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**National
evaluation of
Community
Forensic Child
and Adolescent
Mental Health
Services
(Community
F:CAMHS)**

Final report

Acknowledgments

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Glossary

Agencies – other: this refers to any other agencies as defined by data collectors. This is a free text box and examples of other agencies reported include adult mental health services and residential placements.

Child and Adolescent Mental Health Services (CAMHS): NHS services providing support for children, young people, and their families experiencing mental health and wellbeing difficulties.

Children and young people: includes children and young people up to the age of 18 years.

Contact source – other: this refers to any other contact source as defined by data collectors.

Education status – other: this refers to any other education status as defined by data collectors.

High risk behaviour: this refers to behaviours which include physical self-harm, harm to others, and impulsive and antisocial behaviours including alcohol and substance misuse. For the purposes of the present data collection and analysis, these behaviours are grouped into the following: absconding, food-based difficulties, oppositional behaviours, self-harm and suicide attempts, sexually harmful behaviours, substance misuse, violent behaviours and vulnerabilities.

Level of input – other: this refers to any other level of input as defined by data collectors. This is a free text box and examples of other levels of input reported include assessment only, both direct and indirect.

Living arrangement – other: this refers to any other living conditions as defined by data collectors.

Other referral: this refers to any other referral as defined by data collectors. This is a free text box and examples of other referrals reported include written advice provided and direct contact with family.

Reason for discharge – other: this refers to any other reasons for discharge as defined by the data collectors. This had a free text box and examples of other levels of input reported include movement out of the area and did not engage.

Referral source – other: this refers to any other referral source as defined by data collectors.

Social care status – other: this refers to any other social care status as defined by data collectors.

Youth justice status – other: this refers to any other youth justice status as defined by data collectors.

1. Executive summary

1.1 Background

Community Forensic Child and Adolescent Mental Health Services (F:CAMHS) are 13 new services commissioned by NHS England & NHS Improvement as part of a national service specification. They are targeted towards children and young people with complex and high risk presentations who are giving cause for professional concern and are beyond traditional Tier 3 remit. The model is being implemented in response to literature which suggests that children and young people accessing these services experience multiple, complex needs and are more likely to present with high-risk behaviours (e.g., substance misuse), high levels of harm to self and others, more mental health difficulties, and high vulnerability of victimisation.

1.2 Aims

The overarching aim of the evaluation was to examine whether the implementation of the new national service specification, for high risk children and young people, lead to improved understanding of needs and improved case coordination and support. In particular, this report focuses on the experiences of staff and professionals in contact with the service; the characteristics, experiences, and outcomes of children, young people and parents/carers accessing the service; and the cost-effectiveness of Community F:CAMHS.

1.3 Methodology

We used a mixed-method realist evaluation. We collected two sets of quantitative data from all sites: staff surveys completed at early, mid, and late implementation stages and routine site data submitted at early, mid, and late implementation stages. Qualitative data were collected primarily from four focus study sites and included interviews/focus groups with staff, children and young people, and parents/carers.

Table 1.3: Data collection sources included in the report

Data source	Number included in report
Routine site data on cases	6,122 cases from 13 sites
Staff surveys	208 from 13 sites
Qualitative data from interviews/ focus groups with staff	70
Qualitative data from interviews with professionals in contact with the service	34
Qualitative data from interviews with children, young people or parents/carers	23

1.4 Findings

1.4.1 Mental health and wellbeing

In the routine site data, there were significant improvements (using t-tests) in the mental health and wellbeing (as measured by the HoNOSCA) and overall health and quality of life (as measured by the EQ5DY) for children and young people during the period in which they received input from Community F:CAMHS. In particular, although children and young people’s HoNOSCA and EQ5DY scores improved over time for both early and late implementer sites, there were higher levels of improvement in the early compared to the late implementer sites. Moreover, the two key items from the HoNOSCA – **‘Disruptive, antisocial or aggressive behaviour’** and **‘Emotional and related symptoms’** – improved over time for all sites, however there were higher levels of improvement in early than late implementer sites. This difference in improvement levels could result from service expertise, maturity and connectedness with the broader network which could facilitate collaboration and improved access to a wider range of services.

1.4.2 Feedback from professionals in contact with the service

Professionals in contact with Community F:CAMHS described the impact on the network around the child, with Community F:CAMHS containing the network's anxiety, facilitating thinking around care and risk management, promoting interagency working, and providing direct intervention where needs were not met or identified.

Professionals in contact with Community F:CAMHS described the impact on children and young people and their parents/carers as managing and improving children and young people's wellbeing and risk, supporting parent or carer wellbeing, and being instrumental in aiding children and young people and their parents/carers in accessing and engaging with appropriate help. Professionals described the input of Community F:CAMHS as improving confidence in managing complex or high risk cases.

Several professionals in contact with the services noted that Community F:CAMHS' involvement resulted in a lowering of risk presented by this group of young people, both as a result of consistency in the network and an increased understanding of the young person's risks and needs; for example:

[If Community F:CAMHS didn't exist] it would've taken us longer I think, children's social care to kind of understand the complexities of the case. And it would've increased the risks because it's vital that they're involved because of this young person's range of, level of need. (Referrer Phase 2)

There were some examples where professionals in contact with the service believed that their contact with Community F:CAMHS had an impact on diverting young people from admission to secure services, for example:

[...] enabled to get him a safeguarding level and engaging in others services, to basically stop him from being criminalised. (Referrer Phase 2)

In particular, they described Community F:CAMHS as accessible and responsive, and this continued to be reported in phase three when COVID-19 restrictions were in place:

the referral is so much quicker and it's dealt with properly and it's... I don't know, I just felt it was very efficient and very supportive. (Referrer Phase 1).

Yes, I did work with them before the pandemic. The only thing that's changed is that we haven't met in person. But otherwise, yeah, they seem to be able to do lots of their assessments over

the phone or via video call, which is really good. And when I've needed consultation or a chat, I just email and that seems to be fine. (Referrer, Phase 3)

Professionals in contact with the service described Community F:CAMHS as promoting the inclusion of other agencies and children, young people and parents/carers in care. Professionals reported that this inclusive approach helped to, in turn, promote children and young people's social inclusion in care and society.

1.4.3 Children, young people, parent and carer feedback

Mirroring this, children, young people and parents/carers who received input from Community F:CAMHS said that overall, the teams across the board, were offering support to parents/carers and children/young people that is of high quality, focused on good communication between and within involved parties, and individualised to their needs - parents/carers often expressed they had not experienced such tailoring to individual need in services before. One of the strongest indications from the Phase 3 data was that the Community F:CAMHS teams were able to better understand young people, in a way that the families had not experienced before, and that this then promoted the sense of receiving truly individualised support. Parents/carers and children/young people suggested that the Community F:CAMHS teams had still been able to provide 'consistent and supportive' care through the move to remote provision in light of the global COVID-19 pandemic.

They reported that Community F:CAMHS staff spent time in getting to know them, treated them well, and were non-judgemental. They spoke of the positive work of Community F:CAMHS staff in the context of facilitating and supporting wider multi-agency input and to 'hold' cases. They conveyed a mutual trust which led to the children and young people feeling safe. For example:

He's kind of stayed in the background and helped out with everything. And phoned in to all of the meetings. And has just generally been there helping with everything. (Parent Phase 1)

They don't just look at you for being what people label you, for what people think of you. They get to know you and treat you how you wanna be treated and not how people say that you are. (Young person Phase 2)

I think it's because they listened. They listened and they observed, and there was no judgement; and their professionalism and expertise. (Parent Phase 2)

Parents/carers also discussed the importance of the knowledge and experience of Community F:CAMHS teams 'stepping in' to provide management and clarity in the situation, for example:

What you find is everyone has their own opinion, so you've then got everyone's opinions, and that's very difficult, when everyone's trying to self-diagnose [...] you know, giving their ideas, they're all, "Oh, I think this" and "I think that". And you need someone who is professional and trained and qualified to step in. But he was there for our son as much as anybody. It was very much his voice that was heard, which was good. (Parent Phase 3)

Community F:CAMHS was described by children, young people, parents and carers as meeting the needs of children and young people in contact with the service in relation to quickly identifying and addressing difficulties. For example, in relation to medication and promoting a better outlook through effective support strategies. There was a sense that the children and young people felt that the Community F:CAMHS staff were knowledgeable and well trained, enabling them to feel supported. For example:

How well he [staff] knows me has really helped build a picture of – a true representation of how I've progressed. (Young person Phase 1)

So it felt like if you get the right people identifying the problems as quickly as possible, you'd be saving huge amounts of resources and time, and stress. And also you're nipping problems in the bud hopefully earlier. (Parent Phase 2)

Further, parents/carers discussed how the Community F:CAMHS teams had provided both them and their child with coping mechanisms to help them to

move forward in positive ways, which had not been possible previously. For example:

I feel that the coping mechanisms that they have given her [...] has given us ways of coping with things; if I didn't have them, I'm not sure how I would have coped with everything myself. (Parent Phase 2)

So now I can go about things a little bit differently. [...] So approaching situations at home differently for both of us, I would say has helped the situation. (Parent Phase 3)

In addition, parents/carers discussed the key role of the Community F:CAMHS team in helping both themselves and their child to understand the difficulties. In some cases, they discussed this as a transformative agent of change. They also discussed how a better understanding self and others is a facilitator for making effective strategic changes, for example in one's own reactions to situations. For example,

[...] a massive impact. A good impact at that. The understanding for [CYP's name] of his diagnosis as well. So he could get his head around it. So he understands and he will now quite openly talk about [autism spectrum disorder]. And not think of it as anything different from anybody else. (Parent Phase 3)

It has made things a lot easier because he knows that they have explained to him why he might be feeling a certain way. So, it definitely has helped home-wise. And understanding maybe how I feel at the same time. Why I might get a bit upset or why I might get a bit angry and shout. And then taught me that if I shout at him, that aggravates him. (Parent Phase 3)

However, there was also a sense that more time given to the children and young people would have been beneficial; for example:

Maybe if they could have stayed for a little bit longer, they would have seen her unravel a little bit and see what she's really like, rather than just an hour's appointment. (Parent Phase 2)

The children, young people, and parents/carers interviewed expressed positive comments about the multi-disciplinary team working with Community F:CAMHS and other teams. They spoke of all agency meetings and feeling as though different teams were working together. For example:

We had an all agencies meeting -At [CYP]'s school that he was at that time. And [Staff] came along to [...] he'd read [CYP]'s reports and everything, and he came along to the meetings.
(Parent Phase 2)

[Professional's name] met him a few times in clinic, and he's also attended meetings mostly at the new school which he's at. And he's keeping in contact with the new school, so he's not dropping [CYP]'s case while he's there because he's aware there may be turbulence and that he will need that support from CAMHS. Yeah, he's very supportive. (Parent Phase 2)

Children, young people, and parents/carers discussed a range of positive experiences and impacts following input from Community F:CAMHS, including improved mental health and wellbeing. The culture of being non-judgmental and containing risk was described as a key facilitator to positive impact. For example:

It felt good to get it off my chest. It felt kind of like they weren't judging me or anything. (Parent Phase 3)

In terms of outcome, parents/carers discussed how the input from Community F:CAMHS teams had a significant improvement to their family life. This includes relationships between parents/carers and children and between siblings. There is a transformative sense to this, where some parents/carers discussed an overall positive change in family life, some discussing feeling that their families had been 'saved'. For example:

There was a lot of attachment issues, and all those types of issues. So, it did help us with the relationship, and it stopped, I think, a family breakdown, which was really high. (Parent Phase 2)

They have definitely saved our family. And also it has given us food for thought, just in terms of being more open to family and

talking about mental health issues, and acknowledging that it's okay to have struggles. (Parent Phase 3)

There were further examples of the transformative input provided by the Community F:CAMHS team from both parents/carers and children/young people. For example:

It's just completely changed how – like my take on life.
(Child/Young Person Phase 1)

I couldn't praise them enough. And without them, I think my whole life and [CYP's name]'s whole life would be a lot different. So I'm forever grateful. (Parent Phase 3)

Finally, the parents/carers interviewed in the final phase of data collection expressed that it would be beneficial for the service to be rolled out more widely, geographically, and for the provision to continue beyond 18 years of age. For example:

I think the thing is with mental health, what we've realised, is you have an awful lot of small departments, and when you're the other side of it, getting pushed from pillar to post and it would be lovely to see F:CAMHS as a much bigger establishment and be able to provide that service to more people. (Parent Phase 3)

The only downfall is that help finishes at 18. I'd say that's the only downfall. It's such a shame because it takes such a long time to get help through the system and then to find a service that they have continual case workers is very rare, and then to have it taken away at 18, that I would say is the only downfall [...] Then if you're lucky you go back into CAMHS and you'll never see the same person twice, and they're doubly busy.
(Parent Phase 3)

1.4.4 Staff feedback

A Thematic Analysis was conducted on interview and focus group qualitative data from Community F:CAMHS staff in Phase 1 and 2 and five primary themes. The first primary theme, '**Characteristics and identity of Community F:CAMHS**', includes five secondary themes related to types of case, flexibility of the service, accessibility, expertise and staff satisfaction. The second primary

theme, **'Ways of working'**, includes five secondary themes related to the challenges involved, adopting a consultation model, being a child-centred service, teamwork and promoting interagency working. The third primary theme, **'Gaps in the system and additional support provision'**, includes six secondary themes. These related to anxiety in the network, Community F:CAMHS catching CYP at risk of falling through the gaps, a lack of resource or expertise in the system, previous challenges to assess or engage, parity of provision and areas of unmet need and the system around the child not understanding their needs or risk. The fourth primary theme, **'Impact of Community F:CAMHS'**, includes eight secondary themes. These relate to impact of Community F:CAMHS feedback received from professionals in contact with the service, young people, and parents/carers; Community F:CAMHS supporting the network of services; F:CAMHS managing the anxiety seesaw; Community F:CAMHS filling the gaps; Community F:CAMHS holding services accountable and Community F:CAMHS upskilling other agencies. This theme also includes secondary themes on the impact Community F:CAMHS has on improving young people's engagement, placement, transition and risks as well as life chances through the pivotal role it has been able to play in the sentencing and sentence management of young people they work with; for example:

But she has been protected or supported to avoid a custodial and what an impact that will have (Staff, phase 2)

The fifth primary theme, **'Implementation'**, includes five secondary themes related to challenges and roll-out strategies, service maturity, making service known and managing expectations that professionals and agencies have of the service.

In addition to being non-judgemental and containing, staff working in Community F:CAMHS shared that the service also has a strong focus on being child-centred. One member of staff described that children and young people who were referred to Community F:CAMHS **are considered almost like hot potatoes that no service wants to touch'**, which means that there could be a **'superficial view of them'** as they may not engage or may be viewed as too high risk (Staff Phase 1). In such cases, the **'voice of the child sometimes gets lost'** (Staff Phase 1). Community F:CAMHS staff across the teams interviewed expressed the importance of giving the young person and their family a voice in their care, despite the difficulties in engagement and risk. Please see Section 10.3.1 for detailed qualitative findings for staff working in Community F:CAMHS. All teams interviewed identified significant gaps in service provision in their regions, although specific needs differed across the areas. Another important impact that Community F:CAMHS has is on filling the gaps in service provision, providing continuity of care and holding services accountable to meeting the needs of children and young people, for example:

So I think we're filling a gap and without the service, I think we would be relying on an overused, underserved, understaffed model that is effective to some degree but there are children that aren't being reached. (Staff Phase 1)

Multi-agency working

The role of multi-agency working was also reflected in the routine site data. For example, 48.1% of cases were indirect cases with multi-agency consultation and 21.9% of cases were indirect cases with single agency consultation (see p.22). Moreover, 34.4% only indicated 'Working with wider system/multi-agency working'.

High risk behaviours

In the routine site data, risks or concerns identified at referral were again assessed on discharge for whether they were still a concern or whether they were less of a concern / there was a suitable management plan in place. Of children and young people for whom violence and aggression, sexually harmful behaviour or fire setting was a concern at referral, between 39% and 52% were no longer a concern or had a suitable management plan in place at discharge. In regards to the impact of Community F:CAMHS on risk and offending, staff described the role the service has in identifying both vulnerability and risk and

Helping the group think about both of those things together.
(Staff Phase 1)

Staff discussed that Community F:CAMHS does have an impact on reducing and managing risk but is also ready to acknowledge that risk may increase as understanding of the young person increases. Children and young people interviewed discussed having a different outlook on life set apart from past high risk and offending behaviours; for example:

So the reason why I got involved with Forensic CAMHS was due to my [...] previous offending behaviour. And all the strategies that they've helped me with, I haven't gone back on that, that kind of lifestyle again. (Young Person Phase 1)

Generally talking to the other services and just telling them from his [F:CAMHS staff] point of view on where I was a year ago to where I am now. And then where he [F:CAMHS staff] thinks I'll

be in a few years. It's completely different to what I would have pictured a few years ago. (Young Person Phase 2)

Commissioner feedback

Community F:CAMHS commissioners (n=2) described that the national provision of the services meant that access to specialist, regionally focused community forensic expertise was no longer a '**postcode lottery**' (Commissioner, Phase 2). Furthermore, commissioners shared that they have received feedback from professionals in contact with the service that there would be a huge loss without the provision of Community F:CAMHS which would significantly negatively impact on overall local management of this group of high risk children and young people.

1.4.5 Economic analysis

When examining the early implementing focus sites, the time of sustained wellbeing required in children and young people for direct cases (in a sample with complete HoNOSCA at T1 and T2) might be considered clinically plausible for some cases. Early sites seem to have improved since the Interim Report. This supports the potential for the care to be considered cost-effective, at a willingness to pay threshold of £30,000. However, caution should be taken and these results do not reflect all care offered by Community F:CAMHS.

Longer term follow up data is required to evidence if the average time required for each child is achievable.

If 57 children in direct cases are seen in 'early implementation' Community F:CAMHS teams and assessed in the emotional, disruptive behaviour, and substance misuse HoNOSCA domains

and 35 children clinically improve for emotional and related symptoms , for an average of **14 weeks** each

and 43 children clinically improve for disruptive, antisocial or aggressive behaviour for an average of **7 weeks** each

and 18 children clinically improve for substance misuse for an average of **7 weeks** each

then the 57 F:CAMHS cases might be considered cost effective at a willingness to pay threshold of £30,000.

Cost savings as a results of Community F:CAMHS should also be considered. The published data reviewed suggests that there could be significant savings to society and the public sector as a result of decreased engagement in crime. In addition to cost savings, a reduction in reoffending would avoid a reduction in quality of life and wellbeing of the victims of crime. If Community F:CAMHS could reduce recidivism, for example, if 1/100 young people aged 15-17 years

avoided a year's detention, this alone could make Community F:CAMHS a cost neutral, if not cost saving, service in the longer term.

1.5 Limitations

Despite this evaluation being clear that participation is anonymous and confidential and a range of views are sought, responses were consistently positive across all phases of the data collection periods. As with research in general, there is a risk of social desirability bias: it is possible that individuals with more positive views were more likely to volunteer to participate and complete materials.

There are likely to be differences in how the different Community F:CAMHS teams coded and collated the routine site data, and that the data does not reflect all cases seen. Findings pertaining to the relatively small number with complete data at two time points may not be generalisable to all children and young people who receive input from Community F:CAMHS.

The global COVID-19 pandemic had an impact on the amount of data it was possible to collect during the Phase 3 data collection period. This was particularly related to the recruitment of children/young people and parents/carers, due to the natural reduction in cases seen by Community F:CAMHS and difficulties with physical access to participants.

1.6 Conclusions

The report findings provide evidence that Community F:CAMHS continues to provide a clinical service for children and young people who present with a high forensic risk in the context of mental health difficulties; this is as the service is commissioned via the NHS England & Improvement National Service Specifications. Input from Community F:CAMHS results in an improvement in the mental health and wellbeing and the overall health and quality of life of the complex, high risk group of children and young people it is commissioned to support. The findings indicate that this is most prominent for those Community F:CAMHS described as early implementers; this suggests that the efficacy and quality of Community F:CAMHS provision increases beyond the initial implementation period. The findings of this report highlight that the Community F:CAMHS model was not only able to readily adapt to changes in provision due to COVID-19 but moreover, it was able to thrive through increased flexibility of remote working.

The findings of this report suggest that Community F:CAMHS is particularly effective in promoting the voice of the child / young person. This is especially important when the child /young person exhibits high risk behaviours; the network around the child may need to be supported to maintain safeguarding considerations. Similarly, Community F:CAMHS appears effective in promoting improved communication amongst professionals working with this group of complex and high risk children and young people; this is important from a

clinical and risk management perspective. In addition to the expertise of Community F:CAMHS, consistently reported by different stakeholders throughout the evaluation, the service's unique position in the system but somewhat removed, would seem to be particularly helpful in this regard.

Further linking Community F:CAMHS with other actors in the wider system for children and young people with high levels of vulnerability is recommended, particularly with the Children and Young People's Secure Estate. When considering the sustainability and scale-up of Community F:CAMHS, it is important to acknowledge that expansion of the service should not come at the expense of losing its distinct and unique role.

Working towards a system of integrated care across the system for children and young people with multiple and complex needs is an ongoing and multifaceted challenge. The findings of this report suggest Community F:CAMHS provides a vital and effective solution to this, although it can only be a part of the solution. The successful implementation and impact, evidenced in this report, highlights the importance of sustaining and scaling up Community F:CAMHS as a service. It also highlights the potential to scale up the *model* of Community F:CAMHS to other vulnerable groups with multiple and complex needs (e.g., Autism Spectrum Disorder or learning disability), potentially bringing us closer to achieving integrated care across a dynamic, multifaceted system.

2. Background

Recent policy in child and adolescent mental health, for instance Future in Mind and the Five Year Forward View, mark a need to improve mental health care and support for children and young people^{1,2}. Research has largely suggested that mental health difficulties are more prevalent in children and young people who present with high risk of harm to self or others, or 'high-risk children and young people', than in children and young people in the general population^{3,4,5}. For some very vulnerable children and young people, particular mental healthcare requirements may be difficult to meet through conventional services due to their unique and complex circumstances².

Community Forensic Child and Adolescent Mental Health Services (F:CAMHS) are 13 new services covering all of England, commissioned by NHS England & NHS Improvement in response to Future in Mind and the Five Year Forward View⁶. Being delivered through the Children and young people Mental Health Transformation Workstream, part of the wider Programme, funded 2016–2021. Services are targeted towards children and young people with complex and high risk presentations who are giving cause for professional concern and are beyond traditional Tier 3 remit. The service specification is being implemented in response to literature which suggests that children and young people accessing these services experience multiple, complex needs and are more likely to present with high-risk behaviours (e.g., substance misuse), high levels of harm to self and others, and high vulnerability of victimisation⁷.

The challenges of addressing these multiple needs means that children and young people often experience multiple transitions between services and geographical displacement^{3,8}. Previously, the provision of support for high-risk children and young people across services has been deemed to be fragmented and lacking in co-ordination⁷ and the provision of forensic child and adolescent mental health services in the community has been described as geographically 'patchy'⁸.

Community F:CAMHS have been created to support the network around children and young people who present as high risk of harm to self or others, or are in contact with the youth justice system, about whom there are concerns regarding mental health or learning disability⁹. The services also aim to provide advice about the interactions between a child and young person's mental health and risk presentation and improve pathways and transfers between local services and secure inpatient services in cases where hospitalisation cannot be avoided¹.

The new Community F:CAMHS provide two overarching types of input to mainstream services working on high complexity/risk cases: 1) advice and consultation and 2) direct assessment and direct intervention⁶. All sites will fully deliver the new model, implementing via a process of mobilisation, transition, and transformation. Therefore, some sites are early adopters, implementing the full model, while others are partially delivering the new model at the current time, either as late implementers or due to phased implementation (e.g., across large geographical areas).

Figure 1 demonstrates an overview of the Health and Justice and Specialised Commissioning Children and Young People Mental Health Transformation Workstream, which Community F:CAMHS sits within.

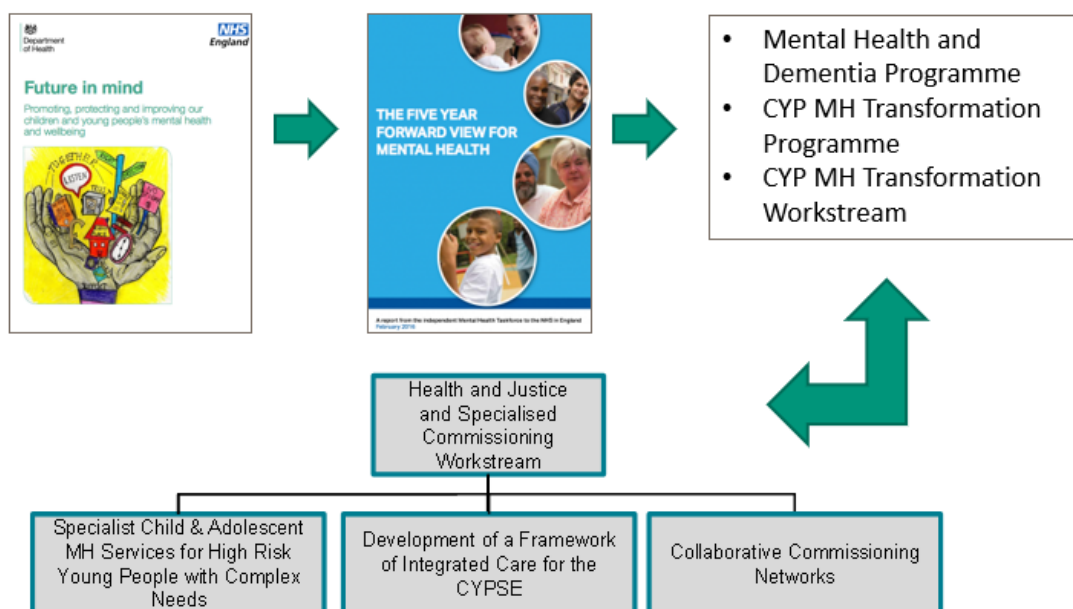


Figure 1: Transformation Workstream

In 2018, the Anna Freud National Centre for Children and Families was commissioned by NHS England & NHS Improvement to conduct a large-scale evaluation of the Community F:CAMHS model.

In early 2020, a global COVID-19 pandemic was declared by the World Health Organisation, which caused a huge impact to daily life. Nationwide restrictions to social contact were implemented, which saw a rapid transfer from face-to-face contact, to remote clinical provision across the board. These incredibly sudden changes to daily life had a knock-on effect on the services that were delivered to communities, including a hurried move to remote education provision for most children and young people. In terms of Community F:CAMHS, face-to-face contact was delivered remotely, primarily by telephone, and this period of time saw a natural reduction in the amount of referrals and cases taken on by Community F:CAMHS teams. Nevertheless, an increase in the levels of need, complexity and risk of referrals received by Community F:CAMHS was reported during this period. Consequently, there were fewer participants available to be involved, and there was a potential disruption to the support provided to families, which has been explored via the interviews with staff, children/young people, and parent/carers in this report.

The global COVID-19 pandemic was declared at the mid-point in our evaluation, just after the second Phase 2 data collection window. We supported sites to participate in the evaluation during the pandemic. This involved increased remote communication with sites to provide support and to prepare for remote data collection from qualitative sites during Phase 3, building on the successful

strategies for remote data collection that we had already put in place in anticipation of this. We also worked with sites to build on the narrative interpretation of findings and worked with some sites for additional data on staffing, which has informed the economic analysis.

Given the existing vulnerabilities of the population of children and young people supported by Community F:CAMHS teams, there are further concerns about the impact of the global COVID-19 pandemic, which has been described as another adverse childhood experience. There are specific concerns about the potential increase in high risk-high harm behaviour¹⁰. The impact of the global COVID-19 pandemic must be taken into consideration when reflecting on the findings of the evaluation overall.

3. Aims

The overarching aim of the evaluation is to examine whether the implementation of the new national service specification, for high risk children and young people, leads to improved understanding of needs and improved case coordination and support. Other questions include:

1. What are the characteristics of children and young people accessing Community F:CAMHS?
2. What are the outcomes and experiences of children and young people accessing Community F:CAMHS?
3. What are the experiences of staff (including professionals in contact with the service) working in Community F:CAMHS?
4. What is the cost effectiveness of Community F:CAMHS?

4. Methodology

The overall approach is a longitudinal prospective Realist Process Evaluation, which is a theory-driven framework that aims to explore 'what works, for whom, in what context and to what extent'¹¹. It focuses on the ways that the context or setting of a social intervention interacts with the underlying processes or structures to produce outcomes, and how outcomes in turn impact on subsequent contexts and processes or structures.

Realist Process Evaluation uses multiple methods and data sources to help provide a comprehensive understanding of what processes are triggered by systems change and how they have an impact on the existing social processes sustaining the behaviour or circumstances that are being targeted for change. The approach is suitable for use in real-world settings, so the evaluation can be embedded and sustained beyond the end of the project. Realist Process Evaluation has been used in previous research exploring services for children and it is used to explore the effectiveness of implementing evidence-based interventions and policy¹². It can produce rich data on implementation¹³.

The first step in the Realist Process Evaluation is to develop a logic model identifying the different elements of the intervention and the processes by which change occurs. It encourages thinking about what change is being sought, for whom, what might be the triggers, and what might be the preconditions and context-specific elements. The five components that can be specified in a logic model are:

1. the population targeted by the intervention
2. a summary of the key components of the intervention
3. the proposed mechanisms by which the intervention causes an effect
4. the expected outcomes of the intervention
5. the contextual factors moderating the effect of the intervention.

The logic model below was developed by the evaluation and implementation teams to underpin the Community F:CAMHS evaluation.

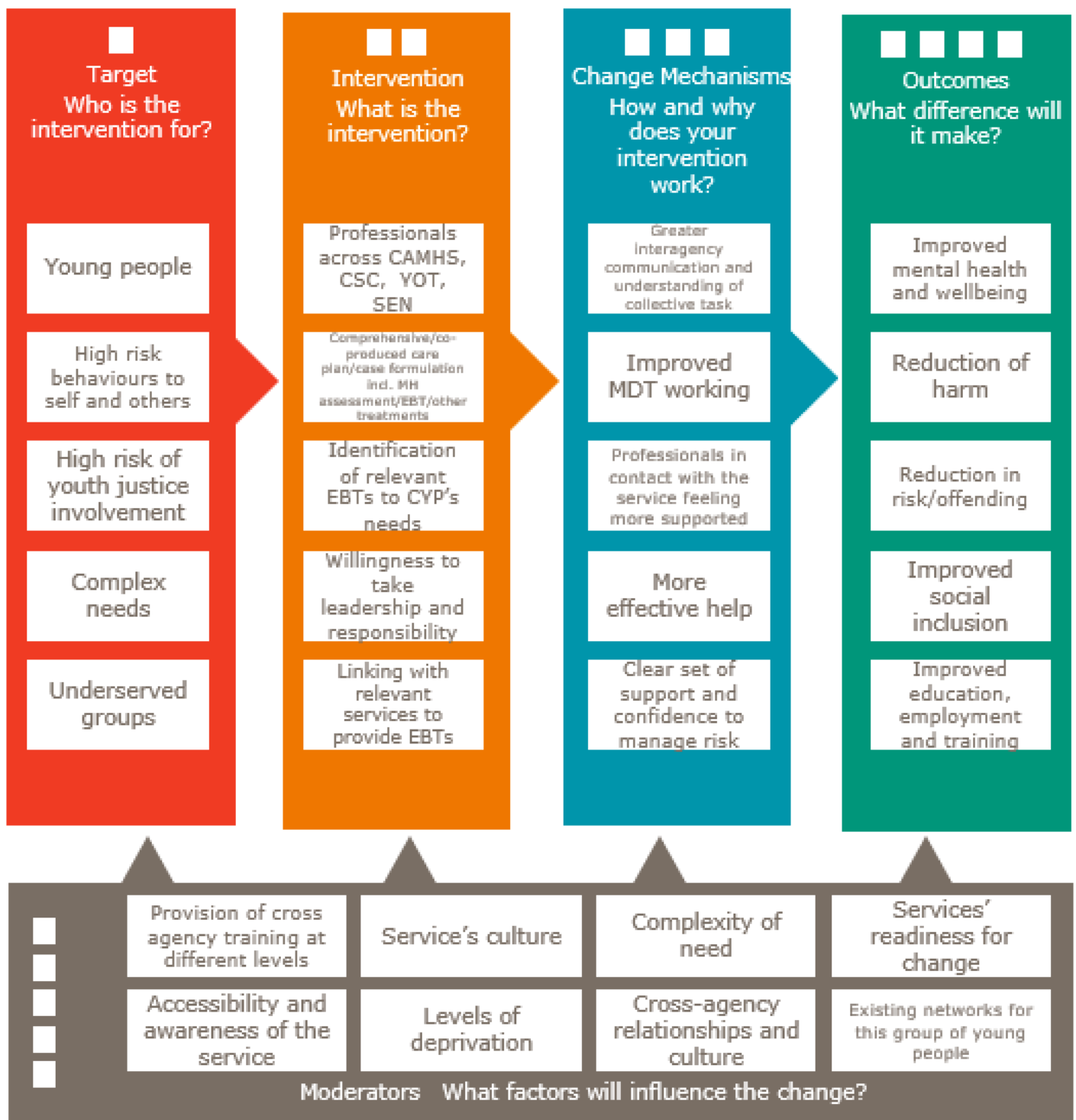


Figure 2: Logic model for Community F:CAMHS evaluation

4.1 Data collection and data submission windows

We collected two sets of quantitative data from all sites:

1. **Routine site data** submitted at three data submission timepoints. Secondary analysis of anonymised routine site data will examine the characteristics (including risk factors) of young people in these sites. Data was only shared if: a) a young person/parent/carer provides consent and b) necessary data sharing agreements are in place. Data are securely transferred using the UCL Data Safe Haven Secure Transfer Portal.
 - a. As part of the routine site data, sites submitted **feedback collected from professionals** in contact with the service, young people, and parents/carers, which examine experience of service use (Phase 1 and 2 only, to avoid over-burdening sites during the COVID-19 pandemic).
2. **Questionnaires completed by staff** at three data collection timepoints to examine staff experience of implementing the service specification and the perceived impact. We also examined the impact of the model on staff in relation to satisfaction, burnout, and culture.

All sites aimed to fully deliver the new model, implementing via a process of mobilisation, transition, and transformation. Therefore, some sites are described as early implementers, implementing the full model, while others are partially delivering the new model at the current time, either as late implementers or due to phased implementation (e.g., across large geographical areas). Phase 1 data submission window was in late, Phase 2 in late 2019 and the Phase 3 data submission window took place from winter 2020.

4.2 Ethics and risks

Ethical approval for data collection from staff has been granted from the University College London (6087/007) Research Ethics Committee and Her Majesty's Prison and Probation Service (2018-335). Ethical approval for data collection from children, young people, and parents/carers has been granted from the Health Research Authority (18/LO/1569) and Her Majesty's Prison and Probation Service (2018-274).

Listed below are the current top four operational issues of the evaluation.

1. COVID-19: Routine service data submissions are delayed due to various restrictions, particularly restrictions in movement and 'social distancing', and staff shortages due to illness, self-isolation, and self-shielding. The evaluation's data submission window for Phase 3 was August to October 2020, which in light of COVID-19 was expanded to November 2020. We communicated with sites, offering remote support to them, and were able to accommodate all sites.
2. COVID-19: Restrictions impacted site visits and qualitative data collection. In line with local and national guidance, all visits were postponed. We received an ethics amendment approval to ensure qualitative data could be collected remotely (e.g., via phone, skype, or letters from children and young people), which was implemented at the commencement of research activity in September 2020.
3. Missing data: Overall missing data will impact the analysis and results of the study and reduce validity and generalisations. We worked closely with sites to maintain overall engagement with the evaluation.
4. Qualitative data from children, young people, and parents/carers. The initial low levels of recruitment (due to the nature of services' interactions with children, young people, and parents/carers) was well addressed through flexible participation methods (e.g., remote interviews) and by involving more sites than the focus sites in recruitment, with good recruitment of these groups being achieved. However, due to the impact of the COVID-19 global pandemic, and the reduction in face-to-face activity, it was more challenging for sites to identify and recruit children and young people for qualitative interviews. As such, our Phase 3 participants were mainly parents/carers.

5. Findings

5.1 Summary of findings by key service deliverables

The findings are summarised based on the overarching deliverables for the three-year evaluation.

a) Improved mental health and wellbeing among this cohort of children and young people

In the routine site data, there were significant improvements (using t-tests) in the mental health and wellbeing of children and young people who received input from Community F:CAMHS as measured by the HoNOSCA and overall health measured by the EQ5DY. In addition, an ANOVA showed that although children and young people's HoNOSCA scores improved over time for both early and late implementer sites, there were higher levels of improvement in the early than late implementer sites. Moreover, the two key items – 'Disruptive, antisocial or aggressive behaviour' and 'Emotional and related symptoms' – improved over time for all sites; however there were higher levels of improvement in early sites compared to late implementer sites. Similarly, children and young people's global health and quality of life as measured by the EQ-5D-Y significantly improved over time for both early and late implementer sites, and there were higher levels of improvement in the early compared to late implementer sites. The key areas of improvement were in 'Feeling worried, sad or unhappy' and in 'Doing usual activities'.

Professionals in contact with the service described Community F:CAMHS as efficient and effective in helping to improve the mental health and wellbeing of children. They described the impact on children and young people and their parents/carers as managing and improving children and young people's wellbeing and risk, supporting parent or carer wellbeing, and being instrumental in aiding children and young people and their parents/carers in accessing and engaging with appropriate help.

In Phase 3, professionals in contact with the service found it harder to describe direct impacts on children and young people's mental health and wellbeing as direct work had for the most part stopped with many children, young people and families. Professionals in contact with the service described the impact on children and young people to be the result of consistency in the network's approach and understanding. In regards to risk, several professionals in contact with the service noted that Community F:CAMHS' involvement resulted in risk being lowered, both as a result of consistency in the network and an increased understanding of the young person's risks and needs; for example:

[If F:CAMHS didn't exist] it would've taken us longer I think, children's social care to kind of understand the complexities of the case. And it would've

increased the risks because it's vital that they're involved because of this young person's range of, level of need. (Referrer Phase 2)

Other professionals noted that although risk presented by children and young people who received input from Community F:CAMHS did not necessarily substantially reduce, the risk management plan put together with Community F:CAMHS involvement was more consistent and robust; for example,

I mean it is a very complex case with very high-level risks. But yes it certainly has [reduced risk]. And that's kind of just from things like consistency of the worker, consistency of consultation with the FCAMHS kind of head line manager and stuff. (Referrer Phase 2)

Some professionals also discussed the impact of Community F:CAMHS input on the families'/carers' wellbeing; one referrer stated that the **'family are now thriving'** (Referrer Phase 1) and another shared that the family are now **'getting the right level of support'** (Referrer Phase 2). One professional in contact with the service also expressed that the care plan developed with Community F:CAMHS meant that the family, as well as their child, were engaging more with services and were:

So it's been enormously helpful because now the family we've been struggling with for a long time are getting the right level of support, of quite intense support. So it's a massive relief for us, for me and for I think for the clinic [...] it seems that they are going to get what they really need now. (Referrer Phase 2)

Children, young people, and parents/carers discussed a range of positive experiences and impacts following input from Community F:CAMHS, including improved mental health and wellbeing; for example:

It's just completely changed how – like my take on life. (Child/Young Person Phase 1)

I was worried because I did a lot when I was angry [...] I was a different person. (Child/Young Person Phase 1)

I've become better in myself and a lot more happier and I've made a really good recovery with them, from where I was when I started seeing them to now. I do things I never thought I'd do before. (Child/Young Person Phase 2)

They have definitely saved our family. And also it has given us food for thought, just in terms of being more open to family and talking about mental health issues, and acknowledging that it's okay to have struggles. (Parent Phase 3)

This included discussion about the development of coping skills, and improved social skills, for example:

I feel that the coping mechanisms that they have given her...has given us ways of coping with things; if I didn't have them, I'm not sure how I would have coped with everything myself. (Parent Phase 2)

[...] and all the strategies that they've helped me with, I haven't gone back on that, that kind of lifestyle again. (Child/Young Person Phase 2)

I used to be really socially awkward and anxious. And now I can go up to people and ask them for things [...] they've like make me feel comfortable and opened me up more to the world and people. I've just become a better person. (Child/Young Person Phase 2)

Now I'm at the point where I have made some friends at college and whatnot, which I struggled with last year. (Child/Young Person Phase 3)

Staff in Community F:CAMHS also noted changes in children and young people's emotion regulation and coping abilities:

Some people are better able to manage their thoughts, their anxieties, their mood swings, their anger. (Staff Phase 3)

The culture of being non-judgmental and containing risk was described as a key facilitator to the positive impact; for example:

He's kind of stayed in the background and helped out with everything. And phoned in to all of the meetings. And has just generally been there helping with everything. (Parent Phase 1)

They don't just look at you for being what people label you, for what people think of you. They get to know you and treat you how you wanna be treated and not how people say that you are. (Child/Young Person Phase 2)

I think it's because they listened. They listened and they observed, and there was no judgement; and their professionalism and expertise. (Parent Phase 2)

Children and young people also expressed a sense of being happier and some children and young people described the transformative input provided by the Community F:CAMHS team and changing their life view. For example:

I've become better in myself and a lot more happier and I've made a really good recovery with them, from where I was when I started seeing them to now. I do things I never thought I'd do before. (Child/Young Person Phase 2)

Life is really good now. (Child/Young Person Phase 2)

It's just completely changed how – like my take on life. (Child/Young Person Phase 1)

Parents discussed how the input from Community F:CAMHS teams had a significant improvement, not only directly to the mental health and wellbeing of the children and young people, but also to their family life. This included relationships between parents and children and between siblings. There is a transformative sense to this, where some parents discussed an overall positive change in family life, some discussed feeling that their families had been 'saved'. For example:

There was a lot of attachment issues, and all those types of issues. So, it did help us with the relationship, and it stopped, I think, a family breakdown, which was really high. (Parent Phase 2)

They have definitely saved our family. And also it has given us food for thought, just in terms of being more open to family and talking about mental health issues, and acknowledging that it's okay to have struggles. (Parent Phase 3)

Importantly, Community F:CAMHS may have indirectly contributed to positive impacts by creatively engaging with young people, helping them gain a better understanding of their problems, and just allowing them a safe space to be heard:

A couple of [young] people have talked about getting a better understanding, feeling contained about what's spinning round their head, and feeling reassured and not judged. Some of the work we do is building engagement, relationships, helping people understand their problems. (Staff Phase 3)

Staff also may have impacted young people's outcomes by supporting and empowering other professionals in the network, whether it be containing anxiety in the network, offering a space for reflective practice, or simply:

By shining the spotlight on a young person's needs you're then able to address them. (Staff Phase 1)

b) (i) Identifying the mental health needs of high risk children and young people in a range of secure, residential and community settings:

Across the three submission periods, a total of 6,122 cases were submitted by the 13 services (80.4%, 4924/6122 male; mean age = 14.3, standard deviation = 2.46). Of these, 2,908 were advice-only cases (77.1%, 2243/2908 male; mean age = 14.3 years, standard deviation = 2.6 years) and 3,214 were referrals (83.4%, 2681/3214 male; mean age = 14.3 years, standard deviation = 2.31 years; 76.4%, 2454/3214 White - British). Of the 3,214 referrals, 2,295 were indirect cases, 699 direct cases, 57 other referral, 141 referrals rejected, and 22 with no data. The most common referral sources across all sites were CAMHS (44.5%, 1431/3214), social care (26.1%, 841/3214), and youth justice (13.9%, 447/3214).

In terms of referral cases, 79.3% (2550/3214) of all cases in the data presented with at least one problem related to psychosis, anxiety, depression, post-traumatic features, attention deficit and hyperactivity disorder, autism, and conduct and long-standing behaviour disorders, with 55.4% (1780/3214) of children and young people having multiple presenting problems. In addition 70.6% (2270/3214) of cases had experienced/witnessed at least one traumatic event and 56.5% (1817/3214) had experienced/witnessed multiple traumatic events. In the staff survey, there were high levels of agreement that the input of Community F:CAMHS leads to professionals having a better understanding of a young person's needs: 93% of staff agreed / strongly agreed in Phase 1, 100% of staff agreed / strongly agreed in Phase 2, and 100% of staff agreed or strongly agreed in Phase 3.

Community F:CAMHS staff described direct and indirect roles in identifying young people's needs. At times, staff conducted their own assessments because previous services had been unable to assess the severity of the young person's needs:

Some of the children that we get referred are rejected by CAMHS or paediatric services because sometimes it's described as behavioural or not meeting the threshold. So, sometimes we end up doing assessments in those cases and that can be really helpful to the network to maybe change perspectives a little bit to think about what the formulation is and if there are health issues. (Staff Phase 3).

However, more commonly F:CAMHS acted as a facilitator in helping the network around children, young people and families identify needs, for example, by gathering and sharing information, providing expertise that led to essential signposting, or managing the network's anxiety:

Everybody comes in with their own expertise, and sometimes F:CAMHS' role is about trying to hold all these different perspectives in mind, whilst at the centre placing the young person, ultimately, which can be really challenging. (Staff Phase 3)

If you get an objective view coming in, just looking at the risk of mental health, I think that offers some clarity and it can be quite containing in that system. (Staff Phase 2)

Parents/carers discussed the ability of the Community F:CAMHS teams to quickly identify the high needs of the children/young people and families. This was often expressed as support that was offered 'at the right time' and in comparison to services and input received by the families previously. For example:

[Staff] was amazing, he could see that this child wasn't off the rails and a juvenile delinquent and was able to [...], allow us to keep [CYP's name] at home and ultimately try and make him stay in [area] so I didn't – my perception of what I thought it was going to be like was different to how it was, and the support that we got was just what we needed at the time we needed it. (Parent Phase 2).

They've already arranged assessments for our young person to see if he's on the spectrum. Because no one had ever really identified what was the issues with him behind the crime. (Parent Phase 3)

b) (ii) Addressing the mental health needs of high-risk children and young people in a range of secure, residential and community settings:

In the routine site data, there were significant improvements in mental health and wellbeing as measured by the HoNOSCA, and overall health and quality of life, as measured by the EQ-5DY amongst children and young people over the period they received input from Community F:CAMHS. This suggests that the input of Community F:CAMHS contributed to addressing the mental health needs of high-risk children and young people. Staff working in Community F:CAMHS, professionals in contact with the service, and the children, young people, and parents/carers were very positive in their views and experiences of the service. For example, 94% of staff in Phase 1, 98% of staff in Phase 2, and 98% of staff in Phase 3 agreed / strongly agreed that the input of Community F:CAMHS leads to professionals having a more suitable risk plan in place, and 94% of staff in Phase 1, 93% of staff in Phase 2, and 98% of staff in Phase 3 agreed / strongly agreed that the input of Community F:CAMHS leads to professionals having a more suitable treatment plan in place. Staff working in Community F:CAMHS reported high levels of self-efficacy in identifying a child or young person who is presenting risk to others (Phase 1 mean: 7.99/10, Phase 2 mean: 7.59/10, Phase 3 mean: 7.95/10), helping people to address the severity of risk to others (Phase 1 mean: 7.83/10, Phase 2 mean: 7.18/10, Phase 3 mean: 7.56/10), and identifying an appropriate service to refer someone on the basis of risk (Phase 1 mean: 7.53/10, Phase 2 mean: 7.08/10, Phase 3 mean: 7.55/10).

According to Community F:CAMHS staff, the non-judgemental, containing perspective and general willingness to help of staff in the service seemed to be a unique experience to professionals in contact with the service given the high-risk client population, for example:

Sometimes the more concerning youngsters are presented to F:CAMHS as if the professional network's been poking them with a stick through a cage without actually sitting down in the cage and talking with the young person. (Staff Phase 1).

We will say it how it is, but help services to move forward. (Staff Phase 1)

I think people like us to contain their anxiety. (Staff Phase 1)

There's definitely a lot of supporting the professional network. I think, like I say, helping people to feel validated, helping people to feel heard. Having a space for people to listen to, but also bringing together that multi-professional network. (Staff, Phase 2)

Community F:CAMHS staff addressed children and young people's mental health needs by helping the system to better understand risk and supporting the network in moving things forward; e.g. staff's expertise and links with wider networks helped with onward referrals and effective signposting. In their direct work, staff filled gaps in service provision or completed

assessments to evidence the severity of a young person's difficulties and place accountability on other services to address the needs and provide appropriate support. In one case, staff described working on a second opinion for CAMHS:

It was me and the psychiatrist and we both feared that if we pulled out of this case, this young person would remain trapped in their bedroom for another 18 months, ravaged by anxiety and obsessive-compulsive symptoms [...] we undertook a couple of assessments. I attended meetings. I kicked up a bit of a fuss and stuff. And fortunately, we were able to gain the attention of these services and able to get to some provision for this young man. (Staff Phase 3)

Related to holding services accountable, staff also needed to manage expectations for what the service can provide:

We do get those families going, "So, you're not going to do ...sessions of CBT for my kid's self-harm?" And you're like, "That kind of isn't our role." And they go, "Yeah, but CAMHS won't see us." And you're in that dynamic of they want you to fill someone else's shoes kind of thing. (Staff Phase 3)

Professionals in contact with the service described Community F:CAMHS as efficient and effective in helping to improve the mental health and wellbeing of children. In particular, they described Community F:CAMHS as accessible and responsive; for example:

The referral is so much quicker and it's dealt with properly and it's... I don't know, I just felt it was very efficient and very supportive. (Referrer Phase 1)

Professionals in contact with the service described the impact on the network around the child, with Community F:CAMHS containing the network's anxiety, facilitating thinking around care and risk management, promoting interagency working, and offering provision where needs were not met or identified. Working with Community F:CAMHS was described as increasing professionals', in contact with the service, confidence and their feelings of being supported. This seemed to be a result of receiving prompt and proportional support when the network was struggling and being part of the equation when it came to decision-making. This was also apparent in cases where professionals in contact with the service were reassured that they had the right plans in place for the young person. The additional support was identified as being the result of the service's expertise and having an extra service involved. For example:

But actually, with F:CAMHS, we've got a nurse who can provide much more bespoke support around the young person's needs. She comes out and meets him [young person] at home or in the community. It's long term. She can completely tailor it to his needs rather than being a set of six sessions in a clinical setting. So it's much more tailored to the young person, and he's actually engaging quite well with that. So that's the other thing, F:CAMHS, in our area, does in a way that's more child friendly than CAMHS proper if that makes sense. (Referrer Phase 3)

A significant secondary theme was the effect Community F:CAMHS' involvement had on containing the anxiety of the network, even when this was confirming that the plan in place was appropriate. The authority and expertise of Community F:CAMHS, and the involvement of an additional service, was said to contain anxiety. Professionals in contact with the service shared that they felt taken seriously and listened to, which was particularly helpful in situations where their confidence was lacking. They also reported feeling supported in delivering the recommendations of Community F:CAMHS, resulting in direct impacts on the mental health needs of the young people.

Mirroring this, parents/carers expressed how they felt the Community F:CAMHS teams are able to take the specific and individual needs of the families into consideration. This was often described within the context of understanding the children/young people and families' unique circumstances and offering quick and appropriate support. They spoke of the great work of Community F:CAMHS staff to manage multi-agency input and 'hold' cases. For example:

I think they definitely join the dots, and they definitely look at things, not only from a clinical point of view, but a very holistic point of view as well, in terms of what the family needs, what siblings need, what [CYP name] himself needs. So they I think have got a very good, solid knowledge of the family, where other services that we've had experience with, they just don't have that. (Parent Phase 2).

Further, children, young people, and parents/carers said that they found Community F:CAMHS staff to be very helpful, supportive, and clear and that Community F:CAMHS staff got to know them, treated them how they wanted to be treated, and were non-judgemental. They conveyed a mutual trust which led to the children and young people feeling safe; for example:

[...] and they never judged me. (Parent Phase 1)

They don't just look at you for being what people label you, for what people think of you. They get to know you and treat you how you wanna be treated and not how people say that you are. (Young Person Phase 2)

It felt good to get it off my chest. It felt kind of like they weren't judging me or anything. (Parent Phase 3)

Community F:CAMHS was described as meeting the needs of children and young people, in relation to quickly identifying and addressing needs, including access to the right medication (e.g., **'She sped up the process to get medication to help for when I went back to school'** (Child/Young Person Phase 1) and promoting a better outlook through effective support strategies, for example:

Generally talking to the other services and just telling them from his [staff] point of view on where I was a year ago to where I am now. And then where he [staff] thinks I'll be in a few years. It's completely different to what I would have pictured a few years ago. (Child/Young Person Phase 1)

There was also the sense that careful and individualised management of the child/young person's difficulties was key and what Community F:CAMHS staff were able to provide. Parents/carers expressed that this is often via working with the child/young person at a pace and in a way that is most suited to them, for example:

With my experience of normal CAMHS, it just felt like I was a name on a spreadsheet. But F:CAMHS generally do treat you as a human – as an individual human, rather than just a name on a spreadsheet. (Parent Phase 1)

They've already arranged assessments for our young person [...] no one had ever really identified what was the issues with him behind the crime. (Parent Phase 3)

[...] because they were so relaxed and didn't put any pressure on [CYP], it was so easy to deal with. (Parent Phase 3)

c) Support to access relevant provision across agencies in line with the children or young person's identified needs, including transition to secure, other residential or adult services:

In the routine site data, multi-agency case management (44.3%, 1423/3214) and ongoing indirect monitoring (39.7%, 1275/3214) were the most common primary intervention types for all referrals. Of the 2,472 discharged cases, 4.7% (118/2472) transitioned to a new specialist setting (e.g. custody, welfare secure, special educational, in-patient, residential).

Just over half of discharged cases (54.8%, 1355/2472) had an integrated care plan in place at discharge. In addition to the above, staff working in Community F:CAMHS and professionals in contact with the service reported a range of positive views and experiences of the model in relation to provision of care to meet children and young people's needs:

- 68% (46/68) of staff in Phase 1, 71% (57/80) of staff in Phase 2, and 71% (42/59) of staff in Phase 3 agreed or strongly agreed that Community F:CAMHS has clear referral criteria.
- 78% (53/68) of staff in Phase 1, 75% (59/80) of staff in Phase 2, and 64% (38/59) of staff in Phase 3 agreed or strongly agreed that Community F:CAMHS has clear patient pathways.
- The majority of professionals in contact with the service (94%, 250/261) either agreed or strongly agreed that they were satisfied with the response received from Community F:CAMHS and that they would recommend this service to a colleague.
- 67% (175/261) of professionals in contact with the service agreed or strongly agreed Community F:CAMHS led to a better treatment plan being developed.
- 69% (181/261) of professionals in contact with the service agreed or strongly agreed Community F:CAMHS led to a better risk plan being developed.
- 79% (206/261) of professionals in contact with the service agreed or strongly agreed Community F:CAMHS led to a better understanding of the child and young person's needs.

Community F:CAMHS staff identified communication and promoting interagency working as central to their ways of working. One staff member described this as:

Getting everyone pulled together and have that joint shared formulation (Staff Phase 1)

Staff described their roles as gathering and sharing information, bringing services together and ensuring all those who should be involved are, including young people and families, for example:

So often you are putting together that professional network, making sure they've got each other's contact details, that they will share information that's relevant. (Staff Phase 1)

Another important impact that Community F:CAMHS has is filling the gaps in service provision, escalating cases, and providing continuity of care; for example:

So I think we're filling a gap and without the service, I think we would be relying on an overused, underserved, understaffed model that is effective to some degree but there are children that aren't being reached. (Staff Phase 1)

We continue to try and look for those gaps in provision and escalate things where we can. Especially around young people who can't access services like harmful sexual behaviour. (Staff Phase 3)

For example, a staff member shared that if services or interventions are not available (e.g. if there is no one who has a particular training in given a service for a therapy that is appropriate), then Community F:CAMHS may facilitate this if they think it would be beneficial. Staff shared that the Community F:CAMHS model '**fosters continuity and attachment**' (Staff Phase 1).

Community F:CAMHS staff spoke about supporting with transitions out of secure care or into adult services, such as conducting '**adaptive living skills type assessments**' (Staff Phase 3). However, they expressed a need to develop stronger links with in-patient services and secure residential services due to a low number of referrals. They also noted challenges with differing parity of provision between youth and adult services:

There isn't the same parity of service with adult community forensic provision that there is now with F:CAMHS [...] so that's a problem as well. (Staff Phase 1)

Children, young people and parents/carers interviewed expressed positive comments about the multi-disciplinary team working with Community F:CAMHS and other teams. They spoke of all agency meetings and feeling as though different teams were working together; for example:

We had an all agencies meeting -At [CYP]'s school that he was at that time. And [Staff] came along to... he'd read [CYP]'s reports and everything, and he came along to the meetings. (Parent/carer Phase 2)

They were really clear and open about what they were doing...they explained and made sure I was comfortable with what they were gonna do. (Young Person Phase 2)

Parents/carers expressed that they appreciated the consistency of care, but that did not stretch to the transition to adult services. They discussed the need for continuity of care beyond age 18. This is indicative of challenges within the wider system, which is an area of continued exploration, in order for children/young people to be supported into adult services wherever relevant. For example:

[In comparison to CAMHS] I found them really good because they were consistent. We had the same therapist, practitioner, throughout, and it was the same person who was our case worker throughout. You find, when you're

in the system, that you don't usually see people more than a couple of times. So, it was lovely to have someone who was consistent. (Parent Phase 3)

I think the only thing is that it finishes at 18 because we are unable to carry on with CAMHS because he doesn't meet the threshold. But when you actually look at the complex needs our son has and the length of time he's been under CAMHS, etc. and different schools, it would have been lovely, now that he's built that lovely relationship with [professional], if they could carry on to say 20, 21, really. At 18 people think you're an adult and actually it's when you need people the most. (Parent Phase 3).

In addition to being non-judgemental and containing, staff working in Community F:CAMHS shared that the service also has a strong focus on being child-centred. One member of staff described that children and young people who are referred to Community F:CAMHS **'are considered almost like hot potatoes that no service wants to touch'**, which means that there could be a **'superficial view of them'** as they may not engage or may be viewed as too high risk (Staff). In such cases, the **'voice of the child sometimes gets lost'** (Staff). Community F:CAMHS staff across the teams interviewed expressed the importance of giving the young person and their family a voice in their care, despite the difficulties in engagement and risk.

Professionals in contact with the service discussed that Community F:CAMHS had a significant impact on children and young people accessing appropriate help, ranging from a more suitable educational placement, diversion from secure services, or better engagement with services and interventions. Community F:CAMHS was described as having a key role in identifying the most appropriate placements for children and young people, including educational or residential placements; for example:

I think with the one child, it really helped to find—to know what sort of school to go for and then to find one. I think he did go to the school that was recommended or suggested by the forensic psychiatrist. (Referrer Phase 3)

d) Local provision that is supplemented with specific specialised input where necessary:

In the routine site data, 48.1% (1547/3214) of referrals were indirect cases with multi-agency consultation and 21.9% (704/3214) of cases were indirect cases with single agency consultation. Early implementing services had a higher rate of direct input (28.7%, 436) compared to late implementing services (12.7%, 215). In the 3,048 cases with complete intervention participants data, 34.4% (1050/3048) indicated 'Working with wider system/multi-agency working' as the only participant, 1.90% (58/3048) indicated 'Working with wider system/multi-agency working' and 'Group' as the participants, and 2.76% (84/3048) indicated 'Individual', 'Parent/Foster Carer' and 'Working with wider system/multi-agency working' as the participants.

Community F:CAMHS staff identified gaps in provision for young people with behavioural problems, complex needs, speech and language difficulties, harmful sexual behaviour, and those at risk of exploitation. They also described significant gaps and delays in autism and learning disability assessments. Staff acknowledged Community F:CAMHS' role in filling gaps in service provision and ensuring continuity of care, but also juxtaposed this with managing expectations and holding services accountable, for example if they should be providing a service and are not:

So sometimes we need to very much be an advocate... for the child if actually due process doesn't seem to be happening. (Staff Phase 1)

We were giving them the advice and the consultation and the support to do exactly what they needed to do. But I felt that their expectation was that we will come in and do it for them. (Staff Phase 3)

Staff expressed the impact of Community F:CAMHS in these cases may be fast tracking referrals, raising or escalating safeguarding concerns, or helping professionals to get services involved. Staff also stressed the importance of coordinating and pulling together the network - or sometimes even building one from scratch - and the challenge of getting everyone to buy into the recommendations put forth.

It is just about bringing the network together and making them communicate with each other, properly, regularly and appropriately. (Staff Phase 3)

I think sometimes the network doesn't always want to hear what you have to say as well. (Staff Phase 3)

Everything is only as effective as getting that buy-in from the other community agencies working with you. (Staff Phase 3)

Community F:CAMHS staff described the impact the service has on supporting the network of professionals and services around the young person, including supporting services to do direct work, facilitating thinking (e.g. around the meaning behind a young person's actions, around need and vulnerability, around risk) and offering reassurance. The staff's expertise and outside perspective can provide a new way of looking at a problem and help clarify or 'unstick' a plan. Also, by holding a reflective space for professionals, F:CAMHS staff contain some of the anxiety in the network which may improve professionals' self-efficacy to problem-solve.

And really all that's about is just creating a slowed down reflective space for these teams that are under so much pressure and anxiety to just think a bit differently. (Staff Phase 3)

I think the impact we have is about bringing people back to the skills that they have, and the stuff that they know and applying the knowledge they already have. (Staff Phase 3)

Support from Community F:CAMHS staff also extended to supporting parents/carers, e.g.

Participant 1 (P1): I met with the parents and they said you know we're very grateful because this is the first time that anybody has actually been curious about what we've been through as the parents. P2: And in a non-judgmental way. (Staff Phase 1)

Professionals in contact with the service described a significant strength of Community F:CAMHS as being their role in liaising with the network and **"pulling services together"** (Referrer Phase 1). There was a sense that working with Community F:CAMHS supported and promoted interagency working practices and a team approach, bringing professionals together in the interest of the children and young people. This was also true for keeping the professionals in contact with the service involved, with one describing the work as **"a dialogue"** (Referrer Phase 2). In particular, it was noted how helpful having Community F:CAMHS on board was for including schools and families in discussions and for communication generally.

Professionals in contact with the service described the expertise and knowledge Community F:CAMHS staff had compared to other services in their local areas. One professional in contact with the service described how instrumental the input from Community F:CAMHS had been in commissioning support services needed in their local area where provision was low;

Also I can then use their recommendations to then approach our commissioners, and say, "Right, well, this child needs X, Y and Z, the specialists have said it. We need to now provide it." Because in [Location] we had *** all in terms of service provision. (Referrer Phase 2)

Parents and carers expressed that whilst they had positive experiences with the Community F:CAMHS teams, they were conscious that teams are small and it would be beneficial for there to be a wider geographical coverage. One parent/carer expressed feelings of guilt for having the Community F:CAMHS team travel a long way to visit their family. The wider coverage of Community F:CAMHS was always expressed by parents/carers as a positive forward move that would mean more families could be helped, for example,

If it was bigger [...] I think if it was a bigger thing, if there were more of them and they were closer to me, I think I wouldn't have felt so bad about maybe having to bring them down again. You know, they never made it an issue, it

was absolutely fine every single time, but I felt a little bit like [...] because they were so far away, I felt bad bringing them. (Parent Phase 3)

I suppose really it would be nice if they had more staff. I'd imagine their workload is very large, so I think if anything, it would be nice if they had more staff. But I personally couldn't fault them, I think they had time, they were kind, they would listen [...]. (Parent Phase 3)

e) Reduction of risk of harm from self-harm, suicide substance misuse, violence and other harmful behaviours linked to poor mental health:

In the routine site data, risks or concerns identified at referral were again assessed on discharge for whether they were still a concern or whether they were less of a concern/there was a suitable management plan in place. Of children and young people for whom violence and aggression were a concern at referral, this was less of a concern/there was a suitable management plan at discharge for 45.7% (925/2026). Of children and young people for whom sexually harmful behaviour was a concern at referral, this was less of a concern/there was a suitable management plan in place at discharge for 39.2% (315/803). Of children and young people for whom fire setting was a concern at referral, this was less of a concern/there was a suitable management plan in place at discharge for 51.6% (142/275).

As was described with the impact of Community F:CAMHS input on young people's mental health and wellbeing, professionals in contact with the service described how Community F:CAMHS expertise helped to facilitate thinking around risk and put in place appropriate care plans and support. Additionally, their help creating consistency in the network also helped indirectly reduce risks of harm for the young people.

So actually, the way that parents interact with this young person has improved. So his risk-taking behaviour has reduced; he's not as violent at home, because mum and dad have been able to change the way that they interact with him. So yeah, there has definitely been a change [in risk], which is really important. (Referrer Phase 2)

Community F:CAMHS staff similarly felt they indirectly helped to reduce risk by providing support to professionals, helping them understand risk, or upskilling them to conduct risk assessments:

We give them that clarity and we help them to formulate them [young people]. And we give them some predictions around what the future risk is going to be and what they need to be worried about, what they don't need to

be worried about, what they're doing really well, what they need to probably change. (Staff Phase 3)

The clinicians find it just very containing to have someone that can say, "Look, these are the risks and these are the potential consequences, but this is the plan, this is what we can do. (Staff Phase 3)

Where there was not a noticeable decrease in risk, professionals in contact with the service and F:CAMHS staff described the input of Community F:CAMHS at least preventing the risk of harm increasing for the young people; for example:

Sometimes it's about stopping disasters happening. (Staff Phase 3)

Professionals in contact with the service described how Community F:CAMHS expertise around risk was helpful in supporting the network to understand levels of risk quicker which meant the right support could be put in place promptly for the young person and the whole network would all be working consistently to manage the risk. Community F:CAMHS were an invaluable source of consultation for professionals in contact with the service:

I think it's invaluable and we couldn't have managed it. So we've managed to be able to really investigate some of the challenges within the case because of FCAMHS support and get really, really expert advice really to inform our thinking and inform how we formulate longer term plans. (Referrer Phase 2)

They also pointed out certain areas that we might not have considered as well in respect of this young person, such as their access to the internet and some of the people who they may be in contact with online. So, although it wasn't ongoing risk, it made sure we were just robust in terms of how we manage the risk. It was a helpful experience. (Referrer Phase 3)

A significant theme was the effect Community F:CAMHS' involvement had on containing the anxiety of the network, even when this was confirming that the plan in place was appropriate. The authority and expertise of Community F:CAMHS, and the involvement of an additional service, was said to contain anxiety. Professionals in contact with the service shared that they felt taken seriously and listened to, which was particularly helpful in situations where their confidence was lacking. Calming the network down was said to create spaces where everyone could catch up and be on the same page, rather than this being crisis driven. Professionals in contact with the service described a sense of relief when the input of Community F:CAMHS resulted in plans being implemented successfully and children, young people, and parents/carers engaging.

Whilst a reduction in harmful behaviour was less explicitly mentioned, sometimes children/young people described a change in behaviours related to mental health difficulties such as anger, for example:

I was worried because I did a lot when I was angry [...] I was a different person. (Child/Young Person Phase 1)

Additionally, parents/carers described being in 'crisis' before the Community F:CAMHS teams' input, and the turnaround their families had made as a result. For example:

We were in absolute crisis [...] we needed to stabilise and we needed to turn it around in a positive way. And it's taken the team [...] who are all very good and came in and helped and now we don't feel like we are in crisis anymore. (Parent Phase 2)

I honestly don't think, hand on heart, that my son would be in my care if I didn't have that support. (Parent Phase 3)

Further, parents/carers and children/young people discussed the helpful strategies they have been able to implement based on their contact with the Community F:CAMHS teams, often expressing how this has made them feel more equipped to deal with any difficulties and to improve things, referring to a sense of being equipped to deal with future challenges. For example:

Whereas I think before F:CAMHS got involved, it just felt very frightening and overwhelming, and we really didn't have the answers. Whereas I think we're more equipped to deal with a lot of the challenges that can often be presented. (Parent Phase 2)

It was a serious situation that I was in, so it definitely did help me to take a step back and look at what I had done and learn to improve myself. (Child/Young Person Phase 2)

f) Reduction in offending and risk of offending:

In regards to the impact of Community F:CAMHS on risk and offending, staff described the role Community F:CAMHS has in identifying both vulnerability and risk of harm to others and **"helping the group to think about both of those things together"** (Staff, Phase 2). Staff discussed that Community F:CAMHS does have an impact on reducing and managing risk but

is also ready to acknowledge that risk may increase as understanding of the young person increases:

The fact that we do a lot of linked work with youth offending teams, with linking with secure accommodation, with youth custody, and thinking about planning for a young person coming back after serious offence or multiple offending behaviours, it does make a difference. (Staff Phase 3)

Children and young people interviewed discussed having a different outlook on life set apart from past high risk and offending behaviours; for example:

So the reason why I got involved with forensic CAMHS was due to my [...] previous offending behaviour. And all the strategies that they've helped me with, I haven't gone back on that, that kind of lifestyle again. (Child/Young Person Phase 1)

Generally talking to the other services and just telling them from his [F:CAMHS staff] point of view on where I was a year ago to where I am now. And then where he [F:CAMHS staff] thinks I'll be in a few years. It's completely different to what I would have pictured a few years ago. (Child/Young Person Phase 2)

Staff noted long-term follow up would be needed to see the full impact of Community F:CAMHS in reducing risk, but that it would also be challenging to attribute impact directly to the service. One staff described the impact of F:CAMHS is '*to create a better sense of what a person needs holistically*' (Staff, Phase 3), which would then influence offending and health outcomes:

[There] might not be difference between when they first see us and we discharge them but with the things that perhaps we've helped pull together and the connections we've helped them to make and the plans we've helped them to establish, you'd like to think that further down the line there would be a risk reduction. (Staff Phase 1)

Staff also expressed the potential for lasting impact is most likely with younger children and young people, as input from F:CAMHS may reduce the need for future service involvement:

If we could get those referrals younger, those 10-year-olds, 11-year-olds, 12-year-olds [...] I think we can put stuff in place for them which means that they're less likely to offend in the future, considerably less. (Staff Phase 3)

Professionals in contact with Community F:CAMHS echoed the thoughts of Community F:CAMHS staff, with it being hard to describe the impacts of Community F:CAMHS in reducing offending or risk of offending. The complexity of need for the young people they were referring and the need to still provide support meant impacts on offending could not be described.

Parents/carers and children/young people expressed improved outcomes for children and young people, in terms of a reduction in risk/harm/offending, and a sense that they would not return to previous harmful behaviours. Across the board, these reductions in risk/harm/offending behaviours were attributed to the input of the Community F:CAMHS teams. For example:

It was a serious situation that I was in, so it definitely did help me to take a step back and look at what I had done and learn to improve myself.
(Child/Young Person Phase 2)

So the reason why I got involved with forensic CAMHS was due to my [...] previous offending behaviour. And all the strategies that they've helped me with, I haven't gone back on that, that kind of lifestyle again. (Child/Young Person Phase 2)

I had a lot of anger and I wasn't sure where that was coming from and they helped me understand that more. (Child/Young Person Phase 1)

[Professional] did keep her out of prison and that's something I am grateful for because without his intervention she would have definitely gone to prison.
(Parent Phase 2)

g) (i) Promotion of social inclusion for children and young people within the service remit:

Staff working in the service described facilitating assessment, development of Education, Health, and Care (EHC) plans, and correspondingly, pathways to better social inclusion. For example, staff described the route to receiving a diagnosis of autism spectrum disorder in one area to be highly detrimental due to the need for a panel with a considerable backlog of cases to sign-off an assessment. The service described that in some cases, children and young people had an assessment with recommendations and had to wait a year to have these implemented. For some, this had taken too long to inform an EHC plan, and the children and

young people may already be transitioning to adult services. By Phase 3, staff noted the increased need to keep children and young people safe from exploitation through 'county lines' and through the internet, as COVID-19-related restrictions raised these risks. Global events such as the Black Lives Matter protests also sparked some informal reflections about the accessibility of the service and ways to promote inclusion.

It may be very important to focus a bit more on the proportion of referrals that we're getting. (Staff Phase 3)

I think that it's allowing more of an open conversation about that. Certainly I think clinically with other professionals, it can feel as though it feels a bit safer to talk about it. (Staff Phase 3)

Professionals in contact with the service described Community F:CAMHS as promoting the inclusion of other agencies and children, young people and parents/carers in care; for example:

The FCAMHS team were really helpful in helping to put things in context and attend a couple of senior meetings [...] to be able to articulate that in a better way than I can. (Referrer Phase 1)

I was actually part of the equation of decisions and helping and sorting out. So it was kind of more on a problem-solving way, rather than being done to children, done to the family, done to us. (Referrer Phase 2)

I felt like they were very supportive, they were open to speaking to whoever, they were flexible with the times and frequency. They asked me what I thought was helpful- and so it was kind of led by us as well. So I think it's very important. (Referrer Phase 2)

They were really clear and open about what they were doing...they explained and made sure I was comfortable with what they were gonna do. (Child/Young Person Phase 2)

This inclusive approach helped to, in turn, promote children and young people's social inclusion in care and society. Parents and children/young people interviewed described the input of Community F:CAMHS as having helped them improve their social inclusion:

I used to be really socially awkward and anxious. And now I can go up to people and ask them for things [...] they've like make me feel comfortable and

opened me up more to the world and people. I've just become a better person. (Child/Young Person Phase 2)

[...] it managed to get him to control his feelings a little bit, I would say in groups, in that he didn't need to be the centre of attention. To be in a group. (Parent Phase 3)

Now I'm at the point where I have made some friends at college and whatnot, which I struggled with last year. (Child/Young Person Phase 3)

Staff working for Community F:CAMHS were instrumental in challenging pre-existing strategies for managing high risk young people that did not promote social inclusion. For example, staff described a young person who had a plan which stated that they should be **"separate from all other pupils at all times"** (Staff Phase 1), but they were able to challenge this strategy and suggest amendments which promote inclusion and engagement at school:

But actually as we know social isolation is a risk factor in of itself and yes we can understand why the schools have done that [...] but actually we can come in and often sort of challenge that say, "well actually there's there is a need for this child to have some social engagement, how are we gonna sort of put that in place. (Staff Phase 2)

g) (ii) parity of provision for children and young people within the service remit: (please also see deliverable i)

Community F:CAMHS staff noted the importance of the flexibility, accessibility, availability and adaptability of the service. Staff described being flexible with appointment locations, methods of communication, referral thresholds and accepting re-referrals. During COVID-19 related restrictions, staff felt the new reliance on technology (e.g. Microsoft Teams/Zoom) increased their service's accessibility and ability to respond in a timely manner. Having a child-centred approach was related to Community F:CAMHS' ability to provide parity of provision to young people, as they were seen according to need and not location:

It's never about where they are or how we have to travel or anything like that. They are at the centre, that's the first consideration [...] it's, "What does this child, what can we do for this child?" regardless of where they are. (Staff Phase 3)

Moreover, flexible referral criteria (e.g. no age limit or diagnosis required) allowed staff to see cases which may not traditionally meet CAMHS thresholds. For example:

We can support really anybody who has a high-risk young person, or somebody who is engaging with or in youth offending in some way. I think that's really helpful for referrers, because where CAMHS can't or won't, then we will and can. And that's filling the gap there, I think, for those young people. (Staff Phase 2)

I think because we are a small specialist team, sometimes it's in our gift to be able to be very responsive and we don't have the unwieldy wheels of a much bigger service. (Staff Phase 3)

Professionals in contact with the service described turning to Community F:CAMHS when CAMHS thresholds had not been met or when CAMHS could not offer any more support to a young person, for example:

He didn't meet thresholds for social services' statutory involvement and assessment. And CAMHS were saying there was nothing more that they could do, because they had diagnosed this young person with an attachment disorder, and that was all that they could do. (Referrer Phase 3)

Staff also spoke about staying involved in cases which may not have been appropriate in order to safeguard and provide support, for example:

On a case-by-case basis we'll go, "Might not be for us, but we'll help you out because this sounds serious." (Staff Phase 3)

The fast acceptance of referrals and communication around this was discussed in a positive way by parents, for example:

So they were really, really quick to accept, which was great, and came down to... rang me up within a week and spoke to me and explained everything I needed to know. How it all worked and how they would be involved. (Parent Phase 3)

There was also the sense that where involvement of the Community F:CAMHS staff had naturally reduced due to good handling of the case and positive progress having been made, the team was still accessible to families if needed, for example:

So if I need them, I know that I can contact them straight away and they will help me out. Which is a massive relief, isn't it, you know? (Parent Phase 3)

There was also a sense that it would be helpful to have an earlier linkage of services. For example:

I don't know if there is better linkage, in an earlier stage, before we get to the serious offending stage, which is when F:CAMHS got involved. (Parent Phase 1)

For us there have been definite points in [young person's] development where we could have needed the support of F:CAMHS before we were given it. (Parent Phase 2)

However, other parents/carers expressed that once the Community F:CAMHS team are involved, they are good at exploring the linkage of services early on in their involvement, for example:

This is by the quickest and easiest, because if something doesn't go how they like it, they look into something else straight away, without having to wait and wait and wait. They were straight on the ball. (Parent Phase 2)

The parents/carers and children/young people interviewed in Phase 3 were asked about the impact of the global COVID-19 pandemic on the provision. They discussed the practical differences in the service, where they were offered remote contact with the Community F:CAMHS teams. Some children/young people expressed a preference for face-to-face meetings, and both parents/carers and children/young people discussed the absence of body language signals in a remote setting. For example:

It's not face to face in the same room. We're doing online meetings and they're attending all the online meetings. (Parent Phase 3)

It's different, because when you are in a room you see body language, you see how people are hearing or seeing each other. Whereas on a screen you don't actually get that same interaction. I wouldn't say there's a negative or a positive because you can still use your voice so that's fine. (Parent Phase 3)

I prefer in person because it's a lot more friendly because you can actually see the person, you can see what they're doing or not. You can see if they're writing down notes. When I'm talking to them on the phone and that, I'm kind of worried that they're going to start taking notes about stuff, which looks incriminating and stuff, things that'll make me look bad. (Child/Young Person Phase 3)

However, overall, parents/carers discussed how, despite the changes in provision, the Community F:CAMHS teams were still able to provide consistent support to them. Here, parents expressed that their children still felt supported by the teams. For example:

Even though you've had a change of staff, and things have changed around, there's been no hiccups, it's been consistent and reassuring. And we have I would say every four to six weeks we have regular meetings, which they attend and they always attend. (Parent Phase 3)

But very good. He still carried through; he'd built up a very good relationship with our son, so we carried on through Zoom calls and telephone calls. (Parent Phase 3)

They're very involved with my young person and our son feels very supported through COVID. (Parent Phase 3)

Likewise, in Phase 3, professionals in contact with Community F:CAMHS were also asked about the impact of COVID-19 on their experience with the service. Similarly to the parents/carers above, referrers described the service as continuing to be accessible and responsive, and in some cases it was easier to contact staff as they were not travelling as much. There was a loss of direct assessment and work with children and young people, but the consultation model of the service was described as invaluable:

Yes, I did work with them before the pandemic. The only thing that's changed is that we haven't met in person. But otherwise, yeah, they seem to be able to do lots of their assessments over the phone or via video call, which is really good. And when I've needed consultation or a chat, I just email and that seems to be fine. (Referrer Phase 3)

In Phase 3, Community F:CAMHS staff were thinking more about service development and how to increase visibility and accessibility of the service to mitigate against children and young people who have fallen through the gaps and are therefore not referred. Staff described using data from their referrals to identify groups that may not be accessing the service and developing links with in-patient services, secure residential services, schools, and pupil referral units; for example:

There's probably been surprisingly little in terms of referrals for children coming in and out of custody. (Staff Phase 3)

I'm part of the team that's starting up a schools project where we're trying to integrate ourselves in provisional education and pupil referral units. (Staff Phase 3)

Increasing visibility and accessibility was reflected in the interviews with professionals in contact with service. Many of the referrers reported coming across Community F:CAMHS by chance and described concerns about areas of the network that were unaware of the pathway to Community F:CAMHS, meaning some children and young people could be missing out on support and advice:

I think in terms of equity for resources for young people, I don't think anybody knows about it. I'm still finding people not having a clue that they exist. So I think that is a problem in that maybe young people could be referred in for that advice and guidance, and additional oversight that I've had, that have massively benefitted the families that I work with. (Referrer Phase 3)

Relating to parity of provision, the Black Lives Matter protests encouraged some staff to question unconscious bias and to consider ethnicity and culture more in formulations and team meetings:

Before the summer break, there was even a talk about [...] carving out a time in our team meetings to really start to think a lot about the inequalities and the racial profiling that unconsciously goes on within networks that we work with. (Staff Phase 3)

h) Improvement of life chances in relation to better health, education, training, housing and employment opportunities:

The children, young people, parents/carers, and staff interviewed expressed positive comments about the input of Community F:CAMHS on their general outlook, related to harmful and offending behaviour (see section e above). They spoke of their life course being different if it was not for the input of the Community F:CAMHS teams. For example:

Generally talking to the other services and just telling them from his [staff] point of view on where I was a year ago to where I am now. And then where he [staff] thinks I'll be in a few years. It's completely different to what I would have pictured a few years ago. (Child/Young Person Phase 1).

I couldn't praise them enough. And without them, I think my whole life and [CYP]'s whole life would be a lot different. So I'm forever grateful. (Parent Phase 3).

I think for him there has been that shift [...] He's on medication, which has really helped him, he's had a diagnosis. [...] And he's now got an apprentice... so I think there's been some huge change, because he was in gangs, there was lots of concerns about drug dealing and weapons so quite a lot going on for him and exclusion from school. (Staff Phase 3).

There was also a sense that Community F:CAMHS was central in the prevention of further harmful events, for example:

So it did help us with the relationship, and it stopped, I think, a family breakdown, which was really high. (Parent Phase 1)

They have definitely saved our family. And also it has given us food for thought, just in terms of being more open to family and talking about mental health issues, and acknowledging that it's okay to have struggles. (Parent Phase 3)

Staff described that their involvement in cases can often lead to appropriate placements being found, appropriate services being involved, improved supervision plans and provision being put in place, and perhaps providing early interventions so that young people do not become forensic patients as adults:

Without [our] assessment it would have easily turned him into [...] a patient potentially when he wasn't. (Staff Phase 1)

We went in and it resulted in her getting a quick assessment, a diagnosis, treatment, a school placement, move out the family home. But I mean we battled along for months but she, she was you know she would have caused quite a lot of harm and her needs were clearly not met. (Staff Phase 1)

Staff also described that the advice and consultation function of the service model was instrumental for the outcomes achieved for the young person. For example:

There's quite a lot goes on at the advice or consultation level which makes a difference to the trajectory of the child, I think. (Staff Phase 1)

Even if that opinion is that obviously this young person's a victim and they're not a forensic case, it can actually change the whole trajectory of that young person's treatment or their care or their placement. (Staff Phase 3)

In relation to education, staff gave examples of impacting children and young people's outcomes via EHC needs assessments or finding appropriate educational placements. There was also a marked progression to expand Community F:CAMHS provision into schools from previous phases; however, staff noted a lack of services focussed on transitioning young people back to school and supporting them as they catch up on education:

I think particularly for children with neuro-developmental difficulties we can make quite a big...Frequently they have very clear needs. Educational frequently, things like EHCPs, being in the wrong school, being out of school. A whole range of those where we can actually really help with thinking about what many...and often the really difficult behaviours recede once they're in the right environment that is actually meeting their needs properly. (Staff Phase 3)

For us it was clear that this young person's probably been sexually abused. But they weren't having any local authority provision, they weren't seeming to get the severity of it. So, we basically really escalated things up [...] I think we were able to then get this young person accommodated in a specialist residential education facility. (Staff Phase 3)

I'm part of the team that's starting up a schools project where we're trying to integrate ourselves in provisional education and pupil referral units. (Staff Phase 3)

Community F:CAMHS staff spoke about the pivotal role they have been able to play in the sentencing and sentence management of young people they work with. For example:

But she has been protected or supported to avoid a custodial and what an impact that will have. (Staff Phase 1)

Being able to have an influence on getting a deferred sentence was thought to be instrumental for children and young people's life outcomes and risk of harm given the known detrimental effects of institutionalisation. By Phase 3, staff discussed plans to link in more

with youth offending services, secure residential services, and in-patient services. It was raised that this coordination may require a national lead:

I think it needs to be a [quality improvement] project in a sense that is across F:CAMHS and across the Secure Estate. Us, in a sense, just going in as individuals from one F:CAMHS when we cover 13 areas, I think really doesn't address the sociological issue. (Staff Phase 3)

Professionals in contact with the service described the input of Community F:CAMHS as affecting diagnosis, medication, placement, and parents'/carers' understanding; for example, supporting children and young people to access more suitable education settings.

The impact [of Community F:CAMHS input] has been that the young person has been able to successfully go back to their home, successfully go back to education. Any disruption that might have occurred has been sort of mitigated. The impact has been positive one for the young person. (Referrer, Phase 3)

This was mirrored in child/young person and parent/carer interviews, whereby knowledge and support from Community F:CAMHS team members was acknowledged as a leading factor in children and young people returning to education, for example:

Without the knowledge from the forensic psychologist that I've had I wouldn't ever have got funding for - to become a student at [Specialist school/residential group]. (Parent Phase 1)

If it wasn't for F:CAMHS, I probably wouldn't have [name] in this school that he's in now, which he's doing brilliantly with. (Parent Phase 2)

They've been advising us what's best, really, because he was very resistant to wanting to go to college because he really struggles with learning and has a big fear of learning [...] so they've been very supportive in us making the changes for him to do working environment rather than educational environment. (Parent Phase 3)

i) Promoting parity of approach in services that care for this cohort of children/ young people, so that children and young people experience care and treatment delivered by a psychologically informed and trauma-aware workforce:

The accessibility of Community F:CAMHS was identified as a core feature of the service. This translated to ensuring the service was accessible to a variety of agencies, such as schools and social care. Community F:CAMHS staff expressed that the accessibility of the service as being central to the service specification, e.g. no age limit or diagnosis required for referral and being able to phone the service for advice, for example:

Anybody can ring us up and have a discussion about a case they're worried about. (Staff Phase 1)

In practice, staff shared that their accessibility is illustrated through Community F:CAMHS responsiveness and coming on board very quickly where required:

Just because it was a special service they weren't waiting 6 weeks or whatever and they were very grateful. They were often surprised when they rang us like 'oh I didn't think we were going to speak—be able to speak to you. (Staff Phase 1)

The children, young people, and parents/carers interviewed said that they found Community F:CAMHS staff to be very helpful, supportive, and clear; they said that Community F:CAMHS staff got to know them, treated them how they want to be treated – like individuals – and were non-judgemental, for example:

They don't just look at you for being what people label you, for what people think of you. They get to know you and treat you how you wanna be treated and not how people say that you are. (Young Person Phase 2)

I think it's because they listened. They listened and they observed, and there was no judgement; and their professionalism and expertise. (Parent Phase 2)

It felt good to get it off my chest. It felt kind of like they weren't judging me or anything. (Parent Phase 3)

When they got involved and we started to understand a little bit more, and I felt a bit more supported. (Parent Phase 2)

There was a sense that the parents/carers and children/young people felt that the Community F:CAMHS staff were knowledgeable and well trained, enabling them to feel supported and understood. For example:

I think they definitely join the dots, and they definitely look at things, not only from a clinical point of view, but a very holistic point of view as well, in terms of what the family needs, what siblings need, what [CYP] himself needs. So they I think have got a very good, solid knowledge of the family, where other services that we've had experience with, they just don't have that. (Parent Phase 2)

All of the experience, knowledge and his own reputation, it really gives more of a professional look on it and the advice he gives might not be in the standard advice and training that other services get. (Parent Phase 1)

I couldn't fault them. 100% I couldn't fault them. I don't know what the process is to match you with the right person at the beginning, but it obviously worked, because [professional's name] and our son gelled very quickly, he was very good, he knew how to connect with our son terribly quickly – and that's not an easy thing. And he just made it very a bespoke, tailor-made package to our son. (Parent Phase 3)

Staff working in Community F:CAMHS reported that the service was well placed to provide support for this cohort of children and young people; for example, 82% (56/68) of staff in Phase 1, 71% (62/80) of staff in Phase 2, and 90% (54/60) of staff in Phase 3 agreed or strongly agreed that they have been given sufficient training and/or support to deal with the complexities of their role, 91% (62/68) of staff in Phase 1, 91% (73/80) of staff in Phase 2, and 95% (57/60) of staff in Phase 3 agreed or strongly agreed that they can rely on their team for input on referrals, and 68% (46/68) of staff in Phase 1, 78% (62/80) of staff in Phase 2, and 80% (48/60) of staff in Phase 3 agreed or strongly agreed that they receive regular clinical supervision.

Community F:CAMHS staff expressed the importance of upskilling other agencies in the network and provided training to groups such as social workers, youth offending staff, and CAMHS staff. Key areas of training that were shared included attachment and trauma training, sexual health and behaviour, forensic services, risk assessment, safeguarding, drug training, and formulation awareness. For example:

Through helping people like this, they become skilled up. So, that was one of the sub-functions, really, I think in some ways is to widen the knowledge and help people in the system. (Staff Phase 3)

Staff also described how, during the implementation of their service, Community F:CAMHS would support services to identify their gaps and training needs in their area:

We also sort of take a role in supporting other services who are um coming into contact with high risk young people and thinking about kind of service gaps and training needs in that area to kind of make sure the provision for young people is as good as it could be. (Staff Phase 1)

All teams interviewed identified significant gaps in service provision, resource and expertise in their regions, although specific needs differed across the areas. Staff raised concerns for children at risk of exploitation and reported gaps in community services/outreach and AIM-trained [i.e. harmful sexual behaviour] professionals. Staff pointed to a gap in provision for children/young people with conduct difficulties in residential units, as well as a gap in the staff's skill set to manage and contain behaviour. Another significant gap was for children/young people who may engage in threatening behaviour in school. Limited resources and expertise in schools was perceived to result in excluding children/young people and referring them to the police. The gap extended to supporting young people with transitioning back into school.

In some instances, it was evident that Community F:CAMHS contributed to filling these gaps, for instance conducting interventions or assessments swiftly where waiting lists would otherwise delay a diagnosis and subsequent EHC plans. However, staff raised concerns about filling gaps in service provision relating to sustainability and staff capacity, managing expectations, and holding services accountable to do the work; for example:

How do we use the expertise of our partners that we work with rather than offering to do everything ourselves. (Staff Phase 3)

We do deliver interventions of that sort, however, I think we are always very, very keen to make clear to professionals that F:CAMHS are not the prime provider of harmful sexual behaviour interventions. (Staff Phase 3)

Staff also shared the complex issues of transitions in and out of services and to adult provision and frequently reported transitions as significant areas of risk and where provision may need the most support. This was amplified by the disparate picture nationally of available services and their thresholds and was described as resulting in transitions to adult services being an issue for children from earlier an age. For example, some teams described that in their region there is a considerable gap in service provision for children and young people aged between 16 and 18 years, where CAMHS do not accept referrals for young people over 16 and young people must be 18 to be eligible to access Adult Mental Health Services. It was also identified that having secure provision locally would aid in transitions in and out of secure services and reduce the need for children to be placed out of area.

Community F:CAMHS commissioners described that the service offering a national service meant that access to specialist community forensic input was no longer a “**postcode lottery**” (Commissioner Phase 2). Furthermore, commissioners shared that some services had received feedback from professionals in contact with the service that there would be a huge loss without the support of Community F:CAMHS and this would devastate local provision.

There were frequent reports of referring to Community F:CAMHS because other services had previously been unable to identify and meet the needs of children and young people; for example:

So far the, despite you know a lot of clinicians being involved, they have not succeeded, but it seems that actually what they do need is what they're getting now. (Referrer Phase 1)

But CAMHS in [Location] were saying there was absolutely no therapeutic intervention that they could put in place for him [young person]. He wasn't meeting criteria apparently for any sort of service. So F:CAMHS, really when I found out about them were a sort of last-ditch attempt of, I'll do anything. And then it was [F:CAMHS staff] that came and did the assessment for that young person and the wrote a fantastic report that they collated with the educational psychologist. And it all contributed to this young person actually got an EHCP based on some of the work that was done by F:CAMHS. (Referrer Phase 2)

This was mirrored by the expression from parents/carers that it would be beneficial for Community F:CAMHS to have a wider coverage, both geographically, as discussed above, and to support the transition into adulthood. For example:

The only downfall is that help finishes at 18. I'd say that's the only downfall. It's such a shame because it takes such a long time to get help through the system and then to find a service that they have continual case workers is very rare, and then to have it taken away at 18, that I would say is the only downfall [...]. Then if you're lucky you go back into CAMHS and you'll never see the same person twice, and they're doubly busy. (Parent Phase 3)

5.2 Clinical interpretations and recommendations

The below summary of clinical interpretations has been discussed and developed via the Steering Group and through consultation with the National Clinical Advisors.

The report findings provide evidence that Community F:CAMHS continues to provide a clinical service for children and young people who present with a high forensic risk in the context of mental health difficulties; this is in line with the aims of the service commissioned via the NHS England & Improvement National Service Specifications¹⁵.

Input from Community F:CAMHS results in an improvement in the mental health and wellbeing and the overall health and quality of life of the complex, high risk group of children and young people it is commissioned to support. The findings indicate that this is most prominent for those Community F:CAMHS described as early implementers; this suggests that the efficacy and quality of Community F:CAMHS provision increases beyond the initial implementation period. This has validity in the context of the implementation and development of any new service; following staff recruitment there is a period of growth in the team's expertise and experience, alongside ongoing key stakeholder engagement. Building a mutual understanding between stakeholders and Community F:CAMHS regarding the clinical model also takes time, and this helps to understand why those services where this is most developed (early implementors) have the most positive clinical outcomes. Moreover, regions that did not have a previous similar service to Community F:CAMHS, late implementer sites in particular, may have required more time to build a specialist forensic workforce, adding further to the time required to embed practices and building relationships in the local service ecologies.

The feedback from professionals in contact with Community F:CAMHS; from children, young people, parents and carers; from Community F:CAMHS staff; and from commissioners indicate that the Community F:CAMHS model is effective and valued. This has been sustained over the course of the evaluation. This clinical model places emphasis on consultation and liaison for the multiagency network around the child / young person, rather than taking over direct clinical and risk management. It is clear that this approach is clinically valid for this group of complex and high risk children and young people and can be safely and effectively delivered across a range of geographical regions. The value of bringing together different actors within the system and helping them to not only take the perspective of the child and young person, but also that of other actors in the system, cannot be overstated. In addition to the expertise of Community F:CAMHS, consistently reported by different stakeholders throughout the evaluation, the service's unique position in the system but somewhat removed, would seem to be particularly helpful in this regard.

The findings of this report highlight that the Community F:CAMHS model was not only able to readily adapt to changes in provision due to COVID-19 but moreover, it was able to thrive through increased flexibility of remote working. In particular, Community F:CAMHS were able to respond to and support with referrals in this period, which were described by staff as being more complex and acute. Community F:CAMHS was also more able to input into multi-agency meetings online to a greater extent than before. While these changes to provision may perhaps be desirable to maintain once restrictions are lifted, networking with professionals,

training, and informal contact with actors in the system was described as being more challenging remotely. COVID-19, placement moves, isolation, and reported increases in geographically diverse problems (e.g., county lines), has also highlighted the importance of retaining continuity of care for children and young people and also continuity of knowledge about and understanding of children and young people. The role of Community F:CAMHS in holding this knowledge and understanding and sharing it with other services is critically important, as is the opportunity to bring together the network of the Community F:CAMHS providers for a broad national oversight of these geographically diverse problems.

The findings of this report suggest that Community F:CAMHS is particularly effective in promoting the voice of the child / young person. This is especially important when the child / young person exhibits high risk behaviours; the network around the child may need to be supported to maintain safeguarding considerations. Similarly, Community F:CAMHS appears effective in promoting improved communication amongst professionals working with this group of complex and high risk children and young people; this is important from a clinical and risk management perspective. It seems that Community F:CAMHS is particularly successful in coordinating and empowering professional networks to understand forensic mental health issues in children and young people, and to promote the development and implementation of risk management plans. This is especially important in a multiagency network that may be characterised by financial constraints, long waiting times, understaffing, and staffing groups in lower bands with fewer formal qualifications. In addition, Community F:CAMHS appears to be providing input regarding children and young people whose needs are not necessarily previously identified as requiring input from, or being met by, mainstream services. This enables Community F:CAMHS to be well placed in identifying gaps in current service provision.

An important consideration arising from the findings of this report is how the unique role and identity of Community F:CAMHS can be sustained when the service becomes further embedded in existing provision, as is likely over time. In particular, maintaining the unique function and remit of Community F:CAMHS may become increasingly challenging if it begins to assume functions that are commissioned to be provided by other services (such as local Community CAMHS) or gaps in existing service provision/commissioning. This is a particular risk in the context of increased demands on those other services. This may result in Community F:CAMHS becoming less specialised and with a reduced ability to meet the specific forensic mental health needs of children and young people.

When considering the sustainability and scale-up of Community F:CAMHS, it is important to acknowledge that expansion of the service should not come at the expense of losing its distinct and unique role. Moreover, the service is not yet reaching every child and young person who needs it – while this is unlikely to be achievable, approaches to increasing reach should be considered. The importance of relationships with children, young people, families, and the professional network was consistently evident across the evaluation. Ongoing engagement with stakeholders, especially with professionals in education, social care, and youth offending teams, will be particularly important to increase reach and increase inclusivity, so that the children and young people most in need but least visible to the system are supported. It will be important to protect time for Community F:CAMHS to continue to build and maintain relationships with professionals in contact with the service, including refers, perhaps through dedicated engagement roles. This is important to reach more children and young people and to continue to educate refers about the remit of the service (i.e.,

forensic cases). Indeed, Community F:CAMHS will not be able to meet all types of needs. Nevertheless, the Community F:CAMHS model may be transferable to other services and needs; for example, a nationally consistent, regional team providing consultation, co-ordination, and assessment and intervention for children and families with Autism Spectrum Disorder or learning disability.

Further linking Community F:CAMHS with other actors in the wider system for children and young people with high levels of vulnerability, such as secure and medium-secure hospital settings, should be prioritised. For example, referrals for medium-secure settings are routinely discussed with Community F:CAMHS to understand current care arrangements and/or to perform a joint assessment. Similarly close working with the Children and Young People's Secure Estate is encouraged. Here, the ambition could be to have an ongoing dialogue between these settings and Community F:CAMHS, so that at an early stage knowledge is shared about every child or young person entering and leaving these settings, regarding what is already known about the child or young person's needs and current care provision. The co-produced, multi-agency formulation, which is a core component of SECURE STAIRS, may provide such an opportunity. Common formulation processes in community settings (such as Community F:CAMHS) with those used in the Children and Young People's Secure Estate could enable the sharing (where appropriate) of these formulations as children and young people move across different parts of the system. Such collaborations and joint-working would also be valuable in helping to ensure that children and young people from minoritised backgrounds have equal pathways throughout these systems. There seems to be an over-representation of White or White British children and young people receiving input from Community F:CAMHS when compared to the known over-representation of children and young people from minoritised ethnic backgrounds in the criminal justice system. It is crucial that Community F:CAMHS is inclusive of those children and young people in most need, with the aim of supporting early intervention and reducing the risk of criminalisation in the context of mental health difficulties.

Continued evaluation and routine site data collection and analysis (such as through the Mental Health Services Data Set) is recommended to help evidence practice and facilitate learning. A multiagency community of practice with representation across Community F:CAMHS, building on the Clinical Network meetings, is also recommended.

Working towards a system of integrated care across the system for children and young people with multiple and complex needs is an ongoing and multifaceted challenge. The findings of this report suggest Community F:CAMHS provides a vital and effective solution to this, although it can only be a part of the solution. The successful implementation and impact, evidenced in this report, highlights the importance of sustaining and scaling up Community F:CAMHS as a service and also as a model, potentially bringing us closer to achieving integrated care across a dynamic, multifaceted system.

6. Economic analysis

6.1 Summary

The appraisal and evaluation of policies and interventions is a key part of the decision-making process for policy makers. Being able to assess the costs and benefits enables evidence-based decisions so that decision makers use limited budgets to best effect and ensures that interventions deliver value for money.

The economic analysis was tasked with answering the question 'is Community F:CAMHS cost effective?' It aimed to build on and reflect the data on benefits in the main evaluation. Threshold cost utility analysis was used to consider 'How effective would Community F:CAMHS need to be to be cost effective?' In other words, the question addressed 'What would "good" look like for children and young people, for how long, and is the taxpayer willing to pay for it?', in terms of benefits to children and young people and wider society.

Well established NICE methodology and decision-making rules about willingness to pay were used to estimate the benefit to children and young people in the threshold analysis. This approach is useful to decision makers' judgments, as it estimates the scale of change required for an intervention to be of value.

The complexity of Community F:CAMHS is a reflection of the multiple applications and tasks the service undertakes when advising those providing care for complex, vulnerable, high risk young people and/or when providing that care directly.

Please see the Full Economic Report and accompanying Appendix for full details on the economic analysis.

6.1.2 Methods

The following approach was taken to inform the threshold analysis in this report:

- Using realist methodology, a priori theories and stories were formed using 'If...then...' statements for different levels of Community F:CAMHS input (time) within the parameters of the study logic model.
- Input from Peer Power experts with lived experience.
- The time of Community F:CAMHS staff was estimated using expert opinion. Staff time was costed using published unit costs, as is normal for economics evaluations.
- A large systematic review of published utility values was conducted to:
 - inform the threshold analysis with published QALYs to enable estimates of the potential value of Community F:CAMHS to children and young people
 - included studies were also used to summarise the wider societal impacts of using interventions for children and young people, as reported by the economic evaluations
 - assess the cost impacts of using interventions for children and young people as reported by existing UK economic evaluations.
- Interim results and the potential of long term cost savings were discussed and interpreted by a panel.
- Quantitative study data for direct cases from four focus study sites was used to estimate the potential duration of benefits to children and young people.

6.1.3 Threshold analysis – two early focus study sites

When examining the early implementing focus sites, the time of sustained wellbeing required in children and young people for direct cases (in a sample with complete HoNOCOSA at T1 and T2) might be considered clinically plausible for some cases. Early sites seem to have improved since the interim report. This supports the potential for the care to be considered cost-effective, at a willingness to pay threshold of £30,000¹⁶. However, caution should be taken and these results do not reflect all care offered by Community F:CAMHS.

Longer term follow up data is required to evidence if the average time required for each child is achievable.

If 57 children in direct cases are seen in 'early implementation' Community F:CAMHS teams and assessed in the emotional, disruptive behaviour, and substance misuse HoNOSCA domains

and 35 children clinically improve for emotional and related symptoms, for an average of **14 weeks** each

and 43 children clinically improve for disruptive, antisocial or aggressive behaviour for an average of **7 weeks** each

and 18 children clinically improve for substance misuse for an average of **7 weeks** each

then the 57 F:CAMHS cases might be considered cost effective at a willingness to pay threshold of £30,000.

6.1.4 Threshold analysis – two late focus study sites at the end of the evaluation, vs. two early focus study sites at the interim time stage

When examining the late implementing focus sites, there is not evidence that direct cases might be considered cost-effective. Longer follow-up over an extended time period is needed to assess this, as sites may need more time to embed the Community F:CAMHS model and achieve comparable outcomes to the early implementing focus sites. This casts more uncertainty over the cost effectiveness and value of the improvement of all sites.

Early focus study sites: interim report for 2 HoNOSCA Categories

If 22 children from direct or indirect referrals to 'early implementation' Community F:CAMHS teams are

Late focus study sites: final report for 2 HoNOSCA categories

If 25 children in direct cases are seen in 'late implementation' Community F:CAMHS teams and assessed in the emotional, and disruptive behaviour, and

assessed in both the emotional and disruptive behaviour HoNOSCA domains substance misuse HoNOSCA domains

and 8 children improve for emotional and related symptoms, for an average of **24 weeks** each

and 7 children clinically improve for emotional and related symptoms, for an average of **93 weeks** each

and 13 children improve for disruptive, antisocial or aggressive behaviour for an average of **9 ½ weeks** each.

and 11 children clinically improve for disruptive, antisocial or aggressive behaviour for an average of **40 weeks** each

then the these 22 F:CAMHS cases might be considered cost effective at a willingness to pay threshold of £30,000.

then the 25 F:CAMHS cases might be considered cost effective at a willingness to pay threshold of £30,000.

6.1.5 Considerations

Late versus early implementing sites

The panel discussed the differences between late and early implementing sites. They emphasised that the time needed to achieve high quality relationships and to build a reputation that allowed significant influence and traction with referring organisations and other stakeholders should not be underestimated. It was noted that the two early implementing sites were in regions where a previous similar service had existed and this may account for the difference seen in HoNOSCA domain outcomes. In newly established areas, teams were still becoming known to many stakeholders and relationships were not yet fully established.

In addition, it may be that the transition of staff from CAMHS or other forensic services, to the new approach of Community F:CAMHS takes time to learn. For example F:CAMHS is not case holding in the same way as CAMHS, and the full efficacy of the consultation approach has yet to be realised.

The panel discussed the results of the interim analysis and felt that the weeks of wellbeing required was high and might not be consistently achievable. However, the cost of doing nothing (i.e. no service) also needs to be considered especially when the implications for victims are potentially serious and costs to the public sector high.

Wider impact

The opportunity and potential for significant long term cost savings also needs to be taken into account. From the systemic review it could be argued that avoiding criminal activity is the significant driver in public cost savings. However, 7/9 studies reviewed for cost impact reported that use of interventions for children and young people resulted in additional cost compared to no interventions. Two studies^{16,17} took a societal perspective for measuring cost savings, and both found that use of an intervention resulted in cost savings compared to no

intervention. The cost savings were mainly caused by reduction in crime related cost, followed by reduction in treatment cost of mental health disorders.

In the UK, the cost of crime reported in the studies ranged from £550 (cybercrime) to £3,217,740 per case (homicide). The annual cost of treating mental health disorders in a UK study (reported in Euros) ranged from €11,687 (anxiety disorders) to €19,238 per person (mood disorders).

The cost of keeping one male age 15-17 in a YOI ranges from £103,675 to £135,468 per annum, with an average of £113,071¹⁸. From time estimates of an early implementing site we suggest that if Community F:CAMHS avoided a year's custodial sentence for roughly 1/100 cases the service could be considered cost neutral, and more likely cost saving, given additional public sector costs in the courts, police etc.

6.1.6 Conclusion

The importance of developing a trusting relationship with a person is of significant importance to children and young people. They report that someone who believes in them is the thing that makes the biggest difference to all areas of their lives and wellbeing.

Limited data from two early and two late implementing focus study sites (with complete cases for HoNOSCA T1 and T2) suggest that Community F:CAMHS may be approaching cost effectiveness if the weeks of wellbeing in children and young people are realised across a year (see the threshold analysis above). Later implementing sites do not yet appear to be achieving the same levels of improvement. The panel felt that the difference was primarily due to the time required to achieve good working relationships between Community F:CAMHS staff and other staff working with complex, vulnerable children and young people. The panel expressed that the time required should not be underestimated and believed that similar results could follow in time. Longer term follow up data is required to evidence this.

Cost savings as a results of Community F:CAMHS should also be considered. The published data reviewed suggests that there could be significant savings to society and the public sector as a result of decreased engagement in crime. In addition to cost savings, a reduction in reoffending would avoid a reduction in quality of life and wellbeing of the victims of crime. If Community F:CAMHS could reduce recidivism, for example, if 1/100 young people aged 15-17 years avoided a year's detention, this alone could make Community F:CAMHS a cost neutral, if not cost saving, service in the longer term.

7. Limitations

Despite being clear that participation is anonymous and confidential and that we are seeking a range of views, responses were consistently positive across all data collection phases and as with research in general, there is a risk of social desirability bias with interviews. It is possible that individuals with more positive views were more likely to volunteer to participate and complete the data collection materials. Nevertheless, a large amount of data are included in this report, representing a range of services, including geographic spread, different stages of implementation, and different levels of maturation.

There are likely to be differences in how sites coded and collated the routine site data and the data do not reflect all cases seen. Moreover, findings pertaining to the relatively small number of cases with complete data at two time points may not be generalisable to all children/young people coming into contact with the service. Nevertheless, there were no significant differences between those with complete T1 and T2 HoNOSCA data and those only with complete T1 HoNOSCA data. Without a randomised controlled design, inferences about causation cannot be made, nevertheless the triangulation of data from the realist process evaluation design enables us to test the Community F:CAMHS logic model. Moreover, to fully test the impact of Community F:CAMHS, a long-term follow up of mental health, social inclusion, and offending behavior is needed, beyond the scope of the present study.

The main challenge to this evaluation, as described elsewhere in this report, is the impact of the COVID-19 global pandemic, which had an impact on the usual running of services, the number of referrals and cases accepted, and consequently, on the methods of data collection and the data quality.

8. Conclusions

8.1 Overall

The report findings provide evidence that Community F:CAMHS continues to provide a clinical service for children and young people who present with a high forensic risk in the context of mental health difficulties; this is in line with the aims of the service commissioned via the NHS England & Improvement National Service Specifications¹⁵. Input from Community F:CAMHS results in an improvement in the mental health and wellbeing and the overall health and quality of life of the complex, high risk group of children and young people it is commissioned to provide. The findings indicate that this is most prominent for those Community F:CAMHS described as early implementers; this suggests that the efficacy and quality of Community F:CAMHS provision increases beyond the initial implementation period. The findings of this report highlight that the Community F:CAMHS model was not only able to readily adapt to changes in provision due to COVID-19 but moreover, it was able to thrive through increased flexibility of remote working.

The findings of this report suggest that Community F:CAMHS is particularly effective in promoting the voice of the child / young person. This is especially important when the child / young person exhibits high risk behaviours; the network around the child may need to be supported to maintain safeguarding considerations. Children, young people, and parents/carer discussed a range of positive experiences and impacts following input from Community F:CAMHS, including improved mental health and wellbeing, often in a transformative way.

Similarly, Community F:CAMHS appears effective in promoting improved communication amongst professionals working with this group of complex and high risk children and young people; this is important from a clinical and risk management perspective. In addition to the expertise of Community F:CAMHS, consistently reported by different stakeholders throughout the evaluation, the service's unique position in the system but somewhat removed, would seem to be particularly helpful in this regard. Community F:CAMHS commissioners described that Community F:CAMHS offering a national service meant that access to specialist community forensic input was no longer a 'postcode lottery'. Furthermore, commissioners shared that some services had received feedback from professionals in contact with the service that there would be a huge loss without the support of Community F:CAMHS and that this would devastate local provision.

Further linking Community F:CAMHS with other actors in the wider system for children and young people with high levels of vulnerability is recommended, particularly with the Children and Young People's Secure Estate. When considering the sustainability and scale-up of Community F:CAMHS, it is important to acknowledge that expansion of the service should not come at the expense of losing its distinct and unique role.

Working towards a system of integrated care across the system for children and young people with multiple and complex needs is an ongoing and multifaceted challenge. The findings of this report suggest that Community F:CAMHS provides a vital and effective solution to this, although it can only be a part of the solution. The successful implementation and impact, evidenced in this report, highlights the importance of sustaining and scaling up Community

F:CAMHS as a service. It also highlights the potential to scale up the *model* of Community F:CAMHS to other vulnerable groups with multiple and complex needs (e.g., Autism Spectrum Disorder or learning disability), potentially bringing us closer to achieving integrated care across a dynamic, multifaceted system.

8.2 Economics

The importance of developing a trusting relationship with a person is of significant importance to children and young people. They report that someone who believes in them is the thing that makes the biggest difference to all areas of their lives and wellbeing.

Limited data from two early and two late implementing focus study sites (with complete cases for HoNOSCA T1 and T2) suggest that Community F:CAMHS may be approaching cost effectiveness if the weeks of wellbeing in children and young people are realised across a year (see the threshold analysis above). Later implementing sites do not yet appear to be achieving the same levels of improvement. The panel felt that the difference was primarily due to the time required to achieve good working relationships between Community F:CAMHS staff and other staff working with complex, vulnerable children and young people. The panel expressed that the time required should not be underestimated and believed that similar results could follow in time. Longer term follow-up data is required to evidence this.

Cost savings as a results of Community F:CAMHS should also be considered. The published data reviewed suggests that there could be significant savings to society and the public sector as a result of decreased engagement in crime. In addition to cost savings, a reduction in reoffending would avoid a reduction in quality of life and wellbeing of the victims of crime. If Community F:CAMHS could reduce recidivism, for example, if 1/100 young people aged 15-17 years avoided a year's detention, this alone could make Community F:CAMHS a cost neutral, if not cost saving, service in the longer term.

9. References

1. NHS England. (2015). Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. London: Department of Health.
2. NHS England. (2016). The five year forward view for mental health. London: NHS England.
3. Department of Health. (2009). Healthy Children, Safer Communities – A strategy to promote the health and wellbeing of children and young people in contact with the youth justice system. London: Department of Health.
4. Harrington, R., Bailey, S., Chitsabesan, P., Kroll, L., Macdonald, W., Sneider, S., Kenning, C., Taylor, G., Byford, S., & Barrett, B. (2005). Mental health needs and effectiveness of provision for young offenders in custody and in the community. London: Youth Justice Board.
5. Ryan, M., & Tunnard, J. (2012). Evidence about the health and wellbeing needs of children and young people in contact with the youth justice system. London: Department of Health.
6. NHS England. (2017). Community Forensic Child and Adolescent Mental Health Service: Service Specification. Available from <https://www.england.nhs.uk/wp-content/uploads/2017/08/service-specification-community-forensic-child-and-adolescent.pdf>.
7. Hindley, N., Lengua, C., & White, O. (2017). Forensic mental health services for children and adolescents: Rationale and development. *BJPsych Advances*, 23(01):36-43.
8. Peto, L. M., Dent, M., Griffin, M., & Hindley, N. (2015). Community-based forensic child and adolescent mental health services in England, Scotland and Wales: a national mapping exercise. *The Journal of Forensic Psychiatry & Psychology*, 26(3), 283-296.
9. Dent, M., Peto, L., Griffin, M., & Hindley, N. (2013). Community Forensic Child and Adolescent Mental Health Services (F:CAMHS): a map of current national provision and a proposed service model for the future. London: Solutions for Public Health.
10. UK Parliament. (2020). Children and young people in the custodial estate during COVID-19. Available from: <https://publications.parliament.uk/pa/cm5801/cmselect/cmjust/299/29907.htm#footnote-011>
11. Pawson, R., & Tilley, N. (1997) *Realistic Evaluation*, London: Sage.
12. Kazi, M. (2003). Realist evaluation for practice. *British journal of social work*, 33(6), 803-818.
13. Salter, K. L., & Kothari, A. (2014). Using realist evaluation to open the black box of knowledge translation: a state-of-the-art review. *Implementation science*, 9(1), 115.
14. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.
15. Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology*, 13(1), 117.
16. NICE (2016). Transition from children's to adults' services for young people using health or social care. Available from: <https://www.nice.org.uk/guidance/ng43>
17. Fonagy P, Butler S et al. (2018). Multisystemic therapy versus management as usual in the treatment of adolescent antisocial behaviour (START): a pragmatic, randomised controlled, superiority trial. *The Lancet Psychiatry* 5: 119-133.

18. MoJ information release (October 2018). Available from:

<https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2018>

10. Appendices

10.1 Evaluation team structure at the time of writing

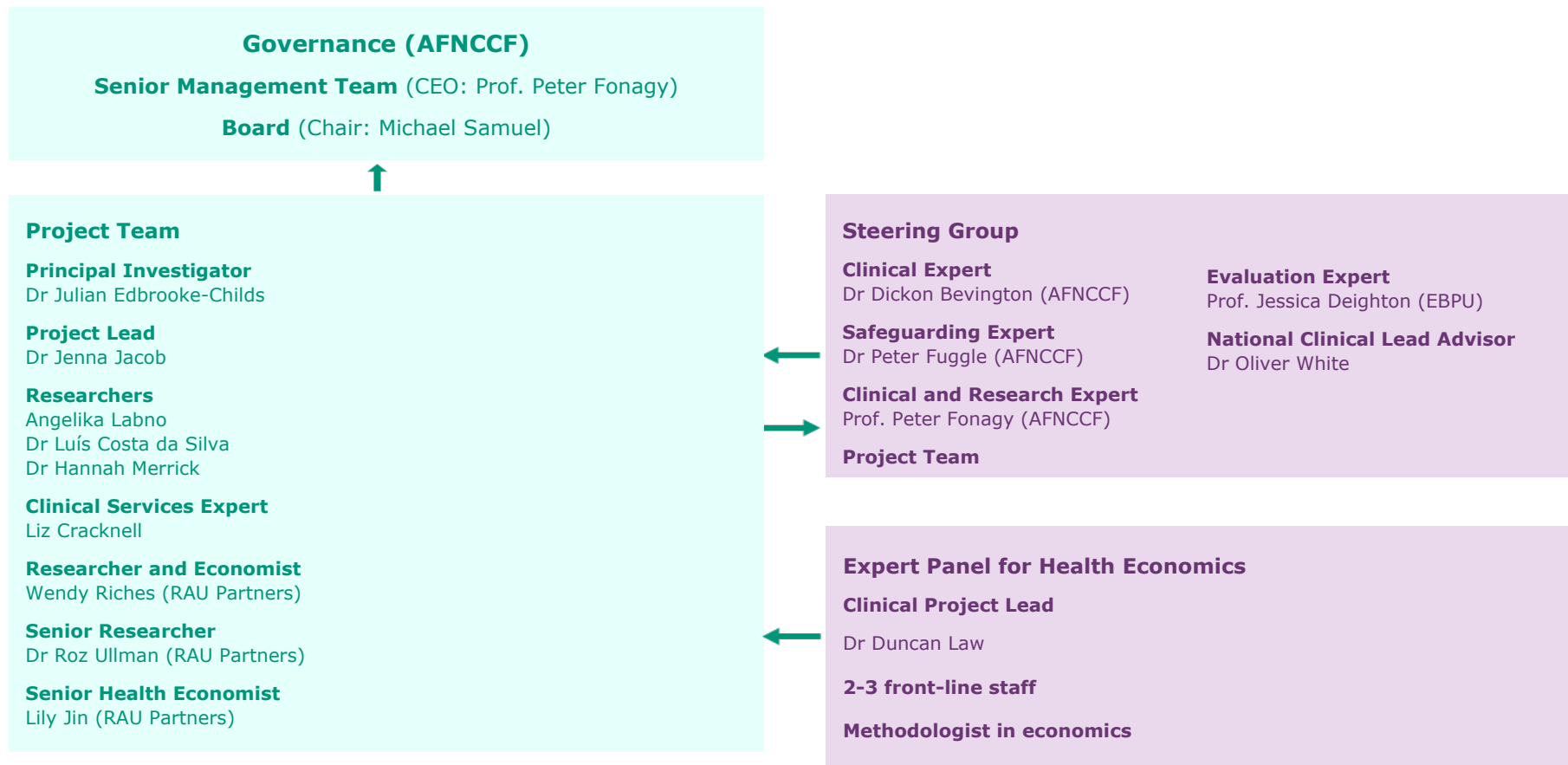


Figure 10.1: Evaluation team structure

10.2 Detailed staff survey findings

10.2.1 Phase 1 Sample Description

Overall, 77 staff members from sites expressed an interest in taking part in the staff survey. Of those, 72 provided consent and we obtained 68 complete responses from 13 sites. There were between 2 and 10 participants per site.

The demographic characteristics of staff who completed the survey are as follow:

- a) 68% (46/68) were female and 32% (22/68) were male
- b) The majority were White British (88%) and 90% of respondents were aged between 25 and 54 years old
- c) Just under half (44%, 30/68) had delivered the training
- d) The most common roles of those who responded were forensic/clinical psychologist (22%, 15/68), followed by psychiatrists (18%, 12/68), nursing (9%, 6/68), and management (9%, 6/68).

10.2.2 Phase 2 Sample Description

Overall, 83 staff members from sites expressed an interest in taking part in the staff survey. Of those, 80 provided consent and we obtained 80 complete responses from 13 sites. There were between 2 and 10 participants per site.

The demographic characteristics of staff who completed the survey are as follow:

- a) 69% (55/80) were female and 31% (25/80) were male
- b) The majority were White British (93%) and 92% of respondents were between 25 and 54 years old
- c) Just under half (49%, 39/79) had delivered training
- d) The most common roles of those who responded were forensic or clinical psychologist (18%, 14/80), followed by psychiatrists (16%, 13/80) psychiatrist, and mental health practitioner (13%, 10/80), and assistant psychologist (13%, 10/80).

10.2.2 Phase 3 Sample Description

Overall, 70 staff members from sites expressed an interest in taking part in the staff survey. Of those, 60 provided consent and we obtained 60 complete responses from 13 sites. There were between 2 and 9 participants per site.

The demographic characteristics of staff who completed the survey are as follow:

- a) 65% (39/60) were female and 35% (21/60) were male
- b) The majority were White British (92%) and 25% were aged 25-34 years, 37% 35-44 years, and 35% 45-54 years
- c) Just over half (57%, 33/58) had delivered training

- d) The most common roles of those who responded were forensic or clinical psychologist (25%, 15/60), followed by psychiatrists (15%, 9/60), other specialist worker (10%, 6/60), and mental health practitioner (8%, 5/60) and administrator (8%, 5/60).

Table 10.2.1: staff survey findings

Item	Phase 1 Mean, 95% CI	Phase 1 n, %, 95% CI	Phase 2 Mean, 95% CI	Phase 2 n, %, 95% CI	Phase 3 Mean, 95% CI	Phase 3 n, %, 95% CI
The input of F:CAMHS leads to professionals having a better understanding of a young person’s needs	4.35, 4.20- 4.50	63, 93%, 84-98%	4.48, 4.36- 4.59	80, 100%, 95-100%	4.53, 4.39- 4.66	59, 100%, 94-100%
The input of F:CAMHS leads to professionals having a more suitable risk plan in place	4.32, 4.18- 4.46	64, 94%, 86-98%	4.43, 4.30- 4.55	78, 98%, 92-100%	4.46, 4.32- 4.60	58, 98%, 91-100%
The input of F:CAMHS leads to professionals having a more suitable treatment plan in place	4.32, 4.18- 4.46	64, 94%, 86-98%	4.26, 4.13- 4.39	74, 93%, 84-97%	4.32, 4.17- 4.47	58, 98%, 91-100%
Our F:CAMHS has clear referral criteria	3.81, 3.58- 4.04	46, 68%, 55-78%	3.94, 3.72- 4.15	57, 71%, 60-81%	3.81, 3.52- 4.11	42, 71%, 58-82%
Our F:CAMHS has clear patient pathways	3.96, 3.77- 4.14	53, 78%, 66-87%	3.95, 3.77- 4.12	59, 75%, 64-84%	3.78, 3.54- 4.02	38, 64%, 51-76%

Phase 1 N=68. Phase 2 N=79-80. Phase 3 N = 59.

Table 10.2.2: staff survey findings – Burnout questions

Item	Phase 1 Mean	Phase 1 95% Confidence Interval	Phase 2 Mean	Phase 2 95% Confidence Interval	Phase 3 Mean	Phase 3 95% Confidence Interval	Comparator (Kristensen et al., 2005)
Work burnout: Do you feel worn out at the end of the working day?	28.23/100	24.26-32.20	33.88/100	30.17-37.60	34.08/100	30.30-38.86	33.0
Personal burnout: How often are you emotionally exhausted?	30.76/100	26.36-35.16	34.65/100	30.20-39.07	33.55/100	29.29-37.80	35.9
Client burnout: Does it drain your energy to work with clients?	10.54/100	7.69-13.38	16.15/100	12.93-19.36	14.12/100	13.76-17.49	30.9

Phase 1 N=68. Phase 2 N = 80. Phase 3 N = 59. Higher scores indicate higher levels of burnout. Kristensen, T. S., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work & Stress*, 19(3), 192-207.

Table 10.2.3: staff survey findings

Item (agree/ strongly agree)	Phase 1 Number	Phase 1%	Phase 1 95% CI	Phase 2 Number	Phase 2%	Phase 2 95% CI	Phase 3 Number	Phase 3 %	Phase 3 95% CI	Comparator (NHS survey, 2017)
I am enthusiastic about my job	66	97%	90-100%	77	96%	89-99%	58	97%	88-100%	73%
I am satisfied with the support I get from my immediate manager	56	84% ^a	73-92%	69	86%	77-93%	49	82%	70-90%	68%
I am satisfied with the support I get from my work colleagues	63	93%	84-98%	78	98%	91-100%	59	98%	91-100%	81%
I always know what my work responsibilities are	54	79%	68-88%	71	89%	80-95%	51	85%	73-93%	87%
I am satisfied with the recognition I get for good work	54	79%	68-88%	64	80%	70-88%	48	80%	68-89%	53%
I am able to meet all the conflicting	44	65%	52-77%	49	61%	50-72%	44	73%	60-84%	45%

demands on my time at work										
There are enough staff at my organisation for me to do my job properly	38	56%	43-70%	42	53%	41-64%	33	55%	42-68%	31%
My training, learning or development has helped me to do my job more effectively	63	93%	84-98%	69	86%	77-93%	55	92%	82-97%	84%
My training, learning or development has helped me to stay up-to-date with professional developments	62	91%	82-97%	67	84%	74-91%	54	90%	79-96%	88%
My training, learning or development has helped me to deliver a better patient/service	52	87%	76-94%	66	83%	72-90%	53	88%	77-95%	82%

user experience									
I receive regular clinical supervision	51	75%	63-85%	62	78%	67-86%	48	80%	68%-89%
I feel that my caseload is manageable	46	68%	55-78%	54	68%	56-78%	46	77%	64-87%
I can rely on my team for input on referrals	62	91%	82-97%	73	91%	83-96%	57	95%	86-99%
I have been given sufficient training and/or support to deal with the complexities of my role	56	82%	71-91%	62	71%	67-86%	54	90%	79-96%

Phase 1 N=68. ^aPhase 1 n = 67. Phase 2 N = 80. Phase 3 N = 60.

Table 10.2.4: staff survey findings

Sample Item	Phase 1 Mean, 95% CI	Phase 2 Mean, 95% CI	Phase 3 Mean, 95% CI
Participatory Safety^a: People feel understood and accepted by each other	4.42/5, 4.26-4.57	4.32/5, 4.16-4.49	4.33/5, 4.14-4.53
Support for Innovation^a: The team is open and responsive to change	4.36/5, 4.2-4.53	4.3/5, 4.14-4.46	4.25/5, 4.04-4.64
External collaboration^a: We work collaboratively with referring services	4.42/5, 4.27-4.56	4.48/5, 4.37-4.59	4.51/5, 4.39-4.63
Therapeutic Hold^b: Staff take a personal interest in the progress of children and young people	16.68/25, 16.08-17.30	17.39/25, 16.77-18.00	16.28/25, 15.38-17.18
Assessment self-efficacy^c: Identify a	7.99/10, 7.49-8.49	7.59/10, 7.02-8.15	7.95/10, 7.39-8.51

person who is presenting risk to self			
Manage self-efficacy^c: Help people to minimise the severity of risk to others	7.83/10, 7.34-8.32	7.18/10, 6.61-7.75	7.56/10, 7.01-8.11
Refer self-efficacy^c: Identify an appropriate service to refer someone on the basis of risk	7.53/10, 7.03-8.04	7.08/10, 6.52-7.64	7.55/10, 6.98-8.13

Phase 1 N=68. Phase 2 N = 80. Phase 3 N = 58-60. ^aKivimaki, M., & Elovainio, M. (1999). A short version of the Team Climate Inventory: Development and psychometric properties. *Journal of occupational and organizational psychology*, 72(2), 241-246. ^bSchalast, N., Redies, M., Collins, M., Stacey, J., & Howells, K. (2008). EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. *Criminal Behaviour and Mental Health*, 18(1), 49-58. ^cDelgadillo, J., Moreea, O., Outhwaite-Luke, H., Dace, T., Nicholls, B., Ramseyer, G., & Dale, V. (2014). Confidence in the face of risk: the Risk Assessment and Management Self-Efficacy Study (RAMSES). *The Psychiatric Bulletin*, 38(2), 58-65.

10.3 Detailed qualitative findings

A mixture of framework analysis and thematic analysis techniques were used. The framework analysis categories were based on the logic model, using the high level, overarching headings of target, intervention, mechanisms and outcome.

Table 10.3: Qualitative Data Collection Sources

Type of data	Phase 1 data collected up to April 2019	Phase 2 data collected April 2019 – December 2019	Phase 3 data collected July 2020 – October 2020
Observation	6 observations complete. Types of meetings observed (e.g., team meeting, case review meeting, MDT meeting).	4 observations complete. Types of meetings observed: team meeting, case review meeting.	Observations not conducted due to COVID-19 related restrictions
Staff focus group	5 focus groups with 31 staff.	4 focus groups with 21 staff.	4 focus groups with 20 staff
Staff interview	7 1:1 interviews with staff.	8 1:1 interviews with staff, 3 1:1 interviews with commissioners	3 1:1 interviews with staff
Child, young person, and parent/carer interviewer	2 interviews with children and young people and 5 interviews with parent/carers	2 interviews with children and young people and 10 interviews with 11 parents/carers	1 interview with a child/young person and 3 interviews with parents/carers
Professionals in contact with the service interview	2 interviews with professionals in contact with the service.	21 interviews with professionals in contact with the service.	11 interviews with professionals in contact with the service.

10.3.1 Staff working in Community F:CAMHS

Thematic Analysis¹⁴ was conducted on Community F:CAMHS staff qualitative data from Phase 1 (i.e. prior to April 2019) (N=38), Phase 2 (N=29), and Phase 3 (N=23) using a data-driven approach, analysing the data and deriving dominant themes. Transcripts of interviews and focus groups with Community F:CAMHS staff from 4 focus sites were analysed and organised into secondary themes, which were then grouped according to primary themes. The five primary themes identified are (1) Characteristics and identity of Community F:CAMHS, (2) Ways of working, (3) Gaps in the system and additional support provision, (4) Impact of F:CAMHS, and (5) Implementation. Before detailing these five themes, the analysis is introduced by briefly describing the participants and their description of the service.

Participants

Community F:CAMHS staff who participated in the interviews and focus groups were from a range of roles and clinical backgrounds, including psychiatrists, psychologists (including assistants and trainee), psychotherapists, mental health practitioners, nurses, clinical engagement workers, peer support workers, service managers, operational/service managers, project managers, assistants, administrators, and team secretaries.

Overview of the service

Staff provided some examples of the types of cases they see, although all agreed that “**there’s not a typical child that we see**” (Staff Phase 1). An illustrative indirect case described by staff involved working with a school, parents, and charity to improve access to health services for a very young person from a traveller community with aggressive behaviour. An illustrative direct case described by staff involved a young person downloading illegal digital content who was referred by a Youth Offending Team and had current contact with CAMHS. After working with the Youth Offending Team and CAMHS, Community F:CAMHS made immediate recommendations and it then became necessary for the young person to have an assessment by Community F:CAMHS, which was used to help inform the work of the Youth Offending Team and CAMHS.

Staff generally agreed on the main role and goals of the service. A common role identified was being useful; for example:

The main thing would be to be practically of use to the child, family, and professionals working with them. Practical. And to be seen to be supportive and providing the right level of support in

a group of young people who people frequently need help and support about. (Staff Phase 1)

In regards to goals, frequently staff shared common goals of working together as a specialist service to support children and young people and provide scaffolding for other services working with the child or young person:

One of our goals is to try to use our knowledge to enable networks and possibly direct work with young people but more likely other teams to be able to have the confidence to engage and stay with young people that are very difficult to engage. (Staff Phase 1).

Staff also expressed having a role in introducing recovery agendas and promoting co-production.

Main findings

Tables 10.3.1.1-10.3.1.5 detail the secondary themes, key points, and illustrative quotes corresponding to the five primary themes. The first primary theme, '**Characteristics and identity of Community F:CAMHS**', includes five secondary themes related to types of case, flexibility of the service, expertise, accessibility, and job satisfaction. The second primary theme, '**Ways of working**', includes seven secondary themes related to the challenges involved, adopting a consultation model, being a child-centred service, teamwork, promoting interagency working, inclusivity, and adaptations due to Covid-19. The third primary theme, '**Gaps in the system and additional support provision**', includes six secondary themes. These related to anxiety in the network, Community F:CAMHS catching CYP at risk of falling through the gaps, a lack of resource or expertise in the system, previous challenges to assess or engage, parity of provision and areas of unmet need, and the system around the child not understanding their needs or risk. The fourth primary theme, '**Impact of Community F:CAMHS**', includes eight secondary themes. These relate to impact of Community F:CAMHS feedback received from professionals in contact with the service, young people, and parents/carers; Community F:CAMHS supporting the network of services; F:CAMHS managing the anxiety seesaw; Community F:CAMHS filling the gaps; Community F:CAMHS holding services accountable and Community F:CAMHS upskilling other agencies. This theme also includes secondary themes on the impact Community F:CAMHS has on improving young people's engagement, placement, transition and risks as well as life chances through the pivotal role it has been able to play in the sentencing and sentence management of young people they work with; for example:

But she has been protected or supported to avoid a custodial and what an impact that will have. (Staff Phase 1)

The fifth primary theme, '**Implementation**', includes five secondary themes related to challenges and roll-out strategies, service maturity, service development, making the service known, and managing expectations that professionals and agencies have of the service.

In the tables below, Phase 1 quotes are italicised, Phase 2 quotes are in standard formatting, and Phase 3 quotes are bold and italicised.

Table 10.3.1.1: Characteristics and identity of Community F:CAMHS, secondary themes, key points and illustrative quotes.

Secondary theme	Key points	Illustrative quotes
<p>'There's no typical F:CAMHS case'</p>	<p>Describing their work, Community F:CAMHS staff shared <i>'there's not a typical child that we see'</i> as a result of Community F:CAMHS having no referral thresholds and broad referral criteria and due to the variety of services Community F:CAMHS works with. More generally, staff described the population as <i>'in one sense quite neglected 'cause they're difficult to engage but also they cost society so much money'</i>.</p> <p>Common characteristics of children and young people requiring Community F:CAMHS input included children and young people accessing CAMHS, those with harmful sexual behaviour, and children and young people about whom there were concerns about violent behaviour and aggression towards peers and adults/professionals; e.g., <i>'It covers a real spread so we can have effectively convicted terrorists that are in jail to a seven year old at home whose parents are struggling'</i>.</p> <p>In Phase 3, staff reflected that <i>'the majority of the young people we see are usually from areas of high levels of social deprivation, poverty, poor social inclusion'</i>. Some staff observed an increase in the severity of referrals during COVID-19, such as cases of children and young people exploited</p>	<ul style="list-style-type: none"> • <i>'Whilst the service is quite clear on its model, I don't think any case is the same.'</i> • <i>'There's no typical case'</i> • <i>'lockdown has meant that there's been a huge influx of young people being exploited by County Lines. There's been huge issues with sexual exploitation on the internet. And so, that's probably increased exponentially due to lockdown.'</i>

through County Lines and through the internet due to COVID-19 related restrictions.

'We remain flexible'

The flexibility of the service was mentioned by many Community F:CAMHS staff, relating to various ways of working. Firstly, staff expressed the flexibility in team structures, particularly with many staff working part time. Secondly, the *'flexibility and adaptability of the service'* was described as a core feature of Community F:CAMHS in its ways of working with professionals and clients. For example, Community F:CAMHS staff expressed that they are *'very mobile'* and flexible on appointment location. Staff shared they are flexible in their ways of communicating, for example calling and sending text reminders in addition to letters. Staff also provided examples where they had conducted home assessments over several days to accommodate for any difficulties experienced by young people and their families. **During Phase 3, staff continued to express the benefits of flexibility to their clients. Examples of these were being able to remain involved and provide continuity of care, the referral threshold and that young people and families have a certain degree of agency and choice in expressing which clinician they would like to see and where.**

Some participants spoke of the importance of the flexibility of referral criteria as this helped services engage at risk young people who would have otherwise fallen through the gaps. **This was also discussed in Phase 3, particularly in terms of the**

- *'What was good I think was that we were able to say [to the young person], 'well look it doesn't matter today's perhaps not a good day but what we can do it be flexible, we can come back another day let's book another date now'*
- *'The other thing I'm just wondering about is I think what the team do is reach the hard to reach kids, they get that engagement one way or another. And whether you're texting or meeting them in a coffeeshop, or they can't sit still in an office, go for a walk.'*
- *'I think the service will be very sustainable providing it can remain fairly flexible, so to not get too rigidly stuck into a kind of particular model at this stage...it's quite nice actually being able to do this on an individual basis.'*
- *'The other thing that sustainability is really important for is not getting rigid in our ways because as I said, systems are changing all the time and there's no point in us just continuing to do exactly the same if actually all the systems are around. And a good example of that is with, you know, a lot of the children we see now are being designated as exploited, whereas ten years ago they'd have been seen as delinquent or whatever.'*

broad spectrum of need that the service responds to and described staying involved in cases which ordinarily may not have been appropriate in order to effectively safeguard and provide support.

The flexibility of the service was described to be key to sustainability, ensuring the services continues to respond to changing needs and systems.

- 'I think I'd add to that and say the free, but also the flexible criteria of entry is really important. That there is... That we can support really anybody who has a high-risk young person, or somebody who is engaging with or in youth offending in some way. I think that's really helpful for referrers, because where CAMHS can't or won't, then we will and can. And that's filling the gap there, I think, for those young people.'
- *'there's a lot of things that people say and we respond to in terms of who they're seeing, how they want to be seen, where they're seen, I think we do it intuitively.'*
- *'we also have that degree of flexibility where on a case-by-case basis we'll go, "Might not be for us, but we'll help you out because this sounds serious." And we make that judgement to try and be as supportive as possible to the agencies around us.'*
- *'sustainability is really important for is not getting rigid in our ways because as I said, systems are changing all the time and there's no point in us just continuing to do exactly the same if actually all the systems are around.'*

Expertise

The expertise in the team was often described as a core feature of Community F:CAMHS, contributing to their role of information gathering and problem solving. This relates to Community F:CAMHS authority in the

- *'I think they're [parents are] often relieved that somebody with the right skill mix who has got a good understanding of the mental health, neuro and all of*

network and the service's ability to add weight to reports or referrals. **This was again described in Phase 3, whereby reports from Community F:CAMHS consultation allowed for plans to move ahead and for individual professionals to act upon recommendations. Furthermore, there was an additional sense that Community F:CAMHS, as a result of their expertise, are able to 'respectively challenge' and 'say the difficult thing', supporting the network in making difficult decisions and addressing risks.**

Staff also shared examples where the team's expertise led to essential signposting, e.g. urgent assessment by CAMHS. One Community F:CAMHS staff member shared *'we have a certain area of expertise which can be really helpful to these children and young people.'* **This was again described in Phase 3, where the team's links with wider networks allows for the service to support with onward referrals and effective signposting, highlighting Community F:CAMHS role in service liaison.**

The team's expertise relates to further core characteristics of the service, in particular being trustworthy, autonomous, independent and non-judgmental. Staff shared experiences of professionals and families being relieved and grateful for speaking to a helpful, experienced and non-judgemental service. e.g. *'we were fed back to us was that it was a relief, as we've already said, to come into a service where there was no judgement attached to the um antisocial or*

the risk issues as well can come in and give a better opinion or can tie things together or put pressure on agencies. So I think they've been really grateful and feel listened to.'

- *'I had a similar experience with a family I think just the value of being able to talk to someone who has experience of these cases so that they don't have a clinician who's shocked and have that transference you know where they have someone who can still continue thinking, talk them through it, have a plan it's not normalising things it's accepting what is so you can put an effective risk management plan in place.'*
- *'And also adding a specialist knowledge of risk assessment perhaps; bringing that to the network as well, to support the existing risk assessment and assessments generally that are going on.'*
- *'Within the trust, we're trying to well, we would be the leads on risk management.'*
- *'It's a separate opinion and a more objective, more objective eye on everything and we tend to dig into everything.'*
- *'So between us we've got lots of kind of erm modes of clinical input and I have to say I think we draw on all of those.'*

criminal or disturbing acts that had been perpetrated by the young people that we're able to try and understand this behaviour as a communication.'

This was again described as helpful in Phase 3, where Community F:CAMHS may support with cases which professionals have been trying to escalate for some time and do not react negatively when faced with worrying material.

The team's expertise also plays a role in within team working and borrowing from each other's disciplines, e.g. *'we bring so much variety'* and learning from each other.

During Phase 3, staff again reflected on the expertise within their team. Staff described the challenges of team members leaving with a wealth of specialised knowledge, noticing a considerable gap. Staff also shared the complexities of complementing team expertise for recruitment.

- *'To be honest the biggest skill is to go in and start getting all the information which is already in the system with people haven't looked at it or haven't kind of pulled it together.'*
- *'[there] might not be difference between when they first see us and we discharge them but with the things that perhaps we've helped pull together and the connections we've helped them to make and the plans we've helped them to establish, you'd like to think that further down the line there would be a risk reduction.'*
- *'So there are numerous agencies involved, so really at the start it was about gathering information, liaising with everyone too so that everyone knew what was going on.'*
- *'...we are absolutely vital as a kind of glue between services, children, frameworks'*
- *'...we operate as a bit of a catalyst in that sense that we get involved and enable and empower and direct and withdraw again.'*

- *'And they will trust your judgement and expertise. I think that's what you've been saying. And that is becoming more evident, that's very good.'*
- ***'I think often people will call for advice and I think they know that with F: CAMHS, that we've got links with different agencies. So it may be that it doesn't necessarily fit a certain criteria that actually you can point them in the right direction and F:CAMHS will give that liaison. So I think that's maybe why we get so many advices that we do. Because it doesn't just meet that and we've got the links with the other agencies maybe.'***
- ***'we lost a member of staff who was really experienced. And there's now probably an element of skill shortage where it comes to harmful sexual behaviour. We don't really have that level of experience that we once had.'***
- ***'we are looking to pull together another recruitment as well and we are thinking very hard at the minute as to what kind of competencies would complement what we've already got.'***
- ***'I think often will get comments more about, "Thank you so much, can you come to this meeting because we really want you there." And I think we sometimes can... what do I say... respectfully challenge, but think about those***

really difficult conversations that it always seems to be F:CAMHS that are the ones that are kind of a voicing that.'

- ***'not pleasing people but do what's right for the young person. And if that means that we say no contact or things like this is our recommendation, that doesn't sound nice, and nobody wants to hear that, but sometimes that is what needs to be said.'***
- ***'of being willing to say the difficult thing and to bear the brunt of that reaction. Like it feels like for me it's a nice opportunity to turn up and be willing to do that for professionals. And that might not be happening locally around the young person, even when a negative reaction happens, there's a sense that on some level perhaps the network might experience that needed to be said, and that's a useful thing.'***

Accessible and available

The accessibility of the service was identified as a core feature of the service. This translated to ensuring the service was accessible to a variety of agencies, such as schools and social care. Community F:CAMHS staff expressed that the accessibility of the service is central to the service specification, e.g. no age limit or diagnosis required for referral and being able to phone the service for advice, e.g. *'anybody can ring us up and have a discussion about a case they're worried about.'* In practice, staff shared that their accessibility is illustrated through Community F:CAMHS responsiveness

- *'So whatever news they [families] receive they got the understanding that there's something of a a you know a safety net in terms of our support which I think has been reassuring for them.'*
- *'Even after the case is closed sometimes they'll just ring up just for reassurance about something.'*

and coming on board very quickly where required: *'just because it was a special service they weren't waiting 6 weeks or whatever and they were very grateful. They were often surprised when they rang us like 'oh I didn't think we were going to speak—be able to speak to you.'*

Furthermore, Community F:CAMHS staff shared that their accessibility also extended to accepting re-referrals. Staff expressed that they are very clear that referrers and parents/carers can come back if this was felt necessary, even if Community F:CAMHS recommendations were not followed: *'we've obviously made it possible for them to come back and see us again whatever the outcome is.'*

A challenge relating to accessibility by one member of staff was the difficulty of measuring the team's accessibility in clinical time. Furthermore, the accessibility of the service may be challenging to manage on an organisational level, e.g. *'So this is one thing that we've [...] had to preserve ourselves within our own organisation is the ability for people to phone up when there's a pressure to feed everything through a single point of access.'*

The service's ability to respond in a timely manner was again described in Phase 3, particularly through the advice part of the service. Increased accessibility in this Phase was facilitated through the use of MS Teams/Zoom etc.

- *'We've obviously made it possible for them to come back and see us again whatever the outcome is.'*
- *'People have always said that it's useful to be able to phone us up. So this is one thing that we've we've kind of had to preserve ourselves within our own organisation is the ability for people to phone up when there's a pressure to feed everything through a single point of access.'*
- *'Just because it was a special service they weren't waiting 6 weeks or whatever and they were very grateful. They were often surprised when they rang us like 'oh I didn't think we were going to speak—be able to speak to you.'*
- *'He was also very grateful with how quickly we responded. I do remember him saying how much he appreciated that 'cause I think he felt he'd been carrying this on his own for quite a while.'*
- *'I think people like the telephone bit because they know they can ring anyway to just see if it's appropriate referral just to get some erm information.'*
- *'The other thing that the service seeks to do is to be very much available to other agencies. And so, it's not a question of just accepting referrals from young*

Accessibility of the service illustrated by the range of individuals contacting the service, e.g. 'it goes from people who are very on the ground, sometimes care systems or something like that, to people who are very senior, like CAMHS commissioners or directors of social services and things like that. And that's very satisfying really, seeing that range of people who get in touch.'

As part of service development, one of the team was rolling out an outreach program in schools to increase visibility and accessibility of the service but also encourage integrated working. This also constitutes part of an effort to mitigate against missing children and young people who are not in contact with other agencies and therefore aren't referred, one of the challenges to F:CAMHS accessibility highlighted by staff.

people, we'll accept contact from anybody. Because lots of people work with high-risk young people. And, often, they're not the most qualified but, actually, they're very experienced. And we would want that sort of person to be able to get in touch with us, just like a consultant colleague in a CAMHS service.'

- *'Well, the role of the service is to be both an accessible and a specialist service. And those things don't always go together.'*
- *'the referral process, that comes as quite a surprise to a lot of referrers because I am aware that our referral process is very responsive, it's very quick. We respond in a very timely manner and that's certainly welcomed by professionals and I think because we are a small specialist team, sometimes it's in our gift to be able to be very responsive and we don't have the unwieldy wheels of a much bigger service.'*
- *'especially looking at the feedback [...]. I've got the impression from comments that people find it really helpful how easy it is in some ways to just be able to call up for advice or continued consultation and that happens quite quickly. Rather than in lots of services it can be really delayed process but it has to have a formal meeting set up months from now.'*

		<ul style="list-style-type: none">• <i>'just thinking about one family in particular, they just rang us when they were worried, and we were able to help them. And that was really helpful, because otherwise it takes forever to get hold of someone.'</i>• <i>'I think it's a great model, it's really innovative, the reality is that you can have a forensic opinion within a week, and that is quite amazing.'</i>
Job satisfaction	<p>The majority of Community F:CAMHS staff expressed really enjoying working with the service, receiving appropriate training and having opportunities for learning. The stress and hard work involved in their roles was mentioned by staff members, although in many cases this mentioned in conjunction with the positives, e.g. <i>'you enjoy doing what you're doing but at the same time what you're doing is stressful and difficult'</i> and <i>'I really do enjoy it but yeh it is it can be can be pretty pressured and hard work.'</i></p> <p>The importance of managerial direction was mentioned by staff as being central to the implementation of the service and impacting on job satisfaction.</p> <p>The best things about the job were the work itself and working with professionals and families. Being <i>'a small and close knit team'</i> was described as helpful and contributing to job satisfaction. Staff also expressed enjoying the problem solving involved in their work and being able to help those who have not been receiving the care they need. One member of staff from a late</p>	<ul style="list-style-type: none">• <i>'I think for my wellbeing I've actually found it a very exciting challenge because setting something up from scratch is you know it's very rewarding.'</i>• <i>'you enjoy doing what you're doing but at the same time what you're doing is stressful and difficult'</i>• <i>'The best thing for me is erm is is getting to tap into families who maybe haven't had a much support or any support and being able to offer something, perhaps something a bit new, perhaps a fresh pair of eyes and perhaps feel like you've actually really made a difference'</i>• <i>'Every day's not the same 'cause each case is very different and it comes with it's own different elements [...] I think it just develops your knowledge and your skill base quite a lot'</i>

implementing service expressed that *'it's also refreshing to come to a new service where you're not picking up lots of problems from historical times.'* **These themes were echoed in Phase 3, where staff described enjoying working with a range of professionals and experiencing satisfaction when the network comes together to form an agreed plan.**

The worst things related to difficulties in offering a regional service, including travel arrangements and being dispersed, with some elements not being integrated or acknowledged within the model. Furthermore, part time staff expressed challenges of splitting time and not being able to predict demand or workload. Please also see 'accessible and available' above.

- *'I feel really lucky. Erm I think we all get on really well and everyone's got their own expertise and the cases are really interesting.'*
- *'I find it very interesting. I'm never quite sure what I'm going to see in terms of my clinical work.'*
- *'So probably the best thing is the types of cases, that chance for me to learn new things'*
- *'our mileage drops down after three and a half thousand miles and we're probably going to do about eight or nine thousand and it just feels a little bit sometimes like, come on guys you're asking us to do all this but there's no model for things like that to just be taken care of and that does impact on your working. It's the stuff like that in the model you would want things like that to be acknowledged'*
- *'My feet have not touched the ground since I've started, well before I started the job.'*
- *'it's been really great to be honest. Like it's really exciting and the excitement hasn't left yet which is nice, that with all the pressure and stress of work and being [role], it's still really exciting and it feels like it's just the beginning of something that's going to be quite huge.'*

- *'You've got quite a lot of autonomy as a practitioner, as frequently in specialist services is the case. And I suppose you have, therefore, quite a lot of autonomy as to how you develop a service, and how you practise yourself.'*
 - *'It's very varied, the people you come across one way or another, and also, you should have access to very senior people in a range of different agencies because of the group of children and the concerns they cause.'*
 - ***'It's incredibly rewarding because you get to learn about and work with so many diverse agencies and professionals, which I think is really, really great and also really challenging.'***
 - ***'when it feels as if the network sort of comes to that general understanding, whether that's from our intervention or not, there's a sense of satisfaction in that.'***
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Table 10.3.1.2: Ways of working, secondary themes, key points and illustrative quotes.

Secondary theme	Key points	Illustrative quotes
Challenges	<p>Community F:CAMHS staff shared challenges they face within their role, including challenges of being a Community F:CAMHS clinician, challenges of working with professionals and challenges in communication.</p> <p>A marked challenge of being a Community F:CAMHS clinician was the increase in referrals and managing caseloads, as well as the high demand and turnover of responses/reports. The unpredictability of the demand was an additional challenge, where for example a simple consultation on the surface may require much more work than anticipated: <i>'I had one and I went, 'oh this is just a letter I'll do a letter' got there and, 'yeh he is under investigation for murder in London.'</i> This was again discussed in Phase 3 in relation to safeguarding and providing effective care and support, e.g. 'I know sometimes I come away and I've got two cases in one day, and both of them are very high risk, high safeguarding. You do your very best to try and make sure that you've put everything in place you possibly can.' Furthermore, staff shared they would see the service bigger with more staff to manage the demand.</p>	<ul style="list-style-type: none"> • <i>'It might be like a long waiting list for CAMHS so then people kind of rely on us to fill that gap and it's hard to say yes to some people because then other services 'll hear about that and be like, 'can you do this' and before you know it we're doing loads of assessments which CAMHS should really be doing.'</i> <i>'the referrals are coming in faster than ever erm we had set ourselves targets of what to what we would say would be a comfortable amount to work with and err we're now probably err eight or nine clients over that comfortable level'</i> • <i>'it's a big patch, you can spend longer driving to an appointment than actually being in the appointment with a young person'</i> • <i>'we probably find the calming down more more straight forward sometimes than the escalating 'cause other people probably can't escalate or don't want it to escalate for various reasons'</i> • <i>'we keep offering consultation and does not being taken up so that's constantly the kind of wish to have the consultation but the referrer is sort of most of the time unavailable'</i>

Another challenge identified was accounting for meetings (e.g. supervision) and regional travel within clinician's time and adjusting expectations accordingly, e.g. *'it's a big patch, you can spend longer driving to an appointment than actually being in the appointment with a young person.'* This also relates to challenges of measuring the team's accessibility in clinical time. **In Phase 3, this was also discussed in relation to pressure to complete work and staff well-being, particularly in those services with limited clinical staffing.**

The challenges of working with professionals from other services primarily focussed on managing expectations, holding services accountable and working with the existing resources. Many Community F:CAMHS staff shared their experiences of managing professionals' expectations on what the service can provide and holding services accountable where there should be a service provided. **In addition to these, in Phase 3 staff shared that it can be challenging coming in as an external expert, which may not always be well received if the network has failed to assess or engage. This may also be perceived as a threat to the services already involved in the network around the child.**

The tension between filling gap and doing what another service should be doing was expressed by many staff as a challenge. **This was again described in Phase 3 in relation to sustainability, e.g. *'How do we use the expertise of our partners that we work with rather***

- *'That can feel quite difficult to manage and actually sharing that information with an F:CAMHS practitioner can really help to, I suppose, share accountability and create a plan together in partnership to feel, I suppose, more safe really, to think, 'Actually, is this managed support being overseen by a multi-disciplinary team,' because we discuss all of our cases, as well?'*
- *'Because that's the only time where you hear the "Oh", like of kind of, "Oh, so you're not going to do the therapy?" Because usually people are really grateful and then you kind of explain and then they're usually okay, but sometimes you hear that slight disappointment, just initially, until they really get what we do.'*
- *'one of the things I think we recognise is that it'd be really good to have a fairly quick turnaround for a really good Autism assessment and a risk assessment combined erm but if we're often waiting for an Autism assessment that can be like three years before people get round to it. Another year to have an Education Health Care Plan and then they're adults.'*
- *'you and your consultations can go on and on and on 'cause you've got to use your judgement in terms of "I can't leave this team with this young person right at this point", even though I'm done it wouldn't be ethical, it wouldn't be fair, they need another, another*

than offering to do everything ourselves.' Concerns were also raised in relation to a possible 'post-COVID surge' and how they would manage this.

Staff also described cases where they disagreed entirely with the recommended plans or where their escalations were less well received than reassurance. **This theme also arose in Phase 3, where staff described instances where part of the network did not agree with their input and how this impacted their work, e.g. 'I think we are seen as really helpful and we work really well to unpick the risk and develop a formulation around that and the risk management plans, but if it's not always what people want to hear it can be difficult as well to manage sometimes' and 'naming some very difficult realities for the young person and being on the receiving end of some quite strong and negative responses.'**

Staff also expressed some challenges around 'letting go' of services after being very supportive and closing a case. However, their flexibility and accessibility was said to help in these occasions.

Challenges around communication included working with very thinly resourced services and receiving worrying referrals with no follow-up. Some staff shared experiences of offering consultations but the referrer was too busy, requiring additional liaising. **In addition, staff raised in Phase 3 that a challenge of**

meeting or another hand holding or it suddenly becomes child protection and they want you at the case conference. You can do that can you? But then that does impact a lot on your week.'

- *'So, I think the experience is good, I haven't come across anything that hasn't... I suppose it's thinking about those different viewpoints that I haven't really come across any difficulties with.'*
- **'the younger you get them, that kind of preventative work is far more effective, I think. And everything is only as effective as getting that buy in from the other community agencies working with you. So, areas where you've got a low level of service provision, your outcomes are going to be poorer, I think.'**
- **'we're trying to be creative about how we see young people, so that they're comfortable. Because obviously, having [Personal Protective Equipment] on is not ideal when you've never met someone before and you arrive and you're covered up. So, we're trying to think about that. Hopefully the young people realise that we're trying our best.'**
- **'I think sometimes the network doesn't always want to hear what you have to say as well.'**

Community F:CAMHS is that its impact is reliant on integrated interagency working and well-resourced services, e.g. 'having that other inter-agency support is really essential, it's got to be. I think the effectiveness of us as a service is contingent on how well we can work collaboratively with other agencies' . Furthermore, staff expressed challenges of their recommendations not being followed in some cases or concerns are not taken seriously, e.g. 'I think largely when there's concerns, people do actually behave and draw together and come up with a good plan. There's occasions where people don't fully appreciate it [...] And then, the problem with that is that sometimes it takes another incident for people to realise that actually, we did mean that that was quite worrying, which feels like a shame. And some colleagues have had some fairly serious things happen where they haven't been listened to in terms of their level of concern.'

Staff also shared instances where it was difficult to determine who was clinically responsible for a case.

Additional challenges identified in Phase 3 related to staff turnover in other agencies, especially social workers. This created complexities when working with local authorities in Child Protection cases.

- **'Lots of the young people we're involved with have multiple failures and multiple issues. And so, people feel very threatened about entering a consultation, where it might be that there'll be discussions of failures in social care or issues like that. And so, that can be quite difficult to manage.'**
- **'I think the other thing is the nature of the material that we're working with. And if people are in their home environment with that there are two things. One is that there are other people around who one would want to protect from that sort of material. I suppose the other thing is making the distinction between home and work.'**
- **'is there someone who's clinically responsible involved? And is there someone who's holding the risk? And so, that's always something that comes up, and it's actually at times really, really difficult to identify who that person is. And I think that's about shifting of responsibility, that nobody wants to say, "Yes, that's me."'**
- **'Our limiting factor is our capacity, if we had more professionals, I could have those more referrals. I would have a much larger team.'**

A challenge relating to COVID-19 is the service's reliance on co-working and flexible working, for instance in using partner agencies' office facilities, e.g. *'the numbers are increasing and people's willingness to offer their venues for direct assessments, I think that's going to take a little bit of time to develop again.'* Another included donning Personal Protective Equipment (PPE) and how this many impact communication and engagement of young people. Furthermore, staff described the difficulties of boundary setting and shielding families and switching off from distressing material home working.

Consultation model

Consultation was described as a new way of working by many Community F:CAMHS staff. Some staff expressed a concern around losing clinical skills due to the increase in indirect working, e.g. *'I think the worst thing for me at the moment is err kind of wondering what's happening to my clinical face to face skills um and err that not being maintained in being a CBT practitioner and just from a kind of nursing point of view I'm just like keeping that skill, engagement, rapport and stuff.'*

Staff had mixed views on the consultation model, some viewing indirect work as a less effective way to get a full picture of a case which warrants attention, e.g. *'Just feel that you only get half the picture a little bit when you just do um consultation.'* In some cases, this was said to some within team conflict with different team members having differing views. One member of staff shared *'if a young person is of significant concern to those professionals working with them to warrant um a*

- *'So I think the most valuable part of F:CAMHS is advice and consultation. So my perspective would be that in a sense having embedded more in CAMHS – they're using the advice line a lot more, they're using consultation a lot more, I think that is very, very useful.'*
- *'My understanding of the service is that it is really a consultation service, to support other services and professionals within our borough with these often incredibly complex, chronic, interactive, all sorts of cases where they're often seen, you know, there's often a kind of real worry about risk, forensic risk on one hand, and on the other hand young people, who find it really hard to engage with services and statutory services.'*

referral to a specialist forensic service, then certainly you you know as a as a referring professional you might expect that specialist service to actually lay eyes on that young person.' This was particularly the case for high profile cases, for example those involving working with Prevent or Channel, e.g. *'I don't feel like it would be appropriate to hold a consultation because if something were to happen I think you know erm I think we would be in a real err compromised situation that, 'why didn't you clap eyes on them, why didn't you go and speak to them?''*

Other staff expressed confidence in the model and excitement for a new way of working. For example, members of staff shared that in their view Community F:CAMHS should not be involved directly unless it is necessary to in order to not overcrowd the young person and family and confuse plans, e.g. *'Multiple people descending on a child and family because there's a perception that it's high risk, they're likely to make the situation worse if it's not really well coordinated'* and *'I think it can be difficult retelling your story for the twenty-fifth time. People have been through it haven't they quite often for five years and at the end of their tether with it and then two shiny new professionals turn up and say, yeh "but we're not going to stay involved" you know that is I think that's there's a tension there isn't there?'*

Amidst these discussions, staff expressed that the consultation model adds additional constraints to what service can offer. For example, the role of the clinicians

- *'having that feedback when people are saying the consultation actually does work and they do want to be educated, they do want to get used to working with these cases'*
- *'It's a consultation model as well, and consultation – I've found that consultation in 90% of cases is much better than coming in as an expert and doing an assessment, and then providing a report. Because it's mostly meaningless to most of the people that pick it up; they just read the recommendation bit and then they do what they're told. And in a consultation model you just focus on their experience of the case, and the way it sort of brings together and brings the case alive.'*
- *'I have done it quite a lot where I've been to a consultation and I've got a picture of somebody and I've gone to actually meet the young person you get a totally different view of them.'*
- *'And I think that accessibility thing is really important so it's not just about the young person, but it's actually for the professionals who are working with them, so they know they can just ring if they're not sure. And I think the advice bit of our service has been really well-used in that respect.'*

involves more indirect work that in other services, limiting follow-up and reviews. As the consultation model is very flexible on one hand, this can prove difficult when staff are limited by their caseload.

In Phase 3, challenges around the consultation model related to staff recruitment, particularly in inducting new staff and staff turnover. Nevertheless, staff expressed that remote working and the use of technology due to COVID-19 facilitated people's the consultation model, as well as others' understanding of the model, e.g. 'it's almost as if the technology cemented the model.' COVID-related restrictions were also observed to solidify the consultation model in services adapting the service to Community F:CAMHS from previous ways of working.

- *'I think the home visit helped certainly for me helped me really get a sense of what it's like to like in that house and how each member of the family must feel and and why the risk for this young lady in particular, why she was sort of lashing out and getting angry and getting frustrated'*
- *'I think the conflict's arisen where some people within our team would say I'm more invested in trying to work within a consultation meet- model and some of us have almost... 'I don't think that works, I'm going to try and stick to doing doing answering things via an assessment process.'*
- *'it's a difficult role as a consultant in a forensic service, and I think we see that in our team, and our staff retention would probably speak to that fact that the role in itself probably isn't for everyone. And we've found out that people don't really know it until they have a go at it. And I think that that's all part of the learning here, and we're not looking at that as a negative thing at all. But the role is a very particular one, and it requires quite a lot of confidence and expertise and assurance in yourself to do the work.'*
- *'I suppose what's interesting is I felt, and a couple of colleagues felt that sometimes doing the consultation people didn't always get it, even though we would explain it, and we'd run through what it was like and what the outputs*

would be. People didn't quite get it, even though they say, "Yes, yes, yes." And actually, this COVID remote business has helped people get it.'

- **'I think initially, if you're not used to the consultation-based model, it can be quite a steep learning curve as a clinician coming into the service.'**

Child-centred

Community F:CAMHS staff expressed the importance of a child-centred approach in their work, involving the young person and their families, especially where previously this was missing. Staff also shared that their work involved encouraging other services to do the same and reiterating the importance of communication so that everyone, including parents and the young person where appropriate, is on the same page. One member of staff described the context of the work as follows: *'I think one of the main things within our service is to be person centred because I think when it's risky, when it's high risk situation it's really easy for everyone to forget about the young person whose actually at the centre and it's really easy to concentrate on everything but them.'* **This was again reiterated in Phase 3, e.g. 'we can tap into things like child in need meetings and say, "Well, actually this might be a good setting for you to have these discussions about this child.'"**

Community F:CAMHS staff also emphasised the balance of bearing both risk and needs of the young person in

- *'one of the other things we noted was actually the young person's not had much involvement in the planning recently so that um um I'm keen that when we see him we're in we start to involve him better in the in the decisions that are being made.'*
- *'So it just is the... I mean it basically shows that psychiatry works, in the sense that just... Or F:CAMHS work; by shining the spotlight on a young person's needs you're then able to address them. ... You know, that's our job really, to reduce the potential for harm.'*
- *'But just generally, I just think we're very competent, professional people working on the team, and so they bring a professionalism to the interaction. Which you'll see with other teams they don't have; that people are very stressed, they'll be sending odd emails, breaching confidentiality, panicking, you know, arguing. So to just have someone come in who actually is putting the needs of the child first, and not getting involved in all*

mind in their work, e.g. *'FCAMHS have become involved to try and help move it forward in a kind of safe way whilst keeping risk in mind, but the needs of the young person.'* **This was again described in Phase 3, in addition to highlighting F:CAMHS role of helping the network think about the child and not be 'blinded' by anxiety around risk, e.g. 'everybody comes in with their own expertise, and sometimes F:CAMHS' role is about trying to hold all these different perspectives in mind, whilst at the centre placing the young person, ultimately, which can be really challenging.'**

As examples of child-centred approaches, Community F:CAMHS staff shared their experiences of creating and adopting visual resources that are child-friendly for consent and care plans, helping the children and young people understand what these are and that they are accessible. In regards to meetings and assessments, staff also shared the importance of offering child-friendly spaces to meet where the young person feels comfortable. This relates to the theme of flexibility of the service. **In addition, the flexibility of the service appeared to be central to staff's ability to work in a child-centred way in Phase 3. For example, staff were able to advocate for young people and families and go above what their service specification lays out if it is for the best. Furthermore, having a child-centred approach was related to Community F:CAMHS' ability to provide parity of provision to the young people**

of the other side issues, or enacting something, I think is very helpful.'

- *'I think one of the main things within our service is to be person centred because I think when it's risky, when it's high risk situation it's really easy for everyone to forget about the young person whose actually at the centre and it's really easy to concentrate on everything but them.'*
- *'FCAMHS have become involved to try and help move it forward in a kind of safe way whilst keeping risk in mind, but the needs of the young person.'*
- *'I think the most important thing, actually, for NHS England to know, is you listen to the young people as well. And what they want. And don't change services without taking that into account. That is what I would say. Always ask the young people. Because it's for them. They're a 'really hard to reach' client group. And, actually, I think we do pretty well with that. And it's about having those approaches and knowing what works. And maybe sharing that, actually.'*
- *'So, it's using the formulation, really, formulating around a young person and identifying what their needs are and actually planning around that and how we can support them, the family and the wider network importantly around that person.'*

across their region, whereby young people were seen according to need and not location.

Further examples provided in Phase 3 related to following young people when placed out of area (related to continuity of care) and ensuring that young people and their families are supported, e.g. *'We had a child who was being questioned about [about a crime] and spent quite a lot of time with making sure that in the police station he was being supported and his mother was being supported.'*

- *'we went a little bit on and above of what our service specification is. Because we spotted a need that wasn't being addressed, but didn't back away from that, and just thought right, we're going to advocate for the patient on this on and try and get them what we need.'*
- *'When we talk about any of our cases the first thing that's discussed is the need of the child or the young person, followed by what the referrer expects and what we can do. And it's never about where they are or how we have to travel or anything like that. They are at the centre, that's the first consideration; it's not, "This child's..." [...] it's, "What does this child, what can we do for this child?" regardless of where they are.'*
- *'it's about that drip, drip effect of keeping the child in mind, bringing people back to basics a lot of the times, so I think sometimes people get blinded by what they see as really something quite high risk, so they'll be an incident or a child will say something, and peoples' anxiety will raise and they will forget to just go back to very basics around function of the behaviour, around what's happening to the child'*
- *'I've been very clear on a lot of calls when they say they're going to go from one parent to another and social care will say, "That's out of*

		<p><i>area," I've been really clear that actually we would stay open to support them, or the professional network. And I work with one young person, just over the telephone, not direct and she's out of area and it's working well and that was needed.'</i></p>
<p>Team work</p>	<p>Community F:CAMHS staff shared the importance of team work and the value of a supportive network. In particular, the roles of assistant psychologists and administrators were highlighted as being essential to data collection and the smooth running of the service, e.g. <i>'Without admin you really are flooded.'</i> This was echoed in Phase 3, in addition to highlighting the value of having trainees on the team, e.g. <i>'[admin] is the glue that holds us all together.'</i> Staff also described instrumental support provided within the team, e.g. <i>'So I think we support and link in with each other really well.'</i></p> <p>Staff described the support of the network of services and of NHS England and NHS Improvement during set up was <i>'incredibly useful.'</i> In particular, late implementer services described the support of early implementer services, or more mature services, and NHS England and NHS Improvement Central Implementation team as very helpful and they could ask questions and adapt materials. Teams also shared that joint practices, such as having peer supervision with other Community F:CAMHS teams and shared training, were really helpful ways of working together and learning from others, e.g. <i>'while it's not a core function it's actually the survival of FCAMHS means that you</i></p>	<ul style="list-style-type: none"> • <i>'We've also got a national network where all the services meet up together. So all of those things are actually supportive of both teams and individuals working within them I think.'</i> • <i>'And I guess the relation with other F:CAMHS teams is good. Like it's not kind of like taken that we don't want... There's that kind of open flow. So it kind of feels like it's a more cordial relationship between teams, so that you can have those open conversations about what makes most sense for that particular case.'</i> • <i>'We've found the central team so supportive and [Commissioner] you know brilliant and so interested and so willing and he's come down to the [service] quite a few times and you know it's just all there's a really positive energy to everything I think.'</i> • <i>'while it's not a core function it's actually the survival of FCAMHS means that you need to have that kind of community I think feel with your other FCAMHS teams so that you can help each other out'</i>

need to have that kind of community I think feel with your other FCAMHS teams so that you can help each other out.'

In Phase 3, some staff reflected on the importance of team dynamics in such small teams, where losses feel considerable and changes in staff impact team dynamics, e.g. 'we entered January, February in a state of flux as a team. We'd had one really highly experienced member of the team leave. We then had a new member of the team start. And as a small team, these small shifts can have a real impact on the way a team works and how it functions.'

Furthermore, staff reflected on the impact of COVID-19 on teamwork and team building, especially through informal discussions and face to face support, e.g. 'a particular barrier, especially not having the whole team around you, where we used to have these big team dialogues just in the office. All of a sudden, for an hour a debate would appear in the office, and we'd all just be arguing our different viewpoints and that was really, really healthy. But that's all lost now' and 'just not having that sense of being a room supported by people, I think it's been really different as well.' Staff raised a risk of losing sight of what colleagues are doing and working in an 'insular' way.

- *'And the biggest positive for me was the other F:CAMHS that had already been set up, especially [in regions], because they were so helpful. You know, they shared information, they were quite happy to share – on the calls we've had; they're quite open and honest about the challenges. And they said to us, you know, beware of this, or look out for this. So that's brilliant, yeah.'*
- *'I think if it's part of what we're looking at, the service and commissioning, there should be in my view a different role, because [name] is more than an administrator. And she does a lot in terms of that initial clinical, she knows exactly what questions to ask. She's so professional, I think that role should be different, actually, for the forensic CAMHS.'*
- *'I think all the different roles, we work really well together and like you say, we always say [STAFF NAME] is the glue that holds us all together, but I think we all support each other really well. For example, [STAFF NAME] is able to attend a really important child protection conference, because I'm unable to go. So I think we support and link with each other really well.'*
- ***'F:CAMHS is such a big community, because there's always someone there that you can free chat to and ask questions of. [...] I really***

	<p>In Phase 3, teamwork was also related to Community F:CAMHS providing parity of provision across their patch. This was facilitated through having different team members as key contacts for different areas, e.g. 'I think we cover an area pretty equitably. You know, we've got a senior clinician who's the point of contact for each area and local clinicians know who that is.'</p>	<p><i>appreciate working with the other professionals within F:CAMHS itself. And you learn so much just from being around them.'</i></p>
<p>Communication and promoting interagency working</p>	<p>Community F:CAMHS staff identified communication and promoting interagency working as central to their ways of working. One staff member described this as 'Getting everyone pulled together and have that joint shared formulation.' Staff described their roles as gathering and sharing information, bringing services together and ensuring all those who should be involved are, including young people and families, e.g. 'So often you are putting together that professional network, making sure they've got each other's contact details, that they will share information that's relevant.' The importance of encouraging communication within the network, promoting interagency working and including families was discussed again in Phase 3, e.g. 'a lot of the time it is just about bringing the network together and making them communicate with each other, properly, regularly and appropriately.'</p> <p>Another member of staff expressed their key role in 'liaising in a case and how important that can be.' Although some staff described good communication in the network, the majority shared experiences of where interagency working could be improved. In Phase 3,</p>	<ul style="list-style-type: none"> • 'I see FCAMHS as very much like acting as a bridge, [...] sort of plugging the gaps in terms of what there is out there between your social care, CAPT, conventional CAMHS, neuro CAMHS, and a way of sort of joining that together, giving advice, giving liaison, and really linking it all together so that everyone can work in the best possible way to support the young person. I think it's really needed.' • 'So there are numerous agencies involved, so really at the start it was about gathering information, liaising with everyone too so that everyone knew what was going on.' • 'So often you are putting together that professional network, making sure they've got each other's contact details, that they will share information that's relevant' • 'And it gets them talking and communicating with each other, which means sometimes we can just take a step back, and just oversee the case. And they're doing

Community F:CAMHS' role in coordinating and pulling together network was reiterated. This was also significant in cases which were described as having lacked leadership in the professional network, so Community F:CAMHS remained involved to coordinate a safe response for the child. Staff also described instances where they have had to build up a network from scratch.

Staff repeatedly expressed that their role is to work with other services rather than complete the work independently, e.g. *'I wouldn't say it's for us to dictate it's for us to work jointly to think about what the young person needs'* and *'it's a very different way of working. It involves a lot of cohesion as in you have to be like the cohesive as it were, you're bringing people together. You're sort of developing resources within an authority and supporting them rather than going in there and going like "I can solve this" which is sort of maybe other people's expectations would be.'* **In Phase 3, staff continued to describe instances of joint working with agencies, including other Community F:CAMHS services. Some staff reflected that there was perhaps resistance in the network originally to work with Community F:CAMHS but that upon understanding the service better, services were keen to refer and accept the service.**

This relates to communication and the consultation model, e.g. *'being consultation service you know it's about effective communication.'* **In Phase 3, this was**

what they need to do, in a more joined up way as well, which they don't always'

- *'I suppose it's binding, sort of like you're bringing agencies together working alongside, it's about multiagency working'*
- *'And so I suppose the trick of it, the real work, is trying to get that joint understanding amongst professionals working around a child and that's often something which we spend lots of time doing.'*
- *'the involvement of parents and the working with referrers and other professionals is really crucial and in fact in some ways for a service like this, that interface with other professionals is crucial because that's what makes the difference for the child and the family.'*
- *'A big part of the role is attending meetings, networking meetings, child in need meetings, child protection meetings. So, that's a large part of it, but also working with young people and families as well. And sometimes that might involve what we've spoken earlier today, where a young person maybe a trauma has been identified but actually, they're not in the right place where they can have direct interventions.'*
- **'You get a referral in and it's a very high-risk case and you look around and there might be**

again described, highlighting the importance of lay language.

Staff reflections on the past year were that interagency working has perhaps improved as a result of home working and use of teleconferencing tools, with observations of increased attendance at consultations and professionals' meetings.

Staff also reflected on their role working across the region and their knowledge of services, being able to share insight and success stories to services with similar difficulties which although may geographically be close, are governed separately, e.g. *'You can at least offer that view, because remember, people work in their own localities, and it's a bit counterintuitive really, even if they are not far from each other, they may not know what's happening around them in other areas. And we happen to be sometimes in that fortunate situation that we are working across and hearing things which are challenging as well as hearing things which seem to work.'*

The importance of interagency working was associated with ensuring that Community F:CAMHS is accessible to young people who may be traditionally underserved, e.g. *'it's really thinking about how we can link up with police,*

only one or two people in the network. And those people might be voluntary or it might be someone like a schoolteacher who they're not a lead professional, if you like. The child has to go to school, but some of the children then get excluded from school or whatever. And the network at times can be very, very miniscule. So we've had a few cases recently where we've had to really build up a network from nowhere. And there are cases where there's significant safety concerns, they need health input, they need five or six people.'

- *'there was other services within the community that I think at times can feel a little bit threatened by F:CAMHS in the sense that again, it feels as if we may come in [...] and start doing the work that they could traditionally do, and that's again definitely not within our remit. We're there to complement and support. But interestingly enough, once you get across it, one we rolled out these educational sessions or information sessions, then agencies and schools were really interested in getting involved and taking up the service.'*
- *'Having a space for people to listen to, but also bringing together that multi-professional network. Sometimes you'll chat to the professional team and it's quite clear they've not spoken to one another. And both have got really important information, and actually our team can*

with social services, with voluntary agencies to try and access those populations.' The increased benefits of integrated working and having a coordinated response were also highlighted in terms of impact of the young person and their outcomes, e.g. ***'if you think the traditional models are that you're doing an assessment with the young person, a report, and then that's shared with the network. To think that now you're mobilising a network of potentially 10 people and getting them to coordinate together, to actively think about project managing a young person's life and family to actually get them back on course. I think the opportunities for change is huge.'***

help to pull that together, to pull those important strands together.'

- ***'Everyone had a bit of information but didn't share it. And in this instance, it's like there wasn't leadership from all the agencies involved. So, I said, "Right, well, I'm going to sort this out." And pulled everyone together then.'***
- ***'I try to work alongside a social worker, so that you have that relationship with them. So, rather than you being an expert to provide some advice or consultation, you come and go, "Right, I'm here to support you, as a social worker. We'll work this case together. I will sit next to you in the meeting or we will do the assessment together, and then we will produce something together." And I think you then get that better engagement from them, because they think you're a colleague, a teammate who's working with them. And then, you can upskill them at the same time.'***
- ***'I think that's one of the things that perhaps other people quite like is that we're not telling people what they need to do unless they're not doing what we think they should do and we really think they should, but we're trying to develop something conjointly with them in terms of a plan. So if we were going to escalate a case for example, in social care, we make sure that we've told the social worker involved that we***

	<p><i>were going to do that rather than just doing it to someone senior without telling them. So we do it with their agreement really is part of a plan.'</i></p>
<p>Inclusivity</p> <p>During Phase 3, staff were asked to reflect on the potential impact that global events, including the Black Lives Matter protests had on their work. Many staff reflected that these had not had a substantial impact on Community F:CAMHS, partly because they generally work with a very neglected group of children and young people but also because the overrepresentation of minoritised ethnic groups in the systems they work with has been an area of concern for some time. Furthermore, teams have experience of working closely with Prevent and Channel and managing cases involving extremism, such as far-right extremism. Nonetheless, many staff described that the movement has allowed for informal conversations to take place and encouraged staff to share articles with colleagues.</p> <p>Others shared that these protests have helped bring to forefront that perhaps Community F:CAMHS is still not reaching the underserved and the communities who may engage less with services, or for whom services are less (culturally) adapted. These brought on conversations about how the accessibility of the service is limited by the agencies who refer, e.g. <i>'But it's about how people get to us that is the problem. And actually, if then people are not</i></p>	<ul style="list-style-type: none"> • <i>'I can't off the top of my head say to you that anything has come to us which would be very different as a result of the Black Lives Matter movement.'</i> • <i>'I think overall, it's not filtered in too much into our day to day work and I don't know as a service we've really reflected on whether there's anything that we need to think about in terms of our practice.'</i> • <i>'those communities that are White British and people of Pakistani heritage there's quite a division in between them. And what we see a lot from there, from the White British community is sometimes some far-right extremism. So, that's always been a topic within our team, and I don't think the Black Lives Matter campaign really emphasised that any more for us, because it was a current issue for us, really.'</i> • <i>'we've had some discussions. Maybe as individuals, but just kind of thinking about how somebody's ethnicity can impact on how their behaviour is perceived, or their risk level is perceived. I think that it's allowing more of an open conversation about that. Certainly I think</i>

accurately picked up as they come into the system and the service, then they're not going to accurately come to us either, if that makes sense. So, there is an issue there.' This was described as a 'systemic issue.'

Furthermore, some staff shared that these protests have encouraged them to question unconscious bias and to consider ethnicity and culture more in formulations and in their team meetings. Staff shared feeling empowered by the movement to discuss race and ethnicity more openly and to challenge others, with others sharing that their Trusts are rolling out unconscious bias training. Staff also discussed the diversity of their teams and how this does not always reflect the populations they work with, and the need to look closely at their service data as to who is accessing the service.

To promote inclusion, staff discussed a 'grassroots' approach, with increased community provision and youth work. Such initiatives were unfortunately reported to be limited by resourcing and funding, e.g. *'I think the basic lack of services has always been the key factor in over representations of young people going to custody.'*

clinically with other professionals, it can feel as though it feels a bit safer to talk about it'

- *'Our figures for all of our population, including under 12, are also predominantly White British. So, absolutely there is that live conversation that we may not be seeing the representative numbers of the ethnic minorities in our region, which there absolutely are pockets of. So, it's an ongoing discussion, the problem is that this is not an agency where people self-refer. So, then, that adds another layer of complexity, that we are dependent on our referrers as to how much they penetrate or link in with the ethnic minorities in their area.'*

'I would say that after Black Lives Matter, I've been a lot more inclined to challenge institutions to think a lot more about safeguarding, to try and use the police effectively. Liaising with police to try and give them a better understanding of perhaps the impact of trauma and why these young people are behaving as they are.'

- *'I don't know that we've had any particular team discussions about it. There have been some interesting things circulated about various... various articles that have been written and taking that perspective, and I think that's very important, but I don't think we've particularly altered our practice. I would hope we're very*

inclusive anyway, but I think we all do need to bear in mind that it's very important. It may be very important to focus a bit more on the proportion or referrals that we're getting'

- *'should we be having more representations within the team? Thinking that as a team we're not as mixed as we could be.'*
 - *'I do think we've integrated or definitely tried to think more about differences in culture and race definitely within our team meetings, our MDT meetings. Before the summer break, there was even a talk about [...] carving out a time in our team meetings to really start to think a lot about the inequalities and the racial profiling that unconsciously goes on within networks that we work with.'*
 - *'I think as a service, actually we probably do a reasonable job of picking up the, god, I don't know all the correct terms, really. But the group of people who fall under the net, don't always get services, have particular needs, issues, difficulties, related to poverty, race, less so gender, I think. But I think our service seems to do better than some other mainstream services around that. I think however, [...] it's a systemic issue'*
-

Adaptations due to COVID-19

Staff described the adaptations the services made due to COVID-19 related restrictions in Phase 3. These largely revolved around remote working and a reduction in face-to-face contact (therefore direct work). Many staff discussed these changes positively, sharing that they were more productive and saved time on travel and commuting. Staff described that their day-to-day varied more due to COVID-19, with some reflecting that their role has been more focussed on safeguarding (possibly related to the perceived increase in exploitation cases described above).

Nevertheless, for some staff, particularly those with children, home working was described a challenge due to distractions of parenting and the nature of the work and the cases worked with. In addition, increasing productivity was observed to have some impact on staff wellbeing, particularly in not having a break between virtual meetings. Some staff were additionally redeployed and providing cover for colleagues, which added uncertainty to their work, requiring some re-adjusting, and reduced team capacity. Other difficulties were associated with “reactionary” responses from Trusts and the uncertainty for service provision at the beginning of the first lockdown, with some staff needing to discharge many cases. From a managerial perspective, staff described challenges of obtaining PPE for the

- *'I think the main impact that that's perhaps had on us is that we haven't done as many face to face assessments with young people. So we had a couple of months, probably three, four months now, really where we haven't seen any children face to face and we're only just starting to.'*
- *'I think how we move from where we were to this new COVID operating system was quite easy for us, actually. I think it was quite an easy transition. And it's because a lot of our work can be done with just professionals who are also working at home, so we do the consultations over the internet.'*
- *'We tried to do assessments via Microsoft Teams, that has not been effective. If you try and sit with a kid on Microsoft Teams, they get all shy, they get embarrassed, they don't really listen, they start fiddling with things. And it's been an absolute nightmare, it's not been particularly effective at all. So, we started ramping up those assessments again, using local units, wearing personal protective equipment, face masks and using hand sanitiser. And we're gradually continuing to pick them up.'*
- *'Social workers are predominantly working from home at the moment or undertaking appointments on the doorstep. What we've*

team and the complexities of ensuring safe working.

Staff shared that they were able to maintain their consultation work and respond to increasing referrals. This was facilitated through the use of teleconferencing software, such as Microsoft Teams. Some staff reflected that other than their ability to do direct work, the shift was less significant due to the service's flexible way of working and the consultation model. Staff were grateful for the significant improvements (albeit slow at first) they observed to other agencies IT resources and use of online communication platforms.

Conducting direct work and assessments over Microsoft Teams was said to work less well so staff have relied on conducting them face-to-face with PPE when restrictions allow. However, staff shared that they habitually use local authority or children's centre buildings for assessment, which have been closed, adding another barrier to this work.

Some staff reflected that though the types of cases were similar, referring agencies changed due to school closures. This resulted in a gap in knowledge in the professional network as no one was able to speak to behaviour and functioning at school. Similarly for social workers, reduced contact and insight into young people's day to day

noticed is because their contact with young people is more restricted, their level of input or information they're able to provide into the consultative process is probably less than it used to be, because they're not maybe seeing the young person or the family as much. Or being able to ask the questions, because they're on the doorstep and don't have that kind of confidentiality.'

- *'quite a lot of the third-sector services have dropped off the radar quite a bit. We're seeing less involvement. CAMHS services, they still don't appear to have ramped back up. I've got a case at the moment who was referred into CAMHS in March at the start of lockdown and they said, "We'll pick you back up at the end of lockdown, at the start of school in September because of the COVID issues." So, they've been very absent throughout this process. So, yeah, that's been a bit of an issue.'*
- *'people will now just send me Microsoft Teams invites and they're appearing, literally doubling up in your calendar.'*
- *'often we were the people who were dialling in and there weren't proper dial in facilities, so you always felt like the poor relation who... and somebody would throw an iPhone on the*

resulted in restricted input, and CAMHS practitioners were not able to work at full capacity. In one service, complexity was added with a custody suite closing down, resulting in a larger number of young people being out of area. This was described to impact the network and the information which would feed into formulations.

There were mixed views of the impact on workload, with some staff reporting a reduction in referrals due to reductions in provision of other agencies. Other staff reported that the scaling back of other services has increased the workload of Community F:CAMHS, in attempts to fill the gaps, and their ability to find appropriate solutions and have required increased escalation for plans that were described as '*stuck*'. In addition, staff noticed a tendency for professionals to misattribute difficulties to COVID-19, and having a role in helping services take a step back and consider the child more holistically.

Moving forward, staff described that they hope to preserve some of the strategies and tools developed and consolidated this year, including offering more virtual appointments.

table and expect you to pick up all the sound or whatever. So one of the positives has been that people are more... have the resources now or the ability to set up audio facilities or this kind of thing to help and it makes life easier for us because we cover such a large area.'

- '*most places had just closed the door walls and weren't able to think about things properly, so we had high risk children that were even harder to find solutions for and to make safe'*
- '*I think going forward even post-lockdown, if we start to work in groups or in buildings again, I think we'll probably do or certainly offer to do more stuff virtually than maybe we'd offered before.'*

Table 10.3.1.3: Gaps in the system and additional support provision, secondary themes, key points and illustrative quotes.

Secondary theme	Key points	Illustrative quotes
An anxious network	<p>Staff described their experience of working with anxious networks and the concerns there are when working with high-risk cases. In particular, many staff expressed cases where the network was not 'linking up' and where it was difficult to get some services involved, e.g. police.</p> <p>The concerns when working with high risk cases was a particular issue described by Community F:CAMHS staff, relating to young people at risk of falling through the gaps, e.g. <i>'I think just generally people in a range of services just getting very anxious about working with risk to others, so it becomes a hot potato issue. So I think those children often are bouncing around services, either not getting picked up or people are trying to refer them on quickly because they get very anxious about them.'</i> This also contributes to young people's poor experiences of services a result of not having consistent follow-up or support.</p> <p>In cases where professionals in the network were anxious about a case, staff shared that this would impact their ability to complete and focus on the work they should be doing, e.g. <i>'if they [professionals in contact with the service] feel unhappy and anxious about a case, then they can't get on with doing what they're really supposed to be doing.'</i></p>	<ul style="list-style-type: none"> • <i>'If they [professionals in contact with the service] feel unhappy and anxious about a case, then they can't get on with doing what they're really supposed to be doing.'</i> • <i>'I think just generally people in a range of services just getting very anxious about working with risk to others, so it becomes a hot potato issue. So I think those children often are bouncing around services, either not getting picked up or people are trying to refer them on quickly because they get very anxious about them.'</i> • <i>'there's a reticence to take the high risk ones in when they need residential care and so frequently [...] independent care providers are saying 'we can't take this child' posing social care enormous problems in terms of what they do with a case when they know that environment's not right, that the child is really high risk and can't be contained. And they have no alternative but to place the child back in the home setting [...] More recently it's becoming an issue and there's almost sort of learned helplessness in the system about the chances eventually identifying somewhere where the child can go.'</i>

Although one service described a case of good interagency working within the network, the majority of staff shared experiences of poor communication across services, poor information sharing and some instances where there was simply a lack of information available. One staff member shared their experience of working on a case where professionals surrounding the child *'haven't even met or spoken or shared information'*.

Although this was less of a theme in Phase 3, staff continued to speak to the anxiety in the network around the child, often arising from to limited capacity and options.

- ***'we often get referrals from professionals who have explored all the available options to them, available to try and manage the young person's behaviour or to keep them safe. And they have effectively come to the end of their tether, and they don't know what to do next. The anxiety in the system around that child is really, really high. There might be a lack of professional confidence due to things not working particularly well.'***

Community F:CAMHS catching CYP at risk of falling through the gaps

Relating to the anxious network and lack of resources and expertise, staff expressed that children and young people are at risk of falling through the gaps between services, with Community F:CAMHS providing a vital role in catching these young people. For example, *'So health think it's the social problems so social care should deal with it, social care think it's a mental health or neurodevelopmental problem and they think they should deal with it and then this child falls through the middle, is bounced back and forward and that can be around the idea that you know there's been a lot of trauma or attachment problems or there's social problems in terms of housing or substance misuse, but the agencies won't seem to work together'*. Community F:CAMHS staff expressed witnessing significant issues in continuity of care: *'young people that bounce from placement to placement to placement and not one,*

- *'there seems to be quite a number of sort of eight, nine, ten, eleven year olds that are referred for various because of um sort of aggression, violence within the home maybe some sexualised behaviour which might come from sort of being in that toxic environment, seeing adults doing things that children shouldn't see basically'*
- *'your core CAMHS wouldn't take a young person just with behavioural difficulties generally'*
- *'unfortunately the way services are it's not long term is it it's not unfortunately and I do feel that looked after kids are the ones that take that hit and they're the ones that are disadvantaged and discriminated against and getting a poor, a poor deal really.'*

there's not one clinician tracking that so [...] their needs get lost'.

In order to provide some context, a member of staff described the previous national picture prior to Community F:CAMHS implementation: *'if our children went out of county or if children from elsewhere came into county, then there weren't forensic CAMHS services either where they came from or where they were going. And that was a big problem because we might do a good assessment here and make some clear recommendations and also be quite able to think about the risk without too many people getting involved and too many people getting worried about someone, be able to recommend what we thought was needed, but then there wouldn't be someone else to take that over if the child moved and vice versa'.*

In particular, staff commented that those who are looked after children and those needing ongoing support are at particular risk. One staff member expressed that those most at risk are young people frequently changing placement but also those at home in unsafe environments, where perhaps the family encouraging aggression and violence, e.g. *'young people are at home and they're really really vulnerable and that there's really significant safeguarding concerns around that part but also there's lots of worries around their behaviour and actually it's like the the family home is impacting the parents around them are colluding with them, getting them making them aggressive or violent'*. Community F:CAMHS staff also described observing a

- *'In CAMHS the same thing happens, cases are opened, closed and then the child is allocated to someone else frequently rather than thinking actually we need to prioritise them seeing the person they saw before if at all possible. It's almost like the processes have taken over from that what we know about continuity and attachment and for these sorts of children that's an incredibly important thing, continuity.'*
- *'So health think it's the social problems so social care should deal with it, social care think it's a mental health or neurodevelopmental problem and they think they should deal with it and then this child falls through the middle, is bounced back and forward and that can be around the idea that you know there's been a lot of trauma or attachment problems or there's social problems in terms of housing or substance misuse, but the agencies won't seem to work together'*
- *'a lot of services working with each other at the moment don't prioritise continuity. And so a child will get one worker when they arrive in the service, then they'll be passed to another worker when they move to a different part of the service, and then another worker when they're decidedly going to be staying with that service'*
- *'young people that bounce from placement to placement to placement and not one, there's not one clinician tracking that so [...] their needs get lost'*

rise in the numbers of young children who are referred to Community F:CAMHS and a shift in offense types, with an increase in digital offenses observed.

Staff described frequently coming across cases where young people's symptoms, for example externalising distress, becomes labelled as a behavioural problem rather than being thought of as a mental health condition which results in the young person being excluded from mental health services. Strict inclusion criteria of other services results in many young people not accessing the help they need, e.g. *'your core CAMHS wouldn't take a young person just with behavioural difficulties generally'*.

A further area of concern was also exploitation and people's views of exploitation, in relating to county lines but also child sexual exploitation. **This was again discussed in Phase 3, whereby labels of exploitation can be misleading and result in risk being overlooked and children being missed. Furthermore, as exploited children are likely to be moved around, staff called for a national service to identify and manage such cases, e.g. *'because they move around the country and they're so hard to, in a sense, capture, [...] is there a national service that could coordinate to really help those young people who are probably at the most risk?'***

In Phase 3, staff described their role in supporting the network with offering parity of provision across the region, largely linked to lack

- *'I mean it's been... It's meant that we've been able to stay involved, where somebody wouldn't. So we've been able to join the narrative up for them, so that the next person didn't have to start from the beginning or didn't miss something important.'*
- ***'we do need to be open to cases which are presented to us as exploitation cases [...] because frequently they're seen as being as exploited. But the other side of that child, who is vulnerable possibly in that respect, is that they may be very concerning in terms of their behaviours and everything else, so actually if we weren't taking cases that other people are labelling as exploited, we might be missing some of our very clear brief.'***
- ***'because this is a big worry for us, that we're not in a sense accessing certain communities where there's huge stigma. So, it's not so much populations. We're not so worried about the White Caucasian population, or the Black population, they seem to be able to access the service. It's other populations that we're not seeing, Asian, because of the stigma of mental illness or Somalian. So, we're wondering where are these young people? Are they just being seen once they present to youth offending institutes? And so, it's thinking about how we can perhaps work more closely with YOT to think how do we get to those populations earlier? But I think the schools project is hugely invaluable for that,***

of resource elsewhere and challenges of accessing other services, such as CAMHS. This is possible due to the service's responsivity and flexibility. However, staff reflected more on those cases in which they are still not able to provide access. In particular, staff reflected on those children/young people and families who may be mistrustful of services, or those who take time to engage, therefore relying on other services to have built positive relationships. Furthermore, staff shared that in cases where children/young people or families who do not engage with services and who may not have a diagnosis, it can be difficult for Community F:CAMHS to justify remaining involved, e.g. *'it's difficult because they're the children who are unlikely to have a diagnosis because a lot of the time they won't have engaged with anybody so it's really hard to evidence the need for us to stay involved because they might not meet that [...] basic criteria of having a mental health problem or learning disability, so it's really hard to justify to keep going to see somebody or to go that extra mile.'*

Gaps between social care and CAMHS were again discussed, with suggestions that efforts such as joint commissioning structures and integrated service provision may support with addressing these issues, e.g. *'massive gap between social care and health. The amount of children that get lost fighting between who needs to respond to what and all the stuff that goes with that, so to*

because in a sense, one of your biggest risk factors is being out of school.'

- *'we'll accept those referrals from lots and lots of different partner agencies, not just CAMHS, GP or something like that. Which means I think we do get the kids who fall through the gaps, because a CAMHS team might not accept someone without a formal diagnosis or some specific concerns about their mental health. Or it doesn't meet their threshold, but they'd absolutely meet our services.'*
- *'I think the hard to reach children are more likely to be referred through a social care referral rather than through maybe CAHMS. I mean my experience of the hard to reach groups that they never reach CAHMS so actually although we are an FCAHMS, actually a lot of the really truly hard to reach children and the children who really fall through the gaps wouldn't be seen there. So I suppose the referrals we get for some of those young people are through social care so we're really relying on social care to refer them to us or if they are not in social care, they might be in the offender services, but again our referrals from there are probably not as high as they should be.'*
- *'I think covering six counties as well is a challenge because if you do manage to get a referral for a child or family that maybe very*

hear a strategy across health and social care, that's easy to achieve, so if they could just pull it out of the bag that would be great'.

distrusting of services or not willing to engage in services easily or for whatever reason, then we are probably only going to go so many times to try and see them [...] I know how hard you have to work to build relationships with families and with some children and young people and F:CAMHS just doesn't allow for that really. That child would have to be quite well engaged with another agency for us to work alongside that agency [...] it would suggest then that perhaps we are not reaching the very hard to reach.'

Lack of resource or expertise

Community F:CAMHS staff were able to swiftly identify many gaps in resource and expertise in their regions. One member of staff described this as a 'postcode lottery' of whether the services around you work together or not.

Staff described the role of Community F:CAMHS as providing additional resource and expertise to the network. One staff member described that having no threshold for referral to Community F:CAMHS can result in Community F:CAMHS picking up cases that other services do not have capacity for, e.g. 'So to give a bit of a working example erm if you're a CAMHS worker and you've got eighty cases and you've got three who are particularly aggressive you might then refer then onto FCAMHS rather than trying to manage them yourself where they may not particularly be forensic cases because you haven't got the capacity to give them the time and thought you need. So at some point we're gonna have to have you know, 'this is what an FCAMHS case looks like, this is what we will accept', 'cause

- 'So to give a bit of a working example erm if you're a CAMHS worker and you've got eighty cases and you've got three who are particularly aggressive you might then refer then onto FCAMHS rather than trying to manage them yourself where they may not particularly be forensic cases because you haven't got the capacity to give them the time and thought you need. So at some point we're gonna have to have you know, 'this is what an FCAMHS case looks like, this is what we will accept', 'cause otherwise the we will out net will collect every young person especially when other services are more and more pressured.'
- 'children are already happier than their parents' so actually there's not always the right services to support the wellbeing of the parents who would then be able to be present for their children, that's a gap.'
- 'a case we've had fairly recently whereby there was a sort of circular difficulty in that such sort of deserts of services where the youngster is from, that things got

*otherwise the we will out net will collect every young person especially when other services are more and more pressured'. Community F:CAMHS staff expressed that this also impacts the sustainability of Community F:CAMHS and whether recommendations can be implemented. **This was again an area of concern in Phase 3, with staff reporting instances where recommendations could not be applied.***

A significant challenge that staff shared of their role was how difficult it is for young people and their families when there's nothing they can access in terms of their wider needs, e.g. a secure placement: *'really inappropriate placements that continue to keep going because there's nothing else available, which are actually quite detrimental to the young person developmentally. But there seems to be a... I don't know it's a gap in the system or the system isn't able to kind of move forward because of resource'. A staff member shared that in one case, the network were unable to follow Community F:CAMHS recommendations due to lack of resource (placement) and another offense took place.*

Gaps were also identified in provision for children and young people with behavioural problems, children and young people with complex needs, mental health provision for parents/carers and young people with speech and languages difficulties.

really bad before anything could be kind of done and because of the extreme nature of the behaviours that had built up over time and were pretty well embedded, this youngster's required over the top inputs in a secure provision that is now causing this under-resourced service to be spending literally about a million pounds a year because of the need to take up more than one youngster's place in the highly staffed environment. So you know an under-resourced place is even more under-resourced because of one really challenging case'

- *'your using all your skills and your recommendations and your evidence base that is the best thing but whether that will actually materialise in the real world's a different matter isn't it?'*
- *'there's different things in different areas, so even some of the basic stuff isn't there which would be about youth services and things like that or people are realising that they need to put those back in having lost them a few years ago.'*
- *'there's a gap with sort of the usual difficulties with placements and thirty-eight week, fifty-two week residential, there's quite a scarcity of that'*
- *'really inappropriate placements that continue to keep going because there's nothing else available, which are actually quite detrimental to the young person developmentally. But there seems to be a... I don't*

In regards to expertise, Community F:CAMHS staff expressed the importance for staff being trained in attachment as well as trauma, in particular CAMHS staff.

Additional gaps were identified in Phase 3. Staff raised concerns for those children and young people at risk of exploitation. In particular, staff identified gaps in service provision which extended beyond risk assessment for this group, e.g. 'the gaps are more in the young people that are being exploited and what the service is, apart from people that might be looking at the risk management and doing all that, but what is there for them really?' Furthermore, staff reported gaps in community services/outreach and AIM [i.e. harmful sexual behaviour] trained professionals, and shared that children's social care authorities or CAMHS are not delivering interventions or facilitating assessments as they should. In addition, staff described significant gaps and delays in autism and learning disability assessments, often required for service input, a lack of post-diagnostic support for these groups and more generally lack of expertise in the network around the difference between attachment difficulties and autism and ADHD.

Staff reflected that some services are having to prioritise the areas of the service that they can meet as they are under-resourced (e.g. not conducting cognitive assessments to allow budget/capacity for more face-to-face work).

know it's a gap in the system or the system isn't able to kind of move forward because of resources.' [

- *'But yeah, if you define forensic CAMHS in terms of high need, high vulnerability, high risk, high complexity, that's what child and adolescent mental health is, really, these days with all the added pressures of social media and all that. So, I think build it and develop it and expand it. I think very sustainable and loads more we could be doing.'*
- *'I just think there needs to be more resource. I think looking forward and if we want to stay proactive, we need to be doing more into schools and possibly primary schools. And I know that there is a whole programme working into schools, but I think we're the extreme end of that. So, you need that input.'*
- *'So the high risk young people really... You know, they're already really overstretched and can't handle the stuff that they are commissioned to do. So then a young person that presents with some of the really complex forensic, or potential forensic, risks really is just unmanageable for those teams that are struggling to cope with the routine.'*
- *'But I think it's also about we're only as good as the services we work with. So if they are continually overstretched, and continually unresourced, and they're struggling more and more, they're not going to have the time to even think about using us. So I think*

Some of these difficulties, such as lack of beds, were observed to be worse due to COVID-19. In addition to a lack of residential beds, staff shared that there is a gap in provision for children and young people with conduct difficulties, and a gap in expertise for staff in such residential placements to manage and contain behaviour and support the young people appropriately.

Such gaps were described to contribute to young people being placed in the wrong services and not receiving adequate and tailored care, for instance young people with neurodevelopmental needs being over-represented in forensic services.

Another significant gap was for children who may engage in threatening behaviour at school. The limited resource and expertise schools have was perceived to result in young people simply being excluded and referred to the police, and not offered adequate support or supervision. The gap also extends to a lack of services focussing on transitioning young people back into school and supporting them with catching up on education.

The lack of expertise in the network is related to the complexities of staffing a team such as Community F:CAMHS.

there's something about we can be helpful when working with services who can do the job.'

- *'the medium secure units are often quite filled with young people with neuro-developmental presentations. That they were never really intended to work. And I came to the team from a neuro-developmental team, really keen to work in this space between forensics and neuro-developmental to keep that going. Because so many young people with autism or ADHD, depending on how you think about that, they're also over-represented in the prison system. And they're disproportionately excluded from school, and we know minority ethnic group young people are also weirdly both over- and under-diagnosed with those difficulties.'*
- *'One of my biggest concerns is a skills shortage within the wider agencies and networks with who we will recruit from for the future. When I've been doing my little bits of work on in-patients and stuff like that, I don't feel or I don't get the sense that the people who are coming through maybe have the level of expertise or training which is going to allow them to progress to come to F:CAMHS and provide that role. [...] that's a big worry for me because it's going to make recruitment really, really difficult in the future. And actually, the services we will be working with will also have a lot less skills, a lot less ability to take on and run with the*

recommendations that we're making. So, that's a real worry.'

- ***'when it's a resource issue, and so, we're finding a lot in the pandemic that even though residential placements have been recommended or things like that, that young people are still being placed back with families where there's active risk ongoing.'***
- ***'we do not have any sort of multi-agency response for young people who are engaged in threatening or violent behaviour in school. [...] At the moment, that kid is managed by expelling them and then referring them to the police. But there's no assessment of that young person's needs, there's no thinking about how we're going to get them transitioned back into school.'***
- ***'I think people know that there's not enough residential care units for people. [...] I think there is a massive gap for provision for conduct disorder children. So, one of the main problems we have is residential units taking people and then complaining about their behaviour. And they will say that they're able to do X, Y and Z, but they're not.'***

Previous challenges to engage / assess

In many cases, staff described instances where their involvement was a result of previous challenges within the system to assess, engage or address the needs of the young people and their families. Staff were able to

- ***'especially the cohort of young people that would be referred to FCAMHS there's there can sometimes be a bit of assessment fatigue because they might have***

identify examples, particularly around exploring a diagnosis of autistic spectrum disorders or learning difficulties where assessments were not completed. In most cases, staff identified lack of resource and expertise within CAMHS to be contribute to these challenges, e.g. *'And quite often we see young people referred to us and then you tease back and you can see that there has been a previous CAMHS assessment or referral or some kind of concerns much more... much earlier than any kind of high risk presentation could have been like depression or self-harm, and they just didn't meet the criteria for any meaningful intervention and then they bounce back a few years later with you know much higher needs and perpetuating the risk factors, so I think that's... that's really sad to see that even from a CAMHS perspective it's difficult to meet the needs'*.

This was also described as impacting Community F:CAMHS and requires real skill to conduct a further assessment and collate the information needed. Staff argued that this contributes to some challenges of being a Community F:CAMHS staff member as these experiences significantly affect young people and families' views of services and their desire to engage, e.g. *'I think it's hard a lot of the time as well when we're going to see young people and the families that have already been involved with CAMHS 'cause they've such a negative view of CAMHS and we go and say 'we're FCAMHS' all they time they're like, 'we don't want to speak to you, we've done this before, we've answered all your questions, you did nothing, you weren't helpful,*

already been assessed and assessed and assessed for a multitude of different things'

- *'I think it can be difficult retelling your story for the twenty fifth time. People have been through it haven't they quite often for five years and at the end of their tether with it and then two shiny new professionals turn up and say, yeh 'but we're not going to stay involved' you know that is I think that's there's a tension there isn't there?'*
- *'And CAMHS has traditionally been very worried about this group of young people and this group of young people has been very worried about CAMHS actually because a lot of these kids don't want to sit in a room talking about their difficulties for very long.'*
- *'you know couple of case that just come up they may not have gone to CAMHS but also they may have referred to CAMHS and been batted back.'*
- *'And quite often we see young people referred to us and then you tease back and you can see that there has been a previous CAMHS assessment or referral or some kind of concerns much more... much earlier than any kind of high risk presentation could have been like depression or self-harm, and they just didn't meet the criteria for any meaningful intervention and then they bounce back a few years later with you know much*

we were waiting for ages, we've had no reply, we've been messed around'. So trying to kind of re like get their relationships back is really difficult'.

In Phase 3, staff continued to describe instances where staff in services working with children were not able to assess the severity of their needs or provided unhelpful interventions.

higher needs and perpetuating the risk factors, so I think that's... that's really sad to see that even from a CAMHS perspective it's difficult to meet the needs.'

- *'I think it's hard a lot of the time as well when we're going to see young people and the families that have already been involved with CAMHS 'cause they've such a negative view of CAMHS and we go and say 'we're FCAMHS' all the time they're like, 'we don't want to speak to you, we've done this before, we've answered all your questions, you did nothing, you weren't helpful, we were waiting for ages, we've had no reply, we've been messed around'. So trying to kind of re like get their relationships back is really difficult.'*
- *'they're used to professionals turning up and going away and not having any feedback about what's going on and one needs to think very carefully about ensuring that they and their parents are kept in the loop.'*
- *'These are a tricky group of people because they've had experience of multiple engagements or lack of engagements with services, they're usually quite suspicious or worried about getting involved yet again or they've not had good experiences before'*
- **'When we took on that case, we discovered this young man was isolated, and there was the**

development of a mental illness, which was really all of the stuff, all of the concerning behaviour that had come prior could be attributed to this developing mental illness. And it had been missed. No, that's wrong. CAMHS were aware of it, but they did not get the severity of it.'

- *'what we see time and time again, which is probably never talked about, is interventions that have made young people worse. And so, the popular perspective is that you go and see a psychiatrist, psychologist, whoever, and either you get better or things are okay. But what we see is that children are left in families where they're abused perhaps longer than should be for whatever reason.'*

Parity of provision and unmet needs

Relating to children and young people at risk of falling through the gaps, staff were also able to identify specific areas of unmet need. Staff provided examples of areas of concern, including drugs and alcohol, harmful sexual behaviours, exploitation and county lines. One staff member described their experience of parity of provision being *'really patchy'* across regions. **These areas did not differ substantively in Phase 3, where staff continued to identify regional gaps, particularly in terms of sexually harmful behaviour services, including third-sector, and neurodevelopmental assessments. This mapped**

- *'So things that are available in the west aren't available in the east and vice versa which makes it quite difficult as a professional trying to work out what services are available actually for the young people as well as what I have available.'*
- *'we don't have key services like harmful sexual behaviour although there might be a couple of staff who were once trained in it who might be doing something that kind of might look like it but no one quite knows where they are and who'*

onto previous concerns over 'postcode lotteries' of service provision and resource.

Community F:CAMHS staff expressed that different regions and services have different priorities, resources and thresholds, contributing to the complexity of the national picture, the variety of cases they see and challenges for Community F:CAMHS as a service, e.g. *'So things that are available in the west aren't available in the east and vice versa which makes it quite difficult as a professional trying to work out what services are available actually for the young people as well as what I have available'.*

In Phase 3, the focus of this discussion across both early and late implementers was on the varying provision of mental health support in youth offending services and social care thresholds, e.g. *'It's very patchy with the youth offender services as to what health provision they get' and 'with particular regard to children's social care, I think the threshold in different areas varies such a lot'.*

Staff expressed challenges with differing parity of provision between the children and young people and the adult services, adding further complexity to transition journeys and fragmented services: *'There isn't the same parity of service with adult community forensic provision that there is now with FCAMHS you know with child and adolescent so that's a problem as well'.*

- *'I think [region] [...] has been quite behind the times in terms of exploitation in terms of ignoring the fact it was around and it won't happen to [region].'*
- *'mental health provision [...] for neurodevelopmental disorders but also [...] for emotionally dysregulated children'*
- *'it's all about thresholds in individual areas'*
- *'the more deprived areas where the high crime and there's not much you know there's high level of poverty you can see that the circumstances are really stripped back'*
- *'There isn't the same parity of service with adult community forensic provision that there is now with FCAMHS you know with child and adolescent so that's a problem as well'*
- *'I think the degree of it... probably what we need to be working with, is the professional response because there are all sorts of services saying, "That's exploitation, that's not our bag," or something like that. And actually, what we really need to be saying is, "Let's just make the links with the police stronger" or "Let's make the links."'*
- *'You can at least offer that view, because remember, people work in their own localities, and it's a bit counterintuitive really, even if they are not far from each other, they may not know what's happening*

Gaps in provision were linked in Phase 3 to challenges for Community F:CAMHS in ensuring they are accessible, e.g. *'I think it does become trickier if groups are already not able to access the services for whatever reason, it makes it harder. The more stretched the clinicians are and the less we're able to do, the more difficult it becomes to introduce say, assertive outreach type techniques to reach into the wider community or hard to reach communities'*.

around them in other areas. And we happen to be sometimes in that fortunate situation that we are working across and hearing things which are challenging as well as hearing things which seem to work.'

- ***'that's a massive gap and you can almost shade in areas of the country around where you're unable to get a provision, avoiding the outskirts of cities. If you live in that bit, you are not going to get any harmful sexual behaviour work unless you're on child protection'***
- ***'you might have a response from social care in one area, and your young person would quite easily meet the threshold for child in need or child protection. And professionals in that area will recognise that very quickly. In another area, you can have a similar child with similar difficulties, and they don't come anywhere near that threshold. So, I think that's a particular skill that we have developed in recognising that there's a lot of difference between the areas that we work in, certainly with regard to children's social care.'***
- ***'some YOT teams have mental health practitioners, some don't. The ones that don't, get a lot more referrals from them because you haven't got that buffer, that professional who's willing to take on those cases or goes, "That's not an F:CAMHS case, I can do that." So, that's a***

real need and that's a bi-funding issue between youth justice services and NHS.'

- ***'in terms of the youth offending services, the provision is so patchy across the country and there needs to parity across the country, that all young people in youth offending services have access to decent psychological and mental health and support and developmental services as well. It's well known those children don't go to CAHMS, they don't turn up to CAHMS, they're not brought to CAHMS. CAHMS doesn't meet their needs or CAHMS doesn't accept them so there really needs to be thinking about provisions for those hard to reach populations, and particularly those in youth offending services [...]They are the most expensive children of any population at that age. They are going to be the most expensive children going forward to so I don't understand why they get the least provision.'***

System not understanding the YP or risk

Related to lack of expertise in the system, staff consistently shared experiences where services were not able to understand the young person's needs and risks. In particular, one staff member expressed that risk to self and risk to others are conceptualised differently which is a challenge for services and is an area of concern, e.g. *'I think it translates the tolerance for self-harm versus or risk to self versus risk to others'*.

Staff shared experiences where levels of concern are disproportionate to the level of risk, as well as instances where the information around a high risk case is lacking

- *'I think just in thinking about some of the evaluation of discharge forms and stuff; sometimes our involvement can lead to other risks becoming known. So sometimes the risk may look higher at the point of discharge than it was at the point of referral, because certain risks have been overlooked and minimised because of various things. So we have young person who was referred because of a risk of violence, and actually through the course of our assessment and write up, we realise that there is a risk of harmful sexual behaviour, that had been somewhat minimised or not really thought about sufficiently. So that was*

or false, e.g. *'sometimes it's responding to concern whether or not that concern is correctly placed or not. So sometimes people are overconcerned about a case and that child is suffering as a result'* and *'there were bits that nobody seemed to know'*.

This theme was also raised in Phase 3, where staff continued to discuss gaps in understanding in the network around the young person. In particular, this was discussed in relation to services not understanding perpetrators of risk, such as chaotic home environments, and not working in a child-centred way. Staff also described that often referrers will expect an intervention to work without consider young people's basic needs.

something that we had to highlight.'

- *'I think it translates the tolerance for self-harm versus or risk to self versus risk to others.'*
- *'sometimes they're under quite a lot of pressure to be punitive, to contain the risk by closing down the opportunities for the young person to develop and of course that's a thing that's guaranteed to you know drive the the disturbing behaviours further underground and therefore increase the risk.'*
- *'sometimes it's responding to concern whether or not that concern is correctly placed or not. So sometimes people are overconcerned about a case and that child is suffering as a result.'*
- *'there were bits that nobody seemed to know.'*
- *'that becomes a bit of a question mark but that links in with the previous history that nobody's ever looked properly'*
- *'I think something that our team does very well is think about risk in a context of formulation and motivation and support other professionals to understand, I suppose, what's motivating that action or what the young person might be getting from it. So what's the motive, what's the rationale and really thinking about understanding that to support other professionals to understand it and then you can think*

about how to change it. Because I feel like you can't manage risk unless you understand the motives of the young person and why they're doing it because it's different for everyone, isn't it?'

- ***'nobody bothered to look at the relapse prevention plan so he started to behave quite aggressively, "Oh, it's down to COVID," was the answer, and when I looked at the relapse prevention plan, it was like no, this is exactly what happened last time and it was as simple as that.'***
 - ***'something we've come across time and time again at meetings where someone is so unstable but [the network are] just like, "You need to deliver a therapy." There always seems to be that that is going to be the magic answer when the bottom parts of that triangle and none of them a kind of in place, really.'***
 - ***'it really depends on the interventions as to what happens to the young person and recidivism. If we send any young person back to community, to that same environment, we can't expect any change, really, no matter how good the intervention was'***
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Table 10.3.1.4: Impact of Community F:CAMHS, secondary themes, key points and illustrative quotes.

Secondary theme	Key points	Illustrative quotes
Engagement, placement, transition, risk	<p>Community F:CAMHS staff generally shared positive experiences of engagement with young people and being able to witness direct impacts that the involvement of the service has had on children and young people and their families. This includes having a positive experience of services where young people and parents have felt involved and listened to: <i>'lot of the feedback from the young people is generally been that they've felt respected by the staff that have worked with them erm, that they've felt listened to. Erm in terms of the parents we've had some good feedback around consistency within our approach'</i>. In Phase 3, staff also shared some of the creative ways they engage with people, for instance virtually (due to COVID-19). For some young people with social or communication difficulties, these were described as very positive, e.g. 'one of the people I've seen quite a few times virtually who has autism, I think that person actually really likes the virtual appointments. So, I think some children, if they do have developmental disorders like autism, some of them might respond better if they don't have to be looking at someone's eyes all the time. They might feel it's more comfortable'. Text messaging was also identified as a helpful method to engage and support young people and to use lay</p>	<ul style="list-style-type: none"> <li data-bbox="1243 406 2027 837">• <i>'the SENCO and the safeguarding leader at school did actually remark that when the young person has seen us and she came back into school erm she did have very positive things to say about our service and she liked the fact that we went to her erm she didn't have to go somewhere erm in a clinic setting perhaps and she she liked the fact that that we came to her erm there was no particular you know we didn't say right you know, 'we're here at eleven o'clock you've got 'till twelve o'clock to tell us absolutely everything' so you know I think at the flexibility erm I think young people like that.'</i> <li data-bbox="1243 869 2027 1157">• <i>'We'd obviously like to think it would reduce re-offending. And I think there's some new thing out from YOT at the moment, actually where that's all been measured. So, I don't know, in terms of actually statistically what those figures are in my head, I don't know. I think the amount of new people at the first point of entry is reducing massively. I'd like to think that the re-offending is as well.'</i> <li data-bbox="1243 1189 2027 1292">• <i>'And I suppose it's our intervention and everything that we've talked about, in trying to help... to reduce that risk. But obviously, with some you might be</i>

language, e.g. **'I think texting really helps and the ones that are really difficult just continuing to say "Well, I'm here," and every so often go back and say, "Well I'm still here, actually." So think there's that and like you say going out of our way really to wherever they are or if they DNA then it doesn't matter, just continuing to try and do that'.**

Staff also described their work with young people and families as collaborative, working together to implement plans, and communicating clearly. Staff expressed having received feedback that parents value the fact that Community F:CAMHS is completely independent to other services, has experience of such cases and is non-judgemental, e.g. *'the parents that I've spoken to, I think they're just really grateful that somebody's coming in that kind of will speak about this stuff openly. I think a lot of people shy away from it or [...] panic about it'* and *'I think from the parents and carers I think they've often found that their children are bouncing around services, so from their perspective I think they're really grateful that somebody is looking at it in that bigger picture, not just looking at it from a one service perspective'.* **This was furthered in Phase 3, e.g. 'A couple of [young] people have talked about getting a better understanding, feeling contained about what's spinning round their head, and feeling reassured and not judged. Some of the work we do is building engagement, relationships, helping people understand their problems'.** Staff also shared that some young people view Community

reducing other risks, but they still might continue to commit other offences.'

- *'the parents that I've spoken to, I think they're just really grateful that somebody's coming in that kind of will speak about this stuff openly. I think a lot of people shy away from it or [...] panic about it'*
- *'parents have said, "oh I'm glad you – you have listened to everything I've said"'*
- *'I think from the parents and carers I think they've often found that their children are bouncing around services, so from their perspective I think they're really grateful that somebody is looking at it in that bigger picture, not just looking at it from a one service perspective.'*
- *'I think it's about building up those relationships [with parents] during the assessment process and giving them the key points there and then and being really explicit and transparent to them actually, "this is what's going to happen next are you OK about that part?"'*
- *'lot of the feedback from the young people is generally been that they've felt respected by the staff that have worked with them erm, that they've felt listened to. Erm in terms of the parents we've had some good feedback around consistency within our approach'*

F:CAMHS as any other forensic or mental health service and will not want to be there.

Staff described that their involvement in cases can often leads to appropriate placements being found, to appropriate services being involved and perhaps providing early interventions so that young people do not become forensic patients as adults: *'without [our] assessment it would have easily turned him into [...] a patient potentially when he wasn't'* and *'we went in and it resulted in her getting a quick assessment, a diagnosis, treatment, a school placement, move out the family home. But I mean we battled along for months but she she was you know she would have caused quite a lot of harm and her needs were clearly not met'.*

However, in Phase 3 staff reflected that some of their role is to prevent things from getting worse which is difficult to measure, e.g. 'some of it is about preventing deterioration at a vulnerable time [...] And I think that's a result frequently of these very complicated cases'.

In Phase 3, staff also shared the impact that they have in terms of public safety due to: improved supervision plans being put in place; supporting with transitions out of secure care or into adult services; advocating for a young person's needs; helping young people remain in school or finding more appropriate provision; supporting with mental health needs; offering continuity of care; and offering ongoing support where needed. Furthermore, staff described their indirect work

- *'but what we were able to do was to provide a place for the family to talk about their experience because there'd been a dawn raid and all that sort of thing and they hadn't actually had anywhere where they had been able to speak about what they'd been through as a family and that seemed to be very helpful for them, very containing'*
- *'the kids we see sometimes have such chaotic backgrounds you can't, it'd be sort of slightly naïve know simplistic to say well, 'we'll just reduce risk', 'cause we don't necessarily but what we do do is we erm can put in we can support other professionals and all of them working together can then reduce ... to reduce some of the risks.'*
- *'I suppose when somebody has a young person behaving very worryingly, having that opportunity to share both with us, and also as part of that, professionals meeting with their other local colleagues, regarding the risk, is I think generally seen as a positive experience for them. And also kind of helpful in developing appropriate risk management strategy.'*
- *'Yeah, so I think the impact is I think it can be quite life changing, really. Even if it's in terms of getting them their medication, reviewing, attending meetings, thinking about what might best suit their needs. I think the impact for them and their families is really significant. And I think that's one thing that we do have a lot of feedback for. And I think some of that like I said is our perseverance when we won't*

with other professionals as having direct effects on young people, e.g. 'the youth workers do work with them, so in an indirect way we work with the youth workers and we can support those young people who are falling through the cracks of the systems, if you like'.

Even in cases requiring no forensic input, staff described this can be helpful for the young person, e.g. 'even if that opinion is that obviously this young person's a victim and they're not a forensic case, it can actually change the whole trajectory of that young person's treatment or their care or their placement'.

Speaking to the longer term impact was more difficult for staff, with many sharing they have no way of measuring this currently and may not observe that change if it is further down the line. However, in some cases where young people have been under Community F:CAMHS care for some time, staff were able to speak to their outcomes, e.g. 'I also think of [...] who's been with our team a long time and he's coming up 18, and was getting into lots of trouble actually a couple of years ago. And I think there might not be proof as such, but one of the evidence would be that there's no police contact, definitely that we are aware of or going in and out of custody, so there are things that we would be aware of. So I think for him there has been that shift [...]. He's on medication, which has really helped him,

discharge, we're almost the opposite, I'll just send another letter.'

- **'other important bits I think is about that transition into adult social care. I think often that bit for these young people gets really, really lost and I think those sorts of requests for adult social care input get batted back really quickly, and there's very poor understanding actually [...] So there's been a lot of work really about preparing for that so we do a lot of adaptive living skills type assessments now and that's partly in terms of diagnosing learning disability, but also it's about showing that even though somebody might be quite communicative it doesn't mean that they have got a great deal of adaptive living skills and actually that needs to be thought about in terms of the transition into adult social care. I think that sort of long term transition is really helpful to be involved in as well.'**
- **'some of the outcomes people have engaged better in school or we've helped them change school and that has helped. So, sometimes the plan and the outcome is broad, sometimes it's specific. Some people are better able to manage their thoughts, their anxieties, their mood swings, their anger'**
- **'I think that with the more formal end of things, the fact that we do a lot of linked work with**

he's had a diagnosis. [...] And he's now got an apprentice... so I think there's been some huge change, because he was in gangs, there was lots of concerns about drug dealing and weapons so quite a lot going on for him and exclusion from school'. Importantly, however, staff shared it is not straightforward as to whether change can be attributed to positive outcomes.

youth offending teams, with linking with secure accommodation, with youth custody, and thinking about planning for a young person coming back after serious offence or multiple offending behaviours, it does make a difference.'

- *'by hosting a consultation and hosting a professionals meeting, there have been a number of occasions whereby our recommendations have been that tripartite funding for instance should be arranged for that young person. In order for them to access the specialist residential placement that they obviously need to manage their risk.'*
- *'Frequently, I think particularly for children with neuro-developmental difficulties we can make quite a big... Frequently they have very clear needs. Educational frequently, things like EHCPs, being in the wrong school, being out of school. A whole range of those where we can actually really help with thinking about what many... and often the really difficult behaviours recede once they're in the right environment that is actually meeting their needs properly.'*
- *'there is a large proportion that we're probably not seeing, and we try to see them in indirect ways.'*

Improving life chances

Staff spoke about the positive impact Community F:CAMHS has had on young people. Community F:CAMHS staff spoke about the pivotal role they have

- *'Well, I think the young girl we spoke about in the team meeting... But she has been protected or supported to avoid a custodial and what an impact that*

been able to play in the sentencing and sentence management of young people they work with. For example, *'But she has been protected or supported to avoid a custodial and what an impact that will have'*. Being able to have an influence on getting a deferred sentence was thought to be instrumental for young people's life outcomes and risk of harm given the known detrimental effects of institutionalisation.

During Phase 3, staff reflected on the difficulty in assessing the impact of Community F:CAMHS on young people and their families. Nonetheless, staff described many examples whereby noticeable and impactful change was made upon Community F:CAMHS recommendations and involvement, including obtaining appropriate accommodation for a young person, ensuring a young person has an EHCP, improving family dynamics, and ensuring young people are safe from exploitation.

Staff shared some of the impact of Community F:CAMHS will be observed later in time and may be difficult to link to Community F:CAMHS specifically. Furthermore, staff described one of the challenges of using outcome measures being that the young people Community F:CAMHS work with have a range of specific issues, which many broad outcomes measures may not capture. Staff described the impact of Community F:CAMHS is *'to create a better sense of what a person needs holistically'*, which would in time impact on offending and health outcomes. Staff also

will have. I think that's a massive example. And there's so many young people who don't get that. And just go down a very different route.'

- *'In terms of our CAMHS, I think, in quite a lot of our direct cases... well, the consultation cases, quite a few children then end up with much better... The safeguarding concerns are identified. There are, as I said, the criminal justice side of things. So there's quite a lot goes on at the advice or consultation level which makes a difference to the trajectory of the child, I think.'*
- *'We've worked with a judge [recently] who deferred a sentence on the basis that we helped develop a strong community plan involving our service, the Youth Offending Service, Education for a young [person] who'd been involved in a very serious violent offence against somebody else. And we were then involved in reporting back to the judge on a regular basis.'*
- *'So it's not necessarily a recognised mental health intervention, but it makes a huge difference to the mental health of the young person. And that's where I think it's made significant difference. I think parents have been very, very grateful for the continuity the service provides as well as the specific input.'*
- *'The kind of longer term view, not beyond five years, but maybe 15, 20 years. Because if someone ends up with a life sentence in prison, you know, how much is that going to cost the state; and then they struggle to*

expressed lasting and meaningful impact is most likely to happen with younger children and young people, whereby their input may reduce the need for future service involvement. Furthermore, staff added some of their impact is ensuring needs and risk do not increase, which is difficult to measure.

Staff also reflected on the role in advocating for service provision and making recommendations for commissioners, indirectly influencing outcomes, e.g. 'we try and do a lot of work to ensure that these kids still get through to us, still get a service. And we make that push for local authority to continue to go to panel and fund those provisions and those enhanced educational packages and stuff like that'.

get a job, and to think about the life spans...So it may cost a lot more money in the short term, because you might be identifying more costly placements, but actually they have a better chance of actually working. You know, and therefore then supporting someone to get into a slightly more functional, better quality of life for the rest of their lives.'

- *'you've got a section of society that doesn't want to be seen, and doesn't want to get involved. And so we're trying to find different routes to basically either get them involved, or to support those that are helping them that are in other sectors...but it's about thinking over a life time, 30 years ... what's the benefit to society; rather than thinking just in terms of service for the next few years.'*
- *'So, I think for [young person] there has been that shift in change. He's on medication, which has really helped him, he's had a diagnosis. Referred from when he was initially in Liaison and Diversion, then over to F:CAMHS. And he's now got an apprenticeship... so I think there's been some huge change, because he was in gangs, there was lots of concerns about drug dealing and weapons so quite a lot going on for him and exclusion from school. And actually he's another one who I worked with quite well, obviously with [staff name] jointly, but now [staff name] just sees him for reviews because I think that's all that's needed now.'*
- ***'we've had just very good reduction in offending and improvement in family dynamics, preventing***

children from actually being at acute risk due to exploitation. So, it's really hard, it's hard to put it into words, but some of the biggest successes have been removing children from families that are dysfunctional and changing that. So, it's the usual: reducing risk, preventing suicidality, locating appropriate placements.'

- ***'I had another case like that of a young person who we did the assessment, we made some recommendations, but for us it was clear that this young person's probably been sexually abused. But they weren't having any local authority provision, they weren't seeming to get the severity of it. So, we basically really escalated things up, went to deputy director of children's services. And as a result of that, I think we were able to then get this young person accommodated in a specialist residential education facility.'***
- ***'sometimes we see some really fantastic outcomes, but it wouldn't have happened without our input, but sometimes it's about stopping disasters happening. So these children probably need quite a long time of recovery and sustainability themselves, you know, in a healthy setting with a good network round them to really see positive changes over time as well.'***
- ***'I would say that the young people who come to us who have offended, despite our involvement,***

will likely go on to offend again in the future. Because they are so far down the path in some respects, maybe involved in that kind of criminal community, that our recommendations are unlikely to make the most dramatic change in that young person's life. Whereas, if we could get those referrals younger, those 10-year-olds, 11-year-olds, 12-year-olds, we'd even get 8-year-old cases sometimes. I think we can put stuff in place for them which means that they're less likely to offend in the future, considerably less'

Feedback

Community F:CAMHS service was generally described as very positive and supportive for professionals in contact with the service, e.g. 'a lot of people say [...] they couldn't get this help before'. Staff shared that in some cases, Community F:CAMHS may not be so positively viewed. For example, the existence of Community F:CAMHS promotes services such as CAMHS to work with high-risk cases, which they have been described as trying to avoid. Community F:CAMHS staff described an anxiety coming from CAMHS service in particular, whereby having a Community F:CAMHS service would mean that CAMHS would be 'swamped with children who had horrible conduct disorders which they couldn't do anything about'. Furthermore, staff shared experiences of providing views and recommendations which referrers or families may not want to hear and the challenges this has in regards to collecting feedback, e.g. 'we're going to have to get social care involved [...] and it can make us seem I

- 'We've had, I would say, but we've had exceptional feedback. These really desperate mums with these really wild boys. You've had some great ones.'
- 'Yeah, I think the families actually, they're so appreciative, which is lovely. And actually I don't know if I've correlated this, but can, so particularly emails, I get lots of emails or texts, because they like to correspond in that way, it's so much easier. So, some very lovely emails from parents that are actually so grateful, and particularly to [staff name] as well, what ones that we're doing jointly...Because I think of the responsiveness, as well of the service. And yeah, I think we've managed to sometimes keep people in education, as we've talked about in the case earlier, keeping them out of having a custodial sentence.'

suppose like bad cops if you like [...] which isn't always a good thing. Particularly not when you handed in that sheet where you're trying to get them to say nice things you want them to say nice things about you'. This was echoed again in Phase 3, particularly thinking about delays in impact and change resulting from Community F:CAMHS input, e.g. 'I think immediate impact is probably lower than what the family would hope for and expect. I think they only probably start to understand the impact of it when you're a few months down the line and the specific recommendations were started to put in place and progress has started to take shape'.

During Phase 3, staff continued to describe the different types of feedback received, largely overlapping with those previously raised, e.g. 'the feedback we get from young people and their family is actually, "You've come and seen us. That was really helpful. People haven't really spoken to us. Sometimes they haven't really asked us those questions before. It was great to get a report which helped us to understand and explain things to us. And we feel like you've come along and gave everyone a bit of a kick up the bum, and you've advocated for us when we've been shouting and asking for help and not received it." [...] On the other hand, we do get those families going, "So, you're not going to do [...] sessions of CBT for my kid's self-harm?" And you're like, "That kind of isn't our role." And they go, "Yeah, but CAMHS won't see us." And you're in that dynamic of they

- *'They report back that, actually, they find our involvement in consultation very helpful because we have quite a broad sphere of reference and, actually, we can be quite practical about what we suggest or not...And also, they feel that it's supportive of them in their professional roles because sometimes these people are working beyond their... or are expected to be working beyond their competencies and sometimes we need to recognise that. And so, people are grateful in that respect.'*
- *'So it's not necessarily a recognised mental health intervention, but it makes a huge difference to the mental health of the young person. And that's where I think it's made significant difference. I think parents have been very, very grateful for the continuity the service provides as well as the specific input.'*
- *'we've had quite a few occasions of that, where we've worked alongside a professional... And they've come back and said they've had a really good session with them; you know, they opened up, they started to make eye contact, started to. So I think that's the evidence for us – or for me, anyway.'*
- ***'You're going to them [young people] and saying, "We're going to put this, this and this in place to try and stop you from going missing from home so often and getting in trouble with the police." And they're like, "I like going missing and doing what I do. I don't want those things to change." So, we're never able probably***

want you to fill someone else's shoes kind of thing'.

Whilst exploring the impact of Community F:CAMHS in interviews with commissioners of the service, they described that Community F:CAMHS offering a national service meant access to specialist community forensic input was no longer a **'postcode lottery'** (Commissioner). Furthermore, commissioners shared some services had received feedback from professionals in contact with the service that there would be at a huge loss without the support of Community F:CAMHS and that this would devastate local provision.

going to meet their expectation [laughs]. They would probably rather us not be involved, so to speak.'

- **'I think certainly families can perceive that we are part of their local CAMHS team. And if they haven't had a particularly good experience with them, then it can be quite difficult to get impartial feedback from our particular part of the overall service. But generally, we do get good feedback, certainly the feedback from professionals is they liked the fact that they can access us for telephone advice'**
- **'I think feedback from young people that's been more difficult to collect. However, we have managed to do that. And by and large, the themes that come out of that are well, actually somebody asked me all these questions that nobody's ever asked me before.'**
- **'from a referrer perspective I've had quite a lot of verbal feedback that actually nobody's really done this before.'**
- **'people don't want to have the forensic label, so there's a lot of stigma around that.'**

Supporting the network

Community F:CAMHS staff described the impact the service has on supporting the network of professionals and services around the young person, including supporting services to do direct work, facilitating

- **'the [referring] team seem really stressed and really like full up and just like having their own consultation**

thinking (e.g. around the meaning behind a young person's actions, around need and vulnerability, around risk) and offering reassurance. This also extends to supporting parents, e.g. *'Participant 1 (P1): I met with the parents and they said you know we're very grateful because this is the first time that anybody has actually been curious about what we've been through as the parents. P2: And in a non-judgmental way'. This was again discussed in Phase 3, e.g. 'they feel like they're stuck, they're at their wits' end, they don't know where to go next, what resources are out there, what's available. And they've been very grateful and very appreciative that somebody's taken the time to listen and to consider' and 'there's definitely a lot of supporting the professional network. I think, like I say, helping people to feel validated, helping people to feel heard'.*

Staff shared the impact of Community F:CAMHS in some cases involves validating any concerns, agreeing with plans or creating a space for the network to think in a tailored way for that service, e.g. tailored to professionals working in education: *'actually I was able to say to them, "that seems good, that seems really logical and reasonable and looks like not only you guys are implementing it but you guys are sharing concerns around as well"'* and *'So I think we can provide some time to think about the young person in a way that frees them up a little bit and enables them to kind of continue on in a way that's more helpful for them and helpful for the young person'.*

thinking space people seem to value quite a lot just even in like just in an offloading way'

- *'And I'm not sure every service has the time that we have to sit down and talk to somebody about what's going on, and then help them think it through. And I think that is the benefit of F:CAMHS, that we have more time than some of these other super stretched services. So they can get that kind of instantaneous support that they need, as opposed to saying, 'Well, we'll get back to you in a months' time.'"*
- *'P1: I met with the parents and they said you know we're very grateful because this is the first time that anybody has actually been curious about what we've been through as the parents. P2: And in a non-judgmental way.'*
- *'we're just here so if things become difficult you can always refer so it is that confidence and capacity building to say "you've done all that"'*
- *'it's a function of us to hold their hands and you know keep them involved'*
- *'we say "we can't keep you forever but we'll help ease that transition", and referrers are really relieved about that'*

This is also related to the accessibility of Community F:CAMHS and promoting interagency working.

In addition, during Phase 3 staff shared the impact they have on professionals largely revolves around providing a new way of looking at a problem, involving other services who should have been involved, escalated concerns, and allowing for plans to become clearer and 'unstuck'. This is also related to the services' accessible and responsive nature. Furthermore, staff described their role in containing anxiety in the network, facilitating reflective conversations, and providing 'extra thinking space', e.g. 'we offer the opportunity to stay involved for a longer period time and offer some slowed down relational, psychodynamic, psychoanalytic thinking that a lot of the teams just don't have or don't carve out that space for themselves. [...] And really all that's about is just creating a slowed down reflective space for these teams that are under so much pressure and anxiety to just think a bit differently. And I feel that really makes this team very valuable and it speaks to the sustainability of the service as a whole'.

A reflection by a member of staff was that informal support is perhaps lost due to remote working during COVID-19 restrictions and not having those chance encounters with colleagues, e.g. 'This is probably a big gap from COVID that's

- *'actually I was able to say to them, "that seems good, that seems really logical and reasonable and looks like not only you guys are implementing it but you guys are sharing concerns around as well"'*
- *'just that extra understanding can really help them [professionals/referrers] feel stronger'*
- *'but they've not thought of doing that yet so we may not necessarily have to take it away and do it ourselves if we can help them to think about it and get on with'*
- *'so I think a lot of the time though the other teams are really... they're grateful for extra kind of support with a case they feel that they're not skilled enough or they've got stuck into a position where they don't know where to go with it.'*
- *'So I think we can provide some time to think about the young person in a way that frees them up a little bit and enables them to kind of continue on in a way that's more helpful for them and helpful for the young person.'*

completely lost. I used to go to a consultation over a YOT building, and as I'm walking out, someone shouts, "[...], can I just grab you for a second to talk about a case?" That's all gone now. That's only just come to my mind now, those informal conversations and networking, that's all lost. And that's maybe one of the downsides of COVID, and this new way of working. We've lost that'.

- *'Even the people that ring us up, for an advice call, and it's not necessarily for us, but because of our links, we can pinpoint them to other areas – even services in their areas that they didn't particularly know about. You know, we're over here, and they're in [area], and we're saying to them, "Have you tried this service in your area?" And they didn't know about it. And that's got to help.'*
- *'So I think it fits in like ... it's reducing burnout and promoting resilience. So it's to try and keep those workers in their jobs really. So hopefully reduce staff turnover by them having that sort of insight into how they're working.'*
- *'So you know, it's that kind of... How do you do the health economics. And I think when you're saying about the systemic, systematic review and that kind of thing, the kind of time scales you're looking at – you can look at short, medium and long term, but I think the cost savings will come in the very long term, and I think that's the challenge. It's about how health policies and how NHS England, and associated bodies, take a view on that. And take a view on how this could cost health money, but actually save money in education, justice, the welfare system, all of these things.'*
- *'I think it offers sort of an objective view on risk for the referrers. I think it can work, it can contain their*

anxieties and concerns about risk and give them a clear opinion on that. Because sometimes it's difficult if you're involved heavily in case management and you can get caught up in quite a lot of complexities. So if you get an objective view coming in, just looking at the risk of mental health, I think that offers some clarity and it can be quite containing in that system.'

- ***'if you imagine that you've got a case that's potentially keeping you up at night, it's going to lead to a complaint, or worse, it's going to lead to you potentially being at an inquest or a murder inquiry. So, the clinicians find it just very containing to have someone that can say, "Look, these are the risks and these are the potential consequences, but this is the plan, this is what we can do."***
- ***'And sometimes it's just reassuring people, so we do quite a few advice calls. And sometimes the professionals are doing everything, or we might have a few suggestions for them, and they can be really thankful sometimes for just very brief interventions.'***
- ***'I think the first impact is people being able to vent and unload and us being able to take on some of their anxiety in a really containing and non-judgemental way. For people to go, "Oh, thank god I got that off my chest. That's brilliant, I've been really worried about this young person, I've been sleeping not all night." So, it's almost***

like peer supervision, initially. And then, we come through and we go, "Right, now we're going to help you to understand that young person." So, we give them that clarity and we help them to formulate them. And we give them some predictions around what the future risk is going to be and what they need to be worried about, what they don't need to be worried about, what they're doing really well, what they need to probably change.'

- *'because people get blinded by anxiety themselves, they forget that actually, just because this behaviour is risky, it doesn't mean that we forget all of the stuff that we know about behaviour or how people function. So for me I think the impact we have is about bringing people back to the skills that they have, and the stuff that they know and applying the knowledge they already have'*
- *'It's very much that we provide a framework to allow the clinicians to think of an appropriate treatment plan, appropriate actions forwards'*
- *'if people come to ask our advice, then we have to give the best advice even if it's not what they want to hear.'*
- *'there's a kind of helping people kind of calm down a little bit approach but also in some cases people need to get a bit more worried as well'*

Anxiety seesaw

Many Community F:CAMHS staff expressed a key role of the service is both containing anxiety in the network but also escalating this where this is necessary. The tension between the two was apparent as they were often spoken about in juxtaposition, e.g. *'So sometimes a professional will come to us very worried and we'll need to work with them and it may be that actually they don't need to be so worried. And sometimes we'll come*

across a case where people have got quite used to it and don't seem to realise how worried they need to be. And actually we need to be saying they need to be very worried about it'. The impact on how other services view and respond to risk and anxiety was viewed as central to the service: 'there's a kind of helping people kind of calm down a little bit approach but also in some cases people need to get a bit more worried as well'.

This also related to the Community F:CAMHS team containing their own anxiety and supporting each other and to services having a shared understanding of a young person: *'it's always about making sure people are understanding the risk and there's a shared understanding and agreement of how worried you need to be'.*

Staff continued to express their role managing anxiety in relation to risk in the network in Phase 3, e.g. 'I can't think of any children where the risk in a sense hasn't been either highlighted or reduced. So, we do have a lot of cases where risk will be being ignored or neglected for a number of reasons. And so, the positivity in those cases is bringing the risk to the forefront, so that people then address it'.

Staff shared there are cases where professionals are 'blinded' by risk and are unable to observe other factors of concern, for instance around safeguarding, e.g. 'I think sometimes we get contacted and there's a lot of anxiety often about

- *'But I think a long with that is sometimes validating the professionals and the network experience, and the fact that it's a very challenging case, it's...No wonder that they're feeling like they are, and it's hard to think, or hard to kind of... So sometimes it's also acknowledging that they're bound to have some feelings about the cases that they're working with, because they provoke either fear or distrust, or panic.'*
- *'is a lot of the role for F:CAMHS in holding the anxiety in a number of professionals and kind of helping other professionals develop kind of an awareness and understanding around risk and actually how that can be managed effectively with what resources are available'*
- *'So we have built in to our daily work dedicated time to supervision or group supervision or group you know spaces where anxiety can be dealt with essentially.'*
- *'they're struggling and even just to get somebody to come in and reinforce actually what you're doing is a good job is been really helpful.'*
- *'Sometimes I think the balancing act is having people worry a bit more'*
- *'So sometimes a professional will come to us very worried and we'll need to work with them and it may be that actually they don't need to be so worried. And sometimes we'll come across a case where people have got quite used to it and don't seem to realise how*

a specific risk behaviour. When actually, often some of our role is trying to think about what else might be going on and try to highlight other issues that are also really important. So, things like schooling, things like safety'. In other cases, staff shared subjective bias can result in sociodemographic factors, such as poverty or ethnicity, impacting on clinician levels of concern.

worried they need to be. And actually we need to be saying they need to be very worried about it'

- *'it's always about making sure people are understanding the risk and there's a shared understanding and agreement of how worried you need to be.'*
- *'I was going to say, it just helps I think with the containment. So, often there's really high anxiety around these young people, and actually quite often the teams are managing it quite well. And I think it's just hearing that, so I think the impact for referrers is one that containment, but also knowing how accessible the service is. And I think we're very accessible. So, I think it is around that containment and sharing their concerns about high risk young people.'*
- *'Well, desperate parents get to us and feel heard after you can see, after having the life span of that child, it's not this or it is this and bounced around services. I think they welcome the validation that yes, there's an issue, and yes, we can try and help rather than no, it's not for us'*
- *'And sometimes we're involved in increasing the anxiety because, in those cases where sometimes the child-in-need plan has fizzled out, only two people are turning up for a child-in-need meeting. We need to be saying, actually, this is really concerning and we need to really bump this up rather than accepting the way it is.'*

- *'And feedback from CAMHS is always positive in the sense that to have access to people with that type of expertise is just very, very containing. You know, it's just... To be told you're doing the right thing, or if you're not doing the right thing, how to rectify it. So it's a fair, just approach, as opposed to a critical, blaming culture. And to be told how to rectify if there are issues; to be told how they can support a young person, but also protect their own professional welfare, I think they find very containing.'*
- ***'We do notice that people's understanding of risk can be tainted, if you like, by various things. And actually, when we try and bring a hopefully not too arrogant, but more objective view of risk that can be quite helpful.'***
- ***'I think with one particular case I've got at the moment I probably think the risk is not as worrying as other people think it is, but with another boy I think it's probably more worrying'***

Filling the gaps

Another important impact that Community F:CAMHS has is on filling the gaps in service provision and providing continuity of care, e.g. *'So I think we're filling a gap and without the service, I think we would be relying on an overused, underserviced, understaffed model that is effective to some degree but there are children that aren't being reached'*. For example, a staff member shared that if services or interventions are not available (e.g. if there is no one who has a particular

- *'With forensic CAMHS we're fortunate because we can keep a case like that and we do and actually even though we may not be very regularly directly seeing a child, they sort of know we're there and their family know we're there and that seems to be very important'*
- *'So I think it's important to think F:CAMHS has a bit of*

training in given a service for a therapy that is appropriate), then Community F:CAMHS may facilitate this if they think it would be beneficial. Staff shared the Community F:CAMHS model '*fosters continuity and attachment*'. **Additional examples of Community F:CAMHS filling the gaps provided at Phase 3 included coordinating the network where other professionals were not equipped or did not have capacity to, facilitating neurodevelopmental assessments or harmful sexual behaviour interventions, and providing cover for colleagues in other services throughout the COVID-19 pandemic.**

In Phase 3, staff share their role in filling gaps in service provision was now observable in their data; for instance, with more referrals for concerns for harmful sexual behaviours from areas with little or no specialist provision. Community F:CAMHS response to identifying gaps was also detailed in a late implementing service: '*the team is so unique in its innovation to be able to respond to those needs with good ideas and projects. So I think as we notice the gaps, we respond to them with an idea. So, we noticed a gap in schools, [...] we noticed a gap in training and knowledge around the patch*'.

The challenges of filling the gaps relate to sustainability of the service and managing the expectations of referring services: '*you are always going to be presented with cases which should be managed by other*

an oversight, because we tend to sit above and work with lots of different agencies; so social care, youth offending, CAMHS, you know, education. So we actually do have a better insight than most, because we get to see it across different boroughs and different patches. And get to see actually it's a real... It's really difficult out there for lots of our services. We're in a privileged position, to have time, but they're not. So we can give and support them to do the work, but only if they're also supported by their funders to do the work.'

- '*So I think we're filling a gap and without the service, I think we would be relying on an overused, underserved, understaffed model that is effective to some degree but there are children that aren't being reached.*'
- '*you are always going to be presented with cases which should be managed by other services but due to their ... limited capacity to manage risk you will always start to pick up their slack. So we will continue to get more and more and more cases especially when clinicians in the community feels that under pressure that they can't manage the risks themselves.*'
- '*that kind of links back to the gaps in the provision erm I know that we get a lot of referrals on the cusp of turning eighteen and people panic and think, "we need to get this referral in quick 'cause CAMHS won't have them, FCAMHS don't really have a cut-off it just says*

services but due to ... their limited capacity to manage risk you will always start to pick up their slack. So we will continue to get more and more and more cases especially when clinicians in the community feels that under pressure that they can't manage the risks themselves'. **This was again described as a complexity in Phase 3, e.g. 'interventions for young children who are displaying harmful sexual behaviour. There are a number of us that are AIM trained in the team. And in a small number of cases and that's governed by the geographical area that we have to cover and also the fact that we are a small team and resources aren't bottomless. We do deliver interventions of that sort, however, I think we are always very, very keen to make clear to professionals that F:CAMHS are not the prime provider of harmful sexual behaviour interventions'.**

Filling the gaps is also related to and in juxtaposition with the below secondary theme 'Holding services accountable'. In some cases, a key piece of work needed to be done (e.g. cognitive assessment) but was not being done. Community F:CAMHS both filled the gaps and completed these where necessary, but importantly questioned why they were not being done by the existing services.

In Phase 3, staff also described Community F:CAMHS role in filling gaps in service provision and ensuring continuity of care. However, staff also expressed the challenges of working this way

eighteen they'll get them in", and then we struggle 'cause there's actually no real provision in from people turning seventeen to eighteen, it's straight to adult services and that's it and I think err professionals struggle with that and the young people struggle with that a lot as well.'

- 'I would take over consultant responsibility for the time being because of the concerns about risk and all the rest of it and because it was very complex [...] I've agreed because GPs wouldn't prescribe for him because his medication is complicated that I'd prescribe his medication.'
- 'they're so short staffed that this idea of joint working just isn't feasible you know and so have to be pragmatic and think, you know "I'll do that part of the assessment for you" potentially and feedback'
- 'cause we have the time and the skills and being able to deliver these assessments that definitely YOS and YOT teams can do but they're so overwhelmed and understaffed that it's not always possible to meet the demands. So I think we fill a gap in that way'
- 'Especially with the older young people; you know, 17, 17 and a half, it's not far to transition to adult services. And I think that can be a problem in some respects, because there's no way to transition them earlier, because there are not the resources for adult services to take them. So you have to wait virtually till the last minute, and then there can be a waiting list

(related to being accessible and available), raising concerns for sustainability and staff capacity, e.g. 'What the challenge of that is is that, in being responsive and trying to meet the needs of all those young people, some referrers go, "If I refer to CAMHS it's going to be six months. If I refer to F:CAMHS, they'll probably speak to me tomorrow." Or, "I'll have a consultation next week. They might go out for an assessment in two weeks, why should I wait six months?" [...] that's a challenge and we have to try and negotiate those kinds of things really well and we do get referrers coming back to us time and time again because they know that the response they will get is really, really timely and stuff'.

Staff also described other services, such as third sector or edge of care services, which may be duplicating or taking on some of Community F:CAMHS' work.

for the adult resources, so when there's a drop in service – as in, they're there, but not yet.'

- *'And in terms of sustainability, we're covering six counties within a very small team. And we seem to be getting even better at doing that quite efficiently. I think that we're making clear choices about whether or not something meets our threshold so that we don't get bogged down in work that isn't ours. I think that helps us maintain sustainability as well.'*
- *'I think also, what's missing is the extra time to do some of the intervention stuff. And I think, to some extent, the model was set up with the hope that other things will be around to support an intervention. And that seems to be disappearing a little bit. So, I think, it feels a bit sometimes all very well that we can work out a good plan but no-one can necessarily provide it.'*
- *'I suppose where I think people find it helpful, the outcomes. Part of it is about us having information. So actually, people contact us and wonder what the best course of action is about something. And we're not saying we're the best people, or we give the best advice anywhere, but people get very confused between things like the Children Act, Child Protection, Youth Justice, all of those sorts of things. And we can often cut right through that. And that, frequently, can prevent families having to go to multiple different appointments and meetings and everything else, so that can make quite a difference.'*

- *'So there's a tendency across agency groups, sometimes, to think about the child either being vulnerable or being a risk of harm to others. And sometimes, what tends to happen is that a multiagency group focusses on one or the other and, actually, frequently you've got both present. So the child is vulnerable to exploitation or to whatever it is, but at the same time he could be very dangerous...And I think one of our roles in all of that is helping the group to think about both of those things together. And I think that helps develop a realistic view of risk. And, actually, if we align that with thinking about need, if the group is also thinking about need...Meeting need is usually one of the best ways of managing risk.'*
- ***'We have an opportunity to be able to provide a service that is the same to everybody. So, there's still gaps that continue to exist, but I think we can respond to the ones that we identify quite well.'***
- ***'I think that for some people that have just got stuck because they feel like have gone down every avenue, and I think sometimes we can open doors that other people haven't been able to open for them, because we are able to provide a specialist assessment or an assessment that they just can't get hold of. Autism assessments come up over and over again don't they, or IQ assessments. These are things that we don't do for everybody obviously, but when it's indicated, because it's needed and it can't be accessed***

	<p><i>easily elsewhere, we can either help them to get it commissioned or we can help to do it to unlock resources for a young person, like an EHCP or a learning disability diagnosis'</i></p> <ul style="list-style-type: none"> • 'I think there is a group of people who remain unserved by anyone other than us'
<p>Holding services accountable</p> <p>An important emerging role for Community F:CAMHS identified by staff was holding services accountable, for example if they should be providing a service and are not: <i>'So sometimes we need to very much be an advocate [...] for the child if actually due process doesn't seem to be happening'</i> and <i>'Sometimes that's an appeal to another service but it could equally be a CAMHS service to do what the service spec says that they should be doing'</i>.</p> <p>Staff expressed the impact of Community F:CAMHS in these cases may be fast tracking referrals, raising safeguarding concerns or helping professionals get services involved. This relates to the expertise of the service and the weight of their reports in the system.</p> <p>In Phase 3, staff continued to reflect on their role on supporting the network in moving things forward and holding services accountable, e.g. 'we do try and push services when young people are sat on waiting lists and try and make sure that they get what they need in a quicker and more timely manner'. This relates to their role advocating for the young person and translated</p>	<ul style="list-style-type: none"> • <i>'So sometimes we need to very much be an advocate [...] for the child if actually due process doesn't seem to be happening'</i> • <i>'we're going to concentrate on the risk and giving recommendations about risk, we're going to point to the shared formulation that we've shared with everybody and if you want further assessment that actually should be the local service then kicking in'</i> • <i>'helping um err the social workers involved be be a bit more um reactive to his needs and involving him a bit more.'</i> • <i>'Sometimes that's an appeal to another service but it could equally be a CAMHS service to do what the service spec says that they should be doing.'</i> • <i>'we've been currently working with a young gentlemen whose got Autism erm it's an indirect piece of work erm but it was quite clear that he didn't have any educational support in place, he wasn't going to school, so one of the things we did was to erm we did</i>

sometimes to helping services identify that their support is required, e.g. if difficulties were deemed behavioural and not psychological.

Related to the flexibility and expertise of the service, and its child-centred way of working, one member of staff described an example whereby the team picked up a case that wasn't 'forensic' because they were really worried about the young person and CAMHS was not able to provide support, and Community F:CAMHS managed to get the young person appropriate support: "rather than just going, "This case is not for us" we said, "Right, we're going to assess this kid because we're going to assess his mental health. This isn't our game, but we're going to do it because we're really, really worried about him. So, we'll do it as a second opinion and then we will provide that opinion to CAMHS and give them some direction about what intervention that they should put in place." Because it was me and the psychiatrist and we both feared that if we pulled out of this case, this young person would remain trapped in their bedroom for another 18 months, ravaged by anxiety and obsessive-compulsive symptoms. So, we did that, we undertook a couple of assessments. I attended meetings. I kicked up a bit of a fuss and stuff. And fortunately, we were able to gain the attention of these services and able to get to some provision for this young man'.

a referral to social care but we also linked up with education to look at his EHCP plan erm and because they were struggling at home as well we also linked in with [service] and then got all the professionals together to formulate a risk management plan to move forward'

- *'The second year I think has been much more political in how I found myself advocating for children to be included in things and for the frameworks that they're entitled to and services that they're entitled to should work for them and holding people to account for that... And say, 'Well, actually, education healthcare plan is three years out of date.' Or, "You can't exclude them for having this particular diagnosis and you're a CAMHS service and you need to carry on, actually. We'll help you with that." Or some other issue that's meant that actually it's the statutory services that or they should have been provided it, need to carry on providing it.'*
- *'sometimes we've just got the time to or the ability as people who have stood back in a situation with a bit of experience in maybe complex cases, we can stop and think, "Now, hang on. The basics are missing here and actually we need a social care assessment", whatever...And that experience is usually what helps you drive the challenge as well that you know, actually you know that this child does meet certain criteria and therefore it's down to the other agencies to evidence why. And I think it's about making sure that we get*

Staff also reflected that holding services accountable also extended to the wider provision of services, identifying gaps in provision, and raising these gaps to commissioners.

the evidence and then if there is a difference of opinion, that's okay as well, as long as everything that has been done, and should have been done, has been done, then I think we have to agree to differ sometimes.'

- **'We continue to try and look for those gaps in provision and escalate things where we can. Especially around young people who can't access services like harmful sexual behaviour because that kind of postcode lottery and there isn't the provision available in those areas. We give the advice to their strategic lead and their commissioners to try and build up those resources in those areas'**
- **'In terms of the mental health side of it, I think we have a really positive impact from that point of view, because some of the children that we get referred are rejected by CAMHS or paediatric services because sometimes it's described as behavioural or not meeting the threshold. So, sometimes we end up doing assessments in those cases and that can be really helpful to the network to maybe change perspectives a little bit to think about what the formulation is and if there are health issues.'**

Upskilling other agencies and training

Upskilling other agencies was also described by staff as a core function of the team, whether this be through supervision groups, formal or informal training. Some examples of agencies that Community F:CAMHS staff

- *'I think there's a big role for us to train up and skill up [...] Teams so that we don't have to take everything but enable them to sort of you know be able to*

have trained that were shared are children's homes or residential units, CAMHS, medium secure units, pupil referral units, and third sector agencies. The impact of the training was observed by staff, with other professionals '*quickly getting upskilled*'.

Staff shared they would offer any additional places on a Community F:CAMHS staff training to other professionals to upskill the network. Staff also described how, during the implementation of their service, Community F:CAMHS would support services to identify their gaps and training needs in their area: '*we also sort of take a role in supporting other services who are um coming into contact with high risk young people and thinking about kind of service gaps and training needs in that area to kind of make sure the provision for young people is as good as it could be*'.

Community F:CAMHS staff identified key areas of training shared, including attachment and trauma, sexual health and behaviour, forensic services, digital technology in youth, managing aggressive outbursts, risk assessment, triangulating information, safeguarding, thinking about complex cases, and drug training. **These were also areas of training raised in Phase 3, as well as some training on formulation awareness and trauma-informed practice. Examples of groups trained included social workers, youth offending staff and CAMHS staff.**

manage this, or know what to do or what to think about.'

- '*But training is really at the heart of what we do. It's not only training to us internally, but also taking that out. And I think we're just doing that all of the time; in consultations, more formally, or in groups. I think that's all part of the whole – our whole intervention, is training.'*
- '*And so we're trying to offer more. What they really love is the experiential, so case presentations. And so that's what really... Because the formal training, I think doesn't really hook into – and even when you look at the medical education research, it's all people learn from their cases. And so we're trying to sort of have a balance where you are presenting cases, and getting people to understand. Because really it's all about pattern recognition'*
- '*You can see people quickly getting upskilled'*
- '*we took all of that information and obviously that's being fed into a training matrix that is being set up so that the training that can be delivered by FCAMHS fits the needs of what people want, not just you know generic'*
- '*we also sort of take a role in supporting other services who are um coming into contact with high risk young people and thinking about kind of service gaps and*

In Phase 3, staff described continued engagement and desire in the network for Community F:CAMHS to deliver training and presentations at conferences.

training needs in that area to kind of make sure the provision for young people is as good as it could be'

- *'I suppose there's one other thing which is important is to...not to make other professionals or families experts in an area which we ourselves are experts in perhaps, but actually to provide them with appropriate training to their level in terms of working with this group of young people. So thinking about trauma, thinking about complexity, thinking about continuity, those kinds of things, continuity of provision for a child.'*
- *'We're very involved with thinking about developing services as well as thinking about training people, and thinking about things like working with complex needs, structured risk assessment. And there's quite an emphasis at the moment on trauma-based approaches, or thinking about children who've experienced trauma, and services being thoughtful about that. So there are those sorts of things.'*
- *'help networks to think of these quite dangerous and disturbing young people in a different way as children in need whose needs are not being met'*
- *'I think we're really good at helping people understand risk and thinking about risk.'*
- *'So you're giving them a really clear formulation, you're developing their knowledge base and*

understanding around stuff and helping them explore that a little bit more'

- *'we've been out to do training on just kind of attachment and trauma because basically under in some placements they don't really understand with young people that's kind of a core issue.'*
- *'So we're in the process of developing two training packages, so I'll let -- and -- tell you about the trauma one. The other one is on risk management and I'm doing that with a couple of other colleagues in the team. We're looking at the end of this year, next year to kind of roll those out...But while that's in development, we got some training in for our team and we had some extra spaces left, so we actually offered them to the youth offending teams across the whole region and that worked really well.'*
- *'Within the trust, we're trying to well, we would be the leads on risk management. So, we deliver risk training to everybody within CYP...towards that, we're also collating together what we do offer within the team trauma, risk management, to roll out inductions and have study days within the trust. And then, obviously, we've got [staff name] in her role developing the training programme.'*
- *'Quite a lot of what I do, I think we do quite a bit of training on the job, actually. People understanding*

what the service is. And then there's quite a bit of, I do quite a bit of regional and national training, or awareness raising.'

- *'But things have really developed over the last year; we are running all sorts of work discussion and reflective practice groups. Some of those take place here, sort of special interest groups, so around specific subjects like problematic sexual behaviours and there's also a third sector group here, that's into its second year.'*
- *'And also I think in terms of some of the other things that we've been doing, which is like supporting teams to manage the burden of what they're carrying. So you kind of need like a reflective forum for them to think about some of the high risk cases and how we work with them as a team and the impact on them as a worker; not necessarily about any particular – well, they will bring a particular case – but it doesn't... It's more about thinking about how the team functions and how they respond'*
- ***'we will often work alongside the clinician who's made that referral, we will be trying to upskill them and giving them that experience, the knowledge to be able to deliver that care themselves and to take that on into their continued professional practice.'***
- ***'through helping people like this, they become skilled up. So, that was one of the sub-functions,***

really, I think in some ways is to widen the knowledge and help people in the system. So, I think people will say that they benefit from our service in their own awareness and development, be that formally through particular aspects of skills like learning to do a risk assessment through the SAVRY, which is a particular training we offer out sometimes. Or just having a different framework and different way of thinking about things.'

Table 10.3.1.5: Implementation, secondary themes, key points and illustrative quotes.

Secondary theme	Key points	Illustrative quotes
Challenges and roll-out strategies	<p>Different sites had different experiences of roll-out and different challenges. Some sites had previous experience of working with the target population, whereas others were implementing the new service specification in a geographical area that had no former service of the like. The illustrative quotes outline specific details of roll-out, but in summary, some services split their region in two and had two interrelated teams serving each section of the region while others decided to <i>'stick [...] with one county'</i> in the early implementation to ensure consistency.</p> <p>As well as this, some sites had a wealth of experience while others were building from scratch <i>'trying to engage as many people as possible [...] and let them know'</i> that they exist.</p> <p>Therefore, on the whole, sites had a phased roll-out and some found having a few months to set up being very helpful. Some challenges in the implementation were recruitment and not being fully staffed when coming on board. Trust support was referenced as a key facilitator and that Community F:CAMHS was the first regional service that had been set up with different staffing structures (e.g., full-time vs. part-time staff) therefore this presented some challenges in administration and human resources.</p>	<ul style="list-style-type: none"> • <i>'we felt it was safest at that point to stick it with one county and we did offer a regional service if there were any homicide cases because that was what we felt was safe in terms of clinical delivery.'</i> • <i>'some services only do 2 person assessments, do 2 clinician assessments, whereas capacity wise even if we could do that we wouldn't do that. And our region, I think some regions geographically are much larger than others, and so as a result they operate in some, in different ways. Some services do consultations always in a face-to-face manner.'</i> • <i>'we've split our region into two and a bit teams ... and we we are linking together and working as one erm but I'm aware other areas have one team for that entire patch so I'd be interested to know how which which works best.'</i> • <i>'facilitators certainly were support from central services and the trust.'</i>

In Phase 3, recruitment continued to be a challenge for Community F:CAMHS as described by staff. These difficulties relate to the specific expertise required for team members, but also the wider barriers posed by COVID-19. For example, some staff reflected on how to induct new members of staff when working from home. Late implementers reflected that they would have benefitted from more guidance from early implementers on staffing structures.

Earlier implementing sites were particularly keen on evidencing impact. When asked about sustainability, most staff felt the service was really needed and would be sustainable as long as it remained true to their flexibility of approach; e.g. *'I think the service will be very sustainable providing it can remain fairly flexible, so to not get too rigidly stuck into a kind of particular model at this stage'*.

In Phase 3, staff again shared challenges of evidencing impact and how this may affect commissioners' view of the utility of the service, e.g. *'I guess trying to evidence the value that we bring to a situation. I think that's sometimes a challenge'*. This was also discussed in relation to evidencing change in outcomes, which staff shared were very difficult to measure and often longer term, e.g. *'I think that's variable, to be honest, because sometimes these things take longer. And we might not always have been involved for the longevity, so some cases we might agree with the referrer that we've assisted,*

- *'I think the main challenge has been recruitment'*
- *'And just trying to engage as many people as possible, that was the biggest thing in the beginning; just trying to engage people and let them know.'*
- *'It was, if we think about when we first started implementing it, was quite difficult in some ways. But there was a very clear need, there's no doubt about that. But the 'How' of doing it wasn't quite clear, and people were worried about things like being available to offer advice in high-risk cases without necessarily seeing the child or offering a consultation...And those sorts of worries were there until we got going and people realised that we were being accountable. We were doing what we said we were doing, which was offering advice, or doing consultation in the absence of seeing the child sometimes. Then people accepted that. But we had to be very transparent about all of those things. So there were some anxieties about that.'*
- *'There were some anxieties that the service would get completely overwhelmed and that people would be trying to offload their most complex cases onto the service. And we've always emphasised the need for joint working and for local services to remain involved if we are being asked to get involved ourselves. So that was a bit of a change in attitudes.'*

and then leave them to it. So, there are some cases where the eventual outcome we're probably not privy to'.

In Phase 3, staff also described challenges in relation to changes in commissioning, sharing that Community F:CAMHS requires both local and national oversight, e.g. 'there is a move going on to more localised commissioning and I think that the...Traditionally, the way NHS England has thought about this is either it's localised commissioning or it's national. And I think these sorts of services need both. They need a national steer and there needs some rational consistency as well as a locally focused service'.

- *'I think those are the main things. I think getting people used to the fact that they could just ring us up if they need to for immediate advice was something that they weren't very used to. But actually, people have got very used to that now, and that's part of how the service works.'*
- *'So I think, I would hope that sustainability is there. It would be useful to have a little bit more staff with the services, but they were designed, these services, to be small teams covering relatively large areas and the service model supports that. So the more people adhere to the service model, the more likely the service as intended will continue, I think.'*
- *'I think the service will be very sustainable providing it can remain fairly flexible, so to not get too rigidly stuck into a kind of particular model at this stage.'*
- *'I think actually having the commissioners we had was very helpful. Because they were very interested, and very helpful, in the implementation and in checking in on what was going on. And providing support and ideas about how to – if there were any things that were coming up that we identified as a difficult part of implementation, they would have an idea about or a contact about that. So I think the commissioners really supported the successful implementation of the service. I think that was very helpful.'*

- ***'in the implementation stage it was up to us to write a bid and say what we thought was the right person. And in hindsight, it would have been good also to have a bit of direction about what teams are already established knew about what is the right level of knowledge or skill or banding, whatever [...] perhaps there's something around job descriptions and around the teams that were well established who they had in their teams and giving us a sense of staffing structure. From my perspective in my role, that would have helped me not spend so much time in recruitment.'***
- ***'what I'm worried about is how do I induct this new member of staff into our ways of working, when they might be at home? Because a lot of the things you learn about F:CAMHS are from sat in an office, and turning and having a quick conversation with someone about a case or about a particular aspect of assessing someone or a bit of theory or topic.'***
- ***'it's really important to have that national oversight as well as a local emphasis.'***
- ***'I don't know how it's going to work if they go for a lead provider collaborative process and start to move funding from having it centrally via NHSE and having it more from a local provider, I don't know that will work. I do have my concerns about that. I wonder if it will mean that***

the ethos or the model of the F:CAMHS will start to be blurred with the demands from local services taking precedence.'

Service Maturity

Service maturity was described by staff as important to implementation. For example, more mature services who have had similar service models in the area previously may not have the same challenges in recruitment or making the service known but may have different challenges, such as adapting to a consultation based model and rebranding, e.g. *'well a lot of the staff were brand new so they came into something that was brand new and I think that was actually really helpful rather than having something in existence and trying to change them'*.

The network of other teams was described as being a helpful source of information to draw on learning from more experienced services for those services with less experience in the area. New services expressed being able to learn from more mature services who were perhaps more familiar with the model and could adapt their resources rather than starting from scratch, e.g. *'I mean what has been really helpful in our implementation has been more advanced teams who are much further ahead than us and the network being hugely supportive so that you can go to any one of those teams and kind of get that sense of what happens and then you can tweak it to your own kind of patch as such'*.

- *'that's one of the other advantages of being one of the services that started from scratch because everyone, you know we were all involved very careful with who was recruited to the team and so I think we do share a lot of similar values'*
- *'I think it also just depends on erm sort of the local support you might get so I do wonder about new services um and how they how they function erm having been well established I think people know to use us, know how to use us um and our senior senior managers support that. Um it may not be that case in other areas but that's one of the things that'll be interesting to sort of see really is whether the service is allowed to do what it's allowed to do 'cause there's always constraints'*
- *'I think we're lucky 'cause we've been around for ages and we've got a whole list of training that I think we've done that other people could benefit from over time.'*

Service development

In terms of developing the service further, the key things sites were focussing on included non-clinical work including engaging with systemic issues, and engaging with other agencies across the region in 'high-level discussions' about key social issues faced by the sector, e.g. criminal exploitation.

Engaging in discussions about systemic issues was deemed to be a key component of the service's development and developing 'national links' as well as the local connections with agencies in the area. A member of staff shared that 'as a service, it's really important and satisfying not only to pay attention to the clinical cases, but also to think about those more systemic issues that we get involved with'. Community F:CAMHS are well-placed to feed into higher-level discussions about challenges faced by young people and about mental health and youth justice more broadly because of their in-depth clinical experience.

In addition to the developments described above, it was apparent in Phase 3 that staff were focussing more on service development. For example, staff shared more examples of research they are conducting and how they are going to use their data, e.g. 'there are a couple of research ideas or projects that we are starting to develop and write down'.

Staff were also thinking more about parity of provision and using the data from their referrals to consider groups that may not be accessing the service, e.g. 'I think what we're doing is sort of

- 'We're thinking at the moment, for example, regionally about just trying to get into high-level discussions with social services, other agencies and third sector agencies about [...] criminal exploitation, for example.'
- 'So we're always thinking about service development because the lens of what the worry is tends to change. It's partly socially determined, I think.'
- 'I suppose the other side of things is, thinking about the service development side of things, thinking about the national links as well as the very local links that we have, that makes life interesting. So there's a wide variety of things that we can do in our clinical work and in our non-clinical work, and they complement each other. So, actually, as a service, it's really important and satisfying not only to pay attention to the clinical cases, but also to think about those more systemic issues that we get involved with.'
- 'But it does feel like things are really broadening out now and, I occasionally go back to the original sort of tendering documents and back to what was being asked by NHS England and it does feel like we're moving more towards providing a much kind of more comprehensive service.'
- '**I guess one of the developments that we're doing at the moment is just trying to link a bit more with the youth offending services, so we noticed that the referral service was surprisingly low actually, so we sort of reached out to them in terms of offering training and we've also**

looking at the spread of referrals and where they come from and just looking where we can target a bit more where there's probably less in some areas and that could be geographically or through different agencies. So that's probably what we'll be doing a little bit more this year'.

These conversations included linking with in-patient services and secure residential services, e.g. *'there's probably been surprisingly little in terms of referrals for children coming in and out of custody'.* However, it was raised that this coordination may require national lead to ensure streamlined transitions and integrated working, e.g. *'I think it needs to be a [Quality Improvement] project in a sense that is across F:CAMHS and across the secure estate. Us, in a sense, just going in as individuals from one F:CAMHS when we cover 13 areas, I think really doesn't address the sociological issue. So, it's not about individuals not considering those issues, it's thinking it needs something which perhaps is more national, coordinated, which is more societal'.*

Some services were additionally establishing strong links with schools and pupil referral units, working in an embedded way, e.g. *'I'm part of the team that's starting up a schools project where we're trying to integrate ourselves in provisional education and pupil referral units'.* This was a marked progression from earlier stages.

reached out to them in terms of offering some dedicated slots where they could bring some cases.'

- *'I don't think we have really devoted time to thinking about what's stopping people getting referred, and children that are hard to reach generally, that are just getting missed. I think that's something that we can think about moving forward really. That would be something important to think about.'*
- *'it is sustainable now, but I think it could do with a little bit more cash, really, to do better.'*
- *'The exploitation issue is something that needs further thinking about, because not all of those children meet the forensic CAMHS criteria and they are complex. And we're working quite hard at preparing the ground for trying to see whether there's some extra funding and support for actually just extending over that area and providing some additional support to professionals for children who experience exploitation.'*
- *'I think in moving forward people have been thinking about making research projects of things that they've done so that we can share them.'*

For improvement and the sustainability of the service, staff said the service is sustainable and effective in its current form but would benefit from more staff, e.g. *'it's a very kind of lean service model if you like, and there could be always scope for a bit more support in there in terms of clinical support and admin'*.

Related to working flexibly, staff described thinking about expanding their remit to address current needs, with an increased focus on exploitation.

Making the service known

Staff discussed the important task of making the service known to other services in the region during implementation and building relationships.

This was expressed more by staff in late implementer services, but was also raised by staff in early implementer services when discussing expanding to regions previously not reached and building a wider network of professionals and services.

Early implementers described challenges of being *'the new kid on the block'*, creating an awareness of the service across the region, and making sure relationships and partnerships with other services are built and maintained. Staff shared some strategies used to help become established, such as holding stakeholder events, developing a webpage, and establishing a steering group. Staff also expressed mediums such as newsletters and leaflets allowed them to provide partner services with regular updates, even if not

- *'not step on other people's turf as it were and that some of these organisations in forensics are very...very protective of what's theirs and they've been doing it for many years, and to be the new kid on the block isn't well-received in all boroughs, has been our experience.'*
- *'because there was nothing here before, it's about developing a solid regional specialist service you know that provides really good liaison and advice you know for the majority of cases that we'll come across that people trust, that is evidence-based and that puts the child first.'*
- *'one of the difficulties is establishing the relationships and getting the right level of involvement, you need sometimes quite senior involvement from other agencies'*
- *'we don't find that there's people we can't work with at all because that's one of the things we should be able to do.'*

working directly with them, in order to keep Community F:CAMHS on the map. Staff from late implementing services emphasised the need for time in this process, e.g. *'I think we needed to think about [...] time for relationship building'*.

Staff linked making the service known to challenges in managing the increased influx of referrals as well as trying to ensure parity of provision across the region, e.g. *'it's not just about local stakeholders, it's about you know those further afield and making sure that they feel that the service provided is... that there's parity service across all of the region'*.

It was apparent in Phase 3 that all services, including late implementers, felt established in their region, although staff did share these efforts are continuing and consolidating their role in the network, e.g. *'I think some of our involvement with the wider agencies network has grown and established'*. Staff also shared their referral numbers are continuing to rise and hypothesised that this is a result of being better known as a service and receiving referrals from the whole region they cover.

Related to challenges of recruitment and staff capacity, staff expressed the challenges and importance of continued efforts to engage stakeholders and the effect this could have on sustainability: *"I think some of the other challenges around sustainability will probably be*

- *'the other thing is just raising awareness about the service and making sure that people know and feel able to get in touch I suppose.'*
- *'we've had to do a lot of relationship building and roadshow kind of like who we are, what we're doing and how we can help'*
- *'I am being really proactive, now, in trying to meet all those teams face-to-face. Because I think that makes a real difference to how you can operate in services.'*
- ***'we've established ourselves within the [...] area. So, in terms of being part of a network, we're a lot more accessible now. So, I think from my perspective been doing a lot more advice and informal support of colleagues and I think we've defined our role a bit more, so we're more streamlined in terms of consultation'***
- *'because we're just sort of trying to deal with the referrals coming in, we don't always get the space to do something on clinical functions and the networking that we need to.'*
- *'I think that we are definitely being integrated into our patch this year'*
- *'it's just marketing that we try and split up all the boroughs and make sure that they're split into CAMHS, social care, voluntary, gosh, I can't remember now the other aspect. But the idea is*

staffing [...] to have enough people in post. Because I think that then allows you the space to do particularly the non-clinical evidence of the work and I think the bit we struggle with is sometimes having the time to be able to go out into the different regions and almost market ourselves and sort of share our value'.

that we're doing a rolling roadshow, so that we're targeting each area [...] it's just really about making ourselves visible to as many services as possible so that they understand what's available.'

**Expectations of
Community
F:CAMHS**

A recurring theme throughout the interviews with staff was setting and managing the expectations on what Community F:CAMHS can provide. Some staff reported the need to continue to educate professionals in contact with the service about the role of Community F:CAMHS and that defining the role of the service and the remit of the service was sometimes a challenge. This was primarily in relation to referring agencies, but also extended to what Trusts and commissioners expect from the service.

Staff consistently described having to explain the remits of the service to referrers in particular, for example not holding clinical responsibility or explaining the consultation model: *'people [other professionals] still don't quite get it'*. Early implementers also expressed expectations of referrers was linked to maturity of service and what partner services expect based on previous models. Furthermore, staff expressed the challenges of managing expectations in terms of what they can offer in different parts of the region in order to fill a gap but not replace an existing resource. This links to filling a gap in service provision but also to holding other services accountable.

- *'it may feel great in the moment to pass a case to a forensic service but essentially the case is passed back so it's sort of is a is a different process so we've had some issues where people are wanting erm you know forensic assessments and having to work with them to give them an understanding that you know a forensic assessment or a Autism diagnosis isn't going to change anything for the young person but if their needs can be met then maybe the risk can go down and so it's trying to think how you know that the we're a different type of service and so that communication's been difficult at times'*
- *'people might be expecting a very lengthy [...] assessments and that isn't what we do anymore.'*
- *'I think a lot of people want intervention, so might be a bit disappointed that they're not going to get intervention'*
- *'Getting people used to that and that we're not immediately going to be asking people to come in for assessments and things like that is quite tricky.'*
- *'It's getting the other services to understand the service model because so often services have been used to...*

An expectation of the service described by staff was that Community F:CAMHS would take on any high risk cases. Further examples include expecting interventions, direct work, or for risks to decrease dramatically, e.g. *'It's that feeling that we have this magic wand that we're going to wave and everything's going to be alright'*.

More mature service expressed this eases off with time, that services do get used to expecting both direct and indirect work from Community F:CAMHS and are very grateful for this: *'So once they started realising that we could be very useful in the cases we really needed to be involved with, then people were willing to accept that we might not be able to be involved in others directly'*. **During Phase 3, however, mature services reflected on the challenges of managing expectations of partner services according to their new service model, e.g. *'the challenge for us was not to establish ourselves as a new team, people knew us very well. But to be able to adapt to and manage this new expectation and a new way of working'*.**

This is related to the challenges of being a Community F:CAMHS worker, views of the consultation model, and impacts on sustainability of the service. In addition, staff linked managing expectations to the risk of disappointing referrers.

These challenges continued to be raised by staff in Phase 3, although staff reflected on

referrers have been so used to asking for an assessment and a report'

- *'And I worry that in the same sense that they they're going to become unsatisfied with us if they come to us seeking all the answers and we don't direct them, give them lots and lots of questions that they go and try and answer for us and then we send them away again.'*
- *'You cannot always fix everything immediately and it's sometimes only even slowly or maybe not even ever fix everything at all. [...] So sometimes you do get some quick wins but sometimes it's a slower burn.'*
- *'particularly where maybe somebody stretched or a care worker has left and they are waiting for another care worker to be coming they might be that push to say, 'why can't you do that assessment?', 'why can't you go on and do that as well and provide this, that and the other as well?', and we got thinking that the problem is then you have to think about the more we do it, the more that expectation might build.'*
- ***'That said, some people continue to struggle with us and that can be difficult. So, we do still get people who refer and dump as we say. So, they might refer and then, they might not really want to speak to us. And then, we might try and chase and after a couple of weeks they say, "Why haven't you done this?" "Because we've referred to you." And things like that.'***

progression whereby services had better expectations of what the service provides, particularly for those who had previously referred, e.g. *'some people come back for more, and so you build quite a good relationship with them. They know how it works; they know how we can be helpful. They come back for specific things'*.

Some shared that this was perhaps facilitated through remote working during the COVID-19 pandemic, whereby professionals relied more on consultation, e.g. *'Because actually, people get the consultation bit now, because before they'd say, "No, no, come and see us, or come and see that person." And you can't, so you then have an MS Teams thing, because everyone does that. And actually people understand it better, so it's been quite helpful for that'*.

Others reflected that staff expectations of what Community F:CAMHS can provide is driven by a lack of resource and services, in cases where referrers are desperate for support, e.g. *'now sometimes some of the agencies are looking for us to be more practical and get into that case management role. So, I think that's one that I've noticed, that some agencies are slightly using us differently in that way, but we stay firm in who we are and what we can do. But there is that change, and I think that's the desperation of all agencies around our patch. And everyone's really trying to*

- *'I do get the sense that some referrers would like you to just go, "Right, this is your case now and you take hold of it, do what you need to do. And when that kid's better and not hurting anyone, I'll have it back, please." And I think it can be a little bit disappointing for them when they go, "No, this is what you need to do, here are your recommendations. You need to run with it." But I think they eventually get it, and they understand how we work and what they need to do a little bit differently.'*
- *'we were giving them the advice and the consultation and the support to do exactly what they needed to do. But I felt that their expectation was that we will come in and do it for them. I did not feel that was required. That did not go well, I can tell you that'*
- *'often people come to us and say, "I want a forensic assessment," and think you're going to do something really amazing and magical, and actually what you do is go, "Where's your functional analysis of this incident? What happened? When did it happen?" And I think initially you're met with a little bit of frustration'*

do what's right for these young people and there's not enough resource and there's not enough beds. And so, we are sometimes used as though we have this magic answer, well we don't, really. But I think that's to do with the pandemic and the current situation we're in is that it's just a bit more desperate out there'.

10.3.2 Professionals in contact with Community F:CAMHS: framework and thematic analysis

Thematic Analysis⁴⁵ was conducted using a data-driven approach, analysing the data and deriving dominant themes. During the analysis of the Phase 3 data, new codes were added, and some codes combined. Transcripts of interviews with professionals in contact with the service (N= 34) from 4 focus sites were analysed and organised into secondary themes, which were then grouped according to primary themes (please see Figure 10.3.2.2).

In the Interim Findings Report, the Framework Method¹⁵ was not used to organise the data due to the smaller number of transcripts. Following the collection of Phase 3 data, additional analysis was conducted to organise the data. The researchers and clinicians in the Evaluation Team and Steering Group collaboratively derived an analytical framework. This was derived using a combination of the logic models for the evaluation (see Methods) and 'if...then' statements (see Economic Evaluation), which conceptually follow the journey of professionals in contact with Community F:CAMHS service. The analytical framework comprises 'Context', 'Mechanism', and 'Outcome' as overarching categories. Descriptions are provided linking the Framework analysis categories, with the primary and secondary themes that merged from the Thematic Analysis.

The professionals in contact with the service (also referred to as referrers in places to facilitate interpretation) were from a range of services, including staff working in a youth offending team, a pupil referral unit, secure accommodation, inpatient and community CAMHS, schools, a family solutions team, social care and liaison and diversion teams. The cases they referred to Community F:CAMHS were for a broad range of reasons, including offending, domestic abuse, allegations of a sexual assault, violence against staff, violence towards animals, criminal damage, being at risk of child criminal exploitation, grooming and coercive or threatening behaviours towards other children and young people, plans to harm others, and where there were concerns around risk management and engagement. For example, one professional in contact with the service shared that they referred to Community F:CAMHS as there were concerns around:

How to manage that person, because they weren't engaging very well and there was a concern that CAMHS was just going to discharge this person and I had some additional information from

our perspective that we were a bit worried that to discharge him would increase the risk. (Referrer Phase 2)

Professionals in contact with the service generally described Community F:CAMHS as a consultation service for professionals where there are concerns around risk of a child or young person. Professionals in contact with the service also described seeking consultation from Community F:CAMHS when they were unsure of next steps to take with a young person when the young person was not meeting thresholds for other services, but the referrer had concerns about risk. One professional stated that:

F:CAMHS will provide consultation in about how local services can best manage people who maybe fall through the gaps or are difficult to manage in local services. (Referrer Phase 2)

This suggests that Community F:CAMHS has a role in guiding the network so that children and young people can receive help from their local services and preventing children and young people from not receiving support. Comments on Community F:CAMHS using a consultation model was echoed throughout the interviews, with another professional summarising this by saying:

The team [Community F:CAMHS] is not necessarily going to be working with children, it might be consulting to networks and schools and other professionals and parents. (Referrer Phase 3)

Furthermore, professionals in contact with the service differentiated Community F:CAMHS to CAMHS, describing Community F:CAMHS as a service providing specialist input regarding management of risk; for example:

F:CAMHS is different to generic CAMHS because it has a focus really on children, young people who have mental health problems but also whose behaviour is posing a significant risk to others as well as to themselves. (Referrer Phase 1)

In Phase 3, where professionals had made several referrals to F:CAMHS, referrers spoke of having a helpful ongoing dialogue and consultation process with their local Community F:CAMHS team. This meant there could be continuous

consultation with Community F:CAMHS about whether referrals would be appropriate or to seek advice on a case.

When asked if they would refer again, all referrers said yes based on their experience with Community F:CAMHS. One referrer shared that:

It [Community F:CAMHS] probably would be my first port of call to be honest. If I've got the same kind of problems, and I sit there in the alarm office going 'I know that this will work because I know who to contact and I know that it will be taken in a professional manner and it will be dealt with. (Referrer Phase 3)

Generally, professionals in contact with the service expressed a very positive experience of working with Community F:CAMHS. The suggestions related to improvements or recommendation for Community F:CAMHS included: providing additional direct work, ongoing involvement and training, understanding of types of training available, and the network having a better understanding of the service model, awareness of the service and its thresholds for involvement.

In terms of distance travelled, one professional in contact with the service shared:

When [Community F:CAMHS staff member] spoke about it [Community F:CAMHS] originally to us, he talked about how it is meant to be a responsive team, people who will be accessible to us and not impossible to reach, impossible to get a hold of, and they really have achieved that locally and I can imagine that systems and processes could get in the way of that in other areas and I guess I would just encourage them to listen to what [Community F:CAMHS staff member] is saying because I think it, for us, it really has worked and given us what we need. (Referrer Phase 2)

In Phase 3, an additional question asking about the impact of COVID-19 on the referrers experience of contacting Community F:CAMHS was analysed. Despite the additional challenges to services with the lockdown in relation to the COVID-19 pandemic, new professionals in contact with the service and returning professionals continued to describe F:CAMHS as accessible and responsive to need. In some circumstances, the lack of ability to have face-to-face meetings made the service easier to contact as they were not travelling around. Likewise, multiagency meetings were easier to organise via Microsoft Teams without the need for professionals to travel from different locations. One professional in

contact with service suggested one impact of COVID-19 was a limitation on the types of assessments Community F:CAMHS could offer via MS Teams and a limit in the direct work they could do with young people:

I think with COVID there was a bit of limitation in terms of assessments being offered. Assessments offered virtually, I think, makes it that much more challenging. But I think that's something that is unavoidable. What we've noticed recently is that they team is a lot more responsive. (Referrer Phase 3)

10.3.2.1 Framework Analysis Findings

The framework analysis organised the data into three overarching categories: mechanisms, context and outcomes. Within each of these overarching categories a number of secondary categories were identified (in bold) which also relate to the thematic analysis which provides further details on the experience of professionals in contact with Community F:CAMHS.

For professionals in contact with F:CAMHS a key '**mechanism**' identified was **improvements in interagency communication and understanding the collective task** as reflected in the secondary themes 'communication with Community F:CAMHS' and 'interagency working'. Across the referrers there was agreement that the involvement of F:CAMHS had helped support decisions around care, and most importantly help explain those decisions to the wider network involved in the young person's care. This meant everyone was on the 'same page' and all had the same understanding of the young person's needs and a plan going forward to support the young person:

School had major concerns and so having the member from the F:CAMHS really helped to think about risk from a different perspective because school... school's way of managing risk was different to what we were suggesting, so having the team support our decisions or our recommendations was quite useful. (Referrer Phase 2)

Often, where the network were struggling to come together to agree on how to manage the young person's care, the Community F:CAMHS involvement brought the whole network together. This in turn helped improve the **multi-disciplinary team working** within the networks as well:

They [Community F:CAMHS] helped with that support. Not actually providing it but helping bring people together like

Probation and Youth Offending Team and Early Intervention
Team and Social Services. (Referrer Phase 1)

Professionals in contact with Community F:CAMHS reported increased “joint working” but also that the service helped put referrers in contact with other agencies that could support the care of the young person. For example, one referrer described the involvement of Community F:CAMHS as having helped pull together all the information around the young person and led to a letter of support being provided to bring in a specialist neuro-psychologist.

A final mechanism described by professionals in contact with Community F:CAMHS was the **provision of training** as reflected in the secondary theme ‘training needs’. There were mixed reports from the referrers about accessing training from Community F:CAMHS, with some reporting regularly having F:CAMHS staff attend learning forums sessions:

We’ve actually got an arrangement as part of our learning and development work, we have Forensic CAMHS support us with a monthly learning forum where the service gets together and CAMHS and myself co-facilitate a learning forum around various topics depending on staff interest. So we’ve covered things from masculinity to shame to sexual offending, attachment. We cover all sorts of topics of interest really. (Referrer Phase 2)

Professionals in contact with F:CAMHS referred to training received on what F:CAMHS role and responsibilities were. Many referrers were not aware of additional training being available to them and suggested they would benefit from training on risk assessments, trauma, sexualised behaviours and working with young people with particular diagnoses, for example young people with autism spectrum disorder.

The input of Community F:CAMHS had an impact on the ‘**context**’ in which referrers were working, potentially leading to changes in outcomes. A highly populated category within context was the **accessibility and awareness of Community F:CAMHS** as reflected by, for example, the ‘awareness of the service and understanding of referral criteria’ secondary theme. As is described in more detail in the thematic analysis (see Table 10.3.2.4), across all the phases the referrers spoke about the service being easy to access and responsive to requests for support. However, over the phases there were still consistent reports of referrers only becoming aware of Community F:CAMHS by chance or hearing them being mentioned in meetings or by other colleagues. Once referrers were aware of the service, they continued to use it and continued to share their experience with other colleagues to encourage wider network awareness of the programme:

I guess it's about them being more widely known. Because I didn't really know very much about them, and then it was only because of CAMHS in [location] saying, "This young person would probably be more suitably supported through this Forensic CAMHS service, because of the risky nature of their behaviours." But yeah, I didn't really know about them, so I guess it would just be about local services in the North West region being more aware of what they can offer. (Referrer Phase 3)

Consistently over the three phases, professionals in contact with Community F:CAMHS reported **feeling more supported** as reflected by the secondary theme 'additional support and confidence'. This was a highly populated category in the framework, with referrers reporting the support from F:CAMHS as being "invaluable". For many of the referrers this support came from being more confident in their decisions around a young person's care and having expert backing with a care plan or accessing other agencies and services. In particular, the professionals in contact with F:CAMHS valued the consultancy aspect of the service and being able to call for advice and confirmation they are doing the right thing:

I think they're invaluable with this particular case and we, you know I think we yeah really positive, very very, and I feel like I can ask for advice and guidance, consultation, because you know, I'm not an expert in any of that. So, it's been really really helpful to kind of inform my knowledge whilst working with this young person. (Referrer Phase 2)

This support was also described as improving referrers **confidence to manage care and risk**. Many of the professionals in contact with Community F:CAMHS described how they had referred to the service because they were concerned about levels of risk, how to manage the young person's care, and wanted an expert risk assessment. There was a consensus that the input of F:CAMHS help facilitate teams thinking around risk, offering expertise and new perspectives on risk and how to manage this. These are described in more detail in Table 10.3.2.1. Professionals who reported referring several young people to Community F:CAMHS reported an increased confidence in managing care and risk of other young people through the 'upskilling' that followed from the training, resources and experience they had gained from F:CAMHS for previous cases.

The mechanism of change discussed and changed contexts for professionals in contact with Community F:CAMHS led to the description of positive '**outcomes**' for the young people they were working with. Table 10.3.2.3 presents in more

detail the impact of Community F:CAMHS involvement on the young people, their risk and their families. Having the support of F:CAMHS to improve interagency working and communication and increases in referrers confidence to manage care and risk resulted in **more effective help through better co-ordination of and access to support** as reflected by the secondary theme 'accessing appropriate help'. The input of Community F:CAMHS resulted in the young people receiving the support package they need, a consistency in support from all agencies they were in contact with, as well as benefitting from some direct therapeutic work with F:CAMHS professional when needed:

I think actually the massive impact was that they got a support package that they needed. So if I hadn't had the support of Forensic F:CAMHS, the hospital, I wouldn't have had any professional guidance to go on in terms of I would have had to have accepted what the hospital said. (Referrer Phase 2)

Linked to this category was referrers reporting **better experience of services**. The timely responses of Community F:CAMHS, compared to referrers experiences with other services, meant that young people could access more effective support or placements sooner, rather than referrers having to wait longer for advice and support:

It would all have been a lot more clunky. I would've done the same thing, I think. I think I would have liaised, just independently with [service]. It would have taken me longer to find them, and I think that he would probably have been in hospital for longer and he might not have been discharged. (Referrer Phase 3)

Ultimately, the mechanism of change and context resulted in the outcome of **improved mental health and wellbeing** for the child, young person, and parent/carer. Referrers described the involvement of Community F:CAMHS resulting in young people re-engaging with services, accessing appropriate placements, and diverting young people from inpatient or secure care. Table 10.3.2.3 provides further details of the improvements in young people's mental health and wellbeing.

10.3.2.2 Thematic Analysis Findings

Table 10.3.2.1 details the secondary themes, key points, and illustrative quotes corresponding to the four primary themes identified. The first primary theme, **'Referrer Experience of Community F:CAMHS'**, includes four secondary themes related to Community F:CAMHS being an accessible service with authority

and expertise and providing additional support and confidence to referrers. The second primary theme, '**Impact on network**', includes four secondary themes related to Community F:CAMHS having a role in containing the network's anxiety, facilitating thinking around care and risk management, promoting interagency working, and offering provision where needs were not met or identified. The third primary theme, '**Impact on children and young people and their parents/carers**', includes three secondary themes related to managing and improving children and young people's wellbeing and risk, supporting parent or carer wellbeing, and being instrumental in aiding children and young people and their parents/carers in accessing and engaging with appropriate help. The final primary theme, '**Recommendations**', includes three secondary themes related to recommendations for the service model, increasing Community F:CAMHS' capacity to provide more direct assessments and to co-deliver interventions, and identifying training needs within the network.

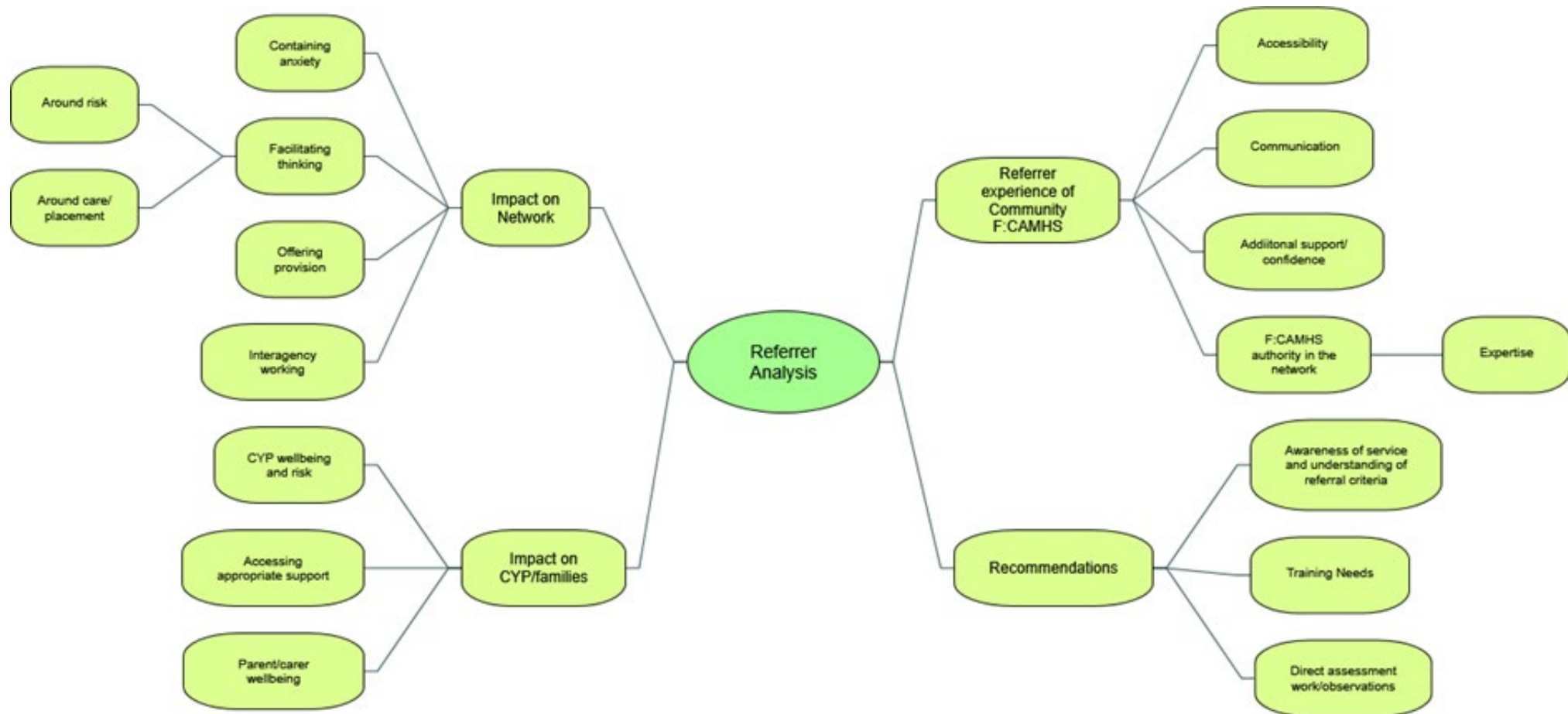


Figure 10.3.2.2: professionals in contact with the service: thematic map

Table 10.3.2.1: 'Referrer Experience of Community F:CAMHS' - secondary themes, key points, and illustrative quotes

Secondary Theme	Key points	Illustrative Quotes
<p>Accessible service</p>	<p>Referrers consistently described Community F:CAMHS as an approachable and accessible service that they could contact if and when they needed to. The referral process was generally said to be easy. Some referrers additionally described this as a refreshing and unique experience of working with a responsive service. The most noted qualities of the service were Community F:CAMHS' responsiveness, willingness, flexibility, and proactive nature, particularly in terms of getting involved at very short notice. A referrer reflected that Community F:CAMHS offering a regional service was particularly useful as it removed the need to locate and liaise with multiple services (e.g., having three in London). Another referrer shared that the experience of directly speaking to and working with a clinician from Community F:CAMHS was really helpful as there were no other channels to go through. In Phase 3, the referrers continued to describe the service as easily accessible and responsive, even with the challenges of the COVID-19 pandemic. In some cases they found it was easier to contact F:CAMHS staff by phone at this time and it was easier for</p>	<ul style="list-style-type: none"> • <i>'the referral process is really quite easy to do' (Phase 2)</i> • <i>'They were really responsive which is refreshing, because it just seems that every time you send a form off you're waiting and chasing people up.'</i> (Phase 2) • <i>'they're incredibly approachable, they're always willing to have a phone conversation, they always respond to emails' (Phase 2)</i> • <i>'the referral is so much quicker and it's dealt with properly and it's... I don't know, I just felt it was very efficient and very supportive.'</i> (Phase 1) • <i>'they've got a very low threshold for referral really, [...] they respond very quickly, within the week definitely.'</i> (Phase 1) • <i>'Absolutely brilliant. Every time I ring up and say please can I just run this case past you, I speak to a duty worker, they have a good chat with me and then they put the referral in. And it all just happens really timely, really efficiently.'</i> (Phase 3)

	clinicians to attend meetings via video call or telephone, increasing access to the service.	
Communication with Community F:CAMHS	<p>This secondary theme was added as part of the Phase 3 analysis. As well as being accessible, referrers consistently described positive communication and relationships with the Community F:CAMHS team members. Referrers described Community F:CAMHS staff showing a genuine interest in supporting them and were invested in supporting the young people. There was consistent reference to being kept informed and updated on plans, recommendations and providing helpful reports and letters. Referrers described how the Community F:CAMHS staff were always receptive to what they were saying, understanding of their level of knowledge and non-judgemental, but also good at challenging the referrers thinking and offering different perspectives.</p>	<ul style="list-style-type: none"> • <i>'I have a really good relationship with the clinicians there. So, we get on really well, I found her really helpful, she always offers really sound advice.'</i> (Phase 3) • <i>'I think they're very non-judgemental about my ignorance... But they won't judge, and they'll explain things patiently. They're open to the challenge.'</i> (Phase 2) • <i>'And I was always kept informed, always in good contact, emails, telephone calls.'</i> (Phase 2) • <i>'I've always found that they're good, active listeners. I don't feel that they rush to conclusions. I think they have a balance and a kind of adroit way of thinking which I really have valued.'</i> (Phase 3) • <i>'the communication, I have found to be very good. So keeping the school in the loop, and the parents, and it all being very open and helpful in that way.'</i> (Phase 2)
Additional support/ confidence	<p>This secondary theme was more subtle than others, whereby there was a sense that working with Community F:CAMHS</p>	<ul style="list-style-type: none"> • <i>'I think they're invaluable with this particular case and [...] I feel like I can ask for advice and guidance,</i>

	<p>increased referrers' confidence and their feelings of being supported. This seemed to be a result of receiving prompt and proportional support when the network was struggling and being part of the equation when it came to decision-making. This was also apparent in cases where referrers were reassured that they had the right plans in place for the young person. As well as confidence in having the right plans and pathways in place, referrers also mentioned increased confidence in delivering the recommendations made by Community F:CAMHS for the referrer to implement, because they knew their support would be there. The additional support was identified as being the result of the service's expertise and having an extra service involved.</p>	<p><i>consultation, because you know I'm not an expert in any of that. So it's been really really helpful to kind of inform my knowledge whilst working with this young person.'</i> (Phase 2)</p> <ul style="list-style-type: none"> • <i>'You know it gave us great confidence in where we thought we were going with him.'</i> (Phase 2) • <i>'I think it's invaluable and we couldn't have managed it. So we've managed to be able to really investigate some of the challenges within the case because of FCAMHS support and get really really expert advice really to inform our thinking and inform how we formulate longer term plans.'</i> (Phase 2) • <i>'the FCAMHS team were really helpful in helping to put things in context and attend a couple of senior meetings [...] to be able to articulate that in a better way than I can.'</i> (Phase 2) • <i>'I was actually part of the equation of decisions and helping and sorting out. So it was kind of more on a problem-solving way, rather than being done to children, done to the family, done to us.'</i> (Phase 3)<i>'Because that's how it made me feel the whole way along the process. That they were very supportive, they're easy to communicate with so that if they had certain</i>
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		<p><i>recommendations they wanted to make to me to implement I would have felt confident to be able to do that with their support.’ (Phase 3)</i></p>
<p>Community F:CAMHS as an authority in the network with expertise</p>	<p>The role of Community F:CAMHS within the network was often portrayed a service whose advice bore weight, as a result of their expertise and channels. Referrers described that Community F:CAMHS was a service that others listened to and took seriously. This was also said to hugely contribute to getting other services involved, such as CAMHS and social care, and engaging children and young people and their parents/carers. Referrers described how having Community F:CAMHS involvement and their expertise provided concrete and crucial backing to plans for young people. It was also expressed that the authority and expertise of Community F:CAMHS in the network meant that cases could progress at a faster rate and needs were identified and met more promptly. In Phase 3, referrers described seeking out the expertise of F:CAMHS when they did not know what else to do, or when agreement on pathways across agencies could not be reached. Community F:CAMHS provided objective, outside opinions and different perspectives on the risk and care management through their expertise.</p>	<ul style="list-style-type: none"> • <i>‘I took that report to social care, that’s how they got involved, on the strength of that report.’ (Phase 2)</i> • <i>‘[F:CAMHS clinician] was then the key to CAMHS, to get them as in working together in that. So often with CAMHS itself it’s really difficult to access who you need to access, but this was a kind of like a multi assessment.’ (Phase 1)</i> • <i>‘[If F:CAMHS didn’t exist] I still feel like we would be having the multiagency risk meeting, we would be having the same conversation, CAMHS needs to be involved but they won’t be and then nothing would actually get done about it’ (Phase 2)</i> • <i>‘school’s way of managing risk was different to what we were suggesting, so having the team support our decisions or our recommendations was quite useful.’ (Phase 2)</i> • <i>‘I just think that kind of level of, level of expertise was kind of helpful because you know we’re working with someone who is very experienced, has</i>

		<p><i>seen a lot of these different cases and patterns before.'</i> (Phase 2)</p> <ul style="list-style-type: none">• <i>'And I felt we would get somebody external, if you like, with the expertise F:CAMHS have just to help the network make the decision.'</i> (Phase 3)• <i>'When there are risks that are in the context of behavioural challenges and there is a difficulty within the system to be able to see clearly which bits are mediated due to an unmet mental health need and which bits are mediated due to a behavioural need that is outside of the scope of mental health, it's useful to have that clarifying lens of F:CAMHS siding one way or the other. It's just useful to get that other piece of expert thinking.'</i> (Phase 3)
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Table 10.3.2.2: 'Impact on Network' - secondary themes, key points, and illustrative quotes

Secondary Theme	Key points	Illustrative Quotes
<p>Containing anxiety</p>	<p>A significant secondary theme was the effect Community F:CAMHS involvement had on containing the anxiety of the network, even when this was confirming that the plan place was appropriate. The authority and expertise of Community F:CAMHS (see secondary theme above), and the involvement of an additional service, was said to contain anxiety. The timely response of Community F:CAMHS, also helped reduce anxiety, rather than professionals trying to support young people and families while waiting longer for other services to offer support which may not meet the needs of the young person. Calming the network down was said to create spaces where everyone could catch up and be on the same page, rather than this being crisis driven. Referrers described a sense of relief when the input of Community F:CAMHS resulted in plans being implemented successfully and children and young people and parents/carers engaging.</p>	<ul style="list-style-type: none"> • <i>'I was very worried and he took seriously what I described' (Phase 1)</i> • <i>'[we do get] some children that we are less confident about or that we need to be able to think about in terms of moving them on or whether we're doing the right things or whether there is something we're missing.'</i> (Phase 2) • <i>'I think it is really about, it's about calming people down in order that people can then plan in a way that everyone feels is the right direction and not crisis... crisis-led driven if that makes sense' (Phase 2)</i> • <i>'But it was just reassuring to have maybe additional members... clinicians kind of suggesting the same or understanding your care plan.'</i> (Phase 2) • <i>'I suppose a third opinion at that point has been very helpful in terms of kind of containing the local authority's concerns.'</i> (Phase 2) • <i>'I think that one of the big things that's always been helpful is that they have helped to calm the network down when things have got very anxious in terms of that sort of behaviour. That they have a very, what I would call, a containing function quite often, particularly the consultant psychiatrist.'</i> (Phase 2) • <i>'I think practitioners would be much more highly anxious without the immediate link to a</i>

		<p><i>Forensic CAMHS service. So I think it would be detrimental to the young people because they would have to wait so much longer for a service that might not fit their needs.’ (Phase 3)</i></p>
<p>Facilitating thinking about risk and care</p>	<p>The biggest impact on the network described by referrers was Community F:CAMHS’ function in facilitating thinking around risk management and care of the children and young people. This is also related to interagency working (see secondary theme below), as this was said to help referrers and the network understand what and why things were happening and help them move forward. This also helped bring professionals from different agencies together so they were on the same page, particularly in schools. There was a sense that this contributed to up-skilling some referrers and increased their understanding when working with children, young people with high levels of risk and need.</p> <p>In Phase 3, referrers discussed how F:CAMHS involvement and expertise allowed them to think about areas of risk they had not considered previously, but also helped prevent the over-estimation of risk and think about different ways of managing of risk that did not always include restriction.</p>	<ul style="list-style-type: none"> • <i>‘we got quite, quite a lot from that consultation in terms of thinking and understanding difficulties that young person in the family had, so it helped us with understanding and also having a better management plan.’ (Phase 2)</i> • <i>‘I think it’s just working with the F:CAMHS team has really informed my practice and knowledge of working with the young person with this high level of needs.’ (Phase 2)</i> • <i>‘I think it helps risk manage the concerns that were from school. They weren’t dealing particularly well with the issues for that young person and having FCAMHS on board helped us explaining to the school the difficulties that a young person with forensic CAMHS needs had from a forensic CAMHS perspective.’ (Phase 2)</i> • <i>‘I suppose it just helps to put stuff in context. Because like I said, what happens with risk is people go, “Oh my gosh, we’ve got to restrict this, we’ve got to stop this.” And that doesn’t always reduce risk. You have to be open to looking at it from different perspectives.’ (Phase 3)</i> • <i>‘So it was hugely beneficial in terms of understanding what the risk actually is and what the likelihood is. I think people outside of that clinical world can massively overestimate risk based on behaviour that – having Forensic CAMHS</i>

<p>Interagency working</p>	<p>A significant strength of Community F:CAMHS was their role in liaising with the network and <i>'pulling services together'</i> (Referrer). There was a sense that working with Community F:CAMHS supported and promoted interagency working practices and a team approach, bringing professionals together in the interest of the children and young people. This was also true for keeping the referrer involved, with one referrer describing the work as <i>'a dialogue'</i> (Referrer). In particular, it was noted how helpful having Community F:CAMHS on board was for including schools and families in discussions and for communication generally.</p>	<p><i>input, in terms of likelihood and what it would actually be, is very helpful.'</i> (Phase 3)</p> <ul style="list-style-type: none"> • <i>'it's been a kind of team approach across from the agencies plus from parents working with us.'</i> (Phase 1) • <i>'I think there would have been work from a professional network [...] but I felt that having FCAMHS involved facilitated that in a way.'</i> (Phase 2) • <i>'they also do a lot of communication with networks, so actually logistically it helps.'</i> (Phase 1) • <i>'it's joint working. It's very multiagency, it's very joined up thinking. [...] we've got a kind of a plan that we're all trying to deliver together.'</i> (Phase 2) • <i>'I think that that kind of pulling together of all various services and looking at sort of things from multidimensional, I think that that's what they're really good at doing.'</i> (Phase 2) • <i>'that needed us to put more support in place with dad and the family, and [F:CAMHS Staff] helped me with that support. Not actually providing it, but in helping bring people together like Probation and Youth Offending Team and Early Intervention Team and Social Services.'</i> (Phase 3) • <i>'it's just encouraged discussion between us and the partner agencies in terms of level of risk- are we all comfortable managing this risk?- and as it results, we all agreed we were probably not comfortable managing this risk. That directed us in</i>
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		<p><i>a more joined-up approach in terms of care planning for this young person.’ (Phase 3)</i></p>
<p>Offering provision</p>	<p>There were frequent reports of referring to Community F:CAMHS because other services had previously failed to identify and meet the needs of children and young people. This related not only to children and young people being discharged from CAMHS for example, but also where other services (e.g., neuropsychology) needed to be involved and required a report from Community F:CAMHS to facilitate this. When asked about what would happen if Community F:CAMHS were no longer available, professionals in contact with the service spoke about the difficulty of accessing meaningful help from CAMHS and other services and this being ‘<i>luck of the draw</i>’ (Referrer, Phase 1). One referrer also spoke about a third sector service which, although they may have been able to, did not identify any other routes to accessing support for the assessment that was required. Community F:CAMHS’ capacity to be thorough and their expertise appeared to result in more successful and tailored approaches, which were more suitable for each young person and their families/carers.</p>	<ul style="list-style-type: none"> • <i>‘[If F:CAMHS didn’t exist] I guess that we would refer them to CAMHS. But, you didn’t always get somebody with the right kind of expertise for this particular cohort of children, and sometimes you’d be caught in a long waiting list. So, it was much more difficult. But, and, it was much more sort of luck of the draw. You know you might get somebody who knows about these kinds of children or you might not.’ (Phase 2)</i> • <i>‘So in the past, we tried to get CAMHS to work with this young person, had just gone round in circles really, we haven’t got anywhere [...] they kind of said ‘oh we’ll do bits of stuff with him,’ and then it just faded out and nothing actually happened, nothing meaningful for that young person’ (Phase 2)</i> • <i>‘So far the, despite you know a lot of clinicians being involved, they have not succeeded, but it seems that actually what they do need is what they’re getting now.’ (Phase 2)</i> • <i>‘it’s always been felt that none of the interventions we’ve provided have been intense or successful enough’ (Phase 2)</i> • <i>‘Because I think he had been assessed by CAMHS and I don’t think that CAMHS had kind of pulled together the physical as well as the emotional things. And although FCAMHS didn’t actually go on to do a full assessment, I then have got like a ticket into sort of neuropsychologists for this young person.’ (Phase 2)</i>

		<ul style="list-style-type: none">• <i>'Because if F:CAMHS hadn't said we need this, this child needs this plan doing, we would never have... I didn't even know it was a thing that the learning disabilities team did, but because F:CAMHS made the recommendation, we were able to access it.'</i> (Phase 3)• <i>So, the first time [they accessed Community F:CAMHS] was with a young person who the multi-agency team just did not know what else to do with. He didn't meet thresholds for social services' statutory involvement and assessment. And CAMHS were saying there was nothing more that they could do, because they had diagnosed this young person with an attachment disorder ... And then [Community F:CAMHS Staff] came and did the assessment for that young person, and they wrote a fantastic report... And it all contributed to this young person actually got an EHCP based on some of the work that was done by F:CAMHS.'</i> (Phase 3)
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Table 10.3.2.3: 'Impact on children, young people, and parents/carers' - secondary themes, key points, and illustrative quotes

Secondary Theme	Key points	Illustrative Quotes
<p>Child and young person wellbeing and risk</p>	<p>Referrers frequently described the difficulty in measuring direct impact of Community F:CAMHS on children and young people's wellbeing, particularly in Phase 3 where there had been limited direct work with the young people and their families due to COVID-19 restrictions. However, referrers shared that a more consistent professional network would result in a better service experience for children and young people, promoting their engagement and wellbeing. Other referrers described their learning, as a result of working with Community F:CAMHS, impacting the support that they could provide. The up-skilling and resource sharing was said to have a ripple effect helping other children and young people too. Advice and consultations on one case, supported the planning and management of care for other young people in the service. The referrers who had heard feedback from Community F:CAMHS' direct work with children or young people described that they opened up to Community F:CAMHS clinicians and felt listened to. One referrer also described an example of when a young person's symptoms reduced since the involvement of Community F:CAMHS.</p> <p>On several occasions, the impact on children, young people was said to be the result of consistency in the network's approach and understanding. In regards to risk, there was a consensus that although risk did not necessarily substantially reduce, the risk management plan put together with Community F:CAMHS involvement was more consistent and</p>	<ul style="list-style-type: none"> • <i>'I think that there's been an element of containing professional anxiety, which does probably help the children, young people in terms of doing a clear, clearer strategy of professionals moving forward, which means that I guess there's just a clearer plan of support.'</i> (Phase 2) • <i>'that had a bit of an impact on that particular child but also a huge impact on a whole range of other children that we've had. [...] I'd say that's had ripples across lots of other children.'</i> (Phase 2) • <i>'when she talked to FCAMHS she felt really that [...] FCAMHS are taking her seriously and we are taking seriously'</i> (Phase 2) • <i>'the symptoms of this girl were slowly slowly reduced. So she almost doesn't display any symptoms of harm to others.'</i> (Phase 2) • <i>'I mean it is a very complex case with very high-level risks. But yes it certainly has [reduced risk]. And that's kind of just from things like consistency of the worker, consistency of consultation with the FCAMHS kind of head line manager and stuff.'</i> (Phase 2) • <i>'[If F:CAMHS didn't exist] it would've taken us longer I think, children's social care to kind of</i>

	<p>robust. Several referrers noted that Community F:CAMHS' involvement resulted in risk being lowered, both as a result of consistency in the network and an increased understanding of the young person's risks and needs.</p>	<p><i>understand the complexities of the case. And it would've increased the risks because it's vital that they're involved because of this young person's range of, level of need.'</i> (Phase 3)</p> <ul style="list-style-type: none"> • <i>'So, they did a mental health assessment with a young person who was in custody at the time. And I think helped the placement that he went on to, to understand his level of risk. And what could be put in place to reduce that risk and to minimise instances where he might be triggered and his anger flare up.'</i> (Phase 3)
<p>Accessing appropriate help</p>	<p>Referrers discussed that Community F:CAMHS had a significant impact on children and young people accessing appropriate help, ranging from a more suitable educational placement, diversion from secure services, or simply better engaging with services and interventions. Community F:CAMHS was described as having a key role in identifying the most appropriate placements for children, young people, including educational or residential placements. Two referrers discussed that Community F:CAMHS was instrumental in diverting children and young people from inpatient services or home treatment teams. One referrer described that the involvement of Community F:CAMHS meant that the therapeutic relationship was repaired and the young person received consistency in care. Community F:CAMHS was described as being very helpful during transitions, <i>'identifying appropriate placements and supporting at that transition process'</i> (Referrer). Community F:CAMHS' authority in the network and expertise resulted, in some</p>	<ul style="list-style-type: none"> • <i>'enabled to get him a safeguarding level and engaging in others services, to basically stop him from being criminalised.'</i> (Phase 2) • <i>'I'd been able to maintain a relationship with the patient who otherwise I think the relationship would have broken down.'</i> (Phase 1) • <i>'I think with the one child, it really helped to find—to know what sort of school to go for and then to find one. I think he did go to the school that was recommended or suggested by the forensic psychiatrist.'</i> (Phase 2) • <i>'it's impacted my practice when I'm working with the young person because I just have a better understanding of being informed of strategies and how things should be managed with this young person with these particular needs. So, and in turn, the young</i>

	<p>cases, in other agencies being involved (see secondary theme in table 10.3.2.2). This was described as enabling safeguarding processes to be set up and as avoiding the child from being exploited and criminalised. Furthermore, in another case, Community F:CAMHS provided an assessment and diagnosis of and medication for attention-deficit and hyperactivity disorder, which provided the network, the child, and their family/carers respite.</p>	<p><i>person has received a more consistent level of support.’ (Phase 2)</i></p> <ul style="list-style-type: none"> <i>• ‘we would’ve needed further consultation with perhaps the home treatment team and perhaps considered that option to support the young person while they were in crisis and actually using FCAMHS service stopped us from needing to do that. We were able to manage the young person in the community. So it was a really good support network really for that young person to prevent them from needing home treatment or needing inpatient.’ (Phase 3)</i>
<p>Parent/carer wellbeing</p>	<p>Referrers expressed that Community F:CAMHS also had a role in containing the anxiety of parents and fosters carers. Referrers described that parents or carers, as a result of Community F:CAMHS, were being heard, included, and understood. One referrer shared that Community F:CAMHS’ work also resulted in parents and carers having a better understanding of what was going on for their child. In some cases, the impact on the families’/carers’ wellbeing was also discussed, with one referrer stating that <i>‘family are now thriving’</i> (Referrer) and another sharing that the family are now <i>‘getting the right level of support’</i> (Referrer). One referrer also expressed that the care plan developed with Community F:CAMHS meant that the family, as well as their child, were engaging more with services and were <i>‘more optimistic’</i> (Referrer).</p>	<ul style="list-style-type: none"> <i>• ‘The family are now thriving with more pro—they’re dealing with the problems better, but they also have an understanding of the problems much better. So that’s helping them deal with it.’ (Phase 1)</i> <i>• ‘also working really well with the parents and we were all working as a team and everything was kept within the arena of everybody being involved and knowing what was going on.’ (Phase 1)</i> <i>• ‘so it’s been enormously helpful because now the family we’ve been struggling with for a long time are getting the right level of support, of quite intense support. So it’s a massive relief for us, for me and for I think for the clinic [...] it seems that they are</i>

		<p><i>going to get what they really need now.'</i> (Phase 2)</p> <ul style="list-style-type: none"><i>• 'somebody was actually beginning to understand that it was far more difficult [for the young person and their parent/carer] than just to visit anger management'</i> (Phase 2)<i>• 'I would say the family are engaging a lot more with professionals on a meaningful basis as is the young person. He still does have issues around sort of around managing his anger, his emotions, but I think that they're kind of a bit more optimistic.'</i> (Phase 2) <ul style="list-style-type: none"><i>• 'So, I think it provided reassurances to the young person and his family that people from his locality cared about him and were interested in him and were thinking about is post-hospital treatment.'</i> (Phase 3)<i>• 'it [F:CAMHS involvement] also gave the parents a bit of reassurance and it made them feel valid and heard, and listened to. That actually this isn't you being a bad parent, which is what their experience of services had been before; it's just parenting issues.'</i> (Phase 3)
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Table 10.3.2.4: 'Recommendations' - secondary themes, key points, and illustrative quotes

Secondary Theme	Key points	Illustrative Quotes
<p>Awareness of the service and understanding of referral criteria</p>	<p>During Phase 3 it was identified that many referrers had come to hear of F:CAMHS by chance or through a colleague that had used F:CAMHS. Many commented that it would be helpful if Community F:CAMHS was more widely known across the network. Once they had been in touch with the service, many referrers then continued to use and advice the use of Community F:CAMHS.</p> <p>Referrers spoke about wanting to know more about what Community F:CAMHS offers and how it assesses risk, so that they can for example, understand <i>'whether a child sort of reaches a threshold where it's actually worth referring them or whether the way we're managing it is the right way to do it'</i> (Referrer).</p> <p>Some referrers also suggested there could be greater understanding of what direct work Community F:CAMHS can do with young people, as well as a greater understanding of what types cases could be referred to Community F:CAMHS.</p>	<ul style="list-style-type: none"> • <i>'the only thing I'd say is, until I came into contact with F:CAMHS, I didn't really know that it even existed, and I think a lot of these services are... it would be useful to know what's out there and exactly what their remit is.'</i> (Phase 2) • <i>'it's really unnerving how many people don't know about F:CAMHS, have never heard about them. And I sort of shout it to everybody; just ring them and ask them for some help, they'll help you.'</i> (Phase 3) • <i>'I didn't really know about them, so I guess it would just be about local services in the region being more aware of what they can offer. (Phase 3)</i> • <i>'It was also helpful just to get a sense of what their role would be and I think that encouraged me to kind of think about referring to them when I have these cases.'</i> (Phase 3)
<p>Direct assessment and interventions</p>	<p>When asked about recommendations for improving the service, multiple referrers expressed a desire for Community F:CAMHS to have more capacity for direct work and to be more involved in the delivery of recommendations in cases. This also</p>	<ul style="list-style-type: none"> • <i>'it might be quite useful to have input clinically with the young person as well'</i> (Phase 2) • <i>'The only thing I said like before is maybe some more work clinically with the children, young people might be</i>

<p>included Community F:CAMHS co-delivering interventions and assessments, and actioning some of their recommendations to share the responsibility. It was also suggested that it would be helpful for the teams to expand to have more capacity for members of staff to co-locate, for instance in schools, or have more local teams. One referrer also mentioned receiving different approaches from different team members and correspondingly, was unsure what the thinking behind this was and expressed that a more uniform approach could be helpful. While many professionals appreciated the consultancy aspect of F:CAMHS, one referrer suggested the balance between consultancy and direct work had tilted more towards consultancy.</p>	<p><i>useful, or even offering some workshops with children, young people or something and understanding where their anger et cetera comes from and why they are aggressive and violent.'</i> (Phase 2)</p> <ul style="list-style-type: none"> • <i>'I felt that no matter what the recommendations of FCAMHS, eventually it was our responsibility to look after and care for this young person. Yes, I felt that there was very minimum input from the consultant psychiatrist of FCAMHS'</i> (Phase 2) • <i>'I think the amount of people that they've got working for them stretches over a wide area. I think maybe to employ more people to work within the service. And have the service in all schools.'</i> (Phase 2) • <i>'their approach all seems really really different. All really useful in different kind of ways, and it's not clear to me whether when we refer and they're allocated to different ones, whether that's thought through, knowing the different team styles and ways of working'</i> (Phase 2) • <i>'I suppose it's just understanding the variation of how it's gone from a year and a half ago. A really proactive service that took on a lot more face-to-face work, even if it was just assessments. It has gone to a very consultative, we will only write reports</i>
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		<p><i>and for the professional network.'</i> <i>(Phase 3)</i></p>
<p>Training needs</p>	<p>Most referrers expressed that they would like to receive training from Community F:CAMHS if it were offered and would be interested to know what type of training could be offered. Other services described currently having robust teams and did not identify any training needs. The training areas identified revolved primarily around increasing understanding of autism and risk, attachment, assessing children, young people's mental health needs and signposting, forensic mental health generally, risk management and deviant behaviour, management of sexualised behaviours and sexually inappropriate behaviours, complex case formulation, and gang affiliation. Some referrers spoke about having received training from Community F:CAMHS on their service model and what they provide, which was received very positively.</p>	<ul style="list-style-type: none"> • <i>'I think people are a little bit anxious about forensic issues and they don't know a lot about that' (Phase 2)</i> • <i>'we do have a lot of children with neurodevelopmental difficulties, especially autism spectrum disorder, and they talk up to this say they have an obsession with knives or they talk about having thoughts about wanting to hurt other people. So managing that kind of risk is, it would be useful to have a bit of training around it.'</i> (Phase 2) • <i>'The one thing that really sticks out for us would be around management of people with autistic spectrum disorders and Asperger's in the community, so how to manage behaviours that are deemed risky, because that's their focus. So you know, if someone with autism has an obsession with guns, and so therefore they focus on that and they talk a lot about it and they do a lot of research about it, that sort of thing makes local services and the police quite edgy. [...] So just ways about how to manage the risk around that.'</i> (Phase 2) • <i>'We've had a little bit of training on attachment, from the F:CAMHS team as well... They came into the home, they created a pathway, we discussed through it with the team... Yeah, it was helpful.'</i> (Phase 3)

10.3.3 Detailed children, young people, and parent/carer qualitative findings

The first stage of analysis of the interview data comprised of a Framework Method¹⁵, whereby the researchers and clinicians in the Evaluation Team and Steering Group collaboratively derived an analytical framework. This was derived using a combination of the logic models for the evaluation (see Methods) and 'if...then' statements (see Economic Evaluation), which conceptually follow the journey of a child or young person and/or a clinician through their contact with a Community F:CAMH service. The analytical framework comprises 'Context', 'Mechanism', and 'Outcome' as overarching categories. Within the overarching categories, primary categories were derived through the consideration of the mechanisms for example, or elements of the programme that will lead to changes in the context and thus, changes in the outcomes of children, young people. The transcriptions from the interviews ($N=2$ children and young people and $N=5$ parents/carers from Phase 1; $N=2$ children and young people and $N=11$ parents/carers from Phase 2 and $N=1$ child/young person and $N=3$ parents/carers from Phase 3) were then analysed and organised into the aforementioned categories, in a process of coding the data into the primary categories.

The second stage of analysis was a Thematic Analysis¹⁴ of the data that had previously been coded into the primary categories using the framework method. The data organised within the primary categories was revisited, one category at a time, and secondary themes were derived through a process of coding the data and identifying themes within it. Alongside the process of analysing the Phase 3 interviews, some existing themes were amalgamated. This was done through a process of reviewing the themes and assimilating the data. Where the themes were revisited and refined, this was part of the usual iterative stages of thematic analysis¹⁴.

In particular, as an overall step, the existing themes were revisited, with a view to presenting the final themes based on all the data to date. Sometimes the decision to amalgamate or to rename themes was driven by new Phase 3 data, but for the most part, this was based on the data in its entirety, where the existing themes reported on in the Interim Findings Report were interim themes. Some of the existing themes contained little data, which we anticipated may have been supplemented with additional data, but throughout this process, on balance with the overall amount of data within the primary category, the decision was made to amalgamate some themes with little existing data. A concrete example of this revision process is where the secondary theme, 'Medication' was subsumed by 'Quickly Identifying and Addressing Difficulties' (note: there is a separate theme in 'Improving mental health and wellbeing' on 'Medication'). This decision was made because even with the inclusion of Phase 3 data supporting the medication theme, there was little data in this theme overall compared to other themes, and therefore more weight was being given to it that perhaps was warranted. In addition, when the examples in the medication theme were revisited, they all seemed to be pertaining to the sense that medication was central to this wider sense of quick identification and addressing needs in an appropriate way. At this stage, additional themes were also created from the Phase 3 data. The amalgamated and new themes are outlined below.

Tables 10.3.3.1, 10.3.3.2, and 10.3.3.3 detail the overarching categories, primary categories, and secondary themes, along with illustrative quotes for each of the secondary themes. In the Initial and Interim Findings reports, we presented the secondary themes consisting of the largest proportion of the data. However, because the present analysis is the full analysis on

all child/young person and parent interview data collected for the evaluation, we present all secondary themes in full below.

From the Phase 2 recruitment numbers outlined above, there were 5 interviews (4 interviews conducted with 5 parents and 1 child/young person interview) which were conducted in February, the analysis of which was not included in the Interim Findings Report. Thus, the analysis of those interviews has been incorporated in the updated Phase 2 findings for this report.

10.3.3.1 Mechanisms of Change

Within the primary category '**Greater Interagency Communication and Understanding of the Collective Task**', four secondary themes were derived from the data:

'Communication', 'Family Needs', 'Too Many People Involved' and 'Working Together', as outlined in table 10.3.3.1. Two new themes were derived from the analysis of the additional Phase 2 data, namely, 'Family Needs' and 'Too Many Professionals Involved'. The Phase 3 data analysed within this primary category was mainly organised into the 'Working Together' secondary theme.

The primary category: 'Staff: consideration of YP's own story' had been previously analysed. During the revision process, all data that was previously organised in this category was recoded into either 'Greater interagency communication and understanding of the collective risk' or 'Reduction in risk, harm or offending'. This comprised of four quotes from parents/carers and children/young people. Part of the decision to do so was the reflection of the small amount of data within the overarching primary theme, which would have become further diluted into thin secondary themes.

The most highly populated secondary theme was, '**Communication**', which was mixed in the previous Phase 1 data analysis, in terms of some parents/carers expressing that they had to manage some of the communication between services themselves, whilst other parents/carers and children/young people discussed the Community F:CAMHS teams adopting this role, with clear lines of communication. For example:

I felt that they would know what they should be doing...they would have clear lines of communication between different services [...] and so I had to do that myself. (Parent Phase 1)

They chased that on my behalf, without me having to go to the school and say, "Alright can you give me the information, or email it to CAMHS" or whatever. (Parent Phase 1)

They were really clear and open about what they were doing...they explained and made sure I was comfortable with what they were gonna do. (Child/Young Person Phase 1)

However, when exploring the data from Phase 2 and Phase 3 interviews within this secondary theme, there seemed to be a move towards more joint up communication, for example:

He's been very good at protecting us, in terms of when people have said we need to get social services to go in, [professional's name] has always said you don't need to have the conversation with them, I will give them the case file and provide them with everything they need to know, so you don't have to go through it. (Parent Phase 2)

And they kept the doctor involved, they kept the school involved, as well as having their opinion. They kept everybody, as well as his dad that they didn't meet [...] they sent forms to his dad to keep him involved in the whole situation. We were all in contact with each other, so everybody knew what was going on. (Parent Phase 3)

'Working Together' was the next most highly populated secondary theme. Within this theme, parents discussed the value of the Community F:CAMHS teams being able to take a leading role in ensuring the teams around the child/young person are working together effectively:

[...] to be there to mop up if he gets it wrong with the team around him.
(Parent Phase 3)

[...] think with F:CAMHS the best thing is that they kind of pull everyone together. They'd come to a lot of the school meetings. Although I wouldn't say they worked directly with us, I'd say they were more the middle person pulling everybody together [...] it was not only the school, but it was them bringing in the residential side, bringing in all sorts of areas, but he was the main man dealing with everybody, trying to put everyone together. He was the main voice, and that helped a lot. (Parent Phase 3)

In addition, there was a sense that the Community F:CAMHS teams were also working together with the families, for example:

F:CAMHS have definitely joined the dots. So they look at the bigger picture and they do their research, they look through the notes, they often refer back to conversations we have had. Which is actually quite reassuring because for us we then go, ok so you have remembered that [name] has a sister and that last time we spoke about. (Parent Phase 2)

Within the secondary theme, '**Family Needs**', which was derived from the additional Phase 2 interviews analysis, parents/carers expressed how they felt the Community F:CAMHS teams are able to take the specific and individual needs of the families into consideration. This was sometimes in favourable comparison to the services the families had been in prior touch with, for example:

I think they definitely join the dots, and they definitely look at things, not only from a clinical point of view, but a very holistic point of view as well, in terms of what the family needs, what siblings need, what [CYP] himself needs. So they I think have got a very good, solid knowledge of the family, where other services that we've had experience with, they just don't have that. (Parent Phase 2)

Finally, within the secondary theme, '**Too Many People Involved**', which was also derived from the additional Phase 2 interviews analysis, parents/carers expressed how they felt that there were incidences when there were too many professionals involved; their suggestions were to have fewer professionals involved with the child/young person as possible to enable relationships to be built. For example:

I guess just not being so many people involved in just trying to keep it to a minimum like one to two people or it does get a bit repetitive and... it's not obviously really enjoyable but it takes the kind of willingness to want to go there away from going to the sessions. (Parent Phase 2)

Within the primary category '**Improved Multi-Disciplinary Team Working**', three secondary themes were derived from the data: 'Effective Multi-Disciplinary Working', 'Lack of Multi-Disciplinary Working' and 'Supported in Work Across Teams', as outlined in table 10.3.3.1. None of the Phase 3 interviews analysed were in this primary category. Outlined below is the updated Phase 2 data analysis. The previously derived theme, 'Increased MDT and sense of things getting better', was subsumed into the 'Effective Multi-Disciplinary Working' secondary theme and a new secondary theme: 'Lack of Multi-Disciplinary Working' was derived from the updated Phase 2 analysis.

The most highly populated secondary theme was '**Supported in Work Across Teams**' which was derived from discussions with parents/carers about their perception of being supported by the Community F:CAMHS teams to help them by holding the communication and therapeutic work across teams. For example:

[Professional's name] met him a few times in clinic, and he's also attended meetings mostly at the new school which he's at. And he's keeping in contact with the new school, so he's not dropping [CYP]'s case while he's there

because he's aware there may be turbulence and that he will need that support from CAMHS. Yeah, he's very supportive. (Parent Phase 2)

The secondary theme, '**Effective Multi-Disciplinary Working**' is closely related to the 'Supported in Work Across Teams', but rather referred specifically to the team around the child/young person working together effectively to help things to progress, for example:

We had an all agencies meeting -At [CYP]'s school that he was at that time. And [Staff] came along to... he'd read [CYP]'s reports and everything, and he came along to the meetings. (Parent Phase 2)

Young people sometimes expressed a sense of things improving once Community F:CAMHS teams were involved, for example:

[Interviewer: And do you feel they could have worked together in a better way?] When F:CAMHS were involved? [...] Not really. That's when it started to – to get better. (Child/Young Person Phase 1)

Finally, the secondary theme, '**Lack of Multi-Disciplinary Working**', derived from Phase 2 data only, encompasses parents'/carers' perceptions that the teams around the child/young person were not working together in an effective way, in contrast to the 'effective MDT working' theme. For example:

[Interviewer: do you feel like different agencies are working together to create a care plan for [CYP]? Not all of them. (Parent Phase 2)

[Interviewer: do you feel like different agencies are working together to create a care plan for [CYP]? No. (Parent Phase 2)

Within the primary category '**Staff: Clear Support and Confidence to Manage Risk**', five secondary themes were derived from the data: 'Communication', 'Effective Management of Situation', 'Knowledge, experience and training', 'Trust' and 'Understanding the Young Person', as outlined in table 10.3.3.1. Two themes that had been identified in previous analysis were amalgamated with two other existing themes, namely, 'Individual' was subsumed into 'Understanding the Young Person' and 'Taken Seriously' was subsumed into 'Effective Management of the Situation'. The Phase 3 data analysed within this primary

category was mainly organised into the 'Knowledge, Experience and Training' secondary theme.

The most highly populated secondary theme was '**Knowledge, Experience and Training**'. This theme related to perceptions that Community F:CAMHS teams were evidencing high quality training, experience, and knowledge to help children, young people and their families. All of the data in this theme was positive. There was a sense that the quality of the knowledge, experience, and training of Community F:CAMHS staff members was enhanced, compared to other services the families had been in contact with. For example:

All of the experience, knowledge and his own reputation, it really gives more of a professional look on it and the advice he gives might not be in the standard advice and training that other services get. (Parent Phase 1)

When they got involved and we started to understand a little bit more, and I felt a bit more supported. (Parent Phase 2)

Parents/carers also discussed the importance of the knowledge and experience of Community F:CAMHS teams 'stepping in' to provide management and clarity in the situation, for example:

What you find is everyone has their own opinion, so you've then got everyone's opinions, and that's very difficult, when everyone's trying to self-diagnose [...] you know, giving their ideas, they're all, "Oh, I think this" and "I think that". And you need someone who is professional and trained and qualified to step in. But he was there for our son as much as anybody. It was very much his voice that was heard, which was good. (Parent Phase 3)

The next highly populated secondary themes within '**Staff: Clear Support and Confidence to Manage Risk**' were both '**Communication**' and '**Understanding the Young Person**' which are likely to go together. The data within the '**Communication**' theme was all positive and related to the sense that communication from the Community F:CAMHS teams was of good quality. Parents/carers discussed how prompt Community F:CAMHS teams were at returning emails and phone calls, which helped the parents/carers to feel supported. For example:

[Name] always included me in emails...there were professional meetings which obviously I'm not included in as a parent, and that any information was communicated that could be. And that's where I'd asked for help from

[name], he always replied. And he was very prompt in supporting us. (Parent Phase 2)

There was a sense that Community F:CAMHS teams were effectively managing risk through retaining good communication with all parties involved, and providing the relevant information to families. For example:

Yeah, if I email them, they get back to me straight away, if I've got any concerns or I need to talk something over because there's been a development, they're very proactive in getting back to me within the same day. Within a few hours, to be honest. (Parent Phase 3)

That's how important they were to me at the time. 100%. And they give me so many helplines and support group information in my local area that they had researched that nobody had given me before. (Parent Phase 3)

The data within the '**Understanding the Young Person**' secondary theme was also largely positive and related to the sense that the Community F:CAMHS teams had a good understanding of the child or young person. One of the strongest indications within this theme was that the staff were able to better understand the child or young people, in a way that the families had not experienced before, and that this then promoted the sense of receiving truly individualised support. This was particularly pertinent from the Phase 3 interviews. For example:

I couldn't fault them. 100% I couldn't fault them. I don't know what the process is to match you with the right person at the beginning, but it obviously worked, because [name] and our son gelled very quickly, he was very good, he knew how to connect with our son terribly quickly – and that's not an easy thing. And he just made it very a bespoke, tailor-made package to our son. (Parent Phase 3)

This sense of being treated like an individual had also been expressed by the children/young people interviewed in previous data collection phases, for example:

How well he [...] knows me has really helped build a picture of – a true representation of how I've progressed. (Child/Young Person Phase 1)

And this theme was also evident in the previously derived secondary theme 'Individual', which, due to the small amount of data within it, was subsumed into this theme. An example quote from the 'Individual' secondary theme, now coded into 'Understanding the Child/Young Person' is:

With my experience of normal CAMHS, it just felt like I was a name on a spreadsheet. But F:CAMHS generally do treat you as a human – as an individual human, rather than just a name on a spreadsheet. (Parent Phase 1)

However, there was also an underlying sense from the Phase 2 interviews that at times, the Community F:CAMHS teams were not able to take enough time to get to know the children and young people, for example:

Maybe if they could have stayed for a little bit longer, they would have seen her unravel a little bit and see what she's really like, rather than just an hour's appointment. (Parent Phase 2)

Yet, this concern was only evident in the Phase 2 data and was not identified in the Phase 3 interviews.

The '**Effective Management of Situation**' secondary theme is concerned with the Community F:CAMHS teams' ability to efficiently manage the care of the child/young person, including co-ordinating multi-agency input. This secondary theme contained positively framed data and there was some indication that the input of the Community F:CAMHS teams, including their oversight and management of various elements of the child/young person's care, had made a significant difference to outcomes, for example:

He's kind of stayed in the background and helped out with everything. And phoned in to all of the meetings. And has just generally been there helping with everything. (Parent Phase 1)

[Name] was amazing, he could see that this child wasn't off the rails and a juvenile delinquent and was able to erm, allow us to keep [young person] at home and ultimately try and make him stay in [region] so I didn't – my perception of what I thought it was going to be like was different to how it was, and the support that we got was just what we needed at the time we needed it. (Parent Phase 2)

There was also a sense of the Community F:CAMHS teams 'holding' the case; providing the relevant support to the parents/carers and families and enabling them to almost step back, to allow the Community F:CAMHS staff to assist them to move forward. For example:

He's kind of stayed in the background and helped out with everything. And phoned in to all of the meetings. And has just generally been there helping with everything. (Parent Phase 1)

It's very hard to let go, because all you want to do is just wrap them up in cotton wool. But they've been very supportive in helping me let go. (Parent Phase 3)

There was also the sense that children, young people and their families felt as though they could '**Trust**' Community F:CAMHS teams to lead this work and effectively manage the child or young person's care. Within this secondary theme, there was a sense that families felt able to trust the Community F:CAMHS staff in ways that may have not been possible before. For example:

I trust the staff in F:CAMHS more than normal CAMHS. (Child/Young Person Phase 1)

I absolutely trust them, yeah. (Parent Phase 2)

10.3.3.2 Mechanisms of Change: Distance travelled across data collection Phases

The Phase 3 data analysed within the '**Greater Interagency Communication and Understanding of the Collective Task**' primary category was mainly organised into the 'Working Together' secondary theme. This was where parents/carers and children/young people expressed that they felt that the teams around them were working together effectively; this was often described as being co-ordinated by the Community F:CAMHS teams. Through the Phase 1 analysis, a sense of disjointed communication across agencies had been expressed, with parents/carers taking on the co-ordination of this communication between agencies themselves. However, the analysis of the data from Phase 2 and Phase 3 interviews within the 'Communication' secondary theme, demonstrated a move towards more joint up communication. This movement towards more joint up working was also evidenced by the data in the 'Lack of Multi-Disciplinary Working' secondary theme, which was derived

from Phase 2 interviews and no Phase 3 data. This may suggest that the children/young people and parents/carers interviewed in Phase 3 did not perceive there to be a lack of Multi-Disciplinary working.

Further, the Phase 3 data analysed within the primary category '**Staff: Clear Support and Confidence to Manage Risk**' was mainly organised into the 'Knowledge, Experience and Training' secondary theme, where parents/carers expressed the importance of the knowledge and experience of the Community F:CAMHS teams, which was often expressed in favourable comparison to other agencies. This was linked to the 'Understanding the Young Person' secondary theme, which related to the sense that the Community F:CAMHS teams were able to better understand children/young people, and that this then promoted the sense of receiving truly individualised support. This was particularly pertinent from the Phase 3 interviews. Where there had been an underlying sense from the Phase 2 interviews that at times, the Community F:CAMHS teams were not able to take enough time to get to know the children and young people. This concern was not evident in the Phase 3 interviews.

Table 10.3.3.1: Mechanisms of Change – primary categories, secondary themes, and illustrative quotes

Primary Category	Secondary Theme	Illustrative quotes
<p>Greater Interagency Communication and Understanding of the Collective Task</p>	<p>Communication</p>	<ul style="list-style-type: none"> • <i>'I felt that they would know what they should be doing [...] they would have clear lines of communication between different services...and so I had to do that myself'. (Parent Phase 1).</i> • <i>'They chased that on my behalf, without me having to go to the school and say, "Alright can you give me the information, or email it to CAMHS" or whatever.'</i> (Parent Phase 1). • <i>'They were really clear and open about what they were doing [...] they explained and made sure I was comfortable with what they were gonna do'. (Young Person Phase 1).</i> • <i>'He's been very good at protecting us, in terms of when people have said we need to get social services to go in, [professional's name] has always said you don't need to have the conversation with them, I will give them the case file and provide them with everything they need to know, so you don't have to go through it.'</i> (Parent Phase 2). • <i>'And they kept the doctor involved, they kept the school involved, as well as having their opinion. They kept everybody, as well as his dad that they didn't meet [...] they sent forms to his dad to keep him involved in the whole situation. We were all in contact with each other, so everybody</i>

		<i>knew what was going on.'</i> (Parent Phase 3).
	Family Needs	<ul style="list-style-type: none"> <i>'I think they definitely join the dots, and they definitely look at things, not only from a clinical point of view, but a very holistic point of view as well, in terms of what the family needs, what siblings need, what [CYP name] himself needs. So they I think have got a very good, solid knowledge of the family, where other services that we've had experience with, they just don't have that.'</i> (Parent Phase 2).
	Too Many People Involved	<ul style="list-style-type: none"> <i>'I guess just not being so many people involved in just trying to keep it to a minimum like one to two people or it does get a bit repetitive and [...] it's not obviously really enjoyable but it takes the kind of willingness to want to go there away from going to the sessions.'</i> (Parent Phase 2).
	Working together	<ul style="list-style-type: none"> <i>'Yeah, definitely [different services work together to provide support].'</i> (Young Person Phase 1).
Improved multi-disciplinary team working	Effective Multi-Disciplinary Team Working	<ul style="list-style-type: none"> <i>'[Interviewer: And do you feel they could have worked together in a better way?] When F:CAMHS were involved? [...] Not really. That's when it started to – To get better.'</i> (Young Person Phase 1). <i>'we had an all agencies meeting -At [CYP]'s school that he was at that time. And [Staff] came along to [...] he'd read [CYP]'s reports and everything, and he</i>

		<p><i>came along to the meetings.’ (Parent Phase 2).</i></p>
	<p>Lack of Multi-Disciplinary Team Working</p>	<ul style="list-style-type: none"> • [Interviewer: do you feel like different agencies are working together to create a care plan for [CYP]? Not all of them. (Parent Phase 2). • [Interviewer: do you feel like different agencies are working together to create a care plan for [CYP]? No. (Parent Phase 2).
	<p>Supported in Work Across Teams</p>	<ul style="list-style-type: none"> • <i>‘[Staff] met him a few times in clinic, and he’s also attended meetings mostly at the new school which he’s at. And he’s keeping in contact with the new school, so he’s not dropping [CYP]’s case while he’s there because he’s aware there may be turbulence and that he will need that support from CAMHS. Yeah, he’s very supportive.’ (Parent Phase 2).</i>
<p>Staff: clear support and confidence to manage risk</p>	<p>Communication</p>	<ul style="list-style-type: none"> • <i>‘[Staff] always included me in emails...there were professional meetings which obviously I’m not included in as a parent, and that any information was communicated that could be. And that’s where I’d asked for help from [Staff], he always replied. And he was very prompt in supporting us’ (Parent Phase 2).</i> • <i>‘Yeah, if I email them, they get back to me straight away, if I’ve got any concerns or I need to talk something over because there’s been a development, they’re very proactive in getting back to me within the same day. Within a few hours, to be honest.’ (Parent Phase 3).</i> • <i>‘That’s how important they were to me at the time. 100%. And they give me so many helplines and support group information in my local area that they had researched that</i>

<p>Effective management of situation</p>	<p><i>nobody had given me before.'</i> (Parent Phase 3).</p> <ul style="list-style-type: none"> • <i>'he's kind of stayed in the background and helped out with everything. And phoned in to all of the meetings. And has just generally been there helping with everything'</i> (Parent Phase 1). • <i>'[Staff] met him a few times in clinic, and he's also attended meetings mostly at the new school which he's at.'</i> (Parent Phase 1). • <i>'The major point was that they took what [name] took seriously, what [name] said.'</i> (Parent Phase 2). • <i>'[Staff] was amazing, he could see that this child wasn't off the rails and a juvenile delinquent and was able to erm, allow us to keep [son's name] at home and ultimately try and make him stay in [region] so I didn't – my perception of what I thought it was going to be like was different to how it was, and the support that we got was just what we needed at the time we needed it.'</i> (Parent Phase 2). • <i>'it's very hard to let go, because all you want to do is just wrap them up in cotton wool. But they've been very supportive in helping me let go.'</i> (Parent Phase 3).
<p>Knowledge, experience and training</p>	<ul style="list-style-type: none"> • <i>'all of the experience, knowledge and his own reputation, it really gives more of a professional look on it and the advice he gives might not be in the standard advice and training that other services get.'</i> (Parent Phase 1) • <i>'a lot more knowledge. Just general – more just general knowledge on different diagnosis and things. And how it affects people more.'</i> (Parent Phase 1)

	<ul style="list-style-type: none"> • <i>'when they got involved and we started to understand a little bit more, and I felt a bit more supported'</i> (Parent Phase 2) • what you find is everyone has their own opinion, so you've then got everyone's opinions, and that's very difficult, when everyone's trying to self-diagnose... you know, giving their ideas, they're all, "Oh, I think this" and "I think that". And you need someone who is professional and trained and qualified to step in. But he was there for our son as much as anybody. It was very much his voice that was heard, which was good. (Parent Phase 3)
Trust	<ul style="list-style-type: none"> • <i>'I trust the staff in F:CAMHS more than normal CAMHS.'</i> (Young Person Phase 1) • <i>'I absolutely trust them, yeah'</i> (Parent Phase 2).
Understanding the Young Person	<ul style="list-style-type: none"> • <i>'how well he [F:CAMHS staff] knows me has really helped build a picture of – a true representation of how I've progressed.'</i> (Young Person Phase 1) • <i>'with my experience of normal CAMHS, it just felt like I was a name on a spreadsheet. But F:CAMHS generally do treat you as a human – as an individual human, rather than just a name on a spreadsheet.'</i> (Parent Phase 1) • <i>'Maybe if they could have stayed for a little bit longer, they would have seen her unravel a little bit and see what she's really like, rather than just an hour's appointment.'</i> (Parent Phase 2) • <i>'I couldn't fault them. 100% I couldn't fault them. I don't know what the process is to match you with the right person at the beginning, but it obviously worked, because [professional's name] and our son gelled very</i>

quickly, he was very good, he knew how to connect with our son terribly quickly – and that’s not an easy thing. And he just made it very a bespoke, tailor-made package to our son.’ (Parent Phase 3).

10.3.3.3 Context

The newly created primary category, '**Impact of the COVID-19 Global Pandemic**', was introduced in Phase 3. Within this secondary theme, parents/carers discussed any changes that had come about in their contact with the Community F:CAMHS teams as a result of the global pandemic. Two secondary themes were derived from the Phase 3 data: 'Consistent and Supportive' and 'Remote Provision', as outlined in table 10.3.3.3.

There was not much data within these secondary themes, but of the two, the most highly populated one was, '**Remote Provision**', where children/young people and parents/carers discussed the practical differences in the service, where they were offered remote contact with the Community F:CAMHS teams. Some children/young people expressed a preference for face-to-face meetings, and both parents/carers and children/young people discussed the absence of body language signals in a remote setting. For example:

It's not face to face in the same room. We're doing online meetings and they're attending all the online meetings. (Parent Phase 3)

It's different, because when you are in a room you see body language, you see how people are hearing or seeing each other. Whereas on a screen you don't actually get that same interaction. I wouldn't say there's a negative or a positive because you can still use your voice so that's fine. (Parent Phase 3)

I prefer in person because it's a lot more friendly because you can actually see the person, you can see what they're doing or not. You can see if they're writing down notes. When I'm talking to them on the phone and that, I'm kind of worried that they're going to start taking notes about stuff, which looks incriminating and stuff, things that'll make me look bad. (Child/Young Person Phase 3)

In the secondary theme, '**Consistent and Supportive**', parents/carers discussed how despite the changes in provision, the Community F:CAMHS teams were still able to provide consistent support to them. Here, parents/carers expressed that their children still felt supported by the teams. For example:

Even though you've had a change of staff, and things have changed around, there's been no hiccups, it's been consistent and reassuring. And we have I would say every four to six weeks we have regular meetings, which they attend and they always attend. (Parent Phase 3)

But very good. He still carried through; he'd built up a very good relationship with our son, so we carried on through Zoom calls and telephone calls. (Parent Phase 3)

They're very involved with my young person and our son feels very supported through COVID. (Parent Phase 3)

Within the primary category '**Accessibility and Awareness of the Service**', five secondary themes were derived from the data: 'Building a Team', 'Earlier Linkage of Services', 'Good Communication', 'Knowledge to Access Support' and 'Wider Coverage of Service', as outlined in table 10.3.3.3. Two new themes were derived from the analysis of the additional Phase 2 data, namely, 'Good Communication' and 'Build a Team'. The Phase 3 data analysed within this primary theme was mainly related to the 'Good Communication' and 'Knowledge to Access Support' secondary themes. One new theme was derived from the Phase 3 data, which was, 'Wider Coverage of Service'.

The most highly populated secondary theme was '**Good Communication**', derived from the Phase 2 data, which is concerned with the expression that, specifically related to accessibility and awareness of the service, children/young people and parents/carers felt as though there was good communication. This included the processes being explained to them, for example:

It was all explained very clearly and [...] it was explained in different words and stuff so it was easy for me to understand why I was there and why I was seeing him...But I do think the leaflet was a bit [...] because I'd never heard of the service or anything as well, I think the leaflet, when it's first given to a parent that doesn't understand and know what's going on, it's a bit scary in that sort of sense. (Parent Phase 2)

Within this theme, fast acceptance of referrals and communication around this was discussed in a positive way by parents/carers interviews, for example:

So they were really, really quick to accept, which was great, and came down to [...] rang me up within a week and spoke to me and explained everything I needed to know. How it all worked and how they would be involved. (Parent Phase 3)

There was also the sense that where involvement of the Community F:CAMHS staff had naturally reduced due to good handling of the case and positive progress having been made, the team was still accessible to families if needed, for example:

So if I need them, I know that I can contact them straight away and they will help me out. Which is a massive relief, isn't it, you know? (Parent Phase 3)

Closely linked to the 'Good Communication' theme was the secondary theme, '**Knowledge to Access Support**', which was concerned with the children/young people and families knowledge about the availability of Community F:CAMHS. Whilst it appears from the 'Good Communication' theme that once they are involved, the communication from the team is very good, there was a general sense across all data collection phases that there is a lack of knowledge that the service exists until the families were at the point of referral. Within this, the parents/carers expressed differing opinions, some stating that this was a hindrance, whilst others were thankful to be referred simply because they had not been previously aware of the service. For example:

I think if it was known more about it, and people were able to access it without maybe having referrals from support workers, it would be beneficial. (Parent Phase 3)

We were very lucky, and CAMHS were very good as well with recommending them because I'd never heard of them. I knew it was quite a new thing and they actually set that up very quickly with CAMHS, so we were lucky. (Parent Phase 3)

Some children/young people also expressed a sense that they were mandated to be involved in Community F:CAMHS, rather than it being a choice. Notwithstanding, this was generally described as being irrelevant to them, as they did not have prior knowledge about accessibility, but now they did know that they could contact the staff member if needed, for example:

I just see him because it was due to mainly a court order so it was [...] I had no choice but to see him. But I could speak to him on the phone if I needed to. (Young person Phase 2)

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Further, some parents/carers stated that they were not aware that one of the roles of Community F:CAMHS is to facilitate joint up working to ensure easier access for young people, for example:

[Interviewer: F:CAMHS tries to do is join up different support services to make it easier for young people to get help. So were you aware that F:CAMHS did this?] No, I can't say I was. (Parent Phase 2)

There was also a sense that it would be helpful to have '**Earlier Linkage of Services**'. For example:

I don't know if there is better linkage, in an earlier stage, before we get to the serious offending stage, which is when F:CAMHS got involved. (Parent Phase 1)

'For us there have been definite points in [CYP]'s development where we could have needed the support of F:CAMHS before we were given it. (Parent Phase 2)

However, other parents/carers expressed that once the Community F:CAMHS team are involved, they are good at exploring the linkage of services early on in their involvement, for example:

This is by the quickest and easiest, because if something doesn't go how they like it, they look into something else straight away, without having to wait and wait and wait. They were straight on the ball. (Parent Phase 2)

No Phase 3 data was related to this secondary theme.

The secondary theme, '**Build a team**', derived from Phase 2 data was related to the sense that the Community F:CAMHS staff were effectively able to build a team of professionals around the child/young person to support their progress, which included ensuring the involvement of agencies such as schools. For example:

We didn't really have much to do with it, did we, to be honest. It was done mostly through [...] so the first school he joined after we had moved, we were having family liaison meetings once every month, and that then became a platform for [multiagency] meetings. So they started to build a team around the family, based on the information that we were providing and they were

witnessing at school. And that's how we accessed F:CAMHS, wasn't it? (Parent Phase 2)

The secondary theme, '**Wider Coverage of Service**', derived from Phase 3 data was related to the sense that it would be beneficial for the service to be rolled out more widely, geographically. One parent/carer discussed living in a remote part of the country and their feelings of guilt related to asking the Community F:CAMHS team to travel a long way, although expressed that the team were happy to do so. For example:

If it was bigger [...] I think if it was a bigger thing, if there were more of them and they were closer to me, I think I wouldn't have felt so bad about maybe having to bring them down again. You know, they never made it an issue, it was absolutely fine every single time, but I felt a little bit like [...] because they were so far away, I felt bad bringing them. (Parent Phase 3)

Other parents/carers discussed the issue of Community F:CAMHS being a small team and therefore the benefit to more children and young people if they were able to expand the service. For example:

I suppose really it would be nice if they had more staff. I'd imagine their workload is very large, so I think if anything, it would be nice if they had more staff. But I personally couldn't fault them, I think they had time, they were kind, they would listen. (Parent Phase 3)

Within the primary category '**Meeting the Complexity of Need**', five secondary themes were derived from the data: 'Appropriate Exploration or Management of Difficulties', 'Having Someone to Speak to', 'Involving Family', 'Multiple Professionals' and 'Quickly Identifying and Addressing Difficulties', as outlined in table 10.3.3.3. Two new themes were derived from the analysis of the additional Phase 2 data, namely, 'Multiple Professionals' and 'Quickly Identifying and Addressing Difficulties'. The Phase 3 data analysed within this primary theme was mainly related to the 'Appropriate Exploration or Management of Difficulties' secondary theme. Two new secondary themes were derived from the Phase 3 data, which were, 'Involving Family' and 'Appropriate Exploration or Management of Difficulties'. Two previously derived themes were amalgamated with existing themes, namely: 'Medication' was subsumed by 'Quickly Identifying and Addressing Difficulties' (note that 'medication' is a separate theme within the 'Outcome' and 'Credibility' were subsumed by 'Appropriate Exploration or Management of Difficulties').

The most highly populated secondary theme was '**Appropriate Exploration or Management of Difficulties**', which, derived from Phase 3 interviews only, was related to the sense that the Community F:CAMHS team's involvement was resultant in the appropriate

exploration and management of difficulties, often in comparison to input the families had received previously. For example, in terms of appropriate exploration and identification of difficulties:

They've already arranged assessments for our young person to see if he's on the spectrum. Because no one had ever really identified what was the issues with him behind the crime. (Parent Phase 3)

When somebody's sitting there saying to you, "No, there's nothing wrong with him. There's nothing wrong with him," and then you've got a professional saying, "Well actually there is. You know, this is how his mind's working, this is what's going on," it just takes so much relief and pressure off you as a parent because you don't think you're going insane. You're actually like, well actually they agree, you know. (Parent Phase 3)

There was also the sense that careful and individualised management of the children/young person's difficulties was key and what Community F:CAMHS staff were able to provide. Parents/carers expressed that this is often via working with the child/young person at a pace and in a way that is most suited to them, for example:

[CYP] really clicked with them, which was brilliant, because that's one thing that he really struggles with. But because they were so relaxed and didn't put any pressure on [CYP], it was so easy to deal with. (Parent Phase 3)

I think because he felt like they were making an effort, he made an effort. And it wasn't in a setting where [CYP] was uncomfortable. (Parent Phase 3)

'Having Someone to Speak to' and **'Involving the Family'** were the next highly populated secondary themes. **'Having Someone to Speak to'** relates to the sense from both parents/carers and children/young people that is it helpful for children and young people to feel as though they have someone to express their difficulties to, and crucially for them to be listened to. For example:

The best thing is having someone to speak to. (Child/Young Person Phase 1)

[...] because a lot of people come and they talk to [CYP], they don't know how to talk to him, it's like they talk at him, you know they're not listening to him. She listened to him. (Parent Phase 2)

However, within this theme, there was also a sense that sometimes the right sort of support was still not available to some children or young people, who find it particularly challenging to speak to others, for example:

mean they kind of go to support groups to talk about autism and stuff like that, but again, it's like, I've done one of those before and I just didn't find it helpful. I'm not an open book. I don't like to sit there with other people and discuss the things that I'm struggling with. [CYP] with autism again, she's not going to talk to strangers, you know, just because of her autism. She has to know somebody quite well first for her to have that kind of relationship with them. (Parent Phase 2)

Within the '**Involving the Family**' secondary theme, derived from Phase 3 interviews, parents/carers discussed how Community F:CAMHS teams were instrumental in ensuring that the family were central to the care and communication around the child or young person. For example:

Very involved. They involve us in forward decisions, forward thinking, in looking back and assessments. (Parent Phase 3)

There was also the sense that the team were able to support parents/carers to be appropriately involved in their child's care:

They would listen to my side of the story. They would look through what I was saying and then they would try to find a way to try and help me. (Parent Phase 3)

Further, parents/carers also discussed how the Community F:CAMHS team involved them in a way that is comfortable to children/young people, for example:

He'd ring and keep us updated and he always told our son that he was going to be there. It was all very open that, "We would ring your mum", but if our

son didn't want it, everything would always be put to our son first. He would only speak to us if it was ok with our son. (Parent Phase 3)

The secondary theme, '**Multiple Professionals**', derived from Phase 2 interviews, is something that was discussed by parents/carers as a negative element of care. Whilst one of the aims of the Community F:CAMHS teams is to facilitate multi-agency working, in some cases this was perceived as unhelpful, for example:

I think that's the only thing that threw [CYP] off is that, you know, [professional] might come and then it might be another doctor, maybe another doctor and then it was just, oh and then, "We'll see this lady about self-harm and then you'll see this lady about such and such." And it's just like, [CYP]'s like, "I don't want to see anybody else." And 'I feel there's too many people involved. So, you know, it wasn't helpful that they were trying to introduce so many people for different things that she was struggling with. She just needs that one person that she can have a relationship with and feel that she's confident to talk to on a level where she can express the struggles that she's having without thinking that it's going to go to another professional and another professional. (Parent Phase 2)

'I feel there's too many people involved. So, you know, it wasn't helpful when they were trying to introduce so many people for different things she was struggling with. (Parent Phase 2)

I think when they try to involve so many professional people with a child, you know, with so many complex needs it's difficult because unless you have got that trust with the young person, you really aren't going to get anywhere with, you know, even holding a conversation or with whatever therapy work they are trying to input. (Parent Phase 2)

Finally, the secondary theme, '**Quickly Identifying and Addressing Difficulties**' relates to the sense from parents/carers that the involvement of Community F:CAMHS sped up the process of both the identification of the child/young person's difficulties and addressing those difficulties. There was a sense that in some cases, families had been experiencing difficulties for some time, and that Community F:CAMHS were able to work quickly with them to help make improvements. For example:

She sped up the process to get medication to help for when I went back to school. (Parent Phase 1)

So it felt like if you get the right people identifying the problems as quickly as possible, you'd be saving huge amounts of resources and time, and stress. And also you're nipping problems in the bud hopefully earlier. (Parent Phase 2)

Within the primary category '**Service's culture: non-judgemental and containing risk**', four secondary themes were derived from the data: 'Different Ways of Thinking', 'Discreet', 'Treated Well' and 'Trust', as outlined in table 10.3.3.3. Two new themes were derived from the analysis of the additional Phase 2 data, namely, 'Different Ways of Thinking' and 'Discreet'. Of all of the primary categories in the 'Mechanisms of Change' section, with one contained the least amount of data overall. The Phase 3 data analysed within this primary theme was mainly related to the 'Treated Well' secondary theme.

The secondary theme, '**Treated Well**' is the most highly populated secondary theme in '*Service's culture: non-judgemental and containing risk*', and is related to the discreet theme described below, in that this was where parents/carers discussed the sense that they had been treated well by the Community F:CAMHS team and similarly to the data in the discreet theme, parents/carers said that they did not feel judged by Community FCAMHS staff. For example:

I think it's because they listened. They listened and they observed, and there was no judgement; and their professionalism and expertise. (Parent Phase 2)

It felt good to get it off my chest. It felt kind of like they weren't judging me or anything. (Parent Phase 3)

The sense of being treated well was also expressed by children and young people. In particular, there was the sense that the Community F:CAMHS teams treated children and young people in the ways that they want to be treated, which may be different to how they had been treated previously. For example:

They don't just look at you for being what people label you, for what people think of you. They get to know you and treat you how you wanna be treated and not how people say that you are. (Child/Young Person Phase 2)

It felt good to get it off my chest. I felt kind of like they weren't judging me or anything. (Child/Young Person Phase 3)

The secondary theme, '**Different Ways of Thinking**', relates to the Community F:CAMHS team offering an alternative way of looking at the child/young person's difficulties. In one incidence, this was where other professionals had made what the parent identified as a judgement, but then the Community F:CAMHS team provided a different perspective on these difficulties. For example:

The school tried to say he had psychosis at the beginning and I thought, "Oh my goodness, oh my goodness." And until F:CAMHS came along and they were like, "No, that's not for them to say," and there are plenty of other things that are just different ways of thinking rather than somebody judging him straight away. Do you see? (Parent Phase 2)

The secondary theme, '**Discreet**' relates to the parents'/carers sense that the Community F:CAMHS teams were very discreet in the handling of the child/young person and family's difficulties, in some cases suggesting that the team were adept at treading carefully when working with the family, for example:

There has never been any judgement. And the team have seen us through some pretty horrific times. But as we've kind of said, they've been really discreet, they've been really gentle; they've often picked up on things without us even talking about stuff. (Parent Phase 2)

Finally, the secondary theme, '**Trust**' relates to the children and young people's sense that they could trust the Community F:CAMHS staff who were helping them and this helped them to feel safe. This theme is closely related to the 'Communication' themes found in other primary themes, such as in 'Staff: clear support and confidence to manage risk':

They made me feel safe [...] I felt like I could be open with them because they trusted me and I trusted them. (Child/Young Person Phase 2)

10.3.3.4 Context: Distance travelled across data collection Phases

The newly created primary category, '**Impact of the COVID-19 Global Pandemic**', was introduced in response to the global pandemic. There were two secondary themes derived from the parent/carer and children/young people interviews in the Phase 3 data collection period, which suggested that the Community F:CAMHS teams were still able provide 'Consistent and Supportive' care through the move to 'Remote Provision'. Some children/young people expressed a preference for face-to-face meetings, and both parents/carers and children/young people discussed the absence of body language signals in a remote setting.

Within the primary category: '**Accessibility and Awareness of the Service**' The secondary theme, 'Wider Coverage of Service', was derived from Phase 3 data only and was related to the sense that it would be beneficial for the service to be rolled out more widely, geographically. This was often expressed in a positive way, where the parents/carers were expressing the need for this important service to be available more widely. There was a general sense across all data collection phases that there is a lack of knowledge that the service exists until the families were at the point of referral. The sense across all data collection phases is that once the Community F:CAMHS teams were involved, there was a high quality level of communication, including communication with the families and across multiple agencies. It is interesting to note that there was no Phase 3 data in the secondary theme, 'Earlier Linkage of Services' which may suggest some distance travelled between data collection phases.

Within the primary category, '**Meeting the Complexity of Need**', the most highly populated secondary theme was 'Appropriate Exploration or Management of Difficulties', which, derived from Phase 3 interviews only, was related to the sense that the Community F:CAMHS team's involvement was resultant in the appropriate exploration and management of difficulties, often in comparison to input the families had received previously. For example, in terms of appropriate exploration and identification of difficulties. There was also the sense that careful and individualised management of the children/young person's difficulties was key and what Community F:CAMHS staff were able to provide. Parents/carers expressed that this is often via working with the child/young person at a pace and in a way that is most suited to them, for example,

Across all data collection phases parents/carers and children/young people expressed the importance of having someone to talk to and the involvement of the family. Within the 'Involving the Family' secondary theme, derived from Phase 3 interviews, parents/carers discussed how Community F:CAMHS teams were instrumental in ensuring that the family were central to the care and communication around the child or young person. It is interesting to note that this secondary theme related to work specifically involving the family was derived from Phase 3 data only and therefore may be suggestive of distance travelled with the development of services. Some parents/carers in Phase 2 interviews expressed concern about too many professionals involved, which also was not discussed by parents in the Phase 3 interviews.

In the primary category, '**Service's Culture: Non-Judgemental and Containing Risk**', the Phase 3 data analysed was mainly related to the 'Treated Well' secondary theme. This

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suggests that the overarching sense from parents/carers and children/young people who were seen in the Phase 3 data collection period was that they were treated well by Community F:CAMHS teams.

Table 10.3.3.3: Context – primary categories, secondary themes, and illustrative quotes

Primary Category	Secondary Theme	Illustrative quotes
Impact of the COVID-19 Global Pandemic	Consistent and Supportive	<ul style="list-style-type: none"> • <i>'Even though you've had a change of staff, and things have changed around, there's been no hiccups, it's been consistent and reassuring. And we have I would say every four to six weeks we have regular meetings, which they attend and they always attend.'</i> (Parent Phase 3). • <i>'But very good. He still carried through; he'd built up a very good relationship with our son, so we carried on through Zoom calls and telephone calls.'</i> (Parent Phase 3). • <i>'They're very involved with my young person and our son feels very supported through COVID.'</i> (Parent Phase 3).
	Remote Provision	<ul style="list-style-type: none"> • <i>'It's not face to face in the same room. We're doing online meetings and they're attending all the online meetings.'</i> (Parent Phase 3). • <i>'It's different, because when you are in a room you see body language, you see how people are hearing or seeing each other. Whereas on a screen you don't actually get that same interaction. I wouldn't say there's a negative or a positive because you can still use your voice so that's fine.'</i> (Parent Phase 3). • <i>'I prefer in person because it's a lot more friendly because you can actually see the person, you can see what they're doing or not. You can see if they're writing down notes. When I'm talking to them on the phone and that, I'm kind of worried that they're going to start taking notes about stuff, which looks</i>

<p>Accessibility and awareness of the service</p>	<p>Build a Team</p>	<p><i>incriminating and stuff, things that'll make me look bad.'</i> (Young Person Phase 3).</p>
		<ul style="list-style-type: none"> • <i>'We didn't really have much to do with it, did we, to be honest. It was done mostly through... so the first school he joined after we had moved, we were having family liaison meetings once every month, and that then became a platform for [multiagency] meetings. So they started to build a team around the family, based on the information that we were providing and they were witnessing at school. And that's how we accessed F:CAMHS, wasn't it?'</i> (Parent Phase 2).
	<p>Earlier linkage of services</p>	<ul style="list-style-type: none"> • <i>'I don't know if there is better linkage, in an earlier stage, before we get to the serious offending stage, which is when F:CAMHS got involved.'</i> (Parent Phase 1). • <i>'This is by the quickest and easiest, because if something doesn't go how they like it, they look into something else straight away, without having to wait and wait and wait. They were straight on the ball.'</i> (Parent Phase 2). • <i>'For us there have been definite points in [young person's] development where we could have needed the support of F:CAMHS before we were given it'.</i> (Parent Phase 2).
	<p>Good Communication</p>	<ul style="list-style-type: none"> • <i>'It was all explained very clearly and... it was explained in different words and stuff so it was easy for me to understand why I was there and why I was seeing him...But I do think the leaflet was a bit... because I'd never heard of the service or anything as well, I think the leaflet, when it's first given to a parent that doesn't understand and know what's going on, it's a bit scary in that sort of sense.'</i> (Parent Phase 2).

	<ul style="list-style-type: none"> • <i>'So they were really, really quick to accept, which was great, and came down to... rang me up within a week and spoke to me and explained everything I needed to know. How it all worked and how they would be involved.'</i> (Parent Phase 3). • <i>'So if I need them, I know that I can contact them straight away and they will help me out. Which is a massive relief, isn't it, you know?'</i> (Parent Phase 3).
<p>Knowledge to access support</p>	<ul style="list-style-type: none"> • <i>'I just see him because it was due to mainly a court order so it was... I had no choice but to see him. But I could speak to him on the phone if I needed to.'</i> (Young person Phase 2). • <i>'[Interviewer: F:CAMHS tries to do is join up different support services to make it easier for young people to get help. So were you aware that F:CAMHS did this?] No, I can't say I was.'</i> (Parent Phase 2). • <i>'I think if it was known more about it, and people were able to access it without maybe having referrals from support workers, it would be beneficial.'</i> (Parent Phase 3). • <i>'We were very lucky, and CAMHS were very good as well with recommending them because I'd never heard of them. I knew it was quite a new thing and they actually set that up very quickly with CAMHS, so we were lucky.'</i> (Parent Phase 3).
<p>Wider Coverage of Service</p>	<ul style="list-style-type: none"> • <i>If it was bigger... I think if it was a bigger thing, if there were more of them and they were closer to me, I think I wouldn't have felt so bad about maybe having to bring them down again. You know, they never made it an issue, it was absolutely fine every single time, but I felt a little bit like... because they were</i>

so far away, I felt bad bringing them. (Parent Phase 3).

- *'I suppose really it would be nice if they had more staff. I'd imagine their workload is very large, so I think if anything, it would be nice if they had more staff. But I personally couldn't fault them, I think they had time, they were kind, they would listen...'* (Parent Phase 3).

Appropriate Exploration or Management of Difficulties

- *'There's a little bit more credibility when you are trying to get other organisations to understand what's happened.'* (Parent Phase 1).
- *'When somebody's sitting there saying to you, "No, there's nothing wrong with him. There's nothing wrong with him," and then you've got a professional saying, "Well actually there is. You know, this is how his mind's working, this is what's going on," it just takes so much relief and pressure off you as a parent because you don't think you're going insane. You're actually like, well actually they agree, you know.'* (Parent Phase 2).
- *'They've already arranged assessments for our young person to see if he's on the spectrum. Because no one had ever really identified what was the issues with him behind the crime.'* (Parent Phase 3).
- *'[CYP's name] really clicked with them, which was brilliant, because that's one thing that he really struggles with. But because they were so relaxed and didn't put any pressure on [CYP's name], it was so easy to deal with.'* (Parent Phase 3).
- *I think because he felt like they were making an effort, he made an effort. And it wasn't in a setting where [CYP's name] was uncomfortable. (Parent Phase 3).*

Having Someone to Speak to

- *'the best thing is having someone to speak to' (Young Person Phase 1).*
- *'...because a lot of people come and they talk to [CYP name], they don't know how to talk to him, it's like they talk at him, you know they're not listening to him. She listened to him.'* (Parent Phase 2).
- *'I mean they kind of go to support groups to talk about autism and stuff like that, but again, it's like, I've done one of those before and I just didn't find it helpful. I'm not an open book. I don't like to sit there with other people and discuss the things that I'm struggling with. [CYP name] with autism again, she's not going to talk to strangers, you know, just because of her autism. She has to know somebody quite well first for her to have that kind of relationship with them.'* (Parent Phase 2).

Involving the Family

- *'Very involved. They involve us in forward decisions, forward thinking, in looking back and assessments.'* (Parent Phase 3).
- *'They would listen to my side of the story. They would look through what I was saying and then they would try to find a way to try and help me.'* (Parent Phase 3).
- *'He'd ring and keep us updated and he always told our son that he was going to be there. It was all very open that, "We would ring your mum", but if our son didn't want it, everything would always be put to our son first. He would only speak to us if it was ok with our son'* (Parent Phase 3).

Multiple Professionals

- *'I think that's the only thing that threw [CYP name] off is that, you know, [professional's name] might come and then it might be another doctor, maybe another doctor and then it was just, oh and then, "We'll see this*

	<p><i>lady about self-harm and then you'll see this lady about such and such." And it's just like, [CYP name]'s like, "I don't want to see anybody else."...I feel there's too many people involved. So, you know, it wasn't helpful that they were trying to introduce so many people for different things that she was struggling with. She just needs that one person that she can have a relationship with and feel that she's confident to talk to on a level where she can express the struggles that she's having without thinking that it's going to go to another professional and another professional.'</i> (Parent Phase 2).</p> <ul style="list-style-type: none"> • <i>'I feel there's too many people involved. So, you know, it wasn't helpful when they were trying to introduce so many people for different things she was struggling with. (Parent Phase 2).</i> • <i>'I think when they try to involve so many professional people with a child, you know, with so many complex needs it's difficult because unless you have got that trust with the young person, you really aren't going to get anywhere with, you know, even holding a conversation or with whatever therapy work they are trying to input.'</i> (Parent Phase 2).
	<p>Quickly Identifying and Addressing Difficulties</p> <ul style="list-style-type: none"> • <i>'She sped up the process to get medication to help for when I went back to school'</i> (Parent Phase 1) • <i>'So it felt like if you get the right people identifying the problems as quickly as possible, you'd be saving huge amounts of resources and time, and stress. And also you're nipping problems in the bud hopefully earlier.'</i> (Parent Phase 2).
<p>Service's culture: non-judgemental and containing risk</p>	<p>Different Ways of Thinking</p> <ul style="list-style-type: none"> • <i>'the school tried to say he had psychosis at the beginning and I thought, "Oh my</i>

	<p><i>goodness, oh my goodness.” And until F:CAMHS came along and they were like, “No, that’s not for them to say,” and there are plenty of other things that are just different ways of thinking rather than somebody judging him straight away. Do you see?’ (Parent Phase 2).</i></p>
Discreet	<ul style="list-style-type: none"> • <i>‘There has never been any judgement. And the team have seen us through some pretty horrific times. But as we’ve kind of said, they’ve been really discreet, they’ve been really gentle; they’ve often picked up on things without us even talking about stuff.’ (Parent Phase 2)</i>
Treated well	<ul style="list-style-type: none"> • <i>‘[...] and they never judged me.’ (Parent Phase 1).</i> • <i>‘they don’t just look at you for being what people label you, for what people think of you. They get to know you and treat you how you wanna be treated and not how people say that you are’ (Young Person Phase 2)</i> • <i>‘I think it’s because they listened. They listened and they observed, and there was no judgement; and their professionalism and expertise.’ (Parent Phase 2).</i> • <i>It felt good to get it off my chest. It felt kind of like they weren’t judging me or anything. (Parent Phase 3).</i>
Trust	<ul style="list-style-type: none"> • <i>‘They made me feel safe...I felt like I could be open with them because they trusted me and I trusted them’ (Young Person Phase 2).</i>

10.3.3.5 Outcome

Within the primary category 'Improved Mental Health and Wellbeing', seven secondary themes were derived, which were related to the children, young people saying that since their contact with Community F:CAMHS, their mental health and wellbeing had improved in a number of ways. *These secondary themes are: 'Changed Life View', 'Coping Mechanisms', 'Happier', 'Improved Family Life', 'Medication', 'Support' and 'Understand Self'. Two themes were derived from the additional Phase 2 interview analysis: 'Support' and 'Improved Family Life'. One theme that had been identified in previous analysis was amalgamated with another theme, namely, 'Prevented Deterioration' was subsumed into 'Improved Family Life'. Most of the Phase 3 data was organised into the 'Changed Life View' secondary theme.*

The most highly populated secondary theme was '**Happier**' within which children/young people and parents/carers spoke of the child/young person, and themselves, being happier as a result of their contact with the Community F:CAMHS team. This included a sense of feeling better within oneself and about a situation and a sense that life is good and For example:

I've become better in myself and a lot more happier and I've made a really good recovery with them, from where I was when I started seeing them to now. I do things I never thought I'd do before. (Child/Young Person Phase 2)

'Life is really good now.' (Child/Young Person Phase 2)

[...] she made me feel normal, she made me feel like I wasn't a bad parent, she assured me I wasn't a bad parent, she made me feel good about myself.' (Parent Phase 2)

[...] our son was very happy [...] [with the support]' (Parent Phase 3)

The next highly populated secondary themes were '**Change Life View**' and '**Medication**'. The '**Change Life View**' secondary theme is closely related to the 'Happier' secondary theme. However, this secondary theme rather than expressing feelings of happiness or discussing how things have improved, the focus from parents/carers, children and young people was that they had a completely different way of approaching situations and are now thinking about things in a more positive way. This secondary theme encompasses examples of the transformative nature of the work of the Community F:CAMHS teams. For example:

It's just completely changed how – like my take on life. (Child/Young Person Phase 1)

I was worried because I did a lot when I was angry [...] I was a different person. (Child/Young Person Phase 1)

I couldn't praise them enough. And without them, I think my whole life and [CYP]'s whole life would be a lot different. So I'm forever grateful. (Parent Phase 3)

The secondary theme, '**Medication**' is focused on parent and children/young people's expressions that the Community F:CAMHS teams had helped them gain access to the correct medication, often after some time. This was always expressed as a positive action which helped the child/young person feel better, for example:

They helped me get medication and spoke to me a lot more and I started doing a lot better. (Child/Young Person Phase 1)

The medication, because we were waiting for that, so she helped push that along with CAMHS. (Parent Phase 2)

The main things was getting the medication right for [name]...and I think we have that right now and [professional] kept in constant contact to make sure we had that right. (Parent Phase 2)

[Professional's name] [...] wrote a prescription to the doctor [...] which was brilliant. (Parent Phase 3)

The secondary theme, '**Improved Family Life**', derived from Phase 2 and 3 data, encompasses the parent/carer perception that input from the Community F:CAMHS teams had a significant improvement to their family life. This includes relationships between parents/carers and children/young people and between siblings. There is a transformative sense to this theme, where some parents discussed an overall positive change in family life, some discussing feeling that their families had been 'saved':

There was a lot of attachment issues, and all those types of issues. So, it did help us with the relationship, and it stopped, I think, a family breakdown, which was really high. (Parent Phase 2)

And also it restores your faith, just in everything. And all those little signs give you the strength and energy to continue. And it definitely helped with the sibling relationship. (Parent Phase 2)

They have definitely saved our family. And also it has given us food for thought, just in terms of being more open to family and talking about mental health issues, and acknowledging that it's okay to have struggles. (Parent Phase 3)

As well as discussing improved family life, parents/carers also discussed how the Community F:CAMHS teams had provided both them and their child with '**Coping Mechanisms**' to help them to move forward in positive ways, which had not been possible previously:

I feel that the coping mechanisms that they have given her...has given us ways of coping with things; if I didn't have them, I'm not sure how I would have coped with everything myself. (Parent Phase 2)

So now I can go about things a little bit differently. [...] So approaching situations at home differently for both of us, I would say has helped the situation. (Parent Phase 3)

Closely related to the secondary theme 'Coping Mechanisms' is the secondary theme, '**Support**', derived from Phase 2 data. Within this theme, parents/carers discussed improvements in difficulties and feeling more confident via receiving appropriate support from members of the Community F:CAMHS team, for example:

I literally love that man to pieces. He got [name] so much support and helped straightaway with his sleeping. (Parent Phase 2)

But also getting more confident about it and having someone like [professional's name] we go , "Do we have to go to this?" Because it gets exhausting....we feel empowered by the team around us to go actually we don't need that and that's okay. (Parent Phase 2)

Finally, within the secondary theme, '**Understanding Self**', parents/carers discussed the key role of the Community F:CAMHS team in helping both themselves and their child to understand the difficulties. In some cases, they discussed this as a transformative agent of change. They also discussed how a better understanding self and others is a facilitator for making effective strategic changes, for example in one's own reactions to situations. For example:

[...] a massive impact. A good impact at that. The understanding for [CYP] of his diagnosis as well. So he could get his head around it. So he understands and he will now quite openly talk about ASD. And not think of it as anything different from anybody else. (Parent Phase 3)

It has made things a lot easier because he knows that they have explained to him why he might be feeling a certain way. So, it definitely has helped home-wise. And understanding maybe how I feel at the same time. Why I might get a bit upset or why I might get a bit angry and shout. And then taught me that if I shout at him, that aggravates him. (Parent Phase 3)

One young person gave a specific example of how they can now understand their own difficulties more:

I had a lot of anger and I wasn't sure where that was coming from and they helped me understand that more. (Child/Young Person Phase 1)

Within the primary category '**Reduction of Harm, Risk or Offending**', three secondary themes were derived, which were related to the children, young people saying that their contact with Community F:CAMHS, had led to a reduction in their risk of harm to self or others, risk, or offending behaviours. These secondary themes are: 'Effective Strategies', 'Helpful' and 'Improved Outlook'. One theme was derived from the additional Phase 2 interview analysis: 'Helpful'. Most of the Phase 3 data was organised into the 'Improved Outlook' secondary theme.

The most highly populated secondary theme was '**Improved Outlook**', within which children/young people and parents/carers discussed the significant improvement to the future as a result of the input from the Community F:CAMHS team. This was often related to a reduction in risk and harmful behaviours, and the avoidance of offending behaviour. For example:

So the reason why I got involved with forensic CAMHS was due to my [...] previous offending behaviour. And all the strategies that they've helped me with, I haven't gone back on that, that kind of lifestyle again. (Child/Young Person Phase 2)

[Professional] did keep her out of prison and that's something I am grateful for because without his intervention she would have definitely gone to prison. (Parent Phase 2)

Sometimes parents/carers described being in crisis before the Community F:CAMHS teams' input and the turnaround their families had made as a results, for example:

Generally talking to the other services and just telling them from his [professional] point of view on where I was a year ago to where I am now. And then where he [professional] thinks I'll be in a few years. It's completely different to what I would have pictured a few years ago. (Child/Young Person Phase 2)

'We were in absolute crisis [...] we needed to stabilise and we needed to turn it around in a positive way. And it's taken the team [...] who are all very good and came in and helped and now we don't feel like we are in crisis anymore. (Parent Phase 2)

I honestly don't think, hand on heart, that my son would be in my care if I didn't have that support. (Parent Phase 3)

Within the secondary theme '**Effective Strategies**', parents/carers and children/young people discussed the helpful strategies they have been able to implement based on their contact with the Community F:CAMHS teams, often expressing how this has made them feel more equipped to deal with any difficulties and to improve things. For example:

Whereas I think before F:CAMHS got involved, it just felt very frightening and overwhelming, and we really didn't have the answers. Whereas I think we're more equipped to deal with a lot of the challenges that can often be presented. (Parent Phase 2)

It was a serious situation that I was in, so it definitely did help me to take a step back and look at what I had done and learn to improve myself. (Child/Young Person Phase 2)

Finally, the secondary theme '**Helpful**' was derived from the additional Phase 2 analysis and encompasses the sense that the input from the Community F:CAMHS team had been helpful in the reduction of risk, harm and offending behaviours overall, for example:

So I guess in desperate times of need it was very helpful. (Parent Phase 2)

'[...] they have achieved really great things. So what they set out to achieve, they have achieved. (Parent Phase 2)

Within the primary category '**Improved Social Inclusion**', did not contain much data and therefore, there was only one secondary theme derived from Phase 2 and 3 data, which was related to the children/young people saying that their contact with Community F:CAMHS had led to a an improvement in their social inclusion via the effective 'Management of Difficulties'. In previous analysis, one secondary theme had been derived, which was called 'Feeling better', which was renamed to encompass more of the data in the theme review and revision stage.

Within the '**Improved Social Inclusion**', children/young people and parents/carers discussed the significant improvement in their ability to make friends and to be more sociable, since the input of the Community F:CAMHS teams, for example:

I used to be really socially awkward and anxious. And now I can go up to people and ask them for things [...] they've like make me feel comfortable and opened me up more to the world and people. I've just become a better person. (Child/Young Person Phase 2)

[...] it managed to get him to control his feelings a little bit, I would say in groups, in that he didn't need to be the centre of attention. To be in a group.' (Parent Phase 3)

Now I'm at the point where I have made some friends at college and whatnot, which I struggled with last year. (Child/Young Person Phase 3)

Within the primary category '**Improved Education, Employment and Training**', two secondary themes were derived, which were related to the children/young people saying that their contact with Community F:CAMHS, had led to an improvement in education, employment or training. These improvements were primarily associated with education. These secondary themes are: 'Improved Outlook' and 'Knowledge and Support'. One previously derived secondary theme, 'Recommendations' was subsumed into the secondary theme, 'Knowledge and Support'. Most of the Phase 3 data was organised into the 'Knowledge and Support' secondary theme.

The most highly populated secondary theme was '**Knowledge and Support**'. Parents/carers who contributed to these areas of exploration discussed how the input of the Community

F:CAMHS teams has helped their child to be supported to improve difficulties they previously had in the area of education. Sometimes this is related to providing advice and assisting with communication, for example:

It has helped. In terms of school it has helped; so [professional] and the F:CAMHS team have helped; they've helped coordinate with us and the school. So we have regular [multiagency] meetings. And so everyone's on the same page, and we all get divvied up what courses of action need to be done by whom, by when, and then we check at the next meeting. So that has helped immensely. (Parent Phase 2)

They've been advising us what's best, really, because he was very resistant to wanting to go to college because he really struggles with learning and has a big fear of learning... so they've been very supportive in us making the changes for him to do working environment rather than educational environment. (Parent Phase 3)

Some parents /carers discussed incidences where the Community F:CAMHS team have managed to help their child go to the appropriate school for them, for example:

Without the knowledge from the forensic psychologist that I've had I wouldn't ever have got funding for - to become a student at [Specialist school/residential group]. (Parent Phase 1)

If it wasn't for F:CAMHS, I probably wouldn't have [name] in this school that he's in now, which he's doing brilliantly with. (Parent Phase 2)

Within the secondary theme, '**Improved Outlook**', there was a general sense that he Community F:CAMHS had helped children/young people and their parent/carers to assist them to make positive changes in the area of education, employment and training. These were often not specific examples, but a general sense that things have improved, or that the child/young person's attitude towards these areas had improved, for example:

She's gone from being at secondary school to college, sixth form college, so that's change, her whole outlook has changed. (Parent Phase 2)

I think he would have been permanently excluded. (Parent Phase 2)

He's gone back to mainstream school [...]. Before he couldn't even [attend] a day. I never thought he'd get back to mainstream school. (Parent Phase 3)

Within the primary category 'More Effective Help: Better Co-ordination of and Access to Support', five secondary themes were derived, which were related to the children, young people and parents/carers discussing their contact with Community F:CAMHS, in terms of access to the support and in comparison with prior support received from other agencies. These secondary themes are: 'Accessible', 'Better Service', 'Communication', 'Confidence and Support' and 'Consistency and Continuation'. Three previously derived secondary themes were subsumed into other secondary themes, namely, 'Confidence' and 'Support' into 'Confidence and Support' and 'Stepping In' and 'Better Co-ordination' into 'Better Service'. The discussions that were organised into the overarching primary theme were in relation to the comparison of the Community F:CAMHS teams to other agencies that had been previously involved with the families. Most of the Phase 3 data was organised into the 'Consistency and Continuation' secondary theme, which was also derived from Phase 3 data only.

The most highly populated secondary theme was 'Confidence and Support'. In this theme, parents/carers discussed how the Community F:CAMHS teams have provided support to them to in turn help their child with their difficulties. For example:

And so once you have people like her or [professional's name], who could very quickly assess the issue, and offer very practical advice that you could look at, you instantly start to feel more confident. (Parent Phase 2)

'I feel very supported and actually the last few months they've been outstanding to help me help [CYP]. (Parent Phase 3)

Within this theme parents/carers also discussed how the Community F:CAMHS teams gave them confidence to deal with the family's difficulties, and often how they have more confidence in the Community F:CAMHS teams than in other agencies that had been previously involved, for example:

Going back to CAMHS, I don't feel the same confidence with them that I do when I speak to F:CAMHS. (Parent Phase 1)

Parents/carers also expressed the perception that they were receiving a '**Better Service**' through their contact with the Community F:CAMHS teams in comparison to other agencies that had been involved previously. For example:

We've had really shocking services from other places. So, yeah, F:CAMHS was definitely a lot better. I don't have anything bad to say at all about the service we received from F:CAMHS, at all. (Parent Phase 2)

Compared to how it was in hospital and the way she was treated in hospital, this was completely different. It was a lot better. (Parent Phase 2)

Some parents/carers discussed how the experience of the Community F:CAMHS teams becoming involved in their care was like a lifeline; a vital active agency who was able to move things forward for them for the better, for example:

To be honest they have been a lifeline [...] because we were stood still, and we didn't really have any direction before they came on board. We were in limbo land and nobody wanted to take on that decision and ownership and responsibility of how we went to the next level. Because we had lost the police interaction and guidance and so we needed someone to give us that. (Parent Phase 3)

Within the secondary theme, '**Communication**' parents/carers discussed their experiences of better communication with the Community F:CAMHS teams compared to other teams that had been involved in their care. Sometimes that was allied with a sense that the professionals had a better understanding of the child/young person and therefore were better able to support the parents. For example:

Yeah, definitely, because [FCAMHS staff] had more of an understanding of [CYP] and what she was going through and her struggles. (Parent Phase 3)

With CAMHS itself we didn't have so much great experiences [...] when [professional] came on board from F:CAMHS I was a bit sceptical [...] I can't praise her enough [...] she kept us updated with everything she was doing.
(Parent Phase 2)

So now I have F:CAHMS, that reassurance of having somebody that I can still phone when things get tough is massive. It's kind of a bit of a relief, because I might ring them up and have a little rant and a rave. But they're fine, and they're like, "That's totally understandable. That's normal. Don't worry."
(Parent Phase 3)

Within the secondary theme, '**Accessible**', parents/carers and children/young people discussed their experiences of the accessibility of the Community F:CAMHS teams compared to other agencies that had been involved in their care. In some cases, this was very positive and parents/carers spoke of the Community F:CAMHS teams being more accessible, whereas other parents/carers spoke of their wish to have accessed the Community F:CAMHS teams earlier in their journey. For example:

I don't think there is anything that could be done to make it better [...]. Over the past three years I've been struggling with different professionals [...] and obviously they've got involved [...] and I just feel that they've just took so much weight off me [...]. I wish I had been referred sooner. (Parent Phase 2)

[Professional] for sure now has been massively accessible [...] because I never thought he would engage me direct. (Parent Phase 1)

Finally, the '**Consistency and Continuation**' secondary theme, derived from Phase 3 data only consists of parents/carers discussing how the Community F:CAMHS teams provided consistency of care to them, in comparison to the care they had received previously from other agencies. Further, parents/carers also discussed the difficulties they face with their child reaching the upper age limit of the Community F:CAMHS provision and discussed the need for continuity of care beyond age 18. For example:

[In comparison to CAMHS] I found them really good because they were consistent. We had the same therapist, practitioner, throughout, and it was the same person who was our case worker throughout. You find, when you're in the system, that you don't usually see people more than a couple of times. So, it was lovely to have someone who was consistent. (Parent Phase 3)

I think the only thing is that it finishes at 18 because we are unable to carry on with CAMHS because he doesn't meet the threshold. But when you actually look at the complex needs our son has and the length of time he's been under CAMHS, etc. and different schools, it would have been lovely, now that he's built that lovely relationship with [professional's name], if they could carry on to say 20, 21, really. At 18 people think you're an adult and actually it's when you need people the most. (Parent Phase 3)

I think the thing is with mental health, what we've realised, is you have an awful lot of small departments, and when you're the other side of it, getting pushed from pillar to post and it would be lovely to see F:CAMHS as a much bigger establishment and be able to provide that service to more people.
(Parent Phase 3)

The only downfall is that help finishes at 18. I'd say that's the only downfall. It's such a shame because it takes such a long time to get help through the system and then to find a service that they have continual case workers is very rare, and then to have it taken away at 18, that I would say is the only downfall...Then if you're lucky you go back into CAMHS and you'll never see the same person twice, and they're doubly busy. (Parent Phase 3)

10.3.3.6 Outcome: Distance travelled across data collection Phases

Within the primary category, **Improved Mental Health and Wellbeing**, most of the Phase 3 data was organised into the 'Changed Life View' secondary theme, where parents/carer and children and young people discussed the input of Community F:CAMHS teams having an integral role in their transformative view of their difficulties and onwards trajectory. Across all data collection phases, there was a consistent sense from parents/carers and children/young people that the Community F:CAMHS teams had helped them gain access to the correct medication, often after some time. This was always expressed as a positive action which helped the child/young person feel better. A secondary theme, which was derived from the Phase 2 and 3 data, 'Improved Family Life', included the expression that Community F:CAMHS teams had a significantly positive impact on relationships between parents/carers and children and between siblings. There is a transformative sense to this theme, where some parents/carers discussed an overall positive change in family life, some discussing feeling that their families had been 'saved'. There is the suggestion of some distance travelled here between Phase 1 and the latter data collection phases. Likewise, the parents/carers in the Phase 2 and Phase 3 interviews discussed having received coping mechanisms and much of the data from the, 'Understanding Self' secondary theme was derived from Phase 3 interviews. This was where parents/carers discussed the key role of the Community F:CAMHS team in helping both themselves and their child to understand the difficulties.

Within the primary category, **Reduction of Harm, Risk or Offending**, most of the Phase 3 data was organised into the 'Improved Outlook' secondary theme. This too was a transformative theme, much like the 'Changed Life View' secondary theme. It is a positive indication that many of the parents/carers and children/young people interviewed in the Phase 3 data collection period expressed these overarching and impactful views of the Community F:CAMHS teams. Within the primary category **Improved Social Inclusion**, there was some suggestion of distance travelled, given that all data within this category was from the Phase 2 and 3 data collection periods. This may be suggestive that children and young people were able to experience these improvements with further developed of the teams.

Within the primary category **Improved Education, Employment and Training**, most of the Phase 3 data was organised into the 'Knowledge and Support' secondary theme. This was where parents/carers discussed how the input of the Community F:CAMHS teams has helped their child to be supported to improve difficulties they previously had in the area of education. Sometimes this is related to providing advice and assisting with communication. This is indicative of the positive improvements in education that parents attributed to the input of the Community F:CAMHS teams and was not seen so much in the Phase 1 interviews.

Within the primary category, **'More Effective Help: Better Co-ordination of and Access to Support'**, the Phase 3 data was primarily organised into the 'Consistency and Continuation' secondary theme, which was also derived from Phase 3 data only. This is where parents/carers expressed that Community F:CAMHS teams provided consistency of care to them, in comparison to the care they had received previously from other agencies. Further, parents/carers also discussed the difficulties they face with their child reaching the upper age limit of the Community F:CAMHS provision and discussed the need for continuity of care beyond age 18. This was not discussed in the earlier data collection periods. Within this primary category, many of the parents/carers in the Phase 2 and 3 data collection period expressed positive perceptions of the Community F:CAMHS teams providing better support and care, including communication, compared to other agencies they had been involved with previously. One highly populated secondary theme from the Phase 2 and 3 data collection periods was the 'Good Communication' theme, where parents/carers discussed the facilitative role of the Community F:CAMHS teams in co-ordinating communication across services, and providing good communication with the families themselves.

Table 10.3.3.6: Outcome – primary categories, secondary themes, and illustrative quotes

Primary Category	Secondary Theme	Illustrative quotes
Improved mental health and wellbeing	Changed Life View	<ul style="list-style-type: none"> • <i>'It's just completely changed how – like my take on life.'</i> (Young Person Phase 1). • <i>'I was worried because I did a lot when I was angry...I was a different person'.</i> (Young Person Phase 1). • <i>I couldn't praise them enough. And without them, I think my whole life and [CYP's name]'s whole life would be a lot different. So I'm forever grateful. (Parent Phase 3).</i>
	Coping mechanisms	<ul style="list-style-type: none"> • <i>'I feel that the coping mechanisms that they have given her...has given us ways of coping with things; if I didn't have them, I'm not sure how I would have coped with everything myself' (Parent Phase 2).</i> • <i>So now I can go about things a little bit differently. ...So approaching situations at home differently for both of us, I would say has helped the situation. (Parent Phase 3).</i> •
	Happier	<ul style="list-style-type: none"> • <i>'I've become better in myself and a lot more happier and I've made a really good recovery with them, from where I was when I started seeing them to now. I do things I never thought I'd do before.'</i> (Young Person Phase 2). • <i>'Life is really good now.'</i> (Young Person Phase 2). • <i>'...she made me feel normal, she made me feel like I wasn't a bad parent, she assured me I wasn't a bad parent, she made me feel good about myself...'</i> (Parent Phase 2). • <i>'...our son was very happy...[with the support]'</i> (Parent Phase 3).
	Improved Family Life	<ul style="list-style-type: none"> • <i>'There was a lot of attachment issues, and all those types of issues. So, it did help us with the relationship, and it stopped, I think, a family breakdown, which was really high.'</i> (Parent Phase 2). • <i>'And also it restores your faith, just in everything. And all those little signs give you the strength and energy to continue. And it definitely helped with the sibling relationship.'</i> (Parent Phase 2).

		<ul style="list-style-type: none"> 'They have definitely saved our family. And also it has given us food for thought, just in terms of being more open to family and talking about mental health issues, and acknowledging that it's okay to have struggles.' (Parent Phase 3).
Understanding Self		<ul style="list-style-type: none"> 'I had a lot of anger and I wasn't sure where that was coming from and they helped me understand that more' (Young Person Phase 1). '...a massive impact. A good impact at that. The understanding for [CYP's name] of his diagnosis as well. So he could get his head around it. So he understands and he will now quite openly talk about ASD. And not think of it as anything different from anybody else.' (Parent Phase 3). 'It has made things a lot easier because he knows that they have explained to him why he might be feeling a certain way. So, it definitely has helped home-wise. And understanding maybe how I feel at the same time. Why I might get a bit upset or why I might get a bit angry and shout. And then taught me that if I shout at him, that aggravates him.' (Parent Phase 3).
Medication		<ul style="list-style-type: none"> 'They helped me get medication and spoke to me a lot more and I started doing a lot better'. (Young Person Phase 1). 'The medication, because we were waiting for that, so she helped push that along with CAMHS'. (Parent Phase 2). 'The main things was getting the medication right for [name]...and I think we have that right now and [professional's name] kept in constant contact to make sure we had that right'. (Parent Phase 2). '[Professional's name]...wrote a prescription to the doctor...which was brilliant'. (Parent Phase 3).
Support		<ul style="list-style-type: none"> 'I literally love that man to pieces. He got [name] so much support and helped straightaway with his sleeping.' (Parent Phase 2). 'But also getting more confident about it and having someone like [professional's name] we go , "Do we have to go to this?" Because it gets exhausting...we feel empowered by the team around us to go actually we don't need that and that's okay. (Parent Phase 2).
Reduction of harm/risk/offending	Effective Strategies	<ul style="list-style-type: none"> 'Whereas I think before F:CAMHS got involved, it just felt very frightening and overwhelming, and we really didn't have the answers. Whereas I think

we're more equipped to deal with a lot of the challenges that can often be presented.' (Parent Phase 2).

- *'It was a serious situation that I was in, so it definitely did help me to take a step back and look at what I had done and learn to improve myself.'* (Young Person Phase 2).

Helpful	<ul style="list-style-type: none"> • <i>'So I guess in desperate times of need it was very helpful.'</i> (Parent Phase 2). • <i>'...they have achieved really great things. So what they set out to achieve, they have achieved.'</i> (Parent Phase 2).
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Improved Outlook	<ul style="list-style-type: none"> • <i>'so the reason why I got involved with forensic CAMHS was due to my...previous offending behaviour. And all the strategies that they've helped me with, I haven't gone back on that, that kind of lifestyle again.'</i> (Young Person Phase 2). • <i>'generally talking to the other services and just telling them from his [F:CAMHS staff] point of view on where I was a year ago to where I am now. And then where he [F:CAMHS staff] thinks I'll be in a few years. It's completely different to what I would have pictured a few years ago.'</i> (Young Person Phase 2).
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Improved social inclusion	Management of Difficulties	<ul style="list-style-type: none"> • <i>'I used to be really socially awkward and anxious. And now I can go up to people and ask them for things...they've like make me feel comfortable and opened me up more to the world and people. I've just become a better person.'</i> (Young Person Phase 2). • <i>'...it managed to get him to control his feelings a little bit, I would say in groups, in that he didn't need to be the centre of attention. To be in a group.'</i> (Parent Phase 3). • <i>'Now I'm at the point where I have made some friends at college and whatnot. , which I struggled with last year.'</i> (Young Person Phase 3).
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Improved Education, Employment and Training	Knowledge and support	<ul style="list-style-type: none"> • <i>'Without the knowledge from the forensic psychologist that I've had I wouldn't ever have got funding for – to become a student at [Specialist school/residential group]'</i> (Parent Phase 1). • <i>'If it wasn't for F:CAMHS, I probably wouldn't have [name] in this school that he's in now, which he's doing brilliantly with.'</i> (Parent Phase 2). • <i>'It has helped. In terms of school it has helped; so [professional's name] and the F:CAMHS team have helped; they've helped coordinate with us</i>
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and the school. So we have regular [multiagency] meetings. And so everyone's on the same page, and we all get divvied up what courses of action need to be done by whom, by when, and then we check at the next meeting. So that has helped immensely.' (Parent Phase 2).

- *'They've been advising us what's best, really, because he was very resistant to wanting to go to college because he really struggles with learning and has a big fear of learning... so they've been very supportive in us making the changes for him to do working environment rather than educational environment.'* (Parent Phase 3).

Improved Outlook

- *'She's gone from being at secondary school to college, sixth form college, so that's change, her whole outlook has changed'. (Parent Phase 2).*
- *'I think he would have been permanently excluded...'* (Parent Phase 2).
- *'He's gone back to mainstream school....before he couldn't even [attend] a day. I never thought he'd get back to mainstream school.'* (Parent Phase 3).

More Effective Help: Better Co-ordination of and Access to Support

Accessible

- *'[Professional's name] for sure now has been massively accessible...because I never thought he would engage me direct.'* (Parent Phase 1).
- *'I don't think there is anything that could be done to make it better...Over the past three years I've ben struggling with different professionals...and obviously they've got involved...and I just feel that they've just took so much weight off me...I wish I had been referred sooner.'* (Parent Phase 2).

Better Service

- *'We've had really shocking services from other places. So, yeah, F:CAMHS was definitely a lot better. I don't have anything bad to say at all about the service we received from F:CAMHS, at all'. (Parent Phase 2).*
- *'Compared to how it was in hospital and the way she was treated in hospital, this was completely different. It was a lot better.'* (Parent Phase 2).
- *'To be honest they have been a lifeline...because we were stood still, and we didn't really have any direction before they came on board. We were in limbo land and nobody wanted to take on that decision and ownership and responsibility of how we went to the next level. Because we had lost the police interaction and guidance and so we needed someone to give us that.'* (Parent Phase 3).

Communication

- 'Yeah, definitely, because he had more of an understanding of [name] and what she was going through and her struggles.' (Parent Phase 3).
- 'With CAMHS itself we didn't have so much great experiences...when [name] came on board from F:CAMHS I was a bit sceptical...I can't praise her enough...she kept us updated with everything she was doing.' (Parent Phase 2).
- So now I have F:CAHMS, that reassurance of having somebody that I can still phone when things get tough is massive. It's kind of a bit of a relief, because I might ring them up and have a little rant and a rave. But they're fine, and they're like, "That's totally understandable. That's normal. Don't worry." (Parent Phase 3).

Confidence and Support

- 'Going back to CAMHS, I don't feel the same confidence with them that I do when I speak to F:CAMHS'. (Parent Phase 1).
- 'She supported us through lots of things'. (Parent Phase 1).
- 'And so once you have people like her or [professional's name], who could very quickly assess the issue, and offer very practical advice that you could look at, you instantly start to feel more confident.' (Parent Phase 2).

Consistency and Continuation

- '[In comparison to CAMHS] I found them really good because they were consistent. We had the same therapist, practitioner, throughout, and it was the same person who was our case worker throughout. You find, when you're in the system, that you don't usually see people more than a couple of times. So, it was lovely to have someone who was consistent.' (Parent Phase 3).
- 'I think the only thing is that it finishes at 18 because we are unable to carry on with CAMHS because he doesn't meet the threshold. But when you actually look at the complex needs our son has and the length of time he's been under CAMHS, etc. and different schools, it would have been lovely, now that he's built that lovely relationship with [professional's name], if they could carry on to say 20, 21, really. At 18 people think you're an adult and actually it's when you need people the most.' (Parent Phase 3).
- 'I think the thing is with mental health, what we've realised, is you have an awful lot of small departments, and when you're the other side of it, getting pushed from pillar to post and it would be lovely to see F:CAMHS

as a much bigger establishment and be able to provide that service to more people.' (Parent Phase 3).

- *'The only downfall is that help finishes at 18. I'd say that's the only downfall. It's such a shame because it takes such a long time to get help through the system and then to find a service that they have continual case workers is very rare, and then to have it taken away at 18, that I would say is the only downfall...Then if you're lucky you go back into CAMHS and you'll never see the same person twice, and they're doubly busy.'* (Parent Phase 3).
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10.3.3.7 Overall considerations for the combined children/young people and parent/carer interview analysis

It is important to note that due to the global pandemic and the associated difficulties in accessing participants, the majority of the Phase 3 interviewees were parents and carers, which means that the child/young person voice within the Phase 3 findings is limited. These findings must be interpreted with caution, particularly regarding distance travelled, because there was $n=1$ child/young person recruited during the Phase 3 data collection period, limiting the applicability of the findings to other children and young people.

During the Phase 3 interviews, a new area of exploration reflected and explored the impact of the COVID-19 global pandemic. This resulted in the newly created primary category, 'Impact of the COVID-19 Global Pandemic'. Within this area of exploration, parents/carers and children/young people suggested that the Community F:CAMHS teams were still able provide 'Consistent and Supportive' care through the move to 'Remote Provision'. Some children/young people expressed a preference for face-to-face meetings, and both parents/carers and children/young people discussed the absence of body language signals in a remote setting, but overall the sense of the ability of the team members to provide continuity of high quality care was positive.

Some of the secondary themes derived from data collection during all data collection phases spanned different primary themes. For example: communication, working together, individualised service, fair treatment and improved outlook, were themes that were derived from data within several primary categories. All of these secondary themes are directed towards the overall suggestion that Community F:CAMHS teams across the board are offering support to parents/carers and children/young people which is of high quality, focused on good communication between and within involved parties, and an individualised service that parents/carers often expressed they had not experienced before.

There were some revisions made to the previously derived secondary themes, where combined and new themes were derived from the Phase 2 or 3 data. Specifically, these newly derived secondary themes were often positively framed and were related to family needs being taken into consideration, good communication across and within teams, building a team around the child/young person, the teams' abilities to quickly identify and address difficulties, providing different ways of thinking in a discreet way to improve family life, and to provide continued care in the context of the global pandemic. From the Phase 2 data, there were more challenging secondary themes derived, which encompassed too many professionals involved and a lack of multi-disciplinary working in some areas. However, these secondary themes were not highly populated with Phase 3 data, suggesting some positive direction of travel.

The Phase 3 data were mainly organised into positively framed secondary themes, which pertained to teams and families 'Working Together', utilising the high quality 'Knowledge, Experience and Training' and 'Knowledge and Support' of the Community F:CAMHS teams. Further, the majority of the Phase 3 data pertained to secondary themes which related to 'Appropriate Exploration or Management of Difficulties' and 'Involving the Family', often

discussed in contrast to services that had previously been involved with the families. 'Good Communication' and 'Knowledge to Access Support' were also secondary themes which were highly populated by the Phase 3 data. Children, young people and families being 'Treated Well', with children and young people being described as 'Happier' with 'Improved Social Inclusion' and an 'Improved Family Life' were secondary themes which were also highly populated with Phase 3 data. One of the strongest indications from the Phase 3 data was that the Community F:CAMHS teams were able to better understand the children/young people, in a way that the families had not experienced before, and that this then promoted the sense of receiving truly individualised support. Families also discussed the need for a 'Wider Coverage of Service' and a 'Continuation' of support after age 18.

In general, these suggestions of distance travelled must be interpreted with caution due to the low number of Phase 3 interviews.

10.4 Detailed Routine Site Data Findings

The 13 services have been collecting data for each child/young person that is brought into contact with them. For the purposes of the data collection, the cases are split into Advice-only cases and Referrals. Advice-only cases are those for which a referral form was not completed by the service and therefore, provides a narrower overview of the children and young people for whom this type of contact with Community F:CAMHS was made. Referrals are cases for which a referral form was completed, and we have been able to collect a much larger dataset for such cases.

Across the three submission windows, we have collected data on 6,122 Advice-only and Referral cases across the 13 Community F:CAMHS. This section presents a broad demographic overview of the sample with specific attention to those where a learning disability that had been identified at referral. Cases refer to those with data submitted and may not reflect all cases in a service. Frequencies of less than 3 have been suppressed to prevent possible identification of children and young people (<3).

10.4.1 All Sites

Across the three submission periods, data for 6,122 advice-only and referral cases were submitted by 13 services (80.4%, 4924/6122 male; mean age =14.3 , standard deviation =2.46).

Table 10.4.1.1: gender breakdown for all sites

	N	Age Range	Mean Age	Median Age	SD
All	6122	2 to 25	14.3	15	2.46
Male	4811	3 to 25	14.3	15	2.49
Female	1054	4 to 22	14.4	15	2.30
Non-binary	4	12 to 16	14.0	14	1.63

113 cases with Gender data missing. 238 cases with Age data missing. N reported is cases with age and gender provided.

The most common contact sources across all sites were CAMHS (46.3%, 2833/6122), social care (23.4%, 1430/6122), and youth justice (14.7%, 897/6122).

Table 10.4.1.2: Contact source for whole service

Contact Source	All		Early		Late	
	N	%	N	%	N	%
CAMHS	2833	46.3	1613	47.8	1220	44.4
Education	387	6.32	177	5.24	210	7.65
Social Care	1430	23.4	786	23.3	644	23.5
Youth justice	897	14.7	513	15.2	384	14.0
Other Health	268	4.38	120	3.55	148	5.39
Self/family	12	0.20	7	0.21	5	0.18
Third sector	36	0.59	19	0.56	17	0.62
GP	38	0.62	18	0.53	20	0.73
Other	64	2.35	93	2.75	87	3.17
Missing	41	0.67	31	0.92	10	0.36

10.4.2 Advice-only cases

There were 2,908 advice-only cases from 11 services across all submission periods (77.1%, 2243/2908 male; mean age = 14.3 years, standard deviation = 2.6 years).

Table 10.4.2.1: gender breakdown for advice-only cases

	N	Age Range	Mean Age	Median Age	SD
All	2908	2 to 25	14.3	15	2.63
Male	2243	3 to 25	14.3	15	2.64
Female	553	4 to 22	14.4	15	2.47
Non-binary	3	14 to 16	14.7	14	1.15

109 cases with Gender data missing. 229 cases with Age data missing. N reported is cases with age and gender provided.

The most common contact sources for advice-only cases were CAMHS (48.2%, 1402/2908), social care (20.3%, 590/2908), and youth justice (15.5%, 450/2908).

Table 10.4.2.2: contact source for advice-only cases

Contact Source	All		Early		Late	
	N	%	N	%	N	%
CAMHS	1402	48.2	946	50.9	456	43.4
Education	182	6.26	86	4.63	96	9.14
Social Care	590	20.3	385	20.7	205	19.5
Youth justice	450	15.5	287	15.4	163	15.5
Other Health	117	4.02	66	3.55	51	4.86
Self/ family	12	0.41	7	0.38	5	0.48
Third sector	25	0.86	14	0.75	11	1.05
GP	16	0.55	5	0.27	11	1.05
Other	103	3.54	54	2.91	49	4.67
Missing	11	0.38	8	0.43	3	0.29

There were 6 advice-only cases aged greater than 25 years who were excluded from the analysis as they were outside the usual age parameters. Upon checking with the services involved, we determined that these cases were primarily referred by 'Other' and were not accepted as ongoing cases, so it was agreed to exclude them from analysis.

10.4.3 Referrals

There were 3,214 referrals from 13 services (83.4%, 2681/3214 male; mean age = 14.3 years, standard deviation = 2.31 years; 76.4%, 2454/3214 White British), including 2,295 indirect cases, 699 direct cases, 57 other referral, 141 referrals rejected, and 22 with no data.

Table 10.4.3.1: gender and age breakdown for all referrals

	N	Age Range	Mean Age	Median Age	SD
All	3214	5 to 18	14.3	15	2.31
Male	2681	5 to 18	14.3	15	2.35
Female	528	5 to 17	14.5	15	2.11
NB	<3	-	-	-	-

<3 cases with Gender data currently unavailable. 9 cases with Age data missing. N reported is cases with age and gender provided.

Table 10.4.3.2: ethnicity breakdown for all referrals.

	N	%
Asian	90	3
Black	156	5
“Other” ethnicity	77	2
Mixed-race	223	7
White British	2454	76
White “other”	96	3
Missing	118	4

N = 3214.

10.4.3.1 Clinical characteristics of referrals

The referral source of 26.1% (840/3214) of cases was social care. Youth justice was the source of 13.9% (447/3214) of referrals. In particular, 11.7% (375/3214) of children and young people referred to Community F:CAMHS presented with a learning disability. For cases where there was learning disability presentation at referral (375/3214), 43.2% (162/375) were referred via CAMHS, 29.6% (111/375) were referred via social care, and 13.3% (50/375) were referred via youth justice. In addition, 72.6% (2333/3214) of children, young people had accessed CAMHS before referral to Community F:CAMHS.

Overall, 79.3% (2550/3214) of all cases in the data presented with at least one problem related to psychosis, anxiety, depression, post-traumatic features, attention deficit and hyperactivity disorder, autism, and conduct and longstanding behaviour difficulties, with 55.4% (1780/3214) of children, young people having multiple presenting problems; 70.6% (2270/3214) of cases had experienced/witnessed at least one traumatic event and 56.5% (1817/3214) had experienced/witnessed multiple traumatic events.

Table 10.4.3.1.1: clinical characteristics

Referral Source	All		Early		Late	
	N	%	N	%	N	%
CAMHS	1431	44.5	667	43.9	764	45.1
Education	205	6.38	91	5.99	114	6.73

Social Care	840	26.1	401	26.4	439	25.9
Youth justice	447	13.9	226	14.9	221	13.0
Other Health	151	4.70	54	3.5	97	5.72
Third Sector	11	0.34	5	0.33	6	0.35
GP	22	0.68	13	0.86	9	0.53
Other	77	2.40	39	2.57	38	2.24
Missing	30	0.93	23	1.51	7	0.41
Social Care Status						
Child in Need	758	23.6	371	24.4	387	22.8
Leaving Care	57	1.77	8	0.53	49	2.89
Looked After S20	347	10.8	171	11.3	176	10.4
Looked After S31	459	14.3	231	15.2	228	13.5
Secure Accommodation Order	52	1.62	22	1.45	30	1.77
Subject to CP Plan	294	9.15	154	10.1	140	8.26
TAC (Team Around the Child)	103	3.20	57	3.75	46	2.71
Allocated Social Worker	99	3.08	27	1.78	72	4.25
No Social Care Plan	703	21.9	311	20.5	392	23.1
Other	295	9.18	135	8.89	160	9.44
Missing	47	1.46	32	2.11	15	0.88
Youth Justice Status						
On bail	175	5.44	82	5.398288	93	5.486726
Recent police contact	881	27.41133	385	25.3	496	29.3
On remand	52	1.62	30	1.97	22	1.30
Pre-court order	58	1.80	16	1.05	42	2.48
Sentenced - community order	312	9.71	170	11.2	142	8.38

Sentenced – custodial	92	2.86	48	3.16	44	2.60
Other	228	7.09	100	6.58	128	7.55
Not applicable	1369	42.6	658	43.3	711	41.9
Missing	47	1.46	30	1.97	17	1.00
	All		Early		Late	

State Provided Support

In receipt of benefits	208	6.47	139	9.15	69	4.07
Living in social housing	63	1.96	41	2.70	22	1.30
Both	323	10.0	191	12.6	132	7.79
None of the above/Not applicable	530	16.5	314	20.7	216	12.7
Missing	2090	65.0	834	54.9	1256	74.1

Education Status

College of Further Education	36	1.12	12	0.79	24	1.42
Home Tuition	132	4.12	60	3.95	72	4.25
Vocational Training	57	1.77	31	2.04	26	1.53
Mainstream	872	27.1	374	24.6	498	29.4
Mainstream SEN	198	6.16	83	5.46	115	6.78
Special School	578	18.0	342	22.5	236	13.9
NEET	588	18.3	256	16.9	332	19.6
PRU	225	7.00	127	8.36	98	5.78
Hospital school	44	1.37	28	1.84	16	0.94
Left School (employed)	24	0.75	13	0.86	11	0.65
SEN	70	2.18	16	1.05	54	3.19
Other	349	10.9	147	9.68	202	11.9
Missing	41	1.28	30	1.97	11	0.65

Living Arrangement

Adoptive Family	191	5.94	64	4.21	127	7.49
Birth Family	1770	55.1	829	54.6	941	55.5
Foster Care	185	5.77	87	5.73	98	5.78
Low/Medium Inpatient Secure	12	0.37	5	0.33	7	0.41
Open Inpatient Unit	64	1.99	16	1.05	48	2.83
Other Family	31	0.96	15	0.99	16	0.94
PICU	163	5.07	85	5.56	78	4.60
Residential Care	38	1.18	11	0.72	27	1.59
Residential School	364	11.3	209	13.76	155	9.14
Secure Care (CJS)	27	0.84	18	1.18	9	0.53
Secure Care (Welfare)	60	1.87	33	2.17	27	1.59
Semi-Independent Living	61	1.90	28	1.84	33	1.95
YOI	119	3.70	51	3.36	68	4.01
Other	50	1.56	21	1.38	29	1.71
Missing	17	0.53	16	1.05	<3	-

N=3,214.

10.4.3.2 Levels of input

Staff at Community F:CAMHS were asked to classify each referral into one of five levels of input; for example, 48.1% (1547/3214) of cases were indirect cases with multi-agency consultation and 21.9% (704/3214) were indirect cases with single agency consultation. Early implementing services had a higher rate of direct input (28.7%, 436) compared to late implementing services (12.7%, 215).

Table 10.4.3.2.1: Levels of input

Levels of input	All		Early		Late	
	N	%	N	%	N	%
Indirect: Single agency consultation	704	21.9	185	12.2	519	30.6
Indirect: Multi-agency consultation	1547	48.1	666	43.8	881	52.0
Direct: Individual consultation and clinical assessment	508	15.8	345	22.7	163	9.62
Direct: Initial consultation, assessment and further clinical intervention	143	4.45	91	5.99	52	3.07
Other	196	6.10	145	9.55	51	3.01
Missing	116	3.61	87	5.73	29	1.71

10.4.3.4 Primary intervention type

Multi-agency case management (44.3%, 1423/3214) and ongoing indirect monitoring (39.7%, 1275/3214) were the most common primary intervention types for all referrals. Looking at cases with complete data (3049/3214), the most common combinations of intervention types recorded were no intervention types (30.7%, 935/3049), multi-agency case management and ongoing indirect monitoring (15.7%, 480/3049), and ongoing indirect monitoring (12.6%, 383/3049).

Table 10.4.3.4.1: Primary intervention type combinations

Intervention type	All		Early		Late	
	N	%	N	%	N	%
None	935	30.7	489	34.8	446	27.1
Multi agency case management, ongoing indirect monitoring	480	15.7	143	10.2	337	20.5
Ongoing indirect monitoring	383	12.6	163	11.6	220	15.6
Multi agency case management	368	12.1	112	7.97	256	15.6
Specialist intervention, multi-agency case management, ongoing indirect monitoring	160	5.25	42	2.98	118	7.18
Specialist intervention	99	3.24	44	3.13	55	3.34
Specialist intervention, standard CAMHS intervention, multi-agency case management, ongoing indirect monitoring	88	2.89	80	5.69	8	0.49
Ongoing direct monitoring	85	2.79	28	1.99	57	3.47
Standard CAMHS	61	2.00	30	2.13	31	1.88

intervention						
Ongoing direct monitoring, Multi agency case management	57	1.87	31	2.21	26	1.58
Other combinations	333	10.9	243	17.3	90	5.47

10.4.3.5 Intervention participants

Of the 3,048 cases with complete intervention participants data, 38.3% (1166/3048) indicated no participants in the intervention and 34.4% (1050/3048) indicated 'Working with wider system/multi-agency working' as the only participant. In contrast, 3.35% (102/3048) indicated 'Individual' and 'Working with wider system/multi-agency working' as the participants and 2.76% (84/3048) indicated 'Individual', 'Parent/Foster Carer' and 'Working with wider system/multi-agency working' as the participants.

Table 10.4.3.5.1: Intervention participants

Intervention participants	All		Early		Late	
	N	%	N	%	N	%
None	1166	38.3	487	34.7	679	41.3
Working with wider system/multi-agency working	1050	34.4	376	26.8	674	41.0
Individual, working with wider system/multi-agency working	102	3.35	65	4.63	37	2.25
Individual, parent/foster carer, working with wider system/multi-agency working	84	2.76	52	3.70	32	1.95
Individual, family, working with wider system/multi-agency working	81	2.66	51	3.63	30	1.82
Parent/foster carer, working with wider system/multi-agency working	73	2.40	31	2.21	42	2.55
Individual, family, parent/foster carer, working with wider system/multi-agency working	69	2.26	43	3.06	26	1.58
Family, working with wider system/multi-agency working	60	1.97	34	2.42	26	1.58

Working with wider system/multi-agency working, group	58	1.90	52	3.70	6	0.37
Individual	42	1.38	18	1.28	24	1.46
Working with wider system/multi-agency working, group, other	42	1.38	41	2.92	<3	-
Other combinations	221	7.25	154	11.0	67	4.08

10.4.3.6 Agencies involved at referral and discharge

At referral, 74.5% (1842/2472) of discharged cases involved social care, 63.0% (1557/2472) involved CAMHS, and 54.6% (1349/2472) involved Education. At discharge, 72.4% cases (1790/2472) involved social care, 59.3% (1467/2472) involved CAMHS, and 57.6% (1425/2472) involved education.

Table 10.4.3.6.1: Agencies involved at referral and discharge

	All		Early				Late					
	Referral		Discharge		Referral		Discharge		Referral		Discharge	
Agencies	N	%	N	%	N	%	N	%	N	%	N	%
Social care	1842	74.5	1790	72.4	875	75.2	854	73.4	967	73.9	936	71.5
CAMHS	1557	63.0	1467	59.3	715	61.5	701	60.3	842	64.3	766	58.5
Education	1349	54.6	1425	57.6	617	53.1	650	55.9	732	55.9	775	59.2
Youth justice	1011	40.9	801	32.4	454	39.0	336	28.9	557	42.6	465	35.5
Self/family	663	26.8	502	20.3	189	16.3	139	12.0	474	36.2	363	27.7
Other health	249	10.1	161	6.51	124	10.7	85	7.31	125	9.55	76	5.81
Third sector	90	3.64	175	7.08	39	3.35	60	5.16	51	3.90	115	8.79
Other	313	12.7	351	14.2	197	16.9	172	14.8	116	8.86	179	13.7

The tables below display the most common combinations of agencies involved at referral and discharge, for discharged cases with complete data. There were 2,440 discharged cases with complete information at referral and 2,416 discharged cases with complete information at discharge.

The most common combinations of agencies involved at referral and discharge were CAMHS, education and social care (13.2%, 321/2440 at referral and 18.0%, 435/2416 at discharge).

Table 10.4.3.6.2: Combinations of agencies involved at referral and discharge

Combinations of agencies involved at referral	All				Early				Late			
	Referral		Discharge		Referral		Discharge		Referral		Discharge	
	N	%	N	%	N	%	N	%	N	%	N	%
CAMHS, education, social care	321	13.2	435	18.0	139	12.1	208	18.4	182	14.1	227	17.7
CAMHS, education, social care, youth justice	216	8.85	157	6.50	86	7.49	68	6.01	130	10.1	89	6.93
CAMHS, social care	212	8.69	189	7.82	99	8.62	91	8.04	113	8.75	98	7.63
CAMHS, social care, youth justice	173	7.09	111	4.59	72	6.27	59	5.21	101	7.82	52	4.05
Education, social care	153	6.27	188	7.78	75	6.53	84	7.42	78	6.04	104	8.10
Social care, criminal justice	150	6.15	127	5.26	63	5.49	52	4.59	87	6.74	75	5.84

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CAMHS, education	125	5.12	167	6.91	61	5.31	79	6.98	64	4.95	88	6.85
CAMHS	121	4.96	106	4.39	60	5.23	57	5.04	61	4.72	49	3.82
Education, social care, youth justice	115	4.71	113	4.68	56	4.88	45	3.98	59	4.57	68	5.30
Social care	89	3.65	107	4.43	46	4.01	60	5.30	43	3.33	47	3.66
Other combinations	765	31.4	716	29.6	391	34.1	329	29.1	374	28.9	387	30.1

10.4.3.7 Presenting problems at referral and discharge

The table below displays the change between referral and discharge information, where presenting problems were and were not indicated a referral. Where a problem was not indicated at referral, the row of interest is 'Yes' (i.e., when discharged, the young was recorded as having the problem); for example, 12.4% of cases had conduct/ behaviour difficulties indicated at discharge but not at referral, 7.18% anxiety, 4.92% ADHD, 4.98% autism, and 2.53% learning disability. Where a problem was indicated at referral, the row of interest is 'No' (i.e., when discharged, the young person was no longer recorded as having the problem); for example, 42.3% of cases had psychosis indicated at referral but not at discharge, 34.1% depression, 21.0% anxiety, 20.2% learning disability, 18.0% PTSD features and 18.9% ADHD.

Table 10.4.3.7.1: Presenting problems at referral and discharge

		Change where problem was not indicated at referral						Change where problem was indicated at referral					
		All		Early		Late		All		Early		Late	
		N	%	N	%	N	%	N	%	N	%	N	%
Psychosis	No	2007	93.7	893	92.4	1114	94.8	55	42.3	24	40.7	31	43.7
	Yes	28	1.31	10	1.04	18	1.53	70	53.8	34	57.6	36	50.7
	Missing	106	4.95	63	6.52	43	3.66	5	3.85	<3	-	4	5.63
Anxiety	No	1085	85.6	407	86.4	678	85.1	171	21.0	83	18.8	88	27.4
	Yes	91	7.18	24	5.10	67	8.41	584	71.7	373	75.5	211	65.7
	Missing	92	7.26	40	8.49	52	6.52	60	7.36	17	7.94	22	6.85
Depression	No	1413	90.3	604	90.6	809	90.2	147	34.1	68	30.5	79	38.0
	Yes	44	2.81	12	1.80	32	3.57	238	55.2	128	57.4	110	52.9
	Missing	107	6.84	51	7.65	56	6.24	46	10.7	27	12.1	19	9.13
PTSD features	No	1318	86.3	556	88.5	762	84.7	77	18.0	31	12.9	46	24.6
	Yes	92	6.02	25	3.98	67	7.44	308	72.1	184	76.7	124	66.3
	Missing	118	7.72	47	7.48	71	7.89	42	9.84	25	10.4	17	9.09
ADHD	No	1267	87.7	520	87.8	747	87.7	122	18.9	40	11.5	82	27.5
	Yes	71	4.92	21	3.55	50	5.87	495	76.6	290	83.3	205	68.8
	Missing	106	7.34	51	8.61	55	6.46	29	4.49	18	5.17	11	3.69
Autism	No	1241	88.3	533	88.0	708	88.5	88	13.6	27	8.74	61	18.0
	Yes	70	4.98	23	3.80	47	5.88	529	81.8	602	84.6	263	77.8
	Missing	95	6.76	50	8.25	45	5.62	30	4.64	34	4.78	14	4.14

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Conduct/ behaviour disorders	No	889	82.9	309	89.8	580	79.7	190	15.9	76	10.7	114	23.7
	Yes	113	12.4	23	6.69	110	15.1	950	79.6	602	84.6	348	72.2
	Missing	50	4.66	12	3.49	38	5.22	54	4.52	34	4.78	20	4.15
Learning disability	No	1612	90.6	698	91.2	914	90.0	58	20.2	19	12.3	39	29.3
	Yes	45	2.53	12	1.57	33	3.25	212	73.9	125	84.6	87	65.4
	Missing	123	6.91	55	7.19	68	6.70	17	5.92	10	6.49	7	5.26

10.4.3.8 Reasons for discharge

The most common reasons for discharge were that Community F:CAMHS was no longer required: ongoing community management by local CAMHS/other mental health service with other agency(ies) (41.3%, 1021/2472); Community F:CAMHS no longer required: ongoing community management by local CAMHS/other mental health service alone (17.0%, 421/2472); and Community F:CAMHS no longer required: other agency(ies) remain involved (14.8%, 365/2472).

Table 10.4.3.8.1: Reasons for discharge

	All		Early		Late	
	N	%	N	%	N	%
F:CAMHS no longer required; ongoing community management by local CAMHS/other mental health service alone	421	17.0	223	19.2	198	15.1
F:CAMHS no longer required; ongoing community management by local CAMHS/other mental health service with other agency(ies)	1021	41.3	435	37.4	586	44.8
F:CAMHS no longer required; ongoing community management: no need for further local CAMHS/other mental health service involvement; other agency(ies) remain involved	365	14.8	181	15.6	184	14.1
F:CAMHS no longer required; transition to new specialist setting (e.g. custody, welfare secure, special educational, in-patient, residential) effected; no need/benefit for ongoing F:CAMHS involvement	118	4.77	64	5.50	54	4.13
F:CAMHS no longer required; no need for CAMHS/other mental health service or other agency involvement with young person	61	2.47	34	2.92	27	2.06
F:CAMHS oversight still required when CYP moves out of area; transfer to new area F:CAMHS	41	1.66	14	1.20	27	2.06
Young person now over 18; transition to adult services effected	78	3.16	50	4.30	28	2.14
Young person over 18; no need for transition to adult services	18	0.73	6	0.52	12	0.92

Young person over 18; transition needed to adult services but not accepted/not feasible	15	0.61	9	0.77	6	0.46
Other reason for discharge	313	12.7	137	11.8	176	13.4
Missing	21	0.85	10	0.86	11	0.84

10.4.3.9 Integrated care plans in place

Of the 2,472 discharged cases, 54.8% (1355/2472) had an integrated care plan in place at discharge. A higher proportion of cases in early implementing Community F:CAMHS had an integrated care plan in place at discharge (56.2%, 654) than in late implementing services (53.6%, 701). Late implementing services had a higher rate of cases being discharged without an integrated care plan than early implementing services (44.5% compared to 35.4%).

Table 10.4.3.9.1: Integrated care plans

Integrated care plan in place?	All		Early		Late	
	N	%	N	%	N	%
Yes	1355	54.8	654	56.2	701	53.6
No	1082	43.8	492	42.3	590	45.1
Missing	35	1.42	17	1.46	18	1.38

10.4.3.10 Concerns identified at referral and management of these concerns at discharge

Risks or concerns identified at referral were again assessed on discharge for whether they were still a concern or whether they were less of a concern/ there was a suitable management plan in place. Violence and aggression remained a concern in 48.9% (990) of discharged cases where it was identified as a referral reason. Sexually harmful behaviour was still a concern in 48.7% (391) of cases where it was identified as a referral reason. Fire setting was still a concern for 29.1% (80) of cases where it was identified as a referral reason. Youth justice was still a concern for 48.6% (320) cases where it was identified as referral reason.

Late implementing services had a higher rate of cases where violence and aggression was still a concern at discharge compared to early implementing services (51.5%, 539 compared to 46.0%, 451). In contrast, early implementing services had a higher rate of cases where youth justice (55.5%, 202 compared to 40.1%, 118), sexually harmful behaviour (40.6%, 154 compared to 38.0%, 161) and fire setting (33.1%, 44 compared to 25.4%, 36) was still a concern at discharge compared to late implementing services.

Table 10.4.3.10.1: Concerns identified at referral and management of these concerns at discharge

Change in concern	All		Early		Late	
	N	%	N	%	N	%
Violence and aggression						
Less of a concern/suitable management plan in place	925	45.7	456	46.5	469	44.8
Still a concern	990	48.9	451	46.0	539	51.5
Missing or not applicable	111	5.48	73	7.45	38	3.63
Sexually harmful behaviour						
Less of a concern/suitable management plan in place	315	39.2	154	40.6	161	38.0
Still a concern	391	48.7	180	47.5	211	49.8
Missing or not applicable	97	12.1	45	11.9	52	12.3
Fire setting						
Less of a concern/suitable management plan in place	142	51.6	64	48.1	78	54.9
Still a concern	80	29.1	44	33.1	36	25.4
Missing or not applicable	53	19.3	25	18.8	28	19.7
Youth justice						
Less of a concern/suitable management plan in place	195	29.6	103	28.3	92	31.1
Still a concern	320	48.6	202	55.5	118	40.1
Missing or not applicable	143	21.7	59	16.2	84	28.6

10.4.3.11 Secure settings at referral/discharge

At referral, 1.56% (50/3214) children and young people were identified as living in a Young Offender’s Institution, 1.87% (60/3214) in secure care (CJS) and 1.90% (61/3214) in secure care (welfare). At discharge, 1.66% (41/2472) children and young people were identified as living in a Young Offender’s Institution, 1.58% (39/2472) in secure care (CJS) and 1.01% (25/2472) in secure care (welfare).

10.4.3.12 Mental health and wellbeing for referrals

The clinician-rated HoNOSCA was essential for direct cases and optional for indirect cases. The summary below includes HoNOSCA questionnaires from both direct and indirect cases. There were a total of 747 submitted HoNOSCA questionnaires at Time 1 (200 Indirect, 538 Direct, and 9 rejected, Other or missing) and 346 submitted at Time 2. Each of the 13 items in the questionnaire were rated on a 5-point scale from 0 ('No Problem') to 4 ('Severe to Very Severe Problem').

The summary below includes questionnaires that had less than 20% of items missing (i.e., rounded up to 3 missing items). After eliminating those with more than 3 items missing, 727 HoNOSCA questionnaires remained at Time 1 and 335 remained at Time 2. The total score was

derived at by summing the values (0-4). Missing items were prorated and items rated 9 ('Don't Know') are treated as if the answer was 0. The maximum total score is 52.

Table 10.4.3.12.1: HoNOSCA scores at time 1 summary statistics

	N	Range	Mean	Median	SD
All	727	0 to 44	20.5	20	7.58
Male	622	0 to 44	20.1	20	7.50
Female	103	5 to 37	21.9	21.5	7.82

<3 cases with Gender data missing.

Table 10.4.3.12.2: HoNOSCA scores at time 2 summary statistics

	N	Range	Mean	Median	SD
All	335	0 to 37	16.6	16	7.69
Male	286	0 to 36	16.3	15	7.73
Female	49	1 to 37	18.8	19	8.30

There are 411 cases with total HoNOSCA score at Time 1 only, and for cases who had total HoNOSCA scores at Time 1 only, the average age at referral was 14.6 (standard deviation = 2.02). There are 316 cases who had total HoNOSCA scores at both Time 1 and Time 2, and the average age at referral was 14.9 (standard deviation = 2.06).

Looking at the HONOSCA total score of cases who had HoNOSCA scores at Time 1 only, the average score was 20.4 (standard deviation = 7.43). For cases who had HoNOSCA scores at both Time 1 and Time 2, the average score was 20.5 (standard deviation = 7.78). The difference between the means for cases that only had HoNOSCA total score at Time 1 compared to those with total scores at Time 1 and Time 2 was not significant ($t(661.76) = -0.17341, p > 0.05$).

Looking at the gender of cases who had total HONOSCA scores at Time 1 only, 85.9% (335/411) were male. For cases who had total HoNOSCA scores at both Time 1 and Time 2, 80.8% (269/316) were male. The difference in gender for cases who only had HONOSCA total score at Time 1 compared to those with total scores at both Time 1 and Time 2 was not significant ($X^2(1) = 0.20416, p > 0.05$).

For cases that had total HoNOSCA scores at Time 1 only, 73.0% (300/411) were White British. For cases that had total HoNOSCA scores at both Time 1 and Time 2, 69.3% (219/316) were White British. The difference in ethnicity of children and young people for cases who only had HONOSCA total score at Time 1 compared to those with total scores at Time 1 and Time 2 was not significant ($X^2(1) = 0.63611, p > 0.05$).

For discharged cases with a HoNOSCA questionnaire completed at Time 1 and Time 2 (N = 282), the mean score at Time 1 was 21.09 (SD = 8.47) and the mean score at Time 2 was 16.58 (SD = 7.97). The difference between the mean scores at Time 1 and Time 2 was significant ($t(281) = 11.18, p < 0.05$). Broken down by early and late implementers, both

groups showed a significant difference in mean HoNOSCA total scores for discharged cases. An ANOVA showed that there was a significant interaction between the effects of implementation status and time point on the HoNOSCA total score ($F(1,280)=17.06, p < 0.05$). Although children, young people’s HoNOSCA scores improved over time for both early and late implementer sites, there were higher levels of improvement in the early than late implementer sites, as shown in Figure 10.4.3.12.1.

Table 10.4.3.12.3: HoNOSCA Total Score summary statistics for discharged cases

	N	Range	Mean	Median	SD
Time 1	282	4-52	21.09	21	8.47
Time 2	282	0-44	16.58	16	7.97
(t(281) = 11.18, p < 0.05)					

Table 10.4.3.12.4: HoNOSCA Total Score summary statistics for discharged cases in early implementers

	N	Range	Mean	Median	SD
Time 1	123	8-41	20.31	20	6.45
Time 2	123	0-35	13.95	13	6.58
t(122) = 10.64, p < 0.05)					

Table 10.4.3.12.5: HoNOSCA Total Score summary statistics for discharged cases in late implementers

	N	Range	Mean	Median	SD
Time 1	159	4 -52	21.69	21	9.73
Time 2	159	1-44	18.68	18	7.968.
t(158) = 5.92, p < 0.05)					

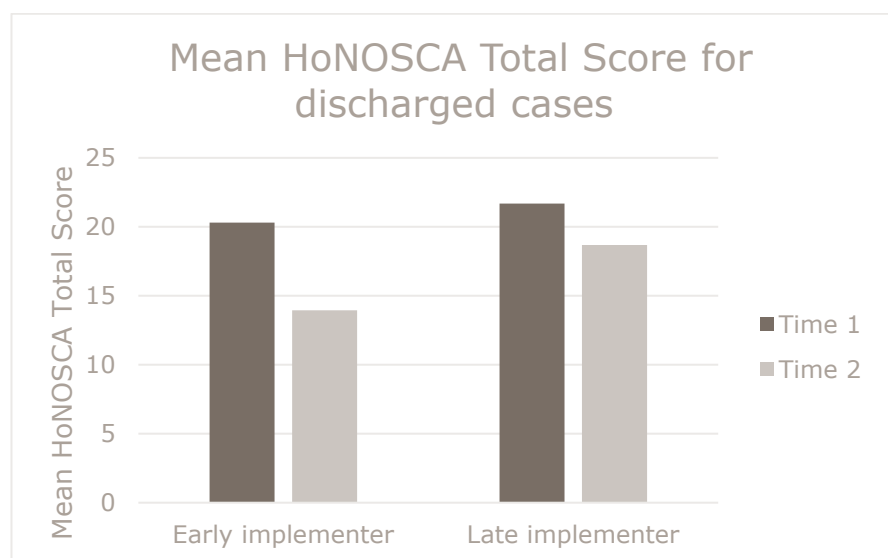


Figure 10.4.3.12.1 Mean HoNOSCA Total Score for discharged cases in early compared to late implementers

Looking at two key individual items, the majority of children and young people had problems pertaining to 'Disruptive, antisocial or aggressive behaviour' at Time 1, with only 5.65% (16/283) having 'No problem' and 30.7% (87/283) having 'Severe to very severe problem'. At Time 2, 17.7 (50/283) had 'No problem' and 12.7% (36/283) had 'Severe to very severe problem'. There was a significant interaction between the effects of implementation status and time point on the improvements in 'Disruptive, antisocial or aggressive behaviour' ($F(1,281)=25.59$ $p < 0.05$).

The majority of children and young people had problems pertaining to 'Emotional and related symptoms' at Time 1, with 6.01 % (17/283) cases having 'No problem' and 25.1% (71/283) having 'Severe to very severe problems'. At Time 2, 8.48% (24/283) had 'No problem' and 11.3% (32/283) had 'Severe or very severe problems'. There was a significant interaction between the effects of implementation status and time on the improvements in 'Emotional and related symptoms' ($F(1,281) = 27.05$, $p < 0.05$).

For both of these key individual HoNOSCA items, although children and young people's scores improved over time, there were higher levels of improvement in early compared to late implementer sites.

Table 10.4.3.12.6: HoNOSCA Disruptive, antisocial, or aggressive behaviour scores for discharged cases

	N T1	% T1	N T2	% T2
No problem	16	5.65	50	17.7
Minor problem requiring no action	26	9.19	53	18.7
Mild problem but definitely present	47	16.6	78	27.6
Moderately severe problem	107	37.8	66	23.3
Severe to very severe problem	87	30.7	36	12.7

N=283

Table 10.4.3.12.7: HoNOSCA emotional and related symptoms scores for discharged cases

	N T1	% T1	N T2	% T2
No problem	17	6.01	24	8.48
Minor problem requiring no action	26	9.19	45	15.9
Mild problem but definitely present	58	20.5	84	29.7
Moderately severe problem	111	39.2	98	34.6
Severe to very severe problem	71	25.1	32	11.3

N=283

10.4.3.13 Global health and quality of life of referrals

The EQ-5D-Y is a measure of global health and quality of life and it was essential for direct cases and optional for indirect cases. Each item on the scale is presented individually. The 5 items are rated on a 3-point scale, from 1 ('No problems') to 3 ('A lot' or 'Very'). The Overall Health Today item of the EQ-5D-Y is measured on a scale of 1 to 100. The mean score at referral on the Overall Health Today item for all discharged referrals with complete T1 and T2 EQ-5-DY (219) was 61.6 (SD = 18.6) and the mean score for these cases at discharge was 70.3 (SD = 16.1). The difference between these two means was significant ($t(218) = -5.1738$, $p < 0.05$). There was a significant difference in the mean scores for this item in early implementing services ($t(94) = -5.9822$, $p < 0.05$) and in late implementing services ($t(123) = -2.2178$, $p < 0.05$). An ANOVA showed that there was a significant interaction between implementation status (early vs. late) and time point on the Overall Health Today score ($F(1, 215) = 12.82$, $p < 0.05$). Although children and young people's overall health improved over time for both early and late implementer sites, there were higher levels of improvement in the early compared to the late implementer sites, as shown in Figure 10.4.3.13.1.

Table 10.4.3.13.1: Overall Health Today summary statistics – Discharged cases

	N	Range	Mean	Median	SD
All referral	219	16 to 100	61.6	60	18.6
All discharge	219	0 to 100	70.3	74	16.1
t(218) = -5.1738, p <0.05					

Table 10.4.3.13.2: Overall Health Today summary statistics - Discharged cases in early implementers

	N	Range	Mean	Median	SD
Early implementers referral	95	25 to 95	60.3	60	17.0
Early implementers discharge	95	35 to 95	73.2	75	12.1
t(94) = -5.9822, p <0.05					

Table 10.4.3.13.3: Overall Health Today summary statistics - Discharged cases in late implementers

	N	Range	Mean	Median	SD
Late implementers referral	124	16 to 100	62.6	65	19.7
Late implementers discharge	124	0 to 100	68.0	70	18.3
t(123) = -2.2178, p <0.05					

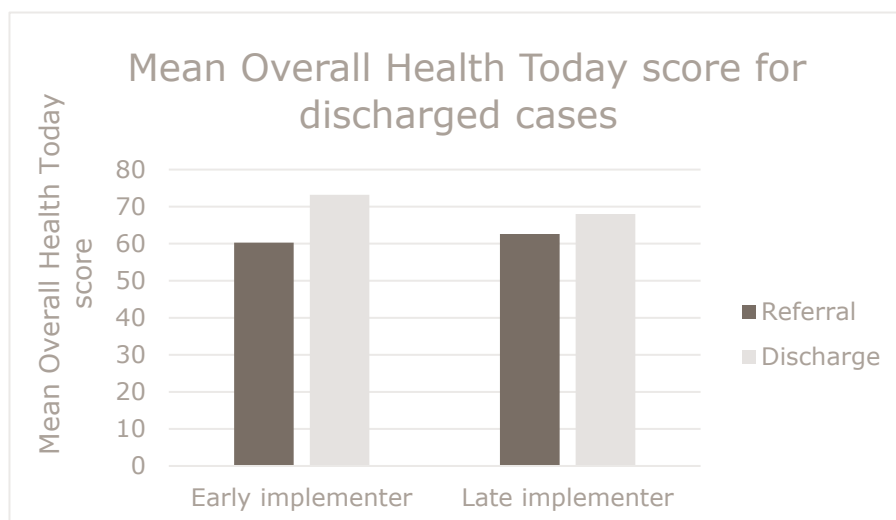


Figure 10.4.3.13.1 Mean Overall Health Today score for discharged cases early compared to late implementers

Looking at three key individual items where children and young people reported problems at Time 1, there were reductions in children and young people experiencing a lot of problems doing usual activities between referral and discharge (20.3%, 44/217 to 9.29%, 18/217) and feeling worried, sad, or unhappy (38.7%, 84/217 to 15.2%, 33/217). The interaction between the effects of time point and implementation status (early vs. late) was not significant for the 'Looking after his or herself' item ($F(1,215)=0.868, p >0.05$). There was a significant interaction between the effects of implementation status (early vs. late) and time point for the 'Doing usual activities' item ($F(1,215)=4.70, p <0.05$) and the 'Feeling worried, sad or unhappy' item ($F(1,215)=20.75, p < 0.05$). Although children and young people in both early and late implementer sites improved in 'Feeling worried, sad or unhappy' and in 'Doing usual activities', children and young people in early implementer sites had higher levels of improvement compared to children and young people in late implementer sites.

Table 10.4.3.13.4: EQ5DY key individual items - Discharged cases

		All				Early				Late			
		T1		T2		T1		T2		T1		T2	
		N	%	N	%	N	%	N	%	N	%	N	%
Looking after his or her self	No problems	169	77.9	182	83.9	71	76.3	79	84.9	98	79.0	103	83.1
	Some problems	40	18.4	32	14.7	18	19.4	13	14.0	22	17.7	19	15.3
	A lot of problems	8	3.69	3	1.38	4	4.30	<3	-	4	3.23	<3	-
Doing usual activities	No problems	102	47.0	134	61.8	33	35.5	56	60.2	69	55.6	78	62.9
	Some problems	71	32.7	65	30.0	44	47.3	33	35.5	27	21.8	32	25.8
	A lot of problems	44	20.3	18	8.29	16	17.2	4	4.30	28	22.6	14	11.3
Feeling worried, sad or unhappy	Not worried, sad or unhappy	38	17.5	69	31.8	8	8.60	29	31.2	30	24.2	40	32.3
	A bit worried, sad or unhappy	95	43.8	115	53.0	44	47.3	58	62.4	51	41.1	57	46.0
	Very worried, sad or unhappy	84	38.7	33	15.2	41	44.1	6	6.45	43	34.7	27	21.8

10.4.3.14 Child Outcomes Rating Scale of Referrals

The Child Outcomes Rating Scale contains 4 items rated by marking a 10cm line. The score is calculating by measuring the length of the line up to the mark. The total score is derived by summing the 4 items. The maximum score is 40. The data contains 95 questionnaires with at least 1 item completed. This analysis used only those that completed all 4 items (89/95). The difference between the means of CORS scores at Time 1 between early and late implementer sites was not significant ($t(88)=-1.5515$, $p > 0.05$) and an analysis of change by implementation was not performed given the relatively small numbers. At Time 2, there were 15 (15/16) questionnaires with all 4 items completed, all 15 also had a CORS score at Time 1. Analysis of Time 2 scores was not performed given the small numbers.

Table 10.4.3.14.1: Child Outcomes Rating Scale at Time 1

	N	Range	Mean	Median	SD
All	89	1.5 to 40	22.2	23	9.73
Male	82	1.5 to 40	22.3	23	9.86
Female	7	9.5 to 31.3	21.4	20	8.76
Early	64	1.5 to 40	21.2	22	9.51
Late	25	7 to 40	25.8	25.8	10.0

Table 10.4.3.14.2: Child Outcomes Rating Scale at Time 2

	N	Range	Mean	Median	SD
All	15	14.3 to 40	26.8	25	7.33

10.4.3.15 Adverse childhood experience questionnaire for referrals

The adverse childhood experience (ACE) questionnaire was completed at one timepoint. The ACE is an assessment of past trauma and an indicator of risk. There are 10 items answered yes or no, the total score is calculated by summing the number of items answered yes. The maximum score is 10. The analysis includes those with 8 or more completed items. There were 195 completed questionnaires and the mean total score was 5.68 (SD = 2.44).

Table 10.4.3.15.1: Adverse childhood experience questionnaire

	N	Range	Mean	Median	SD
All	195	0 to 10	5.68	6	2.44
Male	166	0 to 9	5.54	6	2.47
Female	29	1 to 10	6.52	7	2.11

10.4.3.16 Salford Needs Assessment Schedule for Adolescents

The Salford Needs Assessment Schedule for Adolescents (S.NASA) questionnaire was completed at two timepoints. The S.NASA is a needs assessment tool, which covers 21 areas of functioning including social, psychiatric, educational and life skills. There are 21 items answered on a 5 point scale from 'no problem' to 'severe problem'; the responses collected for each item have been analysed separately.

The data contains 53 questionnaires with at least 1 item completed. The summary below includes questionnaires that had less than 20% of items missing (i.e., up to 4 missing items). After eliminating those with more than 4 items missing, 52 S.NASA questionnaires remained at Time 1 and 21 at Time 2 of which 19 questionnaires had paired Time 1 and Time 2. Analysis of Time 2 and paired questionnaires was not performed due to the relatively small numbers. All S.NASA questionnaires were completed by early implementing services, so analysis by implementation stage could not be performed.

Table 10.4.3.16.1: Salford needs assessment schedule for adolescents

	No problem		Mild problem		Moderate problem		Marked problem		Severe problem	
	N	%	N	%	N	%	N	%	N	%
Self care	24	46.2	13	25.0	10	19.2	4	7.69	<3	-
Diet/ food	25	48.1	17	32.7	6	11.5	4	7.69	0	0
Impact of physical illness on mental health	16	30.8	10	19.2	9	17.3	14	26.9	3	5.77
Education attendance	13	25.0	6	11.5	6	11.5	9	17.3	18	34.6
Education performance	12	23.1	8	15.4	9	17.3	11	21.2	12	23.1
Weekday occupation *	8	15.4	7	13.5	6	11.5	12	23.1	15	28.8
Peer/social relationships	<3	-	5	9.62	10	19.2	15	28.8	21	40.4
Family relationships/ functioning	36	5.77	6	11.5	8	15.4	14	26.9	21	40.4

Cultural/ racial identity*	37	71.2	5	9.62	5	9.62	<3	-	<3	-
Destructive behaviour	14	26.9	6	11.5	11	21.2	17	32.7	4	7.69
Hostile behaviour to persons	8	15.4	7	13.5	9	17.3	17	32.7	11	21.2
Oppositional disruptive behaviour	15	28.8	7	13.5	7	13.5	16	30.8	7	13.5
Inappropriate sexual behaviour	31	59.6	6	11.5	3	5.77	4	7.69	7	13.5
Substance Misuse*	39	75.0	3	5.77	4	7.69	4	7.69	<3	-
Depressed mood	18	34.6	11	21.2	12	23.1	9	17.3	<3	-
Deliberate self harm	30	57.7	8	15.4	8	15.4	4	7.69	<3	-
Psychological distress	8	15.4	9	17.3	12	23.1	13	25.0	10	19.2
Hallucinations, delusions and paranoid beliefs	35	67.3	6	11.5	3	5.77	6	11.5	<3	-
Leisure/ activities	10	19.2	7	13.5	8	15.4	18	34.6	9	17.3
Living situation	14	26.9	4	7.69	7	13.5	17	32.7	10	19.2
Money/ benefits/ allowances	31	59.6	5	9.62	7	13.5	6	11.5	3	5.77

* Missing data is not reported in the table due to small numbers, items marked * had missing data.

10.5 Feedback from professionals in contact with Community F:CAMHS

Services collected feedback from professionals in contact with the service regarding their interactions with Community F:CAMHS. The questionnaire contains 9 questions (5 key items shown) with response categories ranging from strongly disagree to strongly agree. We received data for Phase 1 and Phase 2, which is presented below. Professionals in contact with the service reported high levels of positive feedback.

Table 10.5.1: Feedback from professionals in contact with the service

Item (agree/ strongly agree)	Number	%
Overall, I am satisfied with the response(s) I have received from the Community F:CAMHS team	250/261	94.3
I would recommend this service to a colleague	249/261	95.4
The input of F:CAMHS has led to a better understanding of the young person's needs	206/261	78.9
The input of F:CAMHS has led to a better treatment plan being developed	175/261	67
The input of F:CAMHS had led to a better risk plan being developed	181/261	69.3



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