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Survey of in-patient admissions for children and young people with mental health problems

Young people stuck in the gap between community and in-patient care

Faculty of Child and Adolescent Psychiatry,
Royal College of Psychiatrists

FACULTY REPORT

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Executive summary and recommendations

This survey was conducted by the Royal College of Psychiatrists. It gathered views from child and adolescent psychiatrists about their experience of working with children and young people at the point of admission to in-patient psychiatric facilities. Its conclusions are drawn from the experience of consultants working in community and in-patient settings across the UK.

The survey resulted in some quantitative information, but has a stronger focus on qualitative accounts of the patient journey. The emphasis of this report is in this direction, to reflect the experience of children and young people stuck in the gap between community and in-patient care. The recommendations aim to address concerns arising from this experience.

Recommendations

1. Responsible commissioning groups and health boards need to recognise the increasing pressures on community services and the increasing complexity and risk that characterises the children and young people presenting to services. There are concurrent pressures on multi-agency services, notably education and social care, that have a knock-on effect on health services: these need to be addressed.
2. Resource investment should target strengthening community mental health services in order to minimise the need for admission. This survey points to significant, recent disinvestment in child and adolescent mental health services (CAMHS), which are strongly affecting community services and working in the opposite direction.
3. Intensive outreach services should be comprehensively commissioned by responsible commissioning groups and health boards to ensure an even distribution around the UK. These services need to include crisis assessment and crisis management, services designed to facilitate early discharge and planned intensive home treatments.
4. There need to be financial incentives across the in-patient/community CAMHS boundary that promote services working effectively together, in order to optimise mental healthcare for children/young people, minimise length of stay in in-patient units, and allow for safe, appropriate community care (where this is possible). This should be made more possible by the investment in community services that we recommend above.

5 Joint working across agencies should be encouraged locally through partnership and safeguarding boards. This needs to promote the mental health of young people and to mitigate the likelihood both of delayed discharges and delayed admission.

6 We strongly recommend that careful thought is given to services for vulnerable and high-risk children and young people. We welcome the Government's recent announcement that they will ban the use of police cells as 'places of safety' for children. However, we urge the Government to prioritise investment in crisis care services for children and young people and urge NHS England, clinical commissioning groups and social services to ensure that adequate emergency care pathways are in place as a matter of urgency.

Introduction

This survey was conducted at the instigation of the Royal College of Psychiatrists' Child and Adolescent Psychiatry Faculty Executive. The Executive had a strong impression that admission to hospital for children and young people with mental health problems had become substantially harder during 2013. The Executive wanted to gather views from the membership in order to investigate and thereby make recommendations to improve the situation.

Policy context

Since the data were collected, there have been a number of important initiatives. The review of in-patient care provision commissioned by NHS England is of particular note, and is referred to later (CAMHS Tier 4 Report Steering Group, 2014). Dame Sally Davies, the Chief Medical Officer for England, highlighted concerns about the welfare of children's mental health in her public health report (Davies, 2014). Her report has been enthusiastically welcomed.

The House of Commons Health Committee (2014) report, *Children's and Adolescents' Mental Health and CAMHS*, was extremely welcome. The recommendations have strong echoes of our report, particularly in the following areas: the need to strengthen community CAMHS services; the need to reduce inappropriate placements such as police cells or adult mental health facilities; and the need to bridge the gap between in-patient and community CAMHS by reducing perverse commissioning incentives and ensuring the robust commissioning of intensive outreach services.

In the Government's 2014 autumn statement, it was announced that it would invest £150 m over 5 years in eating disorders services, with the aim of getting young people with eating disorders and self-harm early access to community services staffed by properly trained teams, making hospital admission a last resort. In addition, important work is being undertaken by the Children and Young People's Mental Health (CYP-MH) Taskforce. Their findings are eagerly awaited.

Although these initiatives are all welcome, it is concerning that year-on-year CAMHS funding has fallen by £50 m over the past 5 years, together with a reduction in funding from social care commissioners (Buchanan, 2015). These funding drops confirm the concerns of our members raised within this report.

Design outline

The survey was designed and sent out in November 2013, with a closing date of 20 December 2013. The survey asked about experiences over the last 12 months, covering the full period of 2013. There were 370 responses, giving an estimated return rate of approximately 30% of Faculty members.

Sources of information

The tables in Appendix 1 show that the survey is reasonably representative of the employed population, although it includes a larger than expected proportion of responses from England.

Community CAMHS psychiatrists' perspective

Difficulty in accessing beds

Accessing in-patient beds became much more difficult over 2013. Over 70% of respondents experienced frequent difficulties ('often' or 'always'), and over 50% found the situation much more difficult than the previous year.

When broken down according to country in the UK, the greatest difficulty was reported in England, with a 77% response rate for reported difficulties ('often' or 'always'), declining to 66% for Scotland and 55% for Wales. There was only one response from Northern Ireland, which reported difficulties 'sometimes'.

When looking at the type of respondent, the extent of difficulty was slightly lower if the doctor was working in an intensive outreach team (60%), though not as low as one might anticipate, given the close links with in-patient services that intensive outreach teams could be expected to have.

Types of beds

Bed access difficulties affected all types of bed provision, but predominantly generic adolescent beds, as in Table 1, below. The next most affected were eating disorders units, followed by psychiatric intensive care units (PICUs). Children's units, intellectual disability facilities and, finally, forensic services were less commonly mentioned.

Table 1 Which type of CAMHS tier 4 bed have you had difficulty accessing (select as many as apply)?

Bed type	Number of responses, *n* (%)
Generic adolescent	322 (87.5)
Eating disorder	139 (37.8)
PICU	112 (30.4)
Generic children's unit	78 (21.2)
Intellectual disability	78 (21.2)
Forensic	39 (10.6)
Not applicable	12 (3.3)

This distribution is more or less in line with the distribution and need for units. Therefore, the problem seems to be affecting all types of in-patient services.

The lack of available specialist PICU beds can have a significant impact on the safe and effective functioning of generic units. For example, one respondent stated that:

> 'A patient was left 9 days on a generic unit after an assessment had determined that a PICU bed was required. Resulted in 14 staff assaults. From Jan–Oct 2013 on average 1 patient per month inappropriately placed on adolescent unit when a PICU bed could not be found.'

Effects on safety

Overall, 79.1% of respondents reported safeguarding concerns while waiting for a bed; 76.5% reported young people with unacceptably high risk profiles having to be managed in the community because of a lack of beds; 61.9% reported young people being held in inappropriate settings such as paediatric and adult wards, police cells, Section 136 suites, and accident and emergency (A&E) departments. In total, 14% of respondents' comments described patient suicide attempts while waiting for a bed, and 13% described episodes of violence.

Perceived reasons for difficulty

Perceived reasons for the increasing difficulty in accessing beds were varied and generally thought to be multi-factorial. The following issues were believed to be significant:

- increase in referrals (56.0%)
- decreased capacity of social care (49.5%)
- decreased in-patient capacity (48.4%)
- decreased community CAMHS capacity (47.3%)
- changes in commissioning arrangements (44.0%)
- change in clinical need or complexity of cases (42.9%)
- decreased capacity for intensive outreach (31.0%).

The qualitative information gathered expanded these ideas further.

New national commissioning arrangements in England

Respondents indicated that the new commissioning arrangments have resulted in less local control and accountability.

> 'Our eating disorders service for children was commissioned by the primary care trust to provide enhanced care to prevent and/or shorten admissions. When commissioning shifted to general practitioners, the clinical commissioning group said they could not fund it as it was NHS England's responsibility and NHS England refused to fund it.

Our admission rate has shot up and it is impossible to find beds.'

'Now no financial incentive for tier 3 services to tolerate any degree of risk – all funded centrally. Now no incentive for tier 4 to refuse inappropriate admissions – allows beds to be blocked so that not then expected to take PICU cases that can't be found a bed because no PICU beds free nationally.'

'Our bed occupancy has significantly increased. Since the change in commissioning arrangements we have had young people admitted from as far as Ipswich and Birmingham and have had significant difficulties in arranging transfer back to local services, partly because of other units being full, but also because of differences in criteria for admission/transition to community teams in other areas. This has led to unnecessary delays in discharge and transfer back to local areas for some young people. NHS England do not appear to offer any centralised support to facilitate such moves to more appropriate local areas.'

Community CAMHS and social care services unwilling to manage riskier cases

A number of respondents stated that community CAMHS and social care services have become less able or less willing to manage riskier cases in the community.

'... there has been a reduction in capacity of CAMHS to take positive risks with these youngsters, who are more likely to have emotional instability than severe mental illness. We are also affected by cuts in social care and have several young people with emotional instability who remain in hospital because they are at some risk of self-harm and have no accommodation.'

Increase in cases with complex needs

Respondents indicated that the case mix is changing, with children and young people presenting with increasingly complex needs, particularly eating disorders and recurrent self-harm.

'... there has been an increase in severity of impulsive self harm, whereby young people are actually jumping from bridges, attempting hanging or seriously overdosing rather than just threatening to do so. Several of admissions this year have had broken legs/arms etc ...'

Cuts

We asked the membership about cuts in funding over the last year. Of those who felt they had appropriate information, 78% (of 192 responses) thought that local tier 2/3 services had seen cuts: 29% thought that there had been cuts of 25–50% in the service budget and 49% thought that there had been cuts of <25%. Only 17% thought there had been no cuts.

Cuts were also reported in tier 4 (in-patient services), although less frequently. Overall, 32% (of 95 responses) identified financial reductions of <25%; 53% of respondents reported no cuts.

In addition to cuts in finance, respondents commented on additional pressures on resources that have impacted on service delivery, including the closure of units in parts of the country.

> 'In order to make cost savings because of the mounting bill, some trusts are making staff redundant or offering them mutually agreed resignation or closing units down totally and re-organising staff to provide a tier 3+ service despite there being an on-going need for beds. This is leading to low morale of nursing staff ... and those mental health nurses with mental health officer status are now deciding to take early retirement and leave, leaving with the wealth of experience to those who have just qualified. Some nursing students that have just qualified (i.e. without any working experience of CAMHS ...) are applying for, and getting, band 6 nursing jobs ... The inability of trusts to recruit PERMANENT child psychiatrists continues to be a big problem ... which leads to the use of locum consultants, who invariably struggle to gain a quick grasp of the policies/procedures/working practices of the trust concerned, and invariably ... leave, leaving some families/children, without anyone to take a lead consultant role ... until another locum is employed, who walks straight into complex cases that have sat on a waiting list requiring attention ... It is an unmitigated disaster for those stuck in the middle ... the patient.'

Quality concerns

In line with Lord Darzi's review of the NHS, quality care should be effective, safe and provide a positive experience for patients (Darzi, 2008). The survey highlighted substantial quality concerns:

- out-of-area placements (OOAPs)
- managing unacceptably high risk, with near misses or serious incidents in the community
- inappropriate use of other facilities
- insufficient resource.

The responses suggest that current care provision can be unsafe and ineffective, and that young people, who are already in significant distress, are sometimes subjected to extremely negative experiences.

Out-of-area placements

Overall, 89% of respondents stated that children and young people had been placed in OOAPs. This happened 'often' or 'always', according to 51% of respondents. The greatest distance reported for an OOAP was >500 miles.

OOAPs affect the availability of beds for local children and adolescents, and might in turn necessitate a further OOAP. Concerns were expressed about the detrimental impact of children and young people being placed at a distance from home. In-patient care distant from home presents a considerable challenge for families, units and community services in relation to family work and cohesive multi-agency care planning. Distant in-patient care is time-inefficient and costly in terms of travel, can create additional stress on young people and families, and can increase the potential for delay in discharge. Finally, young people might refuse an OOAP, necessitating local community management with inherent risk. One respondent summarised the startling increase in OOAPs as follows.

> '2011 200 bed days out of area
> 2012 600 bed days out of area
> 2013 1400 bed days out of area in just 8 months.'

Examples of other comments are as follows.

> 'A 17-year-old threatening suicide, no bed available and this lasted 6 days – and the bed found was over 100 miles away.'

> 'One recent case where a patient needed to be admitted, although we are based in (the south of England) we were informed the nearest available

bed was in Aberdeen. Similarly when trying to admit to an eating disorder unit we were informed a bed may not be available for up to 2 months.'

Comments were also made about the inordinate length of time needed to organise OOAPs, taking clinicians away from direct clinical work at a time of great clinical need.

'The process of referral to in-patient bed is inefficient too, as often we have to refer out of area which is lengthy and not standardised so we have to cancel clinics and spend hours on the phone chasing various people and filling [in] numerous forms to end up hearing that there is no suitable bed ...'

Delays in admission resulting in 'near misses' or serious incidents

Respondents described absconsions in the community, risks to families or others, police involvement, and physical and sexual assaults. One respondent simply stated 'hypomanic patient now pregnant', which provides a concerning example of what has been happening while young people have been waiting for a bed. Other quotes are included as below.

'17-year-[old] young person, psychotic with persecutory and paranoid delusions, has acted upon the auditory hallucinations [and] hit the younger brother. Willing to go into a hospital but no beds available. On heavy dose of antipsychotics. But rapidly deteriorating ...'

'Finding a bed has become much harder this year and we are needing to keep children longer on paediatric wards. There are no local tier 4 provisions, which means families have long distances to travel. Rates of referrals and suicidal teens seem to be increasing. In our area we have had five completed suicides this year, which is unheard of.'

'Anorexia patient lost further 10% body weight waiting for bed.'

Inappropriate placements

Medical wards/A&E

Respondents described the difficulties of managing high-risk young people on paediatric wards and reported self-harm incidents on wards and the need for restraint, including the use of security staff and police. One respondent vividly described the difficulties of safely and humanely trying to manage risky incidents when young people are temporarily placed in unsuitable environments.

'... paediatric bed bay unsafe [with] access to glass, ligature points and barricading possibilities. Attempted ligature. Restraint by 5 man [hospital] security team and IM tranquillisation [age 14]. Another, police involved and prolonged handcuffs also age 14.'

Another respondent described the degrading treatment experienced by a young person while they were being shunted around in pursuit of a bed.

> 'A suicidally depressed 14-year-old left on a paediatric ward for 2 weeks – then sent to an in-patient unit where there wasn't actually a bed, then sent back to paediatrics, who initially refused to have her (child in pyjamas throughout).'

Concerns were expressed about the risk to other vulnerable children on paediatric wards.

> 'Mentally unwell patients interfering with paediatric patient's care, or showing sexually disinhibited behaviour in front of young children, during prolonged stays on the paediatric ward.'

Unacceptably long lengths of stay on medical wards were reported, thus restricting bed availability for general paediatric patients. Many incidents of self-harm were described.

> '... one young man managed to take an overdose of his warfarin tablets on a paediatric ward while camped there waiting for us to arrange a bed.'

> 'Young person tried to hang herself in acute paediatric ward while waiting bed.'

Another respondent stated that beds might not even be sought, despite need, with adverse consequences.

> '14-year-old, admitted following suicide attempt to paediatric ward, despite concerns, bed was not even investigated because of shortage mainly. Discharge back home suggested, mother threatened suicide if that was implemented, as she was unable to cope.'

In addition to concerns regarding the inappropriate placement of young people needing secure care in generic units, concerns were also reported about the placement of younger, vulnerable children in adolescent units.

> 'Girl age 12 with depression ... had tried to hang herself twice. There were no age-appropriate beds available in England so she was admitted to a general adolescent unit. There, in just 2 days, she was told by another [young person] about her rape and also learned to self-harm and calorie count. She became so distressed her parents took her home against professional advice, where 2 weeks later she took an overdose.'

Also described is the impossibility of meeting current A&E waiting targets.

> '17-year-old girl with learning disability and bipolar disorder had to spend 4 days at the A&E department as there was no available bed.'

Police cells and Section 136 suites

These accounts speak for themselves:

> 'We had a 15-year-old in a police cell for 4 days awaiting finding an in-patient bed – we had partially completed a Section 2 but were unable to complete as had no hospital [to] name.'

> 'Several young people kept in police cells overnight (worst was 3 nights for a 12-year-old) because of a lack of any bed ...'

'11-year-old held under Section 136 in handcuffs ...'

'Young person (aged 15) on Section 136 in the police cell ... it was not until 38 hours after admission to the cells that a bed was found for a Section 2 in a distant city.'

'Bed could not be found for adolescent with learning disability who had threatened his mother with a pitchfork. He was detained under Section 2 but still no bed. Eventually, in order to keep him safe, we admitted him overnight to our local adult Section 136 suite until a bed was found.'

Adult mental health beds

One of the effects of the tier 4 bed access difficulties has been an increase in the number of young people being admitted to adult psychiatric wards when no suitable adolescent unit is available. In our survey, 64% of respondents were aware of young people being admitted to adult wards owing to lack of bed availability in the past year. Children as young as 12 years of age have been admitted to adult wards, with adverse consequences. It was also concerning to hear that detention under the Mental Health Act was being used as a means of accessing an age-appropriate bed.

'A child who was unable to be admitted to an adolescent bed was sent to an unsuitable adult ward and then no bed could be found without using the Mental Health Act Section 3 to access a low secure unit.'

'Admission to adult ward while awaiting bed has resulted in adverse experiences for some [young people] ... e.g. witnessing successful suicide attempt, assaulted by adult patient.'

'Serious untoward incidents involving 12-year-olds being admitted to adult wards and needing seclusion for a period of over 72 hours.'

A number of respondents commented on an escalation in the use of adult beds since the changes in commissioning.

'We had prevented adult ward admissions for 5 years, but this year 2013 we have had 9 episodes ...'

Insufficent resources

Insufficient community resources were reported for managing high-risk cases, as were cuts to services, and the time needed by community consultants and trainees in terms of finding beds, taking clinical time away from families. Respondents also commented on the significant detrimental effect on staff and staff burn-out.

' ... the constant focus on cost-cutting is increasing risk, placing additional strain on staff, and as cases worsen and need longer, more intensive and more specialist care when they do finally receive a service, this may actually increase cost.'

'As a trainee, we dread being on-call because it has been such a horrendous experience finding beds for patients, liaising with professionals and families and at times acting like a bed coordinator … we were calling everyone around the country to find a bed.'

‘I have not known admissions and risk management to be this bad ever. The pace of work and demand is unmanageable within current resource.’

‘... I feel very unsafe as a clinician at present.’

‘Massive restructuring of teams – fewer experienced team members who can “hold” the anxiety of patients, families and staff.’

Perspective of generic in-patient psychiatrists

The primary focus of this survey was to assess the difficulties in gaining access to beds by community psychiatrists and the ensuing difficulties in managing high-risk young people. However, this increased demand has also affected the working practices of in-patient psychiatrists and the ability of units to function effectively. Of the 370 respondents, 20 were psychiatrists from generic units, mostly from England (one from Scotland). The majority (14) reported increased difficulty accessing beds over the past year. The principal perceived reasons for difficulties in access were as follows:

- decreased capacity of social care (14)
- increased demand (12)
- changes in commissioning arrangements (10)
- decreased capacity of community CAMHS (8)
- increased complexity (7).

Several themes were derived from this survey.

Deteriorating professional relationships

Some respondents suggested that previously positive relations between English local clinicians have been adversely affected by the new gatekeeping role required by NHS England, as well as the raising of thresholds for admission and need to admit from across the country.

> 'Since the change there has been a steep rise in access problems ... It feels as if positive partnerships between local teams and tier 4 units have been overlooked in the setting up of the new arrangements.'

> 'Tier 4 units seem to go out of their way to make out of hours referrals difficult – this may reflect lack of resources, the difficulty of keeping experienced staff in post.'

> 'Children at high level of risk who would have been offered an admission just a year or two ago, now do not meet thresholds. This is very stressful for everyone concerned.'

The increased tensions due to high demand and subsequent raised thresholds for admission have a detrimental effect on working relationships and the morale of tier 4 staff. In addition, the continuing

admission of young people to inappropriate settings for prolonged periods has a negative impact on relationships with other professionals, such as paediatricians, who need to manage those young people in those settings.

Increased risk on generic units

Respondents from in-patient units were particularly concerned about the lack of access to secure beds (14) when this was required, resulting in increased risks.

> 'A patient was left 9 days on a generic unit after an assessment had determined that a PICU bed was required. Resulted in 14 staff assaults ...'

> '... unable to find a bed for forensic patient who had recently moved into the area ... delay in finding a vacant tier 4 bed and the patient assaulted someone ...'

Delayed discharges

Of the 20 psychiatrists from generic units who completed this survey, virtually all respondents reported delayed discharges (19; 8 of these 'often'), resulting in bed-blocking and inefficient use of in-patient beds due to extrinsic factors. A total of 14 also reported re-admissions post-discharge, which might indicate premature discharge (possibly due to increased pressures to reduce lengths of stays), inadequate follow-up care in the community, or potential unavoidable clinical deterioration.

The main reasons for reduced access to beds were as follows:

- reduced capacity of social care services (15)
- lack of adult transition support (11)
- lack of specialist placements (9)
- reduced capacity of community CAMHS including outreach support (7).

Delays in commissioning decisions were also reported as a reason for reduced bed access.

> 'Tier 3 services ... are severely stretched – unable to attend review and discharge meetings'

> 'Increased complexity of admitting young people far from home due to closure of local unit.'

> 'The consistent failure of some services to acknowledge, let alone attend, [Care Programme Approaches] is very apparent ... some young people clearly get offered far less than others when they leave hospital.'

> '... the major factors in delayed transfers of care are: woefully inadequate response by social care; inadequate service delivery model in community CAMHS.'

Staff burn-out

Although in-patient respondents did not directly comment on staff burn-out, the overall picture is of in-patient services that are stretched, in constant demand, and under pressure to reduce length of stay, strained professional relationships, the need to admit from far afield with the consequent increased challenges inherent in such admissions, and pressure to admit adolescents who are potentially too high risk to manage in generic services, with little prospect of being able to easily move such young people to more appropriate settings. Staff have been injured in these situations and it is not surprising that, under such circumstances, staff burn-out is highly likely.

Possible solutions

In-patient consultants suggested several potential solutions in free-text comments. These were not simply suggestions for an increased number of beds, although this was recognised as a need, particularly for specialist services. Adequate provision of community services, including multi-agency working, was frequently stated as important in order to reduce the need for admission, minimise length of stay, and to maximise the most effective use of in-patient beds.

> 'Return funding for tier 4 to clinical commissioning groups and/or include admission avoidant services(e.g. crisis resolution home treatment teams and intensive care) for both generic cases and eating disorders.'

> '... more funding for out-patient CAMHS and other services, mental health is not "sexy" and suffers from cutbacks. Also I dread to think how much tendering has cost the country...'

> '... more alternatives to admission, and CAMHS crisis teams multi-agency solutions to support wrap around care packages support for tier 3 capacity and funding.'

> 'Lack of services for young people with borderline personality disorder.... CAMHS often struggle to provide the level of intensive support required in crises for these patients.'

> 'For those with complex learning disabilities/autism and challenging behaviour there is a lack of appropriate social care support and a pressure to admit to hospital when the family situation breaks down.'

> 'If all tier 3 services functioned at the level of the best things would be much better, rather than seeking new interventions.'

> 'I am not diminishing issues around bed availability, but scarcity is not only reason why beds not always available.'

CAMHS Tier 4 Report

This survey was completed in December 2013. It seemed prudent to wait for the release of the review of in-patient care provision commissioned by NHS England (CAMHS Tier 4 Report Steering Group, 2014) before publishing our results. The recommendations of the review are welcomed and point the way forward in many positive areas.

In particular, some of the review's recommendations fit well with the findings of this survey.

1. Regional gaps in in-patient provision are addressed. This is covered in the report in Recommendations 2 and 14.
2. Adequate specialist provision is provided, in particular, for eating disorders, secure care and intellectual disabilities. This is covered in the report in Recommendations 2, 3 and 19.
3. That the distance travelled to in-patient units is reduced. This will have an impact on the child/young person's experience of admission as well as potentially reducing the length of stay through better linkage between services and safer leave planning. This is covered in the report in Recommendation 2.
4. Pathways are reinforced by clinical commissioning groups and tier 4 commissioners, so that there is strong linkage between community and in-patient facilities. This is covered in the report in Recommendations 7 and 17, 18, 19.

Recommendations 16–19 focus on whole-pathway, collaborative commissioning and alternatives to admission. We also welcome Recommendation 20, which discusses the need to develop an adequate tier 4 CAMHS workforce.

While welcome, the NHS England recommendations do not go far enough. As in the recommendations, additional areas of action are needed, repeated below for ease of reference.

- Resource investments need to be targeted at strengthening community services to reduce admission rates.
- Intensive outreach services should be more clearly commissioned and provided, with a more even distribution across the country.
- There need to be financial incentives applied across the Clinical Commissioning Group/NHS England boundary to encourage services to work together to maximise the time young people spend safely in the community.

We fear that, without further action, young people will continue to get stuck in the gap between community and in-patient care.

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Appendix 1

Table A1 Respondents by region	
Region	Number of responses, *n* (%)
England – London	50 (19.7)
England – South West Penninsula	27 (10.6)
England – Oxford	20 (7.9)
England – West Midlands	20 (7.9)
England – North Western	19 (7.5)
England – Eastern	18 (7.0)
England – East Midlands	16 (6.3)
England – Kent, Surrey, Sussex	13 (5.1)
Scotland	12 (4.7)
England – Yorkshire	12 (4.7)
England – Northern	11 (4.3)
Wales	9 (3.5)
England – Severn	7 (2.8)
England – South Yorks and Humber	4 (1.6)
England – Mersey	3 (1.2)
Northern Ireland	1 (0.4)
Other	12 (4.7)

Table A2 Respondents by current role	
Role	Number of responses, *n* (%)
Consultant psychiatrist CAMHS	204 (80.3)
ST 4–6 doctor CAMHS	29 (11.4)
Specialty doctor CAMHS	5 (2.0)
Associate specialist CAMHS	4 (2.0)
Other	12 (4.7)

Table A3 Respondents by type of service	
Type of service	Number of responses, *n* (%)
Generic community CAMHS (tier 2/3)	156 (61.4)
General adolescent in-patient service (tier 4)	20 (7.9)
Specialist out-patient CAMHS (tier 4)	18 (7.1)
Intensive outreach service (tier 3/4)	10 (3.9)
Other	39 (15.4)

Appendix 2

Survey content and returns

A working group was set up, consisting of the Chair of the Faculty Executive, the Treasurer and two trainee representatives. The survey was sent out to the membership via SurveyMonkey. The membership consists of approximately 2500 practitioners, though many of them are not currently practising. The survey was sent out again with a single email reminder. The survey closed on 20 December 2013.

There were 370 responses. Even though there are 2500 listed members, many are not actively practising so would not be likely to respond. There are about 700 whole-time equivalent (WTE) child psychiatrists in the UK, about 300 WTE trainees, and a number of part-time workers. A probable head count is therefore about 1300. Hence, we estimate the survey had a return rate of about 30%.

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