worker within the team, who is employed by CAMHS and seconded to the YOT. CAMHS also offers basic training and mental health awareness to YOT staff.

which are treated within a paediatric setting, as this is perceived to be less stigmatising. There are specialist clinics focusing on behavioural problems, and the child health and maternity services mapping data for 2006/07²³ found that 15% of community paediatric services provided dedicated services for children with attention deficit hyperactivity disorder (ADHD). The Royal College of Paediatrics and Child Health has recently developed training materials for paediatricians in child mental health, as part of its Child in Mind project.

5.32 Substance misuse services are important stakeholders in work to improve mental health and psychological well-being, given the significant overlap between substance misuse problems and mental health problems. This is increasingly being addressed by service commissioners and providers, with a number of areas having good joint commissioning and delivery arrangements. In this area in particular there is a recognition that it is important to take a child and family-centred approach – especially where parents have substance misuse problems. This is highlighted in the Government’s drugs strategy,⁵⁵ and is being tested through the Family Intervention Projects. *We welcome developments within the Royal College of Psychiatrists, where a specific CAMHS and substance misuse group is being established and good practice guidelines are being produced for CAMHS staff.*

Voluntary sector

5.33 The voluntary sector has a very strong involvement in provision for children’s mental health and psychological well-being, and in many areas is a core part of the provision available. A more consistent approach to the commissioning of services (see **Chapter 7**) can provide a firmer and more sustainable base for the funding of voluntary sector services and increase the time they have available for service development.

No contact with services

5.34 In every area there will be a small number of children and young people who do not come into contact with, or who have been taken out of, clearly established systems. The most common reasons for this are because a child is being educated at home, because they have been admitted to hospital, because they are homeless or because they have run away. Services need to think about what systems can be put in place to ensure that attention is also given to these children’s mental health and psychological well-being needs.

Conclusion

5.35 This chapter has shown that there is evidence of some improvement in access to more specialist services, which will require ongoing implementation and evaluation. However, we have found that it is not always clear what parents can do if they are not able to access a service, or if they are not happy about a service that is being provided. We would like to ensure that all children and young people who require specialist support have access to high-quality provision, and therefore we make the following recommendation.

5.36 **Key recommendation:** Children and young people who need more specialised support, and their parents and carers, should have:

- a high-quality and purposeful assessment which informs a clear plan of action and which includes, at the appropriate time, arrangements for support when more specialised input is no longer needed
- a lead person to be their main point of contact, making sure that other sources of help play their part and co-ordinating that support
- clearly signposted routes to specialist help and timely access to this, with help

available during any wait (see also paragraph 5.38).

- clear information about what to do if things don't go according to plan.

What to do if things don't go to plan

Each organisation providing services for mental health and psychological well-being should have a clear and publicly available complaints procedure. We recommend that, as part of improving parental access to information, advice and guidance, Children's Trusts should ensure that provider organisations make clear to parents what those complaints procedures are whenever a service is being provided. As part of the description of what is available locally (see key recommendation 4.43), we recommend that Children's Trust partners come to an agreement about the procedure to be followed where there is a complaint about access to services. This is a complicated area, and may benefit from national advice on best practice.

5.37 *Those working in specialist services need to have access to ongoing support and training to develop their skills, and there needs to be improvement in access to support for children, young people and families.* One way of achieving this could be for local and regional areas to jointly commission all specialist provision as described in this report. To improve support for people working on a day-to-day basis with children and young people, provider trusts and other services also need to identify how they will simplify and improve access to training, advice and consultation from specialists about individual children and groups of children. This will require a development in local, regional and national performance management and commissioning arrangements so that such approaches are

accorded the same value as direct face-to-face consultation.

5.38 Waiting times remain one of the biggest barriers to access to specialist services for children, young people and families, in situations where the child's needs cannot be met by universal services. Approaches such as the Choice and Partnership Approach have shown some improvement, although those areas that have not structured their approach around all aspects of the system – as experienced by the child – have found that 'hidden' waiting lists still exist in relation to accessing treatment or intervention. *Local areas need to consider waiting times for access to all services. However, we consider that focused attention is still needed for access to CAHMS.*

5.39 **Key recommendation:** It is important to improve the quality of CAMHS experienced by children, young people and families by reducing waiting times from referral to treatment. The Government should set clear expectations around good practice in this area, and specifically promote approaches that have worked well in reducing waiting times for other services.

Everybody's business: services working together

Integrated working

6.1 Multi-agency working is well-established across CAMHS, and is becoming embedded across the wider spectrum of children's services. For a number of years, multi-agency teams have been a key vehicle for delivering services to children and young people with more severe and complex mental health problems.

"It is important for us to have enough time to make all the links, do consultations, think about the children who fall between services, and spend loads of time engaging the different hard-to-reach groups."

Service provider

6.2 The introduction of Every Child Matters has encouraged more integrated working in order to deliver early intervention and preventive services. In the course of the Review, we have seen approaches ranging from the co-located multi-agency team or the 'team around the child' to the joint training of professionals in universal services so that they can better support children themselves and engage more effectively with specialist services. There are also a number of multi-agency teams around the country dedicated to addressing the needs of vulnerable groups such as children in care, children with learning difficulties and disabilities, and young people in contact with the youth justice system.

6.3 During the Review, we found that people are very focused on wanting to improve services and outcomes for children. Nonetheless, very real barriers remain to prevent people from working together in a child and family-centred way, in particular:

- administrative arrangements (for example, separate line management and information-recording arrangements)
- lack of clarity around lines of accountability
- financial constraints – services may be unwilling to fund posts that they see as being outside their 'core' business
- lack of time to carry out the work effectively (multi-agency working can take a lot of time, because so much of it is about building relationships and because different professions have different working patterns).

"Agencies pass you on from one establishment to another – no one seems able to give you an answer."

Parent/carer

However, these challenges are being overcome successfully in a number of areas, suggesting that wider dissemination of good practice is required, as well as professional development for managers in multi-agency services.

6.4 Another key barrier is the difference in the professional cultures of health, education and social care, and also those of some professional groups. We are aware that some individual professionals continue to adopt a very rigid approach to practice, which they might attribute to the demands of their professional and ethical frameworks. At the same time, we have seen many examples of high-quality professional practice provided in a more flexible, child and family-centred way. *We believe that this means there is a crucial role for the professional bodies in encouraging flexibility and diversity of practice across children's services.*

6.5 We have been struck by an ongoing tendency to use the terms 'medical model' and 'social model' to characterise and polarise practice within health and education/social care. This was noted in the national consultation, within published research and in our practice visits. While there are legitimate issues to debate about how best to conceptualise, categorise and classify mental health problems, we found such references to be unhelpful and inaccurate. In reality, good practice in any discipline will consider the individual's situation, their strengths as well as their problems, and their sources of resilience alongside risk factors. The most effective approach is one that considers all aspects of need – in effect, a biopsychosocial approach. Where the biological, psychological or social needs are paramount, particular emphasis is given to addressing these aspects.

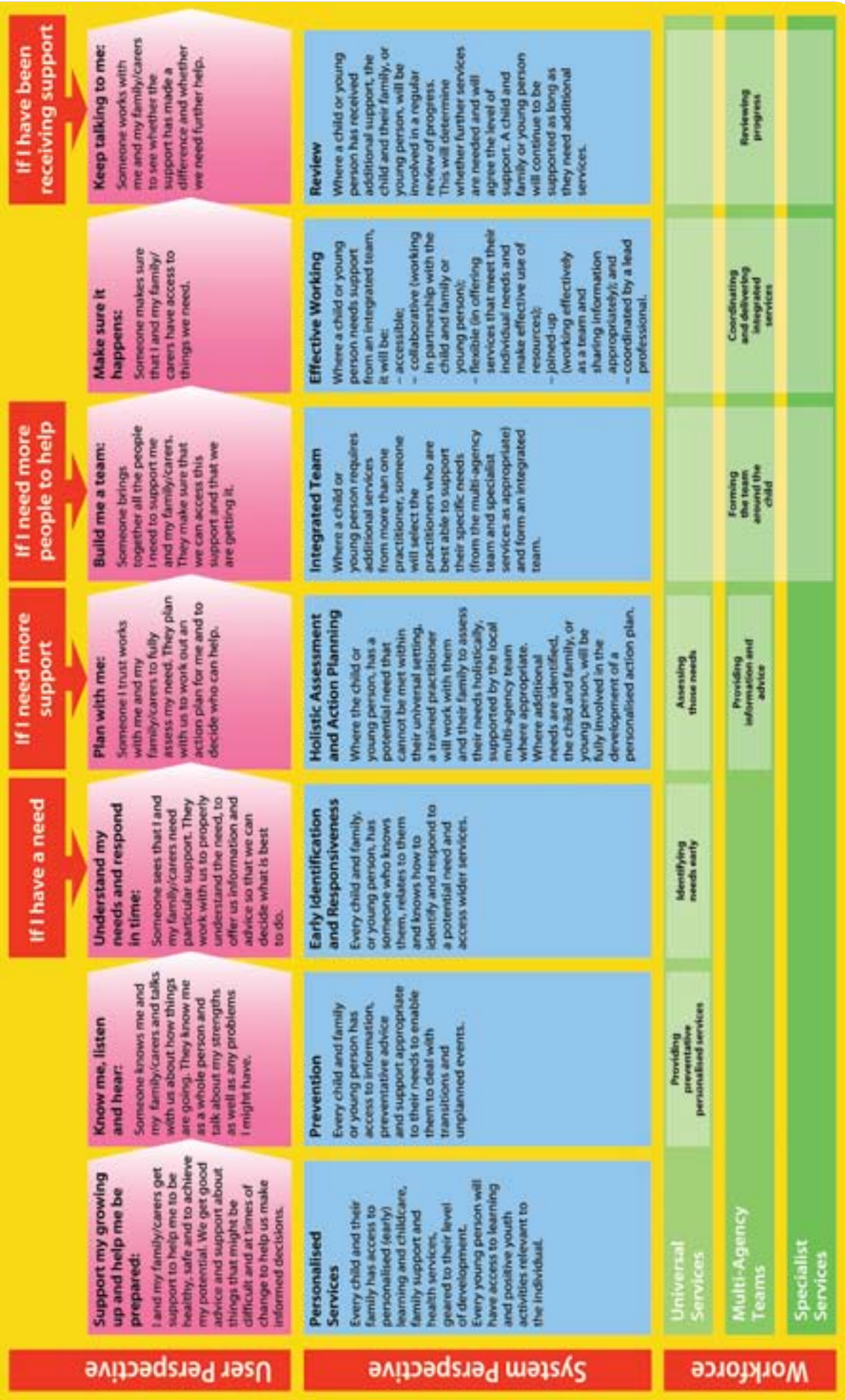
6.6 While there is an increasing amount of research to show multi-agency arrangements working well, we think it is important to sound a note of caution. We have seen examples where multi-agency working is vital, but we have also seen that some arrangements can be time-consuming and expensive. The guiding principle should be that services are needs-led, which means that the decision about whether and how to set up multi-agency structures should start with

the commissioning process and with reference to best practice around dealing with different sets of needs.

6.7 Many schools, social care settings, primary health care practices and other children's services say that they have insufficient access to CAMHS practitioners and services when they most need it. Likewise, CAMHS practitioners frequently say that their need for social care services for a 'child in need' does not reach the threshold for social work intervention. They may also express concerns about the attitude of schools to the children and young people they are working with. Similar problems can arise when CAMHS practitioners try to secure special educational services. This emphasises both the need for effective planning across all sectors and the need to understand each other's roles and responsibilities – as well as the resource constraints that may apply.

6.8 Meeting these challenges does not always require a multi-agency approach, but it does need a recognition across all organisations and sectors that services need to be able to rely on each other. For example, schools and colleges need to have a commitment to mental health and psychological well-being, as part of an overall ethos to keep children and young people motivated, engaged and behaving appropriately in education so that they can learn and achieve. At the same time, CAMHS and other services need to be there to provide support when needed. There is much more mutual dependency than practitioners and services sometimes realise. The development of close relationships and regular dialogue between services and between individual practitioners can help to increase this understanding and foster an approach that does not simply depend upon passing a referral from one agency to another. These changes will be dependent on all practitioners understanding their role within a system which takes a child and family-centred approach to supporting mental health and psychological

Figure 5: Vision for integrated working



well-being and being able to work with other agencies where necessary, in line with the Government's vision for integrated working (see **Figure 5**, page 62).

Care pathways

6.9 The Review was asked to investigate how care pathways can be defined, what is understood by the term, what issues affect their use and how these can be addressed.

6.10 According to the NHS National Library for Health,⁵⁶ an integrated care pathway is a document that describes a process within health and social care and collects variations between planned and actual care. It aims to ensure best practice in terms of the people involved, the actions undertaken, the outcomes achieved and the patient experience. The defining feature is that it enables clinicians to compare planned care with care actually given, which should be reflected in the patient record.

6.11 In other contexts – such as the Children's NSF and other publications⁵⁷ – the term 'care pathways' is used more loosely to describe a 'best practice' route through a particular service or between services, without the focus on identifying and recording variations in care. Practitioners in other sectors also use the

term to refer to the way that services are being delivered to children and young people with multiple needs using the CAF and co-ordinated by a lead professional.

6.12 The evidence gathered for the Review reflects this position. The care pathways described to us follow the looser definition set out above, although there is still significant variation both within and between areas.

6.13 There are examples of very detailed care pathways – for example, the pathway for children and young people with learning disabilities, which was produced nationally with local implementation being supported by the NCSS.⁵⁷ Others focus on particular conditions such as eating disorders or ADHD. There are also areas which see their care pathways as being more informal: dependent on the relationships between services that have been established locally, and offering flexibility and choice. However, there are some concerns that care pathways can become too rigid and are not sufficiently flexible to adapt to the differing needs of children and their families.

6.14 On the basis of this varied evidence, we are of the view that care pathways can be useful in assisting service planning – in particular thinking through every stage of a child's experience. Good practice in care pathways should be shared more



Practice example: Care pathways

Area H uses the term 'care pathways' to describe what is essentially a route for referral to specialist support for certain types of need. Pathways are in place for early intervention in psychosis, eating disorders, transitions to adult services, obsessive compulsive disorder and ADHD. They have also been developed for children with complex needs who require multi-agency support. Referrals are dependent on the availability of local services, so the pathways can only work with the relevant infrastructure in place. Frontline professionals were in broad agreement that there was not yet a common understanding of the pathways across all children's services in the area.

effectively, and further evaluation and development is required in order to establish the best approaches to care pathway implementation.

Flexibility and diversity of response

6.15 The ambitions of the Children's NSF and Every Child Matters (and the concerns of our respondents) can only be addressed if the practice offered by all those working in this sector is child- and family-centred, addressing the specific needs and key concerns of children and families. It should also be effective, in that it makes a tangible and positive difference to children's and families' mental health and psychological well-being.

"When it was happening I wanted to talk to other parents that had gone through similar things – I felt really isolated... I did phone a helpline which was really good – they spoke to me and I felt so calm afterwards."

Parent/carer

6.16 This sets a challenge for local areas to explore ways of being more flexible and diverse in the solutions they can offer to meet mental health problems. The key issues where we think local areas should work with partners to explore new approaches are:

- universal and other services working flexibly together, with opportunities for consultation and training from specialists as well as more direct work being brought into universal settings
- providing services in settings children and young people are familiar with, and which maximise their opportunities to do the 'normal' things that they see other children and young people being involved in
- offering family-centred services, not just child-centred services (this has implications for adult services too)

- offering 'step-down' services to support managed moves from specialist provision to less intensive provision, and to recognise that children and young people move in and out of need and are not simply on a 'trajectory'

- offering services beyond stated age ranges where necessary, in order to ensure continuity of care and contact.

6.17 Practitioners need to be able to have a dialogue with each other about the children and families they are working with. This does not always happen, even where agencies know that work is taking place. We have identified communication difficulties between services about individual children and young people. These are particularly marked where consent is not sought to share relevant information, and mean that children receive inconsistent support to address their problems. At the same time, many of the children and families we spoke to were concerned about breaches of confidentiality. *Good practice in this area, which we endorse, recognises that there should be a clear reason for sharing information, that this should be openly discussed with the child and family and that there should be the consent of the child or family to do it (unless the child is at serious risk, in which case the information should be shared if it will help safeguard the child). If consent is not given, an important good practice point for agencies is that they should keep the dialogue open, as this is often more important and relevant than the sharing of detailed information. There should be an agreement about how to do this if problems around information sharing in particular cases become entrenched.*

6.18 The policy framework is in place to facilitate a significant development in the capacity of the children's workforce to improve mental health and psychological well-being. However, the variations across the country do suggest that further investment is required. There are



Practice examples: New ways of organising and delivering services

Area C has a number of strategic partnerships that include agencies such as social care, education welfare, educational psychology, SEN assessment services, youth offending and CAMHS. These partnerships are forming the basis for developing new ways of working. They share an aspiration to look at outcomes in a holistic way, with the common aims of reducing harm, intervening early and achieving a wider preventive social impact for the individual and consequently for communities. One example is a secondary schools-focused pilot that moves away from 'single issues' such as teenage pregnancy, drug taking or youth offending and considers them together, under the banner of 'risk-taking behaviour'. Schools identify the most at-risk young people and work with the strategic partners to develop interventions. Early indications are that these are helping to engage these young people more effectively, in education and in other areas.

In Area E, work has been undertaken to provide routes out of CAMHS and to prevent a 'revolving door' effect through the provision of ongoing support to families. Offering outreach, liaison and support, the service works with families in the home or other settings. The aim is to help families to make a managed transition away from CAMHS, with access to ongoing advice and support if needed. In addition, a CAMHS consultation telephone service has been established for staff in universal services to obtain advice and consultation. This is staffed by highly qualified mental health staff, in order to avoid further signposting and onward referral for callers. Rather than just putting a referral into CAMHS and feeling that they've 'done their bit', this means that staff are now talking through different scenarios with specialist staff and getting advice on what to do next. This is having two benefits – it is empowering staff in universal services by helping them see that they themselves can actually make a positive difference in many cases and it is reducing inappropriate referrals. The helpline is seen as a useful intermediary service to introduce the early intervention concept and offer other options such as parenting support.

substantial opportunities for practitioners to work in new ways and across services so that what is achieved together is greater than the sum of the constituent parts. We welcome the focus on new ways of working, driven both by the CAMHS 'New Ways of Working' initiative,⁵⁸ and by the Every Child Matters emphasis on integrated working more generally. This will involve developing new and enhanced roles for staff and redesigning systems and processes to support the delivery of child and family-centred care in a way that is

personally, financially and organisationally sustainable.

6.19 Ensuring that the necessary spectrum of services is available for children and young people who are placed in settings away from their home areas remains a serious problem and one that particularly affects children in care. Current guidance to determine the 'responsible commissioner' for a child's healthcare has not solved the long-standing issue of ensuring that these children have the same

access to services as others. While the complexity associated with this issue, including legal constraints, is appreciated, the persistence of this problem is very real and leaves some children and young people doubly disadvantaged. *Efforts to resolve the remaining problems associated with the current guidance should continue.*

"You can't get any support... you want to pour it all out and say 'Listen to me!' but there is nothing out there, because it's the wrong time of the day, or the weekend, or whatever."

Parent/carer

Language and professional perspectives

6.20 Given the vast range of stakeholders involved, it is unsurprising that there is no single, universally agreed language to describe mental health and psychological well-being. We have used this term because it encompasses a range of perspectives (see paragraphs 1.5 to 1.9 for more information). Other common terms include 'emotional well-being' and 'social and emotional health', while young people tend to talk about feeling 'good', 'balanced' or 'in control'.

"I'm not going to a place called CAMHS."

Young person

6.21 Despite the fact that 'mental health' is a positive term, there remain many people – professionals included – who equate it with mental illness or associate its use with the medicalisation of common problems found in childhood and the teenage years. During the course of the Review, we found that young people in the older age range (16 year olds and older) were more likely to view the term positively, while children tended to view it negatively.

6.22 Other ways of referring to children's needs (including mental health needs) are based on definitions within social care, education, youth justice and mental health legislation. They help to determine the special or additional services that a child or young person may require. Within education, for instance, a child may be assessed as having a 'behavioural, emotional and social difficulty', and this will be the terminology used when planning special educational provision to help meet that child's needs.

6.23 The different terminologies used reflect differences in the way that professionals talk about mental health and psychological well-being, which stem from the different theoretical backgrounds of professionals involved in this area; the different legal frameworks within which they operate; and the different points at which a child or young person comes into contact with the system (see the list of additional resources at **Annex F**).



Practice example: Developing a shared language

A prevailing view in Area H is that the four-tiered model is preventing the most effective delivery of CAMHS because it is seen as restricting the delivery of services to types of worker and locations, without regard to the needs of children and their families. Among practitioners, the use of 'Tier 2' and 'Tier 3' to describe where CAMHS practitioners fit into the system was seen as demarcating the roles in a way that was largely academic.

"I didn't even know we were part of CAMHS. Some of the people in the office went 'What is CAMHS?'"

Practitioner

6.24 Such a diverse range of perspectives has value in helping towards a better understanding of mental health and psychological well-being. However, it can also be confusing and divisive and can undermine effective partnership working, in particular around commissioning and delivering a coherent range of services. This is the case at the strategic, service and individual levels.

6.25 A specific example of this is the requirement within some health trusts to record diagnoses of all children and young people seen within CAMHS. This has met with concern from some professional disciplines, who see such an approach as 'medicalising' children's problems. While accurate diagnosis remains important for some specific types of disorder, the eventual implementation of a CAMHS dataset (see paragraph 7.29), which incorporates a problem-focused approach, should help to address this issue.

6.26 **Key recommendation:** To improve consistency and promote greater co-operation and co-ordination, there should be a shared development of the language used to describe services, so that all services can understand that they are part of the comprehensive range of provision to address mental health and psychological well-being.

Suggestions for consistency of terminology

- The term 'children's services' is used to refer to the whole family of services that have a role to play in supporting mental health and psychological well-being from universal to specialist services.
- The term 'CAMHS' is used to refer to those services that have a specific remit to assess and provide specialist mental health support and care for children and young people and their families, and which also are part of the comprehensive range of children's services.
- The terms 'universal', 'targeted' and 'specialist' need to be consistently defined and used at national, regional and local level to improve understanding, increase flexibility and reduce confusion within children's mental health and psychological well-being services.

A needs-led system

7.1 Contributors to the Review highlighted the fact that local areas require a comprehensive understanding of the mental health needs of **all** their children and young people, in order to underpin a sense of common purpose across all children's services. This applies at the following levels:

- **Commissioning level:** Commissioners have to understand the needs of their local population if they are to know what services to commission. This is especially important when dealing with such a wide range of service provision – from mental health promotion activity for everyone through to places in inpatient psychiatric units for a very small minority. A cross-sectoral approach ensures that there are no gaps, overlaps or inconsistencies across provision. The additional involvement of adult service commissioners is needed to ensure that a family focus is achieved and transitions to adult services are addressed. Commissioners also need to consider the mental health and psychological well-being of those children who can easily be forgotten, such as children educated at home, those in hospital and those in the secure estate. To respond appropriately to this at **operational level**, services need to be organised and capable of delivering together to meet the needs of all identified groups and communities across their wider population, as discussed in **Chapters 4 and 5**. They also need to be able to work with and understand the needs of their service users.

- **Individual level:** At an individual level, practitioners have to consider the full range of needs of the individual children, young people and families they are working with, so that the best support can be provided. This requires the ability both to identify the needs and to assess the best way in which they can be met. The tools practitioners use must be an aid to this, not an end in itself.

Commissioning

The commissioning process

7.2 Commissioning is defined as the process of translating aspirations and needs into services that deliver the best possible outcomes, by specifying and procuring the best possible services within the best use of available resources.⁵⁸ It is the area that generated the most comment from respondents to the Review and where the greatest number of challenges emerged.

7.3 Commissioning takes place at a number of levels:

- at national level (for example, places in forensic secure psychiatric units and services for deaf children with mental health problems)
- at regional level (for example, commissioning pilots for residential provision for children in care)
- for a local population (for example, the allocation of primary mental health workers across a local area)

- for a particular community (for example, a Sure Start children's centre)
- for a particular set of needs (for example, a service for children in care)
- within a particular school or GP practice (for example, extended school services)
- between a partnership of schools (for example, increased support from behaviour support services or educational psychology)
- for an individual child or family (for example, a mixed package of care to address complex needs).

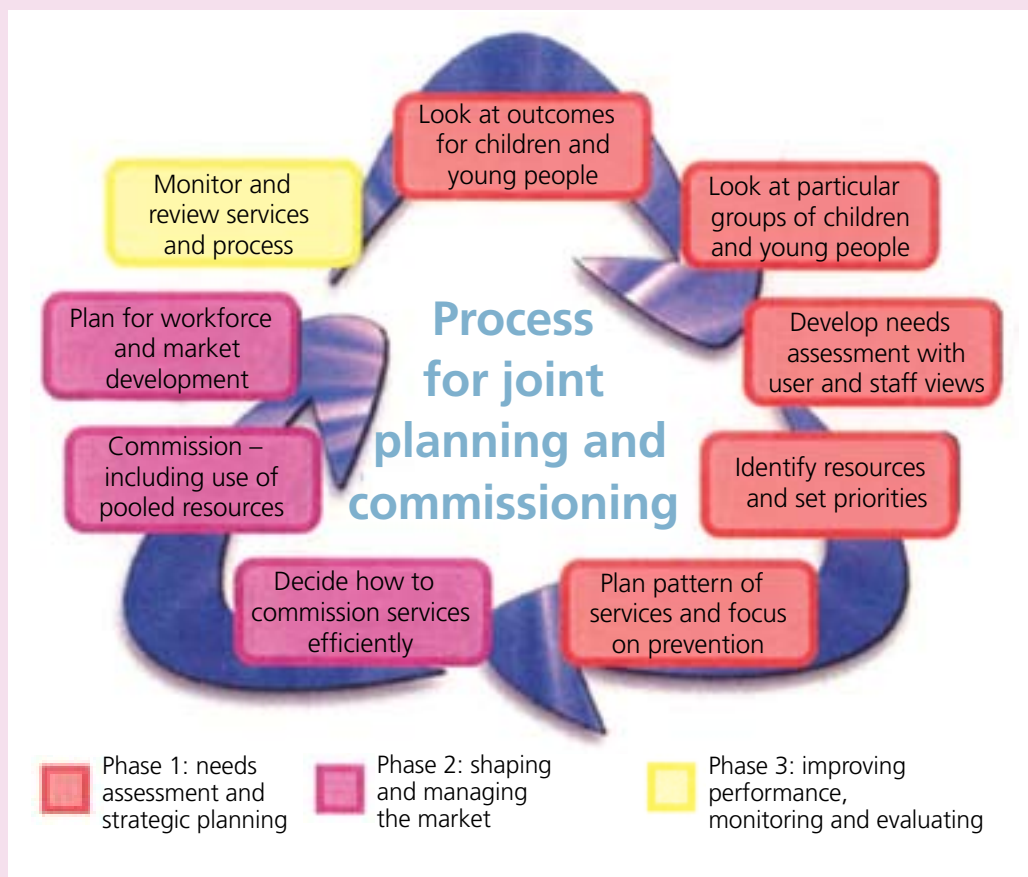
7.4 The language and process of commissioning are firmly embedded within health services and are developing within local authority services. While

commissioners of children's services are generally familiar with the commissioning cycles that underpin the world class commissioning cycle⁵⁹ and Every Child Matters (see **Figure 6** and paragraph 7.14), translating these into effective service planning and delivery is more challenging.

7.5 During our visits, we have seen examples of effective commissioning that is transforming service provision, for example:

- Some areas are bringing 'education' services such as educational psychology and behaviour support alongside CAMHS to deliver a more comprehensive service that improves mental health and psychological well-being across the board.

Figure 6: The Every Child Matters joint commissioning cycle



- In other areas, joint commissioning groups are developing new services by bringing together CAMHS, substance misuse, YOTs and other children's services.
 - For provision in the secure estate, a new commissioning framework is supporting the development of partnership approaches and is raising the profile of young people in secure settings at the local level.⁶⁰
 - a lack of knowledge or awareness among CAMHS staff of the bigger 'commissioning picture' across children's services
 - a lack of communication and a perceived lack of transparency in commissioning decisions
 - a lack of appropriate separation between commissioner and provider in some instances
- 7.6 Overall, however, joint commissioning for mental health provision is still under-developed. The process appears to be more straightforward when commissioners are dealing with new services rather than existing ones. Where there is a dedicated commissioning post, there is evidence that the outcomes are of higher quality, due to better planning and more emphasis on cultural change.

"It isn't something you do silently, you can't just do it in your own strategy area, you have to see yourself as part of a much wider mental health arena and in relation to the national framework – it is a new language for everybody... everybody has a very pivotal role to play."

Service provider

7.7 The range of agencies involved, the different approaches used and the lack of an overarching commissioning framework can create overlap, gaps and confusion. The areas that we visited said that the issues they find most challenging include:

- the competing agendas of different agencies and services
- the complexity of current commissioning arrangements and the lack of a coherent commissioning strategy
- skills gaps around commissioning

- the variation in the level of involvement of schools, colleges and GP practices in the broader commissioning process
- commissioners in some areas lacking the 'clout', skills, time, experience or capacity to work with service users, senior managers and service providers to prioritise and address the full spectrum of need.

7.8 In addition, many areas are missing out on the benefits to be gained from involving clinicians, practitioners and families in the commissioning cycle.

7.9 There is growing evidence of commissioning by schools, groups of schools and GP practices to support mental health and psychological well-being. However, it is not clear whether these approaches are consistent with other approaches used locally, how they are integrated with the local CAMHS strategy and how their quality and effectiveness is assessed. While this gives schools and GP practices greater ability to secure services for their local communities, it can lead to service inequalities, where certain children and young people have access to services, while others with similar needs in a local area do not. It can also have implications for clinical governance, for example where counsellors are engaged by individual schools rather than as part of the overall commissioning framework.

7.10 GP practices are developing a commissioning role, which presents

important opportunities in terms of joint commissioning within the Children's Trust. We suggest that it would be beneficial to identify ways in which GPs can more explicitly support mental health and psychological well-being, within a broader strategic approach. This would help to create a common sense of purpose across agencies and enable GPs to access support for their families from other sectors.

7.11 Joint commissioning for families is under-developed. Family-centred commissioning considers the needs of the whole family rather than either the child's or the adult's needs in isolation, because they are often interdependent. The Family Pathfinders⁶² announced in May 2008 have the potential to test joint commissioning approaches across social care and health services for children and adults. Examples include establishing an

early intervention fund that would allow frontline practitioners to purchase additional services where they form part of a family support plan. *A good starting point for areas not involved in these pathfinders would be for children's and adults' services to commission relevant services collaboratively.*

Commissioning specialist services

7.12 The commissioning of inpatient services for children and young people with more severe disorders is also variable. *At present, some services are commissioned at SHA level through the specialised commissioning groups, and some through collaboration between a number of PCTs. A greater level of consistency of specialised commissioning is being planned and we support this move. Issues that will need to be*



Practice example: Commissioning services

The children and young people we spoke to welcomed a 'one-stop-shop' approach, where they could get help on a wide range of issues, including mental health, as this approach was perceived as being less stigmatising. Having different ways of accessing services (for example by email, text or MSN) was also helpful and seen as more relevant to the lives of children and young people today. That said, some still preferred face-to-face contact. Older children (16 to 18 year olds) requested a combination of practical and emotional support (in line with the model offered by Connexions) to address the complex range of issues they often experience. They felt that the services that support and care for mental health should be better publicised in schools, libraries, youth clubs and GP surgeries.

In Area I, there are six geographical clusters that are intended to facilitate more localised management of targeted services for children from birth to age 11. Most of these services are attached to children's centres and extended primary schools. The clusters are conceived as operational level commissioning partnerships for children up to age 11, but they are currently at an early stage in their development. No significant budgets are currently held by clusters, and their role is more about influencing how other money is used. For example, they are in a good position to influence schools to use best evidence in terms of approaches that they fund. Similar arrangements apply for young people aged 11 to 19, based around four geographical areas and involving secondary schools and youth services. Age boundaries are not rigid, in order to manage transition issues.

addressed include the involvement of service users, identifying consistent sources of information, providing support after discharge and ensuring greater equity across the country and between groups of service users. The provision of these services should remain within the 'specialised definitions set' (which describes which services should be commissioned at a sub-regional or regional level) when it is next revised.

7.13 *We would also recommend that consideration be given to the way in which Regional Improvement and Efficiency Partnerships⁶³ can help to progress joint commissioning.* Based on the information presented to the Review, the development of a more co-ordinated strategic approach will require concerted action on the part of commissioners at local, regional and national level.

Support for commissioning

7.14 Service leaders and commissioners told us that they would welcome a single approach that can properly inform and assist the different types of commissioning that occur. Both DH and DCSF have

embarked on large-scale programmes to support local areas in commissioning. World class commissioning aims to change the way health services are commissioned for adults and children. The key elements of the programme are the vision, the organisational competencies and the assurance programme. PCTs are being supported by SHAs in implementing the framework. DCSF has just launched its Commissioning Support Programme to help Children's Trusts to foster a sustained change in the way they commission children's services. It is operated jointly with DH and will offer training and development opportunities and facilitate peer-to-peer networking. It is intended to be aligned with the world class commissioning programme.

7.15 It is essential that the Commissioning Support Programme is implemented jointly and addresses variations in the quality of commissioning at regional as well as local level. The programme also needs to bring clarity to all commissioning guidance documents being produced nationally so that they are consistent with each other and relevant to all partners in a Children's Trust, not just to individual agencies.



Practice examples: Commissioning specialist services

A CAMHS 'transformation project' in Area D was commissioned across all areas of service delivery, based on a shared vision that is emerging across the area. The area believes that its key challenge will be the de-commissioning of traditionally shaped and delivered services; however, this is necessary in order to enable investment in the development of provision to meet the specific needs of children, young people and their carers in the context of multi-agency partnerships. They will build on existing good practice, where services are already working together to offer a more flexible, accessible and child and family-centred approach. The strategy is seeking to end what some see as a 'postcode lottery' system, where pockets of good practice and good access to services are not replicated across the region. This has arisen because good practice has been dependent on individual leaders and providers, rather than a system-wide approach. Budget arrangements also affect where services are provided. For example, one service is bought directly by schools, some of which decided to engage the service, while others didn't; some people feel that this has resulted in an unplanned and inequitable approach.

7.16 Key recommendation: Each Children’s Trust should develop a local commissioning framework that provides clarity about who is commissioning what at a local level, covering for example children’s centres, GP practices, school partnerships, colleges and other Children’s Trust partners. This will enable the effectiveness and impact of commissioning to be identified and improved and enable the Children’s Trust to identify local inequalities in access to services. To provide clarity and consistency at local level, DCSF and DH should provide integrated guidance and support for commissioners of children’s services for mental health and psychological well-being and relevant adult services.

Commissioning guidance and support

The recommended guidance and support on commissioning should include guidance on joint strategic needs assessment and commissioning approaches, with the aim of moving to a unified approach. It should acknowledge the tension between commissioner and provider roles and address both of these important aspects. It should emphasise the need for child and family-centred commissioning, recognising that the broader needs of the family can have a significant impact on a child or young person’s mental health and psychological well-being.

Joint strategic needs assessment

7.17 A comprehensive needs assessment is fundamental to effective commissioning, hence the requirement on local areas to conduct a needs analysis for children and young people.

7.18 From our practice visits, we learnt that this process generates a wide range of valuable, but sometimes confusing, information. This comes from a range of sources, including the views and

experiences of children, young people, parents and carers, government departments, the CAMHS mapping exercise, education, social care, primary care and public health.

7.19 However, the quality of this data is not always consistent and it is not always considered collectively by those planning children’s services or used to best effect in the commissioning process. There appear to be a number of reasons for this:

- Needs analysis is a complex process that historically has been carried out by different services using different methodologies and systems.
- There is not always a culture of sharing information among different agencies.
- Those required to contribute data do not always appreciate or experience the benefits of sharing it (not only for the local area but also for themselves – for example to use in their own service planning).
- Needs analysis is a skilled process that requires those handling the data to be able to interpret it in a meaningful way.
- Government requirements can mean that local areas have to produce data for other specific purposes, which can make it less useful for analysis of local needs, and can perpetuate a ‘silo’ approach.

7.20 The data from the CAMHS mapping exercise is a valuable source of information and could be used more effectively, particularly if attempts are made to gather information more rigorously across services.

7.21 The introduction of Children and Young People’s Plans have led to the introduction of needs assessments for children in all areas. However, these exercises vary in quality, from comprehensive assessments that cover the whole range of needs and services,



Practice example: Getting young people involved in service design and delivery

In one large city a partnership between the local authority, the adult mental health trust and a voluntary sector organisation has led to the development of a network of family rooms within adult inpatient mental health facilities, designed by children and young people. This has led to improved support for the young carers of adults with mental health problems, who had previously felt ignored and unsupported.

through to local authority-focused exercises that are much more limited.

7.22 The introduction in 2007 of the annual joint strategic needs assessment⁶⁴ is a welcome step towards redressing this balance; however, it does not go into sufficient detail about the needs of children and young people. *The strengthening of the legislation for Children's Trusts should be used to further develop the effectiveness of the strategic needs assessment.*

7.23 Over recent years, there has been an increase in the extent to which children, young people and families are consulted about their needs and views on the planning and delivery of services. However, this is not yet embedded systematically into needs assessments or service design, and there is variation in the extent to which their stated priorities are implemented. This is a critical part of the commissioning process (see **Figure 6**, page 69), and we have seen examples of it quickly influencing service provision for the better – often in very simple ways (see, for example, the practice example above).

Considerations for vulnerable groups

7.24 Many responses and representations from organisations and individuals showed concern about the needs of particular groups of vulnerable children and young people. Commissioning and service provision that is focused on specific groups of children needs to be undertaken

cautiously. Even within a particular vulnerable 'group', the needs of children and young people are not homogeneous – there is as much variation within groups as there is across the whole population of children and young people. In addition, meeting needs outside mainstream provision can restrict the access of some children and young people to the full range of services that may be of benefit. That said, for some groups the additional specialist knowledge related to the circumstances of their vulnerability may be more easily accessed within a service dedicated to their particular group. This may be the case, for example, because they are a refugee or they have a learning disability. These issues need to be considered carefully within the local needs assessment in order to ensure that these children and young people have access not only to a full range of provision but also the specific expertise and knowledge that may be required to successfully meet their needs. To assist commissioners and service providers in ensuring that all children are considered within needs assessments, a list of the vulnerable groups who were mentioned to the Review is set out in **Annex E**.

7.25 In practice, we have found that services are often not being commissioned systematically and in co-ordination with other relevant services. There is still a tendency to think about children's needs in relation only to the agency or service that is dealing with them. For example, children and young people whose learning

is affected by behavioural, emotional and social difficulties, and who therefore have SEN, may be seen as the responsibility of education services alone, with different services – even within the same agency – setting high thresholds for involvement. The reality is that the range of their needs will be very similar to other children, for example, needs around parenting support or general health, as well as mental health (see **Chapters 4 and 5** for a more detailed discussion of the way in which services are currently organised for children and young people involved with different agencies).

7.26 The strategic needs assessment should be used to look at the needs of children and young people holistically and objectively, and for this to drive effective joint commissioning. This means that commissioners should have a good understanding of the range of needs in their area. And they need to know where to find the necessary expertise and sources of support and to identify any gaps in provision. This needs to be shared with practitioners so that they can develop their service provision to meet need. Where there are access issues because of a child or young person's situation, as is the case for children and young people who are

'hidden' from the system or those who do not have English as a first language, these should be taken into account. Finally, commissioners need to ensure that training and development programmes consider the increasing evidence base of what works and delivers the best outcomes.

7.27 *We support the approach taken by complex care panels and the joint commissioning of support for high-need children and their families, and recommend that this approach is taken with children and young people who have complex mental health, social and behavioural needs.* See paragraph 7.63 for our key recommendation on meeting the needs of vulnerable groups.

Information systems

7.28 One of the key frustrations of those contributing to the Review was the fragmented nature of the information available, in three respects:

1. The use of separate IT systems across different agencies.



Practice example: Provision in young offender institutions

One young offender institution has undertaken a whole-site review of young people's mental health and psychological well-being during their stays in custody. Different aspects of the young people's daily lives were observed, followed by interviews with young people, custody officers and other staff, and feedback from parents during family visits and their participation in their child's Detention and Training Order meetings. The study was designed to provide an analysis of similar questions from the three different perspectives. Following the review, the institution introduced a rolling programme of mental health awareness training for officers (provided by the local CAMHS) and a proposed pilot scheme where a primary mental health worker was based on one of the residential wings. Both developments acknowledge the vital role of prison officers (who have responsibility for the daily care of children and young people held in a secure setting) in promoting mental health and psychological well-being. They also build on the high value placed on the work of the on-site CAMHS team by young people and staff.

2. Related to this, the differing purposes for which data is collected, which have an impact on the consistency and comparability of the data.
3. Fundamentally, a lack of compatibility between the Every Child Matters outcomes and the outcomes and outputs being measured by CAMHS, which further complicates the previous two issues.

7.29 These are clearly key issues to be addressed if areas are to improve their needs assessment processes. Local areas require minimum child health data sets and models to enable planners and commissioners across local authorities and PCTs to better understand the complex relationship between spending on children's health and the actual health outcomes. Any national developments in this area should support this. Clearly, the definition of 'health' should be a broad one encompassing mental health and psychological well-being, to ensure that comprehensive and useful data is generated across all aspects of provision for children's mental health and psychological well-being.

Looking ahead

7.30 Going forward, we believe that all stakeholders should contribute to a comprehensive, multi-agency assessment of local need that is used, shared and updated on an annual basis, with a major review every three years. In line with the best practice outlined in the Children's NSF and the Every Child Matters commissioning guidance, this should cover:

- locally adjusted epidemiological information on the prevalence of children's mental health problems to reflect the diversity of the population and other local demographic circumstances

- an assessment of the needs of all children and young people in the locality who are vulnerable or at risk and their families
- an audit of the services currently provided by all sectors that address both directly and indirectly the mental health and psychological well-being of children and young people
- an analysis of current service usage and gaps
- the views of all stakeholders – including the children, young people and families
- the available evidence on the efficacy and effectiveness of interventions and service models
- current national and local policy priorities.

Resource deployment

7.31 Achieving a sustained emphasis on mental health and psychological well-being across children's services has many implications for practice. It also has implications for the way resources – both new money and ongoing revenue budgets – are deployed.

7.32 Over recent years, a substantial amount of additional funding has been made available nationally and locally. However, our visits suggested that much of this has been (or has been perceived as being) short-term grant or project-based. This leads to difficulties in financial planning, the long-term viability of good programmes and workforce stability and recruitment. It also leads to local inequalities in service provision. We saw evidence that some local areas were only commissioning services funded through new money and had not yet considered how to reshape provision using existing funding. The transfer of grants to the three-year Area Based Grant arrangements has brought a degree of certainty as have

the three-year resource allocations, but financial uncertainties remain.

7.33 Short-term and project-based funding also results in higher staff turnover. This in turn has an adverse impact on continuity of engagement with children, young people and their families. This is one of the issues that children and young people have strongly criticised when discussing current service arrangements.

“The CAMHS grant was significant in enabling the reshaping of CAMHS services. It gave the PCT and the local authority additional pools of money... and it did allow creative thinking and it did allow people to think outside the box.”

Commissioner

7.34 A number of areas have pooled budgets to deploy their ongoing revenue budgets more effectively. In the areas that we visited, those that had introduced ‘virtual’ pooled arrangements – where all parties were aware of the various budgets and considered collectively how best to deploy them – were broadly supportive of this approach. By contrast, the actual pooling of budgets was felt to be too time-consuming and bureaucratic. The recent consultation on Children’s Trusts⁶⁵ reflected these findings, with respondents requesting further practical advice and guidance on aligning resources and pooling budgets, as this was often seen as central to ensuring effective engagement between the local authority and health services.

7.35 It is increasingly recognised that investing early – either in the life of a child or in the development of a difficulty – can prevent problems escalating and, in terms of resources, save a great deal of money later. The Child Health Promotion programme is an evidence-based example of such an approach. However, in the Review we encountered a perception that

investment in preventive and early intervention services was unhelpfully taking resources away from specialist services. In such instances, the strategic needs analysis should provide evidence that needs are better met when resource changes take place. We have seen examples of areas that have effectively redeployed resources to develop new service structures that aim to address the full range of needs, though it remains the case that no locality has yet achieved comprehensive provision. One of the methods of supporting these developments has been the use of models such as the CAMHS New Ways of Working model developed within the NCSS programme,⁵⁸ which supports an assessment of skills mix in relation to identified local needs, thereby facilitating the reconfiguration of services.

7.36 Improving mental health and psychological well-being is a strand that runs, implicitly or explicitly, through the work of many children’s services. Currently, however, the overall level of resource that is being leveraged for this work is not being recognised. One of the ways in which the Government can reinforce the emphasis on mental health and psychological well-being is to ensure that the flexibilities for different funding streams are understood, and to encourage agencies to look at how they can contribute to overall service improvements in this area. For example, there is a significant amount of investment in sports, art and other leisure and creative activities. These can and should be considered part of children’s services, so there should be flexibility for local areas to harness these resources in support of improving mental health and psychological well-being. In particular, we would like to see improved commissioning of targeted youth support, particularly focusing on positive activities for young people, in order to embed their role in the overall strategy for improving mental health and psychological well-being for young people.

7.37 The Building Schools for the Future programme⁶⁶ provides opportunities for all new secondary school building projects to have a dedicated 'health space' for young people. This is part of broader plans to put schools at the hub of the communities they serve, offering co-located services for families on the same site, including health, social care, advice and welfare services.

7.38 During the Review, we could not identify strong, independent economic modelling data to quantify the long-term impact of investing in different children's services and types of interventions, with the exception of parenting interventions and conduct problems. As the population ages, and with the need to maximise use of public spending, this would be valuable data in enabling the Government to prioritise the allocation of resources.

7.39 **Key recommendation:** The Government should clarify the extent to which all funding streams – direct and indirect – can be utilised to help support children's mental health and psychological well-being. This should be communicated to all local and regional partners to improve their ability to pool and align funding.

Understanding individual needs, values and priorities

What children and young people told us

7.40 Children, young people, parents and carers value a child and family-centred approach from practitioners. They want to feel listened to and involved in the decisions taken about their situation. They see the establishment of a trusting, ongoing relationship with one or two key individuals as central to effective practice.

"I had a family group worker for over a year who I got really close to and then she had to go and I had to change... it really upset me."

Child

7.41 Children, young people and their parents and carers place a high value on accessible information that helps them to 'navigate the system' and find out more about the different services and interventions available, including their desired effect. They also want to be able to make decisions about the options available to them, where possible. This helps them to feel more able to access services and to communicate with professionals about their needs and preferences.

Assessing, planning and delivering appropriate services

7.42 Assessment is a skilled process that requires practitioners to be sensitive and attuned to needs, as well as being able to negotiate and agree next steps with the child, young person or family they are working with. Sometimes it is not possible to give service users exactly what they want – for a number of reasons – but the skill of effective assessment is in ensuring that the child or young person and their family are informed and involved throughout the process.

7.43 There are numerous assessment and planning systems for individual children and young people across children's services. This is complicated and can lead to the impression that more effort is being expended on assessment and 'ticking the boxes' than on helping the child or young person to address their needs. Systems include the CAF, the Care Programme Approach, the Framework for the Assessment of Children in Need and their Families (used in social care), the SEN Code of Practice and the ASSET assessment used by YOTs.

7.44 The CAF was introduced in 2006 as a concise, non-specialist assessment to help all practitioners – whether adult or child-focused – to assess children’s needs earlier and more effectively. It provides a useful and important prompt for staff in universal services to encourage a collaborative approach, to identify the reasons for difficulties and to do something about it.

7.45 Within CAMHS, the Care Programme Approach is used within some services as a framework for assessing, planning and reviewing needs. Originally developed for adult mental health services, it can be tailored to support the needs of children and young people to provide a framework for delivering effective mental health care for those with severe needs. The four elements of the approach are: assessment of need; a care plan to address needs; a nominated care co-ordinator; and regular review of provision. The framework can be modified at local level to take into account relevant issues such as the implementation of the CAF and the use of the lead professional model of service co-ordination.

7.46 There is currently a wide variation in the degree to which the CAF is being embedded across the country, and there are varying ways in which it is being used. This is unsurprising for such a recent development. A number of training programmes have been introduced locally to familiarise frontline practitioners with the CAF and to improve their confidence and skills in recognising people’s needs. These training programmes appear to be popular, though there is not yet evidence of their effectiveness. To improve the skills of all practitioners who are likely to become involved in identifying the mental health needs of children and young people, and the quality of individual assessments, there should be a professional development programme to equip practitioners with skills in effective needs assessment and analysis, including intervention planning.

7.47 However, we also found evidence of the continuation of a ‘referral culture’ associated with the use of the CAF, in which the CAF is carried out in order to simply refer a child on to other services. This was not well received by other professionals, and is a good example of the cultural change required in delivering support for mental health and psychological well-being more effectively. For example, the first question that needs to be asked by those using the CAF is ‘what can I do to meet this child’s needs?’ Better training and development, and a culture in which everyone understands their role and contribution to children’s mental health and psychological well-being, will help develop more effective practice around this issue.

“He couldn’t answer a lot of the questions... he didn’t feel listened to – he was telling them the same thing over and over again.”

Parent/carer

7.48 We are concerned that adult mental health and social care services are not always aware of, or able to make the connections with, children’s services to meet their duty of care to identify the needs of children of service users. The revised guidance for the Care Programme Approach should be followed,⁶⁷ and Children’s Trusts should ensure that there are formalised links at local level to facilitate this. Though the CAF is seen – and positioned – primarily as a tool for those working within children’s services, staff in adult services should also consider using it with the children of adults they are working with. This family-centred approach to assessment in all local areas is currently being tested through the Think Family approach adopted by Family Pathfinders, where frontline staff seek to find out about and address wider family needs in a more integrated way. This is another useful source of learning.

7.49 The evaluation of the first CAF pilot sites⁶⁸ found that the tool was helping to ensure that provision was in place more quickly for children and families, and practitioners were positive about its potential to achieve better outcomes. This was confirmed in some of our Review visits. We also found that barriers to more effective assessment – whichever tools are being used – include: a lack of co-ordination between the different agencies who might provide support and care; a lack of professional trust; a lack of clarity about the process to be followed; anxiety about increased workload for those undertaking the common assessment; a lack of skills and confidence; a lack of understanding of how to translate assessed needs into an effective plan for intervention; and a lack of support from line managers and supervisors.

"I didn't realise that care pathways start with me – I thought CAMHS started when I filled out a CAF."

Practitioner

7.50 In addition to identifying needs and problems, there is also the important task of ensuring that children and young people are informed about what is happening, and are given the necessary support to make choices and decisions for themselves. Where this is undertaken most effectively, it is carried out on an ongoing basis, rather than on a single occasion.

7.51 Further guidance and training needs to continue to be made available, in order to promote an understanding that the CAF is not only designed to help identify children's needs but also to facilitate collaborative, solution-focused working around identified needs, across the children's workforce and with families – it is not a referral tool. This will help to establish the CAF as the common assessment for lower-level needs across all children's services. We also hold the view that it is timely for the Government to review other statutory assessment

processes to consider how they can interface more productively with an effective common assessment process. This will help to reduce unnecessary duplication, release professional time for intervention and reduce what parents, children and young people consistently describe as the burden of the different assessment systems currently in place.

7.52 The lead professional is being introduced across children's services as a point of contact for children and young people with multiple needs who are involved with a range of agencies. Those taking on the role of lead professional have a key part to play in ensuring that the actions identified in the CAF – or other assessments – are carried out by the relevant services. Early findings from the implementation of the lead professional⁶⁸ found a number of positive ways in which the role was being used to tackle local issues and problems. For example in one site, the lead professional role was being used to smooth the transition from CAMHS to adult mental health services.

7.53 Given the range of issues facing many children and young people with complex mental health needs, we believe that the lead professional way of working is an important principle that should be embedded in practice in an appropriate way across all children's services. This needs to be discussed across all Children's Trust partners to agree the scope and definition, to make sure that it fits local priorities and best practice arrangements, and to ensure that those fulfilling lead professional roles have the right training, designated authority and support to enable them to call others to account if necessary.

7.54 **Key recommendation:** The national roll-out of the CAF should be strengthened by an evaluation of the use of and effectiveness of the CAF in identifying mental health needs and a review of statutory and specialist assessment

frameworks to assess the potential for reducing unnecessary duplication.

Meeting the needs of vulnerable groups

7.55 Reviews and studies repeatedly highlight that children who are at greater risk of experiencing mental health problems are not being identified early enough, nor are they getting a comprehensive range of support and care, including access to promotion, preventive and early intervention work. This review is no different: despite the progress that has been made in the different statutory systems, there are still barriers to addressing the needs of those most vulnerable children and young people who come into contact with numerous agencies – or who do not come to the attention of agencies at all. Some of the recommendations made so far in this Review will help to address this over time. But there remains a need for practitioners to think about how they are working with these children and families, and to question whether they are providing the most effective support and care. Some further issues are considered below.

7.56 Children and young people from black and minority ethnic communities were under-represented as service users in the areas that we visited. Areas were keen to do more to develop the skills of staff in working with people across a range of different cultures. It can be challenging for children's services to fully understand how differences within and between communities impact upon mental health needs, and also how to make services more accessible and acceptable. The voluntary sector was seen as providing an important source of help. Our literature review found inconsistent evidence overall regarding the representation of children from black and minority ethnic groups within CAMHS. It is more likely that their problem will reach a crisis point before they come into contact with services. This may be due to the fact that mental health

issues are sometimes seen as stigmatising. In some areas there may be different referral routes for different minority ethnic groups. Professionals are not always sensitive to different cultural backgrounds, and the use of interpreters can lead to concerns about confidentiality and can make it difficult for practitioners to develop relationships with families.⁶⁹

"Before I didn't know how to speak English. If I explain to someone something they don't get it, the way how I say it... But [my support worker] knows because I've been with her for a long time."

Young person

7.57 The factors that cause a child to be received into care are frequently also those that cause them to be at risk from mental health problems (see paragraph 5.14). Yet evidence shows high levels of unmet mental health need for children in care, despite notable improvements. This may be due in part to placement changes or lack of carer awareness, which result in mental health needs being overlooked. As a minimum, all children and young people in care need access to mental health promotion and personal development opportunities. In addition, a sensitive and child-centred approach should be adopted to address the issue of increased prevalence of mental health issues among this group. Completion of the Strengths and Difficulties Questionnaire is now a requirement for all children and young people in care, and this will help to identify mental health and psychological well-being needs among this group, which is more at risk. The same principles of effective and sensitive use of assessment information by a knowledgeable practitioner apply here. This information also needs to feed into the local needs analysis to ensure that appropriate provision is put in place to support these needs.

7.58 Children and young people with learning difficulties and disabilities generally experience difficulties in accessing support and care. We identified a number of studies that found evidence of families struggling to get referred, being unaware of the available services, being turned down by services, and experiencing geographical variations in acceptance criteria and availability of services.⁷⁰ Recent developments at national and local level have sought to address these service gaps, for example through the introduction of a performance measure and the development of a learning disability care pathway,⁵⁷ though provision across the country remains patchy. For example, the recent review of safeguarding²⁵ found that children and young people with very complex learning difficulties and disabilities were generally well supported, but the high thresholds meant that children and young people with lower levels of need could not access appropriate provision. The Review found particularly limited service provision in specialist therapeutic and respite services, speech and language therapy and CAMHS and, for those with the most complex and severe difficulties, specialist inpatient services. This can lead to a high dependency on out-of-area placements and inpatient care far from home. *There should be a strand of work within the Government's Aiming High for Disabled Children⁷¹ programme that addresses this.*

7.59 Physically disabled and chronically ill children and young people are also at particular risk of experiencing mental health problems, yet they do not always receive the support and care that they require. Reasons for this include a lack of CAMHS involvement on paediatric wards (paediatric liaison service); differences in the culture, structures and working practices of medical staff dealing with physical disorders and those dealing with mental disorders; a tendency to overlook the impact of physical illness on mental health and vice-versa; a lack of expertise;

and difficulties in co-ordinating services where child mental health and paediatric services fall under different employing trusts, which is the case in many areas of the country.⁷³ *These problems continue despite Standard 7 of the Children's NSF, which addresses the needs of children in hospital, and we would suggest that urgent attention is required.*

7.60 During the Review we heard families and children in vulnerable circumstances saying that they need better access to services, more involvement and a more joined-up approach. They want services that do not stigmatise them and that provide continuity. Confidentiality is extremely important to young people but, where they have given permission, they also want staff in different services to talk to each other so that everyone is taking a consistent approach. This has implications at all levels of the system, from the structure of Children's Trusts, the commissioning approach and the ability of different providers to work effectively together, through to the skills of those working with these children and their families.

7.61 The budget-holding lead professional concept was piloted in 16 local authorities to explore whether holding budgets could give lead professionals additional power to ensure that children, young people and families get the public services they need, when they need them (rather than as and when public service organisations grant the services to them), and reduce overlap and inconsistency from other practitioners, thus reducing the costs per 'episode' of intervention. A huge range of services have been procured during the course of the pilot, from counselling, anger management, behavioural support and self-esteem groups, to guided escorts to school and interpreting services. It is envisaged that offering this kind of flexibility – even if the sums involved are relatively small – will encourage families to engage with services that they have previously distanced themselves from.⁷³

7.62 Our concern for all vulnerable children and young people is that their mental health needs are consistently identified by routine rather than chance, and provided for. This should include children and young people who are placed out of a Children's Trust area (for whatever reason). To ensure their needs are better met, we suggest the Government should review whether the current funding and commissioning arrangements are sufficiently robust to ensure that funding, provision and accountability can follow the child where appropriate. In addition, the local description of services (see key recommendation at paragraph 4.43) should include specific reference to the ways in which children at risk of mental health problems will be supported.

7.63 **Key recommendation:** Children and young people and their families who are vulnerable, such as children in care, children with disabilities and children with behavioural, emotional and social difficulties, should be confident that (in addition to the provisions set out at paragraph 3.8 and paragraph 5.36):

- their mental health needs will be assessed alongside all their other needs, no matter where the need is initially identified
- an individualised package of care will be available to them so that their personal circumstances and the particular settings where they receive their primary support appropriately influence the mental health care and support they receive
- for those experiencing complex, severe and ongoing needs, these packages of care will be commissioned by the Children's Trust and delivered where possible in the local area. Effective regional and national commissioning will occur for provision to meet rare needs.

Transitions

7.64 There are a number of transitions that children and young people have to negotiate during their development, and these can be a focus of difficulty and stress. The first day at school, the transition from primary to secondary school or the transition to college, work, training or university can be difficult, and they are times when mental health problems often become identified. The well-documented transition issues facing disabled children and young people have resulted in a number of guidance documents in recent years, as well as a Government-funded 'transition support programme'.⁷⁴ Children and young people in secure settings face transitions to and from home, between establishments and even between different parts of the country. There are also unplanned transitions and changes, such as family breakdown and bereavement, which are known to have a significant impact on children's mental health and psychological well-being.

7.65 However, during our practice visits, it was the transition from CAMHS to adult mental health services that caused children, their families and service providers most concern. These problems are not new, and they relate to the considerable cultural and service criteria differences between the two broad groups of services. The result is that a 16 or 17 year old may not be referred for treatment because providers believe that he or she will not be eligible for subsequent services, or that an 18 year old may find himself or herself without a continuing service. In both cases these young people miss out on valuable potential support and care.

7.66 Those who are most affected include vulnerable groups such as young people in care and young people excluded from school. Young people with some specific types of disorder also encounter particular difficulties, for example those with behavioural problems. Young people who

have ADHD and who require continuing care into adulthood, for example, find themselves particularly vulnerable. This is due to the limited evidence base for the treatment of ADHD in adulthood, and the lack of experience and training in the care of young adults with ADHD both within adult mental health services and primary health care. We welcome the recently published NICE guideline on ADHD,⁷⁵ which not only updates advice on the treatment of ADHD in childhood but also addresses both the transition of care and the treatment recommendations for ADHD in adulthood. This model should be used for other areas of need, for example for young people on the autistic spectrum.

7.67 There are notable examples of services making great strides to address the transition of care from child to adult services. We are aware of a variety of approaches including jointly agreed transition protocols, the appointment of lead practitioners or 'transition' workers, the formation of partnership boards that include representation of adult services as well as CAMHS, and the creation of 'transition services' that include both child- and adult-trained professionals. However, they appear to be the exceptions rather than the rule, despite the expectations on service providers set out in the Children's NSF. The relatively new early intervention services for young people with a first-episode psychosis ('early intervention in psychosis'), which should bring together CAMHS professionals with their adult colleagues, have not achieved all that was expected, despite their potential to oversee effective transitional work for young adults.

7.68 During the course of the Review, a research study commissioned by the National Institute of Health Research Service Delivery and Organisation Programme, on transitions between CAMHS and adult mental health services, was beginning to publish its findings.⁷⁶ This will provide important data to guide commissioners and providers in improving

services at the interface. The issue of transitions has also been addressed in guidance from the Royal College of Psychiatrists.⁷⁷

7.69 This is not, however, just an issue for mental health services, but for all children's services. Their responsibilities differ according to the age of the children and young people that they are working with:

- CAMHS specifies a transition at the age of 18.
- Local authority children's services (including schools, colleges and youth services) are generally provided up until the age of 19, though people can receive services up until the age of 25 if they have disabilities.
- Children in care can continue to receive services from the local authority up until the age of 21, or age 25 if they are following a programme of education or training.
- The youth justice system works with children and young people aged 10 to 17.

7.70 There were calls from some quarters for this Review to recommend that CAMHS should cover young people up until the age of 19, in line with the general responsibilities of local authority children's services. Others proposed the establishment of services for 16 to 25 year olds. Both proposals reflect the need for action to be taken to improve services for young adults. At the same time, we are aware that many CAMHS are still struggling to effectively meet the needs of all young people up until the age of 18. They do not have the resources or capacity to extend their services to 19 year olds, particularly when they are focused on ongoing improvements elsewhere. The establishment of 'young adult services' – for example for 16 to 25 year olds – offers a possible solution, but there would still be



Practice example: Supporting transition to adult mental health services

To provide better transitions for young people with mental health problems, Area C has created three posts to facilitate transitions between child and adult services, and to help adult mental health services provide more appropriate services to the young people that they are involved with.



Practice example: Supporting transition from custody to community

The needs-led and age-developmental approach to managing transitions has been well handled by some of the YOT Resettlement and Aftercare Provision teams. This is a pilot programme designed to help young people with substance misuse problems to resettle in the community after custody. The young people opt-in to receive support with practical difficulties and emotional well-being while they are completing the community part of their Detention and Training Order. The model incorporates best practice principles in responding to children and young people's mental health and psychological well-being.

an age-related interface between services at 16 and at 25.

7.71 This is a long-standing and very real issue for an important group of young people. Chronological age is not the best determinant for appropriate service provision. Instead, it is a focus on the specific needs of the individuals in question that should be the priority for local commissioners and providers. This has implications not just for service configuration and service flexibility, but also for the training of the workforce.

7.72 We consider that all young adults should have the right to service continuity to meet their needs when they reach 18, set out in the local offer. This will require Children's Trusts and adult commissioners to jointly plan and commission this, working with relevant clinicians to develop skills and services.

7.73 Finally, the DCSF and the Department for Innovation, Universities and Skills need to work together to consider the support necessary for employers, work-based learning providers and colleges to meet the needs of young adults as they take up the universal offer of education or training up to the age of 18.

7.74 **Key recommendation:** Young adults who are approaching 18 and who are being supported by CAMHS should, along with their parents or carers:

- know well in advance what the arrangements will be for transfer to adult services of any type, following a planning meeting at least six months before their 18th birthday
- be able to access services that are based on best evidence of what works for young adults and which have been informed by the views of young adults
- have a lead person who makes sure that the transition between services goes smoothly
- know what to do if things are not going according to plan
- have confidence that services will focus on need, rather than age, and will be flexible.

National action to support transition

DH should undertake a piece of joint work between the policy teams responsible for CAMHS and adult mental health services to determine the action that is needed in order to address the current problems in ensuring a seamless transition between CAMHS and adult mental health services. This should address those aspects of mental health policy that have an impact on the differing priorities and cultures of the two services; include an assessment of the current evidence of what has been found to work well; ascertain the resource and training implications; and establish what action may be required at the national, regional and local levels to improve the experiences of young people who need to graduate from CAMHS to an adult mental health service.

DH and DCSF should undertake a piece of joint work between the policy teams responsible for children's social care and adult social care to determine what action may be needed to address the current problems in ensuring a smooth transition between these services, as well as the part that social care services can play in improving the experiences of young people who need to graduate from CAMHS to an adult mental health service.

Developing and supporting people who work with children

8.1 The mental health and psychological well-being of our children and young people depends on the contribution of everyone who works with them – nursery nurses, midwives, health visitors, teachers, social workers, foster carers, psychologists, psychiatrists, mental health nurses and youth and community workers to name but a few. This is a sizeable and diverse group of people, working in the public, private and third sectors with new job roles and with rapidly developing ways of working.

8.2 We have clearly identified a need for a well-informed, well-developed and well-trained workforce who:

- understand what mental health and psychological well-being is
- know what they can do to improve it and, if necessary, when and how to call on additional support
- understand how to work most effectively with families, children and each other
- have access, in a way that is relevant to them, to an accessible and high-quality body of knowledge that covers both the growing evidence base on interventions to improve mental health, as well as best practice in working with children and families.

8.3 The skills of commissioners and service leaders and managers also need to be developed if the scale of change required across this wide and complex area is to be realised. People working in specialist

services need to enhance their skills in working with families and also other agencies.

8.4 It is not just about providing access to training and information. Developing the workforce is also about ensuring that practitioners are operating in an organisational culture that encourages new skills and practices and ensures that they are implemented. This level of change requires systems and approaches in place at service and team level in order to supervise, manage, support and share good and developing practice in all sectors.

“They should tell us a little bit about themselves that we didn’t know before... so they can trust us and we can trust them.”

Child

8.5 This chapter outlines key issues that need to be addressed to support the children’s workforce more effectively, and to ensure continuous improvement in the quality of services.

Training and development

8.6 In our consultation, around 40% of respondents said that the expertise of those working in universal services to identify and assess children and young people’s mental health and psychological well-being was satisfactory. However, more than 30% considered it to be poor. Their expertise in addressing children and young people’s

own concerns about mental health and psychological well-being was considered satisfactory or good by around 50% of respondents, and poor by around 30%.

“She listened to everything we said; she praised my son all the time. I felt like she understood me as a mum; she understood us as a family. We opened up – we told her everything.”
Parent/carer

8.7 Access to training and development opportunities to improve the quality of work around mental health and psychological well-being was considered poor by 30%, satisfactory by 27% and good by 21% of respondents.

8.8 Improving practice is dependent upon practitioners being given sufficient support, time and resources to develop the requisite knowledge and expertise. In addition, leadership programmes are necessary to ensure that there is positive and responsive multi-agency leadership to engage and support the workforce, so that the best and most effective child and family-centred practice becomes the norm.

8.9 With the exception of national pilot programmes such as the Parenting Early Intervention Pathfinder and Health-led Parenting Support (where training opportunities have been exceptional), it is not always easy for all services to gain ready, cost-effective access to opportunities to develop and sustain the skills and competencies necessary for effective practice, although many local areas have been developing approaches on a multi-agency basis.

8.10 *It is our view that the Government’s forthcoming children’s workforce development strategy provides the opportunity to strengthen the strategic approach necessary for the development of a highly skilled workforce. It also provides opportunities to evaluate the impact of training.*

8.11 We found that many practitioners, for example teachers, do not currently receive initial training in child development or in approaches to improve mental health and psychological well-being. Although there are increasing numbers of examples of high-quality in-service training for professionals in early years, education and primary care settings, these are by no means comprehensive. We consider this to be a basic and fundamental gap that should be remedied, in all sectors.

8.12 Training and development can be resource-intensive, and there are concerns about the time required to introduce training on such a wide scale for people who are already engaged in busy jobs. However, we note that there is a precedent in both national and regional developments for time to be made available for training (for example in the curriculum programmes for schools, and in the development of the Royal College of Paediatrics’ child mental health training for paediatricians). While further developing the skills of the current workforce is necessary, stronger initial training provides an excellent opportunity for developing a skilled workforce for the future.

8.13 **Key recommendation:** There is a need for better basic knowledge of child development and mental health and psychological well-being across the children’s workforce. The Government should ensure that all bodies responsible for initial training provide basic training in child development and mental health and psychological well-being. This should be in place within two years. The children’s workforce development strategy should set out minimum standards in relation to key knowledge of mental health and psychological well-being, to cover both initial training and continuing professional development.

Regional, local and service-focused action to improve training and development

- At regional level, SHAs and GOs should develop joint plans to enhance and support the skills and the professional development of commissioners and managers through training programmes and the development of learning networks.
- At local level, PCTs and local authorities should develop a joint strategy for improving the capacity of children's services to improve and support mental health and psychological well-being. This should be a distinct element within the overall workforce development strategy, and should include training on specific interventions and approaches, cultural competency, developing commissioning skills and management of change.
- Within individual services and institutions, leaders and managers should ensure that the skills, qualities and practice of their staff and organisations are consistent with the values and content of the programmes and interventions they are using to improve mental health and psychological well-being.

"The person that I was talking to, they just sat there with a blank face like they just couldn't relate to me – it was like they didn't know what to say to me."

Young person

Supervision and skills

8.14 There are increased expectations on the early years, school, college and residential social care workforces to take responsibility for providing initial help for children and young people with a wide range of problems. But it is often support workers, with the least experience and training, who are working with the children and young people with the most complex needs and problems. Supervision and consultation arrangements in these sectors are not as established as they are in other disciplines. In our view this can create unnecessary pressure and risk. Effective supervision and consultation develops skills and ensures that there is a strong momentum for progress and improvement for individual children. We consider that supervision and consultation arrangements in early years, school, college and residential care settings need to be improved through stronger arrangements with more specialist staff – such as educational psychologists, social workers and CAMHS workers. This will, however, need to be resourced.



Practice example: Training and development

An evening training programme has been established in Area E that is delivered to staff in universal services by CAMHS staff. It includes an introduction to mental health, information about CAMHS and advice on managing challenging behaviour. The programme has now been delivered to 500 frontline staff, and the high take-up rate is felt to show the willingness of staff in universal services to engage with issues around mental health and psychological well-being. At the same time, staff have also noted the importance of supervision and ongoing support if they are to engage fully in this work.

8.15 *Priority should be given to addressing the needs of staff working in special schools, PRUs, children's homes, intensive foster care and custodial settings where children and young people with the most complex difficulties are to be found. In addition to improved supervision and consultation arrangements, more rapid progress needs to be made with improving the qualifications, skills and salary levels of practitioners working in these settings to enable them to better meet the mental health needs of the children and young people for whom they are responsible.*

8.16 **Key recommendation:** At local level, managers and leaders should ensure that all staff – especially those with the least experience and training – are supported by rigorous and clear management systems. Consideration should also be given to supporting practice, particularly early intervention in universal services, through additional training, formal supervision and access to consultation from specialist services.

Evidence and knowledge

8.17 Over the last decade there has been a step-change in our knowledge of 'what works' in supporting mental health and psychological well-being. There is a general recognition that delivering services that are informed by the available evidence base is essential if we are to improve outcomes for children and families. However, there is also a lack of consensus across agencies about what constitutes 'good evidence', a lack of research in certain key areas (notably the evaluation of multi-faceted interventions to address the needs of vulnerable groups), and insufficient evidence of how best to translate findings from carefully conducted research trials into day-to-day practice.

8.18 The improving evidence base has prompted the development of a number of large-scale pilots of specific approaches, including Parenting Early Intervention

Pathfinders, Family Nurse Partnerships, Multidimensional Treatment Foster Care and Multi-Systemic Therapy Pilots. The evidence base has also been used to inform the development of a range of frameworks and programmes, such as the Child Health Promotion Programme, the SEAL programme and the Sure Start personal, social and emotional development training materials.

8.19 We found that a huge amount of material exists about the effectiveness of different approaches for improving mental health and psychological well-being. However, many commissioners, managers and practitioners have limited awareness of the evidence, or do not know how best to use it to inform their practice. Two key reasons for this appear to be that:

- much of the crucial research is located within profession- or agency-specific journals and policy guidelines. This means, for instance, that guidelines from NICE may be seen as relevant only to NHS staff and guidelines from the Social Care Institute for Excellence (SCIE) as relevant only to social care professionals
- keeping up-to-date with research evidence can be time-consuming and this is a challenge for busy professionals. This creates tension for those practitioners who want to improve the quality of their work.

8.20 In addition, our literature review⁷⁸ found that practitioners face other barriers, including: significant gaps in the evidence within their field; some resistance to using evidence from other professional sources; a lack of understanding of what the evidence means for their practice; and a lack of inspirational leadership, training and supervision.

8.21 We believe that steps need to be taken to bring together relevant research evidence, and to improve its dissemination across all agencies so that people working

with children can access information more easily.

Developing and disseminating the evidence base

8.22 The improved co-ordination and dissemination of research material has to be done in a way that practitioners can contribute to and use in partnership with others. This will require better co-ordination between national research bodies, and a greater awareness among managers and practitioners about ways to develop evidence-informed practice.

8.23 Some respondents to the Review proposed the establishment of a new research and effective-practice body, set up specifically to address children's mental health and psychological well-being. However, it is our view that this would add further complexity. A more cost-effective approach would be for the Government – advised by the proposed National Advisory Council and others – to commission existing bodies such as NICE, the Centre for Excellence and Outcomes (C4EO) and the National Academy of Parenting Practitioners, to work on a combined programme to bring together relevant high-quality research evidence, in order to establish links with all the key research organisations and to make recommendations for a future research programme.

8.24 Despite the considerable improvements in the evidence base over the last decade, there are many knowledge gaps that need to be filled. The main gaps we identified during the course of the Review include:

- a lack of accessible information about child development from birth to adulthood, and also about parenting, both of which are central to an understanding of mental health and psychological well-being

- a lack of evidence on effective structures and arrangements for delivering services to support mental health and psychological well-being
- a lack of evidence on the effectiveness of interventions for children and young people who have difficulty accessing services and for those with complex mental health problems, as these often co-exist with family, social and economic difficulties
- a lack of knowledge on how best to implement interventions developed and tested under strict research conditions into day-to-day practice.

8.25 These gaps need to be filled through a focused and targeted programme, driven by the needs identified by key stakeholders, rather than by funding sources. Service commissioners and providers will have valuable contributions to make, as will academic institutions and researchers. Service commissioners often lack the evidence required for effective commissioning, and service providers face the challenge of translating high-quality research evidence into practical approaches within day-to-day practice.

8.26 The proposed National Advisory Council would usefully have oversight of such an exercise and be in a position to contribute to the setting of priorities, monitor the research that is commissioned and ensure that mechanisms for communicating and implementing key research findings are instituted.

8.27 However, simply improving the evidence base and access to it will not, in itself, improve the quality of practice. Service leaders and managers need to create the conditions for developing more reflective practice and for ensuring that all interventions are evaluated, in order to develop practice-based evidence. There may also be training requirements for practitioners, to ensure that they have the necessary skills and understanding to



Practice example: Using the evidence base locally

Area C is looking at the development of new interventions using national and international evidence bases. These interventions focus in particular on addressing issues related to the management of risk and the promotion of resilience; encouraging attachment; and nurturing and ensuring access to emotional support for children and young people who need it. Recent approaches based on the evidence include a programme for children in care, a voluntary sector service for vulnerable children in primary schools, early years autism services and programmes on risk-taking for young people. All of these are being formally evaluated.

translate the evidence base into sensitive practice with a child and family.

8.28 Key recommendation: Given the increased number of guidelines being introduced by NICE and SCIE that recommend specific evidence-based therapeutic approaches to help children and young people who have significant mental health problems and disorders, we recommend that the Government should assess training capacity and, if necessary, fund training centres to ensure that there is training available for the children's mental health and psychological well-being workforce in all parts of the country for evidence-based therapies.

Regional and local action for improvements in training capacity

- At **regional** level, SHAs and GOs should work together, through the recommended regional board, to address the shortfall in the training currently available in their regions.
- At **local** level, PCTs and local authorities should undertake an audit of the current capability of the workforce to deliver evidence-based therapies, including the capacity for training and supervision, and develop plans to address any shortfall.

Monitoring progress and evaluating outcomes

Outcomes-focused evaluation

8.29 Despite an overall increase in spending, there is still considerable variation between areas on the amount of resources committed to the development, implementation and monitoring of effective practice and outcomes.

8.30 The current performance regime rewards the achievement of outputs and structures across a range of government indicators, although this is changing. The three original CAMHS proxy indicators have been necessary in driving improvements in priority areas in recent years. However, they can be open to varying interpretations of compliance and they provide little indication about the quality of services or of the impact of these services, on children's mental health and psychological well-being.

8.31 Within CAMHS, mapping data has provided a better understanding of the numbers of children seen, their presenting difficulties, activity data, and financial spend. There is also useful data from a number of education sources that is currently under-utilised, for example the Foundation Stage assessments on personal, social and emotional development and SEN audit data in relation to children and young people with behavioural, emotional and

social difficulties – including their academic progress. There is less information available on the extent and outcomes of promotion and prevention work across children’s services.

8.32 Outcomes-focused monitoring and evaluation are increasingly being recommended, and are considered to have benefits for individuals involved in treatment; for practitioners in understanding what types of interventions lead to what outcomes for what groups of children; and for commissioners and decision-makers responsible for planning and delivering effective services.

8.33 However, moving to an outcomes-focused system is challenging. It requires a clear strategy, the development of appropriate instruments and approaches, the resources to support implementation and delivery, strong leadership, organisational stability, drive and flexibility. This is not a short-term goal and it will require a sustained focus in the long term to allow for lessons to be learnt and improvements to be made.

8.34 About half of CAMHS are undertaking routine outcome measurement, though not necessarily throughout the service, supported by the work of the CAMHS Outcome Research Consortium. This data is included in the CAMHS mapping. Many educational psychology and behaviour support services also do this, but data is not collated nationally. In our practice visits, four of the nine areas said that they would welcome a better understanding and guidance about outcome indicators, and four out of nine said that they had concerns about the costs and capacity required to move towards an outcomes-focused system.

8.35 Work by DCSF and DH has been commissioned to assess how good-quality, routine outcome monitoring can best be achieved and implemented nationally. We consider this is an essential move in order to secure the consistent

improvements in quality of practice that are necessary, though the challenges should not be under-estimated. We would therefore urge the Government to pursue the conclusion of the first phase of development of this work by April 2009, however it will also have to give long-term sustained support to ongoing development.

8.36 **Key recommendation:** The Review strongly supports the ongoing work to develop outcome measures for children’s services for mental health and psychological well-being.

Work to develop outcome measures

To ensure continued progress, the work to develop outcome measures should be given a sustained focus over the next three to five years to realise the full benefits. It should be seen as a continuing programme and sustained to ensure that lessons from the implementation process are learned, that revisions are made where necessary, and that any further developmental work is undertaken to improve the measures. Careful attention should be paid to any resource requirements that are needed to deliver effective and sustainable outcome measurement at local level. The objective should be to ensure that measures to assess mental health and psychological well-being outcomes are extended across all children’s services in order to reflect the multi-agency contribution to the improvement of mental health and psychological well-being.

Peer review networks

8.37 During the Review we have seen evidence of the potential of peer review networks in promoting better practice. This is particularly important in the drive to improve practice around mental health and psychological well-being, to help professionals within the relevant fields to

learn from each other, and to take ownership of the service improvement agenda rather than feel that it is a process imposed from above.

- Within CAMHS, there are two peer review networks – QNIC (Quality Network for Inpatient Child and Adolescent Mental Health Services) and QINMAC (Quality Improvement Network for Multi-Agency Child and Adolescent Mental Health Services). QNIC is for those involved in inpatient care, while QINMAC is aimed at those delivering Tier 2 and 3 services, and has a multi-agency outlook.
- Within social care and education, Research in Practice and the newly established C4EO provide access to peer support networks and online communities.

8.38 We would urge local areas to consider how peer review can be built into their performance management and quality improvement arrangements more consistently. This will require the support of commissioners and senior managers. We would also like to see the work of the different peer support organisations become more widely known across other sectors. This would give further impetus to collaborative working across the different sectors.

Support and challenge

8.39 We welcome the joint commitment to prioritising mental health and psychological well-being by the Secretaries of State for Health and for Children, Schools and Families during the period of the Review. This commitment underpins PSA 12, the Vital Signs set out within the NHS Operational Framework and the National Indicator Set and Local Area Agreement arrangements.

8.40 While Children’s Trusts in local areas need to lead the comprehensive service improvements, they need to be supported – and challenged – to ensure that it is done in the most effective way. Current support and challenge arrangements have tended to be sector-specific – for example, there are National Strategies’ behaviour and attendance consultants for schools, improvement support for services for children in care and the NCSS for CAMHS. These have led to positive improvements, however they are not aligned with each other, are variable in their approach and do not consistently support the expectations on Children’s Trusts to secure comprehensive change within all services in an area.

8.41 The national support programme that we recommend in this chapter should have the objectives of ensuring that:

- local, regional and national leadership is developed, in place and effective, with the skills to lead and change
- governance structures are being used to secure change
- there is strong commissioning taking place, carried out collaboratively
- higher-quality practice is identified and shared across agencies and professions
- poor-quality practice is identified and challenged.

8.42 *We recommend that the resources to support this programme are drawn from, and build upon, the existing service improvement teams secured or provided currently by the Government and by expert practitioners in local areas. This should reduce any duplication of effort, support local areas more effectively and lead to a more comprehensive focus on the practical changes necessary to improve children’s mental health.*

Performance frameworks

8.43 The frameworks for local performance monitoring need to be sufficiently adept in order to provide a focus on the individual and collective impact of services in preventing and intervening early to support mental health and psychological well-being, no matter who provides the services. *We therefore recommend that, once the national outcomes work is concluded, the performance frameworks are refreshed to ensure that they are fit for this purpose.*

Inspection

8.44 Inspection remains an independent element of the accountability arrangements. We would like to see all relevant inspectorates have a consistent and relentless focus on mental health and psychological well-being, considering:

- the quality and impact of individual services
- the quality and impact of the collective work of all services within a Children's Trust area.

8.45 The current changes to local area and school inspection arrangements will play a part. However, all other inspection regimes and inspectorates need to be consistent in their approach to assessing mental health and psychological well-being.

8.46 This presents a challenge for individual inspectors who will themselves need the relevant skills and expertise to inspect and judge new practices and the effectiveness of collaborative provision, as well as sector-specific effectiveness.

8.47 *We therefore recommend that the relevant inspectorates ensure that their own training and development programmes are aligned with the expectations we set out in this report for the workforce as a whole.* A measure of the success of these arrangements – and all the arrangements described in this section – will be that there is no decrease in the commitment to improve the mental health and psychological well-being of all children and young people.

8.48 **Key recommendation:** The Government's national support programme should be strengthened to facilitate consistency, improvement and sustainability in service delivery. This should include a national multi-agency support team, built upon existing service improvement teams, which will facilitate and support sustainable cultural change at national, regional and local levels.

Implications of the support programme at local, regional and national levels

- At **local** level, a small network of local service improvement leads should be identified, who are able to cover the full spectrum of needs, to work with regional development workers and commissioners to compare findings between areas, aiming to reduce unproductive variations in commissioning, operation and provision. The national support team will develop their capacity to provide peer support and challenge, and embed sustainable models of service improvement. Local areas will also need to make decisions about the outcome measures to be used and the resources required, informed by the national work on outcomes (see key recommendation at paragraph 8.36).

- At **regional** level, there should be better integration and promotion of new ways of working across agencies to drive improvements through the greater co-ordination of existing support arrangements operating in this area. This will provide greater clarity about the way in which mental health and psychological well-being is being prioritised, and encourage a joint approach to improving outcomes, disseminating knowledge and service improvement.
- At **national** level, the support team should act as a catalyst to drive forward an effective change programme.

8.49 **Key recommendation:** There should be a clear strategic approach to monitoring, evaluation, service improvement, knowledge management and inspection across all children's services for mental health and psychological well-being. To achieve this, we recommend that:

- at **local level**, decisions about the measures used and resources required should be informed by the national work on outcomes
- at **regional level**, there should be greater co-ordination of support arrangements with a clear joint approach to service improvement and dissemination of knowledge
- at **national level**, a series of more co-ordinated joint guidance should be commissioned on evidence and knowledge of what works.



Conclusion

Throughout this Review we have been looking for practical but far-reaching ways to improve the mental health and psychological well-being of all children and young people.

We want to be able to assure children, young people and their parents and carers that, in future, they will **all** be able to expect:

- universal services that recognise the importance of mental health and psychological well-being
- services they can access before things reach crisis point
- to be listened to and involved in decisions about services
- the opportunity to develop trusting, ongoing relationships with one or two key individuals
- the necessary information, tools and support to ‘navigate the system’
- to be treated as individuals with a range of strengths and needs, and as members of their wider families.

We know that this is not happening everywhere, for all children and young people at the moment. We also know that the reasons for this have been clearly articulated in many reports and reviews in the past – we are not the first.

We wanted to understand why the aspirations of so many guidance and policy documents have not been achieved, despite all the hard work being

undertaken across the country. Now, having completed the Review, we believe that it is because there has not yet been a comprehensive change in culture and attitudes to accompany the changes in policy and practice.

The recommendations in this Review, if enacted, should ensure that the framework is in place to enable change:

- There will be a local board (or similar arrangement) in every area to give a common focus to mental health and psychological well-being.
- All agencies working to improve mental health and psychological well-being will have access to consistent advice and guidance through relevant regional support structures.
- Different government departments will act as a single department in providing coherent leadership, policy development and support.

We are eager to ensure, however, that the momentum generated by this Review, and the focus which people found so welcome, continues. We consider that this focus and drive would best be achieved through the establishment of a national body to champion children’s mental health, which is why we are recommending the creation of a National Advisory Council for mental health and psychological well-being.

Key recommendation: A National Advisory Council should be established to: champion the importance of mental health and psychological well-being for children

and young people; take ownership of the Review's recommendations and the Government's response; and hold the Government to account for its progress.

The initial tasks of the National Advisory Council

We recommend that these tasks should be to:

1. Produce a single document to clarify individual and joint responsibilities for children's mental health and psychological well-being and ensure a joint approach. This should outline:
 - (a) the respective policy responsibilities of each government department and associated ministers;
 - (b) the responsibilities of SHAs and GOs and their legal underpinnings;
 - and (c) the responsibilities of Children's Trusts, PCTs and provider trusts, including those of the lead member for children's services, directors of children's services and chief executives of NHS bodies.
2. Establish a central reference and co-ordinating point for stakeholders on issues such as policy, practice, evidence and knowledge, roles and responsibilities, training and performance management.

Most importantly of all, this drive and focus to improve the mental health and psychological well-being of our children and young people needs to be accompanied by reflection and change in all of us, as members of families, communities, services and organisations. It is not about other people or agencies shifting their perspectives or practice, but about how each of us thinks about the needs of children and young people – and about what we do to help them be resilient. We saw huge commitment to this during our Review – it is down to all of us now to make those changes.

Notes and references

- 1 Department for Children, Schools and Families. 2007. *The Children's Plan: Building brighter futures*. London: TSO.
- 2 World Health Organization. 2004. *Promoting Mental Health: Concepts; emerging evidence; practice*. Geneva: WHO.
- 3 Department of Health. 2004. *National Service Framework for Children, Young People and Maternity Services*. London: DH.
- 4 World Health Organization. 2008. *Inequalities in Young People's Health: Health behaviour in school-aged children 2005–06*. Copenhagen: WHO.
- 5 UNICEF. 2007. *Child poverty in perspective: An overview of child well-being in rich countries. Report Card 7*. London: UNICEF.
- 6 Collishaw, Maughan, Goodman and Pickles. 2004. Time trends in adolescent mental health. *Journal of Child Psychology and Psychiatry* 45: 1350–62.
- 7 Green, McGinnity, Meltzer et al. 2005. *Mental Health of Children and Young People in Great Britain, 2004. A survey by the Office for National Statistics*. Hampshire: Palgrave-Macmillan.
- 8 Parry-Langdon (ed.). 2008. *Three Years On: Survey of the development and emotional well-being of children and young people*. Cardiff: ONS.
- 9 Meltzer, Gatward, Corbin et al. 2003. *The Mental Health of Young People Looked After by Local Authorities in England*. London: TSO. This survey looked at children and young people living in residential care and foster care, those living with their birth parents, and young people aged 16–17 who were in independent housing under local authority supervision.
- 10 Emerson and Hatton. 2007. *The Mental Health of Children and Adolescents with Learning Disabilities in Great Britain*. Lancaster: Institute for Health Research, Lancaster University.
- 11 Healthcare Commission. 2006. *A Review of Healthcare in the Community for Young People who Offend*. London: Commission for Healthcare Audit and Inspection.
- 12 Department of Health. 2007. *Promoting Mental Health for Children in Secure Settings: A framework for commissioning services*. London: DH.
- 13 Shooter. 2005. Children and adolescents who have chronic physical illness. In Williams and Kerfoot (eds). *Child and Adolescent Mental Health Services: Strategy, planning, delivery, and evaluation*. Oxford: Oxford University Press.
- 14 Ermisch. 2003. *Does a 'Teen-Birth' Have Longer-Term Impacts on the Mother? Suggestive evidence from the British Household Panel Survey*. Colchester: Institute for Social and Economic Research.

- 15 Malek. 2005. Understanding ethnicity and children's mental health. Hodes. 2005. Refugee children in the UK. Both in Malek and Jougin (eds.) *Mental Health Services for Minority Ethnic Children and Adolescents*. London: Jessica Kingsley.
- 16 Department for Education and Skills. 2006. *Priority Review: Exclusion of black pupils. 'Getting It. Getting it right'*. London: DfES.
- 17 Hawton and Rodham (2006) and Childline (2006), cited in Bridget. 2007. *Lesbian, Gay and Bisexual Young People: Evidence-based services and resources*. Online paper available at www.cypf.csip.org.uk
- 18 Department of Health. 2008. *Child Health Promotion Programme: Pregnancy and the first five years of life*. London: DH.
- 19 Audit Commission. 1999. *Children in Mind: Child and adolescent mental health services*. London: Audit Commission. Mental Health Foundation. 1999. *Bright Futures: Promoting children and young people's mental health*. London: Mental Health Foundation.
- 20 Newman. 2002. *Promoting Resilience: A review of effective strategies for child care services*. Exeter: Centre for Evidence-Based Social Services, University of Exeter.
- 21 Department of Health. 1995. *A Handbook on Child and Adolescent Mental Health*. London: HMSO.
- 22 Health Advisory Service. 1995. *Together We Stand: The commissioning, role and management of child and adolescent mental health services*. London: HMSO.
- 23 This mapping is an annual exercise to create an inventory of all dedicated child health services, CAMHS services in Tiers 2 to 4 and maternity services provided in England. Local services provide service- and team-level data. PCTs and local authorities provide commissioning data. It is commissioned by the Department of Health and carried out by a mapping team at Durham University. See www.childhealthmapping.org.uk/
- 24 See www.parentingacademy.org/ for more information about the National Academy for Parenting Practitioners.
- 25 Ofsted. 2008. *Safeguarding Children: The joint chief inspectors' report on arrangements to safeguard children*. London: Ofsted.
- 26 As reported by PCTs and local authorities to the CAMHS mapping exercise (see note 23), so there are limitations to be aware of in the use of this data.
- 27 Department of Health. 2006. *Report on the Implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services*. London: DH.
- 28 Mental health services provided to children receiving physical health care, particularly those admitted to hospital.
- 29 See www.csip.org.uk/~cypf/camhs/national-camhs-support-service-ncss.html for more information.
- 30 See www.healthyschools.gov.uk for more information.
- 31 See www.nationalstrategies.org.uk/what_we_do_secondary_offer_banda.html for more information.
- 32 Children's services advisers were introduced in 2006. Their role is to provide expert support to local authorities, PCTs and their delivery partners on integrated children's services, in conjunction, where relevant, with SHAs.

- 33 See www.tda.gov.uk/remodelling.aspx for more information.
- 34 See www.childrens-centres.org for more information.
- 35 Darzi. 2008. *High Quality Care for All: NHS Next Stage Review final report*. London: TSO.
- 36 Findings taken from a mapping exercise undertaken in focus group work for the Review.
- 37 The Good Childhood Inquiry is being run by the Children's Society. It is seeking to open a debate on what makes for a good childhood today, to help improve the lives of children and young people. The Inquiry is placing a strong emphasis on the views of children and young people. A final report is due to be published in 2009. See www.childrenssociety.org.uk for more information.
- 38 Kurtz, Macleish, Arora and Ball. 2005. *Maternity Services in Local Sure Start Programmes: National evaluation summary*. Nottingham: DfES.
- 39 Department of Health. 2007. *Facing the Future: A review of the role of health visitors*. London: DH.
- 40 Warwick, Maxwell, Simon et al. 2006. *Mental Health and Emotional Well-being of Students in Further Education: A scoping study*. London: Thomas Coram Research Unit, Institute of Education.
- 41 Kramer and Garralda. 2000. Child and adolescent mental health problems in primary care. *Advances in Psychiatric Treatment* 6: 287–94.
- 42 Department for Children, Schools and Families. 2007. *The Children's Plan: Building brighter futures*. London: DCSF, paragraph 6.77.
- 43 Ofsted. 2007. *Building on the Best: Overview of local authority youth services 2005–06*. London: Ofsted.
- 44 Hickey, Kramer and Garralda. 2008. *Primary Mental Health Workers in CAMHS: A survey of PMHWs' perceptions of organisation, management and role*. London: Imperial College, London.
- 45 Kurtz. 2007. *Regional Reviews of Tier 4 Child and Adolescent Mental Health Services: Summary and comment*. Leicester: CSIP/National CAMHS Support Service.
- 46 McDougall, Worrall-Davies, Hewson et al. 2008. Tier 4 CAMHS – inpatient care, day services and alternatives: an overview of Tier 4 CAMHS provision in the UK. *Child and Adolescent Mental Health* 13(4) 173–80.
- 47 See Beecham and Chisholm. 2003. Variations in the costs of child and adolescent psychiatric in-patient units. *The British Journal of Psychiatry* 183: 220–5. Also see Kurtz. 2007. *Regional Reviews of Tier 4 Child and Adolescent Mental Health Services*. Leicester: CSIP/ National CAMHS Support Service.
- 48 The Children's Commissioner for England. 2007. *Pushed into the Shadows: Young people's experience of adult mental health facilities*. London: Office of the Children's Commissioner.
- 49 Shepperd, Harris, Bull et al. 2008. *Systematic Review and Mapping Study of Alternatives to Inpatient Mental Health Care for Children and Adolescents with Complex Mental Health Needs. Report for the National Institute for Health Research Service Delivery and Organisation Programme*. London: NCCSDO.

- 50 Kerfoot. 2005. Children 'looked after' by the state. In Williams and Kerfoot (eds). *Child and Adolescent Mental Health Services: Strategy, planning, delivery, and evaluation*. Oxford: Oxford University Press. Also see Richardson and Lelliott. 2002. Mental health of looked after children. *Advances in Psychiatric Treatment* 9: 249–57.
- 51 Ofsted. 2007. *Pupil Referral Units: Establishing successful practice in pupil referral units and local authorities*. London: Ofsted.
- 52 Cole, Sellman, Daniels and Visser. 2002. *The Mental Health Needs of Young People with Emotional and Behavioural Difficulties. Report for the Mental Health Foundation*. London: Mental Health Foundation.
- 53 Pettitt. 2003. *Effective joint working between child and adolescent mental health services (CAMHS) and schools*, Research Report 412. London: Mental Health Foundation.
- 54 Department for Children, Schools and Families. 2008. *Back on Track: A strategy for modernising alternative provision for young people*. London: DCSF.
- 55 See <http://drugs.homeoffice.gov.uk/drug-strategy/> for more information.
- 56 See www.library.nhs.uk/Pathways/ and select 'About care pathways' for more information.
- 57 See, for example, Pote and Goodban. 2007. *A Mental Health Care Pathway for Children and Young People with Learning Disabilities*. London: CAMHS Publications.
- 58 Care Services Improvement Partnership/ National Institute for Mental Health in England. 2007. *New Ways of Working for Everyone: A best practice implementation guide*. London: DH.
- 59 Department of Health definition at www.dh.gov.uk/en/SocialCare/Commissioning/index.htm
- 60 HM Government. 2006. *Joint Planning and Commissioning Framework for Children, Young People and Maternity Services*. London: DfES/DH.
- 61 Preliminary findings from a national impact assessment study on the commissioning and development of mental health services for children in secure settings (unpublished).
- 62 For more information, see www.everychildmatters.gov.uk/parents/pathfinders/
- 63 A Regional Improvement and Efficiency Partnership (RIEP) is a network of councils, fire authorities and other local services that have come together to challenge, collaborate and share ideas and expertise. They co-ordinate and support improvement, innovation and efficiency work at a regional, and often at a sub-regional, level, and are designed to help councils deliver the outcomes set through Local Area Agreements (LAAs). Each English region has a RIEP. More information is available at www.lga.gov.uk/lga/core/page.do?pageId=18437
- 64 Department of Health. 2007. *Guidance on Joint Strategic Needs Assessment*. London: DH.
- 65 Department for Children, School and Families. 2008. *Children's Trusts: Statutory guidance on inter-agency cooperation to improve well-being of children, young people and their families*. London: DCSF.
- 66 Building Schools for the Future was launched in 2003 and aims to provide all secondary school pupils and teachers in England with modern buildings and facilities to support innovative teaching and learning, in line with the aims of the Children's Plan. See www.teachernet.gov.uk/management/resourcesfinanceandbuilding/bsf/
- 67 Department of Health. 2008. *Refocusing the Care Programme Approach*. London: DH.

- 68 Brandon, Howe, Dagley et al. 2006. *Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation in 2005–6*. Nottingham: DfES.
- 69 Malek and Jougin (eds). 2005. *Mental Health Services for Minority Ethnic Children and Adolescents*. London: Jessica Kingsley.
- 70 See, for example, Fraser. 2005. Children and adolescents who have a learning disability: the challenges to services. In Williams and Kerfoot (eds). *Child and Adolescent Mental Health Services: Strategy, planning, delivery and evaluation*. Oxford: Oxford University Press. See also Rees. 2007. *The National CAMHS Support Service. Learning perspectives from the National Child and Adolescent Mental Health service improvement programme*. London: CSIP. Available at www.csip.org.uk/silo/files/nccs-learning-perspectives.pdf
- 71 See HM Treasury/Department for Children, Schools and Families. 2007. *Aiming High for Disabled Children: Better support for families*. London: HMT/DCSF.
- 72 Shooter. 2005. Children and adolescents who have chronic physical illness. In Williams and Kerfoot (eds). *Child and Adolescent Mental Health Services: Strategy, planning, delivery, and evaluation*. Oxford: Oxford University Press.
- 73 The budget-holding lead professional pilot is currently being evaluated and the report will be available in early 2009.
- 74 See, for example, Department for Children, Schools and Families. 2007. *A Transition Guide for all Services: Key information for professionals about the transition process for disabled young people*. London: DCSF. This is supported by a transition support programme running from 2008 to 2011. See also Department of Health. 2008. *Transition: Moving on well – a good practice guide for health professionals and their partners on transition planning for young people with complex health needs or a disability*. London: DH.
- 75 National Institute for Health and Clinical Excellence. 2008. *Attention Deficit Hyperactivity Disorder. Diagnosis and management of ADHD in children, young people and adults*. London: NICE.
- 76 See www.sdo.nihr.ac.uk/sdo1172006.html for more information
- 77 Lamb, Hall, Kelvin and Van Beinum. 2008. *Working at the CAMHS/Adult Interface: Good practice guidance for the provision of psychiatric services to adolescents/young adults*. London: Royal College of Psychiatrists.
- 78 See, for example, Graham. 2000. Treatment interventions and findings from research: bridging the chasm in child psychiatry. *British Journal of Psychiatry* 176: 414–19; Fonagy, Target, Cottrell et al. 2002. *What Works for Whom: A critical review of treatments for children and adolescents*, New York: The Guildford Press; Rushton. 2003. *The Growth of Evidence Based Social Work in Child and Adolescent Mental Health*, Occasional Paper, Association of Child Psychology and Psychiatry.

Annex A: The Review process

Aims and objectives

The main aims of the CAMHS Review were to investigate:

- what progress has been made, since the launch of Standard 9 of the Children's National Service Framework and the publication of *Every Child Matters* in 2004, in delivering services to meet the educational, health and social care needs of children and young people at risk of and experiencing mental health problems (including those with complex, severe and persistent needs)
- what practical solutions can those developing policy and delivering, managing and commissioning services use to address current challenges and deliver better outcomes for children and young people with mental health problems, and how these solutions can be monitored.

The Review's objectives were therefore to:

- take stock of progress to date in delivering comprehensive CAMHS, through a review of available evidence and information
- identify how mainstream, universal, targeted and specialist services can play a more effective role in promoting the emotional well-being and mental health of children, young people and their families
- investigate the impact of current funding arrangements, specifically whether current resource levels across all major providers are being made best use of,

and whether and how providers evidence value for money – especially when assessed from the point of view of the child or young person

- investigate how care pathways can be defined and what is understood by the term; and identify what the current issues are in relation to 'care pathways' and how they can be addressed
- identify what is required at national and regional level to facilitate the CAMHS elements of the child health and well-being Public Service Agreements (PSAs) – including gaps in performance management arrangements
- investigate current perceptions of the implications of performance management arrangements
- have oversight of the work being led by DCSF/DH on developing a national outcome indicator for children's psychological health for April 2009 which will support improving outcomes for children and young people
- develop priority actions for national, regional and local stakeholders as well as children and young people and their parents/carers, for the next three to five years, in delivering the PSA vision of improving emotional well-being and mental health and CAMHS.

Activities

We carried out a number of activities to gather the information to help us meet these aims and objectives:

1. A review of the literature

We commissioned a review of the wide-ranging literature on policy, practice and service delivery issues relating to children's mental health and psychological well-being. Given the breadth of coverage and the timescales involved, the approach was guided by the 'rapid evidence review approach' developed by the Government Social Research Unit. The review focused on recent literature relating to CAMHS, progress to date and current barriers to improvement. The experience of vulnerable groups, and the views of children, young people and their families were also a priority.

2. A call for evidence

This was carried out between 14 April and 7 July 2008 to enable anyone who wished to contribute to the Review to do so. We had almost 400 responses from the public, independent and third sectors, as well as individual members of the public. They pointed out the key issues from their perspectives, together with practical solutions to tackle persistent problems and examples of good practice. The list of respondents is included at Annex C and information on how to obtain the consultation documents is at Annex F.

3. Focus groups

We worked with the Office of Public Management and the National Children's Bureau to carry out a series of focus groups and face-to-face interviews. These had a dual purpose:

- i. to gain an understanding of children, young people and parents'/carers' experiences and views on mental health and psychological well-being

issues – particularly what they thought needed to change in order to provide high-quality services to effectively meet their needs

- ii. to identify the questions children and young people and their parents/carers wanted to ask of professionals on the issue of mental health and psychological well-being. This was used to inform the structure of our review of practice visits (see below).

4. Review of practice visits

We visited nine local authority/PCT areas across the country to get a picture of the way in which different areas are addressing the mental health and psychological well-being needs of children and young people. The areas were Birmingham, Derby, Dorset, East Lancashire, East Sussex, Hackney, Sunderland, Southend and York.

The visits focused on what has helped or hindered progress in service delivery to date and how best to take the children's mental health and psychological well-being agenda forward and thus improve outcomes for children and young people. Each visit comprised two main elements:

- i. in-depth structured interviews with individuals in strategic or commissioning roles from the local authority, the PCT and CAMHS (30 interviews in total)
- ii. a range of focus groups with:
 - senior managers such as programme directors and heads of clinical services (attended by 96 senior managers in total)
 - front-line staff working across the whole range of children's services, including: mental health specialists such as clinical and educational psychologists, psychiatrists, family therapists; and statutory and

voluntary agencies such as staff in early years, primary and secondary schools, health advisers and youth offending teams (attended by 173 professionals in total)

- parents/carers whose children did or did not have direct experience of accessing CAMHS (attended by 69 parents in total).

5. Stakeholder workshops

In the final stages of the Review we held three stakeholder workshops. The main purpose of the workshops was to test out the findings and provisional recommendations that had emerged from the information and evidence collected for the Review. The workshops also represented another opportunity to collaborate with people from a wide range of backgrounds in the process of the Review.

The workshops were attended by almost 100 professionals from Government Offices, SHAs, regional support services, professional bodies, third sector organisations and front-line staff from across the range of children's services.

6. Work on national indicators

Under the auspices of the Review, the Expert Group has had oversight of an externally commissioned project, led by DCSF/DH, which aims to develop a national outcome indicator of children's psychological health. The Expert Group has provided advice on the project's specification and main outputs (for example, progress reports and early findings) throughout the lifespan of the Review.

Considering the evidence

The main aim of our information collection and consultations was to obtain a comprehensive understanding of relevant issues rather than conduct an empirical

research study. We gathered an Expert Group to consider this wide-ranging evidence and work with the Chair and Vice-Chair on finalising the report and its recommendations. The members of our Expert Group are listed at the front of this report.

The Expert Group identified three specific issues which they thought were important priorities for the Review. To bring a greater depth of analysis to these particularly complex areas, we established three sub-groups comprising members of the Expert Group, plus other experts from across a wide range of relevant professions. The three sub-groups focused on:

- the organisation and delivery of services
- monitoring, evaluation and accountability
- vulnerable groups.

We also established a children and young people's reference group and web forum to ensure that their views and perspectives informed planning and decision-making throughout the process of the Review.

Outputs

The following key outputs have been delivered during the course of the Review:

- an internal progress report (April 2008)
- a published interim report (July 2008)
- a published final report (November 2008).

Annex B: Policy timeline

- 1995: Two key documents – *A Handbook on Child and Adolescent Mental Health*²¹ and *Together We Stand: The commissioning, role and management of child and adolescent mental health services*²² – pave the way for the development of child and adolescent mental health services (CAMHS) with the proposal of a four-tiered framework as a basis for planning, commissioning and delivering CAMHS.
- 1998: The Department of Health provides dedicated funding for local authorities and their health partners to bid to develop **CAMHS innovation projects**. This is the first time that a component of the Mental Illness Specific Grant is designated for children and young people. Twenty-four local authorities are selected. **Quality Protects** is launched by the Department of Health to deliver improved life chances for looked-after children. Children's social services are called on to provide targeted support to help looked-after children take maximum advantage of universal services, in particular education and health. In the same year, the Crime and Disorder Act paves the way for the introduction of **youth offending teams** (YOTs), whose core aim is to prevent offending. A stated objective is to tackle the range of factors (personal, family, social, educational or health) that puts a young person at risk of offending.
- 1999: The Government makes **new funds** available to the NHS for improving **CAMHS** via the NHS modernisation fund. The first **Sure Start** local programmes are introduced for pre-school children and infants. These focus on bringing together early education, childcare, health and family support for the benefit of young children and their parents in disadvantaged neighbourhoods. (All local programmes have now become **children's centres**, and the Government expects that by 2010, every community will have a children's centre.) Also in 1999, the **National Healthy Schools Programme** is launched by the Department of Health and the Department for Education and Employment. This advocates a whole-school approach to promoting emotional health and well-being, among other themes. (The current target is that all schools will be participating in the programme by 2009, and that 75% of schools will have achieved National Healthy School Status by that time.)
- 2000: The **NHS Plan Implementation Programme** includes a requirement that health authorities and local authorities work together to produce a **local CAMHS strategy** to include 24-hour cover, outreach services and increased early intervention and prevention programmes for children. (This was reinforced in 2002 with a target that **comprehensive CAMHS** should be available in all areas by 2006.)
- 2001: A new **Special Educational Needs (SEN) Code of Practice** aims to provide equality of opportunity and high achievement for all children. It stresses the importance of preventive work to ensure that children's needs are identified quickly and that early action is taken to meet them. The Code also emphasises the importance of

developing strong partnerships between parents, schools, local authorities and other agencies that are crucial to success in removing barriers to participation and learning.

- 2003: **Every Child Matters** sets out the Government's agenda for the reform of children's services, including a requirement for agencies to work together through Children's Trust arrangements, to achieve improved outcomes in five key areas (being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic wellbeing). It is supported in legislation by the Children Act 2004. The **National CAMHS Support Service** is established, providing a network of regional advisors to help local areas work towards the target for a comprehensive CAMHS in all areas. The **Behaviour and Attendance Strategy** is also introduced in 2003, encouraging schools to adopt a whole-school approach to tackling behavioural issues, and providing targeted multi-agency support in 25 local authorities facing the greatest challenges through the development of multi-agency **Behaviour and Education Support Teams**.
- 2004: The **Children's National Service Framework (NSF)** sets out a 10-year programme to raise standards, including a specific focus on the mental health and psychological well-being of children and young people in Standard 9, which includes a number of 'markers of good practice'. All 11 standards, the first five of which are described as core standards, reference and have relevance to mental health and psychological well-being.
- 2005: The **Social and Emotional Aspects of Learning (SEAL) programme** is introduced to primary schools. It provides a comprehensive approach to promoting the social and emotional skills that underpin effective learning, positive behaviour, regular

attendance, staff effectiveness and the emotional health and well-being of all who learn and work in schools. (This is followed in 2007 by materials for secondary schools.)

- 2006: **A review of progress** for the **Children's NSF**²⁷ identifies priority areas for service providers and commissioners for achieving the 10-year objectives.
- 2007: A new **Public Service Agreement (PSA)** is published by the Treasury, embedding joint working by both the Department of Health and the Department for Children, Schools and Families on child health and highlighting mental health and psychological well-being as a key area on which success will be measured. Two complementary indicators are introduced for psychological well-being and CAMHS, including an additional proxy measure for CAMHS on the joint commissioning of early intervention support.

Also in 2007 the **Family Nurse Partnership** programme is piloted in 10 local authority/PCT areas. This accompanies a **range of other parenting initiatives**, for example Family Intervention Projects, the development of the parenting practitioner role to deliver parenting programmes to the parents of at-risk young people and the Parenting Early Intervention Pathfinders for the parents of at-risk eight to 13 year olds. In addition, the **Offender Health Programme**, which is overseen by a cross-departmental board, publishes a commissioning framework for promoting the mental health of children in secure settings.

- 2008: The **Children's Plan** is published, setting out new aims and objectives for achieving the Every Child Matters outcomes, and announcing the CAMHS Review. The key areas for reform in relation to mental health outcomes are identified as:
 - **early years settings, schools and colleges** sitting at the heart of a preventive system, promoting well-being and looking for early warnings that children might need more help and by providing facilities for specialist services to operate
 - provision of better **support for parents and families** coping with challenging behaviour by their children
 - improvements in **the local delivery** of high-quality services for young people, focusing on the faster integration of services for the most vulnerable, and a renewed focus on early intervention and prevention to stop problems becoming entrenched
 - stronger action to **tackle behaviour that puts young people at risk** – in particular in relation to alcohol consumption and substance misuse.

Also in 2008, the **Think Family** initiative is launched by the Cabinet Office, accompanied by a series of Family Pathfinders to test new ways of working across adult and children's services. The first **Targeted Mental Health in Schools pathfinders** are established, to identify the most effective ways of delivering mental health support to children aged five to 13. The **Child Health Promotion Programme** is published, emphasising the promotion of psychological well-being through a progressive universal approach starting in pregnancy. An **outcome measure** to enable CAMHS to monitor the impact of their work is currently being developed and is scheduled for roll-out from 2009. Information sharing guidance is published for those working in the youth justice system, and a series of **diversion from custody pilots** are established. The new **10-year drug strategy** prioritises families for the first time and outlines actions to reduce the harm that children experience from either their own or a parent's use of drugs, alcohol and volatile substances (such as glue, gas and solvents). These include a focus on prevention and early intervention, strengthening the role of schools and children's services and integrating substance misuse provision within mainstream services, including targeted youth support.

Annex C: Organisations contributing to the call for evidence

Professional bodies, membership organisations and research bodies

11 MILLION

Anna Freud Centre

Association for Family Therapy and Systemic Practice in the UK (AFT)

Association for Real Change

Association of Child Psychotherapists

Association of Professional Music Therapists

Association of School and College Leaders

Association of Teachers and Lecturers

British Association and College of Occupational Therapists

British Association for Community Child Health

British Association for Counselling and Psychotherapy

British Association of Social Workers

British Medical Association (BMA)

British Paediatric Mental Health Group

British Psychological Society

CAMHS Outcome Research Consortium (CORC)

Child and Adolescent Learning Disability Psychiatry Network (CALDPN)

Childhood Bereavement Network

Council for Disabled Children

Deafness, Cognition and Language Research Centre (DCAL)

English National Park Authorities Association (ENPAA)

Family and Parenting Institute

Fostering Network

Institute of Education

Institute of Psychiatry at Maudsley

London Learning Disabilities Network

Medical Women's Federation

Mental Health Network (NHS Confederation)

Mental Health Research Network

NASUWT

National Association of Head Teachers

National Association of Independent Schools and Non-maintained Special Schools

National CAMHS Trainers' Forum

National Children's Bureau

National Foundation for Educational Research

Neurofibromatosis Local Family Support Group, West Midlands

Northern School of Child and Adolescent Psychotherapy

Peninsula College of Medicine and Dentistry

Permaculture Association (Britain)

Royal College of General Practitioners

Royal College of Nursing

Royal College of Paediatrics and Child Health

Royal College of Psychiatrists

Sainsbury Centre for Mental Health

SEBDA (Social, Emotional and Behavioural Difficulties Association)

United Kingdom Council for
Psychotherapy (UKCP)
University of Hull
University of Manchester
UK and Ireland Paediatric Liaison Interest
Group

Service providers in the public and independent sectors

2gether Foundation NHS Trust
5 Boroughs Partnership NHS Trust
Affinity Healthcare
Avon and Wiltshire Mental Health
Partnership NHS Trust
Bedfordshire and Luton Partnership Trust,
CAMHS
Birmingham CAMHS
Birmingham Children's Hospital NHS
Foundation Trust
Bradford Grammar School
Bristol CAMHS Commissioners
Brookvale – Totton CAMHS Southampton
City PCT
Bryn Melyn Care Ltd
Buckinghamshire County Council
Calderdale and Huddersfield NHS Trust
Cambridgeshire and Peterborough Mental
Health Partnership NHS Trust
Cambridgeshire and Peterborough NHS
Foundation Trust/University of Cambridge
Cambridgeshire Children's Fund
CAMHS Commissioning and Performance
Group, Leicester PCT
Castlegate for Young People 16–25, York
Central and North West London NHS
Foundation Trust
Cheshire and Wirral Partnership
Foundation NHS Trust
City of York Council
Cloughside College
Collingham Child and Family Centre
Cotmanhay Junior School
CSIP East Midlands CAMHS Team

Cumbria Partnership NHS Trust
Derbyshire Mental Health Services NHS
Trust
Devon Children's and Young People's
Services
Doncaster CAMHS
Dorset Healthcare NHS Foundation Trust
Dudley Metropolitan Borough Council
East Lancashire CAMHS
Enfield CAMHS and Education Psychology
Service
Evelina Hospital School
Exeter Royal Academy for Deaf Education
Gay and Lesbian Youth in Calderdale
Gloucestershire Adoption Support Service
Gloucestershire CAMHS
Government Office for the South East
Great Ormond Street and North Middlesex
Hospital
Great Ormond Street Hospital, Child and
Adolescent Mental Health
Great Ormond Street Hospital, Parenting
and Child Service
Greenwich CAMHS
Greenwich Teaching PCT
Guy's and St Thomas' Foundation Trust
Hampshire Partnership NHS Trust
Hampshire's Comprehensive CAMHS
Commissioning Trust
Hartlepool and North Tees Primary Care
Trust
Hertford Regional College
Hertfordshire Children's Trust Partnership
Hitherfield Primary School and Children's
Centre
Howard of Effingham School
Humber NHS Trust
Islington CAMHS
Islington Children's Partnership
James Wolfe Centre for the Deaf
King Edward VI College
Leeds PCT

Leicester City Council Psychology Service
 Leicestershire County Council Children and Young People's Service
 Leicestershire Partnership NHS Trust, Primary Mental Health Team
 Leigham Primary School
 Lime Trees Child and Family Specialist CAMHS (NYYPCT)
 London Borough of Hillingdon
 Loughborough College
 Luton Change for Children Commissioning Unit
 Mid Essex Hospital Services NHS Trust
 Musgrove Park Hospital Foundation Trust
 National Workforce Programme (CAMHS), National CAMHS Support Service
 New Park High School
 Norfolk Health Overview and Scrutiny Committee
 North Essex Partnership NHS Foundation Trust
 North Sefton PCT
 North Somerset Council, Educational Psychology Service
 North Tees PBC Consortium
 North Yorkshire and York CAMHS Partnership
 Northumberland Care Trust
 Northumberland, Tyne and Wear NHS Trust
 Norwich Children's Services, Sensory Support
 Nottingham Community Health
 Oldham Community Health Services
 Oracle Care Ltd
 Oxford and Buckinghamshire Mental Health
 Oxleas NHS Foundation Trust
 Parents As First Teachers UK
 Royal Borough of Kensington and Chelsea
 Royal Free Hampstead NHS Trust
 Royal Liverpool Children's NHS Trust
 Rye Oak Primary School and Children's Centre
 Selby CAMHS Participation Group
 Sheffield City Council
 Slough Borough Council
 Solihull Care Trust
 Somerset Educational Psychology Service
 South Essex Partnership NHS Foundation Trust
 South Gloucestershire Pupil Referral Unit
 South London and Maudsley NHS Foundation Trust
 South Staffordshire and Shropshire Healthcare NHS Foundation Trust
 South Staffordshire CAMHS
 Southwark Child and Family Service
 St George's School
 St Mary's Wrestwood Children's Trust
 St Paul's Academy
 Staffordshire County Council
 Suffolk Mental Health Partnership
 Surrey and Borders Partnership NHS Foundation Trust
 Surrey CAMHS Partnership
 Swalcliffe Park School
 Swindon and Marlborough PCT
 Tavistock and Portman NHS Foundation Trust
 TCCR (Tavistock Centre for Couple Relationships)
 Tees, Esk and Wear Valleys NHS Trust
 Telford and Wrekin PCT
 The Shircore Consultancy
 Tower Hamlets Pupil Referral Unit
 TreeHouse
 West London Mental Health NHS Trust
 Westbourne Sports College
 Whiston Hospital, Paediatric Directorate
 Whitstone Head School
 Whittington Hospital, Child and Family Psychiatric Service

Wolverhampton Children and Young People's Service
Wolverhampton City Council and Primary Care Trust
Woodeaton Manor School
Worcestershire Primary Care NHS Trust

Voluntary and community organisations

4Children
Action for Children
Adoption 22
Adoption UK
ARCOS (Association for Rehabilitation of Communication and Oral Skills)
Autism In Mind
Barnardo's
Booktrust
British Association for Adoption and Fostering
Camden Somali Cultural Centre
Centrepont
Childhood First
Children's Rights Alliance for England
CLIC Sargent
Coram
CSV
Diabetes UK
Down's Syndrome Association
Education Otherwise
Fairbridge
Families Need Fathers
Foyer Federation
Good E.I.dea (emotional intelligence development)
Groundwork UK
I CAN
Journeys Children's Bereavement and Loss Service
Mencap
MIND, Southend on Sea
Nacro Mental Health Unit


National Deaf Children's Society
NSPCC
Papyrus (Prevention of Young Suicide)
Parent Support for Autism in Children
Parentline Plus
Place2Be
Red2Green, Cambridgeshire
Relate
RNID
Selective Mutism Information and Research Organisation
Stepping Stones (Spurgeon's)
Stonewall
Suffolk Young Carers
Sustain
The Anna Freud Centre
The Children's Society
The Mental Health Foundation
The National Autistic Society
The Prince's Trust
Voice for Children in Care
Young Minds
Youth Access
YWCA England and Wales

Government bodies

Sustainable Development Commission
Youth Justice Board for England and Wales

Other

Centre for Child and Family Development, Australia



Annex D: Questions young people would like to ask about the services they receive

For CAMHS partnerships

- What preventive services are available so that we can get help before things reach crisis point?
- What aftercare is available to stop 'revolving door' syndrome?
- How can we be empowered to access services ourselves?
- How can you build better continuity into the system?
- How can you involve us in developing your services and can you give us the support we need to be involved?
- Can we get involved in recruitment?
- Why isn't there more communication between agencies?
- How do you link with adult services and share information?

For schools and colleges

- What support systems are available in schools and colleges?
- Are there any common standards for what schools and colleges should offer to support well-being?

For services for children and young people with mental health problems

- How can we find out about your services?
- How can we contact you?
- Is it easy/not embarrassing for us to access your service?
- Why do referrals take so long?
- Can we have a choice of who to talk to?
- Do you change your staff a lot?
- How important is consistency in your service?
- Why not look at young people's whole lives rather than just their problems and issues?

For staff in these services

- What kind of things do you do to help us? What kind of support do you offer?
- When you meet a child or young person for the first time, do you tell them about yourself?
- Will you be the only person they have to explain their problem to?

- How long will your support be available for?
- Are you there when a child or young person needs you?
- What do you do if a child or young person develops a good bond with you, and then for some reason you have to stop working with them?
- How can someone trust your service and know it's confidential?
- How come people not involved in your case can access your notes?
- Do you and parents talk to each other?

Questions from parents/carers

- How do schools and colleges work with us to promote mental health and psychological well-being?
- What support can CAMHS give us after our child has been referred and while we are waiting for the service to be delivered?

Annex E: Vulnerable groups

Throughout the Review we use the term 'vulnerable children and young people' to refer to those who may be vulnerable for a variety of reasons (see paragraph 1.12). We have deliberately avoided listing specific groups of vulnerable children unnecessarily so as to avoid excluding groups inadvertently.

The list below provides an example of the children and young people who we would include in our use of the term 'vulnerable'. However, it is important to note that this is not a definitive list and although existing evidence suggests that the children and young people in these groups are more vulnerable, it does not necessarily mean they are more likely to have mental health issues. Nevertheless, these are groups that service managers, providers and commissioners need to ensure they consider and plan for:

- children and young people with behavioural, emotional and social difficulties
- children and young people with learning difficulties and disabilities
- children and young people with special educational needs (SEN)
- children and young people with life-threatening conditions (such as cancer)
- children and young people with chronic illness (such as diabetes)
- children and young people with physical disabilities
- children and young people with specific genetic conditions (such as neurofibromatosis)
- children and young people with sensory disorders (such as those who are deaf)
- children and young people with autistic spectrum disorder
- children with other communication difficulties
- children and young people with Down's syndrome
- children and young people in care
- children and young people at risk of suicide
- children and young people who are being abused
- children and young people who misuse substances or whose parents/carers misuse substances
- children and young people who have been bereaved
- children and young people in contact with the youth justice system
- children and young people who are lesbian, gay, bisexual or transgender
- children and young people from black and minority ethnic groups
- children and young people experiencing housing difficulties
- children and young people seeking asylum
- young people not in education, training or employment
- young carers
- young runaways.



Annex F: Resources from the Review

The following resources from the Review will be available through the National Advisory Council:

- literature review
- paper on terminology
- call for evidence consultation questionnaire.



CAMHS

Child and Adolescent
Mental Health Services

The CAMHS Review is an independent review supported by officials from the
Department for Children, Schools and Families and the Department of Health