CHILD AND ADOLESCENT MENTAL HEALTH SERVICES:
REASONED ADVICE TO COMMISSIONERS AND PROVIDERS

Robert Goodman

Does Oliver Twist have a psychiatric disorder?
Is the prescription for child and adolescent mental health services simply “More please sir”?
ABSTRACT

1. The amount spent on child and adolescent mental health services, and the types of services purchased, vary dramatically from one health authority to another. This variability partly reflects the prevailing uncertainty about what sorts of services need to be delivered, for whom, and by whom.

2. Not all childhood maladjustment and distress is a mental health problem. The majority of troubled children and teenagers either require no professional help, or need help from education, social services or voluntary agencies. For the minority of troubled young people who do have mental health problems, a wide range of effective treatments exist. Despite this, many of the treatments currently delivered in everyday child and adolescent mental health settings are of dubious or minimal value. Until this is rectified, spending more money is not necessarily the solution.

3. Comprehensive and accessible evidence-based services will not necessarily cost more than current services. There is considerable scope for obtaining more effective services and better value for money by diverting available resources away from treatments of dubious value and into treatments that have been shown to work. Young people, families and referrers would all benefit if health, education and social services clarified their respective roles. Overlapping and muddled remits stand in the way of effective help.

4. Health provision should focus on young people with core mental health problems such as anorexia nervosa, schizophrenia, severe depression, obsessive-compulsive disorder and severe hyperactivity. At present, these young people often go untreated or undertreated. The “four tier” model is unhelpful, dividing services up in a way that works against good practice. A more promising blueprint for evidence-based services involves: an outpatient service, fully funded by health, for core mental health problems; a contribution to multi-agency services for disruptive behaviours; a hospital liaison service; and intensive services. In addition, integrated district services need to provide consultation and training to primary health services and other agencies, and should take an active role in facilitating self-help groups. Because 16 and 17 year olds are particularly likely to have expensive-to-treat mental health problems, the cost of child and adolescent mental health services depends critically on its upper age limit. Thus a service for 0-18 year olds may be twice as expensive as a service for 0-16 year olds.

5. Education and social services should take the lead in the assessment and management of disruptive and delinquent children and teenagers. Health involvement is only appropriate for the minority of disruptive young people whose troublesome behaviour stems from, or gives rise to, core mental health problems.
MAUDSLEY DISCUSSION PAPER NO. 4
Child and Adolescent Mental Health Services: Reasoned Advice to Commissioners and Providers

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1. Introduction

1.1 Spending on child and adolescent mental health services is very variable

There has recently been a flurry of interest in the funding and organisation of child and adolescent mental health services (CAMHS). This focus is very timely since there is growing evidence that health authorities vary markedly in the importance they attach to CAMHS, as is well illustrated by recent data on variation in expenditure in a single English health region.

Among the health authorities in the North West region, the amount spent per head on mental health services for 0-16 year olds ranged from £3.00 per year in one area to £13.80 in another. For adults, the corresponding range was from £25.60 to £91.60 per person per year. To put the matter at its starkest, mental health expenditure on children in South Lancashire was less than a quarter of that on children in the Wirral, and less than a thirtieth of that on adults in Manchester.

This variation between health authorities was just as marked when allowance was made for area differences in total health expenditure. Thus as a proportion of total expenditure, spending on CAMHS ranged from 0.15% to 0.70%. Furthermore, although 0-16 year olds made up 21.4% of the population, they only accounted for between 1.8% and 9.4% of all mental health expenditure.

Though it would be easy to condemn low-spending health authorities out of hand, branding them as uncaring about children and their mental health, the uncomfortable truth is that both low-spending and high-spending health authorities potentially have a case to make. Reviewing these opposing positions is a convenient way of summarising the debate that represents the starting point for this discussion document.

1.2 The case for high spending

1.2.1 Most epidemiological studies suggest that at any given time roughly

* Superscript numbers refer to endnotes from page 44 onwards. References cited in the endnotes are listed alphabetically from page 53 onwards.
20% of all children and teenagers have psychiatric disorders as recognised by the two main international classifications (ICD and DSM), and some estimates are substantially higher. Since this rate of psychiatric disorder is comparable to the rate in adulthood, it is inequitable to spend far less on young people’s mental health than on adults’ mental health.

1.2.2 A growing number of well-conducted clinical trials have clearly demonstrated the efficacy of some treatments for child and adolescent mental health problems. Illustrative examples of effective treatments are shown in Box 1.1. Depriving young people of these treatments will often condemn them to needless suffering, a blighted education, delinquency or even suicide.

1.2.3 Untreated or undertreated mental health problems are not only a human tragedy for the young people involved and their families; they are also responsible for considerable financial cost to the nation. This cost falls on education and social services; on the victims of juvenile crime; and on other parts of the health service, e.g. if troubled children are increasingly referred to paediatricians instead. In the longer term, untreated children and teenagers may go on to become troubled or unemployable adults.

**Box 1.1: Examples of effective treatments:**
- Behavioural therapy for phobias
- Cognitive-behavioural therapy for anxiety
- Interpersonal therapy for depression
- Exclusion diets for hyperactivity
- Medication for obsessive-compulsive disorder
- Family therapy for anorexia nervosa

1.3 The case for low spending

1.3.1 Though troubled children and teenagers are common, many of them have social or educational problems rather than health problems.
These require social and educational solutions, not health interventions. Though the mental health budget is lower for young people than for adults, the reverse is true for education and social services. Would the advocates of levelling up CAMHS spending to adult levels also support a levelling down of education and social services spending on young people to adult levels on similar grounds of equity? It is also relevant that young people are much less likely than adults to have the sorts of mental health problems - such as schizophrenia, mania or severe depression - that require particularly intensive (and therefore expensive) care.

1.3.2 It is important to remember the injunction: First do no harm. Mental health interventions are not necessarily beneficial for young people, and may even be harmful. Both clinical experience and common sense are fallible guides to effectiveness. Clinical experience has led psychiatrists in the past to make widespread use of techniques such as frontal leucotomy and insulin coma treatment in the genuine but mistaken belief that these were in their patients’ best interests. In much the same way, common sense may mislead clinicians into doing the wrong things with the best of motivations. The Cambridge-Somerville study provides a particularly striking example (Box 1.2), but it is not an isolated finding; other studies have also found that intuitively appealing interventions sometimes make matters worse. It may be that outside help sometimes undermines self-reliance. Alternatively, labelling young people as having “mental” health problems may be damaging to their self-esteem - a necessary evil in some cases but best avoided where possible. Teenagers may be able to leave being a “tear-away” behind them more easily than they can forget having been assessed at a mental health clinic and judged sufficiently disturbed to warrant considerable professional help.

1.3.3 In addition, studies of effectiveness in everyday CAMHS settings often come up with rather dismal findings. For example, although formal treatment trials have shown that some types of child and
adolescent mental health problems can be helped by some sorts of psychological therapies (mainly behavioural and cognitive), there is persuasive evidence that most psychotherapy for young people administered in everyday clinical settings is ineffective or almost so. Several studies have shown that when a family comes to an ordinary CAMHS and professionals recommend individual therapy for the child or teenager, it makes no difference to outcome whether he or she gets that treatment or not. Families who opt out and families who follow the course of treatment do just as well - or just as badly - and this doesn’t seem to be because families who opt out have less severely affected children in the first place. It is also noteworthy that many effective treatments are greatly underused in ordinary practice.

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**Box 1.2: The Cambridge-Somerville study⁷ - common sense interventions do not necessarily help**

Beginning in 1935, boys living in eastern Massachusetts who were at high risk of becoming delinquent were randomly allocated to no special intervention or to a carefully planned package of social and psychological support. In the treatment group, the boys and their parents received counselling - on average fortnightly for some 5 years. Cases were referred on to specialists when this seemed advisable. Around half received academic tutoring, and around half attended summer camps. Most of the boys participated with their key workers in activities such as swimming or sports outings or woodwork. Where possible, boys were enroled into community youth programmes.

Some 30 years later, the effectiveness of the intervention was assessed using four indicators of a bad outcome, namely criminality, alcoholism, psychosis or early death. The surprising finding was not that the early intervention made a highly significant difference, but that the difference was in the unexpected direction: the treatment group did far worse. Furthermore, the boys and families who engaged well in treatment did worse than boys and families who cooperated poorly.
1.3.4 Although recent policy documents on CAMHS have almost invariably recommended more spending and a reorganisation of services into four tiers,1 there is little or no evidence to support these recommendations. Indeed, when a better funded and reorganised CAMHS was compared with a traditional service in the Fort Bragg Project, the results were very disappointing (Box 1.3).

There is no reason to think that the American experience is irrelevant to British services. As the researchers at Fort Bragg noted rather ruefully, their whole project was premature: it made no sense to focus on the financing and organisation of services before working out what the services should be delivering.10 More of what you don’t need won’t necessarily help you feel better.

**Box 1.3: The Fort Bragg Project**

The study at Fort Bragg was an $80 million project that took 5 years to carry out and whose results have recently been published. The evaluation compared ordinary child and adolescent mental health care with a more generously funded version that provided a better integrated and more accessible service, where clinicians were effectively allowed to do what they thought best without having to worry about costs. Not surprisingly, costs went up - they were roughly doubled for comparable cases. On the positive side, families were more satisfied with services. On the negative side, however, the extra input of resources made no difference to outcome - the children and teenagers got better at the same rate regardless.

1.4 Finding a reasoned compromise

Health commissioners do not want to fail young people, but neither do they want to pour scarce resources into ineffective services simply to show that they care. How can they spend money wisely on CAMHS? The rest of the discussion document addresses this question, delineating the sorts of services that provide appropriate and effective help at a reasonable cost.
The recommendations of this document were arrived at by formulating guiding principles and then applying them to the empirical evidence from epidemiological and treatment-outcome studies. An exclusive focus on how much to spend misses the point, since the more fundamental issues are what sorts of services to provide, for whom, and from whom. Buying more of the wrong sorts of services won’t help. The discussion proceeds in successive stages. Chapter 2 examines what sorts of problems a CAMHS should be tackling. Within this remit, Chapter 3 considers what sorts of assessments and treatments should be provided. Chapter 4 discusses how these services can be delivered as effectively and economically as possible. Since even the best planning will never generate a perfect solution, Chapter 5 considers how continuous evaluation and innovation can be incorporated so that each service goes on getting better and better. Chapter 6 calculates how much a model service would cost. Finally, Chapter 7 summarises the conclusions.

Though drawing on an extensive body of empirical evidence, it seemed inappropriate to provide densely referenced justifications for each assertion, since this would have made the text excessively long and off-putting. Neither did it seem appropriate to go to the opposite extreme of presenting the conclusions as though they were rabbits pulled out of a magician’s hat. Instead, the document follows a middle path, presenting the method of working in broad outline so as to allow the reader to follow and check the process of reasoning that led to the conclusions. The comprehensive reviews referenced in the endnotes will allow the interested reader to go back to the original evidence.

Because of limitations in the relevant empirical evidence, it has often been necessary to rely not on incontrovertible facts but on “best guesses” based on a reasoned review of the evidence. Though some of these informed guesses will inevitably turn out to be wrong, this will allow these guesses to be replaced by better guesses - a process of successive approximation to the truth that is more likely to result in progress than reliance on ideological dogmas, historical precedents or clinical experience.
The blueprint for a “model” CAMHS is not meant to be a rigid prescription. Rather, it is intended as a stimulus to promote informed discussion between all parties involved in commissioning and providing CAMHS in any one area. Local needs, wants and resources vary, and all these need to be taken into account when planning local services. The way forward is not to impose one promising solution on everyone. We need instead to generate a range of promising solutions, and then evaluate these alternatives in head-to-head comparisons using the same assessment and outcome measures. Only this will enable us to see how different models work out in practice and subsequently to retain the best from each model.

2. Defining The Scope Of Child And Adolescent Mental Health Services

2.1 A muddled mission

Many agencies are involved in the assessment and treatment of maladjusted and distressed children and teenagers. Why are some of these young people seen by the health service while others are seen by education, social services or voluntary agencies? Do these various agencies have different but complementary roles? At present, it is often difficult to see anything particularly distinctive about the health service’s contribution. Indeed, inter-agency work on child and adolescent mental health problems seems particularly likely to be accompanied by a lack of agreement on roles. If a child has leukaemia and special educational needs, the paediatrician and teacher are likely to be clear about their respective contributions to the child’s wellbeing. But if a child from a multi-problem family is troublesome at home and disruptive in class, there may be great difficulty deciding how to apportion roles between health, education and social services. All three agencies may work at cross purposes, treading on one another’s toes, and employing conflicting terminologies, philosophies and treatments. There may be interminable and unproductive liaison meetings that never seem to lead to coordinated
action. Or no-one may do anything, believing that someone else should be doing it instead.

2.2 The “four tier” model makes matters worse

The muddle has been aggravated by recent attempts to define four tiers within CAMHS,1 with the first tier being largely provided by education, social services, and the voluntary sector. This could be seen as health colonialism. Teachers provide pastoral care to their pupils because this is a core educational task, not because they are doubling as child mental health workers. Much the same can be said about the involvement of social workers and voluntary workers with abused children or delinquent youths. Health should not be seen as the apex of a pyramid, with other agencies playing subsidiary roles in health’s grand plan. Our society works to promote young people’s wellbeing and optimal development in many ways; health is just one component, along with education, social services, voluntary agencies, the criminal justice system, social security, housing, and many other agencies. Health needs to define its mission so as to achieve an efficient division of labour with other agencies, rather than defining a grandiose mission subsuming the work of all other agencies.

2.3 Clear roles help

Without challenging the need for inter-agency teamwork, it often seems to be the case that a team works best when all the members of the team know what they should be doing. You couldn’t run a restaurant where everyone thought they were the cook, and no one wanted to be a waiter or do the washing up. Within any team, a clear division of labour between team members often helps get complex tasks done. Cooperation remains important - the specialised team members still need to work together, though there may be specific tasks that are best carried out by one team member working alone. Cooperation is different from everyone trying to do the same thing and getting in each other’s way. Productive working relations are more likely to stem from reciprocal specialisation and respect for other people’s expertise than from a free-for-all. It seems likely that
inter-agency work for children’s wellbeing has often been undermined by the absence of a clear and rational division of labour between agencies. Shared goals are not enough; agreement on who does what is also important.

2.4 An over-extended remit for the health service

Parents and teachers are seriously dissatisfied with the behaviour of many children and teenagers; these young people can be referred to as maladjusted, in the sense that their behaviour is not well adjusted to other people’s expectations. There is also a sizeable group of distressed children and teenagers who experience a level of stress, misery or anxiety that affronts our or their notion of what childhood and the teenage years should be like. Do all or most of these maladjusted and distressed young people have mental health problems? Many mental health professionals think so, and they have the two main psychiatric classifications on their side. Conduct disorder is a convenient example, since it is not only the commonest of the currently recognised psychiatric disorders; it is also the commonest single disorder seen in CAMHS. Children and teenagers with conduct disorder are naughty, awkward, disruptive, aggressive and antisocial - these are important problems that deserve help, but they are often best thought of as social, educational and moral problems needing social, educational and moral solutions, rather than as health problems that require help from health professionals; a distinctive health component can only be identified in a minority of cases. An over-extended remit is not just evident in over-inclusive classifications. For example, even though sexual and emotional abuse are not classified as psychiatric disorders, child psychiatrists commonly spend much of their time assessing abuse or parenting competence - roles that might often be more appropriately vested in specialist social workers.

2.5 Partitioning the work between agencies in a rational way

In order to promote a rational and productive division of labour between agencies, and thereby promote effective team-work for the good of
young people in general, a valuable first step is to divide the various sorts of childhood maladjustment and distress into three broad categories:

2.5.1 *Conditions where the health service should take the lead*

The health service should take the lead in the assessment and treatment of “core” or “true” child and adolescent mental health problems. The question of how to decide what fits into this category is discussed in detail in Section 2.6. For the moment, two illustrations will suffice: obsessive-compulsive disorder and anorexia nervosa are examples of the sorts of child and teenage problems where the mental health service needs to take the lead in assessment and treatment. Though good treatment of core mental health problems will almost invariably involve close liaison with schools, and may often involve social services and other agencies too, the health component is dominant, distinctive and valuable.

2.5.1 *Conditions where other agencies should take the lead*

There are some types of childhood maladjustment and distress where other agencies should take the lead in assessment and treatment - drafting in mental health professionals as and when necessary. For example, social services should be the lead agency for maltreated children and teenagers. Abuse and neglect are social rather than medical phenomena, though there can be medical antecedents (such as parental mental illness) and medical consequences. Social services will sometimes need to enlist the help of doctors in documenting and treating the causes and consequences. Though many abused young people are distressed and disturbed as a result of their experiences, these problems can often be addressed by social workers themselves without recourse to mental health services. Thus only some abused children and teenagers will need to see a mental health professional. In much the same way, education should be the lead agency for “school refusal”, organising “back to school” programmes for pupils who are reluctant to attend school, and occasionally drafting in the help of mental health professionals when needed, e.g. for the treatment of severe associated depression.
2.5.1 *Conditions where a consortium is needed from the outset*

Some problems involve such a complex mixture of educational, social and health components that although it would not be sensible for the health service to “go it alone”, health professionals could usefully be part of a wider consortium for dealing with the problem. For instance, although the majority of young people with conduct disorder and juvenile delinquency only require social and educational approaches to treatment, the problems of a substantial minority of these children and teenagers have antecedents (such as hyperkinesis) or consequences (such as severe depression) that may need the input of health professionals. Consequently, a comprehensive service for young people with disruptive behavioural problems many well need tripartite funding by social services, education and health. This is a reinvention of the “triple alliance” that has long been the basis for much child guidance work, but that has increasingly been undermined by cuts in social services and education. These cuts have often left the health service struggling valiantly on to provide the same comprehensive coverage from within its own resources - to the detriment of “core” mental health provision. If education and social services are unwilling or unable to contribute to tripartite funding for the assessment and treatment of disruptive behaviour, then health commissioners and providers face a difficult choice. Do they pour in extra funds to provide a comprehensive service single-handed? Do they too pull out of services for young people with disruptive behavioural problems? Or do they try restricting services to children and teenagers with a clear health component? For example, CAMHS might treat disruptive behaviour associated with hyperactivity, but not treat “pure” conduct disorder associated with neglectful parenting or school-based problems.

2.6 **Is it a health problem or not?**

Identifying a distinctive and rational mission for CAMHS is only possible if there is some reasonable method for distinguishing between what is a health problem and what is not. Several possible criteria have been considered and most of them rejected as unhelpful. At present, tradition seems to be the main determinant: a problem is a health problem if it has
traditionally been treated by health professionals. This criterion is best rejected since it is a recipe for perpetuating the present muddle. A variety of a priori rules for defining the scope of the health service also seemed unworkable. For example, the rule that “problems that are partly or wholly biological in origin are the province of health” would not work well – many specific learning difficulties seem to have a substantial genetic component but it would clearly be foolish to put health professionals rather than educational psychologists and teachers in charge of identifying and remediating these difficulties. Nor does it seem sensible to plan health services on the basis of the famous World Health Organisation definition that health is “a state of complete physical, mental and social wellbeing, and not merely the absence of disease and infirmity”. This is potentially a recipe for turning all of life’s trials and tribulations into health problems. The comprehensive wellbeing of all citizens is a laudable aim, but it is not this aim that sets the health service apart; the same aim would be endorsed by any government agency, and by many voluntary agencies as well.

2.6.1 A promising approach

A variety of professions are involved in assessing and helping distressed and maladjusted children and teenagers, both within and beyond the health sector. These various professions have different skills and costs - differences that can form the basis for a pragmatic delineation of the remit of CAMHS. The guiding principle of this approach is that children’s and teenagers’ distress and maladjustment are only appropriately seen as mental health problems when health professionals are uniquely well placed to provide effective and cost-effective assessments and treatments. Some of the key issues here are related to training, setting and statutory responsibilities. For example, doctors are uniquely well placed by their training in physical medicine to treat behavioural problems that stem from physical disorders, need physical investigations, and benefit from drug treatment. Similarly, educational psychologists’ integral roles within the educational system make them the professionals of choice for assessing and managing many school-based behavioural problems. As a final example, given social workers’ statutory responsibilities towards
maltreated children, social workers are usually uniquely well placed to take the lead in the assessment and management of child maltreatment.

Being able to perform a role is not the same thing as being uniquely well placed to perform that role effectively and cost-effectively. Doctors provide a convenient example. Although some doctors make good novelists, this does not mean that doctors are uniquely well placed to be novelists, that all would-be novelists should have a medical training, or that writing novels is a core concern of the health service. Similarly, the fact that some doctors are good at managing dyslexia, bullying or emotional abuse does not mean that these problems are best seen as health problems. The key issue is whether doctors’ unique skills (and uniquely high costs) are called for. If not, these problems would more appropriately be tackled by professionals with less expensive or more relevant training.14 Even if doctors have developed an innovative service, the routine implementation of the new approach should not necessarily remain a medical prerogative. Though Dr. Montessori was medically trained, no one would argue that Montessori nurseries should be staffed or supervised by doctors. But what if doctors happen to be the only local professionals who have some interest and expertise in a particular type of problem? Even if managing the problem does not really need a medical background, surely it is right for doctors to provide a service rather than leave troubled children and teenagers untreated? That may be so in the short term, provided that CAMHS resources are not thereby diverted away from even more needy individuals. In the longer term, though, it is often inappropriate to institutionalise what started out as a make-shift solution to a crisis.

One of the values of a pragmatic definition of mental health is that it allows the boundaries of CAMHS to shift with new discoveries. For example, in the unlikely event that bullying turned out to be a metabolic disorder that needed biochemical assessments and carefully titrated vitamin replacements, bullying would legitimately be redesignated as a mental health problem (which does not necessarily mean that it would stop being an educational problem too). Some children who have pragmatically defined mental health problems will also have social or
educational problems. This is no more surprising than that some children with diabetes or leukaemia have additional social or educational problems.

3. Within The Health Remit, What Should Be Provided?

If problem X does come within the remit of CAMHS, then commissioners and providers need to decide on the level and type of mental health provision for young people with problem X. To facilitate rational decision-making, several subsidiary questions need to be answered in turn. How common is X in the community? What proportion of these young people are likely to attend a well-publicised and well-respected clinical service? What sorts of assessments and treatments are supported by the empirical evidence? In an era of rationed health care, what priority should be given to the treatment of X? Finally, in the light of the answers to all these questions, what level of outpatient and intensive services is required for a specific catchment area? Discussion of some general issues related to each of these questions leads on to the prediction of service needs on a disorder-by-disorder basis.

GENERAL PRINCIPLES

3.1 How common is problem X?

Although there have been plenty of epidemiological studies of child and adolescent mental health problems, it would be naive to imagine that services can be planned on the assumption that if epidemiological studies have shown that y% of young people have problem X, then services need to be provided for this y%. As discussed below, a substantial proportion of these young people and their families may not want any services. In addition, the epidemiological data may themselves be misleading in three ways:

3.1.1 Reported rates are inflated if disorders are judged from symptoms alone

Many epidemiological studies have judged whether or not children and
teenagers have a psychiatric disorder simply from the presence or absence of symptoms. This may seem reasonable enough, but symptoms such as fears, worries, misery, inattentiveness, or defiance are so common among young people that some studies have shown that around half of all children and teenagers in the community meet DSM-III or DSM-III-R criteria for psychiatric disorders, even though most of these individuals are not significantly socially impaired by their symptoms, do not seem in need of treatment, and do not correspond to what clinicians would normally recognise as “cases”.\textsuperscript{3} To circumvent this problem, the definition of psychiatric disorders has been tightened up in the most recent classifications, with DSM-IV and the research version of ICD-10 generally insisting that the individual cannot be diagnosed as having a disorder unless the symptoms have a substantial impact, e.g. causing the young person marked distress, or significantly curtailing his or her life.

Since health commissioners are unlikely to want to spend money on treating symptoms that have little or no impact, services need to be planned on the basis of data from epidemiological studies that define disorders in terms of impact and not just symptoms. This can make an enormous difference to estimated need. For example, one well-conducted study found a prevalence of 37\% for emotional disorders as defined by DSM-III-R, with this prevalence falling dramatically to 6\% when individuals were excluded if their symptoms did not result in social impairment.\textsuperscript{15}

3.1.2 \textit{Most prevalence estimates come from under-treated populations}

As already mentioned, most child and adolescent mental health problems go untreated. When curative rather than palliative treatments are available, prevalence estimates from under-treated populations may result in misleadingly high estimates of service needs. Specific phobias provide a convenient illustration. Many children are afraid of dogs, spiders, snakes, etc. This does not usually warrant a diagnosis since the child’s fear does not cause much distress or impairment. However, some children are diagnosed as having specific phobias on the basis that their fear leads to marked distress, avoidance and social impairment.
For example, children’s lives can become very restricted if they refuse to go anywhere they might meet a dog. Most animal phobias date back to early childhood, and they can be very persistent if untreated - though they often respond very well to behavioural therapy. Imagine, for the sake of simplicity, that 1% of 5-year-olds have an animal phobia, and that they never get treated and never grow out of it. This will lead to a prevalence of 1% at all subsequent ages. It would be a mistake, however, to calculate the need for behavioural therapy on the basis that each year 1% of all schoolchildren need therapy for their animal phobia.

If therapy always worked, and if all affected children were treated at the age of 5, the prevalence in schoolchildren would drop to under 0.1% (i.e. 1% of 5-year-olds and 0% thereafter). In other words, an ideal service would need to provide behavioural therapy for animal phobia to under 0.1% of schoolchildren, not 1%. It is important to note that this effect does not apply to palliative treatments, i.e. treatments that only reduce symptoms for as long as they are being given. If there were only palliative treatments for animal phobia, these treatments would potentially be needed by 1% of all schoolchildren, since treatment early in childhood would not reduce the need for treatment later in childhood.

3.1.3 Comorbidity may be relevant

Among children and teenagers with a psychiatric disorder, roughly half have two or more different disorders. Sometimes, each of these disorders needs to be treated in its own right, but there are occasions when it is enough to treat just one disorder. For example, children who are depressed often have anxiety disorders as well, and there is some evidence that treating the anxiety also relieves depression. Imagine, for the sake of simplicity, that adequate treatment of anxiety disorders always resulted in the complete disappearance of any associated depression. If this were so, the need for depression services would be related not to the prevalence of depression, but to the prevalence of depression in the absence of anxiety disorders. Since comorbidity in general is common, this sort of effect could make a large difference to the overall level of service needs.
3.2 What proportion of community cases will attend services?

Epidemiological surveys have repeatedly shown that the majority of children and teenagers in the community who have psychiatric problems get no formal help from anyone; only 10-20% of psychiatrically disordered young people see mental health professionals. In some instances, there are good reasons why the young person has not been referred for professional help: the symptoms are relatively mild, the family are coping well, and the problem is likely to be rapidly outgrown without external help. In many cases, though, it seems likely that families would have welcomed appropriate professional help but local services were not available, accessible, well-publicised or well-respected. Consequently, the proportion of children and teenagers who would attend an optimal CAMHS is likely to exceed the current 10-20%, though falling well short of 100%. This “attendance fraction” is likely to vary from disorder to disorder, being highest for psychotic illnesses, intermediate for disorders like hyperkinesis that impose a heavy burden on parents or teachers, and lowest for emotional disorders that distress the child without resulting in much social impairment for the child or burden for others.

3.3 Evidence-based health provision

The increasing emphasis on evidence-based health provision has much to be said for it. As discussed earlier, clinical experience and common sense are very fallible guides to what works (section 1.3.2, Box 1.2). As far as possible, services should be concentrating their efforts on interventions that have been shown to work. The strongest evidence for an intervention working comes from randomised controlled trials. In their absence, it seems wiser to rely on less secure evidence - such as comparisons of different clinics with attempts to control for confounders - than on no evidence at all. While the value of an evidence-based approach is beyond dispute, several provisos are in order:

3.3.1 Treatments may not work as well in everyday clinical settings

As mentioned earlier (Section 1.3.3), although formal treatment trials
have shown that young people can be helped by some sorts of psychological therapies (mainly behavioural and cognitive), there is persuasive evidence that most psychotherapy for children and teenagers administered in everyday clinical settings is ineffective or almost so. This ineffectiveness reflects several remediable factors: clinics make too little use of behavioural and cognitive approaches; clinics do not rely enough on specific, focused treatment methods; and clinics are relatively unlikely to structure therapy (e.g. through treatment manuals) or monitor therapy to ensure that the therapist adheres to the treatment plan. All these factors can be overcome.

By contrast, little can be done about clinic samples being intrinsically more difficult to help than the sorts of young people treated in research studies, e.g. because many of the children and teenagers referred to clinics have multiple problems or come from families who attend irregularly - characteristics that would lead to exclusion from many clinical trials.

3.3.2 Clinical judgement still has a role

Although it obviously makes good sense to use treatment approaches that have been shown to work in practice, it would be a mistake to think that a mental health service could operate solely on the basis of published treatment trials and protocols. For example, formal trials are usually carried out on children and teenagers who meet the full diagnostic criteria for operationalised syndromes, whereas many clinic cases have diffuse or partial syndromes that do not meet these criteria. In addition, the young person’s or family’s circumstances and preferences may make standard protocols unworkable.

Furthermore, when an individual does not respond to the “first line” treatments supported by trials, there is often little evidence on which (if any) “second line” treatment to try instead. For all these reasons, clinical judgement and improvisation will have a key role for the foreseeable future, with clinicians sometimes needing to extrapolate from the published evidence on what works rather than following published guidelines slavishly.
3.3.3 Accurate assessment is crucial for effective treatment

Effective treatments are not cure-alls; they are effective treatments for specific disorders. Thus methylphenidate is often useful in hyperkinesis but not in generalised anxiety disorder. Similarly, behavioural techniques can cure specific phobias but not acute psychotic episodes. You couldn’t provide just family therapy or just medication for all comers and expect this to work - this would make as little sense as giving out penicillin to everyone who came along to see their GP. The prescription varies with the diagnosis - get the diagnosis wrong and the prescription is liable to be useless or harmful.

3.3.4 Accurate assessment is important even if it does not lead on to treatment

Though treatment is the main role of a CAMHS, it is important to remember that a thorough mental health assessment is sometimes useful in its own right, even if it does not lead on to treatment. An accurate diagnosis can be helpful in many ways, e.g. reassuring families who came for advice because they feared a more serious problem; or providing a “label” that allows the family to join the relevant self-help group; or leading to advice to the education authority that helps the young person get more appropriate schooling.

3.4 Establishing guidelines for rationing

For the foreseeable future, the potential demands on a well-publicised and well-respected CAMHS are always likely to exceed that service’s resources. For example, a few dozen families requesting daily long-term psychotherapy for their children could potentially use up all the resources of a small city’s CAMHS. When making difficult decisions on what to provide within a limited budget, several criteria seem particularly relevant:

3.4.1 Severity

Other things being equal, it seems appropriate to target young people whose symptoms result in particularly marked distress, social impairment, or burden to others.
3.4.2 Likely chronicity

Other things being equal, provision for children and teenagers with problems that are likely to persist should be given greater priority than provision for young people with problems that are likely to improve spontaneously in the near future.

3.4.3 Likely effectiveness and cost-effectiveness

Other things being equal, resources should be directed towards interventions of proven efficacy. The level of benefit per unit cost is also relevant. Future benefits - such as an increased likelihood that the individual will eventually be able to work, or a decreased likelihood of long-term criminality - need to be considered along with current benefits.

3.4.4 Needs of other agencies

Some assessments are needed by courts. Others are needed by education, social services, and voluntary agencies in order to help them to provide appropriate services. The needs of these other agencies should have a high priority when (but only when) mental health professionals have a unique contribution to make. Thus it would not be appropriate to give high priority to assessing a child on behalf of social services if the assessment would more appropriately be carried out by someone within social services or education.

3.4.5 Equality of access

Young people with mental health problems are disproportionately likely to be disadvantaged in other ways too: by poor physical health; by physical disabilities; by generalised learning difficulties (mental retardation); by specific learning difficulties; and by poverty, family adversity, and other forms of social disadvantage. The presence of these associated problems should not lessen an individual’s likelihood of receiving mental health input. Nor should the individual’s gender or ethnicity.

Each of these factors is important, other things being equal. The problem is knowing what to do when different factors pull in opposite directions,
E.g. when a child has a problem that is severe and likely to be persistent but where the evidence for treatment efficacy is relatively weak. There is no easy solution. Since it is unlikely that health commissioners can specify sensible rules to cover all occasions, it seems best to leave some rationing decisions to clinical judgement, provided suitable mechanisms are in place to ensure that clinicians are collectively accountable for these judgements.  

3.5 What age range should be covered?

When does an individual’s mental health stop being the responsibility of CAMHS and become the responsibility of adult services? There is no clear and consistent answer at present. There is widespread agreement that individuals aged 15 or less are the responsibility of CAMHS, and that individuals of 18 or more are the responsibility of adult services, but there is much less agreement about who should be seeing 16 and 17 year olds. In many areas, 16 and 17 year olds are seen by CAMHS if they are still going to school, but by adult services if they have left school. There is some sense in this, but not a lot. If adult services are judged appropriate for unemployed 16 year olds who are still living with their parents, why are adult services not appropriate for 17 year olds who are about to leave the sixth form for university? The issue is particularly tricky since young people’s mental health problems may account for their having left school in the first place. A 16 year old with schizophrenia who dropped out of school during the prodromal phase of the illness may still be better placed on an adolescent unit than on an adult unit, since adolescent units are generally better placed to reintegrate people back into school or college when that is appropriate.

The issue of when adolescent services end and adult services begin is important since, as described subsequently, mental health services for 16 and 17 year olds are disproportionately expensive - so that comprehensive mental health services for individuals up to their 18th birthday may cost around twice as much as similar services that end at people’s 16th birthday. It is for this reason that estimates of services and costs are presented separately for 0-15 year olds and 16/17 year olds. One commissioning
authority may want all 16/17 year olds to be seen by CAMHS; another authority may want all 16/17 year olds to be seen by adult services; a third authority may want to split the group by age, type of disorder or educational status. All these schemes have advantages and drawbacks - the most important thing is that funds follow patients.

**SPECIFICS**

3.6 Four areas of service

The need for CAMHS has been estimated for a catchment area of 250,000 people (children plus adults). These needs are divided between four different sorts of services:

3.6.1 *Core outpatient services* for the assessment and treatment of core mental health problems such as psychosis, anorexia nervosa, obsessive-compulsive disorder or hyperkinesis. These services will be fully funded by the health service, and the staff could be centralised in hospital- or community-based clinics, or could be dispersed through primary health centres, working alongside GPs, health visitors etc.

3.6.2 *Hospital liaison services* primarily covering paediatric liaison and the assessment and psychological management of deliberate self-harm. This too should be fully funded by the health service, but it could potentially be nested within the child health rather than the mental health budget.

3.6.3 *Contributions to “disruptive behaviour” services*. Though social services and education should be the main funders and providers of services for juvenile delinquents and young people with conduct disorders, the health service may also contribute to this service.

3.6.4 *Intensive services* for children and teenagers with core mental health problems requiring more intensive assessment or treatment than can
be provided by an outpatient service. Some of these young people will need in-patient treatment, while others would be suitably placed in well-staffed day hospitals.

**Box 3.1: Estimating provision for any given disorder:**

\[
P = N \cdot a \cdot I
\]

where:

- **P** is the level of planned provision for that problem in a catchment area with a total population of 250,000 (children plus adults).

- **N** is the likely number of eligible children and teenagers with any given “core” problem in the catchment area. This is estimated from the epidemiological literature, after allowing for the various complicating factors described in Section 3.1.

- **a** is the likely attendance fraction, i.e. the estimated proportion of eligible children and teenagers who would be referred to, and then attend, a well-publicised and well-respected service. As described in Section 3.2, the fraction is assumed to vary from disorder to disorder. The values used are clinically informed guesses, and are clearly error prone.

- **I** is the estimated input from child mental health professionals per case per year. This is based on a review of the evidence on treatment efficacy, allowing for the complicating factors described in Section 3.3. For a curable disorder such as a specific phobia, the input is one course of curative treatment. For a chronic disorder that has a palliative treatment - such as medication and behavioural treatment for hyperkinetic disorder - the input is the initial assessment followed by long-term treatment reviews and top-ups.
<table>
<thead>
<tr>
<th>Disorder</th>
<th>Estimated Prevalence</th>
<th>Number</th>
<th>Attendance Fraction</th>
<th>Recommended Treatments</th>
<th>Average Input Per Case</th>
<th>Staff Input Needed (Whole-Time Equivalents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperkinesis (ADHD)</td>
<td>1% of 5-15 year olds</td>
<td>350</td>
<td>50%</td>
<td>Medication, Diet, Behavioural Therapy</td>
<td>20 new assessments per year, Regular review of medication or diet, 10 behavioural sessions</td>
<td>0.2 Medical input, 0.2 BCI therapy</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>0.2% of 5-15 year olds</td>
<td>70</td>
<td>50%</td>
<td>Medication, Cognitive-behavioural therapy</td>
<td>4 new assessments per year, Regular review of medication, 15 CBT sessions</td>
<td>0.1 BCI therapy, 0.05 Medical input</td>
</tr>
<tr>
<td>Anorexia Nervosa</td>
<td>0.2% of 11-15 year old girls</td>
<td>17</td>
<td>50%</td>
<td>Family Therapy, Monitoring mental and physical state</td>
<td>20 sessions of family therapy, Regular physical and mental state examinations</td>
<td>For 0-15 year olds: 0.4 Family therapy, 0.1 Medical input For 16/17 year olds: 0.8 Family therapy, 0.2 Medical input</td>
</tr>
<tr>
<td></td>
<td>1% of 16/17 year old girls</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>1% of 11-15 year olds</td>
<td>175</td>
<td>20%</td>
<td>Cognitive-behavioural therapy, Interpersonal therapy, Medication (in a minority)</td>
<td>10 sessions of CBT or IPT, Regular monitoring of mental state (and medication)</td>
<td>For 0-15 year olds: 0.4 BCI therapy, 0.2 Medical input For 16/17 year olds: 0.6 BCI therapy, 0.3 Medical input</td>
</tr>
<tr>
<td></td>
<td>4% of 16/17 year olds</td>
<td>280</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific or Social Phobia</td>
<td>3%</td>
<td>100</td>
<td>20%</td>
<td>Behavioural therapy</td>
<td>10 sessions</td>
<td>0.15 BCI therapy</td>
</tr>
<tr>
<td>Condition</td>
<td>Prevalence</td>
<td>17 new cases per year</td>
<td>40%</td>
<td>Cognitive-behavioural therapy</td>
<td>10 sessions</td>
<td>0.05 BCI therapy</td>
</tr>
<tr>
<td>-----------</td>
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<td>------------------------</td>
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<td>--------------------------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>0.5% cumulative prevalence by 16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
<th>200 new cases per year</th>
<th>20%</th>
<th>Cognitive-behavioural therapy</th>
<th>15 sessions</th>
<th>0.4 BCI therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalised Anxiety and Separation Anxiety</td>
<td>4% of 3-15 year olds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
<th>3</th>
<th>100%</th>
<th>Medication</th>
<th>New assessments, then monthly reviews</th>
<th>15 sessions of family work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>0.3/10,000 among 0-15 year olds</td>
<td></td>
<td></td>
<td>Family Work</td>
<td></td>
<td>For 16/17 year olds: 0.4 Family therapy 0.2 Medical input</td>
</tr>
<tr>
<td></td>
<td>15/10,000 among 16/17 year olds</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
<th>40</th>
<th>50%</th>
<th>Behavioural therapy</th>
<th>7 new assessments per year and ongoing reviews/therapy</th>
<th>0.1 BCI therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autistic Disorders</td>
<td>0.1% without mental retardation</td>
<td></td>
<td></td>
<td>Social skills training</td>
<td></td>
<td>0.03 Medical input</td>
</tr>
<tr>
<td></td>
<td>0.2% with mental retardation</td>
<td>80</td>
<td>80%</td>
<td>Medication (occasionally)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
<th>40</th>
<th>80%</th>
<th>Behavioural therapy</th>
<th>3 new assessments per year and ongoing reviews/therapy</th>
<th>0.05 BCI therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-autistic mental health problems associated with severe mental retardation</td>
<td>0.1%</td>
<td></td>
<td></td>
<td>Medication (occasionally)</td>
<td></td>
<td>0.02 Medical input</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
<th>280</th>
<th>15%</th>
<th>Behavioural therapy</th>
<th>5 sessions</th>
<th>0.2 BCI therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool mental health problems</td>
<td>For 3-4 year olds: 3% moderate 1% severe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.7 Core outpatient services

Table 3.1 summarises the estimated level and type of provision for the most important core mental health disorders. Provision for each type of disorder has been calculated by multiplying the likely number of “customers” by the estimated input per customer, following the method described in more detail in Box 3.1. For each disorder, this process has been used to estimate how much clinical input is needed under three broad headings:

3.7.1 Medical input is needed to provide the sorts of assessments and treatments that generally require a medical training, e.g. for pharmacotherapy. This input will usually come from child psychiatrists, though the same tasks could potentially be divided between paediatricians and general psychiatrists. The relatively small need for dietary therapy has not been listed separately and has been included as a medical input, though it could potentially be provided not by doctors but by dieticians, nurses or clinical psychologists instead.

3.7.2 Behavioural, cognitive and interpersonal (BCI) therapies are grouped together because they share several important features: they are psychological therapies that tend to focus on the individual rather than the family as a whole; they concentrate on the here-and-now rather than delving into the past in search of supposed causes; they offer practical techniques and not just “support”; they can often be delivered as standard treatment packages with detailed manuals for guidance; and they are supported by a growing body of outcome studies. Within the health service, these BCI therapies can be delivered by appropriately trained clinical psychologists, psychology assistants, nurses or psychiatrists.

3.7.3 Family therapy is a class of psychological therapy that usually focuses on the family system as a whole rather than just on the family member with the identified problem. In the health service, family therapy can be delivered by specialised family therapists, or by appropriately trained psychiatrists, nurses or clinical psychologists.
What about the other professions that are sometimes included in CAMHS? The current evidence does not convincingly show that psycho-dynamic psychotherapy, play therapy, occupational therapy, art therapy, drama therapy or music therapy are “best buys” for any of the core mental health disorders in childhood or adolescence. Cost-conscious commissioners may be reluctant to opt for these therapies until there is better evidence for their effectiveness and cost-effectiveness. At present, even the best studies of these therapies provide only circumstantial evidence for effectiveness. For example, one carefully conducted study reviewed the case notes of children whose emotional disorders were treated with around 300 hours of psychoanalysis each, reporting rates of improvement that were thought to be better than the spontaneous remission rate - a rather imperfect substitute for a controlled trial. By contrast, there is much better evidence that the same sorts of disorders can be helped by less than 20 hours of BCI therapies. It is hard to escape the conclusion that BCI therapies are better buys than psychoanalysis.

The total amount of professional input needed for the core outpatient service has been calculated by totalling the needs for the specified problems and then adding an uplift to allow for other professional duties, following the method described in more detail in Box 3.2. The staff needs calculated in this way are summarised in Table 3.2. For the reasons discussed in Section 3.5, these needs are reported separately for 0-15 year olds and 16/17 year olds. The disproportionately high input to 16/17 year olds is largely due to their relatively high rates of three sorts of core mental health problems that can be expensive to treat, namely anorexia (and bulimia) nervosa, psychotic illnesses, and severe depression. The estimated number of clerical and administrative staff is based on two assumptions that have opposite effects on the need for administrative support. The first assumption, which reduces the need for routine audio typing, is that the clinical staff will have the skills and equipment to produce many of their own letters and reports. The second assumption, which increases the need for administrative support, is that administrative staff will take a leading role in standardised data gathering to facilitate assessment and audit, e.g. sending parents, teachers and young people standardised questionnaires before and six months after the first assessment.
Box 3.2: Estimating staff needs for all disorders combined:

\[ S = m \Sigma P \]

where:

\( S \) is the level of staffing required in each of the three domains (medical input, BCI therapy, and family therapy).

\( \Sigma P \) is the sum of the estimated provision (P) for each of the problems considered separately in Table 3.1, and calculated as described in Box 3.1.

\( m \) is a multiplier to allow for activities that take up professional time over and above the time needed for the assessment and treatment work listed in Table 3.1. This multiplier has somewhat arbitrarily been set at 2 (i.e. a 100% uplift) to cover additional professional time needed:

1) For assessments of young people who did not turn out to have a disorder warranting treatment. For example, a child referred with suspected hyperkinesis may not have this but may turn out to have specific learning problems requiring input from education rather than health.

2) For seeing children and teenagers who have core mental health problems that are not considered separately in Table 3.1, e.g. anorexia nervosa is a core problem that is included in Table 3.1 while bulimia nervosa is a core problem that is not included in Table 3.1.

3) For consultation, meetings, administration, audit, teaching, supervision and continuing professional education.
### 3.8 Hospital liaison service

Estimates are based on notional catchment area of 250,000 people that is served by a District General Hospital (DGH) that houses the Accident and Emergency department, the paediatric wards, and paediatric outpatients. Mental health liaison work will include:

#### 3.8.1 Assessment and management of self-harm

Children commonly take poisons by accident - this is not a mental health problem. By contrast, when teenagers deliberately harm themselves - e.g. by taking an overdose or cutting themselves - this can be due to a mental health problem such as severe depression. Even in adolescence, though, the majority of deliberate self-harm is not due to mental health problems; the episode is typically an impulsive act driven by a desire for temporary respite from distressing circumstances (functioning rather like getting drunk) or a wish to influence family and friends. It is rarely a “cry for help” directed at professionals, which is one reason why offers of help from professionals are commonly rejected. Though all “parasuicides” should be screened for mental health problems, only a minority will have

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**Table 3.2: Estimated Staff Needs**

<table>
<thead>
<tr>
<th>Service</th>
<th>0-15 year olds</th>
<th>Additional Input to cover 16/17 years olds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Outpatient Services</td>
<td>3.3 BCI therapists</td>
<td>1.2 BCI therapists</td>
</tr>
<tr>
<td></td>
<td>1.3 Psychiatrists</td>
<td>1.4 Psychiatrists</td>
</tr>
<tr>
<td></td>
<td>1.0 Family therapist</td>
<td>2.4 Family therapist</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Liaison</td>
<td>1.0 BCI therapist</td>
<td>1.2 BCI therapists</td>
</tr>
<tr>
<td></td>
<td>0.2 Psychiatrist</td>
<td>1.4 Psychiatrists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.4 Family therapist</td>
</tr>
<tr>
<td>Contribution to Disruptive Behaviour Service</td>
<td>1.0 BCI therapist</td>
<td>1.2 BCI therapists</td>
</tr>
<tr>
<td></td>
<td>0.2 Psychiatrist</td>
<td>1.4 Psychiatrists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.4 Family therapist</td>
</tr>
<tr>
<td>TOTAL (excluding intensive services)</td>
<td>5.3 BCI therapists</td>
<td>1.2 BCI therapists</td>
</tr>
<tr>
<td></td>
<td>1.7 Psychiatrists</td>
<td>1.4 Psychiatrists</td>
</tr>
<tr>
<td></td>
<td>1.0 Family therapist</td>
<td>2.4 Family therapist</td>
</tr>
<tr>
<td></td>
<td>2.0 Secretaries</td>
<td>1.5 Secretaries</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
mental health disorders warranting treatment. As a guideline to need, the Accident and Emergency department of a DGH may deal in an average week with one episode of deliberate self-harm in a person aged under 16 and one episode in a 16/17 year old.

3.8.2 A contribution to psychosomatic work
Psychological factors play an important part in many of the disorders seen by paediatricians, e.g. stress may be a major determinant of recurrent abdominal pain or headache, and can sometimes exacerbate asthma or diabetes. Managing both the physical and psychological side of these disorders is an intrinsic part of good paediatric practice. It would not be in the interests of either patients or paediatricians to undermine this holistic practice by defining paediatrics as purely physical and bringing in mental health professionals whenever there seemed to be a psychological component. Nevertheless, there are some complex cases where paediatricians feel out of their depth and welcome consultation or hands-on help from a mental health professional.

3.8.3 Facilitating physical assessments and treatments
If children with problems such as leukaemia become very distressed by blood tests, transfusions, or other physical procedures, this makes life much harder for the child, the family, and clinical staff. In many such cases, the child can be helped by psychological techniques such as desensitisation, relaxation training, “self-hypnosis” or guided imagery. Similarly, if a child is afraid of having a brain scan, psychological management may be a better response than a sedative or anaesthetic.

Most of the clinical work entailed by these three roles could be handled by a full-time BCI therapist, supplemented by two sessions per week of medical input to cover aspects of liaison work that require a psychiatric training. This makes no allowance for a DGH’s need for liaison for child abuse cases since, as discussed earlier, these needs will most appropriately be met by direct liaison with social services.

3.9 Contributing to a “disruptive behaviour” service.
Conduct disorders and juvenile delinquency are important and common
problems that carry a high social cost. As discussed in Chapter 2, however, these problems are usually best seen as social and educational problems needing social and educational solutions; there is often no identifiable health component. The sorts of treatment approaches that have been shown to work—such as parent management training, multisystemic therapy and whole-school policies to reduce bullying—can be implemented by many different professionals, including social workers and educational psychologists as well as mental health professionals. Health commissioners and providers will be disadvantaging young people with core mental health problems if they divert scarce resources into providing a comprehensive “disruptive behaviour” service that is 100% health funded. A fairer alternative is a health-funded service that is restricted to children and teenagers whose disruptive behaviours are clearly stemming from, or leading to, core mental health problems. An even more attractive option is a comprehensive service for children and teenagers with disruptive behaviours funded primarily by social services and education, with part funding from health too. How large should the health service’s contribution to such a tripartite service be? A full-time BCI therapist plus two sessions per week of medical input would be a generous input for a “disruptive behaviour” service covering a 250,000 catchment area, easily covering the distinctive health component of the service’s assessment and treatment work.25 Alternatively, if it were not possible to negotiate tripartite funding for a comprehensive “disruptive behaviour” service locally, the same number of clinical sessions of medical and BCI input could be added to the core outpatient service; this would enable the core service to provide a restricted service for disruptive behaviours, assessing and treating only those disruptive behaviours that stemmed from, or led to, core mental health problems.

### 3.10 Intensive services

For some children and teenagers with severe mental health problems, outpatient services are not intensive enough. For young people presenting with severe and puzzling symptoms, a period of in-patient assessment may help clarify the diagnosis. The young person may also need to be treated as an in-patient when symptoms are severe and the family’s
capacity to cope has been exceeded. Depending on the young person’s age, the nature of the disorder, and local circumstances, in-patient admission may involve a paediatric ward, a child or adolescent psychiatric ward, or an adult psychiatric ward. Child and adolescent psychiatric wards are often the most expensive option, reflecting their extra facilities (including on-site schooling) and their particular emphasis on rehabilitation. In some instances, a five-days-per-week placement on a child or adolescent day care unit may be a suitable alternative. For adults with acute psychotic illnesses, the need for in-patient beds can be reduced by the availability of intensive round-the-clock community services. Can this model be applied to similar illnesses in adolescence? One problem here is that adolescent psychoses are too rare to justify a district service just for adolescents, while a regional community service for adolescents would usually be covering an unworkably large geographical area. In some instances, adolescents with adult-type disorders may best be treated by adult community services, in consultation with the local CAMHS.

Estimating the need for intensive services is particularly tricky since the level of provision across the country is very variable, without enough evidence to identify the optimum level. Furthermore, the need for intensive services is dependent on the quantity and quality of outpatient services. For example, teams with particular expertise in the outpatient management of eating disorders can successfully treat teenagers whose anorexia nervosa would have needed in-patient admission in districts without specialised outpatient services. The need for intensive mental health services for seriously disturbed children and teenagers also depends on how rapidly other agencies respond to these young people’s educational and social needs. It is not uncommon for children and teenagers to spend considerably longer than necessary on in-patient wards because their families cannot cope with them being discharged until a suitable school placement is found, or until social services support is arranged - and the requisite educational and social package may take a long time to assemble. With efficient educational and social services, and with high-quality core outpatient services, the average need for intensive services for a catchment area of 250,000 people is probably around one
in-patient bed for young people aged 0-15, plus an additional three in-patient beds for 16/17 year olds. The need for beds would be reduced by the availability of intensive day-care or intensive community care.

4. How Should Services Be Provided?

Having decided what sorts of treatments and assessments to provide and for whom, it is still necessary to decide how best the service can be delivered, and by whom. The aim is to make services as effective, economical, accessible and widely available as possible.

Four tiers of service?

Health provision has traditionally been divided into primary, secondary and tertiary services. In this sensible scheme, primary services refer to provision by GPs, health visitors and so on; secondary services refer to outpatient and in-patient provision of specialist services at a district level; and tertiary services refer to outpatient and in-patient provision of highly specialised services at a regional or national level. The same three levels of service apply to child and adolescent mental health provision. Advice from a health visitor on the management of a preschool child’s separation anxiety is an example of primary provision. Treatment of hyperkinesis with behavioural therapy and medication at the local CAMHS is an example of secondary provision. In-patient treatment for a psychotic 15-year-old in the regional adolescent unit is an example of tertiary provision. At times, both in physical and mental health care, the distinction between the three levels of service is deliberately blurred, e.g. with district specialists doing some sessions in primary health care settings, or with regional specialists holding some district clinics. Of late, official reports have increasingly talked not about primary, secondary and tertiary services but about four tiers of service.1 Tier One includes primary health services plus the work of other governmental and voluntary agencies for distressed and maladjusted youngsters; Tier Two and Tier Three largely correspond to secondary services; and Tier Four refers to tertiary services. This scheme has not been adopted for two reasons: the over-inclusive nature of Tier One hinders clear thinking; and
the division of secondary services into Tier Two (which is uniprofessional) and Tier Three (which is multidisciplinary) seems unjustified and inflexible.

4.1.1 *Tier One is over-inclusive*

As discussed in Chapter 2, many governmental and voluntary agencies help distressed and maladjusted children and teenagers. Defining all this work as Tier One mental health work extends the notion of health too far. Cynics might wonder if the underlying motivation is to hide the virtual absence of primary health care for children and teenagers with core mental health problems - with the noteworthy exception of health visitors’ contribution to the assessment and treatment of preschool problems. Though GPs spend much of their time seeing children and teenagers, and though many of these children and teenagers do have psychological problems (only some of which are core mental health problems), there is little reason to think that GPs are good at recognising these problems, treating them, or referring them on to appropriate specialists in social services, education, the mental health service, or the voluntary sector. A clearer division of labour between the various agencies working with maladjusted and distressed children and teenagers would make it easier for GPs to decide who should be referred to whom and for what. So too would strengthened postgraduate education. The notion that some generic child and adolescent mental health workers should be attached to primary health centres is appealing but unproven - formal trials are certainly warranted but widespread adoption of this practice is not currently justified.

4.1.2 *Tiers Two and Three should not be separated*

Dividing secondary services into those that involve just one professional discipline (Tier Two) and those that involve a variety of disciplines (Tier Three) is perhaps best seen as a response to decades of inter-professional rivalries; it is not a particularly sensible distinction as far as young people, families or referrers are concerned. Although it is true that many children and teenagers can be adequately assessed and treated by a single clinician,
it is often unclear at the time of referral if this will be so or not. Many multidisciplinary clinics adopt the practice of having one clinician carry out the very first assessment, sometimes continuing single-handed, and sometimes drafting in colleagues from other disciplines to provide advice, further assessment or treatment. Alternatively, the initial assessment may be multidisciplinary, leading on to single-handed treatment where appropriate. By contrast, segregated uniprofessional (Tier Two) services are likely to promote inflexible and fragmented provision. For example, if a boy is referred along by his GP to a Tier Two clinical psychology service, and if it turns out that the boy would ideally have needed 90% psychology input and 10% child psychiatry input, will he end up missing out on the distinctively psychiatric input he needed, or will he be re-referred to a Tier Three service? Referrers cannot reasonably be expected to distinguish between cases that need 100% psychology input and those that need 90%. Young people and their families are unlikely to welcome having to begin again with a new assessment and new staff if referred on from Tier Two to Tier Three services. These considerations favour the retention of an integrated multidisciplinary team at secondary level, without splitting it into Tier Two and Tier Three services. Many of the children and teenagers attending such a team will have most or all of their contact with just one professional, but the system will be flexible enough to accommodate various sorts of multidisciplinary working too - with clinicians from other disciplines providing consultation, one-off assessments, periodic reviews, or regular co-therapy.

4.2 Getting the skill mix right

The balance of cost and effectiveness is optimised by the right mix of professions and skill levels. Using under-qualified or inappropriate staff reduces effectiveness while using over-qualified staff pushes up cost unnecessarily. The point can be illustrated by considering behavioural, cognitive and interpersonal (BCI) therapies - the largest single component of the model service recommended here. A team of psychology assistants with minimal supervision would be cheap, but they would not be able to deliver the full range of BCI treatments since they would lack the experience and training to handle complex cases. By contrast, a team of
consultant clinical psychologists with the relevant experience and training might end up costing three times as much to employ. The greatest benefit per unit cost is likely to result from a mixture of professions and skill levels, e.g. a mixture of psychology assistants, recently qualified clinical psychologists, nurse behavioural-therapists, and long-established clinical psychologists.

4.3 Using doctors effectively and economically

Doctors have an important role in CAMHS. At the very least, they are needed to provide the medical input summarised in Tables 3.1 and 3.2. Traditionally, child psychiatrists have done this and more besides. Most child psychiatrists have been double trained, qualifying in medicine and continuing to draw on their medical skills while also acquiring specialist experience in one or more of the psychological approaches to assessment and treatment, e.g. in family therapy or cognitive therapy. Consequently, it would in theory be possible to have a CAMHS entirely staffed by child psychiatrists, with them providing all the BCI and family therapy as well as all the medical input. Since doctors are more expensive to train and employ than any other sort of mental health professional, this would not be an economical service. At the other extreme, it would be possible to reduce the number of doctors employed in CAMHS to a minimum by employing child psychiatrists (or a mixture of paediatricians and general psychiatrists) purely to cover the need for medical input, leaving all the BCI and family therapy to non-medical therapists. At first sight this seems the most economical solution. It is possible, however, that employing a dual-trained doctor to provide both medical and psychological input is sometimes particularly good value for money. For example, a child psychiatrist who can administer both medication and behavioural therapy to a child with obsessive-compulsive disorder may sometimes be preferable to the combination of a paediatrician to administer the medication and a psychologist to administer the behavioural therapy. Having all the treatment administered by a single individual is potentially more efficient in many ways, avoiding the need to enquire twice about recent changes, and dispensing with the need for extra meetings to coordinate different treatments.¹⁴
4.4 Partnership with self-help groups

Parents often find it extremely helpful to join the support group for their child’s specific type of disorder, e.g. autism or hyperactivity. These voluntary groups provide mutual support and useful information through meetings, social occasions, newsletters and conferences. The children and teenagers themselves may benefit directly or indirectly. When there is no local self-help group for some particular disorder or set of related disorders, child mental health professionals are well placed to invite potentially interested families to create one. Supporting the work of a self-help group - by hosting meetings, providing speakers, contributing to newsletters, and so on - can be a very economical way of providing these families with help and information. In turn, the families can provide a particularly valuable source of ideas (and sometimes even funds) for improving clinical services.

4.5 Isn’t prevention better than cure?

It is obviously better to prevent the autistic problems associated with congenital rubella or phenylketonuria through immunisation programmes and neonatal screening than to let the problems develop and then try to treat them. There are, however, no preventative strategies of proven worth for the great majority of core child mental health problems (though there are hints that some preventative strategies may reduce the rate of disruptive behavioural problems). For the present, therefore, the money spent on treatments of proven value would not sensibly be diverted into preventative programmes of uncertain efficacy.

There is a stronger case for what is sometimes called secondary or tertiary prevention, namely the early identification and treatment of core mental health problems before they become severe and chronic, or result in secondary handicaps such as loss of friends, or under-achievement at school. CAMHS face the difficult challenge of trying to attract cases before they have become severe and persistent, without being overwhelmed by enormous numbers of children and teenagers who have mild self-limiting problems.
5. Designing A System That Will Go On Improving

There is no such thing as a perfect service - only better and worse approximations to that ideal. Each service, therefore, should be designed to be improvable, with mechanisms in place to help it evolve into a better approximation to the ideal.

5.1 Evaluation and audit

Clinics are losing vital information on how to improve if they do not routinely monitor the outcome of every young person they see. Quick-to-complete outcome measures will usually be satisfactory, provided they are supplemented and validated by more detailed measures on a minority. Ratings by the clinician who worked with the young person and their family will often be valuable, but they do need to be supplemented by independent outcome measures to verify that clinicians are not just giving themselves “a pat on the back”.28 For example, if the clinician thinks that treatment for a child’s hyperactivity has reduced symptoms and improved classroom learning, is this in line with the observations of parents, teachers, the child and the referrer? Establishing this need not be very time-consuming - brief questionnaires sent out before and several months after the first assessment will often be all that are needed.

The desirability of clinical audit is now generally accepted. There is often considerable educational value in reviewing randomly chosen and “poor outcome” cases at regular audit meetings. The value of these meetings could be increased by inviting in “guest auditors” from outside the CAMHS, e.g. from education, social services, general practice, paediatrics and public health. It will be important to explore ways of incorporating the views of parents, children and self-help groups into the audit process without undermining confidentiality.

The satisfaction of “customers” - whether families, referrers or other agencies - is clearly an important measure of success, but it is worth remembering that the degree of satisfaction may not correlate all that highly with the effectiveness of treatment. Families may be pleased with
a treatment that was probably ineffective, or may be unhappy with the way in which an effective treatment was delivered. Commissioners and providers will naturally be interested to know how far the service meets the twin goals of being effective and satisfying customers.

5.2 Innovation

Each service needs to modify its practice in the light of feedback and new research findings - and then monitor these changes to see if they have worked. With so much still to learn about which treatments work for which patients, there is a strong case for harnessing the research potential of every CAMHS throughout the country. Research is not a peripheral occupation to be left to academics.

Clinicians everywhere need to be able to interpret research findings: Are the findings convincing? What are their limitations? What are their implications? Involvement in research is an excellent way of learning about the strengths and weaknesses of research findings. In addition, when clinics participate in multi-centre trials, this often imparts useful assessment, treatment and outcome-evaluation skills - and helps staff feel in the mainstream instead of a backwater. For both staff and patients, there is also generally considerable satisfaction in participating in research that is designed to make the future better than the present. For all these reasons, commissioners and providers will want to foster a research culture and facilitate academic links.

Once most CAMHS are actively involved in research, it will be possible to mount the sorts of collaborative and comparative trials that have revolutionised the treatment of childhood leukaemia. Leukaemia treatment used to make little difference, whereas it now cures most affected children. This is only partly due to the discovery of new drugs and radiotherapy techniques. Most of the improvement in survival has been brought about by nationally coordinated trials that have shown how best to combine and target treatments that have been around for a long time. There is no reason why the same sorts of trials should not similarly revolutionise the treatment of young people’s mental health problems.
6. How Much Would A Model Service Cost?

Method

Indicative costings have been calculated for the sort of model CAMHS described in the preceding chapters. For three of the four components of the service - core outpatient services, liaison, and disruptive behaviour services - costs are calculated as direct staff costs plus 60% overheads to cover premises, heating, lighting, telephone charges, stationary, postage, equipment, medication, and special investigations.29 The cost of the intensive service is calculated on the basis of current extra-contractual referral charges for adolescent unit beds.30

These costings are necessarily indicative rather than precise. For one thing, overheads will vary markedly from one area to another, e.g. depending on the age of clinic buildings and on local property values. Furthermore, areas may vary significantly in their need for CAMHS. For example, socio-economically deprived areas are likely to need relatively higher provision, though the link with social disadvantage is less marked for core mental health problems than for disruptive behaviours and delinquency.31

Indicative costs

Table 6.1 summarises the indicative costings for a catchment area with 250,000 people, presenting the costs separately for 0-15 year olds and 16/17 year olds. These costs are not exorbitant. Thus the cost of the mental health service for 0-15 year olds amounts to roughly £10 per year per individual covered, which is in line with expenditure on existing services (see Section 1.1). Though provision for 16 and 17 year olds is more expensive pro rata, amounting to around £90 per individual covered, this too is within the range of existing services’ expenditure on adults (see Section 1.1). Since costs are not outside the current range of expenditure, there seems no financial reason why excellent CAMHS should not be available in every health district throughout the country.
Table 6.1: Indicative Costs

<table>
<thead>
<tr>
<th>Service</th>
<th>0-15 year olds</th>
<th>Additional Input to cover 16/17 years olds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Outpatient Services</td>
<td>£340,000</td>
<td>£340,000</td>
</tr>
<tr>
<td>Hospital Liaison</td>
<td>£75,000</td>
<td></td>
</tr>
<tr>
<td>Contribution to Disruptive Behaviour Service</td>
<td>£75,000</td>
<td></td>
</tr>
<tr>
<td>Intensive Services</td>
<td>£100,000</td>
<td>£300,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£590,000</td>
<td>£640,000</td>
</tr>
</tbody>
</table>

7. Conclusions

This discussion document began by noting the wide geographical variation in spending on child and adolescent mental health services (CAMHS). Both high and low spending authorities have a case to make. Having reviewed the evidence, there do seem to be solid arguments on each side. On the one hand, there are two pertinent arguments for low spending: firstly that traditional CAMHS have taken on many tasks that should be the province of education and social services; and secondly that traditional CAMHS are of uncertain efficacy irrespective of their level of funding. On the other hand, there are also two strong arguments for high spending: firstly that effective treatments do now exist, and secondly that the human and financial costs of untreated child and adolescent mental health problems are high. Taken together, these arguments suggest that traditional CAMHS need to be rethought by defining their remit more carefully and by focusing their efforts on treatments of proven efficacy; and that once this has happened, these services will be eminently worth funding. This document has presented one possible blueprint for an evidence-based service that is likely to be both effective and cost-effective; the associated costs would be within the current range of expenditure on CAMHS, albeit towards the upper end. Hopefully commissioners will agree that funding this sort of service will be money well spent.
ENDNOTES


(2) NHS Executive North West (1997).

(3) Reviewing epidemiological studies of child and adolescent psychiatric disorders published in the 1980s, Brandenburg et al (1990) found that the overall prevalence estimates of moderate to severe disorders ranged from 14 to 20%. Most subsequent studies have reported fairly similar rates, e.g. Fergusson et al, 1993; Shaffer et al, 1996; Newman et al, 1996; Simonoff et al, 1997. Reported rates are very sensitive to the exact definition of “caseness” used. How severe do symptoms need to be to make a person a “case”? Do the symptoms have to result in social impairment? Several studies have found that if DSM-III or DSM-III-R criteria are used without supplementary impairment criteria, around half of all children and teenagers in the community have psychiatric disorders (Bird et al, 1988; Shaffer et al, 1996; Simonoff et al, 1997).

(4) For example, Meltzer et al (1995).

(5) A variety of physical and psychological treatments for child and adolescent mental health problems have repeatedly been shown to be effective in well-conducted controlled trials (Phillips, 1997).

(6) Child and adolescent mental health problems undoubtedly have sequelae in adult life. For example, hyperkinetic children are at increased risk of impaired social adjustment in adult life (Taylor et al, 1996). Similarly, depression in adolescence is often followed by depression in adult life (Harrington, 1993). In the Dunedin longitudinal study, over 70% of young adults with psychiatric disorders had a developmental history of mental
disorders (Newman et al, 1996). While it is clear that child and adolescent mental health problems often lead on to later adult problems, it is less clear whether successful early treatment of the young person’s problems would have reduced subsequent adult problems - the case is certainly plausible but it needs to be tested empirically rather than simply accepted as an item of faith. Is it conceivable that early treatment might not prevent long-term problems? Unfortunately it is. For example, if childhood hyperactivity were due to underlying neurological abnormalities, and if childhood treatment reduced symptoms without altering these underlying abnormalities, it is conceivable that the individual would still have symptoms due to these abnormalities in adulthood however well symptoms had been suppressed in childhood. This is not a reason to abandon treatment in childhood - reduction in symptoms is potentially valuable at any age, even if it does not alter the long-term outcome.


(9) One example of an under-used treatment is the low rate of prescription of stimulant medication in Britain for the treatment of hyperkinesis (Taylor et al, 1991). Large numbers of well-conducted trials have shown that stimulants substantially reduce inattention and restlessness in a high proportion of hyperkinetic children (Phillips, 1997), and yet only a small minority of hyperkinetic children in Britain have ever been tried on stimulants, and many British child psychiatrists never or rarely prescribe them. Though stimulants have been over-prescribed in some countries (and by some doctors in Britain), we should surely be aiming to prescribe appropriately rather than go to the opposite extreme. Medication may only be one component of a treatment package for hyperkinesis, but it is an effective component that is often inappropriately withheld.
Reviewed in Bickman (1996). Bickman comments that the Fort Bragg results “are consistent with the findings from similar child and adolescent mental health services research. Recent studies have found that changes in the service delivery system (e.g. case management) do result in different services being received, but no study has reported a significant consistent enhancement in clinical outcomes. This and similar research suggest that the mental health field has skipped over a whole generation of research in moving directly from the laboratory-based treatment efficacy studies to system reform efforts without sufficiently studying the effectiveness of clinical services as delivered in community settings” (p.699).

This and related issues are discussed at somewhat greater length in Goodman (1997a), with accompanying commentaries.

There are many other possible a priori rules for defining the remit of the health service. New and Le Grand have recently suggested that the combination of three characteristics sets health care apart: fundamental importance, information imbalance, and uncertainty (New, 1997). Klein (1997) has argued against this. It seems unlikely that New and Le Grand’s criteria would help clarify the remit of CAMHS. The social management of child abuse or the educational management of learning difficulties are characterised by fundamental importance, information imbalance, and uncertainty. It seems unreasonable to conclude that the health service should therefore take over from social services or education the management of all child abuse and learning difficulties.


This and related issues are discussed at somewhat greater length in Goodman (1997b), with accompanying commentaries.


Kendall (1994)

In the original Isle of Wight epidemiological survey, only 10% of 11 year olds with psychiatric disorders were under psychiatric care, and most were receiving no help of any kind (Rutter et al, 1970). In the Ontario Child Health Survey, 16% of 4 to 16 year old children with psychiatric disorders had received some help in the previous 6 months from mental health or social services (Offord et al, 1987). In the Christchurch Health and Development Study, only 21% of 15 year olds with psychiatric disorders were in contact with any service for their problems (Fergusson et al, 1993). In the MECA study, only 16% of 9 to 17 year olds with a psychiatric disorder had received specialist mental health treatment in the previous year - a proportion that rose to 25% if “caseness” was defined in terms of significant social impairment in addition to meeting symptom criteria (Leaf et al, 1996). In the Great Smoky Mountains Study of children aged 9 to 13, most children with mental health needs were not receiving professional help for their problems, and the minority who were receiving help were mostly getting it from the education sector; only 20% of children with a psychiatric disorder and significant social impairment were in contact with specialist mental health services (Burns et al, 1995).

Though most commentators accept that rationing in health care is inevitable, this is not openly acknowledged by most politicians, who choose to focus instead on increasing the effectiveness of health care (Smith, 1996). While there seems little doubt that commissioners probably could get better value for the money they currently spend on CAMHS - and this discussion document is about ways to achieve this - it seems unlikely that providing better value for money will free up enough resources to enable the full range of beneficial treatments to be available without restriction to all those
who could potentially be helped by them. Indeed, it may not make good sense to do so. For example, providing expensive treatments of marginal effectiveness may well be a less appropriate use of public funds than implementing other measures that directly or indirectly promote young people’s wellbeing: improving schools and social service provision, increasing employment, reducing poverty, and so on.

(20) Some would argue that there is a case for positive discrimination, directing CAMHS preferentially towards those children and teenagers who are multiply disadvantaged. For example, when a child with cerebral palsy and learning difficulties develops mental health problems too, this can be the “last straw” for a family that is already stretched to its limit. Many people would agree that it was right to treat this child’s mental health problems with greater intensity or urgency than similar problems occurring in a child without additional physical or learning problems. Arguably, though, this would not be positive discrimination but simply the application of rationing according to severity (Section 3.4.1), since the “same” mental health problem in a multiply disadvantaged child results in disproportionately greater social impairment or burden for others, and therefore warrants a disproportionately greater input in any case.

(21) Klein (1997) summarises the reasons for thinking that no set of rules will cover all eventualities, generating a need for devolved but accountable decision making.

(22) Phillips (1997)

(23) Target and Fonagy (1994)

(24) Paediatric in-patient and outpatient units can potentially generate almost unlimited liaison work for appropriately skilled clinical psychologists or other BCI therapists, who rapidly come to be seen as indispensable members of the paediatric team. Consequently,
the current estimate of need is conservative - there is a strong case for evaluating the relative costs and benefits of more generous provision.

(25) As part of a tripartite service for disruptive behaviours, the health-funded clinicians would be involved in assessments of the core mental health disorders commonly associated with disruptive behaviours, most notably hyperkinesis and depression. In some instances, the health-funded clinicians would also provide the treatments for these associated conditions. For example, an 8 year old boy might be referred to the disruptive behaviour service primarily because of troublesome behaviour at home and at school, but screening questionnaires completed by parents and teachers may raise the suspicion of associated hyperactivity. A detailed assessment by the health-funded clinicians may confirm that the boy does have hyperkinesis as well as disruptive behaviour. This could lead on to an integrated package of treatments, perhaps involving parent management training in a group led by a social worker, behavioural advice to the school from an educational psychologist, and medication plus behavioural therapy for hyperkinesis from the health-funded clinicians. If the need for parent management training and educational psychology advice is short-lived, then long-term care for the child’s hyperkinesis may subsequently be transferred to the “core” CAMHS outpatient service.

(26) Eisler and Dare, in preparation.

(27) Work with children occupies around a third of GPs’ time; a substantial minority of the children seen by GPs have mental health problems, though these commonly go unrecognised (Garralda, 1994). Even if these problems were more commonly recognised by GPs, the assessment and treatment of a substantial proportion of child and adolescent mental health problems would take more time than GPs can commonly spare, and would also take more expertise than most GPs currently possess. Few GPs have had any specialist
experience of child and adolescent mental health work, and many have had little training in child psychiatry beyond a few lectures while at medical school. A recent qualitative study of GPs’ views on hyperactivity found that most of the GPs who were interviewed rarely if ever diagnosed hyperactivity, and felt that they knew little about the recognition and treatment of children’s and teenagers’ behaviour problems (Klasen & Goodman, unpublished data).

(28) The Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA) is one possible clinician-rated measure of case complexity and outcome. However, if provider units know that commissioners are using the HoNOSCA measures to judge how well local services compare with national averages or other local providers, this may create a response bias towards making cases look as complex as possible and outcomes as good as possible. If a box is labelled “Tick here if you should remain employed because you are doing a hard job well”, who won’t tick it? There is clearly something wrong with a method of evaluation that potentially penalises honest respondents. Clinicians’ ratings are an important source of information, but they do need independent verification. Questionnaires completed by parents, teachers and the young people themselves not only provide essential feedback on “customer satisfaction” but can also potentially be used to validate clinicians’ ratings. Thus if clinic A reports a greater average improvement on HoNOSCA ratings than clinic B, but if parent and teacher questionnaires report a lower average improvement for children seen at clinic A, the obvious conclusion is that the staff at clinic A have been more likely to give themselves the benefit of the doubt. But if parent and teacher questionnaires also report a greater average improvement for children seen at clinic A, this provides robust evidence that clinic A really is doing better. This difference would not necessarily be attributable to clinic A providing superior treatment – it would still be essential to establish if the difference in outcome reflected differences in case mix, case complexity, and so on.
(29) Direct staff costs include employers’ on-costs and have been calculated from scales that do not include London weighting. The cost of medical input was calculated from consultant scales. The cost of BCI provision was calculated from the salaries of a mixture of professions and levels of seniority. For example, the 5.3 BCI therapists for non-intensive services for 0-15 year olds were costed as 1.0 senior clinical psychologist, 1.3 middle-range clinical psychologists, 1.0 junior clinical psychologist, 1.0 Grade G nurse behavioural-therapist, and 1.0 psychology assistant. Family therapy input was costed as though the family therapists were paid as middle-range clinical psychologists. Secretarial provision was costed as a mixture of Grade 3 and Grade 5 staff.

(30) In-patient beds were costed at £100,000 per year.

(31) Some core child and adolescent mental health problems are associated with socioeconomic deprivation. Thus hyperkinesis is commoner among children from the inner city or very poor rural areas, and among children from the lowest socioeconomic groups. For other core disorders, there is little or no socioeconomic gradient. In the case of autism, for example, there is no clear relationship with socioeconomic status - the links with high socioeconomic status reported by early studies were probably due to ascertainment bias. There may, however, be a substantial excess of autistic disorders in the children of immigrants, many of whom will be concentrated in socially deprived inner city neighbourhoods (e.g. Goodman & Richards, 1995).

(32) Not all core mental health needs are covered in Table 3.1. For example, anorexia nervosa, obsessive-compulsive disorder and post-traumatic stress disorder are included but bulimia nervosa, Tourette’s syndrome and adjustment reactions are not. The fact that Table 3.1 is not comprehensive is one of the justifications for the “multiplier” used when calculating staff needs for the core outpatient service (Box 3.2).
The attendance fraction has been reduced at times to prevent double-counting of children who do not need full treatments for each of their multiple problems. For example, if a child meets diagnostic criteria for generalised anxiety disorder, separation anxiety disorder, specific phobia and depression, an appropriate course of cognitive-behavioural treatment for this combination may be less time-consuming than would be predicted by totalling the amount of therapy proposed for each condition separately. Allowing for children with multiple disorders is vital since as described in Section 3.1.3 - and referenced in endnote 16 - around half of all children with psychiatric disorders have two or more disorders.

Table 3.1 relates only to outpatient provision. Some children and teenagers with these problems will need in-patient services, day-patient services, or intensive community care. This need for intensive services is considered and costed separately - not as part of core outpatient provision.

“Back to school” programmes for school refusal are not included. Though they are undoubtedly useful, they are most appropriately provided not by health but by education. The attendance fraction for anxiety disorders is reduced to allow for anxiety-related problems that are appropriately and adequately managed by educational interventions alone.
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