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# Children & Young People

For counsellors and psychotherapists working with young people

**22**  
*Equine assisted  
play therapy*

**28**  
*Qualitative  
research*

**42**  
*Using TA in  
supervision*

March 2016

**04**

*Crisis in CAMHS:  
can i-THRIVE  
provide a solution?*



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# CONTENTS

## *Features*

### **04 | CAMHS and i-THRIVE**

Anna Moore on the crisis in CAMHS, and new developments

### **11 | Adventurous groupwork**

Barr Kazer describes her work using 'Adventure Tales'

### **22 | Equine assisted play therapy**

Interview with Tracie Faa-Thompson

## *In practice*

### **15 | 'Talking' sandscapes**

Julie Griffin describes her work with a sand tray

### **18 | Art creativity in client work**

Jennifer Guest offers clients a variety of art worksheets

### **42 | Supervision with TA concepts**

Lynn Martin outlines how and why these are useful

## *Issues*

### **28 | Qualitative research**

Nikki Kiyimba advocates for capturing the nuances of our work

### **32 | The confidence crisis**

Annette Du Bois coaches young people towards confident self-belief

### **35 | Anxiety**

Polly Waite wonders how we can improve interventions with anxious adolescents

## *Regulars*

### **20 | Reflecting on... fairy stories**

Jeanine Connor

### **20 | Thinking about... teenage suicide**

Anna Jacobs

### **21 | Considering... saying what you think**

Nick Luxmoore

### **40 | Updates and resources**

### **46 | Reviews**

### **51 | From the Chair**

# WELCOME

Often, when writing up clients' notes, I find myself metaphorically cheering from the sidelines at the hard work they've been doing in moving towards renewed mental health and wholeness. If I were to think about what awaits them if my support fails and they need even more specialist input, I would probably lose the will to live, given the current general provision for young people's mental health needs.

And these are great. For instance, last December, the *Sunday Telegraph* reported that a survey of nearly 10,500 11 year olds showed that those from broken or rearranged families were three times more likely to suffer mental health problems.<sup>1</sup> And Andy Bell, chief executive of the Centre for Mental Health, commenting in the same article, admitted that we don't know from the information available why children living with *both* parents are less likely to have mental health problems at age 11, but posited that incomes and poverty have their effect and that stress and distress among parents may be an important factor. This, I think, is roughly what we've deduced from our day-to-day work with young people and our knowledge of their family context. But rearranged households are now commonplace and these children will run the country in future. So we need ways of providing suitable timely help.

Which brings me to Nikki Kiyimba, who has written for us about the value of qualitative research in moving towards better services. The significance of it is fairly obvious. Firstly, we need to take account of the *context* of the children we want to help – or provision will miss its target. And secondly, we need to hear exactly what is causing distress in an *individual* child, not 10,500 children in general. Then needs can be met.

I've always been slightly suspicious of mere figures, anyway, because figures only give a broad sweep of a situation. Such as the fact that CAMHS is not coping, that many clients do not reach the threshold now, despite their need, and that waiting times are often horrendous. On the other hand, words tell us individual stories. ChildLine has recently underlined this in its report that about 35,000 of the telephone counselling sessions they conducted in 2014–15 were related to low self-esteem and unhappiness.<sup>2</sup> Although collated

into a numerical announcement, these were 35,000 individual stories when the children rang in, not tick boxes. And the counsellors will not have applied one solution to all of them, but would have listened to each child's predicament and helped them decide what they wanted to do – or not. The child's choice. Most of them would not meet the current CAMHS threshold anyway, so something more is needed *in the community at large*.

And this is why I asked Anna Moore to write about the current state of CAMHS and the roll-out of a new conceptual framework that proposes to work in the system but be distinct and wider in scope. The THRIVE model had been mentioned in an earlier article in this journal,<sup>3</sup> and I felt it warranted further investigation for those of us who hadn't encountered it. The idea behind the THRIVE principles for looking after young people's mental health is to demarcate between treatment and support, between self-management and intervention, and to deliver a whole-system approach, delivered from a much wider group of organisations across communities. i-THRIVE is this vision translated into a model of care. I think the 'care' part is what motivates most therapists. But in the population at large there always has to be a structure, a framework, for things to be rolled out widely. So I, for one, am now cheering at the sidelines for the initiative's success, because nothing is so depressing as knowing there is so little out there for many 'sub-threshold' young people in their family contexts that really touches their needs.

**Eleanor Patrick**  
Editor

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# THE CRISIS IN CAMHS: CAN I-THRIVE PROVIDE A SOLUTION?



**Anna Moore** identifies the problems besetting the provision of mental health services to young people, and assesses the role of i-THRIVE as a new needs-based model of prevention and promoting mental health and wellbeing

Contributing authors: Peter Fonagy, Paul Jenkins, Rita Harris, Miranda Wolpert

Numerous inquiries into Child and Adolescent Mental Health Services (CAMHS) have identified structural problems with service delivery and led to the current unprecedented interest in improving mental health outcomes for children and young people.

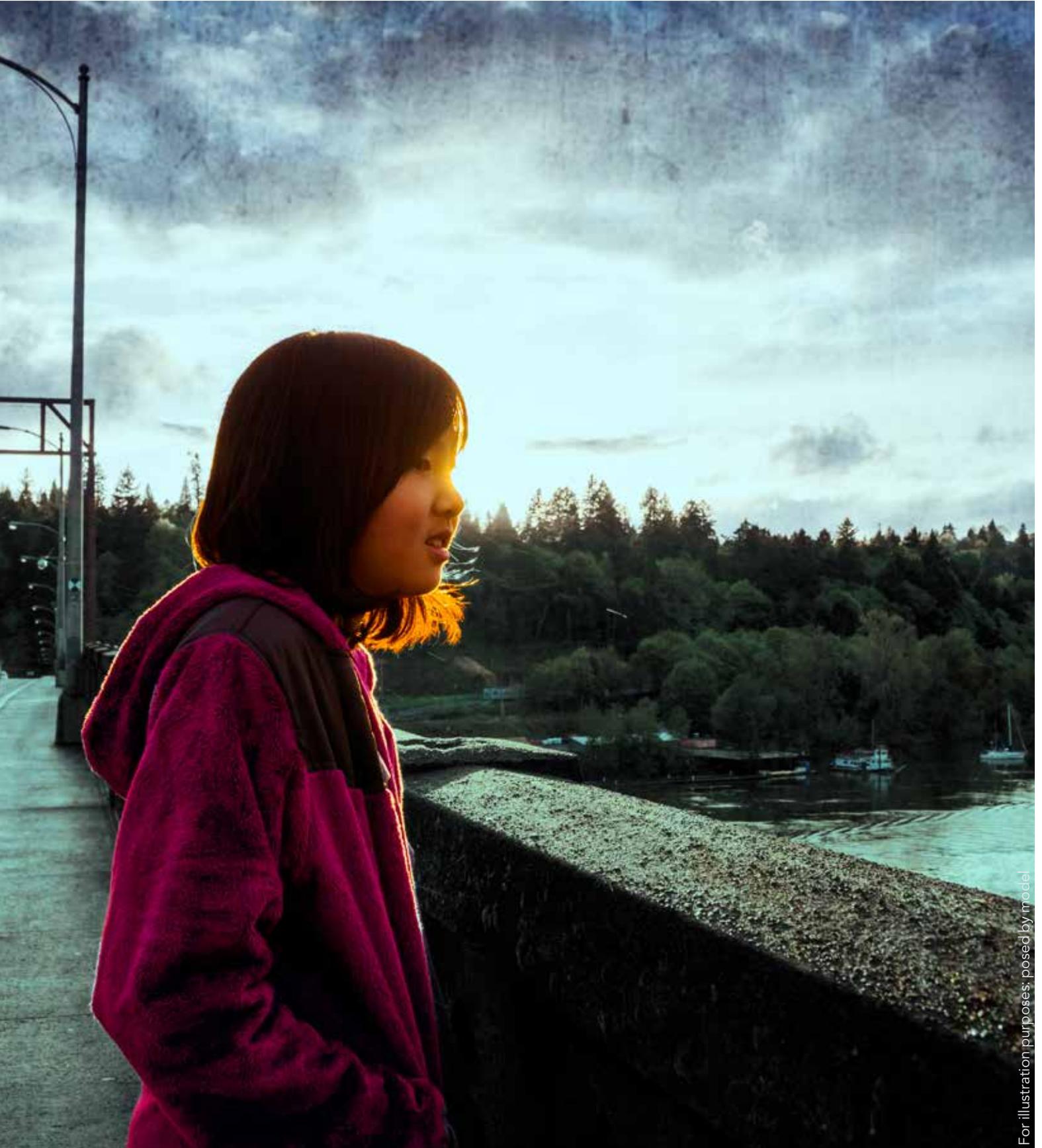
Most recently the Health Select Committee's inquiry into CAMH services and NHS England's review of inpatient CAMHS bed provision in 2014 highlighted major problems. Findings included children waiting long periods for a hospital bed, cuts to early intervention services, long waiting times for CAMHS, children and young people being placed in beds hundreds of miles away from home and being placed on adult wards inappropriately. Coinciding with this was the publication of NHS England's major national policy document, the 'Five Year Forward View',<sup>1</sup> with significant emphasis on parity of esteem for mental health, together with a national emphasis on prevention. In response, Care Minister Norman Lamb announced a government taskforce to review CAMHS. The output was the 2015 policy document, *Future In Mind*.<sup>2</sup>

*Future In Mind* recognises the urgent need to improve quality through better access and timeliness, to make care young person centred, equitable, efficient

and more effective. The problems identified with current provision are summarised in box 1.

Access and timeliness are identified as a problem. This is thought to be largely due to a lack of capacity in services, and challenges in signposting and discharge. The average wait for routine appointments is 15 weeks and urgent help three weeks, with only 31 per cent of children and young people who require intervention accessing services.<sup>3</sup> For those who do receive care, lack of user involvement in assessment, and decisions about preferences for care, have caused poor engagement with services, as highlighted by the recent Department of Health (DH)-funded payment by results study, which found the most usual number of contacts young people have with services is one.<sup>4</sup> *Future In Mind* also recognised the urgent need to make care person centred, highlighting that children and young people must be involved in making choices about their care. Most providers feel that they already undertake a holistic, person-centred assessment: when surveyed, 75 per cent of providers report that they have implemented shared decision making. However, 66 per cent of young people indicate that they feel they have had little or no involvement in decision making.<sup>5</sup> Together, the findings of the task force have prompted the Government to





For illustration purposes; posed by model

### Priorities for improvement for CAMHS

- Treatment gap: only 25%–35% of young people who need support access services, with increasing levels of need in some groups eg young women with eating disorders.
- Difficulty with access: benchmarking shows an increase in the number of referrals and length of waiting times. Waiting times are around three weeks for crises and 18 weeks for routine care.
- Complex commissioning arrangements: lack of clear accountability between providers,
- especially between clinical commissioning groups and local authorities.
- Worse care for vulnerable groups: they find it hard to access services and often can't relate well to them if they do receive treatment.
- Gaps in data collection: lack of useful data and information, and there have been delays in developing payment and other incentive systems.
- Lack of choice and involvement in decisions about care.

commit £1.25 billion to support CAMHS transformation over five years.

### Initiatives to date

Attention has been turned towards the improvement of CAMHS over the past 20 years – see an overview of this in figure 1. The publication of *The Handbook for Child & Adolescent Mental Health* and *Together We Stand*, in 1995, marked the beginning of this, and paved the way for CAMHS development within a four-tier framework for planning, commissioning and delivery.

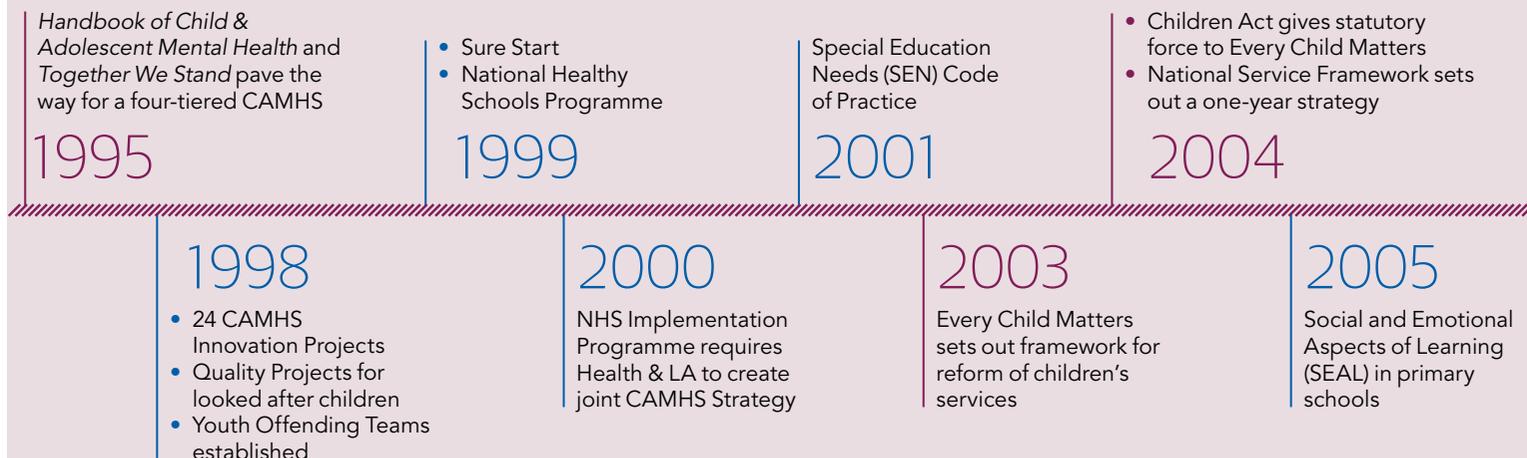
Linked to these policy initiatives was the development of an ever-evolving performance framework, that aimed to incentivise the implementation of these new ways of working and measure effectiveness. The first was linked to the National Service Framework in 2004, emphasising the importance of service delivery process measures, such as waiting times and length of stay. In 2012, the

emphasis shifted from process to outcome measures, and the Secretary of State for Health launched the Children and Young People's Health Outcomes Strategy by establishing a forum. This was closely followed by establishing a national children and young people's outcome board to oversee delivery, chaired by the Chief Medical Officer.

Weaving through these major policy initiatives and performance frameworks was a range of quality improvement and implementation programmes that sought to target the wider determinants of child mental health, such as education or maternal health and wellbeing. The first quality improvement projects to receive national funding were aimed at looked after children in 1998. This was soon followed by projects focusing on parenting and schools, with the launch of Sure Start, Youth Offending Teams and Healthy Schools programmes. Ten years later saw the launch, in 2008, of the Targeted Mental Health in Schools

Figure 1: Timeline showing the major policy initiatives, quality improvement programmes and performance frameworks relating to child and adolescent mental health

- policy documents
- quality improvement projects and performance frameworks



(TaMHS) pathfinders, followed by their formal evaluation in 2011.<sup>6</sup>

The biggest transformation programme to date – focusing on structural reform as well as delivery of evidence-based interventions – was launched in response to *No Health Without Mental Health* and supported by a £52 million investment in children's psychological services. This initiative built on lessons learned from the adult Improving Access to Psychological Therapies (IAPT) programme, launched three years earlier, which aimed to make evidence-based psychological therapies for depression and anxiety widely available in the NHS. The CYP-IAPT programme, compared to its 'grown up' counterpart, was both more and less ambitious. It was less ambitious because it stopped short of creating an entirely new service with therapists specifically trained to deliver treatments for common mental disorders. But it was more ambitious because, rather than providing a relatively narrow specialist service for a specific set of difficulties, it aimed to improve the functioning of existing CAMHS, transforming services provided by the NHS, local authorities and the third sector, by creating partnerships working together with commissioners. Across the country, these partnerships were to have a common, coherent set of principles of service organisation and delivery.

CYP-IAPT has indeed made significant improvements to services. An internal audit, involving 12 CAMHS partnerships with 6,803 young people from 11 services,<sup>7</sup> showed that the key benefit was improved efficiency. The time between referral and assessment decreased by 73 per cent, from 239 days in 2010 to 64 days in 2014. The average number of days between assessment and discharge also decreased by 21 per cent, from 299 pre CYP-IAPT to 235 in 2014. Interviews

also revealed that the staff attributed improved throughput to the use of routine outcome measurement. And the audit showed improvements in accessibility through self-referral routes, single points of access, outreach services and evening and weekend appointments. The average number of accepted self-referrals increased by 195 per cent, although this was from a low base of ~0.5 per cent self-referrals. Interviews with young people and parents confirmed the desirability of this option. CYP-IAPT services were more evidence based in terms of the treatments they offered, and clinicians described feeling more confident in choosing and delivering evidence-based treatments.<sup>7</sup>

### *Reasons for improvement*

These improvements in outcomes have been achieved through a number of mechanisms. First, access to evidence-based therapies was improved by training CAMHS staff in standardised curricula of NICE-approved and best-evidenced therapies. Second, access was also improved through self-referral. Third, user participation was required, not only in individual treatments, but also in service design and delivery. Children, young people and parents were involved at both a national and local level to help steer the programme. Fourth, participation was further assured by using regular client feedback through session-by-session outcome monitoring to guide therapy in the room, with a mixture of individualised goal and symptom measures suitable for all those presenting to community CAMHS. Finally, managers and service leads were concurrently trained in change, demand and capacity management to support the system changes linked to CYP-IAPT. The model of delivery was through five learning collaboratives. These are made

Social and Emotional Aspects of Learning (SEAL) in secondary schools

2007

New Horizons: whole-population mental health strategy

2009

- No Health Without Mental Health
- £52m & CYP-IAPT established
- Suicide prevention strategy
- Me & My School (evaluation of TaMHS)

2011

CYP Health Outcomes Board established, chaired by CMO

2013

- Future In Mind
- £1.25bn for five-year CAMHS Transformation programme

2015

2008

- Children's Plan
- Think Family Initiative
- TaMHS Pathfinders
- Child Health Promotion Programme
- National CAMHS Review
- 2020s Children Workforce Strategy

2010

- National Advisory Council for Children's Mental Health & Psychological Wellbeing's first report
- Age-appropriate environments become a duty of Trusts

2012

- CYP Outcomes Strategy
- No Health Without Mental Health Implementation Framework

2014

- Crisis Care concordat
- Health Select Committee Enquiry into CAMHS
- NHS England review of IP services
- CAMHS Taskforce
- Five-Year Forward View

up of higher educational institutions (HEIs) working with CAMHS partnerships (NHS, local authority and voluntary sector providers). The programme currently includes 82 partnerships, working with services that cover 68 per cent of the 0–19 population nationally, and is setting up new partnerships for 2015/2016.

The core of this initiative is empowering children and young people to take control of their care, to engage in shared clinical decision making, to establish treatment goals appropriate to them, to choose the route to health that's best for them and, through this active engagement, to strengthen their agency and trust. Participating in service design, understanding and modifying treatment progress via patient-rated outcome measures (PROMs) and participating in the training of practitioners and managers, all serve to enhance a sense of agency. While participation of service users in clinical decision making improves the efficiency of healthcare provision across all medical specialties,<sup>8</sup> in mental health it has a special function, as it contributes to the re-establishment of trust in socially transmitted information. This trust is often lost for children and young people whose experience of social adversity, including their experience of healthcare, has made them suspicious to a point where a vital interpersonal channel for learning about the social world is no longer accessible. 'They hear but they cannot listen.'<sup>9</sup> Increased participation, particularly in clinical decision making, serves to restore these young people's trust. Through responding to their preferences, feelings and thoughts, showing them that we are hearing and thinking about what they are experiencing, we enhance their capacity to absorb and respond to socially transmitted information.<sup>9</sup>

### *Moving forward*

Despite the improvements that CYP-IAPT has successfully delivered, *Future in Mind* highlights that mental health provision for young people still has a long way to go. In an attempt to address these issues, the new conceptual framework THRIVE<sup>10</sup> has been developed in collaboration between the Anna Freud Centre and the Tavistock and Portman NHS Foundation Trust. It tackles existing challenges within CAMHS by drawing a clearer distinction than before between treatment and support, and between self-management and intervention. THRIVE is a needs-based model that enables care to be provided according to four distinct population groupings, determined by a client's needs and preferences for care. Emphasis is placed on prevention and the promotion of mental health and wellbeing, and clients are empowered to be actively involved in decisions about their care through shared decision making. The THRIVE framework is shown in figure 2; the diagram on the right shows the five THRIVE groups (which includes the centre group of population, those who are thriving), and the one on the left illustrates the input offered for each group. Each THRIVE group is distinct in terms of (1) needs and choices of the individuals, (2) skills required to meet

these needs, (3) dominant metaphor used to describe needs (wellbeing, ill health, support), and (4) resources required to meet the needs and/or choices.<sup>8</sup>

### *Developing a population health system for delivery of child mental health: going beyond integrated care*

While CYP-IAPT has delivered significant reform of CAMHS services and has gone some way to promoting integration by supporting partnership working between agencies, we need to consider the system beyond health alone if we are to deliver high-value care, defined as the best outcomes achievable for a given resource envelope. To date, integrated care has focused on improving the processes of care *within* the NHS, and, more recently, on more systematically integrating processes between health and social care systems, most notably through the Better Care Fund.<sup>11</sup> The focus has been on effectively co-ordinating care – with the aim of improving value, experience and health outcomes. However, as highlighted by Marmot's Whitehall Study,<sup>12</sup> wider determinants of health have a larger impact on health than access and provision of health and social care alone. It follows that improving the outcomes of populations requires efforts to change behaviours and living conditions of people across communities, and goes beyond merely co-ordinating care better between agencies. In a recent King's Fund Report,<sup>13</sup> Alderwick and colleagues argue that an approach to integration limited to better co-ordination of health provision, or even the provision between health and social care, risks missing the point if the goal is improvement of population health outcomes. Population health improvement can only be achieved by collaboration between a range of sectors and communities, including public health, NHS, local authorities and third sector. Additionally, individuals must be enabled to be active participants in their care as well as supported to self-manage and make use of resources available in the communities in which they live. It follows that accountability for the delivery of those outcomes needs to be spread across communities, and not limited to single organisations, or to health and care. There is a growing number of examples of this approach to delivering improvement, both in the UK and abroad.<sup>13</sup>

THRIVE in fact articulates a set of principles that, when implemented, provide a mechanism to deliver a population health system able to deliver a whole-system approach to improving outcomes and value for young people's mental health. To progress this, the THRIVE conceptual framework has been translated into a model of care, i-THRIVE, which is currently being rolled out nationally as part of the NHS Innovation Accelerator Programme.<sup>14</sup> i-THRIVE has been designed to enable delivery of services that move a step further from integrated care towards delivery of a population health model for child mental health. The approach taken can be described across three system levels: macro, meso and micro.

*Figure 2: The THRIVE Conceptual Framework (reprinted from Wolpert et al,<sup>10</sup> with thanks to CAMHS Press)*

#### Input offered



#### Description of the THRIVE-Groups



**At a macro level,** i-THRIVE involves organisations working together to improve outcomes for child mental health. Unlike typical approaches to integrated care that focus primarily on groups that are frequent users of health and care services, i-THRIVE aims to improve young people's health across the whole of the population, as well as targeting specific interventions at the most deprived groups. Key features supporting the systems at a macro level include:

- population-level data to understand need across populations and track health outcomes
- population-based budgets to align financial incentives with improving population health
- community involvement in managing health and designing local services
- involvement of a range of partners and services to deliver improvements in population outcomes.

**At a meso level,** i-THRIVE is developing different strategies for different population groups, depending on young people's needs and level of risk. By grouping people with similar needs and tailoring services and interventions accordingly, this approach recognises that improving the health of young people with different needs will require a different set of approaches, and involvement from different system partners in order to be effective. Key features that support the systems at a meso level include:

- population segmentation and risk stratification to identify the needs of different groups within the population
- targeted strategies for improving the health of

- different population segments
- developing 'systems within systems' with relevant organisations, services and stakeholders to focus on different aspects of population health.

**At a micro level,** i-THRIVE delivers a range of interventions aimed at improving the health of individuals and their families. These interventions are many and varied, and involve input from a number of organisations and services. They may include digital intervention, peer support, self-help, providing advice, help with housing or education support, exercise programmes and other lifestyle support, as well as more traditional health and care services like care planning and individual case management for people with complex health and care needs. Key features that support the systems at a micro level include:

- effective shared decision making during assessment and throughout care, to understand what matters most to young people about their care, as well as supporting and empowering individuals to manage their own health
- integrated health records and care plans to co-ordinate young people's care
- scaled-up primary and community care systems that provide access to a wide range of services and co-ordinate effectively with other services
- close working across organisations and systems to offer a wide range of interventions to improve people's health.

Across these three system levels, i-THRIVE illustrates what the shift towards population health means in

practice, as well as the range of benefits that can be achieved from pursuing this way of working.

Importantly, i-THRIVE is not looking to replace existing service transformation programmes. Rather, it has been designed to be complementary to successful existing models, eg CAPA,<sup>15</sup> and builds on CYP-IAPT to create a more systematic integration across sectors, as well as shared decision making and routine collection of preference data.<sup>16</sup>

Finally, i-THRIVE describes the practical aspects of developing a whole-system approach to child mental health. Implementation requires the following elements as a minimum:

- shared goals for improving health and tackling inequalities, based on an analysis of needs and linked to evidence-based interventions
- segmentation of the population to enable interventions and support to be targeted appropriately, according to need
- local leadership, drawing on skills from different agencies and sectors, based on a common vision and strategy
- effective engagement of communities and their assets through third sector organisations and society
- pooling of data about the population served, in order

to identify young people's needs and preferences for care, as well as the challenges to good-quality care

- pooling of budgets to enable resources to be used flexibly to meet population health needs, at least between health and social care but potentially going much further
- paying for outcomes that require collaboration between different agencies in order to incentivise joint working on population health.

Currently, 10 sites across England have been identified as implementation accelerators, and are working collaboratively to implement i-THRIVE as part of their CAMHS transformation plans. They are supported by a team made up of members of the i-THRIVE Partnership, which includes the Anna Freud Centre, the Tavistock and Portman NHS Foundation Trust, Dartmouth Centre for Healthcare Delivery Science (US) and UCLPartners. Among the members, there is agreement that a step change is required for CAMHS to meet its statutory objectives, and that this can't be delivered by focusing on CAMHS alone. We hope that this partnership will assist in delivering transformation and will shine a spotlight on structural and cultural barriers to genuinely integrated working that is led by young people and their needs.

**Anna Moore** is a trainee psychiatrist working in child and adolescent mental health services in Cambridge. She is Implementation Lead for the i-THRIVE Partnership, which brings together the Anna Freud Centre, Tavistock and Portman NHS Foundation Trust, Dartmouth Centre for Healthcare Delivery Science and UCLPartners to support implementation of the i-THRIVE needs-based, person-centred model of care for children and young people's mental health. Anna has been awarded a national NHS Innovation Accelerator Fellowship to lead on scaling up i-THRIVE.

She is currently completing an Improvement Science PhD at UCL, focusing on mental health crisis care pathways. Prior to this, Anna was Director of Mental Health at UCLPartners alongside Professor Peter Fonagy. She was the NHS Medical Director's National Clinical Fellow to Professor Sir Bruce Keogh, working as part of the NHS Outcomes Framework team.

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