Maintaining the momentum
towards excellent services for children and young people’s mental health
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Summary

Aims

This report has three aims:

1. to raise awareness amongst the board members of both commissioning and providing organisations about the challenges facing child and adolescent mental health services (CAMHS), and to highlight the present window of opportunity for leaders to respond to these challenges

2. to illustrate the long-term benefits of comprehensively meeting the mental health needs of children and young people, both to the individuals and families concerned, and to public services and the economy as a whole over that individual’s lifetime

3. to show both commissioners and providers what they can actively do, under existing governance arrangements, to ensure that the recent momentum of progress in CAMHS is not lost, and that their area builds upon these foundations.

Key points for commissioners of CAMHS

Although CAMHS is often a comparatively small service with a small budget, investing in these services can prevent problems persisting into adulthood, with the accompanying vicious circles of social exclusion, lost productivity and heavy service use. In this way, it can be a case for 'invest to save'.

Significant unexplained variation exists between primary care trust (PCT) spending on CAMHS. Boards need to critically examine their commissioning arrangements and make sure that spending is not simply based on what happened last year. A thorough needs assessment should be carried out (taking into account the contribution of other agencies) and spending and performance should be benchmarked against other similar areas.

Routine outcomes monitoring data and benchmarking are powerful levers for commissioners of CAMHS. These tools can help them to ensure the services they purchase are appropriate and effective, to monitor quality improvement and to assess value for money (see page 18).

Money originally intended for CAMHS does not always filter down to these services. Commissioners should be given enough authority within their PCTs to ensure that funding reaches services for young people with mental health problems. This should be accompanied by constant monitoring to ensure that most benefit is obtained for local children within resource constraints (see page 19).

PCTs are required to co-operate with their local authority partners in developing strategic plans for local services to meet children’s mental health needs. Many areas have created commissioning roles hosted jointly by PCTs and local authorities, which are highly effective in ensuring close partnership working. PCTs need to think about how children’s trust arrangements will affect them from 2008 onwards if they are not already involved in this (see page 20).
Key points for providers of CAMHS

The points below are applicable to the full range of providers, both within and outside the NHS.

Appropriate CAMHS provision should be available and accessible to all young people up to the age of 18, and there should be clearly defined transition arrangements planned well in advance for young people then needing to access adult services.

Boards need to consider their strategy for ensuring that excellent CAMHS can be sustainably provided in their area, especially in the context of an increasingly plural marketplace. Providers should be able to demonstrate consistent improvement in outcomes and satisfaction. If they do not, PCTs are now more likely to start looking elsewhere.

Boards have the responsibility to ensure that PCTs are well informed about the service they provide, including reporting of reliable outcomes, cost and activity data. This will help to strengthen the commissioning function and improve relationships with commissioners (see page 20).

Young people’s views and satisfaction with services need to be systematically collected and fed into plans for services to make sure they are accessible and appropriate (see page 17).

Although the proxy public service agreement (PSA) targets for 24-hour emergency CAMHS provision, specialist services for children with a learning disability and mental health difficulties, and age-appropriate services for 16–18-year-olds, have almost been met, many areas are far from being able to provide ‘comprehensive CAMHS’. All providers would benefit from assessing their performance against the medium-term objectives set out in the recent National Service Framework (NSF) progress report (see page 21).

There is now a requirement under law to provide age-appropriate accommodation for young people detained under the amendments to the Mental Health Act. Providers and commissioners need to work together to make sure the right facilities are available, particularly given the shortage of inpatient CAMHS beds in some areas (see page 20).

‘There is a requirement under law to provide age-appropriate accommodation for young people detained under the Mental Health Act.’
Introduction

*Shattered Lives*, a recent road safety advertising campaign, depicts young singers, dancers and athletes on their way to stardom, only to be killed in road traffic accidents before their potential can be realised. In many ways, organisations working to meet the mental health needs of young people and children share the aims of that campaign – to avert suffering and to prevent potential being wasted and opportunities being missed.

Those planning, commissioning and providing mental health services for young people hold a huge amount of power to influence the long-term life chances of those at risk of, or already experiencing, difficulties and distress. Most mental ill-health first manifests itself during childhood, which is also the time when major familial, social and educational risk factors contributing to poor mental health arise. Failure of these agencies to promote mental well-being and intervene when things go wrong for children, can mean that there is nothing to stop a vicious circle of social and economic exclusion developing, which can last a lifetime.

The effects on the individual and their family can be devastating. Equally, the effects of that lost potential on the economy and society as a whole can be significant. It makes humanitarian, social and economic sense to invest in services to help improve children’s mental well-being and ensure emotional resilience. This report highlights what board members and leaders of health organisations, whether NHS, private or voluntary, can do to drive this agenda forward.

‘*There is still much to be done and the substantial progress made so far is in great danger of being lost.*’

The NSF Vision

“All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders, have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.”

All children and young people with mental health problems should:

- experience similar high standards of care, no matter where they live
- have their mental health needs met by appropriate CAMHS
- be able to access emergency care 24 hours a day.

The Every Child Matters Vision

All children should be supported to be able to:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being.

The NHS Confederation Mental Health Network believes that board members currently have a window of opportunity to maintain and accelerate the momentum of recent progress in child and adolescent mental health services (CAMHS) development, and to further improve the mental health of the future adult population. It is vital that CAMHS does not fall off the board’s agenda.
This important opportunity arises due to the following combination of factors:

- unprecedented progress over recent years in building the capacity and quality of CAMHS, which provides momentum for future progress
- Gordon Brown’s Government has signalled a new political focus on the well-being of children and families, and has set up the new Department for Children, Schools and Families
- emerging accountability arrangements for a mixture of nationally- and locally-decided performance measures will give more power to local organisations to ensure a continued focus on young peoples’ mental well-being.

CAMHS organisation

CAMHS refers to a wide range of services for children and young people up to the age of 18 with any kind of mental health need. The services are currently organised into four tiers, constituting a stepped-care model (see Figure 1). The intention is that children are seen in the setting and by the professional most appropriate to their level of need. Tier 1 services are known as ‘universal services’ and offer advice, promotion and education, with some simple interventions for the most common problems. These are often delivered in a setting familiar to children, such as a school or surgery, by teachers, GPs, school nurses and others. Tier 2 services provide an important interface between primary care and specialist services. They are often delivered by a CAMHS professional working alone but as part of a network. Care consists of brief interventions for mild or moderate problems. The more specialist provision in Tiers 3 and 4 is provided by mental health trusts, independent sector organisations and local authorities, with some provision housed in acute trusts and primary care trusts (PCTs). These services are staffed by teams of specialist mental health professionals, catering for the most complex and severe needs.

Recent progress and challenges ahead

CAMHS are now reaching more young people than ever before. They are increasing provision of specialist services targeted at particularly vulnerable groups, such as looked-after children and young offenders, as well as improving links with schools to enable early detection and intervention when problems are still emerging.
Local authorities and health agencies, along with actors in the voluntary, community and private sectors, have formed local partnerships to drive CAMHS forward, often sharing a single strategy, budget and commissioning arrangements. This unity of purpose is a solid foundation on which to build services that truly meet the mental health needs of local young people.

We await the imminent Comprehensive Spending Review, but as increases in funding to the NHS as a whole slow down, there is a risk of funding being withdrawn from services such as CAMHS, which are not covered by payment by results. According to anecdotal reports, this has already happened in some areas. In addition, the PSA ‘proxy targets’ for CAMHS only had effect until December 2006, and without specific targets to aim for in the health service, there is again the risk of resources being diverted elsewhere.

Health organisation boards hold the key to maintaining the momentum of progress in services for children and young people’s mental health. The Mental Health Network is working to bring members’ attention to the challenges facing these services, and the ways in which they can help to improve outcomes for young people suffering mental health problems. The Network’s Children and Young People’s Group is working continuously to keep these services high on the agenda of NHS boards across the country.

How can this report help?

Structured around the areas of governance responsibility that boards carry, this report encourages your board to ask questions about the opportunities it has to maintain the momentum of progress in developing high quality, responsive CAMHS. We outline the reasons why an excellent service for your local children is so important to the social and economic life of your community, as well as to the current and future quality of life of many individuals and families.

The types of queries outlined in the box (to the left) are typical of many that the authors have heard, when those with portfolios of responsibility far wider than CAMHS come together to discuss these services.

In budgetary terms, CAMHS are often comparatively small. However, it is important to build the best services possible, given the complexity of the work undertaken by CAMHS, the links they must forge with diverse agencies and the enormous potential they have to deliver long-term benefits to both individual lives and the economy.

We aim to provide a convincing case for board members to promote the interests of local children and young people, and actively drive and engage in CAMHS developments in their area.

**Typical questions about CAMHS**

‘I’ve just been given responsibility for CAMHS. It seems a very small service compared to our other priorities and I don’t know the area in detail. What do I need to know about commissioning and providing high quality, effective CAMHS?’

‘We met all the PSA targets for CAMHS at the end of 2006. Can we just keep doing more of the same, as we seem to be doing well?’

‘Does anyone know what makes a well-functioning whole system of CAMHS? It would be helpful to have some principles to base the service on.’
Why the need to maintain momentum?

The level of need and demand

During the last 25 years the prevalence of many childhood mental health disorders (particularly conduct disorders, anxiety and depression) has increased in the Western world, independently of rates of clinical recognition. Referral rates of young people to specialist CAMHS in England have also greatly increased over recent years, with total caseloads rising nationally by 31 per cent between 2003 and 2005.

The Office for National Statistics survey of child and adolescent mental health, published in 2004, suggested that one in ten young people aged five to 16 suffer from a diagnosable mental disorder. Children in low-income households, living in single parent families, families where parents have low educational attainment, or families where parents are unemployed, are more likely than their peers to suffer from mental health problems. Improving children’s mental health should therefore form an important part of the health sector’s work to reduce health inequalities in local communities. Such inequalities in childhood are likely to contribute to wider inequalities when these children grow up.

There are other areas of concern. The Care matters: time for change white paper on looked after children, published in June 2007, highlights the high levels of mental distress amongst young people in care – 75 per cent of young people in residential care suffer a mental disorder.

According to a Europe-wide study, children in the UK rate poorly for subjective (self-reported) well-being. Furthermore, a UNICEF study of children’s well-being in 21 industrialised countries ranked the UK last overall. For subjective well-being based on life satisfaction, enjoying school and rating of health, the UK rated lowest.

In this context, the Children’s Society launched a two-year inquiry in 2006 to ask whether there is such a thing as a ‘good childhood’ in Britain today. Unsurprisingly, these stories have played out negatively in the media, and have served to reinforce how important it is for the organisations responsible to work together to improve the situation.

‘Inequalities in childhood are likely to contribute to wider inequalities when children grow up.’
Unrecognised or untreated problems

Persistence of problems into adulthood

Mental health problems in childhood have high levels of persistence, particularly if left untreated or unrecognised. Persistence into adulthood can have major effects on future levels of service use and costs to the individual, the NHS and society:

- 25 per cent of children with a clinical emotional disorder, and 43 per cent with a clinically significant conduct disorder, will still have the problem three years later\(^7\)
- 50 per cent of adolescents with severe conduct disorder will have a diagnosable unstable personality disorder as adults\(^8\)
- 40 per cent of children with severe conduct disorders (as rated by their parents) had been arrested by the time they were 30 years old\(^9\)
- young people suffering anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety disorders in adulthood\(^10\).

Costs to the individual

Mental health problems in young people have implications for the individual’s life chances:

- children with diagnosed mental health problems are 17 times more likely to have been excluded from school and are absent from school more often than their peers
- only 55 per cent of children with a mental health problem remain in school full-time past the age of 15
- those aged 16 to 18 with a persistent mental health problem are twice as likely as their peers to have no qualifications at all
- loss of income and high levels of unemployment result if problems persist into adulthood
- relationship and social difficulties are more common in those suffering mental health problems, leading to a reduced quality of life\(^11\).

Economic and social costs

The onset and persistence of childhood mental health problems are mediated by a host of individual and personal, familial, social and environmental factors. If left untreated the young person is more likely than his or her peers to be caught in a vicious circle leading to a low quality of life in adulthood. The costs to society are also considerable. Lord Layard (an economist by background) has pointed out that mental health may now be Britain’s biggest social problem and that it costs the equivalent of 2 per cent of GDP in service costs, carers’ time and lost output. This figure does not include benefit payments\(^12\).

Other studies have shown that public service costs incurred in adulthood, by individuals diagnosed with mental health problems in childhood, can be up to ten times more than the cost of people with no such history – these include costs related to health services, social care and the criminal justice system\(^13\). These findings highlight the long-term benefits of investing in prevention and education initiatives, as well as early intervention.
Interrupting the vicious circles

Examples of how vicious circles of untreated mental health problems can develop are shown in Figure 2. These problems can lead to worsening life circumstances due to missed opportunities in education, employment and social activity. These life circumstances can, in turn, further exacerbate mental distress. This is why intervention in the circle, early in the process, is vital for young people.

As Figure 2 shows, improving young peoples’ mental health and well-being is not simply a health issue. Education and local government agencies should also see the issue as central to their remit. Non-health agencies are taking an increasingly large role in the early detection of problems, and in education and prevention work to promote good mental health. They also have the potential to provide (with suitable training for teachers) simple interventions for mild and emerging problems. Parenting education is another potential area for prevention.

However, health providers and commissioners still have a crucial role to play in arresting the development of mental health problems, through direct intervention and treatment, and through partnering with and influencing other agencies to act in the interest of young people’s mental well-being. The circles in Figure 2 can be broken for an individual if health services act alongside others to treat mental health problems and boost emotional resilience. There is growing evidence about what services can do to break these vicious circles through holistic intervention in an approachable setting.\(^4\)
Policy context

For health organisations, the twin drivers of young peoples’ mental health policy are the National Service Framework (NSF) for children, young people and maternity services (2004), and the cross-governmental children’s services strategy, Every child matters (2004). Both have galvanised the policy direction towards a full range of multi-agency prevention and intervention services in every area of England. Funding increased substantially to support these developments, amounting on the health side to £300 million of extra government grants to local authorities and PCTs over three years from 2003 to 2006.

Every child matters is an overarching framework for all policy relating to children and presents five broad outcomes to be achieved together by agencies working with children and young people:
- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being.

Mental well-being is evidently central to the achievement of these outcomes. It affects both educational attainment and stability in relationships with others, which are essential foundations for a healthy and happy adult life.

In 2002 a public service agreement target was set requiring the Department of Health to ensure increased support for CAMHS to establish services in all areas for children with both mental health and learning disability problems, and specific services for 16 to 17-year-olds. The Priorities and Planning Framework 2003-6 required all areas to have 24-hour provision of appropriate emergency response to young people in a mental health crisis. Future performance management arrangements will help build on theses achievements.

The NSF, published in 2004, is a ten-year programme for improvement in children’s health and well-being. Standard 9 sets out what the Government expects health organisations to do in order to meet the needs of local children related to psychological and emotional well-being.

Other key policy shapers of the future direction of CAMHS fall under three main themes, to be explored later in this report:
- a focus on monitoring outcomes and using these as the basis for commissioning
- an emphasis on promotion and prevention work
- the improvement of partnership arrangements between local agencies, extending to joint commissioning and funding arrangements.

‘The NSF is a ten-year programme for improvement in children’s health.’
CAMHS facts and figures

Headline progress
Between 2002 and 2005, according to CAMHS mapping there was:
- a 27 per cent increase in CAMHS staffing
- a 40 per cent increase in cases seen by CAMHS.

Prevalence of problems
One in ten children has a clinically significant mental health problem:
- 5.8 per cent of 5–16-year-olds have clinically significant conduct disorders
- 3.7 per cent of 5–16-year-olds have clinically significant emotional disorders
- 1.5 per cent of 5–16-year-olds have clinically significant hyperkinetic disorders

System activity
In 2005, the CAMHS caseload in England stood at 113,000 young people, of which:
- 9 per cent were looked-after children
- 8 per cent suffered learning disability as well as mental health problems
- 5 per cent were young offenders.

The number of CAMHS specialist teams in England increased by 16 per cent between 2003 and 2005. 1,051 teams were mapped in 2005.

Providers
- NHS trusts (principally mental health trusts) are the main providers in most areas, receiving 68 per cent of overall CAMHS funding.
- Other providers were:
  - PCTs (15 per cent)
  - local authorities (9 per cent)
  - others, including independent providers of inpatient services (8 per cent).
- Independent sector provision includes many ‘high cost, low volume’ specialist inpatient services, for example, 90 per cent of eating disorder unit beds.

Expenditure
- Spending on mental health services in England in 2004/05 for under-18s comprised 7 per cent of the total mental health budget of PCTs for a group making up 22 per cent of the population.
- Total spending for 2004/05 was £418 million; spending in the 2005/06 financial year is estimated at £513 million.
- 13 per cent of this is spent on NHS primary care services and two-thirds on NHS secondary care.

Trends in spending
The growth in reported budgets for CAMHS (of PCTs and local authorities) was as follows:
- between 2002/03 and 2003/04 spending grew by 18 per cent
- between 2003/04 and 2004/05 spending grew by 24 per cent
- between 2004/05 and 2005/06 spending grew by 19 per cent.
## CAMHS facts and figures (continued)

### Spending variation
- Combined local authority and PCT spending on CAMHS (Tiers 2–4) varies considerably; this was three times higher in the SHA area spending the most, compared to the SHA area spending the least in 2004/05, but some of the lower spending areas were planning some of the largest increases in 2005/06.

### PSA targets (estimated achievements)
- 24/7 emergency access – 97.3 per cent of PCTs achieved by December 2006
- Dedicated service for those with learning disability and mental health problem – 86.8 per cent achieved by December 2006
- Dedicated service for 16–17 year olds – 91.4 per cent achieved by December 2006.

### Workforce
- Total staff working in CAMHS in England increased by 27 per cent over the period 2003-2005 from 7,761 to 9,876 WTE (whole time equivalent).
- There is considerable shortfall of Tier 1 level (non-specialist) mental health staff, the vacancy rate standing at nearly 18 per cent. Consultant child psychiatrists and child psychotherapists are also in high demand.
- The NSF target is for 15–20 WTE clinical CAMHS staff per 100,000 total population for Tier 3. Staffing rates are improving but are highly variable across the country (between 6 and 20.7 WTE) with the average being 11.7 WTE.
How boards can help to maintain momentum

Strengthening services for children

Three key tools to strengthen whole systems of services for children and make the most effective use of resources are setting the future direction for CAMHS development. These concern outcomes monitoring, promotion and prevention, and close partnership arrangements.

Focusing on outcomes and their monitoring

Outcomes need to be monitored to continually improve services and provide the most appropriate care. It is sometimes considered difficult to measure the impact of services because so many variables affect mental health. However, standard measures of symptom reduction and improvements in functioning are widely available. At present, around a third of services use systems of routine outcome measurement. The process allows commissioners to assess the effectiveness of the services they purchase, and in future would allow service users to assess which service they want to access when given a choice of provider. Some commissioners are already using outcome measurement to leverage improvement from their providers. More information on routine outcome measurement in CAMHS is available from CAMHS Outcomes Research Consortium (see Further information on page 34).

Focusing on promotion, prevention and well-being

The National Institute for Health and Clinical Excellence (NICE) is producing guidelines about primary school interventions by teachers and other school professionals both at whole-school level (for example, mental well-being classes) and at targeted level (for vulnerable children and those with emerging problems). If such initiatives are correctly resourced, there is potential for improved recognition and early intervention when problems first surface. This could have dual benefits – firstly, fewer children would be referred to CAMHS with mild problems, and secondly, it is more likely that children who really needed help would be referred to CAMHS in a timely manner.

Work in some trusts has shown that strengthening this type of Tier 1 and 2 provision reduces the level of demand for Tiers 3 and 4. NHS organisations should provide appropriate support to their local government and education colleagues in these endeavours as they will ultimately benefit specialist CAMHS.

Progressing towards a stronger partnership approach to budgets and commissioning

There are now 138 CAMHS partnerships in England. These are multi-agency strategic groups driving progress in their local area, with input from a wide range of stakeholders. Well functioning systems of services for children’s mental health are underpinned by a strategy and priorities that are shared by all major stakeholders, and are led jointly by local government and the NHS. There are several mechanisms for achieving this. Children’s trusts enable the formation of joint commissioning arrangements and pooled budgets to allow the most efficient use of resources towards these shared goals. The Common Assessment Framework is designed to assist the process of closer partnership working as well as early identification and holistic assessment of emerging problems. The Joint Strategic Needs Assessment in the new Commissioning Framework requires stakeholders in children’s mental health to determine a strategy to meet local need.

Under new performance management arrangements due to come into place in 2009, local area agreements will be strong drivers of local activity on CAMHS, with partners accountable to their
communities in the delivery of locally- and nationally-defined targets. The Comprehensive Area Assessment will be the overarching framework of performance assessment, where poor performance on these targets will trigger inspections. This will draw together the performance assessment and management of local government and health.

Building excellent local CAMHS

Maintaining and developing excellent CAMHS in the local area requires boards of all commissioning and providing organisations to critically examine the opportunities and obligations for them to act as part of their governance responsibilities and duties.

The principles of integrated governance require NHS board members to carry collective responsibility for all areas of their organisation’s business. Increasing devolution of accountability to trust level means that board members’ decisions are ever more central to the provision of high-quality, appropriate and timely healthcare. As NHS provider trusts move towards foundation trust status and as competition increases, the power of the board to make this happen is greater than ever before.

Integrated governance and devolved responsibility provide more opportunities for boards to challenge and question themselves about the services they provide or purchase for the population in their area. Indeed, constructive challenge amongst board members is seen as characteristic of a well-functioning, effective board.

The nine reasons why CAMHS should matter to boards are outlined in the box on page 23, providing a convincing case for board members to critically examine the ways in which they commission or provide these services. As discussed, progress during recent years has been significant, but there is a long way to go, and we must be careful not to lose the momentum gained so far.
A series of questions board members might ask themselves about the services they commission or provide for young people locally are outlined on the following pages.

These are grouped under eight areas of good governance:
1. leadership (see page 15)
2. workforce development (see page 16)
3. reflecting the needs and preferences of young people (see page 17)
4. safety and quality assurance (see page 18)
5. financial assurance (see page 19)
6. information governance (see page 20)
7. legal obligations (see page 20)
8. delivery of national objectives (see page 21).

For each of these eight responsibilities, the following are set out:
- why they are important for improving children’s mental health
- questions boards should be asking themselves about current practice
- signposting to helpful tools and further resources for boards to use.

‘Workforce issues come and go, policy initiatives come and go, funding comes and goes. Some services grow, but even good ones get disbanded. The role of the person leading CAMHS development is to maintain a clear and informed view of the needs of young people in the community they serve, and to ensure that all who should be engaged in making decisions about the priorities for development are so engaged.’

Leadership

How can boards ensure there is strong leadership with sufficient authority for CAMHS?
A growing literature, including Department of Health guidance, highlights leadership as key to delivering public service reform, improvement and modernisation. An important driver behind this is the expectation that public services should be seamless, personalised and designed to meet the needs of service users rather than the organisational convenience of service providers.

Recent thinking highlights the need for organisations to combine ‘transactional’ (managerial) and ‘transformational’ leadership modes. In the former, the focus is on producing some degree of predictability and order through planning and budgeting; organising and staffing; and controlling and problem solving. In the latter, change is seen to come through the processes of establishing direction, aligning people, motivating and inspiring.

For CAMHS, with their emphasis on multi-agency and partnership approaches and the need for jointly planned and commissioned services and pooled budgets, clear and robust leadership encompassing both transactional and transformational skill sets, is critical. Whoever is charged with this responsibility in your organisation needs to be able to hold an overview of a range of different perspectives, including those of service users, and to have the skills to engage in all key players from both voluntary and statutory sectors. These are the pre-requisite skills for supporting the development of a coherent and co-ordinated approach to meeting children and young people’s needs.
Leading CAMHS requires strategic skills in setting direction. The board should make sure that there is a multi-agency strategy with shared vision and goals, which underpins all plans for commissioning and providing local services. It is crucial that the strategy is known by all staff, and that it has wide ownership among partners’ services, including children’s, youth offending, substance misuse, adult mental health and learning disability.

In addition, there are some particular challenges to bear in mind. These include a legacy of wide variability in the range and models of service provided, in thresholds for admissions and in the professional mix. There have also been weaknesses in commissioning that have meant little focus on prevention, early intervention and long-term care. There is a history of the smaller and often less visible client group losing out to the more prominent demands of adult services. It is essential that the voice of CAMHS leadership is present at partnership and trust board level, to “ensure that child and adolescent mental health remains a high priority on the agendas of the relevant agencies.”

Workforce development

How is the board responding to the demands on the workforce caused by the expansion of service provision?

The continuing expansion of CAMHS has implications for workforce planning. Improving outcomes for children and young people requires an adequately resourced, trained and motivated workforce. However, across the children’s services workforce, maintaining capacity and capability is a significant challenge. Staff shortages and retention problems are consistently reported in many professional groups.

CAMHS face a serious challenge to create a workforce of sufficient numbers with the appropriate capabilities across all professionally and non-professionally affiliated groups. The modest 3 per cent growth per annum in total NHS workforce, as suggested in the NSF, would produce demand for 305,000 new staff. This needs to be seen within the context of the overall national workforce. There are currently record employment levels and by 2010 there will be 700,000 fewer people of working age.

Vacancies in health and social care are running at a very high level, influenced by legislation such as the European Working Time Directive, and the pressures on workforce spend through implementation of Agenda for Change. For the NHS (based on new service models) a modest estimate of staffing demand that was submitted to the Workforce Numbers Advisory Board (WNAB) in 2003, indicated the need for increases by 2006 of 500 psychiatrists, 3,000 nurses, 1,200 social workers and 600 occupational therapists employed in mental health services, and a 15 per cent annual increase in clinical psychology training places. Additional capacity is also required for other
Maintaining the momentum

Groups, including pharmacists, physiotherapists, child and adolescent psychotherapists, art therapists and dieticians.

Challenges around recruitment and retention specific to CAMHS are reflected in reported vacancy factors across all services and include the issues of poor image, lower status, variable management and supervision, and staff teams that do not reflect the ethnic make-up of the local population.

Reflecting the needs and preferences of young people

What does the board need to do to encourage the active engagement of service users in developing services, and to ensure that the needs and preferences of local young people are addressed?

Developing services that are informed by, and are responsive to, the views of those using them, is central to the Government guidance underpinning the delivery of public services. All recent major CAMHS policy emphasises the need to involve children and young people.

Legislative backing to this approach is provided by the Children Act 2004. This requires local authorities and other agencies concerned with children and young people to work collaboratively in developing a child-centred, outcome-led vision that is informed by the views of local children, young people and their families.

The value of the information gained through involving service users, and consulting with local communities about services, has been demonstrated through a wide range of studies. These findings add to our knowledge of what sorts of services children, young people and families want – what they find accessible, acceptable and appropriate. For example, work by Youth Access indicates that developing services informed by user and community perspectives can lead to improved access to services; the development of more

‘Often teenagers do not know where to seek help, or are ashamed of their illness... Our health systems need to take the next step forward in removing barriers between health professionals and young people. Our health systems need to start listening to what we are saying and what we are asking for.’

Boards should ask:

- Is there a workforce plan for specialist CAMHS that links to plans both in the wider organisation and for children’s services as a whole?

- Where there are shortages, have managers considered and/or implemented New Ways of Working?

- Where there are skills gaps, have managers considered and/or implemented the development of new roles?

- What steps have been taken to address the need for a staffing mix that reflects the wider community and is culturally competent?

- Is there an imaginative training programme that uses shadowing, coaching, mentoring and rotation, as well as conventional educational and training methods?

- Do all staff have a clear career pathway and is this made apparent at the recruitment stage?

- Is there a CAMHS induction programme?
responsive services; improved service performance; informed planning and development; and increased accountability.

We know that certain groups have in the past found it difficult to access CAMHS, or may present a complex array of social and mental health needs that require a holistic and flexible service response. These groups have high levels of mental health need and may also have particular worries about the stigma of approaching mental health services. They include young people from black and minority ethnic groups; young people who are looked after; those with learning difficulties; those with caring responsibilities; young people who are socially excluded, including those excluded from school/education and young people aged between 16 and 17 (the ‘transition’ years).

Safety and quality assurance

How can boards foster a culture of constant quality improvement?

There are a number of ways boards can ensure that services are safe, high quality, offer evidence-based treatment and adhere to national standards for governance, care planning and clinical safety. Undertaking regular and comprehensive audits of what types of service are purchased or delivered to children, young people and families is an important part of quality assuring services. Clear procedures for risk management, for the investigation of complaints and for monitoring the use of the Care Programme Approach (CPA) are also vital. One widely used method to assist in safety and quality assurance is membership of the Quality Network for In-Patient CAMHS (QNIC) and the Quality Improvement Network for Multi-Agency CAMHS (QINMAC), which provide annual audit against service standards via a process of self- and peer-review.

Risk management is a key requirement of all public services and board members should know how incidents involving children and young people are reported and investigated. The mechanisms that exist for shared learning from the outcomes of investigations and inquiries should be clear; CAMHS will tend to have fewer serious untoward incidents than an adult mental health service, and different criteria for judging an incident as serious. One of the questions boards might explore is whether every client requiring one has a risk assessment and management plan that has been reviewed regularly and can be demonstrated by clinical audit. Joint area reviews are key assessments of adherence to child protection, safeguarding and good multi-agency working.

Boards should ask:

- What are children, young people and families currently saying about our services, and what do we need to do to improve their experience?
- How do we gather feedback and can we improve on this?
- Are there particular groups who are under-represented amongst those using our services and if so, what action is needed to rectify this?
- Are the services we provide accessible, meeting identified local needs and working in a way that is responsive to those needs?
- Are there particular pressure points in our provision – for example, services with long waiting lists – that may need to be addressed in our service development planning?
Another area that needs to be kept under review is the clinical effectiveness of services. In their clinical audit, practitioners should be using models of effective practice from the evidence base. The evidence for interventions in CAMHS is still developing and whilst the main source is robust and drawn from a systematic review, there are gaps in the research base that need to be augmented by both values-based evidence (such as national policy) and practice-based evidence (drawn from audits and evaluations of clinicians' own work). Routine outcomes monitoring is an important lever for ensuring clinical quality.

The CPA was introduced for adult services in 1990 and is the process for managing the care and treatment of people using specialist mental health and social care services. Following the 2006 consultation on CPA it is likely that there will be only one level (replacing the previous standard and enhanced) and that more groups, such as young people, will be included in the national guidance. A young person on CPA will need to have a care co-ordinator, a role which will be unfamiliar to some CAMHS professionals. Where both children and their parents are under CPA, their care plans will have to be harmonised and cross-referenced, particularly if the child is on the child protection register. Similarly, excellent cross-boundary co-operation and joint working, as well as advanced planning, will be necessary to effect seamless transitions from CAMHS to adult services.

Boards should ask:

- Does the board receive regular reports about clinical outcomes, risk management and other audits and assessments of CAMHS?

Financial assurance

Why must boards ensure that money intended for CAMHS reaches these services, and that the best value for money is obtained?

Two principal streams of money currently fund CAMHS provision – both local authorities and PCTs receive CAMHS grants, although the PCT money is not ring-fenced. These funding streams are increasingly pulled together in many areas through the pooling of budgets under children’s trust arrangements, which are a statutory requirement by 2008 under the Children Act 2004.

The last decade has seen significant investment in CAMHS. However, much of this has served to remedy a previously very low level of spending and the resultant patchy provision. Findings from the mapping of CAMHS, which is carried out each year for the Department of Health, indicates that expenditure on CAMHS in England has risen from £284 million in 2002/03 to an estimated £513 million in 2005/06.

Analysis by the Department of Health indicates that this investment has resulted in increases in CAMHS staffing and some clearly positive efficiency outcomes in terms of CAMHS seeing more cases sooner. There have been improvements in the three areas set out as proxy measures for achieving comprehensive CAMHS – the commissioning of 24-hour and emergency services (in place in over 85 per cent of PCTs as compared to 2002 when fewer than half had such arrangements); the commissioning of services for 16- and 17-year-olds; and the commissioning of services for children and young people with learning disabilities.
However, it is apparent that serious gaps in services remain, that some CAMHS are short of staff, whilst others are overloaded with long waiting times as a result of growing levels of demand. Wide geographic variations, reflecting different levels of investment, also persist. Such findings highlight the need for continued investment into CAMHS over the years ahead, and for disinvestment to be avoided in those situations where overall budgetary pressures may mean that some services are cut back. Again, robust leadership is needed within CAMHS, backed by commissioning structures that are informed by reliable outcomes, activity and service cost and needs data.

Information governance

What information can boards draw upon to ensure that commissioning decisions are based on up-to-date, accurate and routinely collected outcomes data?

There is an expectation that CAMHS will be predicated upon analysis of population need and evidence of what works. Commissioners require meaningful information on referrals, caseload, case mix and outcomes. As with population needs assessment, the service level data presented to commissioners is less helpful if offered as just sets of numbers and tables.

To commission the most appropriate mix of services within budgetary constraints, commissioners need to know how the data for their locality compares with other similar areas. Use of the national CAMHS Mapping reporting enables managers to benchmark their service with other comparators, such as regional and national averages. The CAMHS Self Assessment Matrix also provides an opportunity for benchmarking and comparisons across the range of elements of a comprehensive CAMHS.

Specialist CAMHS work is multi-disciplinary and takes place in a multi-agency context in which information sharing around the network of services is required. Often the need to share information across children’s services conflicts with an NHS trust’s own information governance, such as the Caldicott rules. Managers and practitioners need support from senior staff, including board members, in managing this tension, so that the needs of the child and family can be met in a co-ordinated way.

In many parts of the country, the ability of CAMHS staff to provide robust and timely information to their commissioners has been hampered by the shortcomings of NHS data systems. Often the most notable deficits are a lack of administrative support and insufficient training of clinical and non-clinical staff in using their IT and data collection systems, both of which create frustration and waste time. This is why continued investment into CAMHS, including their administrative and technical infrastructure, is so important.

Legal obligations

What legislation do board members need to be aware of to ensure that their organisation is compliant with legal duties?

There are several key pieces of legislation that relate to the delivery of CAMHS.

Amongst these is the Children Act 2004, which confers several duties upon NHS organisations and those working for them, including:

- a duty to safeguard and promote the welfare of children
Maintaining the momentum

- a duty for PCTs to co-operate with local government on priority setting in the local area agreement, and achievement of goals centred around the five Every child matters outcomes; by 2008 this will include the duty to co-operate in children’s trust arrangements
- a duty to take part in local safeguarding children boards; some are still under-resourced and failing to engage member agencies at a senior level.

The Mental Health Act (as amended in 2007) also sets out some important requirements for the care of young people. These include ensuring that where a young person is detained, an age-appropriate setting for accommodation is available for them. Staff responsible for detaining young people under the Act must also ensure that they consult a person with knowledge or experience of cases involving patients aged under 18. In addition, the Act stipulates that the court may also request information about the availability of hospital facilities “designed so as to be specially suitable for patients who have not attained the age of 18 years.”

From 2008, NHS organisations will also have a stronger obligation towards looked-after children under the statutory guidance. Both the Looked after children: care matters white paper and Promoting the health of looked after children are relevant here, with the latter including the requirement to develop local health plans for this group. The intention is to “ensure that CAMHS provide targeted and dedicated provision that appropriately prioritises children in care.”

Delivery of national objectives

Does the board engage with the wider young people’s policy agenda to ensure that its services promote social inclusion, ensure smooth transitions to adult services and promote emotional resilience?

Although health services are used to dealing with national service frameworks, when it comes to care for children the overarching policy driver is Every child matters: change for children. The NSF sits within this context and the delivery requirements for NHS CAMHS will be outlined later in this section.

There are various cross-governmental policies, many of them associated with the Every child matters agenda, which are intended to improve multi-agency working. These explicitly apply to CAMHS and the organisations providing and commissioning these services. Among these, the Common Assessment Framework is presently under-utilised by health services, but is an important and useful tool. It provides a single, simple process for assessing the needs and strengths of a child in a holistic way, taking into account the role of family, school and environmental factors on the child’s development. All local authority areas are expected to implement the Common Assessment Framework by March 2008.

Health services also need to consider how they can contribute to the improved well-being of local young people through supporting their partners in education, employment and training. For example, in response to the wealth of evidence that young people leaving school with low levels of educational attainment have a higher risk of experiencing social exclusion throughout their lives, policy aimed at 13 to 24-year-olds has focused on education, training and employment opportunities. New policies to increase young
people’s participation in learning and employment include Connexions, education maintenance allowances (EMAs), the New Deal for Young People and Modern Apprenticeships.

The NSF for mental health principally covers adults of working age, starting at age 16. However, it is of importance to CAMHS when it comes to young people making the transition from children’s to adult services. The Framework highlights areas where services for children and adults interact, for example the interface between services for 16 to 18-year-olds, and the needs of children with a mentally ill parent. CAMHS staff are often left with a problem when a young person fails to meet the criteria for transition to an adult service, but is still in need of mental healthcare. For this reason, close joint working between CAMHS and adult services and clear arrangements for handover should be established so that vulnerable young people do not fall through the net. Some areas have established services for young adults up to the age of 25 to help address this problem.

Youth matters: next steps reports that many people responding to the green paper consultation expressed concern about young people’s emotional health and resilience, and the document testifies to “the inseparable link between good physical and mental health and young people’s ability to learn and achieve.” Of the initiatives outlined in the document, there is a significant commitment to “the development of an adolescent health specialism and, in some areas, dedicated young people’s health and support services.”

How are CAMHS in the area tackling these medium-term NSF objectives?

An interim report from late 2006 on the implementation of Standard 9 of the NSF for children, young people and maternity services reported progress in many areas, but set out priorities for short- and medium-term action for the period to 2009. These are:

• building on the PSA achievements to ensure that 24-hour emergency CAMHS, services for 16 to 17 year olds and services for those with both mental health issues and learning disability, are of high quality and sustainable
• meeting NSF staffing levels and skill-mix requirements. More systematic training is needed for non-specialist ‘frontline’ staff working with children, such as teachers and GPs, in recognising problems and dealing with low-level problems
• improving specialist provision for mothers’ peri-natal mental health needs
• eliminating the use of adult beds for children, except for mature adolescents where such provision is most appropriate
• meeting complex needs locally and in community settings as far as possible
• supporting the development of routine outcome monitoring
• further developing paediatric liaison services, culturally sensitive services and dedicated services for children in care and in the youth offending system
• planning services strategically for a whole area together with local government and adult mental health agencies, with input from other stakeholders such as schools.
Investing in the future: nine reasons why CAMHS should matter to boards

1. **Disproportionate spending.** At present, about 7 per cent of PCT mental health spending is being directed to services for those aged under 18, a group representing 22 per cent of the English population. There is considerable regional variation in spending unexplained by other factors.

2. **Disproportionate burden of disease.** Internationally, children and young people disproportionately bear 30 per cent of the burden of disease resulting from neuro-psychiatric disorders.

3. **Poor subjective mental well-being.** Several international comparative studies have shown the UK’s children to have the poorest levels of subjective mental well-being in the developed world.

4. **Unmet need.** 10 per cent of those aged five to 16 have symptoms amounting to a diagnosable mental disorder. Low levels of recognition amongst professionals in contact with children may be a reason for this. 75 per cent of those young people who have had a mental health problem diagnosed are not in contact with mental health services over a three-year period.

5. **Self harm** is a significant public health problem, which affects one in 15 young people with an average age of onset of 12 years. It is the reason for about 25,000 hospital admissions in the UK each year. In the UK, 19,000 people aged between 15 to 24 attempt suicide each year and 700 succeed. In 2002, a study in schools found that 11 per cent of girls and 3 per cent of boys aged 15 and 16 reported having harmed themselves in the previous year.

6. **Early intervention.** Most mental health problems first manifest themselves in childhood. Early intervention with all these problems can prevent their persistence into adulthood or at least mitigate their severity.

7. **Costs to the individual, society and the economy.** Untreated and undiagnosed mental disorder can have severe knock on effects in a child’s life, affecting their social, personal and educational development. Untreated mental disorder in childhood is likely to persist into adulthood in around half of cases. This will severely impair the individual’s quality of life and cause them to miss opportunities through illness. Recent research has also shown that mental health problems in children give rise to heavy financial costs, which fall on many agencies. Costs for the use of public services (excluding private, voluntary agency, indirect and personal costs) by the age of 28, of children who had been identified with conduct disorder at age ten, were ten times higher than for those with no problems, and 3.5 times higher than for those with less severe conduct problems.
Investing in the future: nine reasons why CAMHS should matter to boards (continued)

8. Significant NSF recommendations are not being met. For example:
   - children with learning disability and mental health problems still do not benefit from targeted, specialist provision in all areas
   - presentations to accident and emergency by children with mental health problems indicate that crisis services are not operating as intended
   - most areas are not operating with the NSF recommended levels of staff
   - children detained under the Mental Health Act are in some cases being accommodated on adult wards. This is largely due to geographical variation in the availability of CAMHS beds – the Royal College of Psychiatrists recommends that between 24 to 40 inpatient CAMHS beds are required per one million total population at a bed occupancy rate of 85 per cent.

9. Inequality. Children’s mental health is influenced by life experiences as well as social and economic factors such as parental mental health problems, low household income, family breakdown and parental unemployment. Looked-after children are particularly vulnerable – 45 per cent of children in care suffer from mental health problems. Appropriate and approachable provision for ethnic minority children is lacking in many areas. If such health inequalities are not to be perpetuated in adult life, early intervention is needed.
Conclusions

There is an unprecedented opportunity for boards to maintain the momentum of progress in CAMHS, given the recent growth in capacity and improvement in quality, a new political focus signalled by the Brown Government and emerging accountability arrangements.

Strengthening CAMHS makes social and economic sense. It is key to averting or mitigating suffering and its knock-on effects for families and communities, to reducing health inequalities and to improving the mental health of the future adult population.

Unrecognised or untreated mental health disorders have costs for the individual, society and a wide range of public services. They can lead to vicious social and economic circles. We know that early recognition and intervention is effective in improving prognosis into adulthood. Persistence of problems can impact on the educational achievement, income, employment and relationships of the individual, with all the negative effects this can have on society.

Today, young people’s mental health policy is driven by a focus on monitoring outcomes and a strengthening of the partnership arrangements between local agencies. The future direction of policy points towards outcomes based commissioning led by local government and the NHS, in which a shared budget, vision and strategy drives CAMHS development in an area, as well as greater education and prevention focus in schools and other child-friendly settings.

To maintain and develop CAMHS in the local area boards need to critically examine the opportunities and responsibilities they have to act. To assist with this, boards can ask a series of questions about how they commission or provide services for young people locally, including:

- Has the person responsible for commissioning/directing provision of CAMHS been given sufficient authority within our organisation, and are they a strategic leader?
- Are we using New Ways of Working to help achieve sufficient numbers of specialist professionals in the right mix to provide a holistic CAMHS?
- Do we actively engage children and young people in expressing their needs and preferences for CAMHS and design services to respond to these?
- Do we use routine outcomes monitoring to benchmark our local service, achieve constant quality improvement and ensure maximum benefit from available resource?
- Have we analysed the gaps in workforce and provision to enable us to build on the foundations of increased capacity and activity achieved in recent years? What groups do we need to do more to engage?
- What can we do to make robust and timely data about services available to ensure appropriate commissioning decisions?
- Are we aware of our responsibilities under the Children Act 2004 and the new amendments to the Mental Health Act?
- How can commissioners and providers work together with other agencies to ensure that national policy objectives, particularly those of the NSF, are achieved?
Glossary

**CAMHS Self Assessment Matrix** – the CAMHS Self Assessment Matrix was developed for the National CAMHS Support Service (NCSS) by the Health and Social Care Advisory Service (HASCAS). It is used by most CAMHS partnerships to help review and plan their priorities, investment and services. This matrix is now available as a web-based tool.

**C-GAS** – Children’s Global Assessment Scale is a 100-point rating scale measuring psychological, social and school functioning for children aged six to 17. [http://depts.washington.edu/washinst/Training/CGAS/CGAS%20Index.htm](http://depts.washington.edu/washinst/Training/CGAS/CGAS%20Index.htm)

**CORC** – the CAMHS Outcomes Research Consortium is a learning collaboration between mental health professionals across the UK who work with children and adolescents. The aim of CORC is to develop and pilot a model of routine evaluation of outcomes. CORC can then use this to provide high quality information on the outcomes and value of therapeutic services for children, young people and their families, which can in turn be used by service providers, commissioners and users. Over half of all NHS services in the UK have staff who are members of this collaboration, with members from voluntary agencies also participating.

**CSIP** – the Care Services Improvement Partnership is part of the care services directorate at the Department of Health, with CAMHS specialists available to work with the statutory, voluntary and private sectors to make the best use of the full range of resources and expertise available. [www.csip.org.uk/about-us/about-us.html](http://www.csip.org.uk/about-us/about-us.html)

**CYPSP** – the Children and Young People’s Strategic Partnership has membership from all children’s agencies in a given location. It exists to produce a local area’s Children and Young People’s Plan (CYPP), which is an important element of the Every child matters reform programme. It has been a powerful force in driving forward better local integration of children’s services.

**ESQ** – the Experience of Service Questionnaire was developed and validated by the then Commission for Health Improvement. It is a 15-item self-completion questionnaire that assesses users’ views of services with respect to accessibility, humanity of care, organisation of care and environment. The ESQ is completed by parents/carers, children and young people and is completely anonymous.

Every child matters – the over-arching policy for children that encompasses the Government’s aim for every child, whatever their background or their circumstances, to have the support they need to:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being.

**HoNOSCA** – Health of the Nation Outcome Scales for Children and Adolescents was developed for children and adolescents (under the age of 18) in contact with mental health services. [www.rcpsych.ac.uk/crtu/healthofthenation/childreddieandadolescents.aspx](http://www.rcpsych.ac.uk/crtu/healthofthenation/childreddieandadolescents.aspx)

**Integrated Governance** – an approach to governance promoted by the Department of Health encompassing the systems, processes and behaviours by which boards lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations. A handbook is available at [www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH_4128739](http://www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH_4128739)
**JPCF** – Joint Planning and Commissioning Framework. No single agency can deliver any one of the five outcomes for children or the 25 aims in the *Every child matters* Outcomes Framework by working in isolation. In principle joint commissioning should be developed wherever the meeting of identified needs requires contributions from two or more children’s trust partners.

**Mental health** – according to research for the children’s charity NCH, mental health ‘involves more than just the absence of emotional difficulties. It involves the presence of a number of abilities which develop from infancy, through childhood and adolescence, and which have implications for adjustment and well-being in adulthood.’ [http://www.nch.org.uk/uploads/documents/Emotional_harm_lit_review2.pdf](http://www.nch.org.uk/uploads/documents/Emotional_harm_lit_review2.pdf)

**Mental health problems/mental disorders** – this covers a broad range of emotional and behavioural difficulties. The difference between a mental health problem and a disorder is the severity and persistence of the condition. Mental disorders have medical diagnostic labels from major psychiatric classification systems, the two principal systems being ICD-10 (International Classification of Diseases 10th Revision), and DSM-IV (Diagnostic and Statistical Manual: 4th Edition).

**National CAMHS Mapping** – CAMHS mapping was developed for the Department of Health to help monitor development of the CAMHS. It has become an annual exercise for the collection of data on specialist CAMH Tier 2 to 4 services. [www.camhsmapping.org.uk/](http://www.camhsmapping.org.uk/)

The mapping creates a database of what services are provided to the population of specified areas (PCT and councils with social services responsibilities). Services are described in of type, cost, staffing and workload.

It offers the facility to analyse and benchmark CAMHS service provision and activity by PCT, LA and NHS trust.

**PSA** – Public Service Agreements provide a framework through which local authorities and other local organisations agree targets with central government. In CAMHS the PSA of achieving comprehensive services has been measured by proxy indicators, which until the end of 2006 included services for 16–17-year-olds, 24/7 access to crisis services and a full range of CAMHS for children with learning disabilities.

**QINMAC** – the Quality Improvement Network for Multi-Agency CAMHS was established by the College Research Unit (CRU) of the Royal College of Psychiatrists in 2005. QINMAC aims to facilitate quality improvement and development in Tier 2 and 3 CAMHS, through a supportive peer-review network. Part of QINMAC’s focus is on the extent to which Tier 2 and 3 CAMHS work with other services and agencies to deliver high standards of care for children, young people and their families.

**QNIC** – the Quality Network for Inpatient CAMHS was developed by the College Research Unit (CRU) of the Royal College of Psychiatrists. It aims to demonstrate and improve the quality of inpatient child and adolescent psychiatric care through a system of review against the QNIC service standards. This process follows a clinical audit cycle with self-review and peer-review.

**SDQ** – the Strengths and Difficulties Questionnaire is a brief behavioural screening questionnaire about 3–16 year olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists and can be completed by clinician, young person and parent. [www.sdqinfo.com/b5.html](http://www.sdqinfo.com/b5.html)
References


11 Meltzer (2003), op. cit.


16 Unless otherwise indicated data taken from CAMHS mapping, www.camhsmapping.org.uk

17 Green et al. (2005), op. cit.


19 Ibid.


21 Mental Health Strategies (2006), op. cit.


25 NHS Confederation (2005): Effective Boards in the NHS?


30 York, A and Lamb, C (2005): Building and sustaining specialist CAMHS Royal College of Psychiatrists Child and Adolescent Faculty.


32 Ibid.


34 National CAMHS mapping reports at www.camhsmapping.org.uk


36 New Ways of Working for Child and Adolescent Mental Health Services (CAMHS) www.newwaysofworking.org.uk/new_ways_of_working/service_areas__underpinning/camhs.aspx

37 Street, C and Herts, B (2005): Putting participation into practice. A guide for practitioners working in services to promote the mental health and well-being of children and young people. YoungMinds.

38 Kurtz and colleagues highlighted in the 2005 report Minority Voices (YoungMinds, 2005), ‘for a service to be effective, it is not enough that the interventions delivered are known to be efficacious; the service must be taken up and, therefore, must be accessible and acceptable.’


40 Street, C et al (2005), Minority Voices.


46 For more information on CAMHS to adult transition, see http://www.hascas.org/camhs_projects_transition.shtml


48 See www.camhsmapping.org.uk


50 The report on the implementation of Standard 9 (see reference 49) notes: ‘research has shown that only 25 per cent of children with a diagnosed psychiatric disorder were accessing mental health services over a three-year period.’

51 See www.camhsmapping.org.uk/

52 See www.childhealthmapping.org.uk/selfassessment/

53 See www.everychildmatters.gov.uk/deliveringservices/informationsharing
69 Simonoff, E, Elander, J, Holmshaw, J, Pickles, A, Murray, R and Rutter, M (2004): ‘Predictors of anti-social personality continuities from childhood to adult life’. *British Journal of Psychiatry*, 184, pp 118–127. This study demonstrated that disruptive behaviour in childhood is a powerful predictor of anti-social behaviour in adult life, enduring at least into middle adulthood. The authors state that ‘reducing subsequent high-risk experiences (such as leaving school early) among those with early disruptive behaviour might alter their life trajectory away from anti-social behaviour.’

70 Scott et al. (2001): op. cit.


72 DfES (2007), op. cit.

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Recent work at HASCAS includes national projects in CAMHS to adult transition, CAMHS partnership facilitation, CAMHS self-assessment, young people’s involvement and workforce development. Local and regional commissions have included needs assessment, service mapping, service review and commissioning.

Dr Cathy Street is a freelance health researcher and consultant. Over the last ten years, she has researched and published widely on a range of topics concerning the provision of CAMHS, in particular Tier 4 in-patient services, services for children with learning disabilities and commissioning voluntary sector and multi-agency service provision. She has also led a number of national projects looking at the involvement of children and young people in public and statutory services; access to public services by young people from black and minority ethnic groups; and gender-based differences in mental health.
Further information

Key policy and guidance


DH (2007): Commissioning services for young offenders with mental health problems.


www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_062778

Developing CAMHS and services for children and young people


www.rcpsych.ac.uk/pdf/str_CAMHS_sep05.pdf


Role of the voluntary sector


Research


National Children’s Bureau (2005): *Children and young people’s views on health and health services: a review of the evidence*.


Street, C et al (2005): *Minority voices – research into the access and acceptability of services for the mental health of young people from black and minority ethnic groups*. YoungMinds.

Tools

QNIC (Quality Network for Inpatient CAMHS), QINMAC (Quality Improvement Network for Multi-Agency CAMHS), information available at www.rcpsych.ac.uk/crtu/centreforqualityimprovement.aspx

York, A and Kingsbury, S, ‘Seven helpful habits of effective CAMHS and the choice and partnership approach’, available at http://camhsnetwork.co.uk/Childlayer1pages/7helpfulhabits.htm


Workforce and service development

DFES (2005): *Children’s workforce strategy: a strategy to build a world class workforce for children and young people*.


CAMHS Outcomes Research Consortium, information on routine outcome measurement at www.corc.uk.net
Maintaining the momentum

Recent progress in building the capacity and quality of child and adolescent mental health services (CAMHS), a new political focus signalled by the Brown Government and emerging accountability arrangements present a window of opportunity to maintain the momentum of progress in CAMHS development. This report aims to raise awareness amongst board members of both commissioning and providing organisations about the challenges facing CAMHS, to illustrate the longer-term benefits of comprehensively meeting the mental health needs of children and young people, and to show commissioners and providers what they can do to ensure the recent momentum of progress is not lost.