

Lightning Review: Access
to Child and Adolescent
Mental Health Services,
May 2016

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Background

The Children's Commissioner has become concerned that not all children and young people are able to access children and adolescent mental health services (CAMHS) and receive the mental health services and support they need.

Using her powers to request data from public bodies we asked all CAMHS trusts about the referrals they received and the access that they gave children and young people in their area during 2015. We have received data from 80% of the trusts we asked (48 of 60) and have also spoken to children and young people about their experiences of accessing CAMHS.

We have heard that:

- Large numbers of children and young people – some with apparently serious conditions – are being turned away from CAMHS upon referral and/or are having to wait long periods of time for treatment;
- Many children are waiting a long time to be seen by mental health services;
- Many children are falling out of the system because they miss appointments and then have to be re-referred;
- There are large variations in practice across the country, suggesting that access to CAMHS is a postcode lottery;

This lightning review is designed to cast light on potential issues that exist in the mental health services vulnerable young people need. In doing so, we hope it will draw commissioners' and policymakers' attention to possible weaknesses in local systems and help them improve provision so that more and more young people can have their mental health needs met and so begin to recover and rebuild their lives.

Summary of findings

According to the data we received, in 2015:

- About 1 in 250¹ children were referred to CAMHS services by professionals, their family/carers or self-referrals (about 40% of referrals came from GPs).
- Large numbers of children and young people were turned away without being offered services:
 - On average, 28% children and young people referred to CAMHS were not allocated a service. However, this varied across England. Whereas, one CAMHS providing services in two regions in England stated that 75% of children and young people referred were not allocated a service only 18% of children and young people referred to CAMHS in the South East and West Midlands were turned away.
 - 79% of CAMHS stated that they imposed restrictions and thresholds on children and young people accessing their services – meaning that unless their cases were sufficiently severe they were not able to access services.
- In some areas, waiting times were extremely long – in one CAMHS in the West Midlands the average waiting time was 200 days – though in others they were much shorter, one CAMHS in the North West saw referred patients, on average, within 14 days.
- Of particular concern were some of the 3,000 children and young people we heard about who were referred to CAMHS with a life-threatening condition (such as suicide, self-harm, psychosis and anorexia nervosa), of whom:
 - 14% were not allocated any provision;
 - 51% went on a waiting list;
 - Some waited over 112 days to receive services.
- It is well known that many young people with mental health problems have difficulty attending appointments². However, 35% of all CAMHS stated that children and young people who missed appointments would face restrictions in accessing their services:
 - 28% of all CAMHS said that children and young people were stopped from accessing CAMHS if they missed appointments;
 - 8% of CAMHS stated that this would happen following 2-3 missed

¹ Based on the data we gathered from 48 trusts and the population (according to the 2011 census) in their respective areas

² Department for Health (2015) 'Future in mind' -

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

appointments. Others stated that there would be a mechanism in place to assess risk and need before being discharged from the service.

Referrals and access to CAMHS

In 2015, **248,264** children and young people were referred to CAMHS and **28,204** were re-referred to the 48 CAMHS from which we received data. A breakdown of these figures by region is as follows:

Region	Total number of children and young people referred to CAMHS 2015 by region	Total number of children and young people re-referred 2015 by region	Percentage of referrals and re-referrals[combined] compared to overall population ³
Greater London	59739	6089	0.55%
South East	46894	1031	0.45%
North West	24623	5096	0.34%
North East	22834	1272	0.75%
Yorkshire and Humber	19848	1182	0.34%
East of England	19570	5839	0.46%
South West	17844	3113	0.36%
West Midlands	16644	2125	0.28%
East Midlands	10779	1965	0.27%
Multiple ⁴	9489	492	0.45%
Grand Total	248,264	28,204	0.42%

44 CAMHS were able to break down the referrals by source, these are as follows:

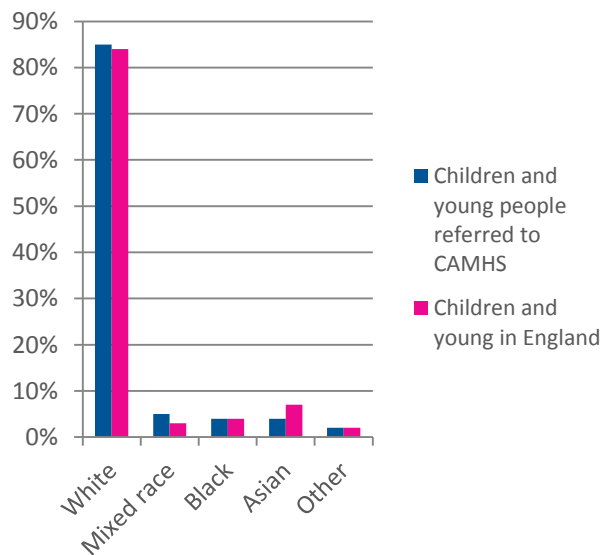
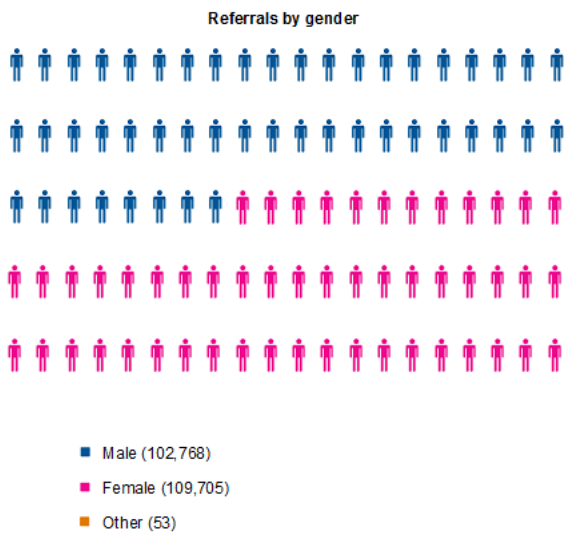
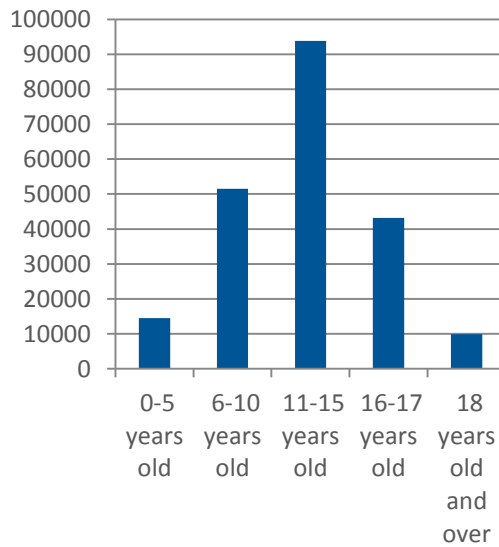
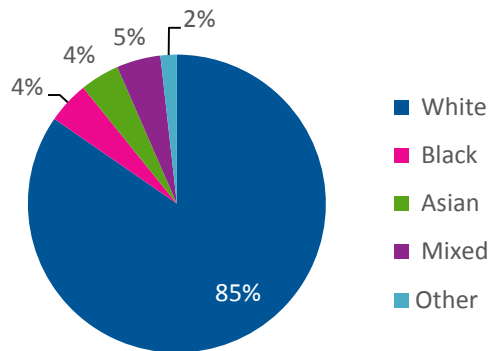
Source of referral	Number of referrals	Number of re-referrals
GP	44%	43%
Community Paediatrician	3%	2%
Health Visitor	0.3%	0.1%
School Nurse	2%	3%
Social Work	5%	5%
Self-referrals	5%	3%
Other/not recorded	41%	43%

³ Percentages were calculated by using the 2011 population Census data to calculate the population for each CAMHS areas and aggregating it up to regional level. The total number of referrals for each region was then divided by the population and multiplied by 100.

⁴ CAMHS that provide services in more than one region.

The characteristics of those referred

In our data request, we asked for information on the children and young people who were being referred to CAMHS. Most trusts were only able to provide data on the age, gender and ethnicity of the children and young people referred to them. These are highlighted below.



The data we gathered suggests:

- a slight over-representation of girls being referred to CAMHS;
- a slight over-representation of children and young people who are mixed race being referred to CAMHS;
- an under-representation of males and Asian children and young people, when compared to the overall population of children and young people in England.
- a major over-representation of children in care. Whilst fewer than 0.1% of children in England are in care, 4% of those referred to CAMHS services were.⁵

Worryingly, over three quarters of CAMHS did not gather data on whether children referred had a disability, and the majority of the CAMHS that did only gathered data on children and young people with learning disabilities because they offered specialist provision in this area. This is particularly concerning as it suggests that these CAMHS are not considering how their services could be made accessible to them and their needs. However, from 1 January 2016 this information has been collected by all trusts as part of the new Mental Health Services Data Set.

⁵ Based on 2011 Census

Young people being turned away from services

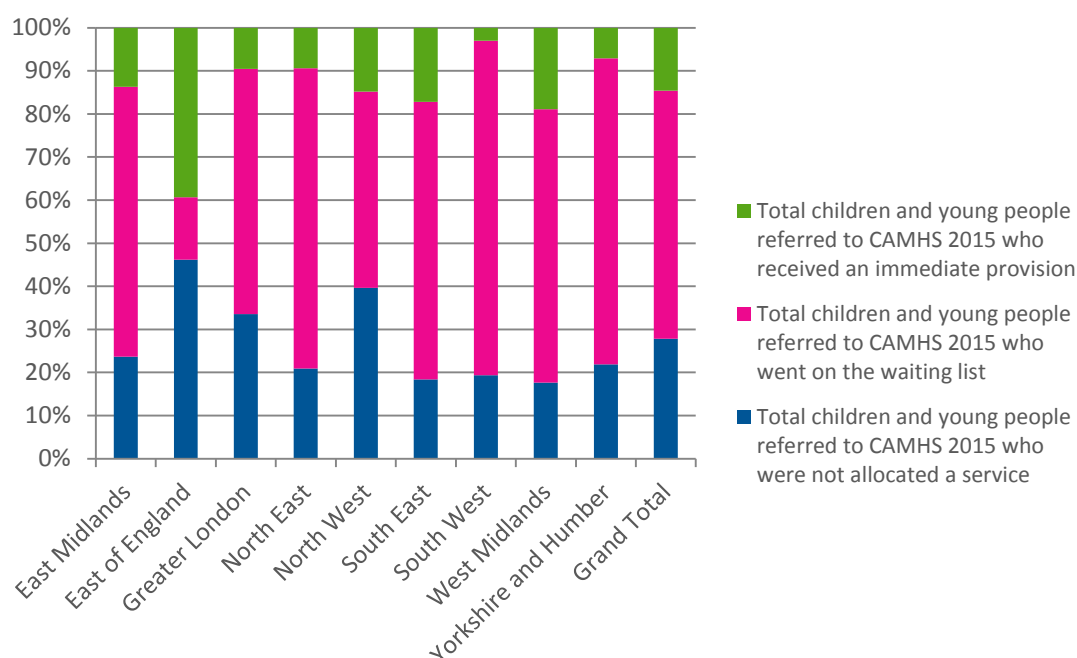
We found that of all those children and young people referred to CAMHS:

28% were not allocated a service. This ranged between 18% and 75% across regions.

58% went on a waiting list. This ranged between 6% and 78% across regions.

14% received provision immediately. This ranged between 3% and 39% across regions.

If we look at these rates across regions, the variations are stark suggesting that ease of access to services varies greatly across the country.



In England, based on the data we gathered, the average waiting time between referral and receipt of services ranged from 14 days (a CAMHS in the North West) to 200 days (a CAMHS in the West Midlands). This indicates that access, the service you receive and how long you are likely to wait for it depends very much on where you live.

The length of time spent on a waiting list can have a significant impact on a child or young person's mental health and associated needs and can lead to failing to engage with the service, and/or, their condition worsening. This does not mean that the child or young person no longer needs support. One young person we spoke to described how a three-month wait for services had impacted on him:

Case Study – George’s Story

From about the age of twelve, George started experiencing very negative thoughts, he often saw himself looking down from a very high building and falling off the edge. He became increasingly worried and anxious when he was awake but also had lots of trouble sleeping. He started falling asleep at school and his attendance dropped off. He preferred to stay in bed most of the day. He couldn’t understand what was going on but began to feel quite paranoid; he believed that he wasn’t real and that everyone was a cast member. He would pinch himself to feel real and he continued to do this until he started to bleed. He felt quite alone and not sure how to get help but knew something was wrong. He referred himself to his GP and his mum went to the appointment with him. He told his GP that he thought he had depression and he was referred to CAMHS.

There was a three month waiting list but after about three weeks he thought things were OK, so when the letter finally came he told his family he was feeling fine and didn’t need to go to his appointment. Another letter came a few weeks later, although addressed to his dad, he opened it, thought it wasn’t needed and discarded it.

A few months later his behaviour got worse. He started to hang around with older people and using lots of recreational drugs. He was sexually active although he was still only thirteen. One day, on a manic high, he stole his dad’s credit card and spent hundreds of pounds. His dad threatened to call the police and his paranoia returned.

It was Christmas Eve, he was fourteen and he went to his Nan’s as he usually did but he wasn’t let in because he was said to be ‘trouble’. He felt very rejected and upset; when he got home he tried to overdose on his dad’s antidepressants and whisky. *‘I felt so sick so I called the NHS helpline, it was all a bit of a blur but the NHS doctor said I was OK. Just a few weeks later on New Year’s Eve, I tried to slice my arm open’.*

George is unclear what if any help was offered after this incident, but describes repeated attempts to take his life. *‘It was after I tried to commit suicide again and drown myself in a canal that for the first time I was assessed by a psychiatrist who told me “you’re not well”’.* He was so relieved that someone seemed to understand his illness he would not have agreed to CAMHS support but he was given a section 16 under the Mental Health Capacity Act 2005 for 28 days. *‘I went straight to tier 4 and skipped tier 3’.*

He felt this was beginning of his help but that 28 days was not enough. After he was discharged he was referred to another consultant but he explains that changing consultants was hard and could add to his anxiety because he never knew if the dynamics would work. He struggled to cope and describes his behaviour as becoming more and more reckless; he had moved out of his parent’s home and was in and out of A&E with poly drug misuse. He says he was then given ‘meds’ to help but no therapeutic support.

When George was seventeen years old he was offered regular weekly sessions of Cognitive Behavioural Therapy, together with developmental group work meetings, through CAMHS. Things then started to improve and although he went on to develop an eating disorder and psychosis, support remained and following another couple of inpatient periods he felt he was made progress. At this time he was living in supported accommodation and relied on the CAMHS provision and when he transferred to adult services, CAMHS stayed with him by offering him opportunities to be part of their young people's participation group. He smiles when he looks back and says that he thinks this might have made the biggest difference because *'adult services are crap but CAMHS valued me and what I had to say, showed me I was worth something.'*

The children and young people we spoke to, who have needed ongoing support from CAMHS told us that every time they were re-referred, they had to wait for a service.

Case Study – Richard's Story

Richard, who is nearly 14, enjoys seeing his CAMHS counsellor and having someone to talk to on a regular basis. He describes his behaviour as 'hyper' and says the meetings have really helped him to be calmer, and although he still fidgets and struggles with friendships he is happier with CAMHS support. His younger sister Emily agrees, and says she didn't get much sleep before. The whole family have engaged with family sessions to better understand and support Richard.

His mum Sarah thinks the CAMHS support they've received has been very good, but she highlights that it was a real battle to get Richard's primary school to recognise and understand his needs. She felt the school was too ready to dismiss his behaviour as a discipline issue, and she felt blamed rather than supported by them. This added to her worry and stress and she took a break from work so she could focus on supporting Richard and getting him the help he needed.

A friend whose child was experiencing similar difficulties recommended the Parent Partnership Service to Sarah. They gave her advice on the process for assessments for special educational needs. She also began her own research which was stimulated by a module on her child development course. On the basis of this she visited her GP to share her concerns, and the GP made a referral to CAMHS.

Following a three month wait Richard was seen, assessed and diagnosed with ADHD. His mum moved him to a new primary school, where both he and his mum feel the staff were much more approachable and helpful. Richard made good progress. Sarah is clear that it was her resourcefulness and determination that secured specialist help for Richard and she wonders how parents of a different nature or who get worn down with obstacles would cope.

When difficulties surfaced again in year eight of Richard's secondary school, his GP supported a referral back to CAMHS. Again there was a wait time of around three months and whilst his mum is sympathetic to the demands on CAMHS, she expresses how hard it can be when you are under strain and need immediate support.

Now that Richard *'has that space and support that CAMHS gives'* things have improved again. She feels that teachers and other professionals need to recognise and value children and parents as experts in their own lives far better. If they could do this, they would take their concerns seriously and be facilitators to specialist services, rather than gate keepers.

Reasons for referral to CAMHS

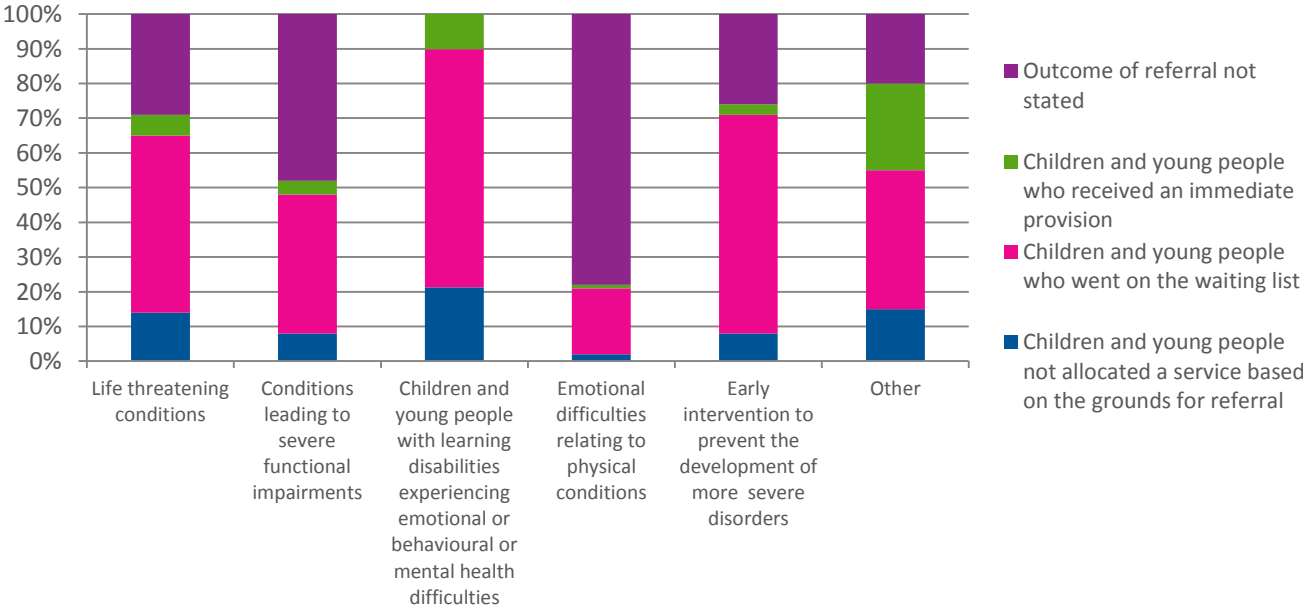
Only 25% of CAMHS were able to provide us with data on grounds for referrals:⁶

Grounds for referral	Percentage of grounds of referrals to CAMHS in 2015	Percentage of grounds of re-referrals to CAMHS in 2015
Life threatening conditions, including <ul style="list-style-type: none"> - Psychosis - Risk of suicide or severe self-harm - severe depressive episode - anorexia nervosa 	25%	22%
Conditions leading to severe functional impairments, including <ul style="list-style-type: none"> - Severe obsessive-compulsive disorder (OCD) - Anxiety/phobic/panic disorders - Bulimia nervosa - ADHD where there is significant psychiatric co-morbidity - Autistic spectrum disorders - Tourette's syndrome - School refusal where mental health disorder plays a significant role - Conduct difficulties which co-exist with other disorders - Severe and/or complex relationship difficulties 	32%	28%
Children and young people with learning disabilities experiencing emotional or behavioural or mental health difficulties	4%	3%
Emotional difficulties relating to physical conditions, including: <ul style="list-style-type: none"> - Diabetes - Asthma - Neurological conditions - Unexplained pain/ somatising disorders 	5%	4%
Early intervention to prevent the development of more severe disorders: <ul style="list-style-type: none"> • Complicated bereavement • Post-traumatic stress disorder (PTSD) • Severe attachment difficulties • Self-care issues 	6%	7%

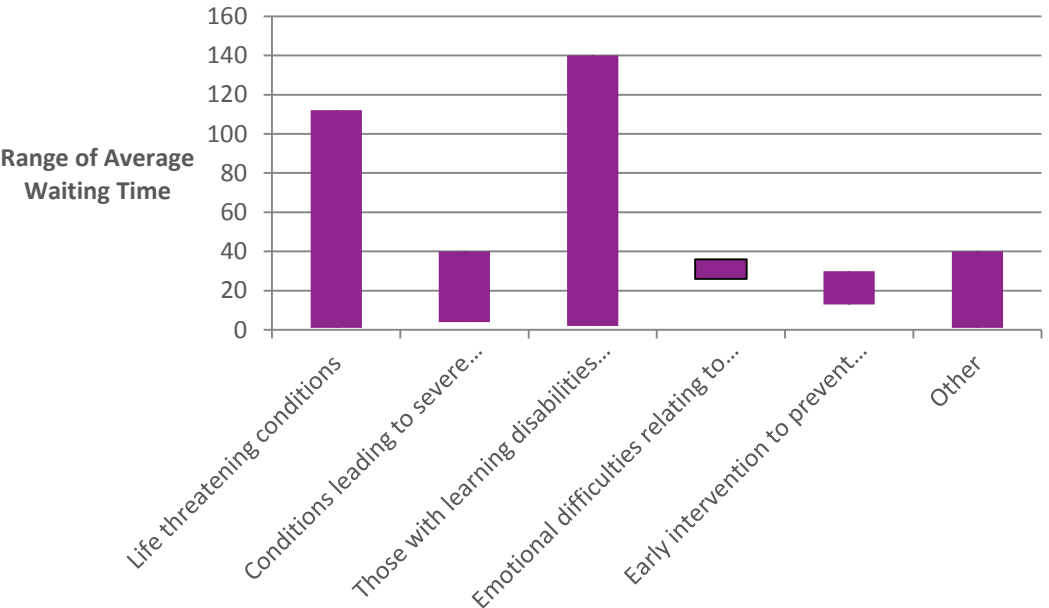
⁶ From 1 January 2016 all CAMHS trusts have been collecting this data as part of the new Mental Health Services Data Set

Other	28%	34%
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In these CAMHS, the majority of referrals and repeat referrals received were relating to 'conditions leading to severe functional impairments' and 'life threatening conditions.'



Average waiting time in days by condition following referral



In the services that responded to the question almost 3,000 children and young people were referred with life threatening conditions and of these, 14% were not allocated a service. For those who went on the waiting list, the average waiting time varied hugely from area to area. In one CAMHS, the average wait for young people with these conditions was 112 days.

Restrictions and thresholds imposed by CAMHS

As illustrated above, in 2015, 28% of children and young people referred to CAMHS were turned away. These are children and young people who were identified as having a mental health need that required a referral to CAMHS but who did not access a service or treatment in CAMHS. When we asked CAMHS about whether they imposed restrictions and thresholds, 79% of CAMHS stated that they did so. One CAMHS in the North West told us:

'As a tier three⁷ Child and Adolescent Mental Health Service, we focus our resources primarily on children and young people presenting with the most severe mental health difficulties. We consider referrals based on the following factors:

Severity: Is the problem at a level that is causing significant distress or disruption to the child/young person's life?

Persistence: Is the problem ongoing and has not been resolved despite input from other services?

Complexity: Is the problem made worse by other factors making change more difficult?

Risk of secondary disability

State of the child/young person's development

Presence / absence of protective or risk factors

Presence / absence of stressful social and cultural factors.

In our data request, we asked CAMHS to tell us about what restrictions and thresholds they put in place. They reported the following:

73% of CAMHS stated that age was a condition to accessing the service. All CAMHS reported that they accepted referrals for children and young people up to the age of

⁷ Severe, complex and persistent diagnosable disorders

18 although not all offered services to children and young people from birth. Within each CAMHS, different teams or provisions would target more specific age ranges. Two CAMHS reported that only in exceptional circumstances (e.g. young people with learning disabilities), would provisions may be allocated to over 18s.

46% of CAMHS stated that they only cater for certain conditions. This means that children and young people with mental health needs that did not have these conditions would not be offered a CAMHS provision. When asked to elaborate, most responses referred to conditions that would be targeted by tier 3, (e.g. severe, complex and persistent diagnosable disorders) or tier 4 (e.g. the most serious problems) services. Some CAMHS also provided specialist services or funding to target particular conditions. This is illustrated by these CAMHS:

CAMHS in East Midlands

'The Specialist CAMHS Outpatient Teams will provide children and families with a range of services to facilitate the assessment and treatment of significant mental health problems and disorders, including:

Psychotic disorders

Severe/moderate depression

Eating disorders

Obsessive disorders

Anxiety disorders

Depression

Diagnostic assessment in complex (as part of the agreed ADHD multi agency care pathway

Diagnostic assessment in complex autism (as part of the ASD pathway)'

CAMHS in the South West

'Mental health disorders included in International Classification of Diseases-10⁸ or Diagnostic Statistical Manual of Mental Disorders 5⁹, in children and young people without a learning disability. There are separate services for young people with: learning disability; with an eating disorder as primary diagnosis; with substance misuse as a primary diagnosis.

⁸ WHO (2016), 'International Classification of Diseases – 10' - <http://apps.who.int/classifications/icd10/browse/2016/en>

⁹Diagnostic and Statistical Manual of Mental Disorders (2015) - <https://www.psychiatry.org/psychiatrists/practice/dsm>

Other CAMHS provided us with their exclusion criteria. One in Yorkshire and Humber and one in the East of England stated that they did not provide services for children with ADHD or autism. Another CAMHS in Yorkshire and Humber said that they do not offer services for children and young people experiencing adverse life events:

CAMHS in Yorkshire and Humber

'Our CAMHS do not offer services for normal reactions to adverse life events, e.g. parental separation/bereavement or for normal child development difficulties'

71% of CAMHS reported that they set thresholds based on the severity of the mental health condition. These thresholds varied by trust. When asked to elaborate, some trusts highlighted that these thresholds were set by their clinical commissioning groups (CCGs). Others mentioned that it depended on the assessments, the diagnosis made, and the impact that the mental health condition is having on the individual and the associated risk to them and others. As highlighted by these CAMHS:

CAMHS in the North West

'Severity is generally used to determine which component of the service can best meet the identified needs/risks but also to identify whether other services within the universal offer (parenting, school nurse intervention, 3rd sector early help) are best placed to provide the intervention required with support/consultation if appropriate.'

Three CAMHS specified that they would triage these cases to assess the severity of the conditions.

CAMHS in the South East

The service operates within the current Service Referral Criteria. All decisions to accept or decline referrals are made on a case-by-case basis taking into consideration the information received in the referral, and collected at triage/assessment.

40% of CAMHS stated that the duration of symptoms were sometimes taken into consideration when granting access to their services. Only three CAMHS stated how long symptoms needed last for them to be considered. This ranged between three and six months. These symptoms were mainly linked to risk, trauma or particular learning difficulties.

Children and young people who miss appointments

35% of CAMHS stated that children and young people would face restrictions to accessing CAMHS if they miss appointments. When we asked about the restrictions children and young people face, 29% of CAMHS stated that they are stopped from accessing CAMHS. Only 8% of CAMHS told us how many appointments they would have to miss before being discharged. This ranged between 2-3 appointments. The remaining responses reported that an assessment would be undertaken to ascertain the next course of action.

CAMHS in the North West

'If there is no contact and no response to reminder letters asking the family to make contact, the young person will be discharged from CAMHS but only after a review of the case and the associated risks as discharge will not take place at this point where there are safeguarding issues or clear risks associated with the discharge.'

CAMHS in Greater London

'Only if a young person consistently did not attend and contact cannot be made with them, then potentially they will be discharged. However, the discharge will not occur until attempts to contact the young person have been made and also the referrer has been contacted to help engage the young person in the treatment.'

'A discharge for this reason would not preclude the young person from having a subsequent referral opened, or assessment / treatment with the service.'

38 CAMHS were able to tell us how many appointments children and young people missed appointments in 2015. The table below provides a breakdown of the total number of children and young people who missed a CAMHS appointment.

Children and young people who missed appointments



- Missed one appointment (56%)
- Missed two appointments (21%)
- Missed three appointments (10%)
- Missed four or more appointments (13%)

The Children’s Commissioner frequently hears from children and young people about the myriad of reasons why they are not able to attend appointments, such as inaccessibility of services and the lack of support to get to attend appointments. Reviews by the Care and Quality Commission, have suggested that issues such as travel and social isolation could impact on children and young people’s abilities to attend.¹⁰ This does not diminish their need for the service and may indicate that there are additional needs that are not being addressed. The case study below illustrates some of the difficulties one young person has in attending appointments, and how provisions were tailored to successfully meet her needs:

¹⁰ CQC (2015) ‘Specialist community mental health services for children and young people Quality Report’ - https://www.cqc.org.uk/sites/default/files/rx2_coreservice_specialist_community_mental_health_services_for_children_and_young_people_sussex_partnership_nhs_foundation_trust.pdf

Case Study – Melanie’s Story

Melanie is 16 years old and living in semi-independent accommodation. She has been engaged with CAMHS over three and half years, seeing her psychotherapist on a one-to-one basis every couple of weeks. This relationship is very important to her in the context of a difficult and turbulent family life that has involved her moving in and out of care. Despite valuing her therapist she explains that it has not always run smoothly. She remembers a first appointment with CAMHS aged ten or eleven years followed by a gap of a couple of years. She continued to struggle with anxiety and attendance at school and so was re-referred to CAMHS by her social worker. She thinks she saw two or three people before she met her current therapist - a child and adolescent psychotherapist - and even then for the first year she rarely made appointments. A family support worker would come over to her house and offer to take her to her appointments but *‘I stayed in bed, and said I felt ill’*. Julia, her therapist continued to be available despite the gaps and would give her a call later that day or in the week, to see how things were and encourage her to come along next time. She made sure that Melanie knew that she didn’t take these absences personally and understood how difficult it was for her to attend in person.

When she moved nearer the clinic she found it easier to attend. She says she has been helped with her Post Traumatic Stress Disorder through moving out of home and also through having a psychotherapist who can apply some Cognitive Behaviour approaches within therapy, as well as addressing the deeper trauma. Julia texts Melanie between sessions and this seems to provide a thread that supports her attendance to meetings, *‘I don’t like phone calls but texts are OK’*.

Julia is the lead child psychotherapist for a specialist CAMHS service for adopted children and their families. Whilst Melanie does not fall within this project brief, Julia says that she uses the approaches of engaging and working with harder to reach children and their families from this project, to all aspects of her therapeutic work. Julia explains that the specialist adoption service is built around what children and young people say they need and want, and in relation to Melanie, she says what has helped the most is that, *‘she knows I will continue to try and make sense of her experiences and that I haven’t given up on her’*.

The 29% of CAMHS that stopped children and young people from accessing their service if they missed appointments told us that, if there were no recorded risks for children and young people missing appointments, the child would be sent a letter detailing that they were discharged from the service and would need to be re-referred to access it. 48% of all CAMHS stated that they would offer alternative provisions to children and young people who miss appointments. As illustrated below, some of these approaches were very inclusive and sought to find the best approach to support that child or young person:

CAMHS in the South West

'We have no formal restrictions and we work collaboratively with agencies to support young people who don't fit easily into services. This is why we have developed the Early Help Hub to intervene quickly and to enable collaborative thinking early to support the young person and their family.'

CAMHS in the North East

'We will contact the referrer to offer ongoing support. If families wish, we will offer alternative suggestions and we work as part of the team around the child, so will support other agencies to deliver interventions.'

Most CAMHS stated they would work collaboratively with other agencies to engage with the child and/or their family, to find an approach that works best for that child or young person.

Young people who are not referred to CAMHS

In addition to the children and young people who are referred to CAMHS, there are a number of children and young people who are in need of a CAMHS provision but are not being referred. In our evidence gathering we spoke to a number of professionals about their experiences of making referrals. One community paediatrician told us that they will often only refer a child or young person to CAMHS if they are certain that they have a diagnosable mental health condition that CAMHS will take on. In 2015, we published our first report in our Inquiry into Child Sexual Abuse in the Family Environment.¹¹ In this we surveyed survivors of child sexual abuse who told us that in childhood they experienced a range of feelings, behaviours and emotions as a result of the abuse they were subjected to. It was only later in life that they felt that they were able to identify themselves as having a 'diagnosable' mental health condition. This suggests that adverse life events can lead to 'diagnosable' mental health conditions particularly if left.

Some of the children and young people we spoke to, who had a mental health condition, had not had their conditions diagnosed until late adolescence. This means that these children were in need of a CAMHS provision, but their need was not being identified and addressed. Although they knew something was not right, it took a long time before they could make sense of it and articulate it. Their symptoms were not identified and recognised by others, and it was only when they recognised the symptoms themselves, that they sought help. As illustrated in the case study below, it took Amber 16 years to recognise that she had a mental health need and only then was her mental health condition diagnosed by a GP and referred on. Three months later she was offered a service which she felt did not meet her needs:

¹¹ Children's Commissioner (2015) - 'Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action,' <http://www.childrenscommissioner.gov.uk/sites/default/files/publications/Protecting%20children%20from%20harm%20-%20full%20report.pdf>

Case Study – Amber’s Story

‘You know, there is a problem here, nobody does bad stuff for no reason but no one stopped me to ask’.

Amber is nearly 18 and has moved in and out of care from aged eight but feels secure and supported by her present foster carer. She has struggled with understanding and managing her anger from an early age and also the number of thoughts and ideas she has in her head at any one time. When she ‘flips’ she has found herself in trouble with the law. She looks back at the multiple school exclusions which started in primary school and wonders why no one tried to understand what was going wrong for her. She says it’s obvious now that she had ADHD from an early age, but she only received the diagnosis after she took herself to her GP when she was 16 years old. He referred her to CAMHS.

Following a three-month wait she arrived at her first CAMHS appointment feeling very awkward. She knew she was there because she had worries about her emotional health but had no idea how to talk about these things and with strangers *‘I could only feel embarrassed because I didn’t know what to say or what I felt, and you want to come across as you know, normal-like’*. She was offered medication and group therapy, she said no to the group therapy. It was *‘too way out’* for her. She was prescribed medication for ADHD. She is still on it but talks casually about the dosage and says it’s down to her to take it, sometimes she does and sometimes she doesn’t. She thinks that was the advice that was given to her – it was up to her. However, she says if she doesn’t take it, she knows she is quicker to get angry and this leads to fights and more problems for her. When I calm down *‘I beat myself up for ages after these things’*.

She thinks that it was just before she was due for a review for her medication, nearly a year later that she stopped eating for six days and had suicidal thoughts. Her social worker called CAMHS and they brought her appointment forward but she still had to wait and reflects *‘you always seem to be seen at the wrong time’*. She recalls being asked to fill in a questionnaire about depression. She says that even with a form *‘you still have that mixed up feeling of wanting help but not knowing how to answer the questions so you can get it but also still be seen as OK’*. She sees someone from CAMHS every three months, *‘I don’t think they’re a counsellor, but they check my weight and meds and say ‘how are you?’*

Conclusion

In our lightning review of CAMHS we found that:

- **Access to CAMHS is a post code lottery.** We found variations in the number and proportion of children and young people being referred to CAMHS across different regions. We also found that once referred, the likelihood of receiving treatment varied significantly across regions from 80% in CAMHS offering services in multiple regions¹² not being allocated a service to 18% in the South East and West Midlands. The average waiting time ranged from 14 days (a CAMHS in the North West) to 200 days (a CAMHS in the West Midlands).
- **Children and young people are being turned away when they need help.** Previous studies have highlighted that restrictions and thresholds set by CAMHS are high. We found that 79% of CAMHS imposed restrictions and thresholds for children and young people accessing their service. Almost half of CAMHS who responded to our request reported to only offer services for particular diagnosable conditions and almost three quarters offered treatment based on the severity of the mental health condition. As a result, 28% of children and young people referred to CAMHS in 2015 were not allocated a service.
- **Children and young people who miss appointments can face restrictions.** 35% of CAMHS stated that children and young people who miss appointments will face restrictions. 29% stated that children and young people would be discharged. 48% of all CAMHS stated that they would try to find alternative provisions for that child or young person. We have found that there are a myriad of reasons why a child or young person miss appointments. Often, missing appointments can be an indication that other needs are not being met and/or a cause for concern. Thus, it is concerning to find that some CAMHS are still discharging children and young people without following up on whether they are ok.

¹² CAMHS that provided services in more than one region in England

Asks from young people

The primary purpose of this lightning review has been to raise issues to help commissioners and policy makers see where there is potential for improvement. Although we do not make formal recommendations, a number of issues have been raised by the young people we have spoken to which we feel it is worth reporting. Here are some of the policy asks we have heard from those who have recently used CAMHS services:

- Shorter waiting times.
- For someone to be available to talk to between the referral to CAMHS and the first appointment, *'they could be like a bridge and help you at the first CAMHS meeting'*.
- Not relying on letters to get you to the first appointment, especially when your family is not reliable. Contacts and reminders should be sent by phone and text.
- Reducing the stigma around being in care or having a mental health need.
- Providing a drop-in service for young people where they could chat about things that worried them and get to know the people running the service.

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