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## Experiences of commissioning services for child and adolescent mental health in England (UK): a qualitative framework analysis

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# Experiences of commissioning services for child and adolescent mental health in England (UK): a qualitative framework analysis

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## **Abstract**

**Objectives:** To explore commissioners' experiences of commissioning services for child and adolescent mental health, their perspectives on the needs of their populations, the challenges they face and their needs for support and data.

**Design:** Qualitative study involving semi-structured interviews. All interviews were audio-recorded and transcribed verbatim. Data were analysed using framework analysis.

**Setting:** England, UK.

**Participants:** 12 integrated care board (ICB) commissioners, responsible for commissioning NHS England Child and Adolescent Mental Health Services (CAMHS).

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**Results:** We identified five themes: *‘reflections on role’*; *‘priorities and tensions: working in a complex and evolving integrated care system’*; *‘insights and evidence: the role and use of data and informants’*; *‘children’s mental health in the limelight: influences and expectations’*; and *‘responding to need “CAMHS as the answer to everything”’*. Combined these themes highlight the integral role commissioners play in providing oversight over the local system and challenges to this role including disproportionate funding for services for child and adolescent mental health, different use and value ascribed to ‘qualitative’ and ‘quantitative’ data, rises in demand, and the limited focus on early intervention and prevention.

**Conclusions:** CAMHS commissioners are currently negotiating a complex and changing political, social and economic environment with competing priorities and pressures. Greater investment in children and young people’s mental health, an increased focus on early intervention and prevention, and more succinct and timely research outputs are needed to better support commissioners in their role.

**Key words**

Commissioners; mental health services; child; adolescent; qualitative

**Article summary**

**Strengths and limitations of this study**

- To our knowledge, our study is the first to examine the perspectives of commissioners of child and adolescent mental health services (CAMHS) following the Covid-19 pandemic.
- Semi-structured interviews allowed us to develop an understanding of the needs and experiences of commissioners. This understanding enables us to consider how we can better

support commissioners to plan services and improve the health of the populations they serve. It also has wider benefits for the translation of epidemiological research into practice.

- Our study has important implications for both research and practice; highlighting the need to provide timely, succinct research outputs designed to support commissioners, as well as proportionate funding for children and young people's (CYP's) mental health services and a greater focus on early intervention and prevention.
- We conducted interviews with twelve commissioners responsible for commissioning services for child and adolescent mental health (including CAMHS) from integrated care boards (ICBs) across England; however readers should be aware that commissioners participating in our interviews may have been more engaged or research-aware than colleagues that did not take part.

#### **Word count**

6,383

#### **Introduction**

According to NHS England, commissioning is the "process of assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health outcomes" (1). In England's current healthcare system, commissioners within Integrated Care Boards (ICBs) have a range of remits, including responsibility for specialist Child and Adolescent Mental Health Services (CAMHS). Policies such as Future in Mind (2) and the NHS Long Term Plan (3) set out the broad direction of travel for children and young people's (CYP's) mental health, but there remains considerable local flexibility in how services are planned and delivered. Less positively, there has been significant variation nationally in spend and in the level of provision (4). Such variation has been found to be only weakly associated with indicators of need (4,5,6).

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72 Historically, policymakers and commissioners have been actively hampered in decision making and  
73 service planning for CYP’s mental health by a lack of data regarding national trends and projected  
74 changes in prevalence (7,8). Since the Covid-19 pandemic, commissioners have also faced challenges  
75 in understanding and responding to rapid changes in the context in which services are delivered  
76 (e.g., the move to online) and the levels of need in their population. These challenges come in  
77 addition to pressures to address lengthy waiting lists as well as an increasing policy emphasis on  
78 prevention and early intervention.

79  
80 Whilst some studies have explored how commissioners use evidence in decision-making or policy  
81 making in general (9), there is little research on approaches to understanding population need in  
82 terms of trends and prevalence. Additionally, to our knowledge, no studies have explored  
83 commissioner experiences of commissioning CYP’s mental health services post-pandemic. Given the  
84 extent and nature of the current challenges in CYP’s mental health, and the central role of  
85 commissioners within the system, this appears to be a significant research gap. An improved  
86 understanding of commissioners’ needs is likely to have wider benefits for the translation of  
87 epidemiological research into practice, by ensuring research outputs meet the needs of key  
88 stakeholders and in optimising the sharing, use and interpretation of data to improve services for  
89 CYP.

90  
91 This qualitative study aims to better understand commissioners’ experiences of commissioning child  
92 and adolescent mental health services, their perspectives on the needs of their populations, the  
93 challenges they face and their needs for support and data. Our research questions were:

- 94 • How do commissioners develop an understanding of the needs of their population?
- 95 • How do commissioners plan and adapt services to meet population need?

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- What challenges do commissioners face in their roles, and how can they be better supported?

## **Method**

### **Participants and recruitment**

We conducted 12 individual, semi-structured interviews with ICB commissioners responsible for commissioning NHS England CAMHS.

We approached and recruited commissioners to take part in the study between May – June 2023 through two main routes: 1) advertisements through social media and commissioner networks; and 2) e-mails to ICBs within England (UK). Advertisements and e-mails encouraged interested commissioners to contact the research team. Commissioners who made contact were sent detailed information about the study. Commissioners completed a copy of the consent form prior to interview via e-mail, providing informed consent to participate.

Of the 12 commissioners who expressed an interest in taking part, all successfully completed a subsequent interview. Details of participants are provided in the results section below.

### **Data collection**

Individual, semi-structured interviews were conducted online using Microsoft Teams and followed a topic guide designed to address our research questions (see Supplementary Material). The topic guide started with questions about the commissioners' role and their perspectives on the key drivers of CYP's mental health need, before moving onto questions about how they develop an understanding of needs, how they use data to inform this understanding, and the approach they



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take to planning and adapting CYP’s mental health services. The topic guide ended by reflecting on some of the key challenges commissioners face in their role. All interviews were one-to-one, audio-recorded and transcribed verbatim. Interviews lasted approximately one hour on average.

All interviews were conducted by KA and TND between May and June 2023. KA and TND are experienced qualitative researchers with experience conducting interviews on mental health and with professionals. Neither KA nor TND had any pre-existing relationships with commissioners who took part in the study however, TND does have experience as a public health consultant and has knowledge of the commissioning process and cycle. ST, who was involved in the analyses, is an academic public health registrar.

**Analysis**

We analysed data using framework analysis; a systematic qualitative analysis method which involves charting and organising data into key themes, as well as highlighting patterns within and links between the data (10 – 12). The analysis involved several interconnected stages which were conducted by KA and TND, with assistance from ST. KA and TND: 1) *familiarised* themselves with the interview data by re-reading interview transcripts and any reflexive notes; 2) *coded* the first few interview transcripts line by line using both inductive and deductive codes; 3) *developed an initial analytical framework* based on the research questions, knowledge of theory and prior research, familiarisation stage, and line by line coding stage; 4) *applied the analytical framework* to the remaining interview transcripts; 5) *charted the data* in a framework matrix; and 6) *interpreted* the data by keeping a regular log of analytical notes and questions throughout the analysis and reflecting on differences/connections between data. KA, TND, and ST developed the analytical framework over the course of the analysis and allowed for flexibility to add new inductive codes throughout. NVivo was used to manage the data.

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## Patient and public involvement

Both young people and commissioners were involved from the early stages of this research and in the funding application. Both groups contributed to the development of the research questions and the design of the study. For example, young people felt it was important to find out more about how commissioners made decisions about services provided, and commissioners thought it would be helpful to ask about support for commissioners. These were incorporated into the topic guide. From conversations with commissioners, we were also aware of the importance of avoiding the inclusion of identifiable information on participant characteristics as this is a relatively small community of practice. Young people and commissioners were not involved in recruitment to, or conduct of the study, or otherwise asked to assess the burden of participation. Commissioners have provided input into the key messages developed from this study and are currently involved in reviewing commissioner and policy-facing outputs.

## Ethical approval

Ethical approval for this study was granted by the University of Exeter Medical School (reference number: 1337925).

## Results

12 commissioners participated in interviews. To avoid identification, details are not provided for individual commissioners. Participants were spread across NHS regions (London n=4; South West n = 1; South East n= 3; Midlands n= 1; North East n = 1; North West n=2) and had varying length of experience in a commissioning role (one to seven years, median 5 years). The majority had a remit of child and adolescent mental health and wellbeing only, but several had a wider remit of children's health more broadly, or child health and maternity.

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170  
  
171 We constructed five key themes (see Figure 1): 1) Reflections on role; 2) Priorities and tensions:  
172 working in a complex and evolving integrated care system; 3) Insights and evidence: the role and use  
173 of data and informants; 4) Children’s mental health in the limelight: influences and expectations; and  
174 5) Responding to need “CAMHS as the answer to everything”.

175  
176 *Figure 1. Themes, sub-themes, and relationships between themes*

177 [INSERT FIGURE 1 HERE]

178  
179 **Theme 1: Reflections on role**

180 This theme is about the role of the commissioner, how it is informed by their background and their  
181 ‘positioning’ in the system in which they work, and how this influences their approach to  
182 commissioning.

183  
184 Commissioners had a range of different formal responsibilities in terms of the remit and reach of  
185 their roles. They came from a range of different backgrounds, including clinical, non-clinical  
186 healthcare, and from professions and organisations outside the NHS. There were different  
187 perspectives on how prior experience might inform current role. For example, some commissioners  
188 from clinical backgrounds described how they drew upon this prior experience in their current roles:

189  
190 *"I’m one of the few commissioners who is actually a clinician...So my role as commissioner is*  
191 *actually informed by decades of actual clinical work and also frontline clinical management"*

192 (C13)

193  
194 However, another commissioner described the benefits of having a breadth of prior professional  
195 experience:

196  
197 *"...(it) allows me to have that kind of broad understanding of a wide range of agendas in*  
198 *making decisions for our communities, which helps"* (C10)

199  
200 Some commissioners clearly 'positioned' themselves as 'non-clinicians', and linked this directly with  
201 how they saw their role or the insights they were able to give:

202  
203 *"because I'm not a clinician, I can't give you an opinion. I can't interfere in the way the*  
204 *operational model works. I want to know if there are issues with the way the operational*  
205 *model works"* (C8)

206  
207 However, regardless of background, common to many participants was a perception that one of  
208 their key roles was oversight and overview of 'the system':

209  
210 *"So, because I kind of work at the strategic level, I can see the different parts of the system.*  
211 *Whereas if you work in specialist CAMHS, you just see that bit. You don't necessarily see, "Oh,*  
212 *there's a school next to me here, and there's, I don't know, a school nurse there and there's the*  
213 *family here." You're kind of just dealing with your one part of it."* (C9)

214  
215 One commissioner described being a 'critical point of failure' (C8) because of this role. In contrast to  
216 the commissioning role, providers were often seen as not having the same overview of the system in  
217 terms of asking whether they were best placed to offer a particular service. Without their oversight  
218 and understanding of connections within the system, confusion or duplication of services could  
219 arise, and the system could be fragmented:

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3 221 *"And I suppose I see my role, and I don't think it is really necessarily what my role is per se, but*  
4  
5 222 *I feel that it should be this, is to try and bring that system together" (C9)*  
6  
7 223  
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10 224 Several commissioners specifically described their roles as supporting system transformations:  
11  
12 225  
13  
14 226 *"I wouldn't necessarily describe us as traditional commissioners, per se. We work on largescale*  
15  
16 227 *transformation, so things like the intermediary between NHS England and our organisation, and the*  
17  
18 228 *subsequent providers that we work with" (C4)*  
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23 230 Many described an increasingly collaborative approach to commissioning in recent years, linked to  
24  
25 231 the advent of provider collaboratives. Commissioners described working together with providers and  
26  
27 232 other organisations to develop consensus around solving problems and addressing gaps. This was  
28  
29 233 closely related to an emphasis on the commissioner's role in building and managing relationships  
30  
31 234 with providers. Trust, openness and communication were also seen as central to allowing providers  
32  
33 235 to raise problems and difficulties with commissioners:  
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39 237 *"So, having an open, trusting relationship with providers, where you can just ask questions, or*  
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41 238 *they feel comfortable and confident enough to flag things that they're finding really difficult,*  
42  
43 239 *knowing that we will try to work through together to improve a pathway, or to support a*  
44  
45 240 *team, or whatever it might be" (C7)*  
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48 241  
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50 242 Some commissioners contrasted their approach and role with 'traditional commissioning' models,  
51  
52 243 which were seen as more adversarial:  
53  
54 244  
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56  
57 245 *"So I'm, sort of, part parent, part grandparent, part commissioner, because there is a formal*  
58  
59 246 *bit to it, I do need to write the specifications, I do need to work with them on their business*  
60

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cases to secure funding.... But I think the fundamental difference is they should feel their commissioners are more approachable, they can talk to them. It's not transactional, it's not adversarial." (C8)

However, commissioners also expressed some uncertainties and concerns over their roles. For some, the shift to provider collaboratives meant that they felt their role had changed, or questioned whether they were even supposed to call themselves 'commissioners':

"...[there needs to be] clarity on the expectations of commissioners, and the commissioning role. Because it seems to be changing, and then assumptions are being made in terms of what the role should be doing" (C6)

"So we are not supposed to call ourselves commissioners anymore because the commissioning function has been stripped with regards to the move from CCG to ICS." (C10)

## **Theme 2. Priorities and Tensions: working in a complex and evolving integrated care system**

Commissioners described a wide range of environmental and contextual factors that influenced their work. These factors were perceived to present both opportunities and challenges to the commissioning of mental health services for CYP.

Many commissioners cited key policies and strategies which they felt had influenced their work in their roles. However, commissioners had mixed views about how national policy impacted their work. One commissioner felt a lack of control due to centralised decision-making, whereas another perceived there to be more scope to tailor national policy to local needs:

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272 " So we'll get money from NHS England or money from the central team and they will be like,  
273 'we're giving you this money, you have to spend it on X, Y, Z.' So there's a lot of stuff that I  
274 don't actually have control over. The stuff that I do have control over is actually really such a  
275 small percentage. If anything a lot of the decisions are already made and then just like we're  
276 told we have to just do it" (C7)

277  
278 "I think tailoring national plans, and national objectives, to our local population, is kind of  
279 what we do. Obviously we have certain access and activity targets to try and hit, and I guess  
280 there are suggestions as to how we do that, but I think what we need to do is really identify  
281 how that would work for our local population" (C4)

282  
283 Participants also discussed the impact of frequent major healthcare system reorganisations. Several  
284 described some of the challenges they faced in adapting to recent system integration and  
285 transformation without much information or guidance:

286  
287 "so it keeps on changing from Clinical Commissioning Groups, to ICBs, to Primary Care Trusts,  
288 all sorts. I think it's going to go back to Primary Care Trusts, at this rate. [Laughs]" (C6)

289  
290 Some felt that frequent changes and 'transformations', along with a reduction in workforce, had led  
291 to a shift towards more reactive commissioning, and to personal stress for commissioners over their  
292 own job security:

293 "the demands are unrealistic. Going through a transformation and integration process. We  
294 are also going through a restructuring, so we've been asked to deliver 30% savings by the  
295 end of the next financial year. So my post is safe for this year, but I don't know if next year  
296 there will be a second round of consultation. And this creates a lot of instability because

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297 *people are losing their jobs, we are going through consultations, so that creates that added*  
298 *stress."* (C2)

300 Related to this, in terms of workload, several participants perceived that they as children's  
301 commissioners had wider remit than they would have in in adult's commissioning:

303 *"Resource is not proportionately allocated to children's commissioning...it's just not enough. It's*  
304 *not enough to give the level of attention and the level of time, yes, just the time that is required*  
305 *to do it justice really"* (C7)

307 Some commissioners also felt that CYP as a group were a lower priority in the system. One  
308 commissioner directly related this to the change from Clinical Commissioning Groups to ICBs:

310 *"(Previously) there was that direct line of responsibility around targeted investment for children*  
311 *and young people and mental health, it felt ringfenced even though it wasn't but it kind of was*  
312 *because you could not not invest in children's mental health, and commissioning groups were*  
313 *regularly challenged by way of their level of investment through professional bodies, for*  
314 *example, the Royal College of Psychiatrists. For some reason, that connectivity with ICBs, it isn't*  
315 *the same. I think that's a major challenge."* (C13)

317 Another felt that other issues were of higher political and media interest than CYP, meaning that  
318 young people did not get the 'airtime':

320 *"Getting airtime to talk about the issues around treatment for young people can be quite difficult*  
321 *because of the operational pressures. You're on the Six O'clock News with a queue of ambulances*  
322 *outside. Guess what, that's going to dominate the discussions that week."* (C8)



**Theme 3: Insights and evidence: the role and use of data and informants**

Commissioners described drawing on a range of sources to develop an understanding of child mental health need and services in their local area. Participants used many different terms to describe these sources, including *information, evidence, data, insight, observations, hunches, conversations, engagement, deep dives*, etc. and had different perceptions on the value and uses of these data.

Service providers were seen as particularly valuable sources of information, being described as commissioners’ *“eyes and ears”* (C4). Insights and observations from providers were *key* to ‘verifying’ initial hunches from quantitative data, and prompting deep dives, engagement work, or requests for further service provider quantitative data:

*“I think we are reliant upon our providers, and also our delivery managers, so our borough-based colleagues, to feedback pertinent issues or common trends or presentations, which are either not typical, or they’re increasing. So I think that gives us almost a bit of a hunch. And then I guess what we would do is try to dive a little deeper into some of the activity, outcome and experience data associated with those presentations, or those levels of need.”* (C4)

This meant that developing strong, trusting relationships with service providers was important, enabling open and honest discussions about problems and levels of need that might not otherwise occur:

*“[if] they feel comfortable and confident enough to flag things that they’re finding really difficult, knowing that we will try to work through together to improve a pathway, or to support a team, or whatever it might be, is much better than having a dynamic where providers might almost try and consume their own smoke, or to – not hide waiting lists, but*

349 *feel as though they can't flag a capacity problem, because they'll get dragged over the coals*  
350 *for performance issues, and it will just create an industry of perhaps unhelpful dialogue."*  
351 (C4)

352  
353 Commissioners also talked of the importance of engagement pieces of work with children, young  
354 people, and families. This type of information helped commissioners to really understand the needs  
355 of their population:

356 *"I think the key things that we've done in [LOCAL AREA] that I think data will never be able to*  
357 *show you is those engagement pieces of work, so actually understanding what children and*  
358 *young people and families are saying, how they feel about mental health support, what are*  
359 *their needs."* (C12)

360  
361 However, this was not always the case, with one commissioner suggesting that engagement events  
362 or co-production wasn't always helpful as it didn't tell them anything new:

363  
364 *"[Talking about feedback from children and young people co-production and engagement*  
365 *events] I wouldn't say that they are to give us a good granular detail direction for developing*  
366 *services, because the narrative is always the same, "Oh, I wait too long, I don't want to go to*  
367 *CAMHS, I want to be seen in the community," these are the main themes."* (C1)

368  
369 Commissioners also reported using 'hard' quantitative data (e.g., service provider data, population  
370 level data, local surveys, academic data) to develop an understanding of child mental health need  
371 and identify gaps in service support. Commissioners talked about population data being useful in  
372 providing a spotlight on general need, evidence for business cases (with quantitative data carrying  
373 more weight than qualitative data), and looking beyond 'levels of access' data:

374 *"I think looking at prevalence rates in boroughs and PCNs, versus the actual activity or access*  
375 *levels, is able to shine a bit of a light on where we have high level of need, but perhaps low*  
376 *levels of access."* (C4)

378 *"I wouldn't need it day-to-day, no, but we would obviously access that when we're looking at*  
379 *papers or bidding or business cases, recommendations or retendering, all of that type of stuff*  
380 *then yes, or writing papers and we need that information, like going on the JSNA and things*  
381 *like that."* (C3)

383 Often, there was a reliance on service provider data (i.e., data on referrals, activity, outcomes, and  
384 wait times), over other forms of quantitative data, to inform commissioners' understanding of child  
385 mental health need. Service provider data had a range of uses; from identifying emerging, context-  
386 specific trends to assessing service performance and identifying where services might be failing to  
387 meet the needs of CYP. However, some commissioners had concerns about the reliability and  
388 accuracy of this quantitative data. For example, service provider data were often reported as  
389 missing, coded inaccurately, or inconsistently captured. This led to a sense that this service provider  
390 data could not always be trusted to inform decision making and qualitative data was needed to *truly*  
391 *understand child mental health need and to "improve [commissioners] view of the accuracy of a*  
392 *numeric"* (C8):

394 *"[quantitative] data informs us maybe of some of the work that we need to do, and the areas*  
395 *in which we need to do that work. Then from there, and again, we wouldn't do this in isolation,*  
396 *as an ICB, we do this with our colleagues, from services, to understand, okay, what is the*  
397 *need? And it may be that we need to do an engagement piece of work in that area."* (C5)

The pressure on service providers to provide quantitative data was seen by one commissioner as having unintended consequences; encouraging service providers to chase referral numbers rather than provide quality support. Furthermore, concerns around the reliability, accuracy, and novelty of quantitative data led some commissioners to ascribe little value to this type of data:

*"It's an odd one, [name] because if you talk to people in health, they'll say, "Everyone knows where the problems are. So why do we need more data to tell us? It's got feathers like a duck and it quacks like a duck. It's a duck. We know where we need to make the changes. We don't need more data or more surveys or more." [...] "I kind of know where the problem is, and I don't have to have empirical data to help me with that." (C8)*

There was a clear tension and variation between the use and value of quantitative versus qualitative data. Commissioners background and experience often influenced the type of data they utilised (e.g., commissioners with a quantitative background talked about utilising and valuing quantitative data, whereas commissioners who were clinicians by background often ascribed greater value to initial hunches or conversations with service providers). As a result, this created a commissioning landscape in which there appeared to be no established way of using data and informants; with sources/type used varying, dependent on the individual commissioner.

#### **Theme 4: Children's mental health in the limelight: influences and expectations**

This theme is about commissioners' perceptions of changes in child mental health in their populations. Most commissioners discussed having seen a rise in demand for services, in terms of referrals and increasing time on waiting lists. Participants listed a range of areas where they felt there had been increases, including neurodevelopmental disorders, disordered eating, depression and anxiety, and self-harming. Many also perceived an increase in complexity and urgency of

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424 presentations. Commissioners made a clear link with the impact of the pandemic, but also  
425 emphasised that rises in demand were already happening pre-Covid:  
426  
*“I don't want to pin it all on COVID because we were seeing an increase in demand before  
COVID. So it's not as if everything was fine and then COVID, you know, just tipped us over.”  
(C9)*  
430  
431 Participants felt that social isolation and online education were key factors that had affected mental  
432 health and child development and contributed to school-based anxiety and avoidance. However,  
433 commissioners also voiced concern over the impact of other systemic social and economic  
434 influences which they felt were driving increases in problems, and which had been exacerbated by  
435 the pandemic:  
436  
*“I might be wrong, but I don't think that there has been a biological shift in how children and  
young people's mental health and emotional wellbeing works. I think that a lot of it's from  
external factors” (C4)*  
440  
441 Inequalities in access to help were also a concern:  
442  
*“I think the pandemic created a larger gap between those who needed help, or need help, and  
those who access it. I think that's been disproportionate for certain children and young people,  
certain demographic profiles as well. (C4)*  
446  
447 There was also much discussion of the effects of increased awareness and understanding around  
448 mental health, and the impact of social media and wider policy in putting mental health “in the  
449 limelight”. This was also seen as uncovering new needs and gaps which services then had to meet:

"I would say that the demand has increased, that's a fact because we've expanded services and still have issues with waiting times and more children needing support. But alongside the demand, because mental health has increasingly been in the limelight, I suppose, there's been more attention to mental health, child, adolescent, mental health in the last five years. Perhaps this has uncovered needs and a prevalence that we weren't aware of before." (C1)

"Disordered eating and things like ARFID [Avoidant Restrictive Food Intake Disorder], seem to be something... sort of newly emerging conditions because we don't have commissioning in place for them. And that's not because it was a gap... well, it's a gap now, but it's a gap that seems to have emerged within recent times. When we, for example, were commissioning our specialist children's mental health service, disordered eating and ARFID were not really discussed as being something that needed to be considered or perhaps disordered eating was looked at differently." (C2)

In terms of drivers of demand, commissioners also appeared to perceive some tensions between positive aspects of awareness and encouraging help-seeking, and risks of 'over-medicalising' normal 'ups and downs' and expectations of mental health which might be unrealistic:

"So there's an awareness from children and young people that they know what good mental health looks like, and how they can promote it. But there's also probably an expectation from that as well...I think a young person, after watching a video, or trying to learn some coping techniques, won't necessarily see a change or an improvement straight away in the same way that, if you've got a headache, you have a paracetamol, and then an hour later you're sorted... (C4)

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**Theme 5: Responding to need: “CAMHS as the answer to everything”**

In addressing the needs of their populations, many commissioners felt that prevention and early intervention were key priorities. They discussed an increasing role for a broader range of agencies including the voluntary sector, social care, and education, with several referencing the Thrive model (13). Participants also cited a range of initiatives aimed at triaging referrals and expanding first-line support and emphasising the role of CAMHS as a specialist mental health service. However, for some commissioners, there were several significant challenges in moving the focus away from specialist child mental health services. For example, lack of capacity in other parts of the system such as schools and communities was seen as a limiting factor in prevention and management of less severe cases, resulting in bottlenecks and pressure on CAMHS:

*“I think there is a real-time reduction in staff time in schools over the past 15 years and that gets expressed in an increased in referral activity to where the lights are on. That’s the NHS. And free at the point of use. So there is a systemwide bottleneck and things just breaking down.” (C13)*

Additionally, commissioners perceived that both professionals and young people still had assumptions and expectations that CAMHS was the place for all child mental health concerns. These expectations complicated efforts to develop other pathways, with some early-support services being seen as under-utilised as a result of a preference for CAMHS:

*“We get reports from services that they are under strain, but there are also parts of other services which are not utilised properly. And then we get feedback from children, “I don’t know what provision is available to me, and waiting times are too large.” So my feeling is we’re still struggling to move the focus away from CAMHS being the answer to everything.” (C1)*

Some expressed frustration that this might mean CYP spent time on waiting lists when they could have accessed support more quickly elsewhere:

*"there's still that mind-set of if someone expresses any concern about mental health, let's refer them into CAMHS, and that's where we see those waits because then they're essentially on a waiting list for support that potentially they might not need and they could have got something a lot earlier."* (C6)

Commissioners also reflected on future directions and challenges and what they expected to see coming down the line. One commissioner thought that funding would never be able to meet need for services:

*"The overarching difficulty is that the money that we've got is never going to be able to meet the full demand of need, so we have to think differently about who we support when"* (C12)

Commissioners had varying degrees of optimism about whether investment in services and early intervention would happen, and whether CYP's mental health would improve in future:

*"Our focus needs to be more on that preventative and early intervention. But that's a massive culture change, so I think hopefully in that long period of time we will see those – I won't say probably a reduction – but levelling off of demand."* (C12)

*"I would say unless, coming back to the main point, we invest properly and proportionately in children's services over the next five years, we're going to be going backwards in terms of children and adolescent mental health. We're not going to be going forwards." [...] "So it*



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527           *sounds pessimistic, but I think we're going to have a worse situation in the next five years*  
528           *unless we drastically change."* (C7)

530    **Discussion**

531    This qualitative study sought to explore and understand commissioners' experiences of  
532    commissioning child mental health services, their perspectives on the needs of their populations, the  
533    challenges they face and their needs for support and data. From interviews with 12 commissioners  
534    based in ICBs across England, we generated five themes: 1) Reflections on role; 2) Priorities and  
535    Tensions: working in a complex and evolving integrated care system; 3) Insights and evidence: the  
536    role and use of data and informants; 4) Children's mental health in the limelight: influences and  
537    expectations; and 5) Responding to need: "CAMHS as the answer to everything". Below we discuss  
538    some of the main insights, challenges and implications of these findings.

539  
540    Our first and second themes illustrate the way in which commissioners see themselves as holding  
541    oversight or a living map of their local systems, and have an increasing role in systems leadership,  
542    rather than focussing on contracts management. It was also evident that some commissioners  
543    experienced tensions and uncertainties over their changing roles, especially when these changes  
544    occurred as part of broader restructuring. Whilst some benefits were seen, there was a strong  
545    perception that frequent reinvention and transformational change had introduced not only stresses  
546    about job security, but also hampered their being able to undertake deeper thinking and proactive  
547    planning over the longer term. Here our findings are in line with previous research suggesting that  
548    whole system changes can result in disruptions to the commissioning process, as well as to the wider  
549    workforce (14).

550  
551    Commissioners also faced challenges in terms of advocating for their population of CYP. Many of  
552    our participants perceived that CYP as a group were seen as lower priority, both in terms of

allocation of commissioning resource, but also in the healthcare system. This accords with wider concerns which have been repeatedly voiced about the (relative) low priority of CYP in policy and strategy in England, and even in the Covid-19 response (15, 16).

A key finding from our third theme: "Insights and evidence" was the various ways in which commissioners developed an understanding of the needs of their populations, and how they perceived the roles of 'qualitative' and 'quantitative' data. Many participants placed a premium on the insights they gained from trusted providers acting as their 'eyes and ears'. This constituted another benefit for commissioners of developing good relationships with their provider networks. Alongside evidence gathered from engagement with children and families, this 'qualitative' data was valued as providing strong narratives and stories which could spotlight areas of need. Other research on policymaking and commissioning has also highlighted the importance of 'people based' sources of information, often as part of informal 'policy networks' (9, 17). Interestingly our research also reveals the concerns held by commissioners about 'quantitative data'. In some cases, concerns around the reliability, accuracy, and novelty of quantitative data led some commissioners to see quantitative data as being lower value. Despite this, most saw a clear role for quantitative data, and would expect to include it in documents required for decision-making such as in needs assessments and business cases.

Commissioners' perceptions of changes in their populations were in many ways in line with findings from epidemiological data, in terms of the gradual increase in prevalence pre-Covid, followed by a more marked rise in problems, particularly in emotional disorders (18, 19). However, commissioners also discussed how and whether increased awareness and understanding of mental health were influencing presentations and demand for services in their areas. Avoidant Restrictive Food Intake Disorder (ARFID) was cited by at least one commissioner as an example of a 'new need' that had been uncovered and which services needed to meet. These discussions appeared to reflect wider

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3 579 societal debate on the impact of broader mental health awareness and the medicalisation of distress  
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5 580 in young people (20).  
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10 582 Linked to this was the theme on ‘CAMHS as the answer to everything’, which described how  
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12 583 commissioners were grappling with system transformation (mirrored by other accounts from  
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14 584 CAMHS staff, e.g. in Rock et al.’s (2021) study). A common area of challenge appeared to be the  
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16 585 challenges of diverting the focus from CAMHS for problems which may not require specialist  
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18 586 support. Some participants perceived that early-help or online groups were under-utilised due to a  
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20 587 preference for CAMHS both from referring professionals and from young people and families. This  
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22 588 presents an interesting contrast with research suggesting that patients and primary care  
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24 589 professionals perceive marked barriers to accessing care and that thresholds for CAMHS remain a  
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26 590 hindrance in getting the support they need (21–23). The accounts of commissioners accord with the  
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28 591 wider drive within integrated care system’s to change the focus of services to include lower intensity  
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30 592 early interventions to support health and wellbeing in the population.  
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37 594 **Strengths and limitations**

38  
39 595 One of the strengths of this paper is the exploration of the perspectives of commissioners, a group  
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41 596 who are rarely the ‘subjects’ of research, but who have considerable influence in the design and  
42  
43 597 delivery of mental health services for CYP. This study represents one of only a handful of papers to  
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45 598 explore their views, and the only study we are aware of to include CAMHS commissioners in a post-  
46  
47 599 pandemic context. We were also able to recruit commissioners across a range of ICBs in England  
48  
49 600 with responsibilities for commissioning mental health services for CYP. The limitations of the study  
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51 601 include the potential for more motivated and research-engaged commissioners to have participated,  
52  
53 602 perhaps affecting the transferability of our findings. It is also possible that those participating may  
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55 603 not have felt fully able to express their views, due to concerns around anonymity. As there are only  
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42 ICBs in England, we have been careful to avoid including information which could link a participant to their ICB and risk disclosure.

606

## 607 **Implications**

608 Our findings describe the complex and changing political, social and economic environment in which  
609 commissioners work, and their role in maintaining oversight of their local systems. It is also evident  
610 that commissioners as a group may struggle with changes as their role evolves, and that they may  
611 benefit from additional resource, training and professional development opportunities. As with  
612 many public sector services, CAMHS commissioners also face challenges in delivering services in the  
613 face of constrained resources. Marked tensions were evident around the need to balance  
614 investment in prevention and interventions earlier in 'the pipeline' with continuing to deliver the  
615 specialist assessment and treatment needed by children with more severe and complex problems.  
616 Whilst there have been longstanding calls for more investment in child mental health since before  
617 the pandemic, it has been argued that services are now even more unlikely to be able to meet  
618 growing need without a step change in thinking by those funding and designing services (24).  
619 Decision-making in this context needs to be as transparent as possible, including developing a  
620 clearer understanding of the data required and used to make commissioning decisions.

621

622 These findings also have important implications for researchers, in terms of how those in the  
623 research community can ensure that relevant and digestible messages find their way to those  
624 commissioning services. Our findings highlight how time, and timeliness, is of the essence for those  
625 in a commissioning role, hence brevity and pace of outputs is key, representing a challenge for  
626 researchers working with slower timescales of funding, approvals and peer-review. Local  
627 relationships and networks are likely to be key for research teams to interact in a more meaningful  
628 way with commissioners. Forums that bring the two groups together, for example, as part of a

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research active Integrated Care System or Population Health Management board, may also be helpful in be exploring joint priorities and co-development of outputs.

**Conclusions**

Our study sought to explore and understand commissioners’ experiences of commissioning services for child and adolescent mental health, including their perspectives on the needs of their populations, challenges they face and their needs for support and data. The findings highlight how commissioners are negotiating a complex and changing political, social and economic environment with competing priorities and pressures. Proportionate funding for CYP’s mental health services was seen as essential to ensure services are able to meet current need, alongside a greater focus on early intervention and prevention. Researchers now need to work alongside commissioners to provide timely, succinct outputs that better support commissioners plan services and improve the health of the populations they serve.

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**Data sharing statement:** No data are available.

Any checklist and flow diagram for the appropriate reporting statement, e.g. STROBE

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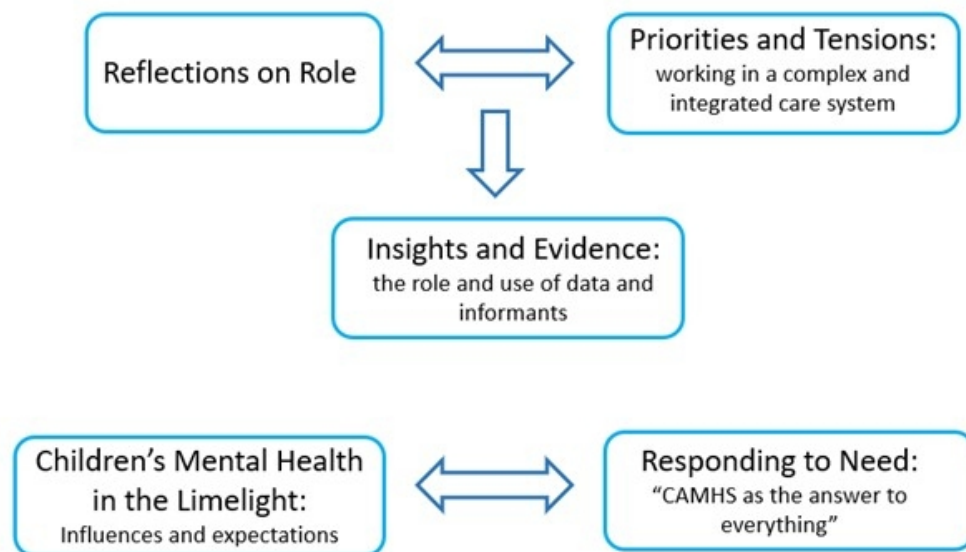


Figure 1. Themes, sub-themes, and relationships between themes

159x93mm (96 x 96 DPI)

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**Supplementary material**

**Interview topic guide**

- 1) Can you tell me a little bit about your role as a commissioner?
- a. Which services are you currently responsible for commissioning?
  - b. How long have you been in your role as a commissioner?
- 2) What recent changes have you seen in child mental health need? (nationally/locally)
- a. In your view, what are the key drivers/determinants/factors responsible for these changes?
  - b. How do you think COVID played a role in these changes?
  - c. Can you tell me about any specific groups that might have been impacted?
- 3) What changes do you expect to see in child mental health need moving forward? (e.g., next five/ten years?)
- a. In your view, what are the future drivers/determinants of child mental health likely to include?
  - b. How do you think CAMHS might need to adapt to meet these changing needs?
- 4) How do you develop an understanding of child mental health needs in your area?
- a. Can you talk me through the process involved?
  - b. Can you tell me about who you work with to help develop this understanding?
- 5) How do you use data to help inform your understanding of local child mental health needs?
- a. What sources of data do you use?
  - b. Can you describe what these sources of data include?

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- c. How do you find accessing/using this data?
  - d. What is *useful* about this data? What is *not so useful* about this data?
  - e. Are there any sources of data that you do not use? Can you tell me about why you do not use this data?
- 6) What approach do you take to planning and adapting child mental health services in your area?
- a. What resources do you draw on?
    - i. How does this help inform your decision-making?
  - b. What expertise do you draw on?
    - i. How does this help inform your decision-making?
  - c. Can you tell me about how you work with others to plan and adapt child mental health services?
  - d. What differences are there, if any, in your approach to planning and adapting mental health services for transition age young people?
- 7) How could the data currently available to you be improved to better support you in your role?
- a. What are the key gaps with the data?
  - b. What are the key problems/limitations with the data?
  - c. What additional information would you like to see in the data currently available?  
Can you tell me about why this data would be particularly important/useful?
  - d. Do you have any key unanswered questions about your population?
- 8) Can you tell me about any specific groups that it would be useful to have data for?

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- 539) What are the key challenges you face in undertaking your role as a commissioner of child
- 54mental health services?
- 55
- 5610) Is there anything else that would be useful to you in terms of commissioning child mental
- 57health services?

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# Experiences of commissioning services for child and adolescent mental health in England (UK): a qualitative framework analysis

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## **Abstract**

**Objectives:** To explore commissioners' experiences of commissioning services for child and adolescent mental health, their perspectives on the needs of their populations, the challenges they face and their needs for support and data.

**Design:** Qualitative study involving semi-structured interviews. All interviews were audio-recorded and transcribed verbatim. Data were analysed using framework analysis.

**Setting:** England, UK.

**Participants:** 12 integrated care board (ICB) commissioners, responsible for commissioning NHS England Child and Adolescent Mental Health Services (CAMHS).



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23     **Results:** We identified five themes: *‘reflections on role’*; *‘priorities and tensions: working in a*  
24     *complex and evolving integrated care system’*; *‘insights and evidence: the role and use of data and*  
25     *informants’*; *‘children’s mental health in the limelight: influences and expectations’*; and *‘responding*  
26     *to need “CAMHS as the answer to everything”*. Combined these themes highlight the integral role  
27     commissioners play in providing oversight over the local system and challenges to this role including  
28     disproportionate funding for services for child and adolescent mental health, different use and value  
29     ascribed to ‘qualitative’ and ‘quantitative’ data, rises in demand, and the limited focus on early  
30     intervention and prevention.  
31     **Conclusions:** CAMHS commissioners are currently negotiating a complex and changing political,  
32     social and economic environment with competing priorities and pressures. Greater investment in  
33     children and young people’s mental health, an increased focus on early intervention and prevention,  
34     and more succinct and timely research outputs are needed to better support commissioners in their  
35     role.  
36  
  
37     **Key words**  
38     Commissioners; mental health services; child; adolescent; qualitative  
39  
40     **Article summary**  
  
41     **Strengths and limitations of this study**  
  
42     

- 43         We conducted interviews with twelve commissioners responsible for commissioning services  
44         for child and adolescent mental health (including CAMHS) from integrated care boards (ICBs)  
            across England; with six NHS regions represented

- Commissioners participating in our interviews may have been more engaged or research-aware than colleagues that did not take part, meaning their perspectives may be different than those not participating.
- As there are only 42 ICBs in England, it is also possible that those participating may not have felt fully able to express their views, due to concerns around anonymity.

### Word count

6,968

### Introduction

Young people's mental health has been recognised by the World Health Organisation as a global challenge. However, despite the existence of evidence-based interventions for children and young people's mental health, Child and Adolescent Mental Health Services (CAMHS) provision in many countries has fallen far short of need (1,2). The process of planning, funding and organising services for children and young people with mental health problems varies according to national healthcare funding models and systems. In the English healthcare system, the Department for Health and Social Care sets overall strategy and funding and has oversight of the system, with NHS England acting as the operational arm (3). According to NHS England, commissioning is the "process of assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health outcomes" (4). In England, the process of commissioning largely sits with regional Integrated Care Boards, of which there are 42, with primary care and more specialised services commissioned by NHS England.

Commissioners within Integrated Care Boards (ICBs) have a range of remits, including responsibility for CAMHS). Policies such as Future in Mind (5) and the NHS Long Term Plan (6) set out the broad

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70 direction of travel for children and young people’s (CYP’s) mental health, but there remains  
71 considerable local flexibility in how services are planned and delivered. Less positively, there has  
72 been significant variation nationally in spend and in the level of provision (7). Such variation has  
73 been found to be only weakly associated with indicators of need (7,8,9).  
74  
75 Historically in the UK, policymakers and commissioners have been actively hampered in decision  
76 making and service planning for CYP’s mental health by a lack of data regarding national trends and  
77 projected changes in prevalence (10,11). Since the Covid-19 pandemic, commissioners have also  
78 faced challenges in understanding and responding to rapid changes in the context in which services  
79 are delivered (e.g., the move to online) and the levels of need in their population. These challenges  
80 come in addition to pressures to address lengthy waiting lists as well as an increasing policy  
81 emphasis on prevention and early intervention.  
82  
83 Whilst some studies have explored how commissioners use evidence in decision-making or policy  
84 making in general (12), there is little research on approaches to understanding population need in  
85 terms of trends and prevalence. Additionally, to our knowledge, no studies in the English healthcare  
86 system have explored commissioner experiences of commissioning CYP’s mental health services  
87 post-pandemic. Given the extent and nature of the current challenges in CYP’s mental health, and  
88 the central role of commissioners within the system, this appears to be a significant research gap. An  
89 improved understanding of commissioners’ needs is likely to have wider benefits for the translation  
90 of epidemiological research into practice, by ensuring research outputs meet the needs of key  
91 stakeholders and in optimising the sharing, use and interpretation of data to improve services for  
92 CYP.  
93  
94 This qualitative study aims to better understand English commissioners’ experiences of  
95 commissioning child and adolescent mental health services, their perspectives on the needs of their

populations, the challenges they face and their needs for support and data. Our research questions were:

- How do commissioners develop an understanding of the needs of their population?
- How do commissioners plan and adapt services to meet population need?
- What challenges do commissioners face in their roles, and how can they be better supported?

## **Method**

### **Study context**

Our study explored the views of commissioners based within ICBs in England who have responsibility for specialist services including NHS England CAMHS, as well as the provision of early intervention support. Commissioners are professionals who will usually have a first degree and postgraduate qualifications, as well as management experience within the health and social care sector. Some may have a clinical background with associated professional registration (e.g. as a social worker, nurse, or in an allied health profession), but this is generally considered desirable rather than essential (13). ICBs are statutory bodies responsible for planning and commissioning healthcare services within NHS England and aim to provide better integrated support across the NHS, local authorities, and community and third sector organisations to meet the needs of local populations (14). ICBs include a chair, chief executive, board members from NHS trusts, local authorities, community and third sector organisations, and primary care, as well as board members with expertise in mental health (14). ICBs are part of broader Integrated Care Systems (ICS), which aim to provide co-ordinated and collaborative healthcare within 42 regions across England (14). ICSs replaced Clinical Commissioning Groups in 2022 as part of a broader healthcare system reform in England (15), which also included the development of 'provider collaboratives'. Provider collaboratives involve two or more provider organisations (NHS Trusts) working together. These collaboratives are intended to 'blur' the

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3121 traditional commissioner/provider split, as they may also take on some of the roles previously

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5122 associated with commissioners, for example, changing models of care, and signal a more

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7123 collaborative approach, with less focus on competition (16).

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13125 **Participants and recruitment**

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15126 We conducted 12 individual, semi-structured interviews with ICB commissioners responsible for

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17127 commissioning NHS England CAMHS.

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20129 We approached and recruited commissioners to take part in the study between May – June 2023

21

22130 through two main routes: 1) advertisements through social media and commissioner networks; and

23

24131 2) e-mails to ICBs within England (UK). Advertisements and e-mails encouraged interested

25

26132 commissioners to contact the research team. Commissioners who made contact were sent detailed

27

28133 information about the study. Commissioners completed a copy of the consent form prior to

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30134 interview via e-mail, providing informed consent to participate. Using the concept of information

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32135 power (17), we estimated a sample of 12-16 participants was required to ensure sufficient data to

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34136 address our research aims and questions.

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38138 Of the 12 commissioners who expressed an interest in taking part, all successfully completed a

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40139 subsequent interview. Details of participants are provided in the results section below.

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45141 **Data collection**

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47142 Individual, semi-structured interviews were conducted online using Microsoft Teams and followed a

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49143 topic guide designed to address our research questions (see Supplementary Material). The topic

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51144 guide started with questions about the commissioners’ role and their perspectives on the key drivers

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53145 of CYP’s mental health need, before moving onto questions about how they develop an

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understanding of needs, how they use data to inform this understanding, and the approach they take to planning and adapting CYP's mental health services. The topic guide ended by reflecting on some of the key challenges commissioners face in their role. All interviews were one-to-one, audio-recorded and transcribed verbatim. Interviews lasted approximately one hour on average.

All interviews were conducted by KA and TND between May and June 2023. KA and TND are experienced qualitative researchers with experience conducting interviews on mental health and with professionals. Neither KA nor TND had any pre-existing relationships with commissioners who took part in the study however, TND does have experience as a public health consultant and has knowledge of the commissioning process and cycle. ST, who was involved in the analyses, is an academic public health registrar.

## Analysis

We analysed data using framework analysis; a systematic qualitative analysis method which involves charting and organising data into key themes, as well as highlighting patterns within and links between the data (18 – 20). The analysis involved several interconnected stages which were conducted by KA and TND, with assistance from ST. KA and TND: 1) *familiarised* themselves with the interview data by re-reading interview transcripts and any reflexive notes; 2) *coded* the first few interview transcripts line by line using both inductive and deductive codes; 3) *developed an initial analytical framework* based on the research questions, knowledge of theory and prior research, familiarisation stage, and line by line coding stage; 4) *applied the analytical framework* to the remaining interview transcripts; 5) *charted the data* in a framework matrix; and 6) *interpreted* the data by keeping a regular log of analytical notes and questions throughout the analysis and reflecting on differences/connections between data. KA, TND, and ST developed the analytical framework over

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170 the course of the analysis and allowed for flexibility to add new inductive codes throughout. NVivo

171 was used to manage the data.

172

173 **Patient and public involvement**

174 Both young people and commissioners were involved from the early stages of this research and in

175 the funding application. Both groups contributed to the development of the research questions and

176 the design of the study. For example, young people felt it was important to find out more about how

177 commissioners made decisions about services provided, and commissioners thought it would be

178 helpful to ask about support for commissioners. These were incorporated into the topic guide. From

179 conversations with commissioners, we were also aware of the importance of avoiding the inclusion

180 of identifiable information on participant characteristics as this is a relatively small community of

181 practice. Young people and commissioners were not involved in recruitment to, or conduct of the

182 study, or otherwise asked to assess the burden of participation. Commissioners are currently

183 involved in reviewing commissioner and policy-facing outputs.

184

185 **Ethical approval**

186 Ethical approval for this study was granted by the University of Exeter Medical School (reference

187 number: 1337925).

188

189 **Results**

190 12 commissioners participated in interviews. To avoid identification, details are not provided for

191 individual commissioners. Participants were spread across NHS regions (London n=4; South West n =

192 1; South East n= 3; Midlands n= 1; North East n = 1; North West n=2) and had varying length of

193 experience in a commissioning role (one to seven years, median 5 years). The majority had a remit of

child and adolescent mental health and wellbeing only, but several had a wider remit of children's health more broadly, or child health and maternity.

We constructed five key themes (see Figure 1): 1) Reflections on role; 2) Priorities and tensions: working in a complex and evolving integrated care system; 3) Insights and evidence: the role and use of data and informants; 4) Children's mental health in the limelight: influences and expectations; and 5) Responding to need "CAMHS as the answer to everything".

*Figure 1. Themes, sub-themes, and relationships between themes*

[INSERT FIGURE 1 HERE]

### **Theme 1: Reflections on role**

This theme is about the role of the commissioner, how it is informed by their background and their 'positioning' in the system in which they work, and how this influences their approach to commissioning.

Commissioners had a range of different formal responsibilities in terms of the remit and reach of their roles. They came from a range of different backgrounds, including clinical, non-clinical healthcare, and from professions and organisations outside the NHS. There were different perspectives on how prior experience might inform current role. For example, some commissioners from clinical backgrounds described how they drew upon this prior experience in their current roles:

*"I'm one of the few commissioners who is actually a clinician...So my role as commissioner is actually informed by decades of actual clinical work and also frontline clinical management"*

(C13)



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3 220 However, another commissioner described the benefits of having a breadth of prior professional  
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5 221 experience:  
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10 223 *"...(it) allows me to have that kind of broad understanding of a wide range of agendas in*  
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12 224 *making decisions for our communities, which helps"* (C10)  
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16 226 Some commissioners clearly 'positioned' themselves as 'non-clinicians', and linked this directly with  
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18 227 how they saw their role or the insights they were able to give:  
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22 229 *"because I'm not a clinician, I can't give you an opinion. I can't interfere in the way the*  
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24 230 *operational model works. I want to know if there are issues with the way the operational*  
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26 231 *model works"* (C8)  
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30 233 However, regardless of background, common to many participants was a perception that one of  
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32 234 their key roles was oversight and overview of 'the system':  
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36 236 *"So, because I kind of work at the strategic level, I can see the different parts of the system.*  
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38 237 *Whereas if you work in specialist CAMHS, you just see that bit. You don't necessarily see, "Oh,*  
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40 238 *there's a school next to me here, and there's, I don't know, a school nurse there and there's the*  
41  
42 239 *family here." You're kind of just dealing with your one part of it."* (C9)  
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46 241 One commissioner described being a 'critical point of failure' (C8) because of this role. In contrast to  
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48 242 the commissioning role, providers were often seen as not having the same overview of the system in  
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50 243 terms of asking whether they were best placed to offer a particular service. Without their oversight  
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52 244 and understanding of connections within the system, confusion or duplication of services could  
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54 245 arise, and the system could be fragmented:  
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246  
247 *"And I suppose I see my role, and I don't think it is really necessarily what my role is per se, but*  
248 *I feel that it should be this, is to try and bring that system together" (C9)*

249  
250 Several commissioners specifically described their roles as supporting system transformations:

251  
252 *"I wouldn't necessarily describe us as traditional commissioners, per se. We work on largescale*  
253 *transformation, so things like the intermediary between NHS England and our organisation, and the*  
254 *subsequent providers that we work with" (C4)*

255  
256 Many described an increasingly collaborative approach to commissioning in recent years, linked to  
257 the advent of provider collaboratives (please see Study Context for more detail). Commissioners  
258 described working together with providers and other organisations to develop consensus around  
259 solving problems and addressing gaps. This was closely related to an emphasis on the  
260 commissioner's role in building and managing relationships with providers. Trust, openness and  
261 communication were also seen as central to allowing providers to raise problems and difficulties  
262 with commissioners:

263  
264 *"So, having an open, trusting relationship with providers, where you can just ask questions, or*  
265 *they feel comfortable and confident enough to flag things that they're finding really difficult,*  
266 *knowing that we will try to work through together to improve a pathway, or to support a*  
267 *team, or whatever it might be" (C7)*

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269 Some commissioners contrasted their approach and role with 'traditional commissioning' models,  
270 which were seen as more adversarial:

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3 272 "So I'm, sort of, part parent, part grandparent, part commissioner, because there is a formal  
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5 273 bit to it, I do need to write the specifications, I do need to work with them on their business  
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7 274 cases to secure funding.... But I think the fundamental difference is they should feel their  
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9 275 commissioners are more approachable, they can talk to them. It's not transactional, it's not  
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11 276 adversarial." (C8)  
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16 278 However, commissioners also expressed some uncertainties and concerns over their roles. For some,  
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18 279 the shift to provider collaboratives meant that they felt their role had changed, or questioned  
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20 280 whether they were even supposed to call themselves 'commissioners':  
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25 282 "...[there needs to be] clarity on the expectations of commissioners, and the commissioning  
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27 283 role. Because it seems to be changing, and then assumptions are being made in terms of what  
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29 284 the role should be doing" (C6)  
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34 286 "So we are not supposed to call ourselves commissioners anymore because the commissioning  
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36 287 function has been stripped with regards to the move from CCG to ICS." (C10)  
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41 289 **Theme 2. Priorities and Tensions: working in a complex and evolving integrated care system**  
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43 290 Commissioners described a wide range of environmental and contextual factors that influenced their  
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45 291 work. These factors were perceived to present both opportunities and challenges to the  
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47 292 commissioning of mental health services for CYP.  
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52 294 Many commissioners cited key policies and strategies which they felt had influenced their work in  
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54 295 their roles. However, commissioners had mixed views about how national policy impacted their  
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56 296 work. One commissioner felt a lack of control due to centralised decision-making, whereas another  
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58 297 perceived there to be more scope to tailor national policy to local needs:  
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*" So we'll get money from NHS England or money from the central team and they will be like,*

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*'we're giving you this money, you have to spend it on X, Y, Z.' So there's a lot of stuff that I*

301

*don't actually have control over. The stuff that I do have control over is actually really such a*

302

*small percentage. If anything a lot of the decisions are already made and then just like we're*

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*told we have to just do it" (C7)*

304

305

*"I think tailoring national plans, and national objectives, to our local population, is kind of*

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*what we do. Obviously we have certain access and activity targets to try and hit, and I guess*

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*there are suggestions as to how we do that, but I think what we need to do is really identify*

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*how that would work for our local population" (C4)*

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Participants also discussed the impact of frequent major national healthcare system reorganisations.

311

Several described some of the challenges they faced in adapting to recent system integration and

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transformation without much information or guidance:

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314

*"so it keeps on changing from Clinical Commissioning Groups, to ICBs, to Primary Care Trusts,*

315

*all sorts. I think it's going to go back to Primary Care Trusts, at this rate. [Laughs]" (C6)*

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317

Some felt that frequent changes and 'transformations', along with a reduction in workforce, had led

318

to a shift towards more reactive commissioning, and to personal stress for commissioners over their

319

own job security:

320

321

*"the demands are unrealistic. Going through a transformation and integration process. We*

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*are also going through a restructuring, so we've been asked to deliver 30% savings by the*

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*end of the next financial year. So my post is safe for this year, but I don't know if next year*

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324 *there will be a second round of consultation. And this creates a lot of instability because*  
325 *people are losing their jobs, we are going through consultations, so that creates that added*  
326 *stress.” (C2)*

328 Related to this, in terms of workload, several participants perceived that they as children’s  
329 commissioners had wider remit than they would have in in adult's commissioning:

331 *“Resource is not proportionately allocated to children's commissioning...it’s just not enough. It’s*  
332 *not enough to give the level of attention and the level of time, yes, just the time that is required*  
333 *to do it justice really” (C7)*

335 Some commissioners also felt that CYP as a group were a lower priority in the system. One  
336 commissioner directly related this to the change from Clinical Commissioning Groups to ICBs:

338 *“(Previously) there was that direct line of responsibility around targeted investment for children*  
339 *and young people and mental health, it felt ringfenced even though it wasn’t but it kind of was*  
340 *because you could not not invest in children’s mental health, and commissioning groups were*  
341 *regularly challenged by way of their level of investment through professional bodies, for*  
342 *example, the Royal College of Psychiatrists. For some reason, that connectivity with ICBs, it isn’t*  
343 *the same. I think that’s a major challenge.” (C13)*

345 Another felt that other issues were of higher political and media interest than CYP, meaning that  
346 young people did not get the ‘airtime’:

347

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"Getting airtime to talk about the issues around treatment for young people can be quite difficult because of the operational pressures. You're on the Six O'clock News with a queue of ambulances outside. Guess what, that's going to dominate the discussions that week." (C8)

### Theme 3: Insights and evidence: the role and use of data and informants

Commissioners described drawing on a range of sources to develop an understanding of child mental health need and services in their local area. Participants used many different terms to describe these sources, including *information, evidence, data, insight, observations, hunches, conversations, engagement, deep dives*, etc. and had different perceptions on the value and uses of these data.

Service providers were seen as particularly valuable sources of information, being described as commissioners' *"eyes and ears"* (C4). Insights and observations from providers were key to 'verifying' initial hunches from quantitative data, and prompting deep dives, engagement work, or requests for further service provider quantitative data:

*"I think we are reliant upon our providers, and also our delivery managers, so our borough-based colleagues, to feedback pertinent issues or common trends or presentations, which are either not typical, or they're increasing. So I think that gives us almost a bit of a hunch. And then I guess what we would do is try to dive a little deeper into some of the activity, outcome and experience data associated with those presentations, or those levels of need."* (C4)

This meant that developing strong, trusting relationships with service providers was important, enabling open and honest discussions about problems and levels of need that might not otherwise occur:

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373 *"[if] they feel comfortable and confident enough to flag things that they're finding really*  
374 *difficult, knowing that we will try to work through together to improve a pathway, or to*  
375 *support a team, or whatever it might be, is much better than having a dynamic where*  
376 *providers might almost try and consume their own smoke, or to – not hide waiting lists, but*  
377 *feel as though they can't flag a capacity problem, because they'll get dragged over the coals*  
378 *for performance issues, and it will just create an industry of perhaps unhelpful dialogue."*

379 (C4)

380  
381 Commissioners also talked of the importance of engagement pieces of work with children, young  
382 people, and families. This type of information helped commissioners to really understand the needs  
383 of their population:

384  
385 *"I think the key things that we've done in [LOCAL AREA] that I think data will never be able to*  
386 *show you is those engagement pieces of work, so actually understanding what children and*  
387 *young people and families are saying, how they feel about mental health support, what are*  
388 *their needs."* (C12)

389  
390 However, this was not always the case, with one commissioner suggesting that engagement events  
391 or co-production wasn't always helpful as it didn't tell them anything new:

392  
393 *"[Talking about feedback from children and young people co-production and engagement*  
394 *events] I wouldn't say that they are to give us a good granular detail direction for developing*  
395 *services, because the narrative is always the same, "Oh, I wait too long, I don't want to go to*  
396 *CAMHS, I want to be seen in the community," these are the main themes."* (C1)

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Commissioners also reported using 'hard' quantitative data (e.g., service provider data, population level data, local surveys, academic data) to develop an understanding of child mental health need and identify gaps in service support. Commissioners talked about population data being useful in providing a spotlight on general need, evidence for business cases (with quantitative data carrying more weight than qualitative data), and looking beyond 'levels of access' data:

*"I think looking at prevalence rates in boroughs and PCNs, versus the actual activity or access levels, is able to shine a bit of a light on where we have high level of need, but perhaps low levels of access."* (C4)

*"I wouldn't need it day-to-day, no, but we would obviously access that when we're looking at papers or bidding or business cases, recommendations or retendering, all of that type of stuff then yes, or writing papers and we need that information, like going on the JSNA and things like that."* (C3)

Often, there was a reliance on service provider data (i.e., data on referrals, activity, outcomes, and wait times), over other forms of quantitative data, to inform commissioners' understanding of child mental health need. Service provider data had a range of uses; from identifying emerging, context-specific trends to assessing service performance and identifying where services might be failing to meet the needs of CYP. However, some commissioners had concerns about the reliability and accuracy of this quantitative data. For example, service provider data were often reported as missing, coded inaccurately, or inconsistently captured. This led to a sense that this service provider data could not always be trusted to inform decision making and qualitative data was needed to *truly* understand child mental health need and to *"improve [commissioners] view of the accuracy of a numeric"* (C8):



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424 *"[quantitative] data informs us maybe of some of the work that we need to do, and the areas*  
425 *in which we need to do that work. Then from there, and again, we wouldn't do this in isolation,*  
426 *as an ICB, we do this with our colleagues, from services, to understand, okay, what is the*  
427 *need? And it may be that we need to do an engagement piece of work in that area."* (C5)

429 The pressure on service providers to provide quantitative data was seen by one commissioner as  
430 having unintended consequences; encouraging service providers to chase referral numbers rather  
431 than provide quality support. Furthermore, concerns around the reliability, accuracy, and novelty of  
432 quantitative data led some commissioners to ascribe little value to this type of data:

434 *"It's an odd one, [name] because if you talk to people in health, they'll say, "Everyone knows*  
435 *where the problems are. So why do we need more data to tell us? It's got feathers like a duck*  
436 *and it quacks like a duck. It's a duck. We know where we need to make the changes. We don't*  
437 *need more data or more surveys or more." [...]* *"I kind of know where the problem is, and I*  
438 *don't have to have empirical data to help me with that."* (C8)

440 There was a clear tension and variation between the use and value of quantitative versus qualitative  
441 data. Commissioners background and experience often influenced the type of data they utilised  
442 (e.g., commissioners with a quantitative background talked about utilising and valuing quantitative  
443 data, whereas commissioners who were clinicians by background often ascribed greater value to  
444 initial hunches or conversations with service providers). As a result, this created a commissioning  
445 landscape in which there appeared to be no established way of using data and informants; with  
446 sources/type used varying, dependent on the individual commissioner.

448 **Theme 4: Children's mental health in the limelight: influences and expectations**

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This theme is about commissioners' perceptions of changes in child mental health in their populations. Most commissioners discussed having seen a rise in demand for services, in terms of referrals and increasing time on waiting lists. Participants listed a range of areas where they felt there had been increases, including neurodevelopmental disorders, disordered eating, depression and anxiety, and self-harming. Many also perceived an increase in complexity and urgency of presentations. Commissioners made a clear link with the impact of the pandemic, but also emphasised that rises in demand were already happening pre-Covid:

*"I don't want to pin it all on COVID because we were seeing an increase in demand before COVID. So it's not as if everything was fine and then COVID, you know, just tipped us over."*  
(C9)

Participants felt that social isolation and online education were key factors that had affected mental health and child development and contributed to school-based anxiety and avoidance. However, commissioners also voiced concern over the impact of other systemic social and economic influences which they felt were driving increases in problems, and which had been exacerbated by the pandemic:

*"I might be wrong, but I don't think that there has been a biological shift in how children and young people's mental health and emotional wellbeing works. I think that a lot of it's from external factors"* (C4)

Inequalities in access to help were also a concern:

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473 *"I think the pandemic created a larger gap between those who needed help, or need help, and*  
474 *those who access it. I think that's been disproportionate for certain children and young people,*  
475 *certain demographic profiles as well. (C4)*

477 There was also much discussion of the effects of increased awareness and understanding around  
478 mental health, and the impact of social media and wider policy in putting mental health *"in the*  
479 *limelight"*. This was also seen as uncovering new needs and gaps which services then had to meet:

481 *"I would say that the demand has increased, that's a fact because we've expanded services*  
482 *and still have issues with waiting times and more children needing support. But alongside the*  
483 *demand, because mental health has increasingly been in the limelight, I suppose, there's been*  
484 *more attention to mental health, child, adolescent, mental health in the last five years.*  
485 *Perhaps this has uncovered needs and a prevalence that we weren't aware of before." (C1)*

487 *"Disordered eating and things like ARFID [Avoidant Restrictive Food Intake Disorder], seem to*  
488 *be something... sort of newly emerging conditions because we don't have commissioning in*  
489 *place for them. And that's not because it was a gap... well, it's a gap now, but it's a gap that*  
490 *seems to have emerged within recent times. When we, for example, were commissioning our*  
491 *specialist children's mental health service, disordered eating and ARFID were not really*  
492 *discussed as being something that needed to be considered or perhaps disordered eating was*  
493 *looked at differently." (C2)*

495 In terms of drivers of demand, commissioners also appeared to perceive some tensions between  
496 positive aspects of awareness and encouraging help-seeking, and risks of 'over-medicalising' normal  
497 'ups and downs' and expectations of mental health which might be unrealistic:

499 *"So there's an awareness from children and young people that they know what good mental*  
 500 *health looks like, and how they can promote it. But there's also probably an expectation from*  
 501 *that as well...I think a young person, after watching a video, or trying to learn some coping*  
 502 *techniques, won't necessarily see a change or an improvement straight away in the same way*  
 503 *that, if you've got a headache, you have a paracetamol, and then an hour later you're sorted...*  
 504 (C4)

#### Theme 5: Responding to need: "CAMHS as the answer to everything"

507 In addressing the needs of their populations, many commissioners felt that prevention and early  
 508 intervention were key priorities within child and adolescent mental health. They discussed an  
 509 increasing role for a broader range of agencies including the voluntary sector, social care, and  
 510 education, with several referencing the Thrive model (a needs-led framework to help create  
 511 communities of mental health and wellbeing support, with a focus on proactive prevention and  
 512 promotion) (21). Participants also cited a range of initiatives aimed at triaging referrals and  
 513 expanding first-line support and emphasising the role of CAMHS as a specialist mental health service.  
 514 However, for some commissioners, there were several significant challenges in moving the focus  
 515 away from specialist child mental health services. For example, lack of capacity in other parts of the  
 516 system such as schools and communities was seen as a limiting factor in prevention and  
 517 management of less severe cases, resulting in bottlenecks and pressure on CAMHS:

519 *"I think there is a real-time reduction in staff time in schools over the past 15 years and that*  
 520 *gets expressed in an increased in referral activity to where the lights are on. That's the NHS.*  
 521 *And free at the point of use. So there is a systemwide bottleneck and things just breaking*  
 522 *down."* (C13)

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524 Additionally, commissioners perceived that both professionals and young people still had  
525 assumptions and expectations that CAMHS was the place for all child mental health concerns. These  
526 expectations complicated efforts to develop other pathways, with some early-support services being  
527 seen as under-utilised as a result of a preference for CAMHS:

528  
529 *“We get reports from services that they are under strain, but there are also parts of other*  
530 *services which are not utilised properly. And then we get feedback from children, “I don't know*  
531 *what provision is available to me, and waiting times are too large.” So my feeling is we’re still*  
532 *struggling to move the focus away from CAMHS being the answer to everything.” (C1)*

533  
534 Some expressed frustration that this might mean CYP spent time on waiting lists when they could  
535 have accessed support more quickly elsewhere:

536  
537 *“there’s still that mind-set of if someone expresses any concern about mental health, let’s refer*  
538 *them into CAMHS, and that’s where we see those waits because then they’re essentially on a*  
539 *waiting list for support that potentially they might not need and they could have got*  
540 *something a lot earlier.” (C6)*

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542 Commissioners also reflected on future directions and challenges and what they expected to see  
543 coming down the line. One commissioner thought that funding would never be able to meet need  
544 for services:

545  
546 *“The overarching difficulty is that the money that we’ve got is never going to be able to meet*  
547 *the full demand of need, so we have to think differently about who we support when” (C12)*

548

Commissioners had varying degrees of optimism about whether investment in services and early intervention would happen, and whether CYP's mental health would improve in future:

*"Our focus needs to be more on that preventative and early intervention. But that's a massive culture change, so I think hopefully in that long period of time we will see those – I won't say probably a reduction – but levelling off of demand."* (C12)

*"I would say unless, coming back to the main point, we invest properly and proportionately in children's services over the next five years, we're going to be going backwards in terms of children and adolescent mental health. We're not going to be going forwards." [...] "So it sounds pessimistic, but I think we're going to have a worse situation in the next five years unless we drastically change."* (C7)

## **Discussion**

This qualitative study sought to explore and understand commissioners' experiences of commissioning child mental health services, their perspectives on the needs of their populations, the challenges they face and their needs for support and data. From interviews with 12 commissioners based in ICBs across England, we generated five themes: 1) Reflections on role; 2) Priorities and Tensions: working in a complex and evolving integrated care system; 3) Insights and evidence: the role and use of data and informants; 4) Children's mental health in the limelight: influences and expectations; and 5) Responding to need: "CAMHS as the answer to everything". Below we discuss some of the main insights, challenges and implications of these findings.

Our first and second themes illustrate the way in which commissioners see themselves as holding oversight or a living map of their local systems, and have an increasing role in systems leadership, and in collaborating with providers, rather than focussing on a more adversarial system of contracts

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management. Many seemed to feel this enabled greater openness over problems and shared challenges. However, it was also evident that some commissioners experienced tensions and uncertainties over their changing roles, especially when these changes occurred as part of broader restructuring. Whilst some benefits were seen, there was a strong perception that frequent reinvention and transformational change had introduced not only stresses about job security, but also hampered their being able to undertake deeper thinking and proactive planning over the longer term. Here our findings are in line with previous research suggesting that whole system changes can result in disruptions to the commissioning process, as well as to the wider workforce (22).

Commissioners also faced challenges in terms of advocating for their population of CYP. Many of our participants perceived that CYP as a group were seen as lower priority, both in terms of allocation of commissioning resource, but also in the healthcare system. This accords with wider concerns which have been repeatedly voiced about the (relative) low priority of CYP in policy and strategy in England, and even in the Covid-19 response (23, 24).

A key finding from our third theme: “Insights and evidence” was the various ways in which commissioners developed an understanding of the needs of their populations, and how they perceived the roles of ‘qualitative’ and ‘quantitative’ data. Many participants placed a premium on the insights they gained from trusted providers acting as their ‘eyes and ears’. This constituted another benefit for commissioners of developing good relationships with their provider networks. Evidence gathered from engagement with children and families through local groups and events was also seen as providing strong narratives and stories which could spotlight areas of need, although the degree to which this process involved under-served groups in the community, as opposed to highly-engaged ones, was unclear. Other research on policymaking and commissioning has also highlighted the importance of ‘people based’ sources of information, often as part of informal ‘policy networks’ (12, 25). Interestingly our research also reveals the concerns held by commissioners about

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3 601 'quantitative data'. In some cases, concerns around the reliability, accuracy, and novelty of  
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5 602 quantitative data led some commissioners to see quantitative data as being lower value. Despite  
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7 603 this, most saw a clear role for quantitative data, and would expect to include it in documents  
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9 604 required for decision-making such as in needs assessments and business cases.  
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14 606 Commissioners' perceptions of changes in their populations were in many ways in line with findings  
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16 607 from epidemiological data, in terms of the gradual increase in prevalence pre-Covid, followed by a  
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18 608 more marked rise in problems, particularly in emotional disorders (26, 27). However, commissioners  
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20 609 also discussed how and whether increased awareness and understanding of mental health were  
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22 610 influencing presentations and demand for services in their areas. Avoidant Restrictive Food Intake  
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24 611 Disorder (ARFID) was cited by at least one commissioner as an example of a 'new need' that had  
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26 612 been uncovered and which services needed to meet. These discussions appeared to reflect wider  
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28 613 societal debate on the impact of broader mental health awareness and the medicalisation of distress  
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30 614 in young people (28).  
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35 616 Linked to this was the theme on 'CAMHS as the answer to everything', which described how  
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37 617 commissioners were grappling with system transformation (mirrored by other accounts from  
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39 618 CAMHS staff, e.g. in Rock et al.'s (2021) study). A common area of challenge appeared to be the  
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41 619 challenges of diverting the focus from CAMHS for problems which may not require specialist  
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43 620 support. Some participants perceived that early-help or online groups were under-utilised due to a  
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45 621 preference for CAMHS both from referring professionals and from young people and families. This  
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47 622 presents an interesting contrast with research suggesting that patients and primary care  
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49 623 professionals perceive marked barriers to accessing care and that thresholds for CAMHS remain a  
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51 624 hindrance in getting the support they need (29–31). The accounts of commissioners accord with the  
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53 625 wider drive within integrated care systems to change the focus of services to include lower intensity  
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55 626 early interventions to support health and wellbeing in the population.  
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5 628 **Strengths and limitations**

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8 629 One of the strengths of this paper is the exploration of the perspectives of commissioners, a group  
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10 630 who are rarely the ‘subjects’ of research, but who have considerable influence in the design and  
11  
12 631 delivery of mental health services for CYP. This study represents one of only a handful of papers to  
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14 632 explore their views, and the only study we are aware of to include CAMHS commissioners in a post-  
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16 633 pandemic context. We were also able to recruit commissioners across a range of ICBs in England  
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18 634 with responsibilities for commissioning mental health services for CYP. The limitations of the study  
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20 635 include the potential for more motivated and research-engaged commissioners to have participated,  
21  
22 636 perhaps affecting the transferability of our findings. It is also possible that those participating may  
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24 637 not have felt fully able to express their views, due to concerns around anonymity. As there are only  
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26 638 42 ICBs in England, we have been careful to avoid including information which could link a  
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28 639 participant to their ICB and risk disclosure.

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34 641 **Implications**

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37 642 Our findings describe the complex and changing political, social and economic environment in which  
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39 643 commissioners work, and their role in maintaining oversight of their local systems. It is also evident  
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41 644 that commissioners as a group may struggle with changes as their role evolves, and that they may  
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43 645 benefit from additional resource, training and professional development opportunities. As with  
44  
45 646 many public sector services, CAMHS commissioners also face challenges in delivering services in the  
46  
47 647 face of constrained resources. Marked tensions were evident around the need to balance  
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49 648 investment in prevention and interventions earlier in ‘the pipeline’ with continuing to deliver the  
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51 649 specialist assessment and treatment needed by children with more severe and complex problems.  
52  
53 650 Whilst there have been longstanding calls for more investment in child mental health since before  
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55 651 the pandemic, it has been argued that services are now even more unlikely to be able to meet  
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57 652 growing need without a step change in thinking by those funding and designing services (32).  
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Decision-making in this context needs to be as transparent as possible to all stakeholders (including the public), including developing a clearer understanding of the data required and used to make difficult commissioning decisions. Similarly, our findings on the variation in approaches to commissioning raise questions about the need for more standardised procedures and guidelines, whilst recognising the importance of local insights.

These findings also have important implications for researchers, in terms of how those in the research community can ensure that relevant and digestible messages find their way to those commissioning services. Our findings highlight how time, and timeliness, is of the essence for those in a commissioning role, hence brevity and pace of outputs is key, representing a challenge for researchers working with slower timescales of funding, approvals and peer-review. Local relationships and networks are likely to be key for research teams to interact in a more meaningful way with commissioners. Forums that bring the two groups together, for example, as part of a research active Integrated Care System or Population Health Management board, may also be helpful in exploring joint priorities and co-development of outputs. Finally, whilst these specific findings are situated in the English healthcare system, we would suggest that many other healthcare systems internationally are facing similar challenges regarding how to plan and deliver services for children and young people's mental health, and hence, some of our findings may be translatable and transferable in an international context.

## Conclusions

Our study sought to explore and understand commissioners' experiences of commissioning services for child and adolescent mental health, including their perspectives on the needs of their populations, challenges they face and their needs for support and data. The findings highlight how commissioners are negotiating a complex and changing political, social and economic environment

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3 678 with competing priorities and pressures. Proportionate funding for CYP’s mental health services was  
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5 679 seen as essential to ensure services are able to meet current need, alongside a greater focus on early  
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7 680 intervention and prevention. Researchers now need to work alongside commissioners to provide  
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9 681 timely, succinct outputs that better support commissioners plan services and improve the health of  
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12 682 the populations they serve.  
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26 688 led on the qualitative analysis, working with ST and TND, and with support from the wider team (FM  
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30 690 AP, and TND) commented on the manuscript, provided final approval for publication, and agree to  
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Any checklist and flow diagram for the appropriate reporting statement, e.g. STROBE

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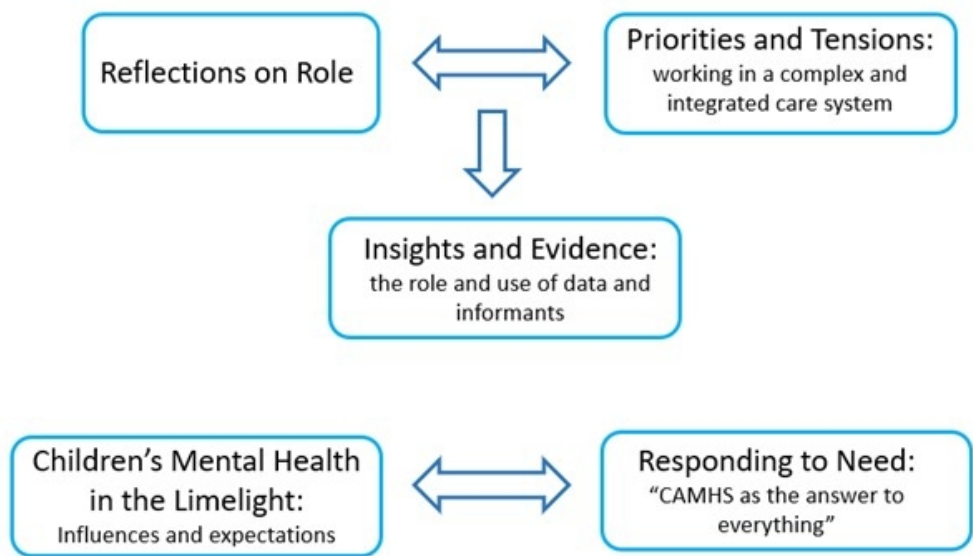


Figure 1. Themes, sub-themes, and relationships between themes  
159x93mm (96 x 96 DPI)

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### **Supplementary material**

#### **Interview topic guide**

- 1) Can you tell me a little bit about your role as a commissioner?
  - a. Which services are you currently responsible for commissioning?
  - b. How long have you been in your role as a commissioner?
- 2) What recent changes have you seen in child mental health need? (nationally/locally)
  - a. In your view, what are the key drivers/determinants/factors responsible for these changes?
  - b. How do you think COVID played a role in these changes?
  - c. Can you tell me about any specific groups that might have been impacted?
- 3) What changes do you expect to see in child mental health need moving forward? (e.g., next five/ten years?)
  - a. In your view, what are the future drivers/determinants of child mental health likely to include?
  - b. How do you think CAMHS might need to adapt to meet these changing needs?
- 4) How do you develop an understanding of child mental health needs in your area?
  - a. Can you talk me through the process involved?
  - b. Can you tell me about who you work with to help develop this understanding?
- 5) How do you use data to help inform your understanding of local child mental health needs?
  - a. What sources of data do you use?
  - b. Can you describe what these sources of data include?

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- c. How do you find accessing/using this data?
  - d. What is *useful* about this data? What is *not so useful* about this data?
  - e. Are there any sources of data that you do not use? Can you tell me about why you do not use this data?
- 6) What approach do you take to planning and adapting child mental health services in your area?
- a. What resources do you draw on?
    - i. How does this help inform your decision-making?
  - b. What expertise do you draw on?
    - i. How does this help inform your decision-making?
  - c. Can you tell me about how you work with others to plan and adapt child mental health services?
  - d. What differences are there, if any, in your approach to planning and adapting mental health services for transition age young people?
- 7) How could the data currently available to you be improved to better support you in your role?
- a. What are the key gaps with the data?
  - b. What are the key problems/limitations with the data?
  - c. What additional information would you like to see in the data currently available?  
Can you tell me about why this data would be particularly important/useful?
  - d. Do you have any key unanswered questions about your population?
- 8) Can you tell me about any specific groups that it would be useful to have data for?

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9) What are the key challenges you face in undertaking your role as a commissioner of child mental health services?

10) Is there anything else that would be useful to you in terms of commissioning child mental health services?

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# BMJ Open

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# Experiences of commissioning services for child and adolescent mental health in England (UK): a qualitative framework analysis

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## **Abstract**

**Objectives:** To explore commissioners' experiences of commissioning services for child and adolescent mental health, their perspectives on the needs of their populations, the challenges they face and their needs for support and data.

**Design:** Qualitative study involving semi-structured interviews. All interviews were audio-recorded and transcribed verbatim. Data were analysed using framework analysis.

**Setting:** England, UK.

**Participants:** 12 integrated care board (ICB) commissioners, responsible for commissioning NHS England Child and Adolescent Mental Health Services (CAMHS).

**Results:** We identified five themes: *‘reflections on role’*; *‘priorities and tensions: working in a complex and evolving integrated care system’*; *‘insights and evidence: the role and use of data and informants’*; *‘children’s mental health in the limelight: influences and expectations’*; and *‘responding to need “CAMHS as the answer to everything”’*. Combined these themes highlight the integral role commissioners play in providing oversight over the local system and challenges to this role including disproportionate funding for services for child and adolescent mental health, different use and value ascribed to ‘qualitative’ and ‘quantitative’ data, rises in demand, and the limited focus on early intervention and prevention.

**Conclusions:** CAMHS commissioners are currently negotiating a complex and changing political, social and economic environment with competing priorities and pressures. Our research indicates that commissioners require greater support as their roles continue to evolve.

**Key words**

Commissioners; mental health services; child; adolescent; qualitative

**Article summary**

**Strengths and limitations of this study**

- We conducted interviews with twelve commissioners responsible for commissioning services for child and adolescent mental health (including CAMHS) from integrated care boards (ICBs) across England; with six NHS regions represented
- Commissioners participating in our interviews may have been more engaged or research-aware than colleagues that did not take part, meaning their perspectives may be different than those not participating.



- As there are only 42 ICBs in England, it is also possible that those participating may not have felt fully able to express their views, due to concerns around anonymity.

## **Word count**

7,111

## **Introduction**

Young people's mental health has been recognised by the World Health Organisation as a global challenge. However, despite the existence of evidence-based interventions for children and young people's mental health, Child and Adolescent Mental Health Services (CAMHS) provision in many countries has fallen far short of need [1,2]. The process of planning, funding and organising services for children and young people with mental health problems varies according to national healthcare funding models and systems. In the English healthcare system, the Department for Health and Social Care sets overall strategy and funding and has oversight of the system, with NHS England acting as the operational arm [3]. According to NHS England, commissioning is the "process of assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health outcomes" [4]. In England, the process of commissioning largely sits with regional Integrated Care Boards, of which there are 42, with primary care and more specialised services commissioned by NHS England.

Commissioners within Integrated Care Boards (ICBs) have a range of remits, including responsibility for CAMHS). Policies such as Future in Mind [5] and the NHS Long Term Plan [6] set out the broad direction of travel for children and young people's (CYP's) mental health, but there remains considerable local flexibility in how services are planned and delivered. Less positively, there has

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70 been significant variation nationally in spend and in the level of provision [7]. Such variation has  
71 been found to be only weakly associated with indicators of need [7,8,9].  
72  
73 Historically in the UK, policymakers and commissioners have been actively hampered in decision  
74 making and service planning for CYP’s mental health by a lack of data regarding national trends and  
75 projected changes in prevalence [10,11]. Since the Covid-19 pandemic, commissioners have also  
76 faced challenges in understanding and responding to rapid changes in the context in which services  
77 are delivered (e.g., the move to online) and the levels of need in their population. These challenges  
78 come in addition to pressures to address lengthy waiting lists as well as an increasing policy  
79 emphasis on prevention and early intervention.  
80  
81 Whilst some studies have explored how commissioners use evidence in decision-making or policy  
82 making in general [12], there is little research on approaches to understanding population need in  
83 terms of trends and prevalence. Additionally, to our knowledge, no studies in the English healthcare  
84 system have explored commissioner experiences of commissioning CYP’s mental health services  
85 post-pandemic. Given the extent and nature of the current challenges in CYP’s mental health, and  
86 the central role of commissioners within the system, this appears to be a significant research gap. An  
87 improved understanding of commissioners’ needs is likely to have wider benefits for the translation  
88 of epidemiological research into practice, by ensuring research outputs meet the needs of key  
89 stakeholders and in optimising the sharing, use and interpretation of data to improve services for  
90 CYP. Such insights may also be relevant to those researching and delivering services within similar  
91 healthcare systems.  
92  
93 This qualitative study aims to better understand English commissioners’ experiences of  
94 commissioning child and adolescent mental health services, their perspectives on the needs of their

populations, the challenges they face and their needs for support and data. Our research questions were:

- How do commissioners develop an understanding of the needs of their population?
- How do commissioners plan and adapt services to meet population need?
- What challenges do commissioners face in their roles, and how can they be better supported?

## **Method**

### **Study context**

Our study explored the views of commissioners based within ICBs in England who have responsibility for specialist services including NHS England CAMHS, as well as the provision of early intervention support. Commissioners are professionals who will usually have a first degree and postgraduate qualifications, as well as management experience within the health and social care sector. Some may have a clinical background with associated professional registration (e.g. as a social worker, nurse, or in an allied health profession), but this is generally considered desirable rather than essential [13]. ICBs are statutory bodies responsible for planning and commissioning healthcare services within NHS England and aim to provide better integrated support across the NHS, local authorities, and community and third sector organisations to meet the needs of local populations [14]. ICBs include a chair, chief executive, board members from NHS trusts, local authorities, community and third sector organisations, and primary care, as well as board members with expertise in mental health [14]. ICBs are part of broader Integrated Care Systems (ICS), which aim to provide co-ordinated and collaborative healthcare within 42 regions across England [14]. ICSs replaced Clinical Commissioning Groups in 2022 as part of a broader healthcare system reform in England [15], which also included the development of 'provider collaboratives'. Provider collaboratives involve two or more provider organisations (NHS Trusts) working together. These collaboratives are intended to 'blur' the

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traditional commissioner/provider split, as they may also take on some of the roles previously associated with commissioners, for example, changing models of care, and signal a more collaborative approach, with less focus on competition [16].

**Participants and recruitment**

We conducted 12 individual, semi-structured interviews with ICB commissioners responsible for commissioning NHS England CAMHS.

We approached and recruited commissioners to take part in the study between May – June 2023 through two main routes: 1) advertisements through social media and commissioner networks; and 2) e-mails to ICBs within England (UK). Advertisements and e-mails encouraged interested commissioners to contact the research team. Commissioners who made contact were sent detailed information about the study. Commissioners completed a copy of the consent form prior to interview via e-mail, providing informed consent to participate. Using the concept of information power [17], we estimated a sample of 12-16 participants was required to ensure sufficient data to address our research aims and questions.

Of the 12 commissioners who expressed an interest in taking part, all successfully completed a subsequent interview. Details of participants are provided in the results section below.

**Data collection**

Individual, semi-structured interviews were conducted online using Microsoft Teams and followed a topic guide designed to address our research questions (see Supplementary Material). The topic guide started with questions about the commissioners’ role and their perspectives on the key drivers of CYP’s mental health need, before moving onto questions about how they develop an

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understanding of needs, how they use data to inform this understanding, and the approach they take to planning and adapting CYP's mental health services. The topic guide ended by reflecting on some of the key challenges commissioners face in their role. All interviews were one-to-one, audio-recorded and transcribed verbatim. Interviews lasted approximately one hour on average.

All interviews were conducted by KA and TND between May and June 2023. KA and TND are experienced qualitative researchers with experience conducting interviews on mental health and with professionals. Neither KA nor TND had any pre-existing relationships with commissioners who took part in the study however, TND does have experience as a public health consultant and has knowledge of the commissioning process and cycle. ST, who was involved in the analyses, is an academic public health registrar.

## Analysis

We analysed data using framework analysis; a systematic qualitative analysis method which involves charting and organising data into key themes, as well as highlighting patterns within and links between the data [18 – 20]. The analysis involved several interconnected stages which were conducted by KA and TND, with assistance from ST. KA and TND: 1) *familiarised* themselves with the interview data by re-reading interview transcripts and any reflexive notes; 2) *coded* the first few interview transcripts line by line using both inductive and deductive codes; 3) *developed an initial analytical framework* based on the research questions, knowledge of theory and prior research, familiarisation stage, and line by line coding stage; 4) *applied the analytical framework* to the remaining interview transcripts; 5) *charted the data* in a framework matrix; and 6) *interpreted* the data by keeping a regular log of analytical notes and questions throughout the analysis and reflecting on differences/connections between data. KA, TND, and ST developed the analytical framework over

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the course of the analysis and allowed for flexibility to add new inductive codes throughout. NVivo was used to manage the data.

**Patient and public involvement**

Both young people and commissioners were involved from the early stages of this research and in the funding application. Both groups contributed to the development of the research questions and the design of the study. For example, young people felt it was important to find out more about how commissioners made decisions about services provided, and commissioners thought it would be helpful to ask about support for commissioners. These were incorporated into the topic guide. From conversations with commissioners, we were also aware of the importance of avoiding the inclusion of identifiable information on participant characteristics as this is a relatively small community of practice. Young people and commissioners were not involved in recruitment to, or conduct of the study, or otherwise asked to assess the burden of participation. Commissioners are currently involved in reviewing commissioner and policy-facing outputs.

**Ethical approval**

Ethical approval for this study was granted by the University of Exeter Medical School (reference number: 1337925).

**Results**

12 commissioners participated in interviews. To avoid identification, details are not provided for individual commissioners. Participants were spread across NHS regions (London n=4; South West n = 1; South East n= 3; Midlands n= 1; North East n = 1; North West n=2) and had varying length of experience in a commissioning role (one to seven years, median 5 years). The majority had a remit of

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child and adolescent mental health and wellbeing only, but several had a wider remit of children's health more broadly, or child health and maternity.

We constructed five key themes (see Figure 1): 1) Reflections on role; 2) Priorities and tensions: working in a complex and evolving integrated care system; 3) Insights and evidence: the role and use of data and informants; 4) Children's mental health in the limelight: influences and expectations; and 5) Responding to need "CAMHS as the answer to everything".

[INSERT FIGURE 1 HERE]

### Theme 1: Reflections on role

This theme is about the role of the commissioner, how it is informed by their background and their 'positioning' in the system in which they work, and how this influences their approach to commissioning.

Commissioners had a range of different formal responsibilities in terms of the remit and reach of their roles. They came from a range of different backgrounds, including clinical, non-clinical healthcare, and from professions and organisations outside the NHS. There were different perspectives on how prior experience might inform current role. For example, some commissioners from clinical backgrounds described how they drew upon this prior experience in their current roles:

*"I'm one of the few commissioners who is actually a clinician...So my role as commissioner is actually informed by decades of actual clinical work and also frontline clinical management"*  
(C13)

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218 However, another commissioner described the benefits of having a breadth of prior professional  
219 experience:

220  
221 *"...(it) allows me to have that kind of broad understanding of a wide range of agendas in*  
222 *making decisions for our communities, which helps"* (C10)

223  
224 Some commissioners clearly ‘positioned’ themselves as ‘non-clinicians’, and linked this directly with  
225 how they saw their role or the insights they were able to give:

226  
227 *"because I'm not a clinician, I can't give you an opinion. I can't interfere in the way the*  
228 *operational model works. I want to know if there are issues with the way the operational*  
229 *model works"* (C8)

230  
231 However, regardless of background, common to many participants was a perception that one of  
232 their key roles was oversight and overview of ‘the system’:

233  
234 *"So, because I kind of work at the strategic level, I can see the different parts of the system.*  
235 *Whereas if you work in specialist CAMHS, you just see that bit. You don't necessarily see, "Oh,*  
236 *there's a school next to me here, and there's, I don't know, a school nurse there and there's the*  
237 *family here." You're kind of just dealing with your one part of it."* (C9)

238  
239 One commissioner described being a ‘critical point of failure’ (C8) because of this role. In contrast to  
240 the commissioning role, providers were often seen as not having the same overview of the system in  
241 terms of asking whether they were best placed to offer a particular service. Without their oversight  
242 and understanding of connections within the system, confusion or duplication of services could  
243 arise, and the system could be fragmented:



244  
245 *"And I suppose I see my role, and I don't think it is really necessarily what my role is per se, but*  
246 *I feel that it should be this, is to try and bring that system together" (C9)*

247  
248 Several commissioners specifically described their roles as supporting system transformations:

249  
250 *"I wouldn't necessarily describe us as traditional commissioners, per se. We work on largescale*  
251 *transformation, so things like the intermediary between NHS England and our organisation, and the*  
252 *subsequent providers that we work with" (C4)*

253  
254 Many described an increasingly collaborative approach to commissioning in recent years, linked to  
255 the advent of provider collaboratives (please see Study Context for more detail). Commissioners  
256 described working together with providers and other organisations to develop consensus around  
257 solving problems and addressing gaps. This was closely related to an emphasis on the  
258 commissioner's role in building and managing relationships with providers. Trust, openness and  
259 communication were also seen as central to allowing providers to raise problems and difficulties  
260 with commissioners:

261  
262 *"So, having an open, trusting relationship with providers, where you can just ask questions, or*  
263 *they feel comfortable and confident enough to flag things that they're finding really difficult,*  
264 *knowing that we will try to work through together to improve a pathway, or to support a*  
265 *team, or whatever it might be" (C7)*

266  
267 Some commissioners contrasted their approach and role with 'traditional commissioning' models,  
268 which were seen as more adversarial:

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3 270 "So I'm, sort of, part parent, part grandparent, part commissioner, because there is a formal  
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5 271 bit to it, I do need to write the specifications, I do need to work with them on their business  
6  
7 272 cases to secure funding.... But I think the fundamental difference is they should feel their  
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9 273 commissioners are more approachable, they can talk to them. It's not transactional, it's not  
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11 274 adversarial." (C8)  
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16 276 However, commissioners also expressed some uncertainties and concerns over their roles. For some,  
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18 277 the shift to provider collaboratives meant that they felt their role had changed, or questioned  
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20 278 whether they were even supposed to call themselves 'commissioners':  
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23 279  
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25 280 "...[there needs to be] clarity on the expectations of commissioners, and the commissioning  
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27 281 role. Because it seems to be changing, and then assumptions are being made in terms of what  
28  
29 282 the role should be doing" (C6)  
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32 283  
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34 284 "So we are not supposed to call ourselves commissioners anymore because the commissioning  
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36 285 function has been stripped with regards to the move from CCG to ICS." (C10)  
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39 286  
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41 287 **Theme 2. Priorities and Tensions: working in a complex and evolving integrated care system**  
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43 288 Commissioners described a wide range of environmental and contextual factors that influenced their  
44  
45 289 work. These factors were perceived to present both opportunities and challenges to the  
46  
47 290 commissioning of mental health services for CYP.  
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50 291  
51  
52 292 Many commissioners cited key policies and strategies which they felt had influenced their work in  
53  
54 293 their roles. However, commissioners had mixed views about how national policy impacted their  
55  
56 294 work. One commissioner felt a lack of control due to centralised decision-making, whereas another  
57  
58 295 perceived there to be more scope to tailor national policy to local needs:  
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" So we'll get money from NHS England or money from the central team and they will be like, 'we're giving you this money, you have to spend it on X, Y, Z.' So there's a lot of stuff that I don't actually have control over. The stuff that I do have control over is actually really such a small percentage. If anything a lot of the decisions are already made and then just like we're told we have to just do it" (C7)

"I think tailoring national plans, and national objectives, to our local population, is kind of what we do. Obviously we have certain access and activity targets to try and hit, and I guess there are suggestions as to how we do that, but I think what we need to do is really identify how that would work for our local population" (C4)

Participants also discussed the impact of frequent major national healthcare system reorganisations. Several described some of the challenges they faced in adapting to recent system integration and transformation without much information or guidance:

"so it keeps on changing from Clinical Commissioning Groups, to ICBs, to Primary Care Trusts, all sorts. I think it's going to go back to Primary Care Trusts, at this rate. [Laughs]" (C6)

Some felt that frequent changes and 'transformations', along with a reduction in workforce, had led to a shift towards more reactive commissioning, and to personal stress for commissioners over their own job security:

"the demands are unrealistic. Going through a transformation and integration process. We are also going through a restructuring, so we've been asked to deliver 30% savings by the end of the next financial year. So my post is safe for this year, but I don't know if next year

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322           *there will be a second round of consultation. And this creates a lot of instability because*  
323           *people are losing their jobs, we are going through consultations, so that creates that added*  
324           *stress.” (C2)*

326   Related to this, in terms of workload, several participants perceived that they as children’s  
327   commissioners had wider remit than they would have in in adult's commissioning:

329           *“Resource is not proportionately allocated to children's commissioning...it’s just not enough. It’s*  
330           *not enough to give the level of attention and the level of time, yes, just the time that is required*  
331           *to do it justice really” (C7)*

333   Some commissioners also felt that CYP as a group were a lower priority in the system. One  
334   commissioner directly related this to the change from Clinical Commissioning Groups to ICBs:

336           *“(Previously) there was that direct line of responsibility around targeted investment for children*  
337           *and young people and mental health, it felt ringfenced even though it wasn’t but it kind of was*  
338           *because you could not not invest in children’s mental health, and commissioning groups were*  
339           *regularly challenged by way of their level of investment through professional bodies, for*  
340           *example, the Royal College of Psychiatrists. For some reason, that connectivity with ICBs, it isn’t*  
341           *the same. I think that’s a major challenge.” (C13)*

343   Another felt that other issues were of higher political and media interest than CYP, meaning that  
344   young people did not get the ‘airtime’:

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"Getting airtime to talk about the issues around treatment for young people can be quite difficult because of the operational pressures. You're on the Six O'clock News with a queue of ambulances outside. Guess what, that's going to dominate the discussions that week." (C8)

### Theme 3: Insights and evidence: the role and use of data and informants

Commissioners described drawing on a range of sources to develop an understanding of child mental health need and services in their local area. Participants used many different terms to describe these sources, including *information, evidence, data, insight, observations, hunches, conversations, engagement, deep dives*, etc. and had different perceptions on the value and uses of these data.

Service providers were seen as particularly valuable sources of information, being described as commissioners' *"eyes and ears"* (C4). Insights and observations from providers were key to 'verifying' initial hunches from quantitative data, and prompting deep dives, engagement work, or requests for further service provider quantitative data:

*"I think we are reliant upon our providers, and also our delivery managers, so our borough-based colleagues, to feedback pertinent issues or common trends or presentations, which are either not typical, or they're increasing. So I think that gives us almost a bit of a hunch. And then I guess what we would do is try to dive a little deeper into some of the activity, outcome and experience data associated with those presentations, or those levels of need."* (C4)

This meant that developing strong, trusting relationships with service providers was important, enabling open and honest discussions about problems and levels of need that might not otherwise occur:

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371 *"[if] they feel comfortable and confident enough to flag things that they're finding really*  
372 *difficult, knowing that we will try to work through together to improve a pathway, or to*  
373 *support a team, or whatever it might be, is much better than having a dynamic where*  
374 *providers might almost try and consume their own smoke, or to – not hide waiting lists, but*  
375 *feel as though they can't flag a capacity problem, because they'll get dragged over the coals*  
376 *for performance issues, and it will just create an industry of perhaps unhelpful dialogue."*

377 (C4)

378  
379 Commissioners also talked of the importance of engagement pieces of work with children, young  
380 people, and families. This type of information helped commissioners to really understand the needs  
381 of their population:

382  
383 *"I think the key things that we've done in [LOCAL AREA] that I think data will never be able to*  
384 *show you is those engagement pieces of work, so actually understanding what children and*  
385 *young people and families are saying, how they feel about mental health support, what are*  
386 *their needs."* (C12)

387  
388 However, this was not always the case, with one commissioner suggesting that engagement events  
389 or co-production wasn't always helpful as it didn't tell them anything new:

390  
391 *"[Talking about feedback from children and young people co-production and engagement*  
392 *events] I wouldn't say that they are to give us a good granular detail direction for developing*  
393 *services, because the narrative is always the same, "Oh, I wait too long, I don't want to go to*  
394 *CAMHS, I want to be seen in the community," these are the main themes."* (C1)

Commissioners also reported using 'hard' quantitative data (e.g., service provider data, population level data, local surveys, academic data) to develop an understanding of child mental health need and identify gaps in service support. Commissioners talked about population data being useful in providing a spotlight on general need, evidence for business cases (with quantitative data carrying more weight than qualitative data), and looking beyond 'levels of access' data:

*"I think looking at prevalence rates in boroughs and PCNs, versus the actual activity or access levels, is able to shine a bit of a light on where we have high level of need, but perhaps low levels of access."* (C4)

*"I wouldn't need it day-to-day, no, but we would obviously access that when we're looking at papers or bidding or business cases, recommendations or retendering, all of that type of stuff then yes, or writing papers and we need that information, like going on the JSNA and things like that."* (C3)

Often, there was a reliance on service provider data (i.e., data on referrals, activity, outcomes, and wait times), over other forms of quantitative data, to inform commissioners' understanding of child mental health need. Service provider data had a range of uses; from identifying emerging, context-specific trends to assessing service performance and identifying where services might be failing to meet the needs of CYP. However, some commissioners had concerns about the reliability and accuracy of this quantitative data. For example, service provider data were often reported as missing, coded inaccurately, or inconsistently captured. This led to a sense that this service provider data could not always be trusted to inform decision making and qualitative data was needed to *truly* understand child mental health need and to *"improve [commissioners] view of the accuracy of a numeric"* (C8):

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422        *"[quantitative] data informs us maybe of some of the work that we need to do, and the areas*  
423        *in which we need to do that work. Then from there, and again, we wouldn't do this in isolation,*  
424        *as an ICB, we do this with our colleagues, from services, to understand, okay, what is the*  
425        *need? And it may be that we need to do an engagement piece of work in that area."* (C5)

426  
427    The pressure on service providers to provide quantitative data was seen by one commissioner as  
428    having unintended consequences; encouraging service providers to chase referral numbers rather  
429    than provide quality support. Furthermore, concerns around the reliability, accuracy, and novelty of  
430    quantitative data led some commissioners to ascribe little value to this type of data:

431  
432        *"It's an odd one, [name] because if you talk to people in health, they'll say, "Everyone knows*  
433        *where the problems are. So why do we need more data to tell us? It's got feathers like a duck*  
434        *and it quacks like a duck. It's a duck. We know where we need to make the changes. We don't*  
435        *need more data or more surveys or more." [...]* *"I kind of know where the problem is, and I*  
436        *don't have to have empirical data to help me with that."* (C8)

437  
438    There was a clear tension and variation between the use and value of quantitative versus qualitative  
439    data. Commissioners background and experience often influenced the type of data they utilised  
440    (e.g., commissioners with a quantitative background talked about utilising and valuing quantitative  
441    data, whereas commissioners who were clinicians by background often ascribed greater value to  
442    initial hunches or conversations with service providers). As a result, this created a commissioning  
443    landscape in which there appeared to be no established way of using data and informants; with  
444    sources/type used varying, dependent on the individual commissioner.

445  
446    **Theme 4: Children's mental health in the limelight: influences and expectations**



This theme is about commissioners' perceptions of changes in child mental health in their populations. Most commissioners discussed having seen a rise in demand for services, in terms of referrals and increasing time on waiting lists. Participants listed a range of areas where they felt there had been increases, including neurodevelopmental disorders, disordered eating, depression and anxiety, and self-harming. Many also perceived an increase in complexity and urgency of presentations. Commissioners made a clear link with the impact of the pandemic, but also emphasised that rises in demand were already happening pre-Covid:

*"I don't want to pin it all on COVID because we were seeing an increase in demand before COVID. So it's not as if everything was fine and then COVID, you know, just tipped us over."*  
(C9)

Participants felt that social isolation and online education were key factors that had affected mental health and child development and contributed to school-based anxiety and avoidance. However, commissioners also voiced concern over the impact of other systemic social and economic influences which they felt were driving increases in problems, and which had been exacerbated by the pandemic:

*"I might be wrong, but I don't think that there has been a biological shift in how children and young people's mental health and emotional wellbeing works. I think that a lot of it's from external factors"* (C4)

Inequalities in access to help were also a concern:

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471 *"I think the pandemic created a larger gap between those who needed help, or need help, and*  
472 *those who access it. I think that's been disproportionate for certain children and young people,*  
473 *certain demographic profiles as well. (C4)*

475 There was also much discussion of the effects of increased awareness and understanding around  
476 mental health, and the impact of social media and wider policy in putting mental health *"in the*  
477 *limelight"*. This was also seen as uncovering new needs and gaps which services then had to meet:

479 *"I would say that the demand has increased, that's a fact because we've expanded services*  
480 *and still have issues with waiting times and more children needing support. But alongside the*  
481 *demand, because mental health has increasingly been in the limelight, I suppose, there's been*  
482 *more attention to mental health, child, adolescent, mental health in the last five years.*  
483 *Perhaps this has uncovered needs and a prevalence that we weren't aware of before." (C1)*

485 *"Disordered eating and things like ARFID [Avoidant Restrictive Food Intake Disorder], seem to*  
486 *be something... sort of newly emerging conditions because we don't have commissioning in*  
487 *place for them. And that's not because it was a gap... well, it's a gap now, but it's a gap that*  
488 *seems to have emerged within recent times. When we, for example, were commissioning our*  
489 *specialist children's mental health service, disordered eating and ARFID were not really*  
490 *discussed as being something that needed to be considered or perhaps disordered eating was*  
491 *looked at differently." (C2)*

493 In terms of drivers of demand, commissioners also appeared to perceive some tensions between  
494 positive aspects of awareness and encouraging help-seeking, and risks of 'over-medicalising' normal  
495 'ups and downs' and expectations of mental health which might be unrealistic:

497 *"So there's an awareness from children and young people that they know what good mental*  
498 *health looks like, and how they can promote it. But there's also probably an expectation from*  
499 *that as well...I think a young person, after watching a video, or trying to learn some coping*  
500 *techniques, won't necessarily see a change or an improvement straight away in the same way*  
501 *that, if you've got a headache, you have a paracetamol, and then an hour later you're sorted...*  
502 (C4)

#### Theme 5: Responding to need: "CAMHS as the answer to everything"

505 In addressing the needs of their populations, many commissioners felt that prevention and early  
506 intervention were key priorities within child and adolescent mental health. They discussed an  
507 increasing role for a broader range of agencies including the voluntary sector, social care, and  
508 education, with several referencing the Thrive model (a needs-led framework to help create  
509 communities of mental health and wellbeing support, with a focus on proactive prevention and  
510 promotion) [21]. Participants also cited a range of initiatives aimed at triaging referrals and  
511 expanding first-line support and emphasising the role of CAMHS as a specialist mental health service.  
512 However, for some commissioners, there were several significant challenges in moving the focus  
513 away from specialist child mental health services. For example, lack of capacity in other parts of the  
514 system such as schools and communities was seen as a limiting factor in prevention and  
515 management of less severe cases, resulting in bottlenecks and pressure on CAMHS:

517 *"I think there is a real-time reduction in staff time in schools over the past 15 years and that*  
518 *gets expressed in an increased in referral activity to where the lights are on. That's the NHS.*  
519 *And free at the point of use. So there is a systemwide bottleneck and things just breaking*  
520 *down."* (C13)

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3 522 Additionally, commissioners perceived that both professionals and young people still had  
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5 523 assumptions and expectations that CAMHS was the place for all child mental health concerns. These  
6  
7 524 expectations complicated efforts to develop other pathways, with some early-support services being  
8  
9  
10 525 seen as under-utilised as a result of a preference for CAMHS:  
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12 526  
13  
14 527 *"We get reports from services that they are under strain, but there are also parts of other*  
15  
16 528 *services which are not utilised properly. And then we get feedback from children, "I don't know*  
17  
18 529 *what provision is available to me, and waiting times are too large." So my feeling is we're still*  
19  
20 530 *struggling to move the focus away from CAMHS being the answer to everything." (C1)*  
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22 531  
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25 532 Some expressed frustration that this might mean CYP spent time on waiting lists when they could  
26  
27 533 have accessed support more quickly elsewhere:  
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29 534  
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31  
32 535 *"there's still that mind-set of if someone expresses any concern about mental health, let's refer*  
33  
34 536 *them into CAMHS, and that's where we see those waits because then they're essentially on a*  
35  
36 537 *waiting list for support that potentially they might not need and they could have got*  
37  
38 538 *something a lot earlier." (C6)*  
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40 539  
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43 540 Commissioners also reflected on future directions and challenges and what they expected to see  
44  
45 541 coming down the line. One commissioner thought that funding would never be able to meet need  
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47 542 for services:  
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49 543  
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51  
52 544 *"The overarching difficulty is that the money that we've got is never going to be able to meet*  
53  
54 545 *the full demand of need, so we have to think differently about who we support when" (C12)*  
55

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Commissioners had varying degrees of optimism about whether investment in services and early intervention would happen, and whether CYP's mental health would improve in future:

*"Our focus needs to be more on that preventative and early intervention. But that's a massive culture change, so I think hopefully in that long period of time we will see those – I won't say probably a reduction – but levelling off of demand."* (C12)

*"I would say unless, coming back to the main point, we invest properly and proportionately in children's services over the next five years, we're going to be going backwards in terms of children and adolescent mental health. We're not going to be going forwards." [...] "So it sounds pessimistic, but I think we're going to have a worse situation in the next five years unless we drastically change."* (C7)

## **Discussion**

This qualitative study sought to explore and understand commissioners' experiences of commissioning child mental health services, their perspectives on the needs of their populations, the challenges they face and their needs for support and data. From interviews with 12 commissioners based in ICBs across England, we generated five themes: 1) Reflections on role; 2) Priorities and Tensions: working in a complex and evolving integrated care system; 3) Insights and evidence: the role and use of data and informants; 4) Children's mental health in the limelight: influences and expectations; and 5) Responding to need: "CAMHS as the answer to everything". Below we discuss some of the main insights, challenges and implications of these findings.

Our first and second themes illustrate the way in which commissioners see themselves as holding oversight or a living map of their local systems, and have an increasing role in systems leadership, and in collaborating with providers, rather than focussing on a more adversarial system of contracts

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3 573 management. Many seemed to feel this enabled greater openness over problems and shared  
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5 574 challenges. However, it was also evident that some commissioners experienced tensions and  
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7 575 uncertainties over their changing roles, especially when these changes occurred as part of broader  
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10 576 restructuring. Whilst some benefits were seen, there was a strong perception that frequent  
11  
12 577 reinvention and transformational change had introduced not only stresses about job security, but  
13  
14 578 also hampered their being able to undertake deeper thinking and proactive planning over the longer  
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16 579 term. Here our findings are in line with previous research suggesting that whole system changes can  
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18 580 result in disruptions to the commissioning process, as well as to the wider workforce [22]. Such  
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20 581 healthcare services reorganisations are not unique to the English context, with one study reporting  
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22 582 on 78 reforms being implemented across 26 European countries, clustering around to changes to  
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24 583 'coverage & resource generation', 'purchasing & payment' and 'hospital care' [23]. Whilst there is  
25  
26 584 often interest in the impact of reorganisation on clinical staff and patients, our findings suggest that  
27  
28 585 attention should also be paid to the impact on those responsible for planning and managing services  
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30 586 in a commissioning role.  
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33 587 Commissioners also faced challenges in terms of advocating for their population of CYP. Many of  
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35 588 our participants perceived that CYP as a group were seen as lower priority, both in terms of  
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37 589 allocation of commissioning resource, but also in the healthcare system. This accords with wider  
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39 590 concerns which have been repeatedly voiced about the (relative) low priority of CYP in policy and  
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41 591 strategy in England, and even in the Covid-19 response [24, 25]. Related to this, there were mixed  
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43 592 reports from commissioners about the extent of their agency within the system, and how much they  
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45 593 could tailor national policy to local need, which suggests that system-level factors within different  
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47 594 Integrated Care Systems may affect the scope of commissioners' decision making.  
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53 596 A key finding from our third theme: "Insights and evidence" was the various ways in which  
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55 597 commissioners developed an understanding of the needs of their populations, and how they  
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57 598 perceived the roles of 'qualitative' and 'quantitative' data. Many participants placed a premium on  
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the insights they gained from trusted providers acting as their 'eyes and ears'. This constituted another benefit for commissioners of developing good relationships with their provider networks. Evidence gathered from engagement with children and families through local groups and events was also seen as providing strong narratives and stories which could spotlight areas of need, although the degree to which this process involved under-served groups in the community, as opposed to highly-engaged ones, was unclear. Other research on policymaking and commissioning has also highlighted the importance of 'people based' sources of information, often as part of informal 'policy networks' [12, 26]. Interestingly our research also reveals the concerns held by commissioners about 'quantitative data'. In some cases, concerns around the reliability, accuracy, and novelty of quantitative data led some commissioners to see quantitative data as being lower value. Despite this, most saw a clear role for quantitative data, and would expect to include it in documents required for decision-making such as in needs assessments and business cases.

Commissioners' perceptions of changes in their populations were in many ways in line with findings from epidemiological data, in terms of the gradual increase in prevalence pre-Covid, followed by a more marked rise in problems, particularly in emotional disorders [27, 28]. However, commissioners also discussed how and whether increased awareness and understanding of mental health were influencing presentations and demand for services in their areas. Avoidant Restrictive Food Intake Disorder (ARFID) was cited by at least one commissioner as an example of a 'new need' that had been uncovered and which services needed to meet. These discussions appeared to reflect wider international societal debate on the impact of broader mental health awareness and the medicalisation of distress in young people [29].

Linked to this was the theme on 'CAMHS as the answer to everything', which described how commissioners were grappling with system transformation (mirrored by other accounts from CAMHS staff, e.g. in Rock et al.'s (2021) study). A common area of challenge appeared to be the



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3 625 challenges of diverting the focus from CAMHS for problems which may not require specialist  
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5 626 support. Some participants perceived that early-help or online groups were under-utilised due to a  
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7 627 preference for CAMHS both from referring professionals and from young people and families. This  
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9 628 presents an interesting contrast with research suggesting that patients and primary care  
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11 629 professionals perceive marked barriers to accessing care and that thresholds for CAMHS remain a  
12  
13 630 hindrance in getting the support they need [30–32]. The accounts of commissioners accord with the  
14  
15 631 wider drive within integrated care systems to change the focus of services to include lower intensity  
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17 632 early interventions to support health and wellbeing in the population.  
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23 634 **Strengths and limitations**

25 635 One of the strengths of this paper is the exploration of the perspectives of commissioners, a group  
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27 636 who are rarely the ‘subjects’ of research, but who have considerable influence in the design and  
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29 637 delivery of mental health services for CYP. This study represents one of only a handful of papers to  
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31 638 explore their views, and the only study we are aware of to include CAMHS commissioners in a post-  
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33 639 pandemic context. We were also able to recruit commissioners across a range of ICBs in England  
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35 640 with responsibilities for commissioning mental health services for CYP. The limitations of the study  
36  
37 641 include the potential for more motivated and research-engaged commissioners to have participated,  
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39 642 perhaps affecting the transferability of our findings. It is also possible that those participating may  
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41 643 not have felt fully able to express their views, due to concerns around anonymity. As there are only  
42  
43 644 42 ICBs in England, we have been careful to avoid including information which could link a  
44  
45 645 participant to their ICB and risk disclosure.  
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52 647 **Implications**

54 648 Our findings describe the complex and changing political, social and economic environment in which  
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56 649 commissioners work, and their role in maintaining oversight of their local systems. It is also evident  
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58 650 that commissioners as a group may struggle with changes as their role evolves, and that they may  
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benefit from additional resource, training and professional development opportunities. As with many public sector services, CAMHS commissioners also face challenges in delivering services in the face of constrained resources. Marked tensions were evident around the perceived need to balance investment in prevention and interventions earlier in 'the pipeline' with continuing to deliver the specialist assessment and treatment needed by children with more severe and complex problems. Whilst there have been longstanding calls for more investment in child mental health since before the pandemic, it has been argued that services are now even more unlikely to be able to meet growing need without a step change in thinking by those funding and designing services [33]. Decision-making in this context needs to be as transparent as possible to all stakeholders (including the public), including developing a clearer understanding of the data required and used to make difficult commissioning decisions. Similarly, our findings on the variation in approaches to commissioning raise questions about the need for more standardised procedures and guidelines, whilst recognising the importance of local insights.

These findings also have important implications for researchers, in terms of how those in the research community can ensure that relevant and digestible messages find their way to those commissioning services. Our findings highlight how time, and timeliness, is of the essence for those in a commissioning role, hence brevity and pace of outputs is key, representing a challenge for researchers working with slower timescales of funding, approvals and peer-review. Local relationships and networks are likely to be key for research teams to interact in a more meaningful way with commissioners. Forums that bring the two groups together, for example, as part of a research active Integrated Care System or Population Health Management board, may also be helpful in exploring joint priorities and co-development of outputs. Finally, whilst these specific findings are situated in the English healthcare system, we would suggest that many other healthcare systems internationally are facing similar challenges regarding how to plan and deliver services for

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children and young people’s mental health, and hence, some of our findings may be translatable and transferable in an international context.

**Conclusions**

Our study sought to explore and understand commissioners’ experiences of commissioning services for child and adolescent mental health, including their perspectives on the needs of their populations, challenges they face and their needs for support and data. The findings highlight how commissioners are negotiating a complex and changing political, social and economic environment with competing priorities and pressures. Proportionate funding for CYP’s mental health services was seen by commissioners as essential to ensure services are able to meet current need, alongside a greater focus on prevention. Researchers now need to work alongside commissioners to provide timely, succinct outputs that better support commissioners plan services and improve the health of the populations they serve.

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**Competing interests:** None declared.

**Ethics approval:** Ethical approval for this study was granted by the University of Exeter Medical School (reference number: 1337925).

**Data sharing statement:** No data are available.

Any checklist and flow diagram for the appropriate reporting statement, e.g. STROBE

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825 **Figures**

826 *Figure 1. Themes, sub-themes, and relationships between themes*

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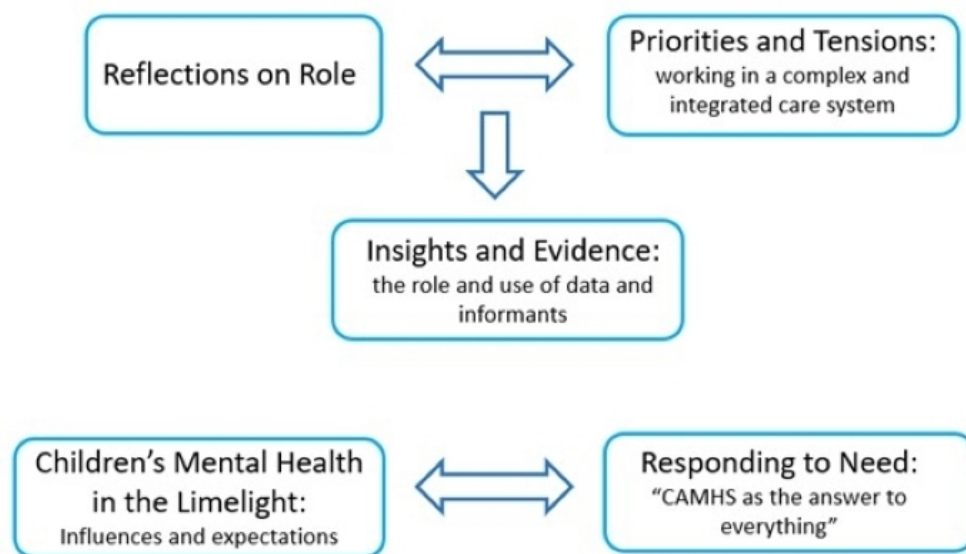


Figure 1. Themes, sub-themes, and relationships between themes

59x34mm (300 x 300 DPI)

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**Supplementary material**

**Interview topic guide**

- 1) Can you tell me a little bit about your role as a commissioner?
  - a. Which services are you currently responsible for commissioning?
  - b. How long have you been in your role as a commissioner?
- 2) What recent changes have you seen in child mental health need? (nationally/locally)
  - a. In your view, what are the key drivers/determinants/factors responsible for these changes?
  - b. How do you think COVID played a role in these changes?
  - c. Can you tell me about any specific groups that might have been impacted?
- 3) What changes do you expect to see in child mental health need moving forward? (e.g., next five/ten years?)
  - a. In your view, what are the future drivers/determinants of child mental health likely to include?
  - b. How do you think CAMHS might need to adapt to meet these changing needs?
- 4) How do you develop an understanding of child mental health needs in your area?
  - a. Can you talk me through the process involved?
  - b. Can you tell me about who you work with to help develop this understanding?
- 5) How do you use data to help inform your understanding of local child mental health needs?
  - a. What sources of data do you use?
  - b. Can you describe what these sources of data include?

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- c. How do you find accessing/using this data?
  - d. What is *useful* about this data? What is *not so useful* about this data?
  - e. Are there any sources of data that you do not use? Can you tell me about why you do not use this data?
- 6) What approach do you take to planning and adapting child mental health services in your area?
  - a. What resources do you draw on?
    - i. How does this help inform your decision-making?
  - b. What expertise do you draw on?
    - i. How does this help inform your decision-making?
  - c. Can you tell me about how you work with others to plan and adapt child mental health services?
  - d. What differences are there, if any, in your approach to planning and adapting mental health services for transition age young people?
- 7) How could the data currently available to you be improved to better support you in your role?
  - a. What are the key gaps with the data?
  - b. What are the key problems/limitations with the data?
  - c. What additional information would you like to see in the data currently available?

Can you tell me about why this data would be particularly important/useful?
  - d. Do you have any key unanswered questions about your population?
- 8) Can you tell me about any specific groups that it would be useful to have data for?

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- 9) What are the key challenges you face in undertaking your role as a commissioner of child mental health services?
- 10) Is there anything else that would be useful to you in terms of commissioning child mental health services?

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