CAMHS: learning from case reviews

Summary of risk factors and learning for improved practice for child and adolescent mental health services

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Child and adolescent mental health services (CAMHS) practitioners have a key role to play helping children and young people rebuild their lives following difficult early experiences such as abuse and neglect. However organisational and operational challenges can result in many vulnerable young people not receiving the help they need when they need it.

The learning from these case reviews highlights these difficulties as well as emerging good practice to resolve these issues.

Authors

This briefing summarises the learning from case review reports. It is an analysis by the NSPCC Information Service, highlighting risk factors and key learning for improved practice.

Reasons case reviews were commissioned

This briefing is based on case reviews published since 2015 which have highlighted lessons for practitioners working in child and adolescent mental health services (CAMHS) to improve safeguarding practice.

In these case reviews, children died or suffered serious harm as a result of suicide or self-harm. For more specific learning from case reviews on suicide and self-harm, please see our briefings: Suicide: learning from case reviews and Teenagers: learning from case reviews.

Key issues for CAMHS in case reviews

The case reviews highlighted examples of good practice including efforts to engage young people who were refusing services; and work to support young people with
complex emotional and behavioural problems who did not meet the threshold criteria for receiving services from CAMHS.

However, the case reviews also highlighted a number of issues for learning.

**Listening to young people**

In these cases, review authors urged practitioners in CAMHS teams to listen carefully to young people and avoid being too optimistic when interpreting the messages they communicate both verbally and non-verbally. If young people do not feel practitioners are listening to them, they will lose confidence in them. They need professionals to act on what they have been told and help them achieve change. Young people need to be fully involved in their own treatment, providing input and feedback which practitioners can use to direct treatment, set meaningful goals and develop services.

Not fully exploring and understanding a teenager's "inner world" is a significant barrier to listening to young people and can result in practitioners drawing oversimplistic conclusions. One case review noted teenagers' tendency to withdraw from adults, becoming "secretive" and relying on their peers to support them and reinforce their view of the world and their place in it. Professionals in CAMHS teams need to avoid taking conversations with young people at face value; look out for any discrepancies between what a teenager does and what they say they are doing; and be aware that not all teenagers who are intent on harming themselves will present with obvious symptoms of depression. In fact, some teenage girls in particular may go to great lengths to maintain an image of high achievement and be reluctant to acknowledge any personal struggles.

Practitioners also need to be prepared to explore what young people write about themselves and their feelings (for example in diaries, or in posts on social media platforms or online discussion forums). One case review underlined how a girl’s diary entries helped to prepare her psychologically for taking her own life. Most practitioners were unaware that she kept these diaries, and those that knew about them held back from discussing them with her for fear of breaching her right to privacy. Her writing actually presented a missed opportunity to explore and challenge her self-harming and suicidal thoughts.

**Understanding how young people behave and interact online**

Young people in these case reviews accessed pro-anorexia websites and social media platforms where they connected with people who encouraged and put pressure on them to self-harm and take their own lives.

Professionals need to understand how young people use social media and be aware of the negative but powerful influence of websites which promote destructive
thinking and behaviour. They must to be able to offer young people guidance on how to make sense of the information they are accessing online as well as how to use social media safely.

**Working with young people who don’t want to engage**

When a young person self-harms they are at greater risk of suicide than the general population, but this does not mean that every young person who has self-harmed is an immediate suicide risk. However, if a young person who has self-harmed refuses to engage with CAMHS this is a factor which could potentially increase the level of risk and should influence any risk assessment. In such circumstances, efforts should be made to find alternative ways of engaging and supporting the young person.

**Seeing the whole picture and making connections**

These case reviews highlighted the issue of CAMHS teams only being able to react to immediate safeguarding concerns and limiting analysis to single causes. This is often because practitioners are working under considerable pressure and do not have the space to consider the inter-play between complex issues which pose a threat to a child’s wellbeing.

There is a particular risk that vulnerabilities caused by historical abuse become ‘invisible’ to the system. One case review author warned that ‘history fades’ very easily. This can happen when there are frequent personnel changes resulting in nobody working with a child or young person who has any direct knowledge of their case history.

One case review highlighted the impact of compounded losses and transitions on the emotional wellbeing of a looked after child. Practitioners working with the child failed to consider and plan for the cumulative effect of losing significant relationships every time she moved.

**Working with parents and carers**

One review highlighted the issue of CAMHS practitioners overestimating the ability of apparently engaged, professional parents to protect their children from the risk of suicide. Practitioners working with professional parents, who share their values and language, may regard them as equals and treat them as partners. Whilst it is good practice for professionals to work in partnership with parents, treating them as partners can sometimes limit professional safeguarding activity, prevent young people accessing the services they need, and place a burden of responsibility on otherwise helpful parents which they are not equipped to carry.
Intervening early

CAMHS undertake work based on strict commissioning and assessment criteria. Nationally, this results in many young people with complex problems which put them at risk of long-term mental health problems falling through the net. This is because their problems do not meet current threshold criteria for specialist mental health services. Case reviews criticised this short-term approach to commissioning services. It comes at the expense of early intervention to support young people before their mental health problems become entrenched and severe, requiring admission to in-patient services.

Using tools to assess risk of self-harm and suicide

Case reviews warned that risk assessment must be founded on a sound understanding of the issues at hand. Assessment tools and recording instruments should be used as an aid to practice rather than as a substitute for analysis. The GRIST assessment tool, described as the ‘ticket’ young people need to access CAMHS services, was being used by practitioners without training and guidance. They were not evaluating information gathered through the process nor were they taking into account sources of error and bias which are common in clinical assessments. Simply “going through the motions” with these assessment tools can increase the risk of practitioners reaching false negative conclusions about the likelihood of future self-harm and suicidal behaviour.

Care planning and managing transitions

When a child is discharged from an in-patient environment which offers total care and support, this can be stressful and difficult for both the child and their family. Discharge cannot happen without making sure that a risk management and care plan is in place.

Care planning and transition management is particularly important for looked after children, many of whom have complex emotional, social and mental health needs. Before they arrive in a new area, discharge planning and preparation for their long-term care needs to take place in liaison with community services in their new area. One case review warned that statutory processes guiding this work were not robust enough and did not enable professionals to co-ordinate their planning successfully. The result was a failure to meet the looked after child’s complex needs.

Working with colleagues in other agencies and sharing information

CAMHS practitioners need to ensure that they communicate risks around self-harm and suicide clearly to colleagues in other agencies. They need to adapt the language they use when communicating with colleagues who do not work in health. They also
need to be aware that if colleagues in other agencies are not used to working with children with mental health problems their perception of risk and complexity may be very different to someone who works in CAMHS. CAMHS practitioners need to brief their colleagues on how to support the child and how to identify and respond to any signs of relapse or deterioration in their condition.

CAMHS practitioners also need to be fully involved in child protection conferences, core groups and review processes and they need to lead and co-ordinate therapeutic interventions. In one case review, CAMHS staff were criticised for passing problems onto children’s social care rather than considering what they could do together. It is particularly important that CAMHS work closely with colleagues in other agencies when planning for the long-term care and support of looked after children.

Effective multi-agency working is underpinned by good record keeping and information sharing practices. Case reviews flagged a number of ‘systemic’ weaknesses including: absent, poor quality or seriously belated records of contacts with CAMHS staff; failure to make patient notes accessible between hospitals and community CAMHS services; records made useless because of illegible handwriting.

**Making referrals to CAMHS**

Professionals from other agencies flagged a number of serious issues around making referrals to CAMHS. These include: extreme delays before they receive any response, and in some cases, having to make another referral; when they do receive a response, not being clear about what will happen next; not being notified when CAMHS involvement has ended and not being told the outcome of the intervention.

Case reviews also warned practitioners against falsely feeling reassured that, once they have made a referral, children will receive the help they need when they need it. If CAMHS are struggling to respond to referrals in a timely fashion, this can result in vulnerable children becoming even more vulnerable.

Staff in schools reported that they were so overwhelmed by the number of children self-harming (30-50 children a year, according to one school) that they did not think it was possible to refer all of them to CAMHS. They said they needed guidance on deciding which pupils were at greatest risk and needed a referral and how to make sure the remaining pupils were well-supported.

**Organisational and leadership issues**

The authors of these case reviews described CAMHS services which were in a ‘state of chaos’ citing examples of deep-seated problems including: poor management systems; low levels of morale; high staff turnover and sickness absence; poor risk management and information sharing practices; frequent changes of senior managers and a consequent lack of leadership and direction.
Of particular concern in these cases was a lack of supervision and oversight from psychiatrists and other senior clinicians in community services. It is especially important that practitioners working with looked after children with complex acute and chronic mental health needs receive adequate supervision and reflective challenge from senior colleagues. It is also essential that senior community clinicians liaise with in-patient teams.

**Learning for improved practice**

**Collaborating with young people**

- Ask young people what they need from you, their opinions on how the intervention is going and the impact it is having on their wellbeing.

- Ensure that the child’s views are also understood, genuinely considered and, as appropriate, acted upon.

- Always approach direct work with children and young people with professional curiosity. Don’t just consider what they express verbally, but hold in mind what they have written in journals, diaries and online. Include guidance on the best way to do this in professional training programmes.

**Understanding how young people behave and interact online**

- Ensure professionals have up-to-date knowledge and information about how young people behave online and the associated risks.

- Make sure assessments are informed by young people’s online activities, particularly their use of social media sites.

- Offer young people guidance on how to evaluate the information they access online and safe use of social media.

**Working with young people who refuse to engage**

- Consider how to respond to vulnerable children and young people wishing to disengage from services. Always consult with children’s services on how best to manage these circumstances.

- Consider changing the appointment schedule or venue for consultations to make it easier for the child or young person to access services.
Working with parents and carers

- Make sure appointments are flexible so that professionals can engage with working parents.

- Where possible, make sure that parents or carers have been consulted and their views considered before completing assessments.

- Frame assessment findings in a way that helps young people and their families make sense of their difficulties.

- Ensure parents or carers are fully supported in understanding self-harm and suicidal ideation and know how to respond and where to turn for help.

- Develop skills in working with fathers, in particular try to take into account the different ways in which men respond to problems compared to women. Always consider the positive impact fathers have on their children’s lives.

Seeing the whole picture

- Make sure mental health assessments and diagnoses are collaborative, drawing on family history and considering social, cultural and biological factors.

- Make sure foster carers understand the impact of repeated losses on looked after children and know how to support them.

- Ensure systems have an alert to remind professionals of ‘invisible’ difficulties such as past experiences of abuse.

Intervening early

- Safeguarding children boards should work with CAMHS and other agencies to ensure children with complex emotional and behavioural problems who do not meet current CAMHS thresholds receive suitable services.

- A case review highlighted the work of one health service and local authority to ensure at-risk children do not fall through the net of services. Arrangements include: CAMHS will not discharge a vulnerable child until there is multi-agency agreement; health services and children’s social care have agreed that high-risk cases which are not proactively managed by CAMHS will be
escalated up to director level to ensure immediate action is taken. The number of cases escalated in this way will be monitored. A new model for CAMHS services includes: a front-door triage team to respond to referrals; greater regard to the concerns of families and professionals in assessments; in-reach work in schools; and extra capacity for working with looked after children and children on the edge of care.

- The same area also has an outreach team working with young people in crisis, who have frequently experienced trauma, but have not received therapeutic support elsewhere. They are offered Dialectic Behaviour Therapy (DBT). In addition, this team continues to support young adults aged between 18 and 25 who have been in contact with CAMHS but do not meet the thresholds for adult mental health services.

**Care planning and managing transitions**

- CAMHS professionals must work with colleagues in other locations and agencies to improve transitional arrangements for children moving across geographic boundaries.

- CAMHS must be involved in a thorough, multi-disciplinary process for planning the long-term care of children (especially looked after children) who are about to be discharged from in-patient care.

- Where there are gaps in discharge and care planning arrangements this should be escalated to senior management and resolved before the child is discharged.

- Care plans made under the Care Programme Approach (CPA) should identify realistic and optimistic long-term goals and the steps needed to achieve them. They should also identify the roles and responsibilities of professionals working with the child. Professionals should discuss the care plan with the child and review it with them at regular intervals.

**Working together and sharing information**

- Following acceptance of a referral, CAMHS should find out about and document details of the child’s involvement with other agencies.

- CAMHS professionals should engage directly in multiagency safeguarding activities such as the Common Assessment Framework and case conferences.
• One case review praised good practice from CAMHS who provided a ‘pathway’ document to guide and support appropriate referrals from multi-agency colleagues.

• All CAMHS staff should attend record-keeping training.

• Electronic communication regarding case management, such as e-mail information must be inserted into individual records.

• Information sharing guidance should set out how to balance safeguarding duties with a young person’s right to privacy.

Leadership and supervision

• CAMHS professionals should be made aware of when and how to involve senior management to resolve difficulties in managing complex cases.

• Safeguarding supervision needs to be embedded into practice.

• High risk cases should be discussed with colleagues and supervisors and the minutes of any meetings recorded and circulated to relevant colleagues and professionals in other agencies.