

THE VALUES-BASED CHILD AND ADOLESCENT MENTAL HEALTH SYSTEM COMMISSION

What really matters in children and young people's mental health

FULL REPORT

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The Commission

Context: why another commission?

The mental health and well-being of children and young people has never been of greater concern. Nearly every day a new story breaks: concerns about rising levels of self-harm, eating disorders and depression; concerns from head teachers that schools are struggling to support pupils with mental health problems and are unable to access advice; difficulties in accessing mental healthcare; and fears that the internet acts as a malign force in children's lives. Perhaps of greatest concern, however, is the fact that these challenges have persisted despite a series of national reports highlighting the problems and offering well-considered solutions: 'Just one more report and we'll get it right', seems to have been the strategy.

Over the past 5 years major reports from England, Wales, Northern Ireland and Scotland have catalogued concerns and suggested solutions.¹ A little further back, the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004) set out solutions to many of the same problems. Reports on child welfare and protection have highlighted similar issues.

1 In England, *Future in Mind* (Department of Health & NHS England, 2015), *The Five Year Forward View for Mental Health* (Mental Health Taskforce, 2016) and *Implementing the Five Year Forward View for Mental Health* (NHS England, 2016). In Wales, *Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales* (Welsh Government, 2012), *Inquiry into Child and Adolescent Mental Health Services (CAMHS)* (National Assembly for Wales, 2014) and *Making Sense* (High Needs Collaborative, 2015). In Northern Ireland, the *RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland* (Regulation and Quality Improvement Authority, 2011). In Scotland, the mental health of children and young people was included in the Scottish Mental Health Strategy 2012–2015 as part of the overall plan (Scottish Government, 2012), which informed the Children and Young People's Act (Scotland) 2014.

An important theme that stands out from these reports is the need to consider services for children and young people with mental health problems within the wider system in and by which they are supported: families and communities, schools, health and social care, and the voluntary sector.

This was the key starting point for the Values-Based Child and Adolescent Mental Health System Commission. In taking a whole-system approach we wanted to explore and understand how different values might drive decision-making, behaviours and practice within and between the various components of this wider system.

This is the report of the Values-Based Child and Adolescent Mental Health System Commission. The Commission looked at the children and young people's mental health system from many perspectives and recommends significant and far-reaching changes. The Commission was supported by the Dinwoodie Settlement, the Faculty of Child and Adolescent Psychiatry of the Royal College of Psychiatrists, the Children and Young People's Mental Health Coalition and Young Minds.

The Commission aimed to look at the issues through a different lens. While the findings we set out here are broadly consistent with those of our predecessors, we have adopted an explicitly values-based approach to the issues. In doing so, we have sought to build on earlier reports by considering how a values-based approach can help to achieve our shared aspiration – improvements in the mental health and well-being of children and young people. It is hoped that our recommendations will help to bridge the gap between the challenges consistently identified by other reports, and successful realisation of their recommended actions.

A key challenge for anyone working in contemporary health and social care provision is 'initiative fatigue'. It seems there is always someone eager to urge us to adopt this or that new approach, with the implication that everything that has been done to date has at best been imperfect, if not wrong

altogether. By contrast, values-based practice in the model adopted by the Commission is about empowering both service providers and service users to understand and build on their own and others' good practice.

The Commission took as its starting point a recognition that tensions within and between stakeholders arise in part, but very importantly, from differences in the values inherent in their working processes and approach. To address these, the Commission drew on the resources of values-based practice.

What is a values-based approach?

By 'values' in this context we mean 'what matters' or 'what is important' to those concerned. The tensions can thus be understood as arising from differences between stakeholders in what matters or is important from their particular perspectives, such as ease of access to services and evidence of their effectiveness. Unacknowledged, such differences can lead to failures of communication and other barriers to joined-up care provision. These same differences though, if understood as differences of perspective on what matters, are not irreconcilable. Rather, they can usefully be regarded as differences of emphasis. When they are openly acknowledged and understood by all parts of the system, it is possible to develop a framework of shared values within which balanced decisions can be made in partnership between those involved, acting in the best interests of children and young people and meeting their mental health needs.

This is where values-based practice is important. Always working in partnership with evidence-based practice, values-based practice provides the skills and other resources needed to support balanced decision-making between stakeholders, within a framework of shared values (valuesbasedpractice.org).

Methodology

The Commission brought together individual, professional and sector representatives from across the child and adolescent mental health services

(CAMHS) system: young people, parents, education, social care, CAMHS, commissioners and voluntary organisations. Almost 120 submissions from the whole of the UK were received in response to our call for evidence. The Commission also took five sessions of oral evidence, and the Commission Chair and the convenor spoke to key individuals. In addition, the Commission convenor and one of the young people carried out a site visit to Liverpool CAMHS, which provides comprehensive services from tier 2 to tier 4, with close links to schools and primary care. The Commission convenor also spoke to a wide range of individuals who had submitted written evidence.

We applied values-based thinking to all aspects of the Commission. Its work as a whole was informed by an extended period of preparatory research, including a structured literature review and qualitative primary research on stakeholders' values.

At the Commission's first meeting, the Commission members participated in a brief training exercise to develop their awareness of differences in values, which helped to shape our later lines of questioning. For example, we focused more than previous commissions on staff values and on evidence of what works well, as well as what hinders the most effective practice. This in turn guided our findings and recommendations.

Our inquiry gathered examples of practice which, in the view of the Commission, demonstrated successful whole-system support for children and young people's mental health and well-being. Our analysis of the written and oral evidence has identified practical solutions to the problems that face this complex system, and some of the values-based approaches that could be adopted to support their successful implementation.

Our report is a synthesis of this information, not a systematic review. It reflects the diversity of practice across the system and provides examples of how a wide range of stakeholders are working to solve the problems that confront them. We found many individual examples of best practice in joined-up, whole-system approaches. Yet, a striking finding was the overall sense of disjunction between different services and the wider system, particularly in the relationships between schools and between education and other parts of the system.

Key findings

- 1 The lack of a shared language and approach for describing outcomes for children and young people is hampering interagency working.
- 2 Schools and the wider education sector are a key component of the CAMHS system, but they feel disconnected from other parts of the system.
- 3 There were several examples of whole-system transformation, but there were also persistent concerns that these are not adequately funded.
- 4 Whole-system leadership is crucial to delivering system transformation, but is not always encouraged and nurtured.
- 5 The workforce is vital for realising effective service transformation, but often feels excluded and devalued.
- 6 Co-production with children, young people, parents and carers is not only good for services, it is also good for children and young people and helps them to achieve optimal outcomes.
- 7 In-patient services need to be managed and commissioned as part of a whole system, and should include the full range of crisis services and alternatives to in-patient treatment.
- 8 Long-term, sustainable relationships between service providers, commissioners, and children and young people are crucial to delivering effective service transformation.

In the implementation-oriented model adopted by the Commission, shared values are important as the starting point for values-based practice and for addressing our key findings. These are underpinned by the 'best interests' principle enshrined in the Children Act 1989, which remains vital and itself embodies welfare and human-rights-based values that are undoubtedly shared by all stakeholders.

Values

The Commission recommends that the following values should be shared, and explicitly adopted, by all those working in the CAMHS system.

Equal partnership

We value children, young people and parents as partners with an equal voice.

Empowerment

We value empowering children and young people to understand their mental health as a critical contribution to their health and well-being.

Workforce

We value the workforce who are providing the services, care and support.

Whole system

We value working together across sectors, recognising that we all have responsibility for the mental health of children and young people – no one sector, or part of society, can do this alone.

Leadership

We value leadership at all levels, especially system leadership.

Long-term relationships

We value the power of long-term relationships as a critical factor in promoting and supporting children and young people's mental health.

Challenges of adopting a values-based approach

The overall purpose of the Commission in exploring a values-based CAMHS system was to promote good outcomes for children and young people's mental health. As already noted, however, there can be tensions between stakeholders arising from unacknowledged differences in values. In other words, while all stakeholders have a shared values base for promoting good outcomes for children and young people's mental health, they have different perspectives on what matters or is important in achieving these.

The Commission believes that the development and application of values-based practice within the wider CAMHS system provides a new opportunity to transform our shared aspirations into sustainable

improvements in practice. It further recognises the need for values-based thinking to be applied across the system as a whole for effective implementation of a values-based approach.

Recommendations

The Commission recommends the following actions as a series of concrete steps necessary for achieving the adoption of these values across the system of services and government.

- 1 Establish a values-based CAMHS system network. The workforce needs opportunities to share and explore its values and their practice implications, and the ability to exchange best practice in a safe space. The network would bring together all parts of the system to achieve this.
- 2 Adopt shared values for the CAMHS system. The departments of state of national administrations and jurisdictions should consider whether they could adopt the Commission's proposed shared values as the basis of a common set of shared outcomes expressed in a common language to guide their work with children and young people.
- 3 Recognise the role of schools and fund them appropriately. Governments should formally recognise schools as a crucial component of the CAMHS system, in the following ways.
 - Undertake mental health impact assessments to ensure that both schools/education policy and wider government policy and legislation are not detrimental to children and young people's mental health.
 - Help schools to develop a framework for empowering and enabling children and young people to better understand their own mental health and to advocate for themselves. Schools should be able to teach children and young people about mental health in the same way they teach them about literacy or numeracy.
 - Ensure that schools are able to identify mental health issues and can easily signpost pupils to relevant support, either within the school or their local community, and have the accountability to do this.

Service improvement

- 4 Single point of access referral systems should be appropriately resourced to provide access to the full range of services, from support through to diagnosis and specialist intervention.
- 5 Co-production with young people and parents should be at the heart of all recovery, service redesign, commissioning and training.
- 6 Clinical pathways to and from in-patient admission should include access to alternatives to admission, such as crisis intervention teams and home treatment teams. These should be jointly commissioned or managed with in-patient care.

Training

- 7 All training for the children's workforce – from clinicians to youth workers – should include training in values-based theory and practice, including an exploration of what matters to clinicians and patients, with the aim of developing a community of shared practice.

Commissioning and leadership

- 8 Commissioners of CAMHS should establish sustainable relationships with provider partners and young people.
- 9 Whole-system leadership should be characterised by a collaborative and mutually respectful approach, and include the active participation of clinicians from specialist services.

Research to support development of a values-based CAMHS system

- 10 Further research is needed in the following areas:
 - the relationship between co-production, values (what matters) and recovery in children and young people with mental health problems
 - staff values (what matters): this is an important and under-researched contribution to understanding why co-production and other aspects of service improvement have proved so difficult to implement in a sustainable way.

Next steps

Subject to continued funding, members of the Commission plan to work with others on implementation plans that include the role of staff recruitment and staff training in developing a values-based CAMHS system.

Literature review and policy context

Current provision and calls for change

The mental health of children and young people has been highlighted across the UK as a priority for improvement and increased funding (Scottish Executive, 2005; Regulation and Quality Improvement Authority, 2011; National Assembly for Wales, 2014; Department of Health & NHS England, 2015). Discrepancies are evident between the services that are currently offered and what young people and their families want. These involve ease of access, thresholds to accessing specialist CAMHS, waiting times for treatment and access to psychological treatments. Most recently, following the publication of *Future in Mind* (Department of Health & NHS England, 2015), commissioners in England have been challenged to produce local transformation plans detailing how additional funding will be used to redesign current services, addressing the concerns raised by *Future in Mind*, such as prevention and early intervention, care for the most vulnerable and development of the workforce. *Together for Children and Young People – T4CYP* (Welsh Government, 2015) has set out significant changes to CAMHS in Wales. There are longer-standing proposals for the development of CAMHS in Northern Ireland and Scotland.

A values-based approach to service transformation

Values-based practice teaches clinicians skills to make difficult decisions (Fulford *et al*, 2012). It refers to three ‘pillars’ that need to be considered and negotiated, which were previously described by Sackett *et al* (2000) in regards to

evidence-based medicine: the evidence base, clinical experience, and patient and carer values. A values-based approach can be applied both to decisions made with individual patients and to decisions relating to service design and commissioning (Heginbotham, 2012; England *et al*, 2013). In essence, values-based practice reminds healthcare professionals that patients should be at the heart of everything we do.

Over the past two decades, there has been an increasing emphasis on involving patients and carers in service design, development and research. *Equity and Excellence: Liberating the NHS* set out the UK government’s vision of an NHS that puts patients and the public first: ‘No decision about me, without me’ (Department of Health, 2010). In Wales, *A Prudent Approach to Health* identified co-production as one of its guiding principles (Bevan Commission, 2015). Organisations such as Young Minds have extensively consulted with children and young people and demonstrated that they are able to participate in important discussions about services for mental health and are passionate about making a difference for other young people (Young Minds, 2011, 2014). Parents and carers are, of course, central to children’s lives and any treatment they receive. Young Minds has involved parents and carers in consultations for the recent Children and Young People’s Mental Health and Well-Being Taskforce and the Children and Young People’s Improving Access to Psychological Therapies (CYP-IAPT) programme (in partnership with GIFT) (Hargreaves, 2011; Young Minds, 2014). NHS England’s Youth Forum has made mental health one of its priorities. The UK Youth Parliament has led a campaign about mental health in England and the Youth Select Committee has conducted an inquiry on mental health. Many local Healthwatch organisations have young people’s groups and some of these focus on mental health.

In Wales, children and young people have played an active role in the development of T4CYP via

Making Sense, which was based on discussions with children across Wales. Work in Wales has also been driven by the Young Wales forums and the Beth Nesa project from the Children's Commissioner for Wales (2016). In Scotland, children and young people played a central role in developing *Protecting Children and Young People: The Charter* (Scottish Executive, 2004) and were extensively consulted during the Scottish Needs Analysis Programme. In Scotland, Wales, Northern Ireland and parts of England, the United Nations Convention on the Rights of the Child has played a fundamental role in promoting children and young people's involvement in services.

Values-based practice also considers the values of professionals and how these affect decisions about treatment and care. Many agencies work with children and young people who experience mental health problems. These groups often have different priorities and perspectives regarding a child's needs and these differences can lead to difficulties in interagency working. Understanding what is important to all parties involved should facilitate better working relationships and is particularly relevant in the current climate, as closer integration of agencies has been advocated (GIFT, 2014; Department of Health & NHS England, 2015). Furthermore, to improve the working environment, it is important to understand the experiences of staff. This good for morale but, even more importantly, there is evidence that the experiences of staff and staff engagement are associated with patient satisfaction, health outcomes and ratings of quality of care (Mental Health Taskforce, 2016).

Values across the four jurisdictions

There are striking similarities in the core values of the policy frameworks that underpin child and adolescent mental health systems in England, Wales, Scotland and Northern Ireland (see Box 1). All systems support approaches which emphasise prevention, early intervention and promoting resilience in children and young people. All emphasise approaches that avoid stigma and encourage the active participation of children and young people in service design, development and delivery. All describe whole-system approaches, although

they use slightly different language to do so. For all four frameworks, workforce development and improving transition are important priorities and in all four frameworks, the voluntary sector plays a vital role. They all either identify vulnerable groups of children and young people (England, Wales, Northern Ireland) or highlight diversity as a key issue (Scotland). Recently, the United Nations Committee on the Rights of the Child (2016) expressed wide-ranging concerns about CAMHS.

The differences are subtle. England emphasises access to information and digital access. England and Scotland highlight high-quality care and Wales uses the concept of 'prudent healthcare', whereas Northern Ireland uses the concept of 'wrap-around care'. Scotland makes explicit reference to consent/confidentiality as an important issue and is the only one that explicitly focuses on inequality. England, Scotland and Wales refer to accountability and transparency, shared vision and outcomes, and commitment and impact. There is no equivalent in the Northern Ireland framework.

Literature review

We carried out a comprehensive review of the literature and consultations published between 2010 and 2015 in relation to values and child and adolescent mental health and well-being. The full literature review is being submitted for peer review.

Summary

The reports and consultations identify many themes that have been noted in other qualitative studies and reviews:

- young-person-centred, holistic approach
- continuity and consistency
- non-judgemental and collaborative attitudes
- trust
- availability of trusted information online
- support from school and general practice
- effective working across agencies.

Common issues regarding the provision of mental health services for children and young people included stigma, referral criteria, waiting lists and transitions.

Box 1 Core values underpinning policy in the four UK jurisdictions

England	Scotland	Wales	Northern Ireland
<ul style="list-style-type: none"> ● Resilience ● Prevention and early intervention ● High-quality services ● Non-stigmatising setting ● Expert care ● Participation ● Whole-system approach ● Place-based commissioning ● No tiers ● Voluntary sector ● Accountability and transparency ● Vulnerable children ● Workforce development ● Transition (0–25) ● Easy access to information ● Responsive: right place/time ● Emergency care 	<ul style="list-style-type: none"> ● Mental health promotion in all settings ● Prevention and promotion ● High-quality services ● Mainstreaming ● Evidence-based services ● Participation and involvement ● Integration and building on existing structures ● Tiered model ● Voluntary sector ● Shared vision and outcomes ● Diversity and competency framework ● Reducing inequality ● Workforce development ● Transition ● Consent and confidentiality ● Accessibility 	<ul style="list-style-type: none"> ● Universal resilience and well-being ● Targeted early intervention for vulnerable/at-risk groups ● Prudent healthcare ● Reducing stigma and discrimination, encouraging equality ● Signposting ● Engagement with children and young people ● Windscreen model – continuum from universal resilience to specialist CAMHS ● Multi-agency approach through Together for Children and Young People ● Mental Health (Wales) Measure 2010: primary and secondary care ● Third sector ● Commitment and impact ● Children with learning difficulties and neurodevelopmental problems ● Workforce sustainability, development and training ● Transition 	<ul style="list-style-type: none"> ● Promotion of mental health and emotional well-being ● Early intervention ● Recovery and wrap-around care ● Embedded, coordinated care ● Effective services ● Involvement of patients and carers ● Integration and importance of education and social care providers, adult mental health services, etc ● Stepped care ● Voluntary sector ● Vulnerable and marginalised children ● Workforce development ● Transition ● Active promotion of outreach ● Flexibility
Sources: Department of Health & NHS England (2015), Mental Health Taskforce (2016)	Source: Scottish Executive (2005)	Source: Welsh Government (2015)	Source: Department of Health, Social Services and Public Safety (2012)

The following more specific concerns were also noted:

- relationship between voluntary sector agencies and CAMHS
- complexity of need for young offenders experiencing other problems (e.g. abuse, homelessness, drug use and gang cultures)
- value of expertise in autism for families and professionals and the difficulties experienced in getting appropriate help for these young people.

Policy context and the effects on values-based practice

The Commission received several submissions relating to the effects of the national policies (policy context) on the way the child and adolescent mental health system works. Clinical leaders from CYP-IAPT revealed that historically there had been significant differences in the ways various government departments and different governments approached child and adolescent mental health. However, *Future in Mind* and the work on local transformation plans had led to educational and health policies on child and adolescent mental health becoming much more closely aligned. Nevertheless, the Commission is aware of reports of ongoing difficulties in local collaboration between health and social care sectors and schools in England. We will explore this in more detail later in the report. Similar processes were described in Wales and Northern Ireland. For example, the umbrella organisation Children in Wales highlighted the role that the voluntary sector plays in ensuring that the different government departments responsible for children (health, education, local government and justice) align policies and outcomes. Clinical leaders from Northern Ireland explained that the process of integrating child and adolescent mental health and social care

services was underway, but that there were still significant barriers to overcome.

The most striking example of fully aligned policies came from Scotland. Getting it Right for Every Child (GIRFEC) is an overarching framework that defines a set of values for work with children. There are associated forms of language and outcomes that all agencies are expected to use (Scottish Government, 2016). GIRFEC was first introduced in 2004 but was made legally binding by the Children and Young People (Scotland) Act 2014. The Commission heard that the language and outcomes of GIRFEC are now used across a range of agencies, including adult mental health. Children and young people, parents and carers were closely involved in the development of GIRFEC. The development of a common language and common set of outcomes for children and young people is having a major, beneficial effect on interagency working. Importantly, it means that children and young people and their parents and carers are clear about the outcomes that the agencies they come into contact with are aiming to achieve.

Recommendations

- 1 Establish a values-based CAMHS system network. The workforce needs opportunities to share and explore its values and their practice implications, and the ability to exchange best practice in a safe space. The network would bring together all parts of the system to achieve this.
- 2 Adopt shared values for the CAMHS system. The departments of state of national administrations and jurisdictions should consider whether they could adopt the Commission's proposed shared values as the basis of a common set of shared outcomes expressed in a common language to guide their work with children and young people.

Community

Children and young people's mental health and well-being is closely linked to the support they receive from their families, friends, peers and schools. The majority of support and intervention for children with mental health problems is provided in community settings.

As might be expected, several of the key values that were identified during the work of the Commission are relevant to children and young people's mental health and well-being in community settings:

- whole system
- equal partnership
- empowerment.

Whole system

Schools and mental health and well-being

Schools are a major part of children and young people's lives. They spend almost a third of their time in school and meet their friends there, and teachers play a major part in their development. Over 10% of submissions to the Commission related to schools and education. We heard of several projects aimed at promoting well-being and mental health awareness. Oxford Health's Young Person's Participation Group has developed a comprehensive approach:

'A Positive Mental Health Resource Pack for KS3, 4 and 6th form.

The resource pack is a set of activities to promote positive mental health, challenge stigma, educate young people and show them how they can look after their own mental health and where they can get support.'

The resource has received very positive feedback from young people and schools. There are plans to develop a formal evaluation.

We heard from Water Hall Primary School, which implemented Kaleidoscope (Box 2). Staff undertook

training, delivered training to school support staff and completed research into the effects of the intervention. A previously failing school became outstanding and children now engage positively with the school and their learning.

'The school teachers we spoke to highlighted that they wanted their expertise in education and knowledge of the children and families they worked with appreciated. At the same time, they wanted CAMHS services to understand that they are not experts in mental health and would like clearer advice.'

Organisations such as Place2Be and the British Association of Counselling Psychotherapists have argued that school counsellors offer an accessible and effective intervention for children and young people with a wide range of difficulties (www.place2be.org.uk).

Responses described multidisciplinary partnerships in school settings. For example, a joint initiative by a child and adolescent psychiatrist and an educational psychologist to provide services for pupils with attention-deficit hyperactivity disorder in special schools, and child psychiatrists delivering anti-stigma campaigns in schools.

Box 2 Water Hall Primary School

- Kaleidoscope uses light, colour, sound and form to build children's self-confidence.
- The school purchased resources, implemented the Kaleidoscope programme in the school and monitored its impact.
- Core values were developed, as were the behaviours associated with them.
- The school linked full-spectrum values to the 'human givens'.
- It worked with staff to build core values into the school and supported staff in building core values with the children.
- Staff at Water Hall developed a whole-school approach to the behaviours associated with values.
- As a result of this comprehensive intervention, behaviours and learning outcomes improved.

The Haven in Budehaven offered the most comprehensive model, with an integrated health centre based within the school. The project was initially funded by a project grant from the Duchy Health Care Trust, but is now funded by the school. Located close to the Cornwall/Devon boundary, it is distant from most specialist services in Cornwall.

Although The Haven collaborates actively with local CAMHS, they are not directly involved in CAMHS commissioning within Cornwall. Education's relative lack of involvement in commissioning was echoed during our site visit to Liverpool FRESH CAMHS (see below) and by other submissions, such as the Black Country Local Transformation Plan.

NESSie (Northherts Emotionalhealth in Schools Service; Box 3) offers an alternative model for coordinating mental health input to schools. It is currently funded for 4 years to coordinate and assure the quality of emotional support in schools in the area.

Box 3 NESSie (Northherts Emotionalhealth in Schools Service)

- **NESSie offers consultancy and support to schools, as well as supervision and training.**
- **It has audited needs across schools and asked the schools directly what they want and what their needs are.**
- **NESSie also enables coordination and strengthening pathways to specialist CAMHS services. However, it is not a formal part of the local transformation plan.**

Early intervention

School counselling was seen as an essential part of early intervention by many submissions (e.g. Milton Keynes local transformation plan). Voluntary sector organisations were seen as accessible, non-stigmatising sources (e.g. Youth Information and Advice and Counselling Services, Young Person's Advisory Service in Liverpool and The Zone in Plymouth). Youth Access argued that the flexibility of voluntary sector organisations, the wide range of services they offer and the fact that they are very user-led mean they are a crucial part of early intervention. With the introduction of

CYP-IAPT, in some areas they had forged better links with specialist CAMHS – but this was not universal.

The Newcastle and Gateshead clinical commissioning group (CCG) argued that a range of early support, from peer support through to formal intervention, was essential. This is similar to the model seen in Liverpool where, for children with neurodevelopmental difficulties, ADDventure provides a flexible system of support based on a social model of intervention and with trained peer-support workers.

Social care

The Association of Directors of Children's Services (ADCS) emphasised the importance of providing the full range of services, from early intervention to specialist CAMHS. He said that the voices of children and young people had often not been heard in services for looked after children. However, he described a change in the relationship between local authorities and children in care, with a growing emphasis on building long-term relationships between social workers and looked after children. The ADCS cited Like Minded as a good example of a mental health service for looked after children. The ADCS said that it felt that specialist CAMHS has drawn away from social care in recent times and described a lack of systems leadership from specialist CAMHS (see chapter on commissioning and leadership). Members of the Commission with experience of a relationship between CAMHS and social care challenged this view, describing episodes of social care drawing away from specialist CAMHS.

We received submissions on a number of consultation liaison services to social care that improved links, both clinically and at a service level, between social care and specialist CAMHS. A specialist service in North London Barnet, Enfield and Haringey Mental Health Trust has established a family therapy service for children who have experienced domestic violence. This service was supplemented by a group for parents who had experienced domestic violence and a strong multi-agency framework. By contrast, the voluntary organization CLEAR (Children Linked to and Experiencing Abusive Relationships) provides

specialised therapeutic interventions for children and young people who have been abused, whether directly or indirectly. They also provide face-to-face psychological therapies from a range of creative interventions, with adult-focused psychotherapy alongside the child-based work to address the systemic issues around abuse.

The wider context: families

Liverpool's Think Family has a system-wide approach to including the family in all work involving children. This approach has been adopted by all agencies working in Merseyside. More specific interventions include the Parents as Partners programme from the Tavistock Centre for Couple Relationships and the Family Drug and Alcohol Court.

Digital

The digital world is clearly a place where children and young people spend a significant proportion of their lives. Many services (e.g. Surrey and Liverpool) are including digital services within their overall offer. However, we should ensure, perhaps, that digital offers are tied into local services and have good clinical governance – one of the values espoused by everyone we spoke to. Our aspiration is that digital becomes just another route into joined-up service delivery.

Specialist CAMHS

The Choice and Partnership Approach (www.capa.co.uk) offers a systematic method of analysing the needs of a service and matching need to capacity. At the heart of the clinical experience is the choice appointment, which aims to match the values of the child and their family and the professional. The Choice and Partnership Approach has been instituted on three continents and in five different countries.

THRIVE is a model for thinking about children and young people's mental health needs (Wolpert *et al*, 2014). It thinks of children and young people in four overlapping groups of need: coping, getting help, getting more help and getting risk support. The approach is currently being piloted in ten sites across England.

The Commission received submissions on a range of specific, specialist services, including CAMHS for children with intellectual disability, CAMHS for deaf children, and the Autism Pathway in Dudley CAMHS. All were characterised by careful consultation with children and young people, parents, carers and other stakeholders. A service in Wales actively involves parents as trainers in the development of their acceptance and commitment therapy service.

A number of clinicians from specialist teams expressed concern about the impact of service cuts on the ability of teams to deliver a core service.

'CAMHS services are currently being destroyed by people who do not understand them. National and local objectives are all directed at small numbers of people and ignoring the bulk of our work. Commissioners seem unaware of the large numbers of children and young people with ADHD and depression who we could help and are putting development money into 'self-harm', risk management and eating disorders in accordance with a journalistic approach and in ignorance of the real needs and what we can do if allowed. None of the current development money is going to core community CAMHS.'

Urgent and emergency care

Access to urgent and emergency care for children and young people with mental health problems has been a major concern across the country. Respondents described innovations that have led to improvements in access to emergency care.

Durham and Darlington and Teesside CAMHS have developed a nurse-led crisis and liaison team, providing a 7-day emergency and crisis response to young people experiencing mental health crisis. An open referral system, its aim is to commence assessment within 1 h (maximum 4 h). It is open to all people, including those with intellectual disability, of 0–18 years of age. The service has significantly improved access to mental health support for young people in crisis and significantly reduced the use of overnight paediatric beds, as well as emergency department attendance, because assessments are offered in the community.

One of the psychiatrists in the Teesside service described the impact of the new service on his working life.

'My working life as a consultant is much improved. My working day and routine outpatient clinics are no longer so frequently disrupted by the requirement to offer an urgent mental health assessment on the same day, requiring the whole team to disrupt their pattern of work (particularly team manager, senior clinicians in the team and the administrative staff). The children who need to be seen within an hour are seen within an hour. Liaison with acute trust hospital accident and emergency departments is excellent and this has now been extended to the paediatric wards when there is an urgent mental disorder or mental distress causing difficulties with paediatric care.

I am less concerned about discharging patients from follow-up in secondary care because I know that they can be seen quickly should their mental health deteriorate. The service has become much more flexible and we are receiving good feedback from commissioners (in local authorities and CCGs) about our improved services.'

In Bedfordshire, the Home Treatment Team was set up because there are no in-patient units in that county, and many young people were being admitted to units a substantial distance from their homes and families. The team tries to keep young people at home instead of admitting them (when possible), instead working with the young person, their family, their school, social care and others involved to support the young person through a serious time in their life. The approach is non-judgemental and involves listening, minimising the medicalisation of the problem (even though this is a mental health team) and working with agreement and consent.

Oxford Health has developed an outreach service for children and young people with severe mental health problems (Box 4). This comprehensive service for children and young people extends beyond immediate crises.

Examples of whole-system approaches

The Commission sought evidence of whole-system approaches to transforming services. It heard evidence from Newcastle CCGs and Surrey and Borders Partnership NHS Trust (SABPT) and carried out a site visit to Liverpool CAMHS.

Clinicians and managers from SABPT described a partnership model involving statutory services, the voluntary sector and private organisations (see

Box 4 Oxford Health Crisis and Outreach Service

- Provides a step-down service for inpatient units and can provide daily support, reducing both the need for inpatient admission and the time spent in hospital.
- Provides home assessment and treatment for patients who are unable or unwilling to attend an assessment at the clinic.
- Provides family support for feeding young people with anorexia at home.
- Outreach and crisis workers also provide a tier 1 service of 4–6 sessions for those with milder conditions.
- Also responsible for vulnerable young people in the service (e.g. looked after children, those with personality disorders).

Fig. 1). SABPT acts as a prime provider within a partnership model (Box 5). SABPT had developed its own values framework (treat people well; involve not ignore; create respectful places; open, honest and accountable). This framework had been developed over several years and was based on careful consultation with those involved with the Trust: partnership organisations, children and young people, staff and other stakeholders.

SABPT reported that local general practitioners (GPs) were very enthusiastic about the prospect of much easier access to services. The service design took around a year and was led by young advisors, local authority partners, the voluntary sector and SABPT. Named Mindsight Surrey

Box 5 Surrey and Borders Partnership NHS Trust: no wrong door

- The Trust offers an online counselling and support service called Kooth, with a direct link to the single point of access referral system.
- An early intervention, self-referral service with links into and out of the single point of access. Pre-referral screening then allows children and young people to be routed to a variety of statutory and non-statutory resources.
- Within CAMHS there are four pathways: community CAMHS, behaviour pathway, crisis, and well-being and resilience.
- These pathways are supported by close liaison with Surrey County Council's Children's Services and Education Department.

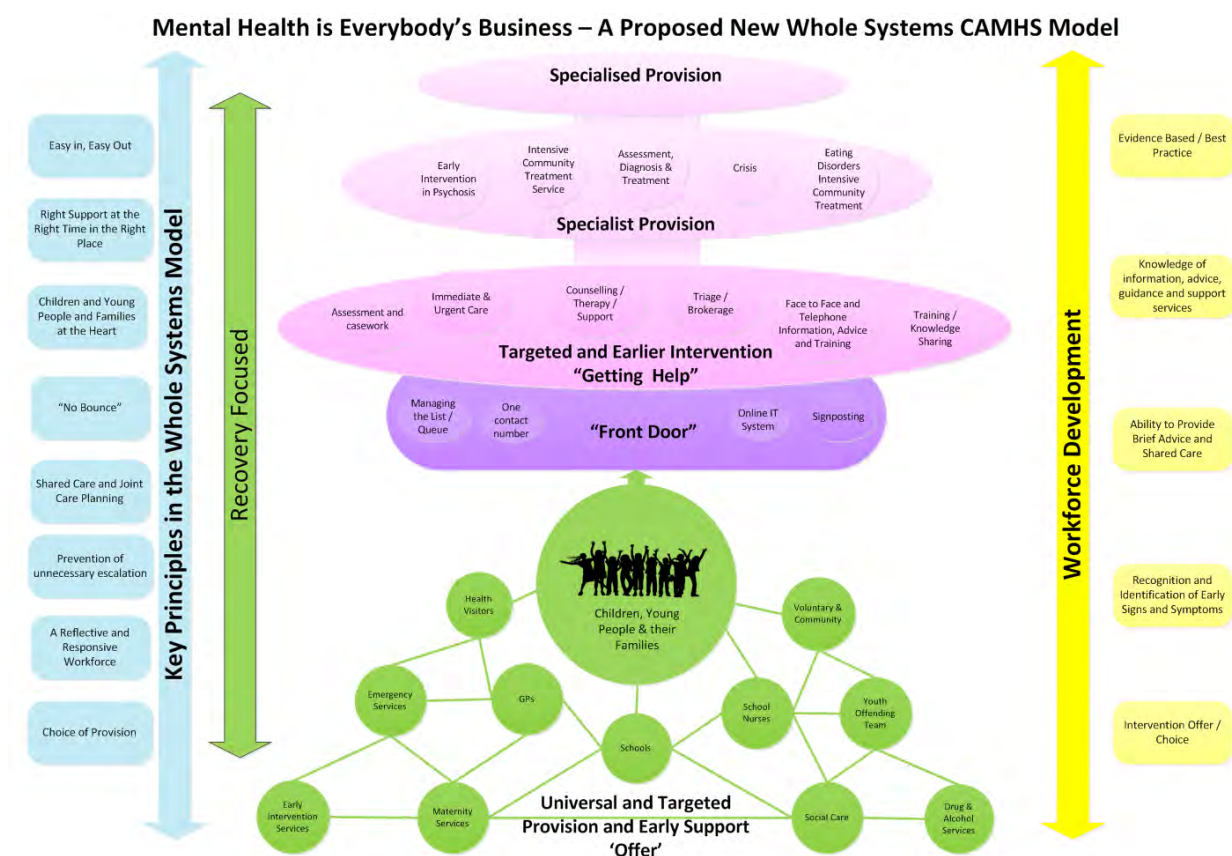


Fig. 1 Newcastle and Gateshead CCG's service model. Reproduced with permission from Newcastle and Gateshead CCG.

CAMHS, the system went live on 1 April 2016. The service model centres around a single point of access – the ‘no wrong door’ approach developed by Beacon (www.beaconhealthoptions.co.uk). This point can be accessed by a variety of means of communication, including electronically.

Liverpool CAMHS described a similar model, FRESH CAMHS, a collaboration between statutory sector organisations, voluntary organisations, social care and local GPs (www.freshcamhs.org). It provides a single point of access with a ‘no wrong door’ approach. The Liverpool model is striking for a number of reasons. First, Liverpool have developed a universal needs assessment tool called the Early Help Assessment Tool (EHAT), which is used by all services working with children (except GPs and emergency services, which use a simplified pre-EHAT). Second, the EHAT assesses the needs of the whole family, rather than just the child. This reflects the Think Family approach that has been adopted by all organisations within the Liverpool area, including adult mental health in Mersey Care. Third, Liverpool's approach to participation is that

it should pervade the system, from each encounter with a child through to the board. An example of active participation is the CAMHS takeover day that took place in October 2015. The takeover day brought together young people who have experienced mental illness to share their experiences with each other and with CAMHS staff. Finally, Liverpool have developed systems to promote easy contact between schools and CAMHS, with named workers for each secondary school and consortium of primary schools. They are piloting similar schemes for GPs.

The Liverpool and Surrey (Fig. 2) models were themselves similar to the model developed in Newcastle and Gateshead. The approach towards the development of this model also entailed some unique features (see pp. 24–25).

The Commission heard from a number of senior clinicians who expressed concerns that ‘no wrong door’ approaches were not being properly resourced and were leading to internal waiting lists in some areas.

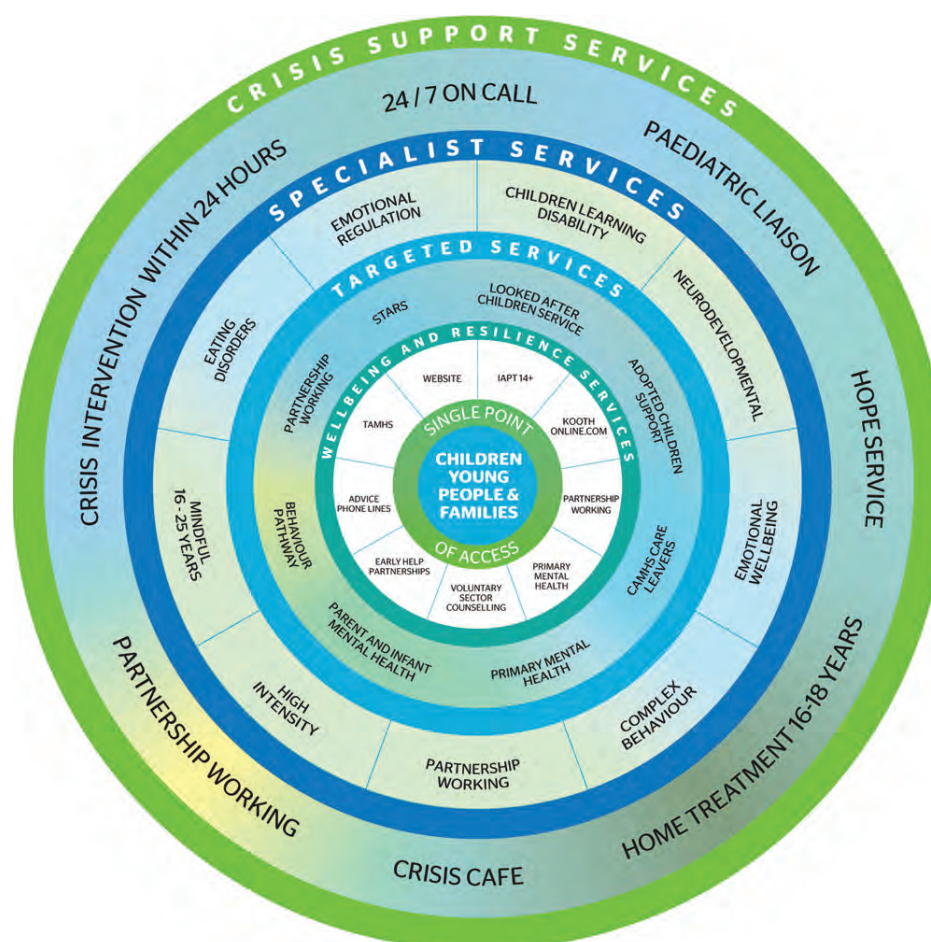


Fig. 2 Surrey and Borders Partnership NHS Trust's service model. Reproduced with permission from Surrey and Borders Partnership NHS Trust.

Equal partnership and empowerment: co-production

The Commission received a number of submissions relating directly to co-production (Box 6).

The Commission was struck by the way in which co-production in Liverpool CAMHS pervaded all aspects of practice (see above), and by Newcastle and Gateshead's approach to embedding co-production into its services, from the beginning of their redesign through to recruitment of young people's commissioners.

Evolving Minds is the CAMHS Young Advisor Network for Leicester, Leicestershire and Rutland. It has worked with Leicestershire Partnership NHS Trust to revise their urgent and emergency care pathway. Eilish, one of the young advisors, who has experience of emergency services, made a video

describing her experience. This is now used as part of the training package for emergency department staff. Eilish has found that the experience of working with Evolving Minds has had a profound impact on her.

'Personally, don't feel so alone, many other people have been through similar experiences, don't blame self so much, feel comfortable to talk about it, I can talk to anybody about it. It was the quiet subject in the family now we can talk more openly.'

Follow-up telephone calls with other young people who had been involved in co-production projects supported Eilish's experience that involvement in co-production has a positive effect on young people's sense of personal well-being and their families' attitudes to their mental health problems.

Conclusions

Future in Mind (Department of Health & NHS England, 2015) highlighted the need to move away

from the rigidity of the tiered model and, over time, children and young people's mental health services should undergo a whole-system redesign. There are new models such as THRIVE, which is based on children and young people's needs. There needs to be a better understanding of workers' current values. A values-based child and adolescent mental health system network would help the

whole workforce share and explore their values and their practice implications in a safe space.

An important, often-overlooked issue is that education plays a crucial role in the mental health and well-being of children and young people. The Commission heard many good examples of schools being used as a hub for services, or running projects to support their pupils. Effective implementation of a school-based intervention requires leadership within the school, with active commitment from the head and senior staff.

Schools also need to be part of the wider system. This requires joint working with other agencies, such as CAMHS, and indeed many schools do have good relationships with statutory or voluntary sector services. In the wider children and young people's mental health service transformation programme, we know that CCGs see the benefits of schools, but this does not always seem to translate into actually involving schools in transformation planning. This may be connected to CCGs not having yet formed these relationships with schools, which is not helped by there being so many schools within any given CCG's area. It is also not helped by schools not being statutory members of health and wellbeing boards (which is also the case for the voluntary sector). It would be very helpful if local voluntary agencies and education services were statutory members of health and wellbeing boards. On the positive side, where there has been a history of joint working, and there are long-term relationships, schools are much more likely to be involved in the whole system.

Children and young people and their families want easy access to mental health support. The emergence of 'single point of access' and 'no wrong door' approaches to CAMHS is to be welcomed. However, there is a concern that, without adequate resourcing of the services behind such approaches, children and young people are likely to encounter further difficulties in accessing assessments, interventions and support. If this does not happen, the single point of access will just be seen as window dressing and compound the sense of frustration that many feel when trying to access services. The whole system, therefore, needs to be appropriately resourced in order for single points of access to really make a difference for children and young people, parents, carers and referrers.

Box 6 Examples of co-production

About Me

- An app developed by a parent, child and professional partnership to improve information sharing and support for children and young people with autism.
- For more information, visit <https://vimeo.com/125445331> (password: aboutme).
- The app was nominated for an NHS Wales Award and a Kate Granger Award in 2015.

Autism Passport (About Me)

- Young people with autism spectrum disorder and their families were involved in this initiative from the outset.
- Evaluation of About Me in clinical practice suggests that it enhances delivery of person-centred care and supports transparency and accountability in clinical practice.
- For more information, visit <http://vimeo.com/50496937> (password: passport).

Hearing stories

- Involving patients and carers in creating a web-based educational resource for training professionals in CAMHS.

My Life with OCD

- The story of a young girl diagnosed with obsessive-compulsive disorder (OCD). She shares her experiences of OCD and her ways of dealing with it (www.youtube.com/watch?v=9EiW_Eq5g00&sns=em).

Good for both of us

- The story of a mother and her son, who has autism, their experiences and opinions (www.youtube.com/watch?v=Aqc2CMExn6s&sns=em).

Living with ADHD

- The story of a girl with attention-deficit hyperactivity disorder, and her grandmother. It highlights their experiences and opinion of CAMHS (www.youtube.com/watch?v=70Fjb2Tby-s&sns=em).

There were good examples submitted to the Commission of services that value children, young people and parents as equal partners. Some services are user-led, and there were good examples of co-production. The examples given in this report highlight how involving children and young people can result in more imaginative and effective service design and delivery, which is helpful for everyone. For example, the About Me project in Wales, which was a professional and parental partnership, led to changes in work practice that benefited everyone. The Evolving Minds group worked with Leicestershire Partnership NHS Trust to revise their urgent and emergency care pathway. This helped the young people to better understand their own mental health and the issues that services have to deal with. Projects such as this can also help young people to develop softer skills, such as how to work in groups, or how to make friends. These skills, and their underlying values, although important for children and young people and their families, have significant benefits for other stakeholders as well.

There were many good examples given in the evidence to the Commission, but there is concern that, although it is no doubt an improving picture, we know that seeing children and young people and families as equal partners and seeing the value of empowering them to understand their own mental health is not always an approach that is actively supported, nor as good as it could be when it is. For instance, we have heard from Healthwatch England that many local Healthwatch organisations were concerned about the limited extent to which CCGs consulted children and young people to inform their local transformation plan.

In summary, co-production with children and young people and parents/carers is good for

everyone and can actually help children and young people achieve better outcomes.

Recommendations

- 3 Recognise the role of schools and fund them appropriately. Governments should formally recognise schools as a crucial component of the CAMHS system, in the following ways.
 - Undertake mental health impact assessments to ensure that both schools/education policy and wider government policy and legislation are not detrimental to children and young people's mental health.
 - Help schools to develop a framework for empowering and enabling children and young people to better understand their own mental health and to advocate for themselves. Schools should be able to teach children and young people about mental health in the same way they can teach them about literacy or numeracy.
 - Ensure that schools are able to identify mental health issues and can easily sign-post pupils to relevant support, either within the school or in their local community, and have the accountability to do this.
- 4 Single point of access referral systems should be appropriately resourced to provide access to the full range of services, from support through to diagnosis and specialist intervention.
- 5 Co-production with young people and parents should be at the heart of all recovery, service redesign, commissioning and training.

In-patient care

In-patient services for children and young people with mental health problems have been a source of concern in all parts of the UK over the past 5 years. Children and young people can face difficulties accessing in-patient care when needed. These difficulties have led to rising numbers of children and young people having to travel long distances to suitable in-patient units and increasing numbers of children and young people being accommodated in paediatric facilities and adult psychiatric in-patient units (National Assembly for Wales, 2000; CAMHS Tier 4 Report Steering Group, 2014; NHS National Services Scotland, 2014). There are also concerns relating to the transition from adolescent units to adult wards.

In England, the difficulties that children and young people can face accessing services have been attributed to a range of causes: the impact of the introduction of national commissioning and the resulting disjunction between local services that are commissioned to avoid admission or facilitate discharge and in-patient services; the poor distribution of specialist and generic in-patient beds; and the relative lack of beds in some parts of the country.

The values that seem pertinent to in-patient care are equal partnership, empowerment, workforce, whole system and leadership.

Equal partnership and empowerment

The Commission received two pieces of evidence about in-patient care. The parents of a young person admitted to Bluebird House forensic adolescent in-patient unit reported a very positive experience. Staff worked closely with both the patient and her parents. However, the young person's transition to adult high-secure services was very difficult.

'Whilst at Bluebird she could manage days out and holidays with us. The move to adult has been a disaster – I believe 18–25s need a separate provision.'

The Adolescent Forensic Psychiatry Special Interest Group (of the Royal College of Psychiatrists) submitted evidence in relation to the pathways into care for young people in the secure services. It highlighted the need for careful liaison between agencies and with young people and their parents and carers. This was needed to ensure that the needs of this vulnerable and complex group of young people are met.

The Commission received evidence from The Crew, a participation group for young people, parents and carers that is based at The Junction, Lancaster and The Platform, Preston. The Crew has existed for 10 years and provides youth participation to Lancashire Care NHS Foundation Trust. It is actively involved in all aspects of service development and service delivery. The Crew played an active part in the development of The Platform, a six-bed in-patient unit for 16- to 17-year-olds in Preston and in the development of therapeutic interventions for young people with eating disorders. Members of The Crew report to the trust's board. They also participate in the recruitment of all members of staff within the service and have made a tangible difference to the appointment of staff. The Crew has just started to provide training to staff. Members of The Crew reported that this level of involvement helped them to understand some of the difficult choices facing the trust. They also felt that they had personally gained from the experience and had been able to share this with other young people and professionals by presenting at conferences and other events. In recognition of their work, two members of The Crew have recently received awards. One said he had recently been told that The Crew has 'a really good reputation for the work that you do in advising around literature, guidance, those kinds of things'.

The Commission also heard from the Huntercombe Group, a private health organisation that provides in-patient and out-patient care to children and young people 11–25 years of age (Box 7). It runs services in England and Scotland and takes referrals from Wales and Northern Ireland. They initially explained how they had developed their organisational values (Fig. 3) and how these values informed the functioning of the organisation. They described two participation programmes: Patient Voice, including parents and carers; and Customer Voice, for referrers and commissioners and paying customers. The Huntercombe Group highlighted one area of disagreement among their stakeholders: specifically, between commissioners and young people about how to provide support outside the in-patient setting, particularly for young people around the age of 18. As a result, the Huntercombe Group is developing a service with commissioners in Devon, ‘something that will help young people

and be much more focused around resilience, life skills and living independently outside’.

Whole system

The West of Scotland CAMHS Network described the work they had done with colleagues to review service models and care pathways with a view to developing shared protocols and pathways between tiers 3 and 4 in the region (Box 8). In the longer term, there is a proposal to develop a managed clinician network (Box 9).

A crucial part of the development of the West of Scotland CAMHS Network was close liaison between colleagues in tier 3 and 4 services throughout the region. The regional forum was a central part of developing a training programme that brought together clinical staff from tiers 3 and 4. The training programme focused on the following areas.

Box 7 Conversation into Action

The Huntercombe Group’s Conversation into Action programme was a key part of the Patient Voice programme. They also used the Friends and Family Test, routine outcome measures and patient surveys and interviews. There is also a budget for patients to plan improvements in the built environment (‘Glamour Your Manor’), with access to a budget to carry out these improvements. The ‘Customer Voice’ programme provides feedback about the quality of current services but also allows the Group to anticipate and plan for future need. Conversation into Action also enables staff engagement and has led to the development of specific training initiatives arising from clinical needs identified by staff. A new career development programme has been designed in collaboration with staff.

Specific examples:

- The refurbishment of the lounge area of their Edinburgh Adolescent Unit into an American diner, designed by the young people in the unit.
- The development of an inpatient and outpatient programme for young people 11–25 years of age with eating disorders. The outpatient programme was partly driven by feedback from young people about their experience of transition and partly by commissioner demand.

- Education and consultation:
 - pathways – clinical vignettes, board issues
 - intensive treatment services
 - eating disorders
 - psychoses
 - sharing good practice
 - emotional abuse
 - forensic CAMHS and risk assessment and management.
- Specific therapy training:
 - behavioural family therapy
 - dialectical behaviour therapy
 - family-based treatment
 - Systems Training Emotional Predictability Problem Solving (STEPPS).

Box 8 Key components when developing a clinical network

- Scoping group/clinical reference group
- Service profiling/meeting teams across the region
- Newsletter
- Patient journeys and patient stories
- Emotional touchpoints
- External consultation

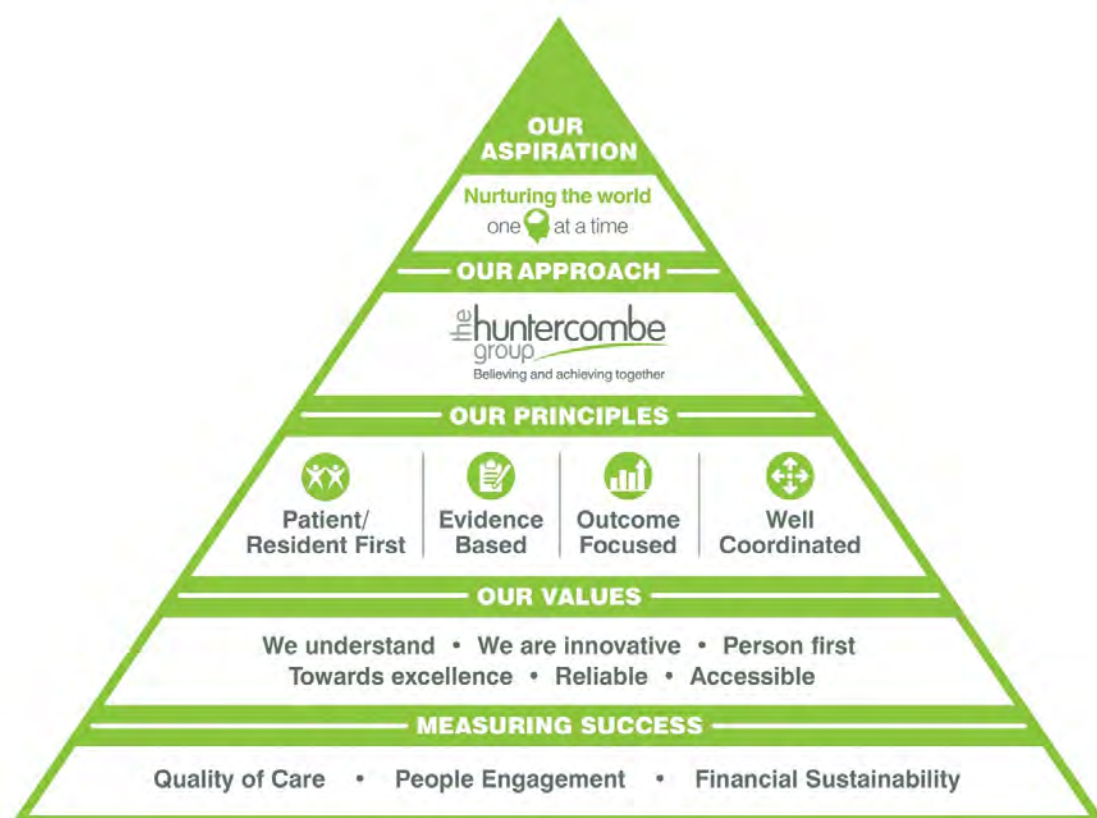


Fig. 3 The Huntercombe Group's approach. Reproduced with permission from the Huntercombe Group.

The forum developed a service model that encompassed tiers 1–4. Following the introduction of the new processes as part of the clinical pathway, average lengths of stay fell significantly and total numbers of admissions rose significantly. Over the same period, the number of out-of-area admissions rose, as did the number of short, local admissions. A key component of this process was

the development of Intensive Intervention Teams to help to manage high-risk children in the community. The confidence of community CAMHS in being able to treat high-risk young people significantly increased. This led to a reduction in admissions to in-patient units.

Conclusions

The Commission was struck by the careful work carried out by in-patient services to understand the competing values within the system. It was also struck by the challenge of commissioning private companies to provide in-patient services, effectively in isolation. How can they meaningfully join up with NHS tier 3 and crisis/outreach services? How can this system work when private providers are focused on developing good in-patient services, whereas most CAMHS clinicians are trying to care for young people as much as possible in the community? Many tier 3 CAMHS consider an in-patient admission to be the last resort, rather than a positive intervention, whereas in-patient units might not see themselves in quite this way.

Box 9 West of Scotland: developing a clinical network

- Effective clinical leadership for the scoping work required to develop the region's thinking on the creation of a managed clinical network.
- Ensuring effective clinical multidisciplinary engagement and involvement in developing the regional position.
- Reviewing service models and care pathways against the regional profile of need.
- Developing appropriate regional service models, care pathways and shared protocols for CAMHS services at tiers 3 and 4.
- Providing guidance and direction for the project officer on clinical matters.

The work presented by The Crew powerfully reinforces the conclusion that co-production is not only good for services but also good for young people, parents and carers. The Commission was profoundly moved by the positive impact that co-production had had on the members of The Crew and hope that this experience can be replicated in other services.

Finally, the work carried out by the West of Scotland CAMHS Network to develop a managed clinical network chimed with evidence submitted in relation to services in the community. In-patient services are part of a wider system. Optimising collaboration between

in-patient services and the wider system is vital to ensuring positive experiences and clinical outcomes for children and young people with complex mental health needs.

Recommendation

- 6 Clinical pathways to and from in-patient admission should include access to alternatives to admission, such as crisis intervention teams and home treatment teams. These should be jointly commissioned or managed with in-patient care.

Training, commissioning, regulation and leadership

An effective CAMHS system depends on a workforce that is well supported and appropriately trained. There need to be effective systems for managing the system. In England, commissioning has a vital function; in the other jurisdictions, central administrations play an equivalent role. However, in all parts of the UK, effective leadership across the system, supported by healthcare regulatory bodies, is vital.

The key values that pertain to these areas of activity are:

- the value of the workforce
- equal partnership
- empowerment
- whole system
- leadership
- long-term relationships.

Education and training

The Commission received a submission about the training of child and adolescent psychiatrists from the Royal College of Psychiatrists. Input from Young Minds led to a significant restructuring of the curriculum, with a new focus on the professional qualities that young people expect psychiatrists to show in clinical settings. The importance of the awareness of cultural diversity was highlighted, with an emphasis on the interaction of cultural diversity and deprivation in their effects on mental health.

Evidence from NHS Education for Scotland stressed the importance of whole-system approaches to education and training (Box 10). It highlighted the importance of supporting staff in understanding the values that underpin the CAMHS system and how this helped to promote collaborative, safe and effective work with young people who use CAMHS. The Commission also heard from NHS Education for Scotland about the positive impact of working within a unified outcome framework.

'I think what's really important now in Scotland is the Getting It Right For Every Child approach, which started in about 2004 and has really, really been implemented quite heavily now with [the] new Children Scotland Act [...] I think it's a really great approach because it tries to, promote the same language across health, education, social work and police, all of the agencies. So that we're trying to think about the child's needs using the same language and using the, the kind of SHANARRI

Box 10 NHS Education for Scotland

A Competence Framework for Child and Adolescent Mental Health Services (Roth et al, 2011)

- The framework was designed to be relevant to specialist CAMHS workers. However, specific parts of the framework are thought to be of relevance to professionals in the wider network of children's services. The framework draws on a number of sources including systematic reviews, published research trials, and a body of literature detailing patient views.

Essential CAMHS

- This online learning resource consists of five modules and was designed for CAMHS workers. The learning objectives for each module were based on the knowledge and skills detailed *A Competence Framework for Child and Adolescent Mental Health Services*. The training was designed to support staff through the transition into working in a specialist CAMHS environment and links to relevant UK and Scottish policy, such as Getting it Right for Every Child (GIRFEC).

Training in psychological therapies and supervision

- NHS Education for Scotland is implementing a plan of work to increase the number of CAMHS clinicians trained in psychological therapies and therapy supervision. NHS Education for Scotland is working with all Scottish health boards to maximise the likelihood that training is implemented and evaluated post-training.

indicators [Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included]. So when we have [a] child of particular concern, the aim is that the children's plan that we create uses [the] language of GIRFEC and each agency by now is quite familiar [with] the language and can relate to it.'

The clinical lead of CYP-IAPT argued that, since 2011, CYP-IAPT had transformed CAMHS. This was because, unlike the adult IAPT programme, the intention had not been to create a separate service but to transform existing CAMHS using service-improvement methodology. Young people's participation and the active acknowledgement of the experiences of children and young people, parents and carers was central to this process.

Commissioning

Whole system

A number of CCGs submitted transformation plans with a strong emphasis on whole-system transformation. The Commission took evidence from Newcastle and Gateshead CCG and undertook a site visit to Liverpool CAMHS.

Newcastle and Gateshead CCG explained that it had a longstanding commitment to children and young people's health and well-being (Box 11). It worked closely with its local authority partners, initially funded by a collaborative commissioning grant and then by funds associated with Future in Mind. This allowed them to come together as

joint commissioners for 2-day kaizen event (a quality-improvement technique drawn from the Toyota Way; Liker, 2004). They also decided to rename the service. After consulting with children and young people, both users of CAMHS and those in the community, they agreed on Expanding Minds, Improving Lives.

After a period of stock-taking across all three partner organisations (the CCG, Newcastle City Council and Gateshead City Council) they embarked on a wide-ranging, extended consultation with all stakeholders. Organisations in Newcastle and Gateshead had decided to move away from a traditional consultation model. The process consisted of structured listening events, surveys, group work, focus groups, one-to-one interviews and online support submissions from a wide range of people. Using a grant from the Paul Hamlyn Foundation, the CCG asked a local voluntary organization, the Helix Trust, to make a film with children who had used the local CAMHS.

One of the outcomes of the film project was that the children identified the need for a more social model of support via peer support. The event that launched the film had also acted as a catalyst to bring together a wide range of services and agencies that had historically not worked closely together. Finally, the CCG decided to recruit Children and Young People's Commissioners to the Partnership board.

Co-production

A number of CCGs submitted evidence about their participation programmes (Boxes 6 and 12). The Commission was struck by how Liverpool CAMHS's longstanding commitment to participation pervades the whole system, as illustrated by their takeover day.

'Takeover week across the Liverpool CAMHS Partnership and wider partners was a great success. With over 60 young people taking part in various activities, and a variety of different services across the city gaining the views of children and young people. All young people that took part had a voice around different services affecting young people's mental health and emotional well-being. They gave some great feedback that will most definitely be used in future work, and then fed back to the young people on how their views have been taken on board.'

Box 11 Newcastle and Gateshead CCG

- A plan to develop services progressively over 3 years
- Upstream early intervention, prevention model
- As easy into services and out of services, as required
- Right place with less-clinical environments
- Recovery-focused from the very beginning
- Shared care and joint planning
- No 'bounce'
- Prevention of unnecessary escalation
- Choice of provisions
- A reflecting and responsive workforce
- Developing a specific Mental Health Partnership Board to provide governance

Box 12 Co-production

- Evolving Minds is made up of young people from across Leicester, Leicestershire and Rutland who are working alongside CAMHS staff to make the service more young-people-friendly. This group enables co-design work to happen more consistently and offers a pathway for other young people to have their voices heard.
- Cornwall CAMHS Young People's Board is an ongoing group project for young people who are affected by mental illness and who may have used NHS or community CAMHS. It has been commissioned by Kernow CCG so that young people are involved in the planning, development, commissioning and evaluation of mental health and well-being services for children and young people.

Adam, a young man who participated in the take-over day, reported that the experience of being actively involved in the service was useful to his sense of well-being.

Long-term relationships

Our visit to Liverpool CAMHS reinforced the importance of committed, informed and engaged commissioners. On this basis, they can develop long-term relationships with partnership organisations and work together to achieve long-term service improvement.

Regulation

The Care Quality Commission's (CQC) defined their core values: safe; effective; caring; responsive; and well led. These values had been developed as a result of a wide-ranging consultation with providers, commissioners and patients. In addition, duty of candour implied a need for transparency in the organisations that the CQC regulates and inspects.

The CQC's commitment to a values-based approach is demonstrated by inspection teams consisting of both clinical and lay experts and experts by experience. Increasingly, when inspecting CAMHS, the inspection teams include young people and carers.

The CQC uses the Think Child programme in all service inspections, including general practice and

dentistry. The CQC's current priorities in relation to children include the following: child sexual exploitation; children's champions within different parts of the CQC; child-safeguarding specialist advisors; guidance on circumcision; children's mental health; and the Mental Health Act 1983. The CQC is working with the Office for Standards in Education, Children's Services and Skills (OFSTED) to conduct joint area inspections (i.e. of all services in one area) and with the National Probation Service and Her Majesty's Inspectorate of Constabulary to look at how systems work together.

The Royal College of Psychiatrists' Quality Network for Community CAMHS (QNCC) and Quality Network for In-patient CAMHS (QNIC) both submitted evidence on the role of quality networks in improving standards. Both networks develop service standards that describe what a good-quality service looks like. These standards are developed by reviewing best-practice guidance and consulting with front-line staff and young people to find out what they think is important to a good-quality service. Participating services score themselves against the standards using self- and peer-review. Services meeting sufficient standards can be accredited by the College.

Aggregated data are published annually to identify national trends in the data and identify areas for improvement. The rest of the work of the networks is focused on preventing services feeling isolated and creating opportunities for networking and sharing of innovative practice. This is done through regular training events and national conferences, newsletters and email discussion groups.

Although they are hosted by the College, both networks are multidisciplinary and involve all professionals who would deliver these services. Over 95% of in-patient providers in the UK are members and approximately 25% of community teams. More recently, network visits have been focused on children and young people's mental health and making use of wider national standards.

Leadership

The Commission heard from experienced voices about the need for system leadership. Former Children's Commissioner Maggie Atkinson argued for the need for the whole CAMHS system to work

together to ensure good access for all children in need. Andrew Christie of the ADCS said that he saw a degree of withdrawal of specialist services from the CAMHS system and lack of clinical leadership. Some clinicians from specialist services in England reported feeling marginalised from the service-transformation process; this was less common with clinicians in Scotland, Wales and Northern Ireland.

Peter Fonagy, National Clinical Lead of CYP-IAPT, argued that the scale of need that was now being presented to services called for a system-wide response, allied with a public-health response. He suggested that the public-health response should rely on mobilising the power of peers and other ‘bystanders’ to support vulnerable children.

Conclusions

Our witnesses demonstrated that values-based practice pervades all aspects of training in children and young people’s mental health and well-being, but not always in formal training. According to the evidence gathered by the Commission, two fundamental values are essential to the effective development and functioning of the CAMHS system: valuing long-term relationships and supporting whole-system leadership.

Recommendations

- 7 All training for the children’s workforce – from clinicians to youth workers – should include training in values-based theory and practice, including an exploration of what matters to clinicians and patients, with the aim of developing a community of shared practice.
- 8 Commissioners of CAMHS should establish sustainable relationships with provider partners and young people.
- 9 Whole-system leadership should be characterised by a collaborative and mutually respectful approach, and include the active participation of clinicians from specialist services.
- 10 Further research is needed in the following areas:
 - the relationship between co-production, values (what matters) and recovery in children and young people with mental health problems
 - staff values (what matters): this is an important and under-researched contribution to understanding why co-production and other aspects of service improvement have proved so difficult to implement in a sustainable way.

Appendix 1. Commission terms of reference

- 1 To examine the role of values (what is most important to children and young people, parents and carers, service providers, referrers and service commissioners) in CAMHS.
- 2 To examine how any differences in the implicit values of the different constituents of CAMHS affect the commissioning of CAMHS.
- 3 To examine how any differences in the implicit values of the different constituents of CAMHS affect the development and delivery of CAMHS.
- 4 To seek best practice as to how working with these differences can lead to better commissioning and provision of CAMHS.
- 5 To examine evidence of why and how service providers use children and young people's participation to improve service development and service delivery.
- 6 To examine evidence of why and how service providers use parents' and carers' participation to improve service development and service delivery.
- 7 To examine evidence of why and how commissioners and managers use children and young people's participation to improve the management and commissioning of CAMHS.
- 8 To examine evidence of why and how commissioners and managers use parents' and carers' participation to improve the commissioning and management of CAMHS.
- 9 To develop recommendations for service providers, commissioners and managers to use when working with differences in values to improve service.
- 10 To develop recommendations for training for service providers, commissioners and managers.
- 11 To develop recommendations for the education and training of CAMHS staff.
- 12 To develop recommendations to key organisations (e.g. Department of Health, NHS England, Directorate of Health and Social Care (Scotland), Department of Health and Social Services (Wales), Department of Health (Northern Ireland)).

Appendix 2.

Membership

Steering committee

Baroness Claire Tyler, Chair

Professor Dame Sue Bailey, Chair, Children and Young People's Mental Health Coalition

Dr Peter Hindley, Chair, Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists and Commission convenor

Ms Sarah Brennan, Chief Executive, Young Minds

Professor Bill Fulford, Collaborative Centre for Values Based Practice in Health and Social Care, St Catherine's College, Oxford

Dr Fran Whitaker, Research Fellow, Royal College of Psychiatrists

Dr Michael Grant, ST4 CAMHS, London

Commission members

Ms Vijaya Nath, King's Fund

Ms Kat Cormack, expert by experience

Ms Alysha Buttress, expert by experience

Mrs Sarah Robinson, parent representative

Dr Anne McFadyen, Scotland

Ms Elaine Bousfield, XenZone

Dr Laurence Baldwin, Senior Lecturer in Nursing, Coventry University

Mr Tony Draper, National Association of Head Teachers

Dr Neela Shabde, Cumbria Clinical Commissioning Group

Mr Rob Henderson, Association of Directors of Children's Services

Appendix 3.

Oral witnesses

National overview

Dr Clare Lamb (Wales)

Dr Anne McFadyen (Scotland)

Ms Anne O’Herlihy (England)

Dr Richard Wilson (Northern Ireland)

Community

Water Hall School, Milton Keynes

Surrey and Borders Partnership NHS Foundation Trust

Tavistock Relationships

National Development Team for Inclusion

Dr Richard Wilson, Northern Ireland

In-patient care

The Junction, Lancashire Care NHS Foundation Trust

Dr Anne McFadyen, West of Scotland Specialist Network

Huntercombe Group

Commissioning

Newcastle and Gateshead CCG

Mr Andrew Christie, ADCS

Leadership, inspection and training

Professor Peter Fonagy, Children and Young People’s Improving Access to Psychological Therapies

Dr Anne York, Care Quality Commission

Dr Fiona Calder and Dr Annie McGrath, NHS Education Scotland

Individual interviews

Professor Maggie Atkinson, former Children's Commissioner for England

Ms Catriona Williams, Children in Wales

Ms Barbara Rayment, Youth Access

Appendix 4. Evidence from the Department of Health

Improving children and young people's mental health and well-being

Introduction

Over half of all mental ill health starts before the age of 14, and 75% has developed by the age of 18. There is a compelling moral, social and economic case for change. Failure to support children and young people with mental health needs costs lives and money.

The government recognises that improving mental health and addressing both treatment and cause is absolutely vital to societal well-being and none more so than in the young. We are therefore embarking on a broader programme of system-wide transformation to improve children and young people's mental health and well-being over the course of this Parliament.

The Department of Health is the lead government department and 'steward' of the health system, working closely with the principal delivery partners including NHS England and other organisations, such as Health Education England, Public Health England, the Local Government Association, the Association of Directors for Public Health, Association of Directors for both adults and children's services (ADASS and ADCS, respectively) and many other national organisations.

We have asked local areas to join up to ensure that children and young people's mental health and well-being is 'everybody's business' and at national level, we are doing the same.

Values-based commissioning: involving children and young people

The government is committed to involving children and young people in decisions that affect them in line with article 12 of the UN Convention on the Rights of the Child. There are many examples in children's mental health of engagement and participation.

For example, every local area in the country was able to evidence examples of how they worked with children and young people to develop their local transformation plan. This was achieved in a number of ways. A qualitative analysis will be published shortly summarising the approach that was taken to involving children and young people in the development of these plans.

The Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) service transformation programme has, over the last 4 years, extensively involved children, young people and parents at a national level and locally in strategic planning and the development of products to improve child and adolescent mental health services (CAMHS). The programme commissioned participation partners to ensure children, young people and families' participation was embedded at every level of delivery and this has contributed to the programme's success.

A Children and Young People's Mental Health Improvement Team, working centrally and across the strategic clinical networks (SCNs), has been commissioned to support the transformation programme, which includes collaborative working with children young people and their families. Young people regularly participate in discussions about children and young people's mental health services. Examples include:

- working with young people to create the new Youth Mental Health Hub, a website designed with young people;
- young people coming into the Department of Health (England) to meet Ministers and key staff for 'Takeover Day' as part of the Takeover Challenge initiative that sees young people 'take over' an organisation.

The 'Parents Say' toolkit, launched in December 2015, was developed by Young Minds as part of NHS England's drive to improve participation of children, young people and their parents and carers in their care. It was commissioned by NHS England to help improve the role of parents and carers in decision making about treatment, improve the availability and accessibility of services, and create better opportunities for parents to have an effective role in how services are run. This follows evidence that improved participation leads to better outcomes for children, young people and their families.

Where are we starting from?

- 1 Children and young people's mental health services are facing a complex set of challenges:
 - significant gaps in data, information and system levers leaving services financially vulnerable;
 - the treatment gap the last UK epidemiological study (more than 10 years ago) suggested that less than 25–35% of children and young people with a diagnosable mental health problem are able to access treatment currently – we anticipate that the new survey will show a similar situation;
 - difficulties in access. There is emerging evidence of a rising need. NHS benchmarking data and recent audits reveal significant increases in referral and waiting times, with providers reporting increased complexity and severity of presenting problems and a consequent rising length of stay in in-patient

facilities. Our best evidence is that these difficulties are the result of financial constraints, accompanied by rising demand;

- complexity of current commissioning arrangements. A fragmented system with schools, CCGs, local authorities, the voluntary sector, justice and NHS England all commissioning services. A lack of clear leadership and accountability arrangements for children's mental health across agencies;
- access to crisis, out-of-hours and liaison psychiatry are variable. There are variations in access to appropriate or age-appropriate in-patient care close to home and available when needed. In some parts of the country, there is no designated health place of safety recorded by the CQC for under-18s;
- specific issues facing highly vulnerable groups who find it particularly difficult to access appropriate services, or services may not be configured to meet their needs.

What are we trying to achieve?

2 *Future in Mind* describes an integrated whole system approach to driving the improvements children and young people want – a genuine choice of where and how to get advice and support that is trustworthy, evidence-based, delivered at the right time in the right place – with the NHS, public health, voluntary and community, local authority children's services, education and youth justice sectors working together to:

- place the emphasis on building resilience, promoting good mental health and well-being, prevention and early intervention;
- deliver a step change in how care is provided – moving away from a system defined in terms of the services organisations provide towards one built around the needs of children, young people and their families;
- improve access so that children and young people have easy access to the right support from the right service at the right time and as close to home as possible. This includes implementing clear evidence-based pathways for community-based care to avoid unnecessary admissions to in-patient care;
- deliver a clear joined up approach: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable;
- sustain a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience;
- improve transparency and accountability across the whole system – being clear about how resources are being used in each area and providing evidence to support collaborative decision making.

Making it happen

- 3 The core delivery mechanism is the system-wide, publicly available Local Transformation Plans for Children and Young People's Mental Health and Wellbeing, with access to additional funding contingent on a bespoke proportionate assurance process for 2015/16, requiring evidence of joint working, transparency, service transformation, workforce development and monitoring improvement.

How will the additional investment in children and young people's mental health be used and what will it deliver?

- 4 The Government committed additional investment of £150 million over 5 years to develop evidence based community Eating Disorder services for children and young people in the Autumn Statement 2014. A further £1.25 billion was announced in the March 2015 budget to deliver the Future in Mind ambition and accelerate improvements in children and young people's mental health.
- 5 The £1.4 billion is being used to reshape and improve significantly the local offer for all children and young people with mental health problems over the next 5 years. This includes:
 - improving access to evidence based services so that by 2020 at least a further 70 000 children and young people receive swift and appropriate care each year, building capacity and capability across the system to ensure measurable progress towards closing the health and well-being gap and securing sustainable improvements in children and young people's mental health outcomes;
 - completing the roll out the Children and Young People's Improving Access to Psychological Therapies programmes (CYP-IAPT) so that by 2018, children's mental health services across the country are delivering a choice of evidence-based interventions, adopting routine outcome monitoring and feedback to guide treatment and service design, and working collaboratively with children, young people and those who care for them. The additional funding will also extend access to training via CYP-IAPT for staff working with children under 5 and those with autism and learning disabilities and counsellors and includes funds agreed for further digital developments. By 2020 our aim is to train at least a further 3400 staff to improve access to more effective services, meaning a total of 5000 existing staff trained since the start of the programme in 2011. In addition, we estimate an additional 1700 new staff will need to be added to the workforce by 2020 to deliver the ambition to increase access;
 - developing evidence based community Eating Disorder services for children and young people to improve recovery

rates, reduce relapse, reduce the numbers of young people requiring in-patient care and reduce the length of stay for those who do. The standard published in August 2015 is for evidence based intervention to take place within 1 week for urgent cases and 4 weeks for routine cases. By 2020 we expect 95% of those in need to be seen within the standard timeframe above. Preparatory work is starting now to gather the data from the Mental Health Services Dataset that will be needed to set, in 2017, the year-on-year trajectory to deliver the ambition for 2020;

- in 2016, NHS England will also lead work to identify options for a generic access and waiting time standard for children and young people's mental health;
- improving specialist perinatal care to support at least 30 000 more women each year to access specialist mental health care during the perinatal period by 2020. Work now underway following the Spending Review to develop a broader five-year improvement programme to deliver the *Five Year Forward View for Mental Health Taskforce Report* recommendation;
- improving access to and use of in-patient care reducing unnecessary out of area placements, providing care as close to home as possible, build capacity in specialist community services and help to avoid unnecessary use of expensive in-patient provision in future years. The new funding will help maintain the additional CAMHS beds commissioned following the Tier 4 review, which brought the total to more than 1400 CAMHS beds – the highest number ever – and the additional case managers to ensure best use of resources;
- bringing education and local children and young people's mental health services together around the needs of the individual child through a joint mental health training programme 22 CCGs are now working with 250 schools across the country to test this model.
- improving care for the most vulnerable. Work here includes:
 - testing of personal health budgets for looked-after children, adopted children and those leaving care to ensure that children and young people with particular challenges in accessing care have more choice and control over when and how they access appropriate support in their community;
 - improvements for those within the youth justice system and in secure children's homes and better coordinated care for highly vulnerable children and young people in the community with complex needs;
 - funding for regional strategic case managers to review the cases of children with learning disabilities in long term care who often have associated mental health problems. In December 2015 there were 158 children and young people with learning disabilities in hospital. The aim is to

have completed Care and Treatment Reviews for all children and young people who need them by March 2016.

Laying the foundations to drive and sustain change over the next 5 years

- 6 Alongside the development of locally driven transformation plans, a national cross sector programme of work is being developed to lay the foundations for wider strategic improvements to sustain and drive further change. This includes work to tackle stigma, improve access to information, build the capacity, capability and confidence of both the specialist and wider workforce alongside work to improve data and information.

Tackling stigma

- 7 We know that fear of stigma can stop young people and their families from seeking the help that they need. This is why we funded the largest ever social marketing campaign targeted at teenagers and the first for parents, which included online films, resources for schools and radio adverts for parents.
- 8 The aim of the campaign is to reduce stigma and discrimination by changing reported and intended behavioural outcomes. As aspects of the campaign are still running, evaluation insights are not yet available but we hope that these will be similar to previous campaigns run with older audiences. We are proposing to continue to fund this work. If we can address societal norms from a younger age and improve attitudes that encourage health seeking behaviour, we have the best chance of improving children and young people's mental health.
- 9 Our campaign reached nearly 2 million young people and over 2 million parents, in partnership with Time to Change. As a result, 50% of young people said they are less likely to judge someone with a mental health problem and a similar number of parents said they were more likely to speak to their children about mental health. Through this work, we aim to remove judgement around mental health issues and encourage people to talk about them.

Strategic workforce development

- 10 A detailed audit of the children and young people's mental health workforce has been commissioned to develop a costed, multi-disciplinary workforce strategy for the future shape and skill mix of the workforce required for providing a transformative service.

Data and information: key gaps and issues

- 11 In devolved systems good data is essential. There has been significant delay in national collection of outcomes metrics, access standards, development of payment and other incentive systems and their alignment across the health, education, and social care systems – all of which are critical to driving change in a

co-ordinated way. The situation compares poorly to data and information on physical health.

12 For that reason, we are prioritising investing in new data sources to secure a sustainable focus on children's mental health. These include:

- a National Prevalence survey: the last national children and young people's mental health prevalence survey was in 2004. DH has commissioned a new expanded survey to be published in 2018 which will reveal the extent mental ill health in the population;
- the What about YOUTH survey of 15-year-olds' health and well-being (reported December 2015);
- a new Mental Health Services Dataset – provider level data on children's mental health services has not been previously collected or published. The new dataset will provide comprehensive data for children (and adults) on outcomes, length of treatment, source of referral, location of appointment and demographic information. The dataset has been designed to allow appropriate linkage with other sources to vastly increase the potential evidence base. Data collection started in January 2016, initial data quality and completeness is likely to be poor, but alongside the LTPs, information from the data set will help provide the baseline to judge progress of the transformation process. These will be developed into a longer term plan for collecting and reporting data, informed by Future in Mind and the Five Year Forward View for Mental Health Taskforce to support plans to implement its recommendations by 2020.
- analysis of Local Transformation Plans – NHS England has commissioned an in depth quantitative and qualitative analysis of all 123 Local Transformation Plans assured in 2015/16. The quantitative analysis (published in April 2016) summarised baseline data on need, spend, activity and workforce collected through the Local Transformation Plan process. There will also be a thematic review in line with the overarching Future in Mind themes.

Strengthening the voluntary and community sector

13 We are providing grants to the voluntary and community sector organisations, one to Youth Access, to develop a quality offer for all YIACS (Youth Information Advisory and Counselling Services) and the Anna Freud Centre to strengthen the voluntary and community sector.

Strong governance arrangements to oversee the delivery of this work

14 The Department of Health has worked closely with the Major Projects Authority (MPA) to develop extensive new cross-system

governance and oversight structures to help ensure successful delivery. This includes setting up a national Children and Young People's Mental Health and Wellbeing Oversight Board. Membership spans health, social care, Youth Justice and education and is aligned with wider structures responsible for adult mental health.

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