



Community paediatricians' experience of joint working with child and adolescent mental health services: findings from a British national survey

Cornelius Ani ,^{1,2,3} Hani F Ayyash,^{3,4,5} Michael Oladipo Ogundele ⁶

To cite: Ani C, Ayyash HF, Ogundele MO. Community paediatricians' experience of joint working with child and adolescent mental health services: findings from a British national survey. *BMJ Paediatrics Open* 2022;**6**:e001381. doi:10.1136/bmjpo-2021-001381

Received 15 December 2021
Accepted 30 March 2022

ABSTRACT

Objectives Children and young people (CYP) presenting to paediatric or child and adolescent mental health services (CAMHS) often have needs spanning medical and psychiatric diagnoses. However, joint working between paediatrics and CAMHS remains limited. We surveyed community paediatricians in the UK to inform better strategies to improve joint working with CAMHS.

Methods We conducted an online survey of community paediatricians through the British Association for Community Child Health (BACCH) on how much joint working they experienced with CAMHS, any hindrances to more collaborative working, and the impact on service users and service provision. This paper is based on thematic analysis of 327 free-text comments by paediatricians.

Results A total of 245 community paediatricians responded to the survey (22% of BACCH members). However, some responses were made on behalf of teams rather than for individual paediatricians. The following were the key themes identified: a strong support for joint working between community paediatrics and CAMHS; an acknowledgement that current levels of joint working were limited; the main barriers to joint working were splintered commissioning and service structures (eg, where integrated care systems fund different providers to meet overlapping children's health needs); and the most commonly reported negative impact of non-joint working was severely limited access to CAMHS for CYP judged by paediatricians to require mental health support, particularly those with autism spectrum disorder.

Conclusion There is very limited joint working between community paediatrics and CAMHS in the UK, which is associated with many adverse impacts on service users and providers. A prointegration strategy that includes joint commissioning of adequately funded paediatric and CAMHS services that are colocated and within the same health management organisations is crucial to improving joint working between paediatrics and CAMHS.

INTRODUCTION

Children and young people (CYP) presenting to paediatric or child and adolescent mental health services (CAMHS) can have needs spanning medical and psychiatric difficulties that require the joint expertise of both

What is known about the subject?

- ▶ There is a significant overlap between the work of paediatricians and child and adolescent mental health service (CAMHS) clinicians.
- ▶ Meeting the needs of children and young people (CYP) with overlapping medical and/or mental health needs requires effective joint working between paediatric and CAMHS services.
- ▶ As key stakeholders, the views of paediatricians are important in understanding the ongoing contexts of joint working between paediatric and CAMHS services in the UK.

What this study adds?

- ▶ The survey identified limited joint working between paediatricians and CAMHS clinicians, and the main barriers to joint working were disjointed commissioning and service structures.
- ▶ Poorly integrated paediatric and CAMHS services were associated with severely restricted access to CAMHS for CYP judged by paediatricians to require mental health support.
- ▶ The gap in access to CAMHS was most notable among CYP with autism spectrum disorder and comorbid emotional and behavioural difficulties.

professional groups.¹ Examples include the management of medical complications of CYP with eating disorders, self-harming behaviours and those with medically unexplained symptoms.^{2 3} More than a quarter of CYP attending general paediatric clinics have mental health difficulties,⁴ and CYP with mental health difficulties are more likely to experience medical problems.¹ Thus, there is a significant overlap between the work of paediatricians and CAMHS clinicians in supporting CYP with complex needs.⁵

In community settings, the work of paediatricians overlaps significantly with CAMHS in relation to the assessment and treatment



© Author(s) (or their employer(s)) 2022. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

For numbered affiliations see end of article.

Correspondence to
Dr Cornelius Ani; c.ani@imperial.ac.uk



of CYP with neurodevelopmental difficulties, such as attention deficit and hyperactivity disorder (ADHD) and autism spectrum disorder (ASD).⁶ In fact the involvement of paediatricians in the management of ADHD in the UK has increased from 15% in 2006 to 63% in 2016.⁶ Furthermore, practice guidelines⁷ recognise the importance of integrated paediatric and CAMHS expertise in ASD diagnostic assessment. In the absence of such integration, CYP assessed for ASD in CAMHS may miss out on important medical and genetic investigations, while comorbid mental health conditions may not be identified in those seen by paediatricians.⁸

The significant overlap between paediatric and CAMHS makes an instinctive case for better integration between both services. The benefits include better user and staff satisfaction, improved health outcomes, and more efficient health systems.^{9–11} These benefits are well illustrated by a recent paper based on simulated patient journeys in the UK health system which found 40% savings in cost and 75% savings in time.¹¹ In the UK, integration of paediatric and CAMHS services is favoured by high-level government policies such as the NHS England Five Year Forward View for Mental Health¹² and the NHS Long Term Plan.¹³ Close collaboration between CAMHS and paediatrics has been jointly endorsed in the UK by the Royal College of Paediatrics and Child Health and the Royal College of Psychiatrists.³ This practice is also promoted by the American Academy of Pediatrics,¹⁴ the American Academy of Child and Adolescent Psychiatry,¹⁵ and the WHO.¹⁶

However, despite the long-standing recognition of the importance of collaborative working between paediatrics and CAMHS, joint working between the two care groups has tended to be limited.^{17–19} In one UK study, only one-third of paediatricians felt that the mental health needs of paediatric patients were being met by CAMHS and all the paediatricians wanted to have closer links with CAMHS.²⁰ A Royal College of Paediatrics and Child Health report indicated a significant reduction in contacts between paediatricians and CAMHS in the UK from 42% to 26.8% between 2011 and 2013.²¹ In relation to ASD diagnostic assessment, a recent survey identified very few integrated paediatric and CAMHS services in the UK.⁸

A key hindrance to integrated working between paediatrics and CAMHS is a worldwide shortage of CAMHS professionals.^{22,23} Another hindrance is under-resourcing of CAMHS.²⁴ However, the more powerful and overarching hindrances relate to structural factors such as commissioning and service designs.^{25–27} Historically, commissioning of services for CYP has favoured vertical care pathways designed for acute medical problems.²⁶ These pathways tend to situate paediatrics and CAMHS in different organisations, which does not reflect the high levels of comorbidity among CYP with medical and/or mental health difficulties.¹⁹

We provide some background about the UK health system in order to contextualise the current study for readers from other regions of the world. The UK has a

publicly funded National Health Service (NHS), which provides healthcare to UK residents free of charge (except in limited circumstances sanctioned by the parliament).²⁸ The funding and regulatory structures of the NHS are described in detail elsewhere,^{29,30} but in summary the NHS is funded by general taxation and the annual budget amounts to about £2300 (about \$3000) per UK resident.²⁹ About two-thirds of the NHS budget is allocated to local integrated care systems (ICS),³¹ which, based on local health priorities, commission and allocate funds to 'provider organisations' to deliver hospital and community health services in their local areas. The vast majority of 'provider organisations' are NHS organisations (called NHS Trusts or NHS Foundation Trusts). However, private organisations can be commissioned by ICS to provide NHS services. In the latter cases, the specific services funded by ICS will be free to UK residents even though the provider is a private profit-making organisation. There are systems of quality control in place to monitor the performance of commissioned NHS and private provider organisations to assure quality of care and good use of resources.³⁰ Thus, the vast majority of paediatric and CAMHS services in the UK are commissioned and funded by the NHS even when the actual service delivery is, in some cases, by private organisations.

The suggestion of persistence of poorly integrated paediatric and CAMHS services in the UK^{8,11} indicates a need to examine the views of front-line clinicians on the extent of the problem and the barriers. Furthermore, it is important to ascertain if recent UK government policies have had any impact on front-line clinicians' experience of integration between paediatric and CAMHS services. For example, on the one hand, the UK government has made prointegration policies such as the NHS Five Year Forward View 2014.¹² However, in response to the 2008 financial crisis, the UK government implemented austerity measures which led to significant funding cuts to health services, particularly CAMHS.³² The net effect of these opposing events on service integration is unknown.

The views of paediatricians, who are key stakeholders, could be informative in understanding the current situation in relation to integration of paediatric and CAMHS services in the UK. This survey focused on community paediatricians, who are specialists providing secondary level of care and whose roles interface closely with community-based specialist CAMHS.³³ Community paediatric and CAMHS services usually share overlapping commissioning and service boundaries such that any difficulties with joint working are likely to be more apparent at that interface. The survey is timely due to recent policy changes that impact service integration and the absence of recent UK-wide data on the experiences of any professional group regarding integration between paediatrics and CAMHS. The aims of our study were therefore to survey community paediatricians to seek their views on how much joint working they experienced with CAMHS, any hindrances to more collaborative working, and the impact on service users and service provision.

METHODS

This online survey of community paediatricians had two objectives. The current paper focuses on the community paediatricians' qualitative reports of their experiences of joint working with CAMHS. The other objective examined the role of community paediatricians in surveillance research case ascertainment of child mental health difficulties and is already published.³⁴

Design

The questionnaire used in the survey had open and closed questions and is publicly available.³⁴ The closed questions were adapted from a previous study³⁵ and examined types of mental health difficulties seen in community paediatric clinics in the UK. Data from the closed questions have been published.³⁴ The open questions are the focus of the current paper. The latter questions sought free-text comments from community paediatricians about their experiences of joint working with CAMHS. The current paper is based on thematic analysis of the 327 free-text comments by paediatricians. Consistent with current research governance in the UK and other countries in relation to low-risk health and medical research,³⁶ ethical approval was not required as the survey was completely anonymous and participation was entirely voluntary by persons not classified as 'vulnerable'. In order to further strengthen the anonymity of responses, the survey avoided seeking any sociodemographic or regional information.

The survey was distributed through the British Association for Community Child Health (BACCH) newsletters and emails to members via a link to SurveyMonkey (www.surveymonkey.com). Responses were obtained between December 2015 and August 2016. As we considered it more important to capture service-level (rather than individual) experiences, the participants could complete one questionnaire on behalf of their 'Teams'. There were 169 distinctly managed community child health services in the UK and 1120 members of BACCH in 2015.⁶

Data analysis

We applied reflexive thematic analysis to the free-text comments using an inductive approach.^{37 38} The inductive approach meant that our coding and theme development were directed by the content of the data rather than by pre-existing ideas or assumptions. The study was conceptually situated in the paradigm of interpretive phenomenology³⁹ as the aim was to understand and interpret the experiences of paediatricians in relation to joint working with CAMHS. The 327 individual free-text comments were copied verbatim and systematically reviewed separately by all three authors to identify codes and themes. Most of the comments contained an average of about 50 words, ranging from 7 to 172 words. Coding was conducted manually without a computer software. First, we reviewed the texts to become familiar with the comments. Second, we identified codes (eg, words or phrases related to joint working with CAMHS).

Third, we examined the codes for common meanings, which were used to generate themes. Next, we jointly reviewed, defined and agreed on the final themes by consensus. Based on reflexive thematic analysis, the aim of the separate three-author theme identification was to ensure that no high-order theme was inadvertently overlooked rather than to assess inter-rater coding reliability.⁴⁰ Also, and consistent with reflexive thematic analysis, we used comparative expressions (rather than frequency or number counts) to indicate relative recurrence of particular themes.⁴⁰ Although all the 327 free-text comments were reviewed and coded, it was observed that data saturation for the main themes was reached with 30% of the responses (saturation was calculated as the point of onset of data redundancy).⁴¹

Patient and public involvement

Patients and/or the public were involved in the design, or conduct, or reporting or dissemination plans of this research. The survey was supported by patient and public involvement representative at the British Paediatric Surveillance Unit and this is acknowledged in the paper.

RESULTS

A total of 245 community paediatricians responded to the survey, which constituted 22% of the 1120 membership of BACCH in 2015. However, the actual response rate is likely to be higher because some responded as 'Teams' rather than as individuals.

The findings are organised along the key themes that emerged from the qualitative comments, which were strong support for joint working between community paediatrics and CAMHS; acknowledgement that joint working was currently limited; barriers to joint working; and negative impact of non-joint working on CYP and their families, on paediatric services and on the wider health system. Positive examples of joint working were very few and these were also highlighted. These themes are now explored, each illustrated with one to three exemplar quotes that are most illustrative and representative of the patterns of comments on the theme.⁴²

Support for joint working

Community paediatricians showed an overwhelming support for joint working with CAMHS. Many referred to the overlapping needs of CYP referred to community paediatrics and CAMHS, the fact that CYP with difficulties do not fit artificial care boundaries and the importance of a holistic approach in supporting CYP and their families.

Children don't come neatly packaged.

It is ridiculous that our work and caseload overlap so much and yet we are such separate services.

Children often have more than one issue which makes compartmentalising this very difficult.

However, despite the clear recognition of the importance of joint working, most of the community paediatricians reported limited joint working with CAMHS. Some described their interface with CAMHS as parallel working.

We seem to work in parallel to CAMHS rather than with the service.

There is poor joint working with CAMHS services here.

Barriers to joint working

Respondents identified many hindrances to their joint working with CAMHS. By far, the most frequently cited reasons relate to service and organisational structures, particularly splintered commissioning (eg, where ICS fund different providers to meet overlapping children's health needs). Many respondents highlighted the commissioning of services along diagnostic pathways that do not recognise that CYP do not present with difficulties that neatly fit diagnostic categories. For example, one service was commissioned to treat 'simple ADHD', whereas comorbidity is the rule rather than the exception for CYP with ADHD.

We should be seeing children with 'simple ADHD' that is, no other psychiatric / psychological comorbidity. However the reality is that we get large numbers of referrals for highly disturbed children that have been rejected by CAMHS.

Services are commissioned based on diagnosis which is a complete disaster.

Arbitrary and disjointed service commissioning

Others reported service and care boundaries commissioned seemingly arbitrarily based on factors such as age or whether or not the CYP needs medication.

ASD is split with under 10s seen by Paediatrics and over 10s by CAMHS.

CAMHS service is limited to children requiring medication or hospital care.

Some of the community paediatricians highlighted that CAMHS services in their areas have been commissioned cheaply or with narrow remit such that they are not able to offer services compliant with National Institute for Health and Care Excellence (NICE) guidelines. Others described their local CAMHS as having been recommissioned without additional resources, resulting

in no change in service quality, access or capacity for joint working.

Commissioners have chosen cheapest non sustainable service option, with lots of staff cuts and lack of service delivery.

CAMHS are commissioned to diagnose but offer little in the way of therapeutic or long term input.

Commissioners may think that this is cheaper, however it does not necessarily meet the NICE standards with the lack of resources.

A number of respondents highlighted barriers to joint working due to isolated commissioning of profit-making organisations to provide CAMHS services. In many cases, these private organisations were given very narrow commissioning remits to diagnose but not to treat, thus creating treatment bottlenecks in the care system. Respondents pointed out that private organisations are profit-oriented, which encourages competition rather than cooperation and hence undermines joint working. Others noted that profit-driven organisations favour linear practices which are antithetical to the integrated care model required by many CYP with mental health difficulties.

ADHD and ASD are being diagnosed by a private provider and there is lack of clarity about ongoing follow up.

Issues relating to bids for work from any willing provider have adversely affected working across organisations.

Disjointed service structures

Several respondents commented that having community paediatrics and CAMHS in different organisations is an impediment to joint working. Some indicated that the CAMHS in their area were part of adult mental health services (AMHS) such that CAMHS operations seemed more aligned with adults than CYP.

CAMHS and Community Paediatrics are in different Trusts making joint arrangements very difficult!

This is what happens when CAMHS service is part of an adult mental illness service rather than integrated with children's services.

Situation is very confused- we have hospital Paediatrics and Psychology in one Trust and CAMHS and Community Paediatrics in another, ASD assessments are done in part by Paediatrics/Psychology joint clinic which doesn't fit in any of your boxes.

Impact of non-joint working between community paediatrics and CAMHS

Respondents reported major and wide-ranging difficulties from lack of joint working between community paediatrics and CAMHS. By far, the most reported operational consequence of non-joint working between the two services was extreme difficulty accessing CAMHS for CYP judged by paediatricians to require mental health expertise. Access to mental health support was so challenging that many respondents felt that CAMHS had become impenetrable.

Very difficult to get into CAMHS service.

It is extremely difficult to access CAMHS and so many patients with mental/emotional health concerns end up being seen by paediatrics.

CAMHS locally return many referrals back to community paediatrics, despite the referrals being at Consultant level.

High thresholds for CAMHS access

In some cases, as the CAMHS access threshold became higher, the CAMHS referral criteria seemed more arbitrary and difficult to interpret. Examples included whether the young person has 'significant mental illness', where it was unclear what is meant by 'significant'. Some CAMHS reportedly insisted that carers attended parenting courses, or that the CYP should have had multiprofessional involvement prior to CAMHS referral.

Difficult to access CAMHS without very significant mental health problems.

Children with anxiety are offered a parental course and CAMHS won't see behavioural problems in children without parents completing a course first.

CAMHS team do not accept referrals from one practitioner, at least two professionals should have involvement before they are allowed onto the CAMHS waiting list.

Impact on CYP and their families

The lack of joint working and the associated limitation to CAMHS access adversely affected CYP and families by creating gaps in service provision, long waits for mental health assessment and treatment, disjointed care, and prolonging subthreshold care within paediatrics for difficulties more suited for CAMHS.

Gaps in service provision

Service gaps were most commonly reported for CYP with ASD and comorbid anxiety. Respondents were concerned that CAMHS approach to such referrals led to diagnostic

overshadowing in that anxiety was inappropriately attributed to ASD rather than as a coexisting difficulty that needed to be assessed and treated in its own right. The same concern extended to CYP with ASD and comorbid depression, intellectual disability, or challenging behaviour.

CAMHS see anxiety as part of ASD so will not see where ASD is diagnosed.

Any child with either a formal diagnosis or even suggestion of ASD is refused CAMHS services for other problems such as severe anxiety, challenging behaviour, depression etc.

There is a shocking lack of involvement of CAMHS professionals in addressing the behaviours associated with autism and/or learning disability.

Effect of non-joint working on quality care for CYP

The confusing pathways and bottlenecks created by non-joint working affected CYP's care, for example, by causing delays due to referrals being 'passed around'. In some places, successful referral of CYP to CAMHS seemed to depend on random factors such as locality/postcode and whether the referral was made by a general practitioner (GP).

Often presentation is to one service but then passed to another after an initial assessment.

Provision depends on the child's postcode.

If someone e.g. GP manages to refer a patient successfully to CAMHS then all these diagnoses will be seen by them.

Some respondents highlighted that non-joint working led to CYP receiving subthreshold care such as use of medication when psychological intervention would have been more appropriate. Others expressed concern that CYP with mental needs continued working with paediatricians who are unable to meet the CYP's needs.

Much psychopharmacology is done in the paediatric setting sometimes at the direct request of CAMHS/ other psychiatric services (yes really!) and sometimes in despair at the lack of psychological intervention.

Unacceptably high threshold for accessing CAMHS support so these poor children end up stuck in the community paediatric service.

Impact on seamless transition to Adult Mental Health Services (AMHS)

Specific difficulties were reported about transitions. This was most common for CYP who would otherwise have transitioned seamlessly from CAMHS to AMHS, but were in paediatric care where the pathway to AMHS was unclear.

Continue to see beyond 18 for ADHD medication review due to lack of appropriate adult services.

We are being pushed to work with over 19yrs particularly for those with Education and Health Care Plan (EHCP) (which specifies the educational, care and health support required by child).

It is very confusing and transition even more.

Impact of non-joint working on paediatric services

A large proportion of the paediatricians detailed examples of the adverse impact of non-joint working on paediatric services. The impact included ethical and professional concerns about their own practice and additional workload and disruptions to care.

In relation to professional and ethical concerns, many respondents mentioned worries about having to take clinical responsibilities for CYP with mental health difficulties, which were beyond their skills, professional expertise and training as paediatricians.

As paediatricians we try to work within the areas of our expertise/training but are under constant pressure to see children who should be being seen in CAMHS but who are repeatedly turned down.

This is inappropriate as Paediatricians are not necessarily trained or equipped to manage mental health conditions effectively.

The Community Paediatric team is holding responsibility for a large number of children who actually require psychological or psychiatric input which is not provided locally.

Another common concern is the backflow of referrals from CAMHS to community paediatrics. Some respondents pointed out that the very high threshold for CAMHS referral meant that other professionals saw community paediatrics as the 'only open door' or 'better than nothing'.

Most patients are automatically referred to the community paediatric services because CAMHS will almost invariably reject all referrals and the primary care have no other place to refer children.

Feels as though community paediatrics is very much a safety net service, not always appropriately.

But if CAMHS won't accept then we are seen as 'better than nothing' which is adding additional strain to our already overstretched services.

Some paediatricians found these difficulties resulting from poor joint working with CAMHS really disconcerting and they highlighted their frustration.

Often frustrated when CAMHS do not accept our referral.

It is very frustrating because then the problems are sent to the paediatric team.

It is also shocking that a young person who has not left the house for 3 months due to anxiety related to school (may or may not be related to ASD) gets no service of any kind.

Impact of non-joint working on local health systems

The challenging experiences described by paediatricians were not limited to that professional group. Respondents highlighted similar difficulties experienced by other CAMHS referrers such as GPs, social workers and schools. In particular, the high CAMHS threshold led to some clinicians in the wider care system feeling under pressure to 'trick the system' by adjusting their referrals, thus raising ethical concerns.

Other agencies will find the wait time to see CAMHS unacceptable and then modify their referral to include, for example, autism and ask community paediatrics to see.

Many respondents indicated that poor joint working between community paediatrics and CAMHS engendered difficulties in the wider care systems that included confusion around boundaries and care pathways, fragmentation and duplication of service provisions, all of which resulted in poor, uncoordinated, unsatisfactory and inefficient care for CYP and their families.

Currently a muddle and is frustrating for patients and their carers and also for professionals.

Examples of good joint working practices

While most responses pointed to limited joint working and the associated difficulties, a few respondents reported some positive although varying levels of established or developing joint working practices.

Paediatrics and CAMHS are in same organisation and we are becoming more integrated.

We have a monthly liaison meeting between CAMHS and paediatrics which helps to determine how the services work together.

There are currently embryological developments to progress to a more streamlined service as opposed to confusion and triplicate working.

Incidentally, only one respondent gave an unqualified positive report of good access by community paediatricians to CAMHS in their area.

we are very fortunate here to have ready access to CAMHS.

DISCUSSION

This survey of community paediatricians' views of joint working with CAMHS identified overwhelming support for more collaborative working between the two professional groups. However, paediatricians' actual experience of joint working with CAMHS was limited. Paediatricians identified the key hindrance to joint working as disincentivising service and commissioning structures. The most proximal negative impact of non-joint working was severely limited access to CAMHS for CYP judged by paediatricians to require mental health support. Other negative consequences for CYP and their families were service gaps, especially for CYP with ASD and comorbid emotional difficulties, disjointed care pathways, difficulties with transitioning to AMHS, and overall poor quality of care. For paediatric services, non-joint working led to significant concerns about working beyond their expertise and dealing with higher workload due to backflow from CAMHS. The wider health systems experienced confusion around care boundaries and fragmentation and duplication of services, resulting in dissatisfaction and inefficient care for CYP and their families. The UK-wide coverage of the survey suggests that these difficulties are widespread and not attributable to local or regional service outliers.

These findings are consistent with existing literature from the UK and elsewhere.^{9 10 18–20 25 26} For example, an earlier UK survey in 2006 found that only a third of the paediatricians felt that the mental health needs of their patients were being met by CAMHS.²⁰ Similarly, previous studies have highlighted difficulties due to different perspectives between paediatricians and CAMHS on the types and thresholds of mental health difficulties seen by CAMHS.¹⁸ Also the disincentivising effect of splintered commissioning of children's physical and mental health services has been documented in a recent review.¹⁹ However, the current study adds three new findings. The first is the reported very severe limitation to CAMHS access for CYP judged by paediatricians to require mental health support. The second is the very high level of service gaps for CYP with ASD and comorbid anxiety

and the suggestion that these CYP were being declined care due to possible diagnostic overshadowing. Finally, it was surprising to see the high degree of service splintering resulting from disjointed commissioning, which included (1) an unwieldy array of service boundaries based on diagnosis, age and whether or not the CYP is on medication; (2) varied service remits, such as 'diagnosis without treatment or follow-up'; and (3) a range of service providers, including voluntary and private profit-oriented organisations.

Paediatricians identified disincentivising commissioning and service structures as the main overarching hindrance to poor joint working with CAMHS. Thornicroft and colleagues²⁷ have highlighted that commissioning and funding can strongly militate against integrated care irrespective of favourable higher macro-policies by national governments. Thus, joint commissioning of adequately funded paediatric and CAMHS services that are colocated and within the same health management organisations could address most of the difficulties identified in this survey.^{10 11 17 25} The aforementioned commissioning goals would support progress towards the highest level of joint working within the three categories of incremental integration framework described by Heath *et al.*,⁴³ which are 'coordinated care', 'co-located care' and 'integrated care'. The UK has some positive examples of jointly commissioned and/or colocated paediatric and CAMHS services that evidence improved quality of care and use of resources.^{2 44} The success ingredients in these services could be distilled and used to inform better integration for other services. In addition, the UK could learn from successful models of integrated care in other regions, such as the Massachusetts Child Psychiatry Access Project⁴⁵ and the Extension for Community Healthcare Outcomes⁴⁶ models in the USA and their adaptations in other countries such as Canada⁴⁷ and Sweden.⁴⁸ However, adapting these models in the UK to improve collaboration between paediatrics and CAMHS would need to consider the additional resource implications for both services, especially for paediatricians who may experience a further increase in workload.^{46 48} In the mean time, pending strategic changes such as in commissioning, front-line clinicians in paediatric and CAMHS services can support improved collaboration by adopting some of the strategies suggested by Fazel and colleagues.⁴⁹

Paediatricians' concerns about exceeding their expertise in trying to support CYP with mental illness is important to note. Given the high proportion of mental illness among CYP attending paediatric services, it is important that paediatricians can recognise common mental health problems among such CYP. This is consistent with the expectation that children's mental health is everybody's business.^{3 50} However, in the UK, the view of the Royal College of Paediatrics and Child Health is that it is not intended that paediatricians take on psychiatric roles such as diagnosis and pharmacological treatment of mental illness (with the exception of ADHD), nor that



paediatric services take on patients who would otherwise be referred to CAMHS.⁵¹ Nevertheless, the situation may be different in other regions, such as in Australia,⁵² USA⁵³ and Canada,⁵⁴ where some paediatricians prescribe selective serotonin reuptake inhibitors for CYP with mental health difficulties such as anxiety. It could be argued that, with additional child mental health training, such extension in paediatric practice and prescribing could be helpful in improving mental health treatment for CYP where CAMHS capacity is otherwise limited.⁵⁵ However, it remains relevant in all regions for paediatricians to have reliable access to CAMHS so that CYP identified by paediatricians to have mental health difficulties can receive the full range of indicated mental health treatments, more so in regions like the UK where paediatricians do not usually treat CYP with non-ADHD-related mental illnesses.^{17 51}

The authors are mindful that this survey of community paediatricians is not balanced by a similar survey of CAMHS clinicians. The first author is a CAMHS consultant and so can offer a CAMHS perspective. It is likely that a survey of CAMHS clinicians would find similar high levels of support for joint working with community paediatrics and would identify similar barriers to joint working. CAMHS clinicians are likely to regret the difficulties with CAMHS access highlighted in this survey and to explain that the main reason is severe demand–capacity imbalance in CAMHS. This survey was conducted in 2015, when CAMHS had been severely cut due to the UK government austerity programme.³² For example, CAMHS budgets were cut by £50million from 2010 to 2013, which amounted to a 6% reduction in funding real terms.⁵⁶ The combination of very high referral rates and reducing capacity created an imbalance that meant that CAMHS had to refocus limited capacity on the CYP with the greatest need, such as those suffering from severe depression, bipolar illness, psychosis and/or at increased risk of suicide. Incidentally, such refocusing of limited resources is consistent with the recommendation of the UK medical regulator (General Medical Council), which states in its ‘Good Medical Practice Guidance’⁵⁷ that doctors should ‘give priority to patients on the basis of their clinical need’ (paragraph 56). From this perspective, both paediatric and CAMHS services could be viewed as ‘co-victims’ of the same systemic service disruption caused by disjointed commissioning and under-resourcing of CAMHS in the UK.

Strengths and limitations

The main strength of this survey is the likelihood of a UK-wide coverage, given that BACCH membership covers all four nations of the UK (England, Scotland, Wales and Northern Ireland). The main limitation is the ‘notional’ response rate of 22%. We use the term ‘notional’ because we believe that the response rate in relation to the 169 community child health services in the UK (instead of the 1120 individual members of BACCH) is likely to be much higher. This is because some responded on behalf of ‘Teams’ rather than as individuals. Also,

for this qualitative analysis, the response rate seemed adequate given that data saturation for the main themes was reached with 30% of responses. Having said that, low response bias may have contributed to the overwhelmingly negative comments. This is because people are more likely to respond to surveys if they have had a particularly salient experience with the subject in question.⁵⁸ In this regard, it is possible that more of the paediatricians who responded are those who had had particularly challenging experiences with CAMHS. A further limitation is the lack of sociodemographic or regional data. We deliberately avoided seeking these data in order to strengthen the anonymity of the responses. Also, while qualitative analysis of free-text responses as in this study can provide valuable information,⁵⁹ we acknowledge the limitation that the comments may not allow the same level of indepth exploration as interviews or focus group discussions.⁵⁹

CONCLUSION

This study found limited joint working between community paediatrics and CAMHS, which is associated with a wide range of adverse impact on service users and providers. It highlighted several challenges, including the importance of commissioning and service structures. This is a complex issue with no simple linear solutions. However, the survey suggests that joint commissioning of adequately funded paediatric and CAMHS services that are colocated and within the same health management organisations is a potentially crucial long-term strategy to address this challenge. The UK now has high-level strategic prointegration policies which provide important motivation. The region also has successful examples of jointly commissioned and colocated paediatric and CAMHS services that can be the foundation for scaling up further integration. Additional strategies can be gained from studying and adapting successful models of collaborative working in other jurisdictions. However, it is important to address other crucial underlying and long-standing macro-level factors such as funding and staffing constraints in both paediatric and CAMHS services.⁶⁰ With supportive strategic policies, enabling commissioning structures and keenness of front-line clinicians, the UK can achieve the goal of closer integration of paediatric and CAMHS services.

Author affiliations

¹Division of Psychiatry, Imperial College London, Faculty of Medicine, London, UK

²Child and Adolescent Mental Health Service, Surrey and Borders Partnership NHS Foundation Trust, Leatherhead, UK

³Executive Committee Member, Child and Adolescent Psychiatric Surveillance System, Royal College of Psychiatry, London, UK

⁴Integrated Department of Paediatrics, Southend University Hospital NHS Foundation Trust, Westcliff-on-Sea, UK

⁵Scientific Committee Member, British Paediatric Surveillance Unit, Royal College of Paediatrics and Child Health, London, UK

⁶Halton Community Paediatrics Unit, Bridgewater Community Healthcare NHS Foundation Trust, Runcorn, UK

Acknowledgements We are highly indebted to Dr Michael Morton (Consultant Child and Adolescent Psychiatrist and Member of CAPSS Executive Committee) and Dr Tanja-Sabine Schumm (Consultant Child and Adolescent Psychiatrist), who were instrumental in setting up the initial CAPSS survey study. We thank Richard Lynn (BPSU Scientific Coordinator and Member of CAPSS Executive Committee) and Madeleine Wang (BPSU Patient Representative) for their support and advice. We are grateful to Dr Oana Mitrofan (Consultant Child and Adolescent Psychiatrist) for initial advice on the thematic analysis of the data.

Contributors HA conceived the research idea and designed the paediatric survey study. All three authors (CA, HA and MOO) analysed the data. CA drafted the first manuscript. All three authors critically reviewed and approved the final manuscript. HA is the guarantor.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Ethics approval This study involves human participants. This anonymous survey was consistent with current research governance in the UK and other countries in relation to low-risk health and medical research, whereby ethical approval was not required as the survey was completely anonymous and participation was entirely voluntary by persons not classified as 'vulnerable' (Scott *et al.*). Thus, informed consent is assumed by the respondents' voluntary participation in the survey.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>.

ORCID iDs

Cornelius Ani <http://orcid.org/0000-0003-0050-7939>

Michael Oladipo Ogundele <http://orcid.org/0000-0003-0744-1434>

REFERENCES

- Muskens JB, Velders FP, Staal WG. Medical comorbidities in children and adolescents with autism spectrum disorders and attention deficit hyperactivity disorders: a systematic review. *Eur Child Adolesc Psychiatry* 2017;26:1093–103.
- Davies V. No wrong door: addressing injustices and achieving better mental healthcare provision for under-18s in acute physical healthcare settings. *BJPsych Bull* 2022;46:20–6.
- Joint statement by the RCEM, RCPCH and RCPsych. Meeting the mental health needs of children and young people in acute hospitals: these patients are all our patients. Available: https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2021/12/21/joint-college-statement-on-meeting-the-mental-health-needs-of-children-and-young-people-in-acute-hospitals?dm_i=43MR,183A6,RDWW,5MQVV,1 [Accessed 16 Feb 2022].
- Glazebrook C, Hollis C, Heussler H, *et al.* Detecting emotional and behavioural problems in paediatric clinics. *Child Care Health Dev* 2003;29:141–9.
- Ogundele MO, Ayyash HF. Evidence-Based multidisciplinary assessment and management of children and adolescents with neurodevelopmental disorders. *Arch Dis Child* 2019;104:A268.
- BACCH/RCPCH. Covering all bases community child health: a paediatric workforce guide. RCPCH Sept, 2017. Available: https://www.rcpch.ac.uk/sites/default/files/2018-03/covering_all_bases_community_child_health_-_a_paediatric_workforce_guide.pdf [Accessed 5 Apr 2021].
- National Institute for Health and Care Excellence. Autism spectrum disorder in under 19s: recognition, referral and diagnosis Clinical guideline [CG128], 2017. Available: <https://www.nice.org.uk/guidance/cg128/resources/autism-spectrum-disorder-in-under-19s-recognition-referral-and-diagnosis-pdf-35109456621253> [Accessed 16 Feb 2022].
- Parr J, Wigham S, Farr W. 1123 UK childhood autism diagnostic services survey 2020: evidence for challenges and innovations, 2021
- Asarnow JR, Rozenman M, Wiblin J, *et al.* Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: a meta-analysis. *JAMA Pediatr* 2015;169:929–37.
- Platt RE, Spencer AE, Burkey MD, *et al.* What's known about implementing co-located paediatric integrated care: a scoping review. *Int Rev Psychiatry* 2018;30:242–71.
- Male I, Farr W, Reddy V. Should clinical services for children with possible ADHD, autism or related conditions be delivered in an integrated neurodevelopmental pathway? *Integrated Healthcare Journal* 2020;2:e000037.
- NHS England - Mental Health Taskforce. The five year forward view for mental health, 2016. Available: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf> [Accessed 5 Apr 2021].
- NHS England. The NHS long term plan. Available: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>
- Committee on Psychosocial Aspects of Child and Family Health and Task Force on Mental Health. Policy statement--The future of pediatrics: mental health competencies for pediatric primary care. *Pediatrics* 2009;124:410–21.
- American Academy of Child and Adolescent Psychiatry. A guide to building collaborative mental health care partnerships in pediatric primary care. Available: https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf [Accessed 5 Apr 2021].
- World Health Organisation. Report by the Secretariat. Sixty-Ninth World health assembly. Geneva: WHO; (2016). Apr 15, framework on integrated, people-centred health services. Available: https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1 [Accessed 5 Apr 2021].
- Court A. Paediatricians and psychiatrists working together: what works best? *Arch Dis Child* 2014;99:708–11.
- Cooper M, Evans Y, Pybis J. Interagency collaboration in children and young people's mental health: a systematic review of outcomes, facilitating factors and inhibiting factors. *Child Care Health Dev* 2016;42:325–42.
- Ogundele MO, Ayyash HF, Ani C. Integrated services for children and young people with neurodevelopmental and co-morbid mental health disorders: review of the evidence. *Journal of Psychiatry & Mental Disorders* 2020;5:1027.
- Woodgate M, Elena Garralda M. Paediatric liaison work by child and adolescent mental health services. *Child Adolesc Ment Health* 2006;11:19–24.
- Royal College of Pediatrics and Child Health (RCPCH-UK). RCPCH medical workforce census, 2013. Available: https://www.rcpch.ac.uk/sites/default/files/RCPCH_medical_workforce_census_2013_-_main_findings.pdf [Accessed 5 Apr 2021].
- Kim WJ, American Academy of Child and Adolescent Psychiatry Task Force on Workforce Needs. Child and adolescent psychiatry workforce: a critical shortage and national challenge. *Acad Psychiatry* 2003;27:277–82.
- Thomas CR, Holzer CE. The continuing shortage of child and adolescent psychiatrists. *J Am Acad Child Adolesc Psychiatry* 2006;45:1023–31.
- McNicholas F, Sharma S, Oconnor C, *et al.* Burnout in consultants in child and adolescent mental health services (CAMHS) in Ireland: a cross-sectional study. *BMJ Open* 2020;10:e030354.
- Ayyash H, Sankar S, Merriman H, *et al.* Engagement of commissioners, primary and secondary care for developing successful ADHD services. *Eur Child Adolesc Psychiatry* 2013;22:45–6.
- Wolfe I, Lemer C, Cass H. Integrated care: a solution for improving children's health? *Arch Dis Child* 2016;101:992–7.
- Thornicroft G, Ahuja S, Barber S, *et al.* Integrated care for people with long-term mental and physical health conditions in low-income and middle-income countries. *Lancet Psychiatry* 2019;6:174–86.
- Guidance: the NHS constitution for England, 2021. Available: <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>
- How funding flows in the NHS. Available: https://www.kingsfund.org.uk/sites/default/files/2020-04/NHS_Funding_Flow_April_2020.pdf
- The NHS: how providers are regulated and commissioned. Available: https://www.kingsfund.org.uk/sites/default/files/2020-03/NHS_structure_March_2020.pdf
- The Kings Fund. Integrated care systems explained: making sense of systems, places and neighbourhoods. Available: <https://www.kingsfund.org.uk/publications/integrated-care-systems-explained> [Accessed 16 Feb 2022].
- Mattheys K. The coalition, austerity and mental health. *Disabil Soc* 2015;30:475–8.



- 33 RCPCH medical workforce. census, 2015. Available: https://www.rcpch.ac.uk/sites/default/files/2018-03/2015_rcpch_workforce_census_v1.1.pdf [Accessed 16 Feb 2022].
- 34 Ayyash HF, Ogundele MO, Lynn RM, *et al.* Involvement of community paediatricians in the care of children and young people with mental health difficulties in the UK: implications for case ascertainment by child and adolescent psychiatric, and paediatric surveillance systems. *BMJ Paediatr Open* 2021;5:e000713.
- 35 Schumm TS, Morton MJS. National survey of child and adolescent psychiatrists' clinical activity using the child and adolescent psychiatry surveillance system (CAPSS). *Archives of Disease in Childhood* 2017;102.
- 36 Scott AM, Kolstoe S, Ploem M. C. (Corrette), *et al.* Exempting low-risk health and medical research from ethics reviews: comparing Australia, the United Kingdom, the United States and the Netherlands. *Health Res Policy Syst* 2020;18:1–8.
- 37 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
- 38 Braun V, Clarke V. Can I use TA? Should I use TA? Should I *not* use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Couns Psychother Res* 2021;21:37–47.
- 39 Tuffour I. A critical overview of interpretative phenomenological analysis: a contemporary qualitative research approach. *J Healthc Commun* 2017;02:52.
- 40 Braun V, Clarke V. One size fits all? what counts as quality practice in (reflexive) thematic analysis? *Qual Res Psychol* 2020;14:1–25.
- 41 pp.Saunders B, Sim J, Kingstone T, *et al.* Saturation in qualitative research: exploring its conceptualization and operationalization. *Qual Quant* 2018;52:1893–907.
- 42 Lingard L. Beyond the default colon: effective use of quotes in qualitative research. *Perspect Med Educ* 2019;8:360–4.
- 43 Heath B, Wise Romero P, Reynolds K. A standard framework for levels of integrated healthcare. SAMHSA-HRSA center for integrated health solutions, 2013. Available: <https://www.pcpc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf>
- 44 Embracing complexity in diagnosis: Multi-Diagnostic pathways for neurodevelopmental conditions. Available: <https://www.autistica.org.uk/downloads/files/Embracing-Complexity-in-Diagnosis.pdf> [Accessed 16 Feb 22].
- 45 Dillon-Naftolin E, Margret CP, Russell D, *et al.* Implementing integrated care in pediatric mental health: principles, current models, and future directions. *Focus* 2017;15:249–56.
- 46 Mazurek MO, Brown R, Curran A. Echo autism: a new model for training primary care providers in best-practice care for children with autism. *Clin Pediatr* 2017;56:247–56.
- 47 Sockalingam S, Arena A, Serhal E, *et al.* Building provincial mental health capacity in primary care: an evaluation of a project echo mental health program. *Acad Psychiatry* 2018;42:451–7.
- 48 Seierstad TG, Brekke M, Toftemo I, *et al.* GPs' and child and adolescent psychiatry specialists' experiences of joint consultations in the GP's office: a qualitative study. *BMC Res Notes* 2017;10:1–8.
- 49 Fazel M, Townsend A, Stewart H, *et al.* Integrated care to address child and adolescent health in the 21st century: a clinical review. *JCPP Adv* 2021;1:e12045.
- 50 Ford T, Hamilton H, Meltzer H, *et al.* Child mental health is everybody's business: the prevalence of contact with public sector services by type of disorder among British school children in a three-year period. *Child Adolesc Ment Health* 2007;12:13–20.
- 51 RCPCH - Role of paediatricians in supporting children and young people's mental health - position statement. Available: <https://www.rcpch.ac.uk/resources/role-paediatricians-supporting-children-young-peoples-mental-health-position-statement>
- 52 Efron D, Danchin MH, Cranswick NE, *et al.* Medication prescribed by Australian paediatricians: psychotropics predominate. *J Paediatr Child Health* 2017;53:957–62.
- 53 Rushton JL, Clark SJ, Freed GL. Pediatrician and family physician prescription of selective serotonin reuptake inhibitors. *Pediatrics* 2000;105:E82.
- 54 Lam D, Gorman DA, Patten S, *et al.* The pharmacoepidemiology of selective serotonin reuptake inhibitors for children and adolescents in Canada from 2005 to 2009: a database analysis. *Paediatr Drugs* 2013;15:319–27.
- 55 Walkup JT, Strawn JR. High-quality antidepressant prescribing: please consider whether "perfection is the enemy of progress". *BMC Med* 2020;18:150.
- 56 pp.Callaghan JE, Fellin LC, Warner-Gale F. A critical analysis of child and adolescent mental health services policy in England. *Clin Child Psychol Psychiatry* 2017;22:109–27.
- 57 General Medical Council (GMC). Good medical practice. General medical Council. Available: https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-20200128_pdf-1527435.pdf?la=en&hash=DA1263358CCA88F298785FE2BD7610EB4EE9A530 [Accessed 5 Apr 2021].
- 58 pp.Groves RM, Peytcheva E. The impact of nonresponse rates on nonresponse bias: a meta-analysis. *Public Opin Q* 2008;72:167–89.
- 59 Garcia J, Evans J, Reshaw M. "Is There Anything Else You Would Like to Tell Us" – Methodological Issues in the Use of Free-Text Comments from Postal Surveys. *Qual Quant* 2004;38:113–25.
- 60 Abrahamson V, Zhang W, Wilson PM, *et al.* Realist evaluation of autism service delivery (RE-ASCeD): which diagnostic pathways work best, for whom and in what context? findings from a rapid realist review. *BMJ Open* 2021;11:e051241.