

# Royal College of Psychiatrists Consultation Response



**Date:** 1<sup>st</sup> March 2018

**Submission of:** The Royal College of Psychiatrists

**Submission to:** Transforming children and young people's mental health provision: a green paper

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations.

Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

We are pleased to respond to this consultation. Our response was approved by Dr Adrian James, Registrar.

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## Introduction

The Royal College of Psychiatrists welcomes the opportunity to respond to the Green Paper on children and young people's mental health. This is a valuable and ambitious document that invites careful scrutiny.

Child and adolescent mental health services (CAMHS), which are provided by the NHS, are overwhelmed by demand and simply cannot provide help to all who need it. It is imperative that anyone working with children feels an increased responsibility to ensure they appreciate the mental health needs of the children they are working with. We therefore welcome the Department for Education and the Department of Health and Social Care coming together to publish this Green Paper.

Our submission focuses on areas of the Green Paper, and questions, that have particular relevance to the work of psychiatrists and the people they care for. Our submission has been informed by a range of people, including:

- Young people who used NHS CAMHS
- Carers
- Psychiatrists working in child and adolescent, general adult, perinatal, intellectual disability and eating disorder psychiatry
- Academics
- Researchers working at the National Collaborating Centre for Mental Health
- Professionals working at the College Centre for Quality Improvement (CCQI)
- Professionals working within the Royal College of Psychiatrists' Strategic Communications Department.

We have also engaged with various stakeholders, including the National Association of Head Teachers, the Children Commissioners' Office and the Equalities and Human Rights Commission. Many thanks to all the people who have shared their expertise and insight with us.

In addition to providing this submission, we have contributed to two joint responses from mental health and education charities from across the United Kingdom:

- The response from the Mental Health Policy Group.
- The response from the Children and Young People's Mental Health Coalition, the Fair Education Alliance and the Partnership for Wellbeing and Mental Health in Schools.

The joint responses represent a consensus of views from various organisations and we have not repeated all the details of these joint submissions in our individual response.

## Summary

A mental health crisis is developing among the country's children. More than half of all mental ill-health begins by the age of fourteen. It is estimated that one in ten children aged 5-16 years has a diagnosable mental health disorder<sup>1</sup> and data suggest that demand for services keeps increasing across the system.<sup>2</sup> This increased prevalence of mental ill-health is also reflected in young adults and university students. There is an increased demand on university counselling/support services and mental health services, as well as an increasing suicide rate among university students. Poor mental health and wellbeing is associated with academic underachievement and an added risk of dropping out of university.<sup>3</sup>

The plans outlined in the Children and Young People's Mental Health Green Paper are welcome, but we urge the Government to be more ambitious in its roll-out. We cannot afford to leave desperate children and their families to struggle alone any longer.

The three-pillar approach is an opportunity to bring schools and NHS services closer together to ensure more children who need treatment can get timely help from specialist services. Working on the frontline with children with mental health needs, our members see the value of helping children when they are at school. Far too many children and young people fall into crisis because they cannot get the help they deserve early enough.

However, some children and young people will continue to need support from specialist services. Improving access and treatment for children with mild problems does not mean that severe problems will disappear. The Green Paper is an opportunity to reiterate the need to increase the capacity of NHS CAMHS as well as adult mental health services, in order to ensure there are enough trained mental health professionals, day-care resources and in-patient beds as well as outreach and crisis teams to provide alternatives to hospitalisation.

We know Mental Health Support Teams (MHSTs) cannot be created overnight; however, under the current proposals, a child who is eight today might not get any extra support before they leave school at eighteen. By the Government's own estimates, a quarter of a million children and young people who could be helped by a MHST will still be missing out in five years due to the time it takes to roll out the proposals.<sup>4</sup> In addition, children younger than school-age will not benefit until they reach school, despite having similar needs and fewer current services available, which are in slow but steady decline.<sup>5</sup>

The role of the Designated Senior Lead for Mental Health (DSL) within schools should be mandatory, with a standardised training course to ensure every child who needs help gets properly supported to access services that are evidence-based and high-quality, with timely referrals and consistent care.

The impact assessment shows that, in the short term at least, the reforms are likely to increase demand on CAMHS as more young people are able to access the services they need. With the number of consultant child and adolescent psychiatrists falling by 6.9% in the last four years<sup>6</sup>, more resources need to be invested in CAMHS to provide the necessary oversight and support to the newly formed MHSTs, and to ensure the four-week waiting time target can be met.

In addition, it is important that the Government considers a system-wide approach including services such as social care. Such additional support is essential to prevent crises and medicalisation of social difficulties, and to ensure that specialist CAMHS are used appropriately. The reforms are also likely to lead to an increased demand on Early Intervention services and student mental health services. Health professionals in all areas and specialties working across these age ranges need to work collaboratively with mental health services.

Overall, the Green Paper is a welcome start but it cannot be the end. There needs to be a significant level of further investment to meet the true scale of need across the country, both known and unknown. Any improvements to mental health support for children and young people will always heavily rely on having a robust mental health workforce.

## Key recommendations for implementation

### The core proposals

1. Be more ambitious in the roll-out of the proposals, following evaluation of the pilots.
2. Put in place a range of measures to improve recruitment and retention of multi-professional teams, including child and adolescent psychiatrists, nurses, psychologists, allied health professionals and social workers.
3. Include child and adolescent psychiatrists, higher trainees and speciality doctors in CAMHS on the national shortage occupation list.
4. Strengthen proposals to address issues in relation to early years, young people aged 18-25 years old, children with special educational needs and difficulties, children with behavioural problems and their families, children who are not in education, young people with substance misuse problems, health inequalities, connections with other parts of the system, data and research.
5. Ensure that the changes that take place are properly evaluated to ensure that we learn from the data generated on how best to support school-age children in the community.
6. Increase and ring-fence national funding for CAMHS.
7. Hold every CCG to account in achieving the MHIS (both including and excluding dementia and learning disability spend), and impose regulatory sanctions on CCGs who have not met the MHIS.
8. Ensure Mental Health Trusts' income continues to grow to reflect additional monies made available to CCGs, the forecast rise in demand on secondary mental health services, and the additional mental health workforce posts required to be in place before 2021.
9. Improve the accuracy of mental health data, and in particular the financial data reported by CCGs, address non-compliance in CCG data returns and take regulatory action where appropriate.
10. Publish the delayed Mental Health Dashboard and commit to a quarterly publication timetable for the duration of the Five Year for Mental Health.
11. Incorporate the Green Paper's proposals post 2021 in the next mental health strategy.

### Mental Health Support Teams

12. Clearly set out which professionals will comprise MHSTs, what their professional standards will be, who will train and supervise them, and where the funding will come from.
13. Ensure MHSTs are integrated both within CAMHS and educational institutions, and test a model by which CAMHS would manage them.
14. Provide more funded staff to CAMHS so that they can offer the necessary oversight and support to the newly formed teams.
15. Ensure training will equip teams with the ability to identify the mental health needs of vulnerable groups of children and young people, and to refer them appropriately.
16. Provide clear guidance to ensure that, when disorders start to move from mild to moderate, MHSTs understand when specialist support is needed and can refer appropriately.

17. Ensure MHSTs help prepare young people for university life and provide appropriate support to vulnerable groups of young people before they go to university (for instance, by helping them identify and write their needs on their university application forms, and facilitate links with the relevant university support services).

### **Piloting a waiting time standard**

18. Ensure that any evaluation of the pilot looks at: the waiting time between first assessment and starting treatment, which professional does the first assessment, the access criteria to CAMHS, the number and types of referrals declined and why, the ratio of staff in each CAMHS team delivering assessment and treatment, and the ratio of referrals to discharges from each CAMHS team.
19. Ensure that local sites bring a whole-system approach to testing the standard, including a system to ensure data can flow easily and safely between different systems and providers.
20. Routinely publish information on waiting time figures in all areas, not just the piloted areas, alongside needed and actual workforce numbers and number of referrals declined.
21. Publish the delayed mental health care pathways for children and young people's mental health services, including the recommended waiting times (developed by the National Collaborating Centre for Mental Health and commissioned by NHS England).

### **Schools and colleges**

22. Make the Designated Lead for Mental Health role mandatory for schools and colleges to give the Green Paper proposals the best chance of success.
23. Ensure training is high-quality, regularly updated and consistent across the country.
24. Make a) the whole of Personal, Social, Health and Economic mandatory from 2019 for all pupils, in all schools, and b) mental health and emotional wellbeing required components of the PSHE curriculum for every age group.

## The core proposals

### Question 1:

Do you think the core proposals have the right balance of emphasis across a) schools and colleges and b) NHS specialist children and young people's mental health services?

The three proposals are well-balanced across the whole spectrum of mental health in school-age children.

- The Green Paper brings opportunities for valuable joint-working and shared responsibilities between schools and children and young people's mental health services, which are particularly welcome. Communication and relationships across agencies are vital to ensure continuous and high quality mental health care is delivered.
- We also see the value of helping children and young people when they are at school. Ensuring that each establishment has a trained Designated Senior Mental Health Lead who is able to coordinate support or access services appropriately is of key importance.
- There is a good emphasis on early intervention with the MHSTs and their knowledge of the 'local context'. These teams should be able to make a significant difference in mental health trajectories.

However, the College believes there are a number of issues with the implementation of these core proposals that require scrutiny.

### Ambition of roll-out

Current plans aim for full roll-out by 2028 – leaving a generation of children without support. In some areas those aged eight will not see Green Paper recommendations until they are eighteen and leaving school.

Given the extent of unmet need, we strongly believe the proposed roll-out of the new approach to between just a fifth and a quarter of the country by the end of 2022/23 falls far short of the ambition needed. We cannot afford to leave desperate children and their families to struggle alone any longer.

We know MHSTs cannot be created overnight, but under the current proposals a quarter of a million children and young people who could be helped by a MHST will still be missing out in five years due to the time it takes to roll out the proposals.<sup>7</sup> It must be possible to set up a programme in under 10 years.

In addition, children younger than school-age will not benefit until they reach school, despite having similar needs and fewer current services available, which are in slow but steady decline.

### Workforce

The number of child and adolescent psychiatrists (all grades, full-time equivalent) has declined by 6.3% between November 2013 and November 2017. For consultants alone (full-time equivalent), the decrease is 6.9% over the same period.<sup>8</sup> Numbers of mental health nurses (full-time equivalent) have fallen by 11.4% between November 2009 and November 2017.<sup>9</sup> These trends are a clear barrier to achieving the proposals of the Green Paper and ultimately supporting more children who would benefit from its implementation.

The impact assessment shows that in the short term the reforms are likely to increase demand on CAMHS. The evaluation of the Targeted Mental Health in School (TaMHS) programme showed that, over time, schools reported increasing amounts of specialist mental health input.<sup>10</sup>

The latest training programmes data show that just over half of child and adolescent psychiatrist training places go unfilled. Medical schools and Health Education England (HEE) need to do more to encourage more trainee doctors to choose psychiatry. The Royal College of Psychiatrists will pursue

its *Choose Psychiatry* recruitment campaign and embark on a campaign to encourage medical schools to accept Psychology A-Level as an entry requirement for medical school.

The College also explores flexibility within training to attract more medical students and foundation doctors to choose child and adolescent psychiatry. A run-through training pathway for CAMHS is being trialled that allows child and adolescent psychiatry trainees to complete all of their training in a single region if they wish to.

For children with intellectual disabilities and mental health needs, school-based services are appropriate. However, finding enough specialised staff to support these children and young people will be hard to achieve.

The HEE mental health workforce plan committed to an extra 100 consultant CAMHS psychiatrists by 2021, but it does not seem that they will be working in community CAMHS teams.<sup>11</sup> We must have more community CAMHS psychiatrists to meet the four-week waiting time and play an active role in the MHSTs. If clinicians are not engaged in the oversight of the teams, there is a risk that there will be different standards of mental health care in NHS settings and schools.

For these reasons, we call on the Government to include child and adolescent psychiatrists, higher trainees and speciality doctors in CAMHS on the national shortage occupation list. Recruiting from overseas will be crucial to achieve the Government's workforce commitments as well as the Green Paper's proposals.

Recruiting and retaining staff in services, especially in more isolated locations, will also be crucial if the Government wants to achieve its target to eliminate all inappropriate out-of-area placements (OAPs) for children by 2020/21 in a safe manner.

We call on the Government to ensure that a single definition of inappropriate OAP for children is consistently applied at both national and local levels, clearly explain how OAPS for CAMHS are being monitored and tracked (including numbers of OAPs, costs, lengths of stay), publicise this data every month, and clarify yearly targets towards total elimination.

### **Gaps and areas where the Green Paper could be strengthened**

There are some important omissions in the Green Paper and areas where it could be strengthened.

- **Addressing early years** – the Green Paper does not set out how those too young for school will get extra support, despite having the same level of mental health problems, and fewer services to help them.<sup>12</sup>

We need reassurance that more resources will be allocated to mental health services for preschool children, as well as perinatal mental health services. A focus on early intervention in these formative early years is crucial for ensuring that parents at risk of struggling with their young children are supported sufficiently, and that all babies and children are given the best possible start in life.

We call on the Government to ensure local areas commission evidence-based parenting programmes, otherwise there is a danger the Green Paper's ambitions will not come to fruition.

The interventions included in the Department of Work and Pensions (DWP) programme to reduce parental conflicts need to be outcome-driven as well as evidence-based. These need to be commissioned and delivered by working closely with local authorities.

- **Addressing young people aged 18-25 years** – there is a well-recognised increase in prevalence of mental ill-health in the university student population and this is reflected in the increased demand on university counselling/support services and mental health services.

Students live a pressured academic environment, away from the immediate family support. There has been an increased suicide rate among university students over the past ten years. In addition, poor mental health and wellbeing is associated with academic underachievement and an added risk of dropping out of university, unless appropriate support and mental health services are available and working together.<sup>13</sup>

The need for wider support for the mental health of 16-25 year olds is acknowledged, but there is a lack of urgency in the proposals. We call on the Government to further develop and fund NHS student mental health services, with agreed protocols for flexibility between home and university-based primary and secondary care mental health services to ensure that students' mobility does not impact on continuity of care.

Funding for Early Intervention services in young adults need to be increased in order to ensure that treatment and interventions can be continued for those with mental health conditions identified when younger and for those who become unwell as young adults.

NHS student mental health services need to be developed based on local needs, with professionals skilled in assessment and intervention with students who have common mental disorders (such as depression and anxiety) and also severe mental illnesses (such as schizophrenia and bipolar disorder), addiction disorders, neuro-developmental disorders (including ADHD, autism spectrum disorders) - and make appropriate referrals to specialist mental health services. They need to work closely with university support and GP services.

We believe all higher education institutions (HEI) and apprenticeship schemes should establish coordinated working relationships with NHS mental health services. The form that this should take would depend on the existing organisation and configuration of NHS services and the level of provision of counselling and other services by the HEI.

These include direct involvement of psychiatrists in primary care or counselling services, where they function both as clinicians and supervisors, the establishment of referral pathways to NHS care, and the development of NHS/HEI networks for consultation, education and the coordination of service provision.

We welcome the development of new models of 0-25 services. The interface with adult services at the age of 25 years rather than at 18 years is clearly more appropriate. MHSTs could also have a role in supporting transitions from CAMHS to adult services. Early Intervention Psychosis would hopefully integrate into any new model, but non-psychotic disorders and episodes of psychosis (whether first-episode or not) also need to be taken into consideration.

- **Supporting children with special educational needs and difficulties (SEND)** – as the SEND system is for children and young people aged 0 to 25, we need reassurance from the Government that these young people will continue to be supported when they leave school at the age of 18.

We would also like the Government to consider how the proposals of the Green Paper may support sections 5.29, 5.32 and 6.21 of the current SEND guidance, to facilitate schools identifying and supporting children with significant neurocognitive, emotional or behavioural difficulties before they begin formal education at 5.

- **Supporting children with behavioural problems and their families** - school-based behavioural policies should use the 'reasonable adjustment' approach for children with neurodevelopmental disorders (such as autism spectrum disorders or intellectual disabilities) to prevent disproportionate and repetitive sanctions for not learning as quickly or not understanding certain rules.



- **Supporting children who are excluded by a school/college-dominated approach** – some children do not attend school, might feel estranged from their school, or prefer to receive mental health services outside the school context.

Children who move from one school to another (in particular looked-after children after placement breakdown), children in residential schools, children who are home-educated, young people who are not in education, employment or training (NEET), children in Young Offender Institutions are all vulnerable children and young people who may need a more targeted approach in order to benefit from the Green Paper's proposals. At present they seem excluded.

The difficulty in supporting any and all of these children over the school holidays needs to be addressed. Furthermore, local employers have an important role to play by providing apprenticeships, placements, and job opportunities for local people who are NEET. Cross-sector collaborations between different local authority directorates (public health, housing, children's services for instance) and also between local authorities, job centres, schools and mental health services have been shown to deliver good results and need to be promoted.<sup>14</sup>

- **Supporting young people with substance misuse problems** – although MHSTs may be able to support young people with substance misuse issues, there are a number of problems that remain unaddressed. Some schools no longer receive the support from early-intervention drug workers, who used to intervene in schools. Moreover, young people's substance misuse services have become fragmented over the past five years, and often merged into adult services, so younger children at an early stage of entry into substance misuse are not picked up.

Evidence indicates that young people with mental health problems and those excluded from school are more likely to misuse drugs and alcohol. All services dealing with children and adolescents need clear screening processes for identifying the use of drugs and alcohol, and referral procedures in place for when they are needed. Age-appropriate pharmacological interventions for substance misuse need to involve specialist services such as CAMHS staff, paediatricians, young people's clinicians and addictions psychiatrists.<sup>15</sup>

This is all the more important as recent survey findings indicate that 24% of pupils reported they had taken drugs in 2016, compared to 15% in 2014<sup>16</sup> (this survey has been carried out in mainstream schools and therefore does not pick up hard-to-reach groups).

- **Tackling mental health inequalities** – the Green Paper misses some key groups, for instance young people from some ethnic communities who face higher risk of poor mental health as they move into adult years. There is also little recognition of the fact that children from the poorest 20% of households are four times more likely to have a mental health difficulty as those from the wealthiest 20%<sup>17</sup>. This has major repercussions for a wide range of policies and public services.
- **Connections with other parts of the system** – to support all children, there is a need to emphasise the importance of system-wide local offers in early intervention, including the role of social care, housing, community support, primary care, paediatric services, youth justice services, charities, youth clubs and children's centres.

As acknowledged in the impact assessment,<sup>18</sup> the implementation of the Green Paper should result in a rise in demand for CAMHS in the short term, as many of the currently unidentified children will be supported to access care. This may also be the case for other services such as local authorities' social services or youth justice services, and we call on the Government to develop a strategy detailing how this will be factored in and costed.

- **Data and research** – we welcome the commitment to publish a new prevalence survey in 2018, and we call on the Government to fund follow-up research to explore the outcomes of the care children receive from this survey. Longitudinal data offers the opportunity to track change over time, while repeated surveys only offer a snap shot.

We would like to have more specific information on research funding. Specific groups who will not be covered (children who are looked after, children from ethnic minorities) should be studied in separate surveys.

## **Funding**

We know that investment in CAMHS is patchy. RCPsych analysis of the *Mental Health Five Year Forward View* Dashboard data found vast differences in how much clinical commissioning groups (CCGs) are investing in young people’s mental health services: 33 CCGs spent less than £35 per head in 2016/17, 148 CCGs spent between £35 and £70 per head while only 28 CCGs spent more than £70 per head.<sup>19</sup>

We also found that over a third of CCGs – 70 out of 209 – spent less than they originally planned on children and young people’s mental health and eating disorder services in 2016-17, and that 22 cut overall mental health funding in real terms from 2015-16 to 2016-17.<sup>20</sup>

The NHS planning guidance for 2018/19 made it explicit that every CCG will be required to increase investment in mental health services in line with their overall increase in allocation each year, known as the Mental Health Investment Standard (MHIS).<sup>21</sup> The RCPsych Dashboard analysis revealed that 32 CCGs failed to meet the Standard in 2016-17<sup>22</sup>, 29 CCGs failed in 2017-18 and 21 planned to fail in 2018/19.<sup>23</sup>

Furthermore, our analysis of annual reports and annual accounts for NHS Trusts and Foundation Trusts in England, revealed 62% of mental health trusts (34 out of 55) at the end of 2016-17 reported lower income than the amount for 2011-12. Only one Trust saw their income rise all five financial years while nine mental health Trusts saw their income fall all five years.<sup>24</sup>

Even at a national level, NHS England has reported that not all the funding promised in *Future in Mind* has been spent in 2015/16 and 2016/17.<sup>25</sup> National funding for CAMHS should be increased and ring-fenced as a first step to ensure money reaches the frontline and is spent as intended.

Funding and commissioning of student mental health services will also be essential. Better data collection (including national census questions) would help commissioners to recognise the specific issues in relation to student mental health in their area and commission services as appropriate.

## **Links with the Five Year Forward View & Future in Mind**

The Government is committed to deliver the objectives set out in 2015’s *Future in Mind* and 2016’s *Five Year Forward View for Mental Health* (FyFV-MH). The Green Paper’s proposals must be closely aligned with both plans and built on principles already set and agreed.

However, as the objectives of the FyFV-MH have to be met by 2020/21, we call on the Government to clarify how this Green Paper will fit in with the post FyFV-MH agenda. We strongly believe that the proposals must be part of a longer-term and comprehensive mental health strategy.

## **Recommendations:**

1. *Be more ambitious in the roll-out of the proposals, following evaluation of the pilots.*
2. *Put in place a range of measures to improve recruitment and retention of multi-professional teams, including child and adolescent psychiatrists, nurses, psychologists, allied health professionals and social workers.*
3. *Include child and adolescent psychiatrists, higher trainees and speciality doctors in CAMHS on the national shortage occupation list.*
4. *Strengthen proposals to address issues in relation to early years, young people aged 18-25 years old, children with special educational needs and difficulties, children with behavioural problems and their families, children who are not in education, young people with substance misuse problems, health inequalities, connections with other parts of the system, data and research.*
5. *Ensure that the changes that take place are properly evaluated to ensure that we learn from the data generated on how best to support school-age children in the community.*
6. *Increase and ring-fence national funding for CAMHS.*
7. *Hold every CCG to account in achieving the MHIS (both including and excluding dementia and learning disability spend), and impose regulatory sanctions on CCGs who have not met the MHIS.*
8. *Ensure Mental Health Trusts' income continues to grow to reflect additional monies made available to CCGs, the forecast rise in demand on secondary mental health services, and the additional mental health workforce posts required to be in place before 2021.*
9. *Improve the accuracy of mental health data, and in particular the financial data reported by CCGs, address non-compliance in CCG data returns and take regulatory action where appropriate.*
10. *Publish the delayed Mental Health Dashboard and commit to a quarterly publication timetable for the duration of the Five Year for Mental Health.*
11. *Incorporate the Green Paper's proposals post 2021 in the next mental health strategy.*

## Mental Health Support Teams

We welcome the Green Paper's recommendation to bring schools and NHS CAMHS closer together. Teachers are usually the first people to spot a mental health condition, and schools are the most likely public service to be contacted about a mental health issue.<sup>26</sup>

### Role and remit

Given existing staff shortages and issues with recruitment and retention in CAMHS, the Government needs to clearly set out which professionals will comprise MHSTs, what their professional standards will be, who will train and supervise them, and where the funding will come from.

If clinicians are not involved in the oversight of the teams, there is a risk that there will be different standards of mental health care in NHS settings and schools. It is vital that CAMHS are embedded into MHSTs. Attention must also be paid to ensuring a common language between the health and education sectors.<sup>27</sup>

We are also concerned about the proposal that MHSTs will be expected to manage moderate disorders, as we have not seen any published evidence that this works. We believe that there needs to be very clear guidance to ensure that, when disorders start to move from mild to moderate, MHSTs understand when specialist support is needed and can refer appropriately. In addition, MHSTs may be able to deliver treatment in moderate cases, if they are overseen by clinical staff (such as a nurse, psychologist or psychiatrist) and the care pathway is approved by them.

The capacity of child and adolescent psychiatrists is already stretched and services will need more funding and capacity to be able to provide the necessary oversight and support to the newly formed teams. This needs to be addressed as part of the long-term strategy for the mental health workforce.

In order to support all children, MHSTs must link with other professionals working in adult mental health services (for older adolescents and young adults), primary care, paediatric services, job centres and employers recruiting apprentices.

### Training

Training will need to equip the teams with the ability to identify the mental health needs of vulnerable groups of children and young people, including people with neurodevelopmental disorders (such as intellectual disabilities and autism spectrum disorders) and to support them appropriately.

Training should include clear guidelines on data protection to ensure that information is shared without compromising confidentiality. MHSTs need to be able to record and share confidential patient information with local authorities and CAMHS. This will ensure a level of continuity and minimise the disruption caused by transitions.

Training should also cover the mental health related risk and resilience factors often found in school, such as bullying. A UK survey showed that 46% of school-aged children had been bullied, and the odds of suicidal ideation and attempts are more than double in young people who report peer victimisation. Bullying can affect children into adulthood with increases in the prevalence of anxiety, depression and self-harm.<sup>28</sup> It is arguably one of our most tractable public health programmes and evidence-based approaches exist to tackle it, notably whole-school approaches.

### Recommendations:

- 12. Clearly set out which professionals will comprise MHSTs, what their professional standards will be, who will train and supervise them, and where the funding will come from.*
- 13. Ensure MHSTs are integrated both within CAMHS and educational institutions, and test a model by which CAMHS would manage them.*

14. *Provide more funded staff to CAMHS so that they can offer the necessary oversight and support to the newly formed teams.*
15. *Ensure training will equip teams with the ability to identify the mental health needs of vulnerable groups of children and young people, and to refer them appropriately.*
16. *Provide clear guidance to ensure that, when disorders start to move from mild to moderate, MHSTs understand when specialist support is needed and can refer appropriately.*
17. *Ensure MHSTs help prepare young people for university life and provide appropriate support to vulnerable groups of young people before they go to university (for instance, by helping them identify and write their needs on their university application forms, and facilitate links with the relevant university support services).*

#### **Question 4:**

Trailblazer phase: A trailblazer phase is when we try out different approaches.

Do you know of any examples of areas we can learn from, where they already work in a similar way to the proposal for MHSTs?

In some areas, NHS CAMHS provide a service similar to that planned by the MHSTs, but they include a consultant psychiatrist and other mental health professionals. These intervene in a variety of settings, including schools, as well as youth services, children's centres, family homes, etc.

The Scarborough, Whitby and Ryedale CAMHS team, provided by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), works with schools, youth services and children's centres. It includes a consultant psychiatrist, an associate specialist, clinical psychologists, mental health nurses, a team manager, social workers, a learning disability nurse, a children's nurse, family therapists and administrative staff. It has a four-week waiting time target from referral to assessment. This example shows the need not to focus solely on schools and to ensure MHSTs can access a broad network of professionals.

The Trust also provides a specialist multi-disciplinary team for children and young people who have a learning disability, with a consultant intellectual disability child and adolescent psychiatrist and learning disability nurses. It will be vital to embed such specialist services into MHSTs so that vulnerable groups of children can receive the support they need.

Much of the success of these teams lies in their ability to build good local relationships with stakeholders, and a strong link with NHS CAMHS. These services must be embedded into MHSTs, so that children and young people with severe needs can be seen by a consultant psychiatrist promptly.

Importantly, previous Government initiatives – such the Mental Health Services and School Links pilots<sup>29</sup> – demonstrated the need for increased resources to ensure there is a regular presence from NHS CAMHS in schools.

#### **Question 5:**

Different organisations could take the lead and receive funding to set up the MHSTs. We would like to test different approaches. Which organisations do you think we should test as leads on this?

The College believes that NHS CAMHS could hold resources for and lead MHSTs. This should be tested in the pilots, alongside other pilots with groups of schools and local authorities leading. As NHS CAMHS will provide oversight and support to the MHSTs, they could lead them clinically and managerially. This would help avoid overlap, unwieldy management and fragmentation. There are models developing across the UK, such as that in Oxford, from which we can learn about how CAMHS and schools can work together and what they find useful.

CAMHS leading would also ensure that the MHSTs use the same record management system as their local NHS services. One of the key recommendations of the Values-Based CAMHS Commission was that we ensure that all the different services speak the same language.<sup>30</sup> As NHS record management systems are already established, it would make sense for any new teams to use these systems.

Whoever receives the funding, it needs to be protected to prevent it being spent for other purposes. Recent analysis by the RCPsych revealed 70 out of 209 CCGs spent less than planned on children and young people's mental health and eating disorders in 2016-17.<sup>31</sup>

The organisations receiving funding also need to be held to account and provide an accurate transparent record of spend to ensure the funding is spent as intended. Previous RCPsych analysis of CCGs' CAMHS spend revealed inaccuracies in the way commissioners reported their spending in the Dashboard.

#### **Question 6:**

MHSTs will work and link with a range of other professionals and we would like to test different approaches. Please identify the three most important 'links' to test in the way they would work with MHSTs.

The three most important links identified by the College are as follows.

#### **1. Child and Adolescent Mental Health Services (CAMHS)**

As already stated above, if clinicians are not involved in the oversight of the MHSTs there is a risk that there will be different standards of mental health care in NHS settings and schools. It is vital that CAMHS are embedded into the teams.

The capacity of child and adolescent psychiatrists is already stretched and services will need more resources to be able to provide the necessary oversight and support to the newly-formed teams.

#### **2. Local authority children and young people's services**

Links and good relationships with local authorities will be crucial, as they can provide public health advice and expertise on how to reduce health inequalities.

#### **3. School-based counsellors, school nurses and educational psychologists**

All of these professionals play a crucial part in supporting young people with mental health problems. As suggested in the Green Paper, the Government must test a range of models to ensure MHSTs collaborate with these professionals.

There could be an unintended consequence of loss of school psychological support. Some schools might choose to no longer employ their counsellor if they perceive MHSTs as playing a similar role. In order to mitigate this risk, there needs to be clear guidance stating what minimum mental health and/or pastoral support team must be available within each school in order for the MHST model to succeed.

Recent data published by NHS Digital revealed that numbers of school nurses (full-time equivalent) declined by 20.7% between November 2009 and November 2017.<sup>32</sup> We support the Royal College of Nursing's call on the Government to provide local authorities with the funds needed for fully-staffed school nursing services.<sup>33</sup>

In order to support all children, MHSTs must link with other professionals working in adult mental health services (for older adolescents and young adults), primary care, paediatric services, job centres and employers recruiting apprentices.

### Question 7:

MHSTs and Designated Senior Leads for Mental Health in schools and colleges will work closely together, and we will test this working through the trailblazer phase. Out of the following options how do you think we should measure the success of the trailblazer phase? Please pick your top three.

The College identified the following options to measure the success of the trailblazer phase.

- **The impact on children and young people’s mental health**  
The decisive test of the proposals would be an evaluation of whether the mental health of the children and young people has improved as a direct result of the implementation of the proposals. This could be properly undertaken by a call for research by the National Institute for Health Research (NIHR), linked to the pilot phase.
- **The effectiveness of interventions delivered by MHSTs**  
The Government must evaluate whether resources are used to good effect. A cost-effectiveness analysis could be carried out to compare the relative costs of interventions to a chosen measure of outcome. This could be included in the NIHR’s call for research mentioned above.
- **The numbers of children and young people getting the support they need**  
The Green Paper’s proposals could be expected to lead to an increase in the number of young people getting the support they need.

### Question 8

When we select areas to be trailblazers for the Mental Health Support Teams, we want to make sure we cover a range of different local factors. What factors should we take into account when choosing trailblazer areas?

To begin with, we would like the Government to clarify the application process to become trailblazers (including timeline), and to ensure decisions on applications will be fair and transparent.

Safeguards must be put in place to ensure that trailblazers do not displace resources for children and young people’s mental health and staff working in CAMHS in other areas. If not done properly, there is a risk that deprived areas will become even more deprived. In order to minimise this risk, we recommend that the evaluation tracks resources and staff movements across the country. Regular interim reports of the findings should be published so that the Government can take appropriate action as rapidly as possible.

We believe trailblazers need to include:

- Areas where there is already good practice, as well as areas who are struggling but keen to improve;
- Urban areas as well as rural areas;
- Deprived areas as well as non-deprived areas;
- Areas with high levels of health inequality.

The ‘trailblazer approach’ should also focus on children and young people with the greatest needs and should be tailored to respond to these needs.

It will be crucial to evaluate how the proposals affect vulnerable groups of children, such as children with neurodevelopmental problems (including ADHD, autism spectrum disorders and intellectual disabilities), children with long-term health conditions, children with behavioural difficulties, looked-after-children, young carers, refugees and migrant children, children with a first language other than English, children in the criminal justice system, young People Not in Education, Employment or Training (NEETs), abused children, LGBT children.

### Question 9:

How can we include the views of children and young people in the development of MHSTs?

Co-production is a critical aspect of delivering high-quality mental health care. It is vital that children, young people and their families are truly involved in the development of MHSTs, and remain so *throughout the entire process*. Engagement activities should be used to find out what they want from the service and how they wish to be treated, what kind of support they feel the MHSTs could provide, how services should be designed, and how staff should be recruited and trained.

We would strongly encourage local stakeholders to adopt a 'value-based approach' to clearly understand 'what matters' or 'what is important' to all those concerned, including children and young people. Values-based practice is key to supporting balanced decision-making between stakeholders within a framework of shared values.<sup>34</sup>

It will be important to engage with children and young people from mainstream primary and secondary schools, but also children and young people from schools for children with emotional, behavioural and social difficulties, special schools, Young Offender Institutions, private schools (including residential special schools), Pupil Referral Units, NHS CAMHS, NHS Learning Disability CAMHS and eating disorder services. NEET young people may have to be engaged through networking with key stakeholders, such as colleges, youth centres, third sector, and other providers that have direct contact with young people.

This will help engage with different groups of vulnerable children and young people, 'at risk' young people and young people who may find it hard to volunteer. Families, carers and third sector agencies also need to be engaged, especially when tailoring these services for children with complex needs.

Engagement activities need to take place in different areas (urban, rural, affluent, deprived) across the country. We believe views should be collected outside the classroom, so that children and young people feel they can express themselves openly. Engagement with current university students on their experiences at school would also help inform future mental health care.

Engagement methods could include:

- Focus groups, advisory groups or task groups
- Individual interviews
- Surveys and questionnaires, including the Experience of Service Questionnaire (ESQ) or Family and Friends Test (FFT)
- 'Brain storming' sessions to generate ideas, possibly led by an agency such as YoungMinds or PlacetoBe; as well as charities such as ADDISS, the National Autistic Society, Mencap and Scope for their relevant groups of children
- Anonymous feedback.

All engagement methods will need to be adapted depending on the needs of participants. For instance, engaging with young people with a learning disability require adjustments in relation to the tone of voice, body language and words used. Charities such as Mencap provides tips for communicating with people with a learning disability.<sup>35</sup>

A subset of children and young people may be selected to further represent their views and participate more fully throughout the process (i.e. in recruitment, training, ongoing relationship building). This subset should be representative. In this way, children and young people will be aware of MHSTs from the start, which will ensure that they are used to their full capacity.



## Piloting a waiting time standard

The four-week waiting time is a bold and welcome ambition; however, properly supporting children with mental health issues goes beyond 'access'.

We support the proposal to pilot the four-week waiting time standard before rolling it out. Any evaluation of the pilot should look at the waiting time between first assessment and starting treatment, which professional does the first assessment, the access criteria to CAMHS, the number and types of referrals declined and why, the ratio of staff in each CAMHS team delivering assessment and treatment, and the ratio of referrals to discharges from each CAMHS team. This should ensure children get a quality assessment and are not left in limbo after a first appointment.

It is crucial that the new waiting time target does not become the focus at the expense of the quality of the service provided. There is a risk that the new waiting time target leads to increased access thresholds. Providing more resources and funded staff to CAMHS and other services would help prevent this new standard from creating perverse incentives.

There is very little detail in the impact assessment on the logistics of the four-week waiting time standard. After the pilot, there needs to be much greater information on either how it will be implemented, or an alternative solution to stop children waiting too long to access healthcare.

Achieving the waiting time target will depend on the provision of other services impacting on children and young people, and in particular social care services. Members told us that some young people with social care needs are inappropriately referred to specialist CAMHS due to the lack of social care support available. In order to achieve the target, CAMHS must be used appropriately, hence the need to enhance system-wide local offers.

Given the wide variation in access to CAMHS across the country, providers and commissioners will need guidance if they are to meet the new waiting time target. We urge NHS England to publish the mental health care pathways with recommended response times and accompanying standards, as agreed in the Five Year Forward View for Mental Health Implementation Plan<sup>36</sup> and developed by the National Collaborating Centre for Mental Health.

While only a few areas are piloting the four-week standard, *all* areas should publish waiting time figures. This transparency is crucial to allow benchmarking of local services at national level, drive improvements in outcomes and hold providers and commissioners to account on access to services in the future. These figures must be published alongside needed and actual workforce needs, as the target could become a punitive measure for teams that might be lacking 50% of their staff.

### Recommendations:

- 18. Ensure that any evaluation of the pilot looks at: the waiting time between first assessment and starting treatment, which professional does the first assessment, the access criteria to CAMHS, the number and types of referrals declined and why, the ratio of staff in each CAMHS team delivering assessment and treatment, and the ratio of referrals to discharges from each CAMHS team.*
- 19. Ensure that local sites bring a whole-system approach to testing the standard, including a system to ensure data can flow easily and safely between different systems and providers.*
- 20. Routinely publish information on waiting time figures in all areas, not just the piloted areas, alongside needed and actual workforce numbers and number of referrals declined.*
- 21. Publish the delayed mental health care pathways for children and young people's mental health services, including the recommended waiting times (developed by the National Collaborating Centre for Mental Health and commissioned by NHS England).*

**Question 10:**

Waiting time standards are currently in place for early intervention for psychosis and for eating disorder services.

Outside of this, are you aware of any examples of local areas that are reducing the amount of time to receive specialist NHS help for children and young people's mental health services? Can we learn from these to inform the waiting times pilots?

Please give your example(s) below.

With the number of consultant child and adolescent psychiatrists falling by 6.9% in the last four years<sup>37</sup>, reducing the amount of time children and young people wait to receive specialist treatment is incredibly challenging.

The services provided by Tees, Esk and Wear Valleys NHS Foundation Trust (described in response to Question 4) have a four-week waiting time target from referral to assessment. Professionals do everything possible to meet this target and manage to assess children and young people quickly. However, once assessed some young people go onto another waiting list for treatment which can take up to two years, due to the lack of workforce.

This demonstrates the need for any evaluation of the pilot to look at:

- The waiting time between first assessment and starting treatment
- Which professional does the first assessment
- The access criteria to CAMHS
- The number and types of referrals declined and why
- The ratio of staff in each CAMHS team delivering assessment and treatment
- The ratio of referrals to discharges from each CAMHS team.

This should ensure children get a quality assessment and are not left in limbo after a first appointment.

## Schools and colleges

Much of the success of the Green Paper depends on every school having a Designated Senior Lead for Mental Health. We are concerned that this role will be voluntary.

We know from experience that tensions between mental health and other school priorities have prevented schools and education services from placing resources into mental health provision.<sup>38</sup> In addition, previous voluntary initiatives such as the Social and Emotional Aspects of Learning (SEAL) programme accentuated inequality because engaged schools took full advantage of the evidence-based information provided, while disengaged schools remained static and became comparatively worse as the engaged schools improved.

Having a Designated Lead for Mental Health in every school is as important as having a named person for safeguarding children and young people. The Designated Safeguarding Person role has been made mandatory, and we believe the Designated Lead for Mental Health role deserves the same. However - based on the SEAL programme evaluation<sup>39</sup> - resources and time have to be made available to allow schools and Leads to engage fully in the implementation of the Green Paper's proposals.

### Training

We are also concerned that schools will be able to choose their own training course depending on the 'skills their lead already has'.<sup>40</sup> Correctly identifying a mental health problem and its severity is not an easy task. Training needs to be the same for all schools to ensure it is high-quality, regularly updated and consistent across the country.

Although half of schools already have a Designated Mental Health Lead, the number of inappropriate CAMHS referrals remains high. This may suggest that, in some areas, Leads do not receive adequate training to make appropriate referrals to CAMHS. We must ensure that every Lead has the same level of knowledge. If Leads are not adequately trained to make appropriate referrals to MHSTs or NHS CAMHS, then there could be additional pressure placed on already stretched services and professionals.

We recommend that three different models of training are trailed and evaluated, so that we can learn from these different approaches and confidently move forward knowing that the training corresponds to what Leads need. Psychiatrists could provide valuable expertise in the designing phase of the training.

The Green Paper is also an opportunity for improved collaboration between education and health sectors, which could be enhanced by mutual contributions to training: in addition to providing training for Leads and teachers, mental health professionals would benefit from specific training to become familiar with the school context. Some practice guidelines have already been developed<sup>41</sup>, but we believe more could be done. For instance, NHS mental health trainees could be given opportunities to work more closely with schools in order to increase their appreciation of the school context and develop consultation-liaison skills.

The CCQI Quality networks for Inpatient and Community CAMHS provide an inspiring learning and standard development model, whereby educational and unit staff support the young person to reintegrate back to their local educational facility.<sup>42</sup>

### Whole-school approaches

The Designated Lead for Mental Health role must run concurrently with a broader, systemic approach, which starts with a minimum standard of mandatory mental health training in the Postgraduate Certificate in Education (PGCE).

Training for teachers should include:

- Child development
- The factors that can affect children's mental health and associated behaviour such as anger and disruptive behaviours

- How to understand and support children going through grief and bereavement
- Mental health screening and identification of common presentations of mental health issues
- Mental health promotion skills and classroom behaviour management strategies – which would help teachers approach emotional and behavioural challenges in their classrooms.

With schools feeling real pressures on their resources, MHSTs need to have the ability to support and train teaching staff and change attitudes as part of the whole-school approach. Training for teachers is all the more important as difficulties with behavioural management can negatively affect teacher-pupil relationships and the classroom environment, which might damage teacher and child mental health. The use of MindEd<sup>43</sup> by school staff, including support staff, should be evaluated as it is an approach that holds promise.

In addition, we call on the Government to make the whole of Personal, Social, Health and Economic (PSHE) programme mandatory from 2019 for all pupils, in all schools. We strongly believe that within this mental health and emotional wellbeing should be required components of the PSHE curriculum for every age group. PSHE forms a vital part of a whole school approach to mental health. It helps develop the knowledge, skills and attributes that all pupils need to keep mentally and physically healthy, safe and prepared for life and work.

PSHE also helps to tackle mental health-related stigma, as it will support pupils to disclose issues and seek professional help when necessary. Statutory status should maximise opportunities for teachers to receive high-quality training to increase the potential for positive impacts on pupils' mental health.

### **Good practice sharing / learning**

Designated Senior Leads in schools should share best practice with other local schools about how to best help children with their wellbeing and mental health. We would like to see a system where Leads in one geographical area can work together to form a 'cluster'.

One of the main benefits reported in the Mental Health Services and Schools Link Pilot was sharing knowledge and good practice.<sup>44</sup> The evaluation of the TAMHS programme showed that '*when implementing interventions [...] on a large scale, it may be of benefit to determine beforehand how best to avoid displacing existing support [...], for example by not requiring that provision be "innovative" or "new" and rather allowing areas to draw on existing good practice*'.<sup>45</sup>

Clusters should be an open forum for learning from each other's successes and pooling resources where necessary. These should have a single point of contact with NHS CAMHS for children requiring intensive support.

Universities across the UK could also learn from those universities that adopted mental health as a strategic priority, implementing a whole university approach, with students and staff involved at all stages of the journey. This is known as the 'step change framework'.<sup>46</sup>

Community CAMHS across the country should also be encouraged to join the Quality Network for Community CAMHS (QNCC) which works with professionals from health, social services, education and the voluntary sector to improve the quality of services. Current members find the network particularly useful to demonstrate the quality of the service to young people, parents and carers and cost-effectiveness to commissioners. They also praise the opportunity to share best practice with CAMHS professionals across the UK.

### **Recommendations:**

*22. Make the Designated Lead for Mental Health role mandatory for schools and colleges to give the Green Paper proposals the best chance of success.*

*23. Ensure training is high-quality, regularly updated and consistent across the country.*

24. Make a) the whole of Personal, Social, Health and Economic mandatory from 2019 for all pupils, in all schools, and b) mental health and emotional wellbeing required components of the PSHE curriculum for every age group.

**Question 11:**

Schools publish policies on behaviour, safeguarding and special educational needs and disability. To what extent do you think this gives parents enough information on the mental health support that schools offer to children and young people?

College members indicated that while some parents receive information, too many do not receive the information they need.

The MindEd<sup>47</sup> platform could be expanded to provide parents with information on mental health support provided in schools. All MindEd learning is online, free, and can be used to support more detailed training programmes.

**Question 12:**

How can schools and colleges measure the impact of what they do to support children and young people's mental wellbeing?

Schools and colleges need a clear and transparent process for measuring outcomes and evaluating the impact of their actions to support children and young people's mental wellbeing. This process should be implemented from the start of any plans or actions, and be made known to all staff, students, families and carers. Children and young people should be involved throughout.

Measuring the impact of implementing mental health and wellbeing strategies in schools and colleges should be a multi-faceted process to accurately capture data across more than one area, including the following.

- Educational outcomes:
  - Attainment outcomes / performance
  - Exclusion rates (fixed term and permanent exclusion as well as managed moves)
  - School attendance and participation
  - Absence and reasons for absence
  - 'Incidents' be that discipline, violence, bullying.
- Mental health and wellbeing factors:
  - Pupils' wellbeing
  - Parental opinion, child opinion of their own mental health (these would all need to be modified and made appropriate for children with intellectual disabilities and difficulties).
  - Quantity and/or quality of referrals to local CAMHS or other services
  - Range of services contacted
  - Patient routine outcome measures during and after any intervention
  - Clinician or staff reported outcomes, and other relevant clinical or non-clinical measures that can clearly demonstrate change over time associated with a particular activity.

There are different ways and tools that can be used to collect these data, including self-report tools, screening tools, anonymous surveys, interviews, small focus groups, open forums, questionnaires (such as the Strength and Difficulties Questionnaire) or through school councils.

Importantly, the Government needs to put measures in place to ensure that school / college governors and headmasters are held to account for putting impact evaluation and engagement with children and young people on their agenda.

## Vulnerable groups

### Question 13:

In the development of the MHSTs, we will be considering how teams could work with children and young people who experience different vulnerabilities. How could the Support Teams provide better support to vulnerable groups of children and young people?

There are many different 'groups' of vulnerable children and young people. Children with neurodevelopmental problems (including ADHD, autism spectrum disorders and intellectual disabilities), children with long term health conditions, children with behavioural difficulties, looked-after-children, young carers, refugees and migrant children, children with a first language other than English, children in the criminal justice system, young People Not in Education, Employment or Training (NEETs), abused children and LGBT children are all vulnerable.

Providing better support for vulnerable groups can occur in a number of ways, and include the following.

- Involving these children, their families and carers, and other relevant stakeholders (such as social services teams, youth offending teams, schools' pastoral teams, charities...) in the planning and delivery of mental health care in schools and colleges. It will be important to engage with these groups in a way that is not stigmatising.
- Providing MHSTs with specialist knowledge to work across multiple schools. For instance, they may need the expertise of a consultant intellectual disability psychiatrist to support a child with a learning disability and mental health needs.
- Allocating MHSTs to 'virtual schools' to offer additional support to looked-after children.
- Including equalities, health inequalities and cultural competence as part of the routine training and supervision of all professionals working with children and young people.
- Investing in specialist resources as appropriate. Using alternative means of communication (such as visual tools, large text, braille or other communication aids), and using translators and interpreters for those whose preferred language is not English.
- Having clear multi-agency agreements in place across services to ensure consistent and coordinated care. Actively engaging with local CAMHS to support joint appointments. Ensuring flexibility in where and when mental health care is delivered.
- Using a whole-school Strengths and Difficulties Questionnaire measurement, correlated with home measurement, with consent to track progress with these groups.
- Offering support to young people from vulnerable groups *before* mental health issues arise. For example, young people going through bereavement could be involved with the Mental Health Support Team to help them process and deal with their emotions rather than them having to deal with these alone which could lead to unhealthy coping mechanisms or mental illness.

### Question 16:

As we are rolling the proposals out, how can we test whether children and young people with special educational needs or disability are able to access support?

We believe that the Education, Health and Care Plan (EHCP) and updates should be part of the Mental Health Services Data Set (MHSDS). This means it will need to be completed using SNOMED CT codes, which is a structured clinical vocabulary for use in electronic health records, and the lexicon the MHSDS uses. It is known as the most comprehensive and precise clinical health terminology product in the world.

## Providing evidence for an Impact Assessment

The Impact Assessment provides some helpful information and details that are not included in the Green Paper. Nonetheless, we identified some gaps and areas that could be strengthened.

For instance, the current impact assessment is not systemic, as the impact on services such as local authorities' social services or youth justice services have not been factored in and costed.

Moreover, there is very little detail on the logistics of the four-week waiting time standard. After the pilot, there needs to be much more information on either how it will be implemented, or an alternative solution to stop children waiting too long to access healthcare.

Most importantly, the Impact Assessment document shines a light on the lack of data, leading the Government to make many assumptions, such as:

- P.2: *'We have assumed that in the 'do nothing' scenario, prevalence of CYP with diagnosable mental health disorders will remain at the last recorded level (measured in 2004), due to an absence of robust population level evidence'.*
- P.3: *'We have assumed that any extra workload burden on CYMPHS will be absorbed by the expansion set out in Mental Health Support teams'.*
- P.4: *'We have assumed that 60% of children with a diagnosable mental health condition who are not currently referred to CYPMHS would benefit from some form of specialist treatment, and that 60% of those would receive specialist support from the new Mental Health Support Teams. We have also assumed that half of the CYP receiving a CYPMHS assessment, but who do not meet the threshold for CYPMHS treatment, would instead receive specialist support through the teams. There is a lack of evidence around the number of CYP who have low level mental health needs (but do not have a diagnosable mental health disorder) who currently would not be referred to CYPMHS but would likely be supported by the Mental Health Support Teams'.*

This emphasises the need to urgently invest in data collection, analysis and research. While we welcome the commitment to publish a new prevalence survey in 2018, we call on the Government to fund follow-up research to explore the outcomes of the care children receive from this survey. Longitudinal data offers the opportunity to track change over time, while repeated surveys only offer a snap shot.

### Question 20:

Please provide any evidence you have on the impact of Children and Young People Mental Health Services therapeutic treatments.

Good specialist mental health can save lives. By helping children early on, we can help prevent a lifetime of problems.

- In a prospective study of all new children and families attending UK CAMHS for assessment and/or treatment over nine months, the majority of parents or carers reported the help offered to be appropriate and two thirds noted improvement in the problem leading to referral. A similar percentage of referrers thought the assessment had met the referral aims.
- CAMHS clinicians themselves reported improvements in 72% of attenders and this was confirmed by significantly improved symptom scores in the children and young people, using clinician and user validated measures.<sup>48</sup>

CAMHS therapeutic treatments include a variety of biological and psychological treatments which have been reviewed by NICE guidelines. Examples of randomised control trials showing clear evidence of therapeutic benefit include:

- A multi-arm randomised controlled trial of nearly 500 children and young people with anxiety disorders showed that 80% of those receiving a combination of medication and psychological treatment were very much or much improved on a measure of global impairment - compared with 23% improved on pill placebo.<sup>49</sup>
- A randomised trial showing attention deficit hyperactivity disorder responds to stimulant medication.<sup>50</sup>
- A trial showing the impact of parenting programmes on conduct problems.<sup>51</sup>

These trials are just examples of a larger evidence base available, which could be even stronger with adequate investment. Despite the WHO calling for parity between research in child and adult mental health, research funding for children and adolescents is less than 30% of the overall mental health spend, which is already less than spending on physical health<sup>52</sup>.

With the evidence about effectiveness of treatments available, it is disappointing that the Green Paper does not include a wider plan to invest in CAMHS. The impact assessment of the Green Paper predicts that at least in the short term the introduction of MHST will lead to an increase in demand for CAMHS creating a real need for more community CAMHS psychiatrists.

There has been a 6.9% fall in consultant child and adolescent psychiatrists since 2013 and, while HEE are planning to recruit an extra 100 consultant CAMHS Psychiatrists by 2021, it does not seem that they will be working in community CAMHS teams.

We call on the Government to:

- Put in place a range of measures to improve recruitment and retention of multi-professional teams, including child and adolescent psychiatrists, nurses, psychologists, allied health professionals and social workers.
- Include child and adolescent psychiatrists, higher trainees and speciality doctors in CAMHS on the national shortage occupation list.



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