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CAMHS funding and priorities

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Executive summary

In light of recent developments, notably passage of the Children Act 2004, subsequent implementation of *'Every Child Matters: Change for Children'* and the recent substantial increase in Child and Adolescent Mental Health Services (CAMHS) funding to councils, the Local Government Association (LGA) asked the National Foundation for Educational Research (NFER) to examine the funding mechanisms and priorities in CAMHS.

The local authority CAMHS grant

- Responsibility for management of the local authority CAMHS grant fell within three primary areas; under personnel with remits in social care (or the equivalent in integrated children's services), partnership working or commissioning. This may have implications for the integration of CAMHS across services and may limit the extent to which education and schools are involved in CAMHS developments.
  Recommendation: It is therefore worth local authorities giving consideration to the location of responsibility for CAMHS developments.

- Usually, decisions about the allocation of the CAMHS grant were made jointly by the local authority and the Primary Care Trust(s) (PCT(s)). Where there was a clear CAMHS strategy and agreed joint priorities, disagreements about the allocation of the grant were reported to be less likely. In addition, close working between commissioners and CAMHS and the development of children's services joint commissioning arrangements were considered to be helpful in preventing disagreements.

The PCT core CAMHS grant

- It was common for the PCT core grant to be effectively, but not formally, pooled with the local authority CAMHS grant. Formal pooling through a section 31 agreement, which was only evident in a few local authorities, was considered to be complex and time consuming and to take control away from individual organisations.

Recommendation: Where the local authority and the PCT grant are treated separately, authorities might wish to consider pooling these monies. Where informal pooling arrangements are already in place, despite the complications involved, putting this on a more legal footing may be beneficial for the security of CAMHS funding.

- There was a local authority view that the amount of PCT CAMHS funding was difficult to distinguish from the overall PCT budget. In addition, some claimed that uncertainty regarding future overall PCT funding meant that PCTs might not be able to honour their joint investment plan agreements. This funding uncertainty was confirmed by health interviewees in at least five areas where PCT funding was reported to remain uncertain or to have been *'lost in the system'*.

Commissioning arrangements

- In the overwhelming majority of cases there were joint local authority and PCT commissioning arrangements.
  Recommendation: Where not currently in place, joint commissioning arrangements could allow a strategic overview of both local authority and health priorities and for service developments to be considered across all four tiers of service delivery.

- A number of local authorities were in the process of developing commissioning more broadly across children's services. This would allow resources across children's services to be examined as a whole, but could mean that CAMHS might easily become *'sidelined'*.
  Recommendation: Local authorities might wish to weigh up the pros and cons of having a joint commissioning group across children's services, of which CAMHS commissioning is a part, together with an advisory sub group with wider, more specialist knowledge to further inform the decision-making process.

- Where commissioning was more provider led, it was thought to make it more difficult to undertake changes

and initiate developments. This may be an important distinction, particularly given the need to move towards comprehensive CAMHS and the traditional view of CAMHS as a clinically based service.
Recommendation: A clearer purchaser/provider split may be more helpful. Evidence to the effect that input into tiers 1 and 2 could reduce waiting lists at tier 3, freeing up clinicians to provide greater quality input to children that require higher level provision, if it were forthcoming, might act as an important lever for CAMHS.

The impact of current funding mechanisms on joint working

- Local authority and health representatives agreed that a lack of formal ring fencing of the PCT CAMHS grant could result in reduced funding for CAMHS and withdrawal of funds in some PCTs had led to difficulties in maintaining working relationships between health and local authority staff. Ring fencing for CAMHS funding was therefore seen as *crucial* for improving joint working.

- Local authority and health staff thought that having pooled budgets and funding streams which require partnership working encouraged an effective use of funds and incited a feeling of shared responsibility, as well as supporting *Every Child Matters* (ECM) and the National Service Framework (NSF) for Children, Young People and Maternity Services. Local authority interviewees and regional health interviewees suggested also that the provision of Local Area Agreements or Service Level Agreements could further aid partnership working.

The impact of current funding mechanisms on preventative work and mental health promotion

- The provision of the local authority CAMHS grant was thought to have facilitated the development of preventative services. However, there was also a view that, with no further increase in local authority CAMHS funding, current progress may suffer.

- Local authority and health staff agreed that government targets and requirements were focused on acute services. They thought that government targets making prevention and mental health

promotion compulsory and dedicated funding for prevention and promotion work would ensure that more funding was spent in these areas.

- There was also some consensus that the high demand for acute services was a further obstacle to preventative/promotion work, together with mixed views as to whether investment in tiers 1 and 2 reduces demand in tiers 3 and 4. The view of CAMHS as a traditionally clinically based service was considered a further obstacle to change as it was felt that changes in working practice could threaten levels of professional expertise.

Effective use of CAMHS funding

- There was evidence that performance management data in relation to CAMHS was considered inadequate. Yet, the availability of evaluation and performance management information was considered vital for gauging service effectiveness and identifying gaps in provision.
Recommendation: With performance management relating to CAMHS in its infancy, it is likely that most local authorities would benefit from the sharing of good practice in this area in order to ensure that service development is based on sound performance management information.

- A wide range of additional sources of CAMHS funding was identified.
Recommendation: Taking a broad view of CAMHS, as is currently the case in some authorities, might enable local authorities to tap into more funding streams than they do at present.

Main CAMHS priorities and gaps in provision

- Perhaps not surprisingly, from both a local authority and health perspective, the main CAMHS priorities identified were areas related to national targets, although looked after children (LAC) were also a frequently identified priority. Beyond this, however, local authority and health priorities tended to diverge and some health interviewees referred to the lack of alignment between the local authority and health with regard to vulnerable groups.

- Support for universal services was identified by local authority interviewees as the most common gap in provision. There was thought to be a need for the

development of professionals' understanding of mental health and for the provision of training, consultation, advice and information for frontline workers. Work with schools, in particular, was identified as an important area for development.

- When talking about the gaps in provision, staff shortages and capacity issues also featured highly in the discourse of health interviewees. They referred to a deficit in the range of professional expertise across the tiers, as well as capacity issues, particularly in relation to work with schools.

The balance between prevention/promotion and acute provision

- The majority of local authority and local health staff sampled stated that there was not enough prevention and promotion work taking place. There was a view that a shift in balance towards preventative work could only be achieved with additional ring-fenced funding.

- However, suggestions were made for managing demand differently or for new working practices. **Recommendation:** Local authorities may need to consider significant changes to CAMHS working practices. A reduction in the use of out of county placements and examination of alternative models of service delivery at tier 4, with a redirection of resources into community facilities, could be beneficial in many authorities.

- It was thought that, with training, frontline staff working with children and young people, such as teachers, could understand and deal with low-level mental health needs. **Recommendation:** One way forward may be to bolster support for universal services to enable them to address low-level mental health needs and to capitalise on the contribution which voluntary and community organisations can make in this respect.

Factors influencing joint working between CAMHS and frontline services

- It was commonly reported that misunderstandings between frontline services (schools in particular) and CAMHS, together with unrealistic expectations of

CAMHS, created barriers to joint working. An understanding of each other's roles and responsibilities, a recognition of each other's skills and clear and realistic expectations, were therefore considered beneficial.

- It was reported that it was becoming difficult for CAMHS workers to develop coherent strategies across an area of schools and that communicating with schools was problematic as they could no longer all be accessed through the local authority. **Recommendation:** The need for joint working may need to be enshrined in government policy in order for this to be effective.

Support for tiers 1 and 2

- Staff working across the different tiers was identified as a means of supporting tiers 1 and 2. **Recommendation:** Where divisions currently exist between tier 1/2 and tier 3/4 services, effective integrated working practices could be achieved by employing staff to work across tiers. There was already evidence of such inter-tier working in about a third of the local authorities in the sample.

- In some areas it was evident that voluntary sector and community organisations currently make a significant contribution to tiers 1 and 2, whilst, in other areas, their involvement was considered limited or lacking. The variation of voluntary sector input across cities or regions and between schools was reported as being unhelpful by health staff and the need for better coordination and evaluation was also highlighted.

Future funding pressures

- Over two-thirds of the local authority personnel and about half of the health personnel interviewed identified that general low funding and the pressure to make savings would be problematic for the development of comprehensive CAMHS. A key concern was the lack of future development money. Local authority staff warned that, with funding for preventative work in jeopardy, this could lead to a vicious circle, with increased demand at tiers 3 and 4 and a subsequent increase in costs.

- There was also consensus on many of the specific areas under future funding pressure, including specialist CAMHS (particularly tier 4 services),

services for children with learning disabilities and services for 16 to 18 year olds.

Main conclusions

- Despite a history of under funding for CAMHS in many areas, the injection of money through the local authority CAMHS grant appears to have led to significant progress in the development of comprehensive CAMHS. However, it is possible that, for current progress towards prevention and promotion to be maintained, further funding, which is protected to ensure it is spent on the purpose intended, may be required.

- The findings indicate a lack of performance management data in relation to CAMHS, this being an area currently in its infancy. Further progress in this area is required in order to inform effective service development.

- There was evidence that, in some areas, the clinical focus of CAMHS has created a barrier to change. This, together with the lack of a clear purchaser/provider split within some local authorities' commissioning arrangements, could hinder local authority progress towards the delivery of comprehensive CAMHS.

- There was also some evidence that, despite the call for greater school involvement in mental health and increasing dialogue between CAMHS and schools, increasing school autonomy could make it more difficult for services, such as CAMHS, to engage with schools and to develop coherent strategies across an area of schools. In addition, there is a need for them to understand each others' constraints more fully.

1   Introduction

In light of recent developments, notably passage of the Children Act 2004, subsequent implementation of *'Every Child Matters: Change for Children'* and the recent substantial increase in Child and Adolescent Mental Health Services (CAMHS) funding to councils, the Local Government Association (LGA) asked the National Foundation for Educational Research (NFER) to examine the funding mechanisms and priorities in CAMHS. The findings presented in this report were elicited through telephone interviews with local authority personnel and local and regional health personnel with responsibility for CAMHS developments. The findings stem mainly from the 52 interviews conducted at a local level. Thirty-one of these interviews provided a local authority perspective and 21 provided a health perspective, although seven interviewees provided both perspectives and, in total, therefore the sample included 45 local interviewees. In addition, nine regional CAMHS development workers were interviewed and relevant findings from these interviews are alluded to where appropriate. Local authority sample characteristics are provided in the appendix. On the basis of interviewee descriptions, the sample included local authorities at different stages of the process towards integrated children's services.

The introduction provides details of the sample of interviewees (including their role/remit and their professional backgrounds) and the local factors that were thought to have an impact on joint working between health and the local authority. It concludes with an outline of the structure of the report.

1.1   The role and remit of interviewees

- Twenty-two of the 31 local authority interviewees (i.e. including those who provided both a local authority and a health perspective) were funded by the local authority and nine were jointly funded by the local authority and health.

- Eight of the 31 local authority personnel (five of which were joint funded posts) had a largely 'CAMHS only' remit, whilst the remaining 23 had a wider remit, in particular, within social

care/safeguarding, but also a wider commissioning role and/or role in partnership working. Interviewees had a wide range of titles, for example, CAMHS Strategy and Commissioning Manager, Assistant Director of Children and Families, and Head of Commissioning and Partnership Services.

- All but two of the additional 14 health interviewees (i.e. not including those who provided both perspectives) were located in Primary Care Trusts (PCTs) and the remaining two were located in health trusts. Six had a commissioning role, with a broader remit than CAMHS (e.g. mental health or children's services commissioning) and three were directors of services with a wider remit (e.g. mental health or children and young people's services). The remaining five were lead clinicians for CAMHS or CAMHS managers.

1.2   The professional backgrounds of interviewees

- The most frequent professional backgrounds of the 31 local authority staff interviewed were, in rank order, social care (sometimes with education, voluntary sector or youth justice); social care and health (sometimes with education) and health (sometimes with education or voluntary sector). It was notable that almost half of the sample of local authority interviewees had no experience of working as a practitioner in health. This could have implications for joint working with mental health colleagues.

- Most of those who had worked within health had worked in CAMHS and all but one of these described themselves as having either experience of both preventative and acute services (seven) or prevention and promotion only (five). This could have implications for the extent to which CAMHS is integrated into universal services.

- The professional background of the additional 14 health interviewees was mainly health orientated, although this group also included three social workers and one teacher, and four had been managers only and not practitioners. Those with a health background included clinical psychologists, a

family therapist, a psychotherapist, a nurse, a speech and language therapist and a health visitor. Of those who noted it, most had worked within acute and preventative provision.

1.3   Local contextual factors

- Local authority and health staff agreed that a lack of coterminous boundaries and having a number of PCTs or local authorities to work with made joint working and the development of services more complex, whilst having a coterminous boundary with a single PCT or a single local authority was reported to facilitate communication and joint working.

- They also agreed that a previous history of good relations between health and the local authority made communication and decision making easier since difficult areas had already been '*ironed out*'. Where there was a history of CAMHS receiving the grant with no accountability to the local authority, the more recent imposition of local authority expectations was described as '*a cultural shift*'.

- However, the complex structure and the reorganisation of the health services were reported by local authority interviewees to make it difficult to communicate with the relevant personnel and for them to engage in the comprehensive CAMHS agenda. In addition, from a regional health perspective, funding cuts in the health service, resulting in job losses and changes to personnel, were reported to have negatively affected working relationships. Similarly, local authority moves towards integrated children's services were also reported by local authority staff to have slowed CAMHS developments and led to issues of trust between agencies because of the uncertainty of individuals' own roles.

- Health interviewees additionally thought that local strategic partnership and planning structures helped to sustain joint working, although the issue of cultural differences between health and the local authority was also raised. They felt that this could create misunderstandings and could lead to health being '*appended as an afterthought*' despite the strategic arrangements being in place.

- Interviewees from a small local authority said it was easier to develop relationships with other agencies and therefore to get the key stakeholders round the table for decision making in relation to CAMHS, whilst in a large authority this was said to be more complex to manage.

- The high level of deprivation and poverty in some areas was said, mainly by local authority interviewees but also by some health representatives, to influence joint working. It was thought to lead to a significant demand for CAMHS, but also to a shared health/local authority challenge. Disproportionate levels of need were thought to result in different amounts of funding being available to different areas and to create difficulties for planning locality specific services.

- Health interviewees also highlighted the local influence that key personnel can have by supporting and encouraging people to work together and the need for government departments to work together, as this has a knock-on effect for local practice. In addition, at a regional level, it was noted that, where the Department of Health had not been consulted by the Department for Education and Skills (DfES) over changes to public policy, it was difficult for health services to provide full commitment and therefore targets remained unmet.

1.4   The structure of the report

The main body of the report covers the following areas:

- the local authority CAMHS grant

- the PCT core CAMHS grant

- other sources of CAMHS funding

- commissioning arrangements

- the impact of current funding mechanisms on joint working

- the impact of current funding mechanisms on prevention and promotion

- effective use of CAMHS funding

- main CAMHS priorities and gaps in provision

- the balance between prevention/promotion and acute provision

- factors affecting joint working between CAMHS and frontline services

- support for tiers 1 and 2

- future funding pressures.

In the final two sections the main conclusions are summarised and the recommendations for local authorities are presented.

2   The local authority CAMHS grant

This section covers the location of responsibility for the local authority CAMHS grant, the criteria for its allocation and the associated decision-making processes.

2.1   Location of responsibility

- Responsibility for management of the local authority CAMHS grant was reported to fall within three primary areas: under personnel with remits in social care (or the equivalent in integrated children's services), partnership working or commissioning. This could have implications for the extent to which comprehensive CAMHS is implemented across services and, in particular, within universal services.

- Various rationales for inclusion of CAMHS within social care were cited: the significance of CAMHS intervention for looked after children (LAC); a view of CAMHS as both a universal and specialist service; social care taking the lead for children's health services; previous links with child guidance; the location of social workers within CAMHS teams as well as the close relationship between social care and CAMHS.

- Local authority interviewees thought that joint posts facilitated an integrated strategic overview of CAMHS, enabling resources and service development to be examined across the four tiers.

2.2   The criteria for allocation

- Local authority interviewees variously described the criteria for the allocation of the CAMHS grant as based on shared priorities, a joint strategy, local needs analysis and the National Service Framework (NSF) or comprehensive CAMHS agenda. In a few local authorities allocation was based on the fit with a local integrated model, demographics (with formula allocation) and mapping against ECM.

- When asked about the performance indicators attached to the funding, almost equal numbers of local authority interviewees stated that there were either no local performance indicators (only national ones), or that the local performance indicators that

did exist were not robust, since they tended to be based on inputs rather than outcomes. However, there were a few instances of local authorities where more sophisticated performance indicators were evident, for example, where a service level agreement had been drawn up with CAMHS and 12 key indicators were being measured to get feedback on outcomes. Interviewees often commented that local performance indicators were in the process of development. One interviewee noted that, where the CAMHS grant had been used to support new initiatives, performance indicators had been more outcome focused.

2.3   The decision-making process

- In all but three local authorities, interviewees referred to joint strategic groups with responsibility for decisions about allocation of the CAMHS grant. These strategic groups were described using a range of nomenclature, which might indicate a focus on 'strategy' as opposed to 'commissioning', for example.

- Where a joint commissioning group (as opposed to a CAMHS commissioning group) was responsible for decision making, this would suggest that CAMHS is a small part of a wider remit (e.g. the commissioning of children's services), enabling consideration of where CAMHS sits within the broader 'children's services' picture, but, at the same time, perhaps limiting specialist CAMHS input into the decision-making process.

- In the overwhelming majority of local authorities in the sample, decisions about the allocation of the CAMHS grant were made jointly by the local authority and the PCT(s). Information provided suggested that strategic decision-making groups were as often chaired by PCT representatives as by local authority representatives (it being a joint responsibility within others). Where stated, local authority representation was mainly from social care and education (or children's services). Other representatives included voluntary agencies, Youth Offending Teams (YOTs), Connexions and service users.

- Where there was a clear CAMHS strategy and agreed joint priorities, disagreements about the allocation of the local authority CAMHS grant were reported by local authority staff to be less likely. In addition, close working between commissioners and CAMHS and the development of children's services joint commissioning arrangements (see also section 5 on commissioning) were felt to be helpful in preventing disagreements. Although local authority representatives reported that they had recourse to higher bodies, only one instance was cited where this had been instigated.

3 The PCT core CAMHS grant

This section covers the arrangements for the pooling of the PCT core CAMHS grant with the local authority CAMHS grant, the criteria for the allocation of the PCT core grant and the associated decision-making processes.

3.1 Arrangements for the pooling of grants

- In over half of the local authorities in the sample, the PCT core grant was reported by local authority staff to be effectively, but not formally, pooled with the local authority CAMHS grant (this was confirmed by health interviewees as being the case in the majority of instances). The two grants were therefore seen as one pot, with decisions made jointly by the local authority and the PCT. This recent shift was emphasised by one health representative who said: '*Five years ago, I would be told what the local authority would be using their grant on.*' However, there remained a few instances where health interviewees reported that the two funding streams remained '*very separate*'.

- Formal pooling through a section 31 agreement, which was only evident in a few local authorities, was felt by local authority staff to be complex and time consuming, and to take control away from individual organisations. It was suggested that, in the future, local authority and health budget powers might be located within children's trusts.

- The amount of PCT CAMHS funding was reported by local authority interviewees to be difficult to distinguish from the overall PCT budget. In addition, some claimed that uncertainty regarding future overall PCT funding meant that PCTs might not be able to honour their joint investment plan agreements. This funding uncertainty was confirmed by health interviewees in at least five areas where PCT funding was reported to remain uncertain or to have been '*lost in the system*'. CAMHS regional development workers also expressed concern that, where joint commissioners or dedicated CAMHS leads were not identified, funding easily became lost.

3.2 The criteria for allocation

- When health representatives were asked to describe the criteria for the allocation of the PCT core grant, in line with the virtual pooling with the local authority CAMHS grant, the criteria closely reflected those identified by local authority staff for the local authority CAMHS grant, i.e. shared priorities, the CAMHS strategy and the NSF or comprehensive CAMHS agenda.

- Performance management data for the PCT core grant was often described by local authority interviewees as non-existent. When asked about performance indicators, health interviewees invariably referred to national targets. However, there was some indication, as with the local authority CAMHS grant, that local performance indicators were in the process of development and becoming more focused on outcomes.

- The PCT grant was perceived by some local authority staff as traditionally being used for funding tiers 3 and 4 specialist CAMHS services and this continued to be the case in some authorities, whilst in others, the development of a joint strategy had led to its use for wider purposes, for example, in one local authority, the establishment of a team of tier 2 primary mental health workers.

3.3 The decision-making process

- Given that 'virtually' pooled budgets were common, the decision-making process described by health interviewees mirrored that outlined by local authority interviewees.

- However, where funding had been withdrawn from the pooled budget by the PCT, there was evidence from health interviewees at both a local and regional level of some friction between local authorities and PCTs. In addition, there was also reported to be some tension where the specialist CAMHS service failed to recognise the wider CAMHS agenda: '*It is not just about health providing a specialist service, it is about all partners having their part to play.*'

4   Other sources of CAMHS funding

When considering other sources of CAMHS funding, some interviewees emphasised that this depended on how broad a perspective was taken of the CAMHS remit. The wide range of sources identified highlights some of the potential funding streams local authorities could tap into in order to support further developments within comprehensive CAMHS.

- The main key sources of additional CAMHS funding identified by local authority and health staff were mainstream local authority funding and mainstream health funding respectively (although the latter was also highlighted by local authority staff). Mainstream local authority funding had been used, for example, to establish multi-agency teams undertaking preventative work and for the development of a wellbeing centre, whilst mainstream health funding had been used, for example, for a range of psychological services and for a child and family consultation service. According to a few of the health staff interviewed, focusing on the CAMHS grant is unhelpful because this is small in comparison to the core health budget, of which a significant amount is spent on CAMHS.

- Another source of funding identified by local authority and health staff was the Children's Fund. This had been used, for example, to finance voluntary agencies undertaking counselling and mental health promotion projects in schools.

- Other sources of funding highlighted by local authority staff included education/school funding (e.g. for mental health promotion through the Healthy Schools Initiative and through Social and Emotional Aspects of Learning) and other more specific local authority grants (e.g. the Vulnerable Children's Grant and an ethnic minority grant).

- Health staff highlighted other sources of funding which included: the mental health initiative grant (e.g. for a schools project which was described as *'a good precursor to current joint work'*); modernisation money; public health funding (e.g. for a mental health promotion worker); workforce pilots; national specialist commissioning from the Department of Health and Medical and Dental Education Levy (MADEL) funding (e.g. for a specialist registrar post). In addition, CAMHS regional development workers identified Strategic Health Authority development and revenue funds as additional sources with which they were able to assist with prioritising.

5   Commissioning arrangements

When asked about the commissioning arrangements, interviewees talked about the development of the commissioning role and the operation of commissioning groups, as well as joint commissioning arrangements.

- The overwhelming majority of the personnel interviewed described their local authority or PCT as having joint local authority and PCT commissioning arrangements, achieved through a joint commissioning group (discussed previously in section 3) or having a joint commissioning post (e.g. where the PCT commissioned specialist CAMHS and the local authority commissioned tier 2 services through the same joint funded post). The appointment of joint posts was said to have resulted in tremendous progress for commissioning within some regions. In some local authorities, joint commissioning arrangements were reported to be in their infancy, with CAMHS leading the way. Having joint commissioning arrangements may be more likely to facilitate a whole-CAMHS view (i.e. across the four tiers) of resources and service development.

- A number of local authorities were in the process of developing the commissioning role to examine commissioning more broadly across children's services. Whilst this would allow resources across children's services to be examined as a whole, this could mean that CAMHS might easily become 'sidelined'. Indeed one children's services commissioner commented that they had insufficient time to devote to CAMHS commissioning because it was part of a wider remit. Some local authorities had installed an advisory group below the joint commissioning group with broader representation and more specialist knowledge to assist with the decision-making process.

- The contrasting circumstances of different local authorities were illustrated by the case of a small local authority that was unable to afford its own commissioner and was therefore reliant on the PCT

commissioning process. Another authority was reported to be appointing a full-time CAMHS commissioner because the CAMHS commissioning role was considered to be a developing one.

- In some cases, CAMHS regional development workers reported that the commissioning arrangements for CAMHS in their region were '*disorganised*', '*very weak*' or '*non-existent*'. This was attributed to the reorganisation of children's services and the PCTs and a lack of sustained profile for commissioners due to frequent changes of personnel. It was also attributed to a lack of resources leading to a situation in which commissioners had minimal time to focus on CAMHS, or where their CAMHS responsibility was tagged onto already large portfolios.

- In some local authorities, commissioning groups included service providers, whilst in others, they were part of a wider sub group with an advisory capacity to the main decision-making group. A few local authority interviewees commented on the lack of purchaser/provider split within the local authority (contrasting this with NHS practice), whilst, amongst health interviewees, there was a recognition that commissioners needed to work closely with the providers, but that, ultimately, decisions about service development are made by commissioners. The local authority interviewees noted that, with commissioning being more provider led, this made it more difficult to make changes and initiate developments. This may be an important distinction, particularly given the need to move towards comprehensive CAMHS and the traditional view of CAMHS as clinically based service alluded to in section 7.3.

- Several local authorities reported being in the process of establishing service level agreements or detailed specifications for CAMHS, although interviewees acknowledged that these were currently '*very loose*'.

6 The impact of current funding mechanisms on joint working

The 'funding' barriers to joint working identified by interviewees centred around three main areas: lack of ring fencing, having separate funding streams and the associated government requirements.

6.1 Lack of ring fencing

- Local authority and health representatives reported that a lack of formal ring fencing of the PCT CAMHS grant could result in reduced funding for CAMHS. Local authority interviewees felt that without ring fencing, there was a lack of PCT accountability for spending on CAMHS and that the grant could more easily be absorbed into mainstream funding and utilised for other purposes (a situation likely to be exacerbated by current health cuts). They therefore felt that ring fencing the funding would facilitate service development free from concern that deficits in mainstream budgets could absorb resources.

- Their health counterparts reported that the financial deficits in PCTs and recent health service cuts created barriers to joint working with the local authority. Withdrawal of funds in some PCTs had led to difficulties in maintaining working relationships. They therefore saw ring fencing for CAMHS funding as crucial in improving joint working between health and the local authority, although one felt that the decision to remove the ring fencing meant that '*the horse has already bolted*'.

6.2 Separate funding streams

- Separate PCT and local authority funding was described by local authority interviewees as '*disjointed*' and '*fragmented*', resulting in territoriality over funds and being time consuming and complicated to manage. They felt that allocating the CAMHS grant via the local authority would lead to improvements in working relationships as it would encourage joint working, identify the local authority as a clear stakeholder and would simplify the process. Interestingly, health interviewees identified this as one of the factors *currently* enhancing their

relationship with the local authority. They felt that CAMHS grant being directed through the local authority necessitated joint working because the local authority had a direct stake in investment and funding was considered more closely through the CAMHS partnership.

- Local authority and health staff thought that having pooled budgets (formal or informal) supported ECM and the NSF, encouraged an effective use of funds and incited a feeling of shared responsibility: '*Pooled budgets have paved the way for partnership working*' (health). Although it was thought that formal pooling would reduce fragmentation and levels of financial risk for the budget holder and create a legal framework to underpin partnership, the complex mechanisms involved were said to make the process time consuming. Local authority interviewees and regional health interviewees suggested also that the provision of Local Area Agreements or Service Level Agreements could further aid partnership working.

- Local authority personnel suggested that bringing the grant streams together under one commissioning arrangement or the receipt of all CAMHS funding through the children's services directorate might further improve the process.

6.3 Government requirements

- Both health and local authority staff agreed that having funding streams which require partnership working had been beneficial for working relations. For health interviewees, this had been the key factor in facilitating effective relationships with the local authority as it had helped to develop multi-agency teams and had given both health and the local authority a '*voice at the table*'. Having a joint CAMHS strategy with clear outcomes was also reported by both groups to facilitate discussions.

- Another suggested area for improvement, from both a local authority and health perspective, was that of national targets and performance management. Whilst the obligation for both the local authority and

the PCT to report on CAMHS targets was considered to facilitate joint working, it was felt that this area could be improved by having more specific targets and more performance management information.

- CAMHS regional development workers highlighted that local authorities may not be aware of the constraints under which the health sector operate. For example, health are not able to move money around in the same way that local authorities are: '*Local authorities must recognise that health come with their hands tied behind their backs*.' It was also said that health have different financial pressures due to accountability and performance measures.

- Health representatives identified further barriers to joint working. The exemption of three star local authorities from reporting was said to make it difficult to intervene in the amount of money allocated to CAMHS and meant that some local authorities were not investing in CAMHS. They also expressed concern that the local authority grant was only earmarked until 2008 which limited any long-term planning. In addition, health interviewees reported differences in priorities between the local authority and health, leading to concerns that funding would not always be allocated to joint priorities. This is discussed in more depth in section 9.3.

7 The impact of current funding mechanisms on preventative work and mental health promotion

Three key areas were identified by interviewees as barriers to preventative/promotion work: funding levels and government targets, the demand for acute services and CAMHS working practices.

7.1 Funding levels and government targets

- Both groups of interviewees stated that low funding levels and financial constraints had led to funds being targeted at provision in higher tiers. Money saving pressures or funding losses had also led to reductions in preventative services, which were widely viewed as more able to withstand funding cuts. Health interviewees explained that high financial deficits across the PCTs meant that there was not enough money for an NSF compliant service and insufficient funds for the entire CAMHS strategy.

- Local authority interviewees and CAMHS regional development workers felt that the provision of the local authority CAMHS grant had facilitated the development of preventative services. They suggested that additional funding in the form of locality funding, funding for voluntary and community sector services and more resources focused on developing comprehensive CAMHS were a means of further improvement. They also stated that, with no further increase in local authority CAMHS funding, current progress may suffer.

- Similarly, health interviewees suggested that longer-term funding, stable funding structures and a willingness to bid for additional funds would facilitate preventative approaches to children's mental health. Two interviewees also stressed the importance of adequate commissioning arrangements in facilitating more preventative approaches.

- Local authority and health staff agreed that govern-ment targets and requirements were focused on acute services, with funds primarily targeted at meeting CAMHS priorities and performance indicators concentrated in the higher tiers. They thought that government targets making prevention and mental health promotion compulsory, and dedicated funding for prevention and promotion work would ensure that more funding was spent in these areas.

- CAMHS regional development workers also saw funding based on needs assessment as key to promoting a more preventative approach, as it provides the opportunity to develop services where they are most needed and has allowed services to be developed at the primary care level. One interviewee expressed the view that it was not necessarily funding mechanisms that facilitated prevention and promotion, but rather the notion of achieving comprehensive CAMHS.

7.2 The demand for acute services

- There was also some consensus that the high demand for acute services was a further obstacle to preventative/promotion work. Local authority interviewees felt that this was exacerbated by inadequate needs assessment and lack of performance management information and as such, better use of needs analysis to inform service development and research into outcomes were considered key to further progress. Health interviewees called for more information on and greater investment in understanding the link between prevention and levels of admissions to acute services.

- As with local authority interviewees, there were mixed views amongst health interviewees who commented on evidence that investment in tiers 1 and 2 reduces demand in tiers 3 and 4. Two interviewees, however, referred to local evidence to support this. In one PCT, referrals to tiers 3 and 4 had been reduced by putting dedicated staff into locality social services. In another PCT, mental health awareness training had been put in place for frontline professionals in order to reduce the need for more expensive provision at higher tiers. This PCT had also developed community based services to prevent the need for residential treatment and, as a result, according to the interviewee, operated on a relatively low use of residential beds.

7.3 CAMHS working practices

- Local authority interviewees reported that the view of CAMHS as a traditionally clinically based service was an obstacle to change as it was felt that changes in working practice could threaten levels of professional expertise. However, they also noted that the CAMHS strategy had encouraged agencies to look at how they configure services and to work in more integrated ways.

- When questioned about CAMHS responsiveness to the need for change, there were mixed views amongst health interviewees, probably reflecting the different standpoint of local teams/personnel. Some of those in agreement praised their CAMHS for being innovative and creative and for increasing their presence in the community. Others felt that, with CAMHS heavily under the spotlight, whilst there was some resistance from clinicians, they had no choice: '*Life has changed ... you [consultants] do what we commission you to do*.' Those who felt that CAMHS was not responsive stated that they often fell back into their traditional ways of working and were resistant to change (e.g. changing the number of sessions or changes to referral procedures). More innovative models of service delivery were thought to be hampered by the view that there is a need to reduce the levels of risk in the community. Interviewees emphasised that it is no longer a service-led culture and that the commissioners made the decisions.

8 Effective use of CAMHS funding

A number of factors were identified by interviewees as important for the effective use of CAMHS funding.

- Local authority and health staff agreed that carrying out a needs analysis to obtain a clear understanding of local needs was critical for identifying priorities and ensuring that services are needs led. When asked about the criteria for allocation of the local authority CAMHS grant, it was evident that about a quarter of the local authorities in the sample had undertaken a local needs analysis to inform its allocation.

- When health representatives were asked whether the local authority and PCT had a good idea of the level of demand for services, mixed views were garnered. However, where a good idea of demand had been ascertained, interviewees reported that meeting the level of demand can be very challenging and that demand is often in excess of capacity. Health interviewees also acknowledged that local authorities are '*more switched on*' to the process of needs analysis than PCTs.

- Coupled with needs analysis, from both a local authority and a health perspective, the availability of evaluation and performance management information was also considered vital for gauging service effectiveness and identifying gaps in provision. Regional health interviewees stressed the need for outcome based funding that feeds into commissioning cycles and demonstrates the usefulness of services. Local health interviewees also highlighted the role of consultation in using funding most effectively, stressing the importance of involving service users and carers in the evaluation of services.

- Both groups of interviewees felt that having a clear strategy and outcomes which had been developed and fully signed up to by all agencies was essential. Alongside this, a focus on partnership working, ensuring a shared understanding of aims and objectives, effective communication, together with the development of a culture of joint working and openness were also considered beneficial by local authority interviewees. Health interviewees were more likely to suggest joint priorities, strict monitoring arrangements and a multi-agency approach to funding.

- For effective use of CAMHS funding, service redesign and changes to current working practices were also called for by local authority and health staff. Suggestions included the integration of professionals across the four tiers, a holistic approach to children's needs, capacity building, workforce development and the mapping and redesign of services so that they function more effectively and efficiently.

- Joint and robust commissioning arrangements were also highlighted, with the need for a clear needs-led commissioning process and the development of joint commissioning priorities. Health interviewees suggested that stricter commissioning arrangements would make more effective use of funds.

9   Main CAMHS priorities and gaps in provision

In this section, local CAMHS priorities and their relationship with national CAMHS priorities, together with the alignment of local authority and health priorities are discussed. This is followed by interviewees' thoughts on the prioritisation of vulnerable groups and the current gaps in provision.

9.1   Local CAMHS priorities

- Perhaps not surprisingly, from both a local authority and health perspective, the three main CAMHS priorities identified were areas related to national targets: children with learning disabilities, services for 16/17 year olds and 24/7 crisis intervention. Looked after children were also a frequently identified priority by both local authority and health staff (see section 9.4 for more details).

- Beyond this, however, local authority and health priorities tended to diverge. Other priorities for local authority staff centred on support for professionals within universal services, ethnic minority groups and children with complex needs, whilst other health priorities included primary mental health/early inter-vention and specialist CAMHS services at tiers 3 and 4, as well as the NSF and comprehensive CAMHS.

9.2   National CAMHS priorities

- Both local authority and health interviewees stated that their current priorities mapped closely on to the national priorities, some adding that they were a mixture of national performance indicators and local priorities. One local authority was said to be increasingly interested in CAMHS as a result of having to report on the national targets. Priorities were also reported by local authority staff to be consistent with the NSF and children and young people's plans.

- However, a few health staff felt that national priorities did not necessarily reflect local needs. They illustrated this with examples. One health interviewee described having to invest a significant amount of new money in on-call consultants to meet the national 24/7

indicator when local needs analysis had identified no need for such a service. Another spoke of the pressure to invest in acute services whilst trying to build up early intervention and reducing the need for young people to go into specialist CAMHS. The need to focus on referral and assessment systems rather than the national indicator areas was also cited because access to CAMHS was reported to be a major issue in one local area.

- Health staff also spoke of other concerns with regard to the national CAMHS targets. They talked about the difficulty with strategic planning because the national performance indicators were published some time after the money was distributed and the way in which the NSF is written makes it difficult for the indicators to be used for performance management purposes. One questioned the relevance of some national indicators, particularly where the basis of their assessment (e.g. in the case of a learning disabilities service), was the existence of a service or not: '*It does not mean you have a high quality service or a service that meets local need*.'

9.3   Alignment of local authority and health priorities

- There were mixed views amongst health staff about the alignment of health and local authority priorities, with slightly more believing that priorities were aligned. Alignment was thought to be a result of the steer from government, shared targets, local authority involvement in the decision-making process and priorities being established through the Children and Young People's Plan.

- A number of examples, however, were provided where local authority and health priorities were considered to be misaligned. The local authority emphasis on ECM and the relative lack of importance placed on the NSF was highlighted. The local authority focus on looked after children and young offenders and on early intervention and prevention were also cited as examples. The potential problems were explained by one health interviewee, referring to the local authority focus on early intervention and

prevention: '*That fills me with concern and anxiety because I am sat in a service that only has 25 per cent of an NSF compliant team. It is very easy for money to get sucked into areas that are deemed to meet the particular requirements of a local authority ... the local authority drives their agenda more towards their needs than necessarily the needs of CAMHS as a whole.*' Concomitantly, the health requirement for a medically led 24/7 service was also reported to be difficult for the local authority to understand. Some local authority and health interviewees referred to the need for more cross departmental work at national level because of the mismatch between local authority and PCT indicators.

9.4 The prioritisation of vulnerable groups

• Health and local authority staff agreed that children with learning disabilities and LAC were the main priorities in terms of vulnerable groups. However, other vulnerable groups considered to be a priority were wide ranging and those cited by both health and local authority staff included: young offenders, ethnic minority groups, asylum seekers and refugees, travellers, substance misusers, teenage parents, young carers, children with behaviour problems, self-harmers and children with eating disorders. Children with complex needs, children who have been sexually abused and sex offenders were only referenced by local authority staff.

• Some health interviewees referred to the lack of alignment between the local authority and health with regard to vulnerable groups. The local authority was thought by some to place an over emphasis on LAC: '*We have to remind [the local authority] that child mental health isn't just about LAC or children with behaviour problems in school, which is what they want to prioritise because it is their children. There are a huge number of children with mental health problems that don't impact on the local authority (e.g. children with eating disorders and self-harmers)*'. It was also noted that it was difficult for CAMHS to take a more preventative role in relation to some vulnerable groups because specialist CAMHS was more interested in clinical areas, such as psychosis, depression and eating disorders, and generally thought to be less willing to engage with other groups.

9.5 Gaps in provision

• Support for universal services was identified by local authority interviewees as the most common gap in provision and, although less of a priority, it was also noted as a gap by a few health interviewees. There was thought to be a need for the development of professionals' understanding of mental health and for the provision of training, consultation, advice and information for frontline workers. It was suggested that the number of primary mental health workers (PMHWs) needed to be increased to support universal services and to deal with low-level needs. However, it was also reported to be difficult to pull this work together because of its scale.

• Work with schools, in particular, was identified as an important area for development since instances were reported where schools could manage cases better themselves rather than referring on for specialist CAMHS input. The notion of expanding support through extended schools or a school cluster model was suggested.

• Gaps in tier 2 and tier 4 provision were also highlighted by both local authority and health interviewees as current gaps. In tier 2, interviewees cited the need for locality based services and family support (e.g. parenting programmes). In tier 4, they referred to the need for the replacement of out of county provision with local hospital based services and the enhancement of intensive support services based in localities.

• From a regional health perspective, common gaps in CAMHS provision were reported to primarily lie within provision for children and young people with learning difficulties. For example, within one London based region, a third of all boroughs were failing to meet their local delivery plans.

• When talking about the gaps in provision, staff shortages and capacity issues also featured highly in the discourse of health interviewees (but not in that of local authority interviewees). They referred to a deficit in the range of professional expertise across the tiers, as well as capacity issues, particularly in relation to their work with schools (see also section 11 on joint working with frontline services).

10 The balance between prevention/promotion and acute provision

The majority of local authority and local health staff sampled stated that there was not enough prevention and promotion work taking place (although there were some exceptions to this). This was largely due to a focus on treatment and a funding bias towards acute services. CAMHS regional development workers, however, were less likely to report that there was not enough prevention and promotion work taking place and identified an increasing move towards preventative services. The current national agenda, the mapping of CAMHS and having a clear CAMHS strategy were cited as factors which had helped shift the balance towards more preventative work. On the other hand, the demand for tier 3 services, a lack of funding for tier 3 and unclear commissioning arrangements were reported to have hindered progress. Interviewees went on to elaborate on how the balance could be shifted, how the demand might be managed differently and the different working practices which might need to be adopted.

10.1 Shifting the balance

- There was a view, amongst both local authority and health staff, that a shift in balance towards preventative work could not be achieved without additional ring-fenced funding. Pump priming was considered necessary because there were some children and young people with huge needs and because it would take five or ten years for any input into prevention and early intervention to take effect.

- A number of other key factors for shifting the balance were identified by local authority staff: managing the demand for specialist CAMHS differently or adopting different working practices; the involvement of mainstream services/schools and linking with other agencies to address low-level need; using evidence based practice to explore the impact of investment on demand in higher tiers; having targets focused on prevention/promotion and ensuring that emotional wellbeing is part of children and young people's plans and ensuring that services in tiers 1 and 2 are represented on CAMHS strategic partnerships.

10.2 Managing demand differently and adopting new working practices

- A number of suggestions for managing demand differently or for different working practices were made by both local authority and health staff. The most common suggestion was that the use of out of county placements or inpatient beds could be limited and the money reinvested in other areas, such as intensive outreach programmes, family support and other community services. Some were keen to examine different models of service delivery at tier 4, which was reported to be a drain on resources, for example, through shorter lengths of stay or by developing more acute community facilities.

- Interviewees also suggested that a shift in balance could be achieved by a greater focus on the development of preventative strategies and initiatives, including supporting and strengthening relevant initiatives within other services, such as anti-bullying strategies in schools, the healthy schools agenda, school counselling and Sure Start, and supporting private and voluntary sector services (see section 12.2 for more discussion). However, the previous discussion in section 7.3 about CAMHS responsiveness to change is also relevant here.

- Other commonly cited strategies were the skilling up of staff working with children and young people (e.g. teachers) to understand and deal with low-level mental health needs and changes to the referral procedures, such as the development of threshold criteria for tier 2 and the education of GPs in appropriate CAMHS referrals. More specific ideas from the local authority perspective included managing cases currently dealt with by the clinical CAMHS service through a team within the children and young people's trust and moving CAMHS services out to different locations within the community.

- However, as noted in section 7.2, amongst both the local authority and health personnel interviewed there was uncertainty about whether a shift towards preventative work would reduce the level of demand for acute services. Some interviewees predicted that the level of demand might rise, at least in the first instance, as more children were identified. However, others (both local authority and health interviewees) proffered examples of evidence to the contrary. One local authority interviewee stated, for example, that the introduction of PMHWs at tier 2 had a '*huge impact*' on tier 3 waiting lists. Similarly, a health interviewee talked about how the introduction of a specialist CAMHS nurse who undertook parenting training with health visitors had led to a significant reduction in referrals from this group of professionals.

11 Factors influencing joint working between CAMHS and frontline services

When asked about the factors which influenced joint working between CAMHS and frontline services, such as schools, the main issues raised by interviewees centred around lack of understanding, finding the time and the money and modes of delivery.

11.1 Lack of understanding

- It was commonly reported, by local authority and health staff, that misunderstandings between frontline services (schools in particular) and CAMHS, together with unrealistic expectations of CAMHS, created barriers to joint working. In addition, different cultures and CAMHS working practices, such as a reluctance to work in non-clinical settings, and an inability to act flexibly and responsively to schools' needs were also highlighted as potential obstacles by local authority interviewees. It was also suggested by CAMHS regional development workers that schools can be caught in a '*referral culture*' so that some cases are passed straight to CAMHS when they would be more appropriately dealt with elsewhere. This was said to be a result of schools' lack of understanding of tier 1 services, as well as unclear referral criteria and 'silo' working practices within CAMHS.

- An understanding of each other's roles and responsibilities, a recognition of each other's skills and clear and realistic expectations, were therefore considered beneficial. Health interviewees reported that, in addition, ambassadorial CAMHS workers were a key factor in successful joint working with schools. It was suggested that where particular CAMHS workers have been able to build good relationships with schools and provide immediate responses to problems, this should be used as a model of good practice. Local authority interviewees suggested that training in mental health awareness for frontline professionals could improve understandings of mental health issues and of the roles and responsibilities of CAMHS staff. They also suggested that more joint working and greater involvement of schools in CAMHS developments would be of benefit.

11.2 Finding the time and the money

- From both a local authority and a health perspective, the lack of capacity within CAMHS and a lack of dedicated time on behalf of CAMHS and the schools to work together were also barriers to joint working. Finding available time to train school staff was also reported to be difficult for both schools and CAMHS. The attitudes of some school staff were also identified as an obstacle because the extent to which CAMHS workers are utilised in school was thought to depend on staff attitudes. The attitude of the headteacher was identified as particularly important and it was noted that some were easier to engage and to work with than others.

- Health interviewees identified school autonomy as a barrier to joint working. With schools increasingly more able to spend their budgets independently, it was reported that it was becoming difficult for CAMHS workers to develop coherent strategies across an area of schools. It was also felt that communicating with schools was problematic as they could no longer all be accessed through the local authority. Furthermore, health interviewees noted that, as schools become more autonomous, they increasingly want to liaise directly with CAMHS rather than through the local authority. Thus, whilst local authority interviewees called for increased dialogue between CAMHS and schools, health staff stated that CAMHS do not have the capacity for such liaison: '*How can you have a dialogue with 80 schools?*' They called for an alignment of government policy to help alleviate this problem.

11.3 Modes of delivery

- A number of other suggestions were made for improvements to joint working between health and schools by both groups of interviewees and these were mostly centred on modes of delivery. It was suggested, for example, that the delivery of integrated services (including CAMHS) through schools (e.g. through the extended schools agenda)

and the development of multi-agency locality teams (e.g. based around clusters of schools) could further facilitate joint working. Information sharing and communication were also thought to facilitate joint working by both groups of interviewees. The establishment of clear referral pathways, with access to alternative services where relevant, was also considered helpful by local authority interviewees.

12 Support for tiers 1 and 2

Interviewees were asked about the support available for services in tiers 1 and 2 from CAMHS services in tiers 3 and 4 and the contribution of voluntary and community organisations.

12.1 Support for tiers 1 and 2 from tiers 3 and 4

- In just over half of the local authorities in the sample, personnel reported that tiers 3 and 4 CAMHS do not currently provide a good level of support for tiers 1 and 2, largely due to ineffective links and a lack of integration across tiers (tier 4 was perceived as being particularly 'remote' in some local authorities). This was especially the case in local authorities where interviewees indicated that they were less well developed in terms of integrated children's services.

- Where support was provided by the higher tier services this was described by local authority interviewees as mainly through consultation (including opportunities within multi-agency liaison meetings), staff working across the tiers (e.g. tier 3 workers based part time in tier 2, joint funded posts across tiers and PMHWs acting as an interface between 2 and 3), training and joint working/projects.

- Over half of the health staff interviewed referred to staff working across the different tiers as a means of support for tiers 1 and 2. Whilst this was reported to be increasingly the case in some areas, others stated that there was local variation. This arrangement was felt to be facilitated by staff having a clear understanding of their roles and responsibilities, good organisation and having good supervision in

place. The varied interpretation of the tiered service structure, preciousness over mental health specialisms and ingrained ways of working were cited as potential obstacles.

12.2 Voluntary sector and community contributions

- In just under half of the local authorities in the sample, it was reported by local authority staff that the voluntary sector and community organisations currently make a significant contribution to tiers 1 and 2. However, in eight local authorities, their involvement was considered limited or lacking, largely due to a lack of local voluntary organisations or to the minimum commissioning of such services.

- The variation of voluntary sector input across cities or regions and between schools was reported as being unhelpful by health representatives. It was also noted that it was often difficult to keep track of their input and this needed to be better coordinated and better evaluated.

- The contributions made by local voluntary or community organisations tended to be in the form of low-level counselling services (e.g. community and school counselling), other work with children and families (e.g. parenting skills, nurture groups and respite care for children with learning disabilities), tier 1 input (e.g. the engagement of children and young people in the emotional wellbeing agenda and mental health awareness raising) and the provision of specific services for Black and Minority Ethnic (BME) communities, as well as support for young carers and services for sexually abused young people.

13 Future funding pressures

Finally, interviewees were asked about their predictions for the future funding pressures for their local CAMHS.

- Over two-thirds of the local authority personnel and about half of the health personnel interviewed identified that general low funding and the pressure to make savings would be problematic for the development of comprehensive CAMHS. For both local authority and health staff a key concern was the lack of future development money, for example, for investment in prevention and promotion and the establishment of multi-agency locality teams. Local authority staff warned that, with funding for preventative work in jeopardy, this could lead to a vicious circle, with increased demand at tiers 3 and 4 and a subsequent increase in costs. The need for current posts/initiatives to be mainstreamed was also raised. Health staff raised concerns that if CAMHS targets were dropped, funding would divert to other services and that services recognised as functioning well might lose funding.

- Local authority and health interviewees also agreed on many of the specific areas under future funding pressure, including specialist CAMHS (particularly tier 4 services), services for children with learning disabilities and services for 16 to 18 year olds.

- The funding of tier 4 services was thought to be problematic due to increasing demand and the rising costs of inpatient services. Some stated that they were keen to examine a model of service delivery where young people stay shorter lengths of time in inpatient care and more acute community services are developed alongside support for professionals working with young people.

- The funding of services for children with learning disabilities was also a concern because of the increasing service demand (for autistic spectrum disorders in particular), the need for specialist CAMHS learning disability service and for costly out of area special placements for those with multiple needs. However, local authority staff in two authorities talked about 'invest to save' measures and using the money from out of county placements for setting up local services, such as family support services.

- Financing the services for 16 to 18 year olds was considered problematic due the extent of need and a lack of additional identified funding. One health interviewee noted that they would either need additional resources for this or the CAMHS threshold would have to be raised very high.

- Local authority staff also highlighted tier 1 and 2 services as a future funding pressure, due to the increased identification of needs at the lower tiers. Health interviewees focused also on the pressures created by workforce development and Agenda for Change, which was reported to have raised the cost of staff. They argued that, with the CAMHS strategy in place, children with mental health needs would be identified more effectively and more money would need to be invested in specialist CAMHS.

14 Main conclusions

The following overall conclusions have been elicited from the findings.

- Despite a history of underfunding for CAMHS in many areas, the injection of money through the local authority CAMHS grant appears to have led to significant progress in the development of comprehensive CAMHS. However, it is possible that, for current progress towards prevention and promotion to be maintained, further funding, which is protected to ensure it is spent on the purpose intended, may be required.

- The findings indicate a lack of performance management data in relation to CAMHS, this being an area currently in its infancy. Further progress is required in order to inform effective service development.

- There was evidence that, in some areas, the clinical focus of CAMHS has created a barrier to change. This, together with the lack of a clear purchaser/provider split within some local authorities' commissioning arrangements (i.e. making them more provider led), could hinder local authority progress towards the delivery of comprehensive CAMHS.

- There was also some evidence that, despite the call for greater school involvement in mental health and increasing dialogue between CAMHS and schools, increasing school autonomy could make it more difficult for services, such as CAMHS, to engage with schools and to develop coherent strategies across an area of schools. In addition, there is a need for them to understand each other's constraints more fully.

15 Recommendations for local authorities

The recommendations which stem from the findings fall into four main areas: the location of responsibility for CAMHS developments, decision making and commissioning, effective use of CAMHS funding and shifting the balance from acute services to prevention and promotion.

15.1 Responsibility for CAMHS development

- In the light of the findings, it is worth giving consideration to the location of responsibility for CAMHS developments within the local authority. This may have implications for the integration of CAMHS across services and therefore the implementation of comprehensive CAMHS. The location of responsibility for the CAMHS grant within social care, rather than wider children's services, for example, may limit the extent to which 'education' and schools are involved in CAMHS developments.

- Given the notable differences in culture between health and local authority services which were alluded to by interviewees, the appointment of a CAMHS lead with multi-agency experience (particularly experience in health) could promote the benefits of joint working.

15.2 Decision making and commissioning

- In order to promote the view that mental health is everyone's business, local authorities might want to consider the benefits of having a broad range of stakeholders, including universal services, such as schools, on CAMHS decision-making or advisory groups.

- Where not currently in place, joint commissioning arrangements could allow a strategic overview of both local authority and health priorities and for service developments to be considered across all four tiers of service delivery.

- In a broader context, local authorities might wish to weigh up the pros and cons of having a joint commissioning group across children's services, of which

CAMHS commissioning is a part, together with an advisory sub group with wider, more specialist knowledge to further inform the decision-making process.

- Where there is evidence that CAMHS are less responsive to the need to change current working practices in the light of new developments, local authorities might usefully reflect on the implications of their current commissioning arrangements and how these could be adapted to facilitate moves towards comprehensive CAMHS. A clearer purchaser/provider split, for example, with providers being involved in an advisory capacity may be more helpful. Evidence to the effect that input into tiers 1 and 2 could reduce waiting lists at tier 3, thereby freeing up clinicians to provide greater quality input to children that require higher level provision, if it were forthcoming, might act as an important lever for CAMHS.

15.3 Effective use of CAMHS funding

- Since the findings point to the apparent success of arrangements for the informal pooling of the local authority and the PCT CAMHS grant (from a local authority perspective), where the local authority CAMHS grant and the PCT CAMHS grant are treated separately, authorities might wish to consider such an approach. Where informal pooling arrangements are already in place, despite the complications involved, putting this on a more legal footing may be beneficial for the security of CAMHS funding. The provision of local area agreements could also further facilitate effective use of funding.

- With performance management relating to CAMHS in its infancy, it is likely that most local authorities would benefit from the sharing of good practice in this area so that service development is based on sound performance management information.

- Given the wide range of funding sources highlighted, taking a broad view of CAMHS, as is currently the case in some authorities, might enable local authorities to tap into more funding streams than they do currently.

15.4 Shifting the balance towards prevention and promotion

- In order to shift the balance of resources more from acute services to prevention and mental health promotion, local authorities may need to consider managing demand for specialist services differently and this may involve significant changes to CAMHS working practices. A reduction in the use of out of county placements and examination of alternative models of service delivery at tier 4, with a redirection of resources into community facilities, could be beneficial in many authorities. Another way forward may be to bolster support for universal services to enable them to address low-level mental health needs and to capitalise on the contribution which voluntary and community organisations can make in this respect.

- Where schools are to be utilised as a vehicle for CAMHS services, local authorities should recognise the need to facilitate training or joint working as a precursor to such a move. Given that the increasing independence of schools was cited as an obstacle to CAMHS engagement with schools, the need for joint working may need to be enshrined in government policy in order for this to be effective. Training will need to cover identification and understanding of mental health problems, the distinction between low-level mental health needs and those that need to be referred to specialist CAMHS, strategies for dealing with low-level mental health needs and where to go for help and support.

- Where divisions currently exist between tier 1/2 and tier 3/4 services, effective integrated working practices could be achieved by employing staff to work across tiers, thereby facilitating effective referral to specialist services and facilitating support for services in tiers 1 and 2. There was already evidence of such inter-tier working in about a third of the local authorities in the sample.

Appendix – local authority sample characteristics

Table A.1   The types of local authorities in the sample

Type	Number
London Boroughs	6
Metropolitan	9
Unitary city	7
Unitary regional	5
County	4
TOTAL	31

Table A.2   The sizes of local authorities in the sample

Type	Number
Large	8
Medium	7
Small	16
TOTAL	31

Table A.3   The Comprehensive Performance Assessment (CPA) ratings of local authorities in the sample

Type	Number
One star	3
Two star	8
Three star	14
Four star	6
TOTAL	31

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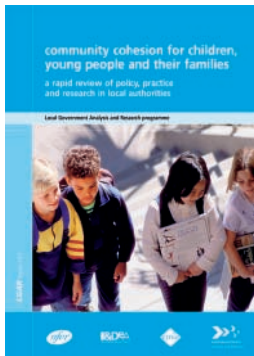
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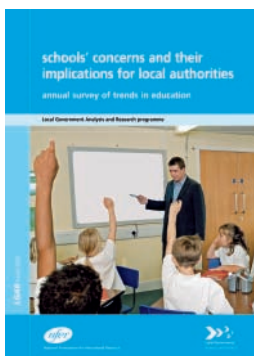
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In the light of recent developments, notably the passage of the Children Act 2004, the subsequent implementation of Every Child Matters agenda and the recent substantial increase in funding to councils for Child and Adolescent Mental Health Services (CAMHS), the Local Government Association (LGA) commissioned the National Foundation for Educational Research to examine the funding mechanisms and priorities in CAMHS.

This report discusses the research carried out by the NFER and looks at:

- the local authority CAMHS grant, the Primary Care Trust (PCT) core CAMHS grant and other sources of CAMHS funding

- commissioning arrangements for the grants

- the impact and effective use of current funding mechanisms.

The report also identifies main CAMHS priorities and gaps in provision and makes recommendations for local authorities.

This research is important reading for all local authority staff, schools, Primary Care Trusts and other organisations involved in social care or the equivalent children's services.