West Sussex Mental Health Needs Assessment (Children and Young People)
July 2014

Background Evidence - Professionals

Report by the
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Engagement with professionals involved with CAMHS in West Sussex:

"If we get in earlier then potentially the trajectory is much, much reduced in terms of the challenges that the children present."

"Not sure anyone realises how much teams are running on empty and morale is very low, even from amazingly skilled and thoughtful professionals."

"Some of the best work that I've done, we've joint-worked things together, worked side by side and it worked well then."

"No one understands the role of CAMHS any more, what they do accept and what they do not and the reasons for this."

"I often feel that young people's emotional health gets neglected due to fact that they may not have a formal MH diagnosis and therefore often don't meet the threshold for a service from CAMHS."

"I find it frustrating that despite the law stating we should act in the best interests of the child, confidentiality within the health profession appears to over-ride this."

"I feel that better communication with the families to help manage their expectations of what CAMHS can actually do would be helpful. Knowing what the service isn't, just as much as what it is, is important for families to understand."

"Stuck in the middle without enough information to help with stressed & angry people asking us to do something."

"It feels as if young people need to fit in to service provision rather than service provision being designed to meet their needs."

"It still feels like CAMHS can still be difficult for people to access and sometimes it seems that there are young people that get missed as a result."

"It's like put all these hoops in the way, all these hurdles in the way and if you might finally get to the end or you get to that stage where you think, 'It's got to be CAMHS,' and they think, 'Well, actually no, it doesn't meet our criteria.'"

"There are some very good, excellent bits of service, but it's not offering a coherent package across the county. Some families get brilliant, or what we think of as fantastic, and you see the difference it makes, and other families don't."

"Many referrals are returned, suggesting we use other services which do not exist, leaving parents and children without the support that they need."

CONTENTS:

EXECUTIVE SUMMARY

1.   *Method and response to the engagement.* To inform the Children's Emotional Wellbeing and Mental Health Needs Assessment engagements were held with professionals across the county in the Autumn of 2013. Six focus groups were held with professionals from Chichester CAMHS, Horsham CAMHS, Worthing CAMHS, Looked after and Adopted Children Staff, Primary Mental Health Workers (PMHWs) and Social Workers (Targeted Team). Interviews took place with: an individual PMHW, a school counsellor and paired interviews with representatives of HomeStart-Chichester and the adjacent Children and Family Centre Manager and separately with CAMHS Commissioners.

In addition, an online survey was developed to capture the views of professionals from a broad range of organisations working with children and young people across West Sussex within Social Care, Education, Health, Youth Services and Commissioning. The findings from these two methods of research are summarised in this engagement report.

Across the research process the Joint Strategic Needs Assessment was welcomed. Professionals welcomed the opportunity to air their views on CAMHS and they articulated a wish for the findings from this engagement to be shared with them and to be acted on.

Because of the timeframe for this study and the breadth of findings, we have, in the main, combined the perspectives of different professionals in relation to the broad themes identified. On occasion the views of particular professional groups have been analysed separately, e.g. GPs, and there could be merit in exploring these different perspectives further.

Of the main issues raised by professionals in the engagement, the extent of insufficient capacity, poor interagency working, insufficient communications, a lack of early intervention and problems with the referral process were the dominant themes.

2.   The referral process and problems experienced during the referral process were a dominant and recurring theme highlighted by professionals (including CAMHS professionals) in the focus groups, interviews and the survey.

The main issues discussed were: knowledge and understanding of eligibility criteria and how to meet them, the quality of referrals, communication between professionals and with families during the referral process, waiting times for decisions and appointments when referrals are accepted, support, training, and signposting to other services, the support and advice provided to families and young people.

There was considerable consistency across all professionals about the nature and extent of these issues. However, there were differing interpretations about responsibilities, e.g. in relation to: signposting alternative or interim support, communicating with parents and communication between professionals.

The bulk of referrals were made by professionals surveyed from Social Care, Youth, Health and Education Services with the latter two groups most likely to find the referral process unsatisfactory or highly unsatisfactory.

Within the survey, GPs had the highest proportion of professionals dissatisfied with the referral process. They were particularly concerned about communication and feedback from CAMHS, the high threshold for accessing the service and they found referral forms unwieldy and unsuited to their 10 minute consultation model. Whilst CAMHS staff were sympathetic to the constraints of GP working practices they felt that GP referrals were often made without sufficient consideration or understanding, with the result that they were of poor quality. Both parties appear to think the other is responsible for signposting, which indicates that neither is claiming responsibility.

Overall, social workers were more satisfied with the process than GPs, although they shared many of their concerns. They also felt that there was occasional tension or disagreement with CAMHS over labelling the 'problem' or 'need' of a client.

Gaps in knowledge and understanding of the referral process were felt by many to be in large part due to a shortage of training, support and access to informed individuals. This also applied to knowledge of services and how to obtain them. Professionals who had a trusted contact with CAMHS staff (often a PMHW) argued that the opportunity for swift, flexible, informal dialogue and advice was invaluable. They especially valued the opportunity to understand better when and how to refer, scope out what support there is and to be signposted towards it. Whilst acknowledging other professionals' needs, some CAMHS staff stated that they no longer have the resources for effective preventative work, training, consultation and signposting. This appeared to have had an impact on morale.

The provision of over-arching information and support via a contact point, with good understanding of current service provision, some ability to track and record individual cases as well as to monitor CAMHS journeys, would be welcomed.

When professionals were asked for their views about how children and families find the referral process, 41% felt that the time from referral to receiving a service was 'not usually' or 'never' acceptable. 34% of professionals thought the support put in place for families and young people between referral and service provision was 'not usually' or 'never' acceptable most of the time. In addition, there was a feeling that recording the time from referral to receiving a diagnosis/support does not adequately capture the length of time it can take for support to be offered nor the number of unsuccessful attempts a family or young person may have made to get help. It is also possible that some children may be slipping through the net and that these children's experiences are not being recorded.

In the main, professionals suggested that families did not find it easier to access support when problems re-occur, which reflects parents' own views.

3.	Early intervention provision was thought by some to be largely inadequate and there was a recurring emphasis on both its efficacy and the need for more. Early intervention was discussed in its widest sense to include not only early CAMHS help but also help within a universal context in relation to: low level work with teenagers on stress, self-esteem, sex education and body image and on emerging challenging behaviours with the aim of reducing the potential life-long impact. The aim of all interventions would be to: prevent issues escalating, stop young people becoming isolated, support them so that they struggle less at school and so that the impact and distress of emotional and MH issues on young people, their families and those around them are lessened.

Professionals recognised that schools have a very important role in early intervention. It was widely agreed that there is a need for more schools to raise the profile of mental health by supporting young people in articulating and discussing their concerns, removing stigma and providing support. Similarly, professionals identified a broader need to support and build parents' behaviour management skills pre-school and to help them reduce their children's anxiety levels, depression and inability to work and learn.

It was suggested that access to services should focus on the level of distress a child or young person presents rather than their specific age. Another specific concern raised was for earlier access to support for attachment issues, especially for looked after and adopted children (LAAC).

The Early Intervention Service (EIS) received praise and was recognised as an essential part of early intervention.

4.	There was a general consensus on the need to raise awareness of the different sorts of services offered by CAMHS and how professionals and users can access them. Few felt adequately aware of what the full range of services available were, what they offered or who could access them.

Professionals felt that staying up to date with the ever-changing array of services/approaches available and their differing remits requires time, effort and resources. Safeguarding training was the most commonly noted form of continuous professional development (CPD) highlighted by surveyed professionals, 148 (44%). More generally, training was most often provided by colleagues, 99 (30%). 161 (48%) professionals indicated that they would like further training to help them support children and young people. They suggested that this should include training to: recognise the signs of different mental health conditions, ascertain which CAMHS service is most appropriate, to make better referrals, to help support and develop Tier 1 and 2 provision in order to alleviate pressure on Tier 3 services. Professionals also articulated the view that education and training about mental health should be a key requirement for all staff working with children and young people.

There was agreement that there is insufficient capacity for training or advice available from PMHWs and educational psychologists and that this provision has been in decline for some time.

Professionals extended the above requirement for better understanding and education about emotional wellbeing and mental health issues to include young people and their families. This would be especially helpful for those accessing interim support if not eligible for Tier 3 referral and for understanding and managing conditions.

More generally, whilst it was thought to be improving, professionals felt that more should be done to de-stigmatise mental health, raise its profile and improve awareness of, and access to supporting resources. There was some optimism for the future in that current government priorities and policy suggest a commitment to improving the understanding of mental health and recognition of the importance of addressing mental health issues.

5.   Professionals identified a range of concerns in relation to young people's perceptions of and potential engagement with CAMHS. The name 'CAMHS', in itself was not always understood and viewed as off-putting to some potential service users.

Comments were made that young people can be reluctant to engage with CAMHS and did not always see the service as friendly or approachable, with some young people fearing it. Others identified insufficient inclusion of young people in consultations about service provision and their voice in decision making was not always perceived to be marked enough. It was suggested that CAMHS could do more to reach out and proactively engage with young people.

Professionals argued that young people and families will often look online for information or support. Current online services were thought to be fragmented, poorly presented, hard to find and inconsistent.   Suggestions for improving online provision included: simple remote counselling and 'apps' that might provide support with specific issues, videos of professionals and young people talking about their conditions and treatment.

6.   Professionals tended to feel that there is insufficient provision at all Tier levels to provide adequate support to children, young people and families. Children's mental health services were regarded by many professionals as fragmented, with inconsistent equity of access across the county. CAMHS was thought by many to be overwhelmed, to be engaging with the 'tip of the iceberg' and only accessible to young people with very severe needs.

There was also felt to be insufficient overall knowledge of mental health provision and incomplete mapping of CAMHS services more generally.

As noted earlier, the responses to referrals, time taken to diagnosis and access to appointments and CAMHS services were all believed to take too long.

There were a number of resource/capacity issues highlighted with potential impact on the quality of care, access to services, number and quality of referrals. - *These issues were raised with varying degrees of consensus from the professionals' engagement.*

- Some Tier 3 workers said they were struggling to find time for all their appointments.

- The number of PMHW's, school nurses, education psychologists and non-teaching pastoral staff in schools is thought by some professionals to have reduced and schools were thought to be lacking in adequate CAMHS provision.
- The commissioned services for those with learning disability or autism were felt to be insufficient.
- Some professionals said that children exhibiting extreme behaviours struggled to receive a response or diagnosis.
- There were a range of areas where some professionals raised concerns regarding insufficient provision of care. These included, behavioural problems, eating disorders, anxiety and severe anxiety, substance misuse, emotional mental health issues, self-harmers, bullying, depression and school avoidance; young people involved in domestic abuse or with parents with drug and alcohol issues; the number of in-patient beds and facilities for young people in crisis (a national problem); support for young people during the transition from primary to secondary school.
- Accessing timely specialist support out of hours (including weekends) was raised as a concern, including support for some young people with severe mental health problems.

7.   Throughout the research a significant theme was the need for all professionals to work together more effectively and for someone to be responsible for reviewing the whole picture including the impact of changes in one service on another. The desire was to improve co-working practices and develop thorough, systematic and collaborative approaches to meeting the needs of young people, and for any changes following the Needs Assessment to be coherent and co-ordinated with other child and young person focused services.

Professionals wanted to create a more holistic approach to mental health and wellbeing. They stressed that the broader familial context and needs should be assessed and addressed and the importance of diet, nutrition and physical health to emotional wellbeing, especially anxiety and depression be considered. Holistic care plans for vulnerable children, positive partnership working and the value of working in a reflective, specialist team with a focus on psychological formulation were all thought to be useful approaches.

Professionals across the research commented on the important role of schools in relation to emotional wellbeing and mental health. There was some concern that signposting, commissioning and provision of Tier 1 and 2 CAMHS provision within schools was increasingly fragmented as a result of changing structures and funding arrangements (free schools, academies, etc.). Within this context GPs currently have a role in making referrals to CAMHS in collaboration with schools. The development of improved training and communication between GPs, schools and other professionals could have a beneficial effect.

The majority of professionals surveyed (75%) did not have experience of young people transitioning to adult mental health services. There was a view that more flexibility over the age of transition could be allowed. Some young people were not thought to be mature enough to move to adult services and the feeling was that CAMHS could offer support to some young people up to age 25.

Occasional concern focussed around an increasing culture of early medication of young people by GPs without them being seen by either a PMHW or consultant.

The impact on children of growing up with parents who have their own unaddressed mental health issues and whose only current provision is medication managed by the GP was not felt to be wholly satisfactory.

Some CAMHS staff hoped that they would continue to be co-located as they believed that this offered opportunities for multi-practitioner working, skill-sharing and supportive reflective practice.

1. INTRODUCTION

A series of 6 focus groups were held with professionals across the county in the Autumn of 2013.

- Chichester CAMHS
- Horsham CAMHS
- Worthing CAMHS
- Looked after and Adopted Children Staff
- Primary Mental Health Workers (PMHWs)
- Social Work (Targeted Team)

Four interviews were also conducted with: a School Counsellor, a PMHW, Home Start and Children and Family Centre Managers (2 staff), CAMHS Commissioners (2 staff).

In tandem with this an online survey was completed by 334 professionals from a range of organisations working with children and young people across West Sussex.

The professionals responding to the survey worked in the following sectors:

Table 1, "What Sector do you work in?"	Number & Percentage
Social Care	89 (27%)
Education	87 (26%)
Health	63 (19%)
Youth Services	53 (16%)
Commissioning	8 (2%)
Other	34 (10%)
TOTAL	334 (100%)

The professionals worked within the following Tiers:

Table 2, "What Tiers do you work within?"	Number & Percentage
Tier 1	225 (67%)
Tier 2	151 (45%)
Tier 3	119 (36%)
Tier 4	67 (20%)

The largest number of professionals responding worked in Tier 1 (225), though they often worked within other Tiers as well. Overall 132 professionals worked in Tier 1 only.

In general there was a good spread of professionals responding who worked in each sector and from across the county.

Primary schools in towns and villages from across the county were well represented. The response from staff in secondary schools was not as comprehensive as it is not clear that there were contributions from Chichester or Horsham secondary schools. However, it is likely that other

professionals who go in to schools in these areas will have responded, e.g. school counsellors, nurses, etc. In addition a number of participants did not mention the specific school they worked in.

Because of the speed of this study and the breadth of findings, we have, in the main, combined the perspectives of different professionals in relation to the broad themes identified. On occasion the views of particular professionals groups have been analysed separately, e.g. GPs, and there could be merit in exploring these different perspectives further.

Of the main issues raised by professionals in the engagement, the extent of insufficient capacity, poor interagency working, insufficient communications, a lack of early intervention and problems with the referral process were the dominant themes.

Key points:

- A series of 6 focus groups was held with professionals from Horsham CAMHS, Worthing CAMHS, Chichester CAMHS, Looked after and Adopted Children Staff, Primary Mental Health Workers (PMHWs) and Social Workers (Targeted Team). Four interviews were also conducted with: a School Counsellor, a PMHW, Home Start and Children and Family Centre Managers (2 staff), CAMHS Commissioners (2 staff).

- An online survey was completed by 334 professionals from a broad range of organisations working with children and young people across West Sussex within Social Care, Education, Health, Youth Services and Commissioning.

- Because of the speed of this study and the breadth of findings, we have, in the main, combined the perspectives of different professionals in relation to the broad themes identified. On occasion the views of particular professionals groups have been analysed separately, e.g. GPs, and there could be merit in exploring these different perspectives further.

- Of the main issues raised by professionals in the engagement, the extent of insufficient capacity, poor interagency working, insufficient communications, a lack of early intervention and problems with the referral process were the dominant themes.

2. REFERRAL PROCESS

The referral process and problems experienced during it were a dominant and recurring theme highlighted by professionals (including CAMHS professionals) in the focus groups, interviews and the survey. There was considerable consistency across all professionals about the nature and extent of these issues.

The main issues discussed were: knowledge and understanding of eligibility criteria and how these would be met, the quality of referrals, communication between professionals and with families during the referral process, waiting times for decisions and appointments when referrals are accepted, support, training, and signposting and advice provided to families and young people.

"Referrals are mostly rejected as being inappropriate, huge waits when they are accepted, and lots of dissatisfied young people, and angry parents to deal with!"

Professionals cited a large range of organisations and ways that referrals are made to professionals at Tier level 2 and above. This includes referrals not only to CAMHS but other higher Tier services such as the Family Resource Service for those under age 10 (FRTu10s) or older (FRTover10s) and the 'Solutions' service they also provide. The general summary shown below, whilst not complete, provides a broad outline of the wide range of processes and people involved.

Schools: school leadership staff, and also school counsellors and ALT, Educational Psychologists SENCOs, INCOs and the Children and the Young Person Planning Forum (CYPPF);

Children's Services: Children's Access Point (CAP) Social Workers - the main route to first contact with Children's services for children, families and professionals, other Social Workers (normally those involved in Adoption work, work with Looked After Children or disabled children (sometimes via the Disabled Children's Placement Panel) as well as Child Protection Conference Chairs, Foster Care placements, Young Carers Service, Family Resource Service (under and over 10) and through the CAF process.
Early Childhood Services (sometimes as a result of offering Solihull parenting courses)
Youth Services: Youth Workers and Emotional Wellbeing Workers
Youth Offending and Employability Services
Action against Bullying Helpline
Asset assessment services
Health Services: GPs, school and other nurses, health visitors, children's wards, Accident and Emergency, Consultants, Child Development Centres (CDCs)
Self-referral (often in emergency situation)
Parents, friends
Police and Courts
CAMHS/AMHS (Including PMHWs)

Referrals and requests for service forms and letters are sent (some by email) and can result from individual conversations with CAMHS staff, GP consultations with parents (some referred via their

child's school or Youth Services), panels that sit to assess referrals (CYPPF) and CAF/CAF+ process, Provision Planning Panels, Family Resource Teams Panel), Child Protection Conferences, Looked After Children Reviews. Referrals are then normally considered at a weekly referral panel meeting held by CAMHS staff where decisions about assessments and outcomes are made.

2.1 Professional's Experience of the Referral Process:

Chart 1, How do professionals find the referral process when they refer up to the next level?

How do you find the referral process if you need to refer up to the next level?
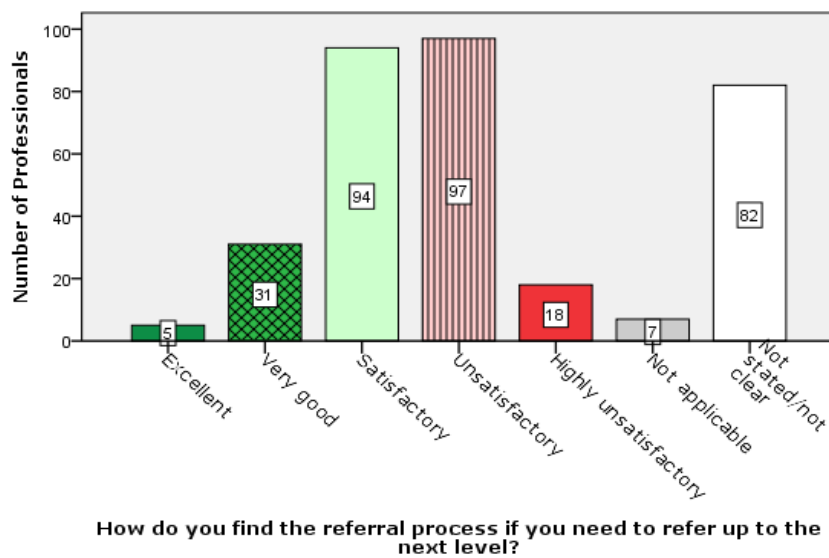
Chart 1 indicates that overall, professionals are as likely to be satisfied as dissatisfied with the process when they need to refer up to the next level. It is interesting to explore this information by sector, as shown in Chart 2.

Chart 2, How do professionals in different sectors find the referral process?

What sector is the organisation in?
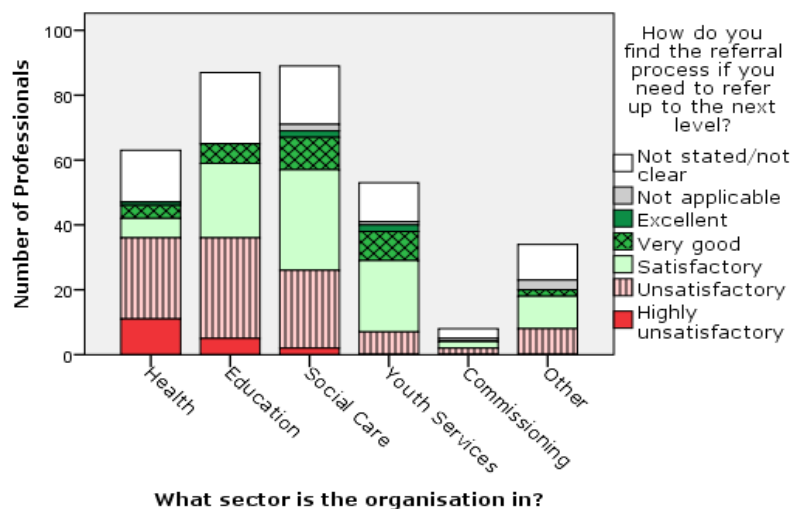
Professionals who responded from within the Health and Education sectors were more likely to find the referral process unsatisfactory or highly unsatisfactory. This mirrors the findings from the

qualitative discussions. The main bulk of referrals were made by Health and Education professionals. From the details noted earlier about the major staff groupings within these sectors it is possible to consider the perspectives of Health and Education professionals in a little more detail, as shown in Charts 3 and 4.

"I have almost given up referring because of limited response."

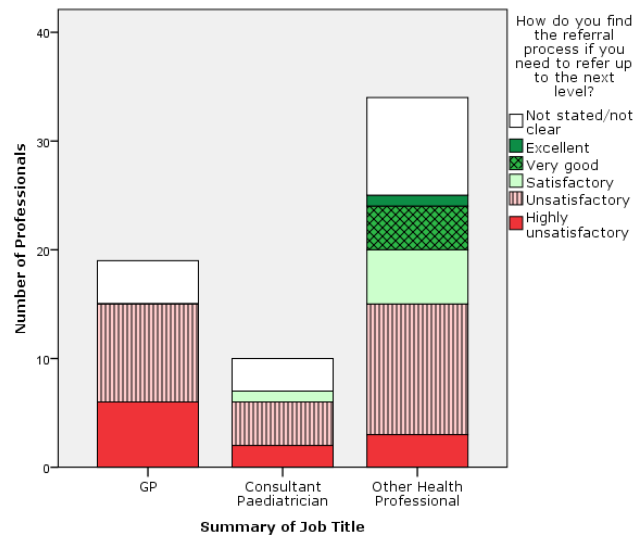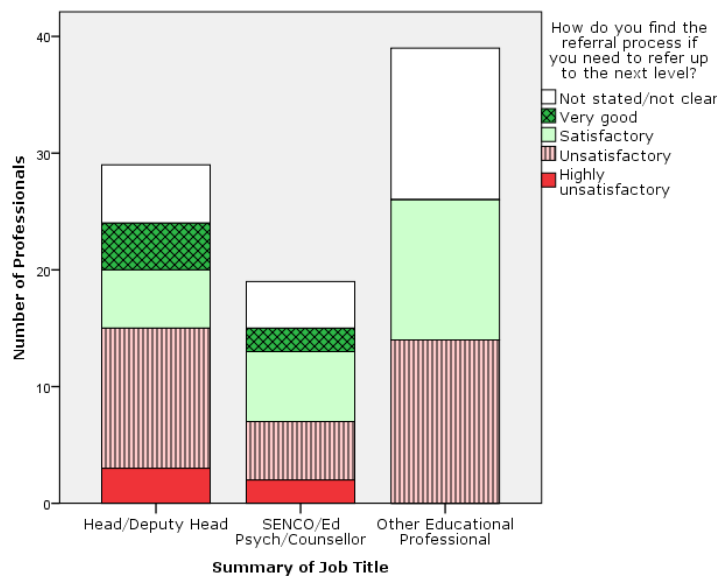**Chart 3, How do different health professionals find the referral process?**

Chart 4, How do different education professionals find the referral process?

2.2 GPs Experience of Referrals to CAMHS:

The GP is often the filter or access point between families and CAMHS. They had the highest proportion of dissatisfied respondents of the surveyed professionals.

They indicated that expectations can sometimes be raised by others to: *"Go and see your GP and get a referral to CAMHS"*, when in fact they suggest that many of the referrals they make are declined. GPs indicated that families often come to them when they have reached a crisis point and the inability of the GP to filter them to an appropriate service can lead to the GP being viewed as obstructive.

"Stuck in the middle without enough information to help with stressed and angry people asking us to do something."

Feedback provided by CAMHS about referrals they had received was generally viewed as poor with the decision to reject a referral often being communicated slowly, if at all, and without suggestions about alternatives services to explore. Where a referral is accepted the service can still take some considerable time to be provided. GPs reported:

"A feeling of resistance from the Tier above to see children, engage with families and a lack of support when trying to get help/advice regarding management."

"I feel it could be easier for professionals to refer. It takes too long to be seen and I don't think clients and their families are 'kept in the loop' enough about the progress of the referral."

GPs found the criteria for acceptance by CAMHS to be too limited; although comments were made that where there was a clear mental health diagnosis or eating disorder the service was good. One GP mentioned that referrals concerning angry outbursts in children or depression were not accepted by CAMHS. This mirrored a general concern that CAMHS do not appear to engage with young people where there are behavioural conditions and alternative provision was considered hard to find.

Referral forms were described as unwieldy, lengthy, unintuitive, subject to change and unsuited to their ten minute consultation model.

These comments from GPs were reflected in the responses of other professionals and summarised elsewhere in this report within the general themes identified throughout the survey and discussions.

"Waiting times can be a long process and this can cause distress with the family in which they contact us many times. They will be asking the same question when will I be seen, so being more transparent and having this known to all staff to say there will be at least X amount of time before they will be seen."

2.3 CAMHS View of the GP Referral Process:

CAMHS staff were sympathetic to the working practices which affected GP referrals but tended to have a different view of why the GP referral process could be problematic. Relationships between GPs and CAMHS workers tended to vary from excellent to poor, depending on the individuals involved.

"It really, really depends. A lot of GPs we have good relationships with and there are some who will phone me, or their practice managers will phone me to find out about things. There are others who get quite cross with us because we haven't dealt with their referrals or they've thought we should deal with it and they get quite angry and cross about it."

Specialist Tier 3 CAMHS staff, in particular, recognised and were often supportive of the difficulties that GPs and other professionals experienced. However, they tended to argue that the quality of referral for Tier 3 CAMHS, from GPs in particular, and to a lesser extent schools, was often poor or inappropriate. CAMHS workers from one of the discussion groups voiced a concern that mental health referrals are not given the same care and attention as physical health referrals:

"It's fascinating because they would never send a letter to an oncologist saying "please see this individual they've got cancer" and just leave it at that…but we get letters saying "please see this child they've got depression" or "they're depressed", well, what makes you say that?"

Some CAMHS staff felt that GPs were liable to refer to Tier 3 services too readily, sometimes as a result of pressure from parents, especially where a GP was keen not to jeopardise their relationship with parents. In some cases GPs were thought to be responding to concerns outlined by parents rather than observing the child directly and this raised questions for some CAMHS staff as to whether GPs were best placed to make an initial diagnosis.

The 'ten-minute model' (which GPs were largely thought to operate within) was also felt to place additional constraints on the quality of GP referrals. Ten minutes was not thought to be adequate to properly complete lengthy referral forms, let alone make an adequate diagnosis and this could result in poor quality referrals.

"I don't think they fully embraced the consultation model because it doesn't fit with the GPs model. They've got a ten minute appointment, they want to be able to make a decision about what they're going to do. So I have a small group of GPs who do use the consultation and they'll phone me and it's like, I don't think this is to you but I don't know what to do with it, you know, and that's great when they do that but the majority of them will send in a CAMHS referral and see what we will do with it. Because that's what they've got the time to do."

There was also exasperation from some CAMHS staff who felt that many GPs did not appreciate the limited scale of CAMHS and may have out-dated perceptions of the scope and nature of CAMHS service provision. Their concern was that the consequent unrealistic expectations of the referral process might also set-up parents, children and young people for disappointment.

"They're still sending a lot of just behavioural problems that we used to do before the other services were replaced, and we still have to work our way through and direct them to the appropriate service."

"I feel that better communication with the families to help manage their expectations of what CAMHS can actually do would be helpful. Knowing what the service isn't just as much as what it is, is important for families to understand."

Accompanying the above was a perception amongst some CAMHS staff that some GPs, and social workers might be treating them as an inappropriate emergency service for their most difficult cases.

Another point raised by CAMHS staff was that GPs were unlikely to adequately signpost families to alternative or interim support. This same issue was raised by GPs who indicated that CAMHS staff were not suggesting alternatives. Both parties appear to think the other is responsible for signposting, which indicates that neither is claiming responsibility.

2.4 Social Care Referrals

As with the majority of those who participated in the engagement, social workers focused on what they felt was very limited access to Tier 3 services. The dominant theme was that CAMHS were too strict in applying their eligibility criteria for access to Tier 3 services:

"It's like put all these hoops in the way, all these hurdles in the way and if you might finally get to the end or you get to that stage where you think, "It's got to be CAMHS," and they think, "Well, actually no, it doesn't meet our criteria."

For those working in local authority services, (from the discussion groups) the process of referring to CAMHS and other services appeared to be more clearly understood. Discussion also showed that awareness of and links with voluntary and charitable organisations were deemed to be reasonably well developed. This group therefore tended to be less dissatisfied with the levels of signposting and support required during the referral process. Nevertheless they still expressed concern and desire for improvement.

When discussing their experience of issues encountered during the referral process some social workers felt there was occasional tension or disagreement over labelling the 'problem' or 'need' of a client. Social workers argued that this occurred more often when there were significant behavioural issues which they felt were symptomatic of underlying mental health issues or complex needs which might disguise underlying mental health issues. There was a shared concern that those with complex needs require additional support and may not always be diagnosed:

"Children with what I regard as complex needs (i.e. self-harmers) appear to fall outside the narrow boundaries of CAHMS and have nowhere to turn. We meet a few on our weight management programme and it is quite shocking how isolated they and their families are."

"Students who are displaying possible mental health issues but have complex needs - there is a genuine fear that these students are not dealt with appropriately."

"For mental health issues or emotion and wellbeing issues that cause behavioural problems particularly with children with attachment needs, I think that's quite poorly resourced, I think those children get passed around the agencies, round social services, "It's your business." "It's yours, it's yours." I think if we could think a bit better about those children rather than try and sort of hand them off to some other service that would be helpful for them. They do need intervention at an earlier stage."

The good understanding of the referral process by social workers, and those others within Social Care Services working with children and young people, was informed by their regular experience of working with the needs of children or young people, many of whom may have already reached the relevant threshold for Social Care or CAMHS involvement.

In group discussions there was some suggestion that the heightened dissatisfaction expressed by some was a result of: longstanding relationship with clients, increased need of clients (given that they were either LAAC or had on-going contact with Social Care Services) or higher expectations of success.

"With all the requests for service referrals I have made, not one has been accepted due to not meeting criteria. This leaves a huge gap in the service and children's needs are not being met."

Further, there was also some sense that any dissatisfaction was informed by the more frequent pushback from Tier 3 services they experienced during the course of their career as well as a perception that over time CAMHS had raised thresholds to Tier 3 services:

2.5 Other Professionals:

Professionals, more generally, acknowledge that differences in understanding and attitude towards the efficacy of the referral process were partly informed by their specific culture and daily practice. However, they tended to share the view that gaps in knowledge and understanding of the referral process were in part to due to insufficient training, support and access to informed individuals:

"No one understands the role of CAMHS any more, what they do accept and what they do not and the reasons for this."

"The CAMHS team [Tier 3] are anonymous to primary care, there are very few links and I have never seen any education events run by them."

Professionals tended to discuss referrals in the context of access to Tier 3 or Tier 4 services where the level of distress of the child or young person and the impact on the family and other services tended to be more severe. However, it was clear that any referral could potentially be problematic, setting-up disappointment for both young people and families and potentially wasted time for needy and vulnerable clients:

"Many referrals are returned, suggesting we use other services which do not exist, leaving parents and children without the support that they need."

Those who wanted to refer to lower Tier services, including some GPs and education staff acknowledged uncertainty about where or how best to refer to an alternative service, especially where cases didn't meet the CAMHS Tier 3 thresholds. This reinforces an earlier finding highlighting that no one group of professionals appear to take responsibility for signposting to alternative services.

Where CAMHS turned down or accepted a referral there was a shared view that the responsibility for communicating this should lie with them rather than the referrer.

The general perception was that there should be some central over-arching information support or contact point that has a good understanding of all current service provision, including community and voluntary services. The support or contact point should also track and record individual cases and monitor their journeys within CAMHS.

"Difficult to keep up with the network of different agencies e.g. who's offering what and thresholds around entry into a service being raised."

"Not everyone knows all the agencies that could be accessed-it would be helpful to have a list to draw from."

It was thought that providing this service could also help manage expectations and perception of service provision and support interim and additional support.

Across the board, professionals that had a trusted contact with Tier 3 specialist CAMHS staff argued that the opportunity for easy, flexible, informal dialogue and advice was a valuable part of their experience. In particular they appreciated the opportunity to understand better when and how to refer, scope out what support there is and to be signposted towards it.

Some CAMHS staff, primarily PMHWs, reflected these views and regretted what they felt was a reduced capacity to offer training, consultation and to support signposting. In discussion and in the survey, professionals largely agreed that they felt the eligibility criteria for referral to Tier 3 had been raised.

2.6 CAMHS Views of Other Professionals' Referrals:

Some CAMHS staff argued that other services, in particular those who most commonly refer to them; schools, Social Care and GPs in particular misunderstood the extent of the services they provide, often refer poorly and can over-estimate the size of CAMHS and the resources available to them.

"Our service at the moment overall consists of 6.6 full time posts so that's all our service is, county wide. So when people are talking about a Primary Mental Health Worker service, that's it. So I think it could certainly be hugely increased to better effect."

Some specialist Tier 3 CAMHS staff felt that Social Care professionals were passing on problem cases that required non-mental health care. They considered that the referring Social Care staff might be experiencing their own emotional challenges dealing with difficult cases:

"I don't think social work teams get enough space to think about the impact of trauma on them, and that gets them stuck and reactive. When it's not processed, people become reactive, or shut down to it."

From the discussions there was also a sense of CAMHS staff feeling pressurised and under-resourced. Morale was perceived to be low and many stated they were struggling to meet the demands of their caseloads.

"Not sure anyone realises how much teams are running on empty and morale is very low, even from amazingly skilled and thoughtful professionals."

"High caseloads and high demand for the service in the absence of enough clinicians can have a negative impact on the time for reflection, professional development and innovative practice."

"It is very difficult to manage an ever-growing waiting list for individual therapeutic work, carer consults or family work. The nature of our client group means issues of trauma and multiple placement moves are salient for all clients; as such needs are high, the system supporting children is often highly anxious and often they despair at having to wait on a waiting list. We constantly review our caseloads and the priorities within the waiting list, but it is a constant battle to meet complex need."

Some CAMHS staff felt that they had been reduced to fire-fighting and that they no longer had the resources or time to engage in much needed and effective preventative work in terms of training Tier 1 and 2 staff, consultation and signposting.

"All of us are up against it, and you will come across this whoever you talk to, is that there aren't enough resources to intervene as early as we would like to, as intensively as we would like to. And provide as quick a service as we would like to."
"We are too busy dealing with the crisis to kind of deal with the stuff that we would like to do proactively."

A few also acknowledged that they needed to be more rigorous about communicating what the service is that they offer at Tier 3 and clear about what therapy means - in particular when working with multi-agency teams and other professionals working with children and young people.

2.7 Professionals' Views About How They Think Children and Families Find the Referral Process:

In the survey, professionals were asked 3 questions about how they think children and families find the referral process. This is shown below in Table 3. The main concerns expressed by professionals related to the time from referral to receiving a service (where 41% said it was not usually or never acceptable) and the support put in place whilst waiting (where 34% said it was not usually or never acceptable).

The comments made by professionals on behalf of children and families mirrored their own concerns about the referral process.

Table 3, *"How Do Professionals Think Children And Families Find The Referral Process?"*	Always	Most of the time	Some times	Not usually	Never	No Answer	TOTAL
The time from referral to receiving a service is acceptable?	6 (2%)	43 (13%)	70 (21%)	113 (34%)	22 (7%)	80 (24%)	334 (101%)
The support put in place to support the family between referral and service provision is acceptable?	4 (1%)	45 (14%)	90 (27%)	104 (31%)	10 (3%)	81 (24%)	334 (100%)
The referral process works smoothly?	4 (1%)	63 (19%)	108 (32%)	77 (23%)	6 (2%)	76 (23%)	334 (100%)

Fewer professionals were concerned about how smoothly the referral process worked (where 25% said the process never or not usually worked smoothly).

In discussion and the survey, there was considerable consensus that children, young people and their families often have to wait an unsatisfactory amount of time during the referral process. Some non-CAMHS professionals wanted to emphasise the amount of time children young people and families spent waiting from first seeking help to receiving it. The sense was that merely recording the time from referral to receiving a diagnosis did not adequately capture the length of time it could take for support to be offered, nor the number of unsuccessful attempts a family or young person may have made to get help:

"The timescale of getting a referral from either a GP or a school nurse to the young person starting to receive treatment can often be many months."

"The waiting time is too long as there are not enough staff to do the work. The time it takes to get the help in the first place is frustrating and some children do not fit criteria exactly which delays essential support."

Professionals also wanted to re-emphasise the insufficient communication, signposting and expectation management for families and young people throughout their journey.

In discussions, some CAMHS staff felt that the responsibility for communicating with families and young people should not lie with them. These staff related that there were times when they had to communicate with families on behalf of GPs and schools who did not always pass on information they receive regarding their patient's or pupil's unsuccessful referrals to Tier 3. They felt this to be an additional drain on already overstretched resources.

Some CAMHS workers believed that many families and professionals hold inaccurate impressions of the service they provide; believing that they are unfairly fighting against an outdated reputation.

"I think those [myths] are being fed down the line, because I saw a GP trainee, registrar trainee myself who said, "What do you do as a job?" I told him and he said, "Oh there's months wait for that isn't there?"

"Yes, it's almost like people just repeat it and therefore it takes on a truth that doesn't exist, but it's simply because it's what everybody says to each other."

"There's a huge time lag between the way we are working and the way we are evolving our services to the GPs, and say referrals catching up so you get this strange myth that you still need to wait six months to a year to see CAMHS. Well no, you get to see them in four weeks." We get parents going, "I can't get time off work, hold on a minute, can you see him in six weeks instead?" So we are working very differently I think to some of the perceptions around."

2.8 Professionals View of Accessing Support When Problems Re-occur:

Table 4 highlights the professionals' views about whether families find it easier to access support when problems re-occur.   38% of professionals did not answer the question; 15% felt it was easy for families to access support 'always' or 'most of the time' when problems reoccurred; slightly more (17%), felt it was 'never' or 'not usually easy'.

The main bulk of responses were more ambivalent, 30% of families found it easy to access support 'sometimes'. This mixed view was reflected in the survey comments and discussion.

Table 4: *"If problems re-occur, is it easy for families to access support?"*	Number and Percentage
Always	1 (-)
Most of the time	51 (15%)
Sometimes	99 (30%)
Not usually	55 (16%)
Never	2 (1%)
Not answered	126 (38%)
TOTAL	334 (100%)

Key points:

- The main referral issues were: knowledge and understanding of eligibility criteria and how to meet them, the quality of referrals, communication between professionals and with families during the referral process, waiting times for decisions and appointments when referrals are accepted, support, training, and signposting to other services, the support and advice provided to families and young people.

- The bulk of referrals were made by professionals from Social Care, Youth, Health and Education Services with the latter two groups most likely to find the referral process unsatisfactory or highly unsatisfactory.

- GPs had the highest proportion of professionals dissatisfied with the referral process. They felt communication and feedback from CAMHS was poor, the Tier 3 threshold acceptance criteria too high and referral forms unwieldy and unsuited to their 10 minute consultation model.

- Overall, social workers were more satisfied with the referral process than GPs, although they shared many of their concerns. They also felt that there was occasional tension or disagreement with CAMHS over labelling the 'problem' or 'need' of a client.

- Gaps in knowledge and understanding of the referral process were felt by many to be in part due to a shortage of training, support and access to informed individuals.

- Professionals that had a trusted contact within CAMHS argued that the opportunity for swift, flexible, informal dialogue and advice was invaluable. They especially valued the opportunity to understand better when and how to refer, scope out what support there is and to be signposted towards it.

- CAMHS staff, whilst sympathetic to the constraints of GP working practices, felt their referrals could be made too readily sometimes as a result of pressure from parents. They found the quality of referrals from GPs, and to a lesser extent schools, were often poor or inappropriate for their service.

  CAMHS staff considered that GPs were unlikely to adequately signpost families to alternative or interim support. This same issue was raised by GPs who indicated that CAMHS staff were not suggesting alternatives. Both parties appear to think the other is responsible for signposting, which indicates that neither is claiming responsibility.

- A need was identified for an over-arching information support/contact point with good understanding of all current service provision who should also track and record individual cases and monitor their journeys within CAMHS.

- Some CAMHS staff felt that other professionals have out-dated perceptions of the scope and nature of CAMHS service provision and this sets up parents, children and young persons for disappointment by giving them unrealistic expectations of the referral process and outcomes.

- Some CAMHS staff reported feeling pressurised and under-resourced, with low morale as they are struggling to meet the demands of their caseloads. They suggest they no longer have the resources for effective preventative work, training, consultation and signposting.

- 41% of surveyed professionals felt the time from referral to receiving a service was 'not usually' or 'never' acceptable for children and families and 34% felt the support put in place whilst waiting for a service was also 'not usually' or 'never' acceptable.

- GPs and schools were said not always to pass on information they receive regarding their patient's or pupil's unsuccessful referrals to Tier 3.

- It was argued that recording the time from referral to receiving a diagnosis does not adequately capture the length of time it can take for support to be offered nor the number of unsuccessful attempts a family or young person may have made to get help. Children and young people may be slipping through the net and these children's experiences are not being recorded.

3. PREVENTION AND EARLY INTERVENTION

Early intervention provision was thought to be largely inadequate and there was a recurring emphasis on both its efficacy and the need for more of it. Early intervention was discussed in its widest sense to include not only early CAMHS help but also help within a universal context:

"There is a massively growing literature about how you can significantly reduce the trajectory and challenge if you intervene at a much younger age."

In discussion and surveys, earlier intervention was understood to be beneficial for children, young people and their families and for the effective use of CAMHS and other service providers' resources. One rationale for earlier intervention was that it may prevent an issue escalating to the point that it required intensive, resource heavy and time consuming intervention thus providing significant cost savings in the medium to long term. Further, it was recognised that the sooner an issue was addressed the less distress would be experienced by the child or young person and the less it would impact on the family and those around them. Professionals were also keen that the child or young person did not become more isolated over time and that important peer support networks should not be lost:

"When a child is seriously struggling to cope and parents are struggling to understand their child's needs - this family is not serviced by MH, SEN or other services. If their mental difficulties are not serious enough it seems that they have to deteriorate severely before being helped. It's frustrating when you can see clear prevention or intervention opportunities missed and a child/family negatively impacted by this delay."

"Number of young people requiring a service is increasing but the number of available professionals is not. Young people seem to need to be at crisis point in order for them to receive a service. More early intervention is needed."

There was a concern that the perceived decline in Tier 1 and 2 services more generally meant young people were inappropriately attempting to access Tier 3 services.

"For me it's that young people won't necessarily get the most appropriate service because there isn't anything else out there so by default they might ring CAMHS and primary mental health workers to work with that family, it's not appropriate and actually they don't need that level of intervention. So they're, but there's nowhere else for them to go now because all those other services have been depleted. So they're kind of left…"

3.1 Early Intervention for Children Looked After and Adopted:

Some CAMHS staff and social workers expressed surprise that by the time they became involved a child or young person's needs may be quite complex and severe. There was particular concern amongst those professionals working with LAAC, whom some argued were most likely to have experienced trauma and maltreatment, that this group were not being supported earlier:

"We are a specialist service, and they will be different. And what I guess is unique about that group is that almost invariably they will have experienced trauma, maltreatment, that is how they come to be looked after or adopted."

"I think sometimes I have been surprised that nothing has happened before people have got [to the team]. That there is very little that seems to have been a support. Not all the time, but there are occasions where things have got pretty bad, and people have arrived here and you think, "How come nothing was done before?"

A specific concern was for earlier access to support for attachment issues. Some professionals working with LAAC argued that it might be possible to provide much earlier pre-emptive intervention in this area, ideally before symptoms manifested. Because of the known history there was an expectation that it may be possible to identify those children where attachment issues were likely before they presented. There was a view that this work could be done by Tier 1 and Tier 2 staff, rather than much later by Tier 3 staff once the child entered adolescence and attachment issues tended to manifest most strongly.

"If we get in earlier then potentially the trajectory is much, much reduced in terms of the challenges that the children present."

3.2 Early Intervention in Schools:

In discussion, some professionals recognised the above but also focussed on the importance of early intervention to prevent children falling behind in school. This group were most concerned that behavioural conditions and in particular children on the autistic spectrum should be diagnosed and supported as early as possible. Educational psychologists, in particular, were seen to be of importance and they were seen to have reduced in number in recent years, by one of the groups:

"I do remember when I started in this team about XX years ago, I remember going to joint meetings with the educational psychologist, and the number of ideas that were mapped out at those meetings, you'd never get an educational psychologist now because there's about three of them. So the advice that you used to get from the Educational Psychologist not that long ago in the class room is drastically different in my eyes, I say that as a clinical psychologist."

In the survey and to a lesser extent in discussion there was some recognition of the important role that schools have in relation to prevention and resilience building and the opportunity they have to support and develop this aspect of emotional and mental wellbeing. Raising the profile and comprehension of emotional wellbeing and mental health, supporting young people in articulating and discussing their concerns, removing stigma and providing support and a confidential environment were just some of the ways in which schools were thought to be able to make a difference:

"More attention could be given to the issues YP have prior to them developing into situations that require referring them up the ladder- preventative work. Feel more could be picked up in schools."

"There is a need to be proactive and have early intervention which is successful, rather than high criteria which must be met prior to a problem being acknowledged by available services."

Some school staff, and other professionals, were concerned that early intervention and preventative strategies appear to be few and far between and that a more proactive approach within schools and the community could be encouraged:

"I think schools do pockets of good work, but it depends on the staff they have at the time; there isn't a coherent kind of movement about how to support people at an early age. I think there's so much adjustment and adaptation to diagnosis at that early age that families do retreat quite a lot when their children suddenly go in special school and their friends' children are in mainstream, and they get very isolated."

Counsellors in schools were discussed in some of the groups and were seen by some to be a good method of providing early preventative care, as part of the wider CAMHS system:

"What they could do with [the child in need] is someone in their day to day life in the school environment to do troubleshooting as they go along. That resource isn't there so you get people ending up in crisis where you think, actually six years ago that young person would have been better supported at an earlier stage and therefore can be diverted out."

3.3 Early Intervention in families:

In discussion and in the survey, a range of professionals expressed a desire to recognise that a whole family approach should be taken when considering early intervention:

"We know that for most of these children, some of them, individual psychotherapy is absolutely the right thing, but for a lot of them, working with their parents or carers, or with the network or parents and children together is where the evidence is. But the adults are often so exhausted or scrambled, or just can't think; their brains are frozen, that they just want literally to kind of throw it at us."

Aligned with this was a recognition that factors such as housing insecurity, debt and poverty, which were considered to contribute to mental health, were likely to worsen. For social workers in particular this was put down to the impact of the current financial climate on family breakdown rates and the pressures that families increasingly face. The anxiety and distress experienced by parents as a result of the 'bedroom tax' was felt to be a potential contributor to this unease:

"I think it's important to recognise that the wider economic issues that we experience mean that there's a much, much higher need around housing and employment and around families that then have a huge impact on the young people in those environments."

"Yeah, they can't have a spare room… So they lose their house. So that's the position that our young people are in with their parents and it's, you know, it's almost untenable so their mental health is going to, you know, go, it's kids self-harming and everything so, you know it's a lot of pressure from the top down, from Government down."

Included in this early intervention approach was the need to support and build parents' behaviour management skills pre-school and to reduce anxiety levels, depression and inability to work and learn:

"I believe more people could benefit if groups were run for the 0-5 year old age group so parents can get into the way of thinking about communication and behaviour management of their disabled children, which would be more preventative work."

There was positive mention of Family Link Workers undertaking 'Dealing with Feelings' and also for Family Outreach workers, the Emotional Wellbeing Project and some other groups working with families and young people. The Emotional Wellbeing project and Think Family project also drew positive comment for their preventative work.

When provided, CAMHS' contribution to early intervention via CYPPF was highly valued. Preventive work with young people in the YSDS was also thought to be an example of effective practice.

"I think from the positive side that we are working more closely as an integration service. I think that the children and young kids planning forums have worked very well and create the network of people that are able to discuss and find the most appropriate services for cases and similarly with our 'one request for service' form which comes into the referral meeting and we have a member of integrated services and from intensive targeted youth support. Coming to those I think has worked quite well."

3.4 Early Intervention at Any Age:

Comment was also made that age limits were not always appropriate or were too rigid for managing access to services. There was a view amongst some professionals that access to services should focus on the level of distress a child or young person presents rather than a specific age. This would allow for greater flexibility. Comments in the survey suggest that age limits for access to services were not always thought to be appropriate (e.g. Support for young people under age 15 with eating problems or access to counselling for children under age 5).

The Early Intervention Service, whilst acknowledged as limited in capacity, received praise in discussion and the survey for their quick response with assessment and support and their flexibility in meeting young people where they wish. The role of alternative providers was also generally recognised as an essential part of early intervention and CAMHS service provision more broadly:

"I appreciate that CAMHS should only be seeing serious mental health difficulties, but referrals are often made in crisis situation, which would not happen if there was an effective lower Tier service."

In the survey some wished to emphasise the insight that the concept of early intervention did not only apply to younger children but to older children as well and that supporting those who face other low level mental health issues as early as possible was key:

"Well we do have a service that runs across 14-25s so we have an early intervention service, so if young people are in danger of developing psychosis there is a service that bridges across young people into adults... things are improving."

Work with teenagers on self-esteem, sex education and body image and on emerging challenging behaviours to reduce potential life-long impact were all felt to be important and require additional support where possible.

Key points:

- Early intervention provision was thought by some to be largely inadequate and there was a recurring emphasis on both its efficacy and the need for more. Early intervention was discussed in its widest sense to include not only early CAMHS help but also help within a universal context.

- Early intervention can: prevent issues escalating, stop young people becoming isolated, struggle less at school and mitigate the impact and distress of MH issues on young people, families and those around them.

- CAMHS staff and social workers expressed surprise that some LAAC children and young people's needs were often so complex and severe by the time they became involved. A specific concern was for earlier access to support for attachment issues.

- Professionals recognised that schools have a very important role in early intervention. They felt that there is a need for more schools to raise the profile of mental health by supporting young people in articulating and discussing their concerns, removing stigma and providing support.

- Professionals identified a broader need to support and build parents' behaviour management skills pre-school and to help them reduce their children's anxiety levels, depression and inability to work and learn.

- It was suggested that access to services should focus on the level of distress a child or young person presents rather than a specific age.

- The Early Intervention Service, whilst acknowledged as limited in capacity, received praise for their quick response with assessment and support and their flexibility in meeting young people where they wish

4. AWARENESS, ACCESS TO ADVICE, TRAINING AND INFORMATION

4.1 Awareness:

Throughout the discussion and survey, few professionals (including some CAMHS staff) felt adequately aware of the full range of services available, what they offered or who could access them.

Many professionals did not feel that they were sufficiently, proactively informed or able to easily discover what services are available, the remit of those services, the contact details, their location, capacity or waiting times. The shared consensus was that there was a need to raise awareness of the different sorts of services offered by CAMHS and other services and how professionals and users can access them:

"The other thing is we're working across different localities, so it's hard to have a county view of what we do as a team and there might be something available in Worthing that's not available in Horsham, something that's available, things like the WORTH Project and things, it varies what you can access."

Professionals were also keen to ensure that young people and families were as well informed as possible about all levels and aspects of emotional wellbeing and mental health. They believed this was important not only for accessing interim support where a young person was not eligible for Tier 3 referral, but also for understanding their condition, managing it and coping between referral, diagnosis and when a service comes to an end.

Professionals thought that any improvement in the provision of information and advice could save them time as they can be asked many times by parents about the details of service provision, how long a referral takes and the many other aspect of CAMHS and the referral process:

"Waiting times can be a long process and this can cause distress with the family in which they contact our service many times. They will be asking the same question when will I be seen, so being more transparent and having this known to all staff to say there will be at least X amount of time before they will be seen."

4.2 Changing Awareness:

There was some feeling amongst professionals that levels of awareness about mental health, as a commonly experienced health concern that merited support and resource, were improving. There was also a view that professionals, as well as children, young people and their families, were increasingly aware that there are tools and resources available to assess and support them. It was hoped that more would be done to continue to de-stigmatise mental health, raise its profile and the awareness of supporting resources.

Some reported optimistically on the positive focus now placed on continuing professional development across the children's workforce in terms of training professionals to support children and young people with MH issues and hoped that this would continue and develop.

Across the survey there were also hopeful remarks to the effect that current government priorities and policy suggest a commitment to improving the understanding of MH and the importance of addressing MH issues.

"I think raising, sort of like, de-stigmatising the whole idea about mental health has had a lot of positive press over the last few years so I think more people are willing to, want to have services from CAMHS which is a good thing. Sort of hopefully, but we're not going to be able to reap the benefits of that until years down the line."

4.3 Training and Access to Advice:

Some non-CAMHS professionals felt, and CAMHS professionals tended to agree, that there was insufficient effective training or advice available from PMHWs and that this provision has been in decline for some time:

"We still do the one… one day of each a year, with 25 places… I think it was the increased demand for direct work, there were so many referrals for direct work. But something had to give and it was the training."

Where CAMHS professionals were able to provide training or to act as a named or regular contact, perceptions of CAMHS services were generally more positive. There were also felt to be benefits in relation to how professionals from other agencies were able to deal with Tier 1 and 2 issues and make referrals to Tier 3.

Table 5 highlights the training and development opportunities professionals in the survey had accessed.

Table 5, *"What Training/Development Opportunities Have You Had To Support The Emotional Wellbeing And Mental Health Needs Of Children And Young People?"*	Number and Percentage
Training from colleagues	99 (30%)
Peer support	79 (24%)
Qualifying training including consideration of children	57 (17%)
Training from colleagues at a Tier above you	54 (16%)
Spending time with specialist MH services staff	48 (14%)
Work shadowing	35 (10%)
Counselling training specific to children and yp	30 (9%)
Online training	26 (8%)
Working as a volunteer	26 (8%)
CPD training - safeguarding	148 (44%)
CPD training – self harm awareness	80 (24%)
CPD training - attachment	80 (24%)
CPD training – impact of domestic abuse on children	76 (23%)
CPD training – MH awareness	73 (21%)
CPD training – substance abuse	70 (21%)

Within continuing professional development 148 (44%) professionals responding to the survey, had received training on safeguarding. More generally, training was most often provided by colleagues, 99 (30%).

Some wished to highlight that what training they had received was some time ago or was not all carried out in West Sussex. One professional highlighted the benefits of being part of effective, reflective consultation and network meetings and one respondent drew attention to a forthcoming book chapter of particular interest to GPs in addressing CAMHS in a 10 minute consultation. This will be published in The Good GP Training Guide (RCGP publications, 2014).

4.4 Training and Information Needs:

Table 6 highlights the continuing interest of many professionals involved in the survey in training to support their role.

Table 6, "Would You Like Further Training To Help You Support Children And Young People?"	Number and Percentage
Yes	161 (48%)
No	14 (4%)
Not sure	39 (12%)
Not answered	120 (36%)
TOTAL	334 (100%)

161 (48%) professionals indicated that they would like further training to help them support children and young people.

Aligned with the desire by some professionals to receive more training was an interest by others in providing more training. In the survey, educational psychologists requested more opportunities to provide training and supervision in schools around emotional wellbeing, mental health (including bereavement and attachment), whilst PMHWs lamented their lack of capacity to offer more training:

"There used to be a much bigger team and we used to do a lot more training of primary care professions we used to do a lot more consultation and I think our percentage used to be something like 60/40 or 60 consultation and training to 40 per cent perhaps direct work now I don't know what other people think but I would say the percentage is more like 80 per cent direct work and perhaps 20, if we're lucky, on consultations and training. And there does seem to have been a sort of huge increase in the demand for direct work because of lack of other services or, I don't know, growth of referrals but the less we give consultation and training, the wider the, it's like a vicious circle."

Some professionals articulated the view that education and training about mental health should be available for all staff working with children and young people:

"I would like training/information provided to myself and other professionals making referrals, of the specific role of CAMHS, what their eligibility criteria is, and specifically, what cases are they able to, and do engage with, as part of their role."

Professionals across the research specifically requested training to recognise the signs of different mental health conditions, ascertain what CAMHS service was most appropriate and to make better referrals.

The expectation was that additional training and consultative work would help support and develop Tier 1 and 2 provision and potentially alleviate pressure on Tier 3 services:

"Well I think the training and consultations are always so well valued and in a sense it, you could, in many ways help more children and young people through other people."

Lower Tier staff, and on their behalf Tier 3 staff, argued that early intervention and better support throughout the whole of a service user's journey would be improved by providing professionals with access to a wide range of training.

Social workers requested access to training in direct therapeutic work to support their work with traumatised children. Other areas identified for additional training were support for those with lower level needs, attachment and bereavement.

Non-CAMHS professionals requested access to informal telephone conversations, and increased opportunities for occasional face-to-face access to CAMHS staff able to answer their queries speedily and authoritatively.

Professionals also called for additional training and advice for parents and carers to support them and enhance the care they provide for their children and young people.

Key points:

- There was a shared consensus on the need to raise awareness of the different sorts of services offered by CAMHS and how professionals and service users can access them. None felt adequately aware of what the full range of services available were, what they offered or who could access them.

- There was a need identified for young people and families to be better informed about all levels and aspects of mental health and emotional wellbeing. Especially for accessing interim support if not eligible for Tier 3 referral and for understanding and managing their condition.

- Professionals felt that staying up to date with the ever-changing array of services available and their differing remits requires time, effort and resources.

- Whilst it is improving, more should be done to de-stigmatise mental health, raise its profile and awareness of supporting resources. Current government priorities and policy suggest a commitment to improving the understanding of mental health and recognition of the importance of addressing mental health issues.

- There was agreement that there is insufficient capacity for training or advice available from PMHWs and educational psychologists and that this provision has been in decline for some time.

- Some professionals articulated the view that education and training about mental health should be a key requirement for all staff working with children and young people.

- 161 (48%) professionals indicated that they would like further training to help them support children and young people.

- 148 (44%) had received CPD training on safeguarding. Training was most often provided by colleagues, 99 (30%).

- Professionals would like more training to; recognise the signs of different mental health conditions, ascertain what CAMHS service was most appropriate, to make better referrals, to help support and develop Tier 1 and 2 provision and potentially alleviate pressure on Tier 3 services.

- Professionals also called for additional training and advice for parents and carers to support them and the care they provided for their children and young people.

5. YOUNG PEOPLE'S PERCEPTIONS, BRANDING AND ONLINE

In discussion there was some agreement, by both CAMHS and education staff, that young people did not always see CAMHS as friendly or approachable. This awareness reflected a general concern that children and young people have a poor understanding of CAMHS; some fear it and others worry about what any contact with them would entail. As a consequence the professionals felt that young people may be reluctant to engage with the service.

Professionals agreed that some young people and families were concerned about the stigma, both immediately and in the long-term, associated with having a mental health issue, and this was a concern they shared.

They also identified a deficiency of trust, amongst some young people, of those tasked with supporting them, especially where that support is operating within a context that is already complex e.g. school. This concern was most keenly felt in connection with disengaged young people, some of whom already refuse to attend school.

"Also appointments offered at CAMHS have long time scales and often the children I am working with who refuse to attend school will also refuse to go to appointments and therefore may have to wait a long while for a repeat."

Additionally there was a concern that the name 'CAMHS', in itself often not understood, could be off-putting to potential service users.

From the survey it was also clear that some professionals feel there is a deficiency of inclusion in consultations, that young people's views of service provision and their voice in decision making were not always marked enough. Professionals also identified reluctance by some ex-service users to return to therapy.

The abiding sense was that CAMHS could be doing more to reach out and proactively engage with young people, ideally in ways that resonated with their concerns and preferred methods of accessing information/support. To this end there was some perception across the research that CAMHS and other services should make sure their online presence was as youth appropriate as possible and take advantage of the reach and accessibility of social media in a far more developed and youth friendly way.

Professionals argued that young people and families looking for information and support would often look online. The survey responses showed that current online services are perceived to be fragmented, poorly presented, hard to find and inconsistent. It was felt that more could be done with online and social media to mitigate anxiety over the nature of MH services, support understanding and awareness of MH conditions and facilitate communication with the services on offer.

Some also recommended that online services could be enhanced to provide simple remote counselling, videos of professionals and young people talking about their conditions and treatment,

'apps' that might support them with specific issues and especially to co-ordinate, improve and facilitate sign-posting to additional services and means of support.

There was also a view that the Internet does not always provide accurate or appropriate information and that parents can misdiagnose symptoms.

Key points:

- Professionals were concerned that young people do not always see CAMHS as friendly or approachable and can be reluctant to engage with the service. The name 'CAMHS', in itself was not always understood and could be off-putting to potential service users.

- Some argued that there is a lack of trust, amongst some young people, of those tasked with supporting them, especially where they are already disengaged or that support is operating within a context that is already complex e.g. school.

- Some identified a lack of inclusion of young people in consultations about service provision and their voice in decision making was not always perceived to be marked enough.

- It was thought that CAMHS could do more to reach out and proactively engage with young people.

- Current online services were thought to be fragmented, poorly presented, hard to find or inconsistent and young people and families looking for support will often look online.

- Suggestions for improving online provision include; simple remote counselling and apps that might support them with specific issues, videos of professionals and young people talking about their conditions and treatment.

6. RESOURCES AND CAPACITY ISSUES

Some of the issues noted here have been raised in earlier sections of the report. They are repeated here to provide a comprehensive view of resource and capacity issues.

The shared view, across the research, was that there is insufficient provision at all Tier levels to provide adequate support to children, young people and families. Tier 3 services were believed to be only engaging with the 'tip of the iceberg' and services across the Tiers were felt to be at or over capacity. The general conclusion was that CAMHS appear to be overwhelmed and in order to access Tier 3 provision young people need to present with severe issues.

"Finding a bed is a nightmare and very time consuming."

"Service offered to YP with autism diagnosis and their families is poor."

"At school we are concerned for many of our children who witness DV or parents with drug and alcohol issues. We feel that we can't meet the needs of all the children we would consider need support. I am also very aware that the examples above are just the tip of the ice-berg in my school."

The provision of mental health services was felt by some to be piecemeal, fragmented and inconsistent; with pilot programmes and other ad-hoc services potentially producing inequity of access across the county. There was incomplete knowledge of and mapping of the totality of mental health services. It may, therefore, be that there is additional capacity available that professionals are not aware of.

"There are some very good, excellent bits of service, but it's not offering a coherent package across the county. Some families get brilliant, or what we think of as fantastic, and you see the difference it makes, and other families don't."

"Levels of input seem to be very inconsistent too - we had one case where someone from CAMHS came and worked with the child weekly in school for a fixed period of time and another family who can't seem to access any support despite there being considerable unexplained behaviours which need investigating."

"If they're not clear, how are we supposed to be."

"Clear, publicised support framework for GPs to use/refer to for their patients, e.g. NICE guidelines recommend parent/training programmes in cases of suspected ADHD, where do we access this?"

Consistently across the research, responses to referrals, time taken to diagnosis and access to appointments and CAMHS services were all believed to take too long. Concerns were raised by some professionals that urgent cases were not always being treated as such, resulting in unacceptable delays in receiving their first appointment.

"The time between first referral and being seen can feel like a long time. In one case although only 2 weeks for the first meeting it felt like a long time."

"Length of referral time is far too long. 14 year old LAC (who has had a sexual assault against them) has been waiting 18 months+."

The abiding concern of some professionals was that the impact on young people and families of service shortcomings would leave them isolated and in some distress with little in the way of support or contact to mitigate their anxiety. They believed that there are needs across the whole system and too many agencies to operate effectively without coherent planning:

"It feels as if young people need to fit in to service provision rather than service provision being designed to meet their needs."

"It can be tricky getting something in between a one off consultation and a full blown intensive service via a specialist placement."

"Too many agencies, not enough cohesive planning for the child and family."

"Services are patchy and there doesn't seem to be a cohesive offering across the whole county."

Some professionals also stated that accessing timely specialist support out of hours (including weekends) was a concern, including support for some young people with severe mental health problems.

"Acute psychosis, severe anorexia, emotionally distressed but not 'mentally ill' 3 episodes I can remember where severely psychotic young people were not seen by CAMHS for over 18 hours and were contained in acute hospital."

"Some admissions to the ward are simply because CAMHS is not available."

A broad range of specific services were mentioned by various professionals during the survey and discussions as potentially being under-resourced. These were described as:

- Tier 3 workers are struggling to find time for their appointments
- The number of PMHWs, school nurses, educational psychologists and non-teaching pastoral staff in schools is thought to have reduced and schools were thought to be lacking in adequate CAMHS provision
- Insufficient help for behavioural problems, eating disorders, anxiety and severe anxiety, substance misuse, emotional MH, self-harmers, bullying, depression and school avoidance
- Children exhibiting extreme behaviours were felt to struggle to receive a response or diagnosis from CAMHS
- Insufficient support for young people involved in domestic violence or with parents with drug and alcohol issues
- Insufficient support for young people during the transition from primary to secondary
- Insufficient support for young people moving in and out of mental health facilities
- Poor mechanisms for dealing with those that return to CAMHS

- Insufficient number of in-patient beds and facilities for young people in crisis (a national problem) occasionally leading to young people being left in risky situations and staff spending large amounts of time searching for beds
- Poor transition to adult services, the lapse between age 16-24 is said to be poorly served on occasion
- Insufficient provision for out of county Looked After Children
- A shortage of Family Link Workers, 1 to 1 support, play therapy and cognitive behaviour therapy input
- Length of time taken to get to counselling or Time to Talk is too long
- Shortage of psychologists and psychiatrists to give targeted input to a wider caseload (not just severe cases)
- Not enough capacity to work the CAPA model properly
- Alternative support for young people who are not engaging well with CAMHS
- (view that many young people are coming into the criminal justice system needlessly)
- Inadequate post diagnostic service for those with autism
- Insufficient help for siblings of autistic young people
- Some lack of ownership of responsibility for supporting children with autism/ADHD resulting in disputes between CAMHS and Child Development Centres
- Difficulty accessing short term alternative learning provision to prevent mental health deterioration
- Inadequate IT and record-keeping systems
- Shortage of family therapy workers and courses
- Insufficient support for young people and awareness raising for those that are well so that they know how to support peers and recognise problems in themselves
- Dearth of new initiatives such as SALT, music and art therapy opportunities
- Need for equality of service provision comparable to adult integration of social services
- Families having high levels of need and with children with complex needs e.g. Autism and mental health issues or learning disabilities and mental health issues, were felt to be especially in need of additional support.
- Ideally all families with children experiencing mental health issues would be given advice, signposting and where necessary support and workshops and training opportunities to help them support their affected child as well as to help them address any issues that may be contributing to a child or young person's emotional and mental health.

In summary, the general view was that there are needs across the whole system. Resources are limited and to operate effectively, coherent planning across agencies is essential.

Key points:

- Professionals tended to feel that there is insufficient provision at all Tier levels to provide adequate support to young people and families.

- Tier 3 services were thought by some to be only engaging with the 'tip of the iceberg' and all services were felt to be at or over capacity.

- CAMHS services have been perceived to be overwhelmed and in order to access Tier 3 provision young people need to present with severe issues.

- Some mental health services were regarded as fragmented and inconsistent with the potential for some inequity of access across the county.

- There was incomplete knowledge of and mapping of the totality of mental health services.

- Time taken to diagnosis and access to appointments and CAMHS services were all believed to take too long.

- Professionals were concerned that the impact on young people and families of service shortcomings would leave them isolated and in some distress with little in the way of support or contact to mitigate their anxiety.

- Some Tier 3 workers are struggling to find time for all their appointments.

- Tier 4 are over-stretched, unable to provide the continuity of care or offer a sufficient level of face-to-face contact over extended periods of time.

- The number of PMHWs, school nurses, education psychologists and non-teaching pastoral staff in schools are thought to have reduced and schools were thought to be lacking in adequate CAMHS provision.

- The commissioned services for learning disability and autism were felt to be insufficient and those exhibiting extreme behaviours were felt to struggle to receive a response or diagnosis from CAMHS.

- Other resource issues identified include: insufficient help for behavioural problems, eating disorders, anxiety and severe anxiety, substance misuse, emotional MH, self-harmers, bullying, depression and school avoidance.

- Insufficient support for young people involved in domestic violence or with parents with drug and alcohol issues.

- Insufficient support for young people during the transition from primary to secondary.

- Insufficient support for young people moving in and out of mental health facilities.

- Poor mechanisms for dealing with those that return to CAMHS.

- Insufficient number of in-patient beds and facilities for young people in crisis (a national problem) occasionally leading to young people being left in risky situations and staff spending large amounts of time searching for beds.

- Accessing timely specialist support out of hours (including weekends) was raised as a concern, including support for some young people with severe mental health problems.

- The general view was that there are needs across the whole system. Resources are limited and to operate effectively, coherent planning across agencies is essential.

7. INTERAGENCY WORKING

Throughout the research a significant theme was the need for professionals to work together and to develop a more coherent interagency approach. Where professionals had experienced a joint working, they could be very positive about it.

"Some of the best work that I've done, we've joint-worked things together, worked side by side and it worked well then."

Some professionals in the survey wanted to create a broader, more holistic approach to emotional wellbeing and mental health. They emphasised that diet and nutrition and physical health were important, especially in relation to anxiety and depression.

The use of holistic care plans for vulnerable children, positive partnership working and working in a reflective team were all thought to be useful approaches.

Similarly, professionals stressed that the broader familial context and needs should be assessed and addressed. This could be the support available to foster and adoptive parents dealing with their children's trauma:

"The secondary trauma that the parents themselves... I'm just thinking of such really competent, skilled people, who are foster parents and adoptive parents, who have really got every chance of it working, and yet because of the depth of the trauma, they themselves can't think straight, or can't feel straight, or whatever."

Alternatively, it could be the impact on children of growing up with parents who have their own unaddressed MH issues and whose only current provision is medication managed by the GP:

"There is very little support for parents or children other than medication. Many of our children would benefit from therapeutic interventions which don't seem to be available."

In relation to schools, a holistic approach was considered to be one which embraced the whole child and their wellbeing and not just academic performance.

In terms of the relationship between different services, a holistic approach would be to consider the impact of changes in one service, e.g. Youth Services, on other services as well as on children, young people and families.

Another theme was the need for someone to be responsible for reviewing the whole picture and the impact of changes to one service on another. The sense was that not only should there be a holistic regard for the child but around all of the services that interface with children and young people too:

"I think what we're doing though is to try to make mental health not just the responsibility of CAMHS but sharing it with civil services. I think that the perception's got to catch up with that, as practitioners that's what we want to do, the ethos for the general public isn't there yet. They think mental health problems has got to be CAMHS, it can't be met at any other Tier."

"There are a lot of arguments because of resources and money that happen between the local authority and health, everybody, about who should provide what."

As is seen throughout the findings there were critical views between the different professionals groups. Equally, however, there was also a consistent desire to improve co-working practices and develop thorough, systematic and collaborative approaches to meeting the needs of young people. Whilst professionals tended not to talk in these technical terms the research process revealed a mutual understanding that it was in the best interests of children and young people to ensure all services developed a collective responsibility and understanding of how best to support them:

"I think it, for me, it is a need for the expertise to sort of come together; for education and mental health to come together and work together, and I think that we are doing an awful lot of that but maybe we need to just do it bit more but we don't have the capacity to do more. And you know, we've all experienced doing that joint working in schools, but it is not having capacity to do that."

"We have some apprehension about opening up referrals to schools, in that it's the fear that CAMHS would be flooded because education resources have diminished over the last few years, which is why we're doing the pilot, because we want to think about it very carefully. We think we'll get better referrals from schools than GPs but we're worried about getting quite a lot of referrals that actually will divert us from our main purpose which is around children's mental health."

Professionals across the research commented on the important role that schools and staff working within them have in relation to children's emotional wellbeing and mental health. Some schools appeared to embrace this role:

"Taking the County overview, some schools are very good in looking after young people's emotional health and I think if you work with them you've got much more chance of success. Other schools are not particularly good at managing emotional health and those are probably the schools that need more input." When asked where was the best place for that input to come from, one group member said "One way is the schools: some schools have commissioned their own primary mental health workers and when they've done that they've tended to have improved, so I think there are really good examples of some very successful work with some of the most needy children and young people in the County and actually and that's now taking a step back, so there are really high priority young people getting much less of a service now than they would have done just last year."

"There is still a varied difference of opinion in schools on the importance of healthy emotional well-being and its impact on children and families."

There was also more general concern that children and young people whom are withdrawn, lacking in social communication skills or whom are suffering emotional, wellbeing or mental health issues might fail to be identified.

School nurses were seen as offering essential support for children and young people experiencing difficulties as well as providing a useful and informed link between CAMHS staff and other service providers.

Many professionals shared the concerns of school staff about falling numbers of educational psychologists, school nurses and counsellors and the potential impact on quality of care, access to other services and the number and quality of referrals received at Tier 3.

There was some concern that signposting, commissioning and provision of Tier 1 and 2 CAMHS provision within schools was increasingly fragmented as a result of changing structures and funding arrangements (free schools, academies, etc.). Within this context GPs currently have a role in making referrals to CAMHS in collaboration with schools. The development of improved training and communication between GPs, schools and other professionals could have a beneficial effect.

"There is considerably more that could be done by investing in prevention or early intervention services, e.g. at Primary school or Secondary or Community where we can better and more easily engage with young people."

There was an issue around who is responsible for leading communications both between the two agencies and with parents and what the nature of that communication should be.

In terms of confidentiality, priorities varied as to whether data protection laws or the needs of the child or young person came first.

"I find it frustrating that despite the law stating we should act in the best interests of the child, confidentiality within the health profession appear to over-ride this."

Professionals were concerned that the conflict around interpreting data protection laws and the need to share information with professionals in other agencies should be explored further and resolved. Some professionals argue there is information that would help other professionals to better support the child, which is not being shared. Similarly, where parents' wellbeing and 'fitness to care' was being assessed, permission is required from the parent (to access information from other agencies) and there was a view from the survey that should this permission not be given, the quality of care may be compromised.

7.1 Lack of Interagency Working:

There was some concern around what was perceived to be an increasing culture of early medication (primarily anti-depressants) of young people without them first being seen by a mental health specialist. The insufficient monitoring and the shortage of routine involvement of staff that observe and work with the young people were also caused concern.

A specific concern was identified where services experienced difficulty obtaining support for out of county looked after and adopted children.

Similarly, as mentioned, there was some concern that young people with a mental health issue were being passed back and forth between Mental Health and Social Care services, with neither taking responsibility.

7.2 Transitioning to Adult Mental Health Services:

The majority of professionals, 251 (75%) did not have experience of young people transitioning to adult services.

In view of this, it is difficult to comment in any depth. More professionals were satisfied than dissatisfied with transitioning.

Table 7 highlights how professionals rate transitioning to Adults Mental Health Services.

Table 7, "Transitioning to adults mental health services? If yes, how would you rate this?"	Number and Percentage
Excellent	3 (1%)
Very Good	7 (2%)
Satisfactory	40 (12%)
Unsatisfactory	26 (8%)
Highly unsatisfactory	7 (2%)
Not answered	251 (75%)
TOTAL	334 (100%)

The main issues identified in the survey were that there is not enough provision, it can be difficult to make the transition to adult mental health services and it can take too long.
There was also a concern about insufficient flexibility in the system and that if one appointment was missed the young person might be removed from the system and have to start again.

There was also a view that more flexibility over the age of transition be allowed. Some young people were not thought to be mature enough to move to adult services and the feeling was that CAMHS could offer more support for them up to age 25.

"The transition, on lots of levels, for an 18 year old into Adult services is very unsatisfactory - pressure needs to grow on providing services that support an age range of 12-25 year olds."
"I am also aware that as young people approach the age of 18, CAMHS tend to want drop them like a hot potato."

Some felt there was some tension between the services.

"Having recently joined CAMHS from Adult Services I have experience of transition from both services. The current process is highly unsatisfactory for CAMHS, Adult Services and the young person. The likelihood of conflict between services is high."

"CAMHS would benefit from the flexibility to work with the 18+ age group as some of these may require more support than adult services are able to provide."

"A need for more support and preparation for the young person."

"I have one young person currently transitioning and they have been told an adult mental health representative will be invited to the next network meeting, but there could no guarantees on attendance or who the person would be. I feel there needs to be a small team of people who would responsible for this process to happen smoothly."

"There is such a gap and the provision is so poor it almost might not exist."

7.3 CAMHS Morale:

Comments in the survey and the groups showed some concern about the impact of work pressure on staff within CAMHS. The potentially negative impact of such pressures on morale, time for reflection, professional development and innovative practice were mentioned. CAMHS staff drew strength from each other in terms of sharing expertise and insight across disciplines and this was a valuable aspect of their work experience, which could enhance morale. Some of their number expressed the hope that they would continue to be co-located as this offered opportunities for multi-practitioner working, skill-sharing and supportive reflective practice:

"Demand is incredibly high at the moment and all teams are very stressed and under pressure. In this situation often the first things to go are time to think about cases and share risk and supervision. This often increases stress on the staff."

"It's the opportunity for us to come back from very difficult meetings and actually have an informal debrief, as well as our formal supervision, and just reflect with other people in the same room, just for five or ten minutes, even, after a difficult phone conversation, or dealing with a very traumatised young person, you can support each other, which we wouldn't be able to do if we were in different locations."

"There are days when my work takes me all over the county, as it does for other people, and I won't get back here sometimes for three days. I can really feel the impact upon myself and my work, from not being in this building with the people who kind of shore each other up and help each other through what is very difficult work."

Key points:

- Throughout the research a significant theme was the need for all professionals to work together to develop a coherent interagency approach.

- Some professionals in the survey wanted to create a broader, more holistic approach to emotional wellbeing and mental health.

- There was also a desire to improve co-working practices and develop thorough, systematic and collaborative approaches to meeting the needs of young people and the broader familial context.

- Schools and staff working within them were felt to be important in relation to children's emotional wellbeing and mental health and there was a concern about falling numbers of qualified staff with knowledge of mental health.

- There was also a concern that those more withdrawn children with MH issues may not be identified.

- A need was identified for someone to be responsible for reviewing the whole picture and the impact of changes to one service on another

- Professionals wanted communication between GPs, schools and parents to be improved.

- In terms of confidentiality, some professionals expressed concerns that priorities varied as to whether data protection laws or the needs of the child or young person came first.

- Occasional concern focussed around what was perceived to be an increasing culture of early medication of young people without the young people being seen by a mental health specialist.

- The majority of professionals (75%) surveyed did not have experience of young people transitioning to adult mental health services. More professionals were satisfied than dissatisfied with transitioning.

- There was a view that more flexibility over the age of transition could be allowed since some young people were not thought to be mature enough to move to adult services at 18. The feeling was that CAMHS could offer more support for them up to age 25.

- There was shared concern about the impact of work pressure on staff within CAMHS.

- CAMHS staff hoped that they would continue to be co-located with colleagues, as this offered opportunities for multi-practitioner working, skill-sharing and supportive reflective practice.

- CAMHS were sympathetic to the growing pressures on schools to support the mental health needs of children and young people.

FURTHER READING:

In addition to the broad scale engagement, there were numerous reports and examples of previous research which have advised on the interpretations of the data collected.

The role of primary mental health workers in education:

From the National Foundation for Educational Research (FNER), 2010: "This review evaluates the role of Primary Mental Health Workers (PMHWs) to date, focusing in particular on their role within education, and presents illustrations of PMHWs' practices. It can inform the development and expansion of PMHW links with education. It will be of interest to policy makers and practitioners in education and mental health, including PMHWs, CAMHS specialists and education staff."

Available at: http://www.nfer.ac.uk/publications/PMH01

A guide to confidentiality in health and social care:

From the Health and Social Care Information Centre (HSCIC), 2013: "People using services deserve a lot more than just information security. Individuals need the teams of professionals who are responsible for their care to share information reliably and effectively. Confidential information about an individual must not leak outside the care team, but it must be shared within it in order to provide a seamless, integrated service." P. 6

Available at: http://www.hscic.gov.uk/confguideorg

General Practitioner experience and perception of Child and Adolescent Mental Health Services (CAMHS) care pathways; a multimethod research study:

Hinrichs S, Owens M, Dunn V, et al, 2012: A pilot study with the objective of investigating general practitioner perceptions and experiences in the referral of mentally ill and behaviourally disturbed children and adolescents.

"There are longstanding structural weaknesses in the services for children and young people in general, reflected in poor multiagency cooperation at the primary care level. GP-friendly guidelines and standards are required that will aid in decision-making and help with understanding the referrals process. We look to managers of both commissioning and providing organisations, as well as future research, to drive forward the development of tools, protocols, and health service structures to help aid the recognition and treatment of mental illness in young people." P. 1

Available at: http://www.bmjopen.bmj.com/