Children and Young People's Mental Health: Time to Deliver

The report of the Commission on Children and Young People's Mental Health

Emily Frith

November 2016

EDUCATION POLICY INSTITUTE

Children and Young People's Mental Health:
Time to Deliver

The report of the Independent Commission on Children and Young People's Mental Health

Emily Frith

About the author

Emily Frith is the Education Policy Institute's Director of Mental Health and Rehabilitation. Prior to this she was Special Adviser to the Deputy Prime Minister, with responsibility for Health and Welfare policy from 2013 to 2015. During this time, she coordinated on behalf of the Deputy Prime Minister the campaign to improve mental health services. Emily has also worked for the Prison Reform Trust on support for people with mental health problems in the criminal justice system, and the Driver Youth Trust on the identification and support for children with special educational needs. From 2005 to 2009, she was External Affairs Manager for Turning Point, the social care organisation which provides services for people with a substance misuse problem, a mental health problem or a learning disability.

About the Education Policy Institute

The Education Policy Institute is an independent, impartial and evidence-based research institute that aims to promote high quality education outcomes, regardless of social background.

Education can have a transformational effect on the lives of young people. Through our research, we provide insights, commentary and critiques about education policy in England - shedding light on what is working and where further progress needs to be made. Our research and analysis will span a young person's journey from the early years through to higher education and entry to the labour market. Because good mental health is vital to learning, we also have a dedicated mental health team which will consider the challenges, interventions and opportunities for supporting young people's wellbeing.

The core research areas include:

- Accountability and Inspection
- Benchmarking English Education
- Curriculum and Qualifications
- Disadvantaged, SEND, and Vulnerable Children
- Early Years Development
- School Funding
- School Performance and Leadership
- Teacher Supply and Quality
- Children and Young People's Mental Health
- Education for Offenders

Our experienced and dedicated team works closely with academics, think tanks, and other research foundations and charities to shape the policy agenda.

Children and Young People's Mental Health Commission

The Education Policy Institute established an Independent Commission on Children and Young People's Mental Health in December 2015. Chaired by former Mental Health Minister Rt. Hon. Norman Lamb MP, the Commission aims to understand and explore progress in transforming children and young people's mental health services in England. The other Commissioners are:

- Roy Blatchford, Director, National Education Trust
- Sarah Brennan, Chief Executive, Young Minds
- Professor Tanya Byron, clinical psychologist, writer, broadcaster and government advisor
- Kat Cormack, mental health consultant
- Jacqui Dyer, adviser to Department of Health and NHS England, service user and carer
- Professor Peter Fonagy, Chief Executive, Anna Freud Centre, London
- Dr Lise Hertel, GP, Clinical Lead for Mental Health, NICE, Newham CCG
- Tim Horton, Health Foundation, former advisor to Ed Miliband MP
- Dr Charlie Howard, Founder, MAC-UK
- Dan Mobbs, Chief Executive, MAP, advice and counselling service, Norfolk and Norwich
- Rt Hon. Nicky Morgan MP, former Secretary of State for Education

Contents

Foreword by Rt Hon. Norman Lamb MP

There is a strong moral and economic case for investment in improving the wellbeing of our children and young people. The long term cost to our economy of mental health problems has been estimated to be as high as £105bn per year[1] and three quarters of these problems emerge by the age of 18.[2] That's why in government, along with coalition colleagues, I launched *Future in Mind*,[3] a strategy to improve access to care by additional investment of £250m a year by 2020.

This is the third and final report of the Education Policy Institute's Mental Health Commission. The Commission was established to understand and explore the progress and barriers relating to the transformation of children and young people's mental health in England, since the publication of *Future in Mind*. Our research over the last year has uncovered a treatment gap, where specialist services are turning away one in four of the children referred to them by their GPs or teachers for treatment. We also found wide variation in waiting times once a young person has been accepted into the service.

In exploring progress so far, we welcome the hard work being undertaken across the country by many local health and care leaders. We also raised concerns that it is not possible to identify whether the funding has reached frontline services and noted variation in the quality of local plans to improve care, finding that only 15 per cent of plans were of good quality on a series of five key measures devised by the Commission.

In this report we set out the Commission's policy recommendations for government and our checklist for frontline commissioners, based on our research and experience of what will help to increase access for young people to high quality care. The country has started a journey to improve mental health services for young people and to move towards equality between mental health and physical health services. It is vital that we retain this focus in the years ahead.

Rt Hon. Norman Lamb MP

---

1   The Five Year Forward View for Mental Health, NHS England, 2016 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FY-FV-final.pdf
2   https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health
3   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Executive Summary

The Education Policy Institute has identified that specialist mental health services are, on average, turning away 23 per cent, or almost one in four, children and young people referred to them for treatment by their teachers or GPs. We also identified a postcode lottery of waiting times for those whose referrals were accepted.

The Institute's investigation into progress and challenges in the transformation of children and young people's mental health care has found wide variation in the quality of local strategies. Under our scoring system, only 15 per cent of local areas were found to have 'good' plans. We also identified significant barriers to progress. For example, 8 out of 10 providers face recruitment difficulties, and there has been an 80 per cent increase in expenditure on temporary staffing in the last two years.

New data has since provided further evidence of a 'treatment gap'. According to NHS England's own analysis of local transformation plans:[4]

New government guidance on eating disorders was released in July 2015, alongside the new investment in children's mental health.[5] The NHS England analysis of transformation plans this year found that only 16 per cent of areas had eating disorder services which met the new guidelines. Only 18 per cent of areas were meeting a 4 week waiting time for routine cases. Only 14 per cent of areas were meeting one week waiting times for urgent cases.

Additionally, according to the Adult Psychiatric Morbidity Survey published this autumn,[6] **two thirds (66.9 per cent) of young people aged 16-34 who had attempted suicide had not subsequently received medical or psychological help.** Older age groups were more likely to receive help, for example the same figure for over 55s was 47 per cent.

Qualitative research findings

In September and October 2016, the Education Policy Institute undertook four research visits to complement our quantitative analysis and desk research with further qualitative evidence of the progress and challenges in implementing change on the ground. We identified ten themes from these discussions:

1. Prioritisation

Children's mental health was often being identified as a local priority by healthwatch organisations, MPs and council Overview and Scrutiny Committees, which provided means of holding local commissioners to account. There is a risk, however, that the NHS Sustainability and Transformation Plans (a national programme of planning for NHS redesign over the next five years) is distracting attention from the children and young people's mental health transformation process.

2. Rising Demand

Many of the young people's mental health services we visited were experiencing increasing demand. For example, in Essex the number of referrals had more than doubled in a year, from 3000 to 7000 open cases. The new national survey data on the prevalence of children and young people's mental health problems, which will become available in 2018 will provide national and local data to capture where this increased demand is occurring and therefore provide evidence for increased capacity.

3. Partnership working

Our research visits highlighted the complexities of partnership working across the child and adolescent mental health system. Local health and care leaders had to overcome barriers such as overlapping geographical boundaries and different financial, procurement and governance timescales and protocols.

4. Early Intervention

---

4   Children and young people's mental health Local Transformation Plans – a summary of key themes, July 2016, NHS England
5   https://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf
6   Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014, NHS Digital, September 29, 2016

Specialist mental health services are part of a wider system of early intervention support and universal services such as schools and GP surgeries. In some areas, innovative integrated models are being developed on a 'no wrong door' approach, where easy access, drop-in centres were part of the overall service delivery. Our analysis of local transformation plans in our second report and NHS England's own analysis, outlined in detail in this report, indicates that this approach is not being replicated in many areas across the country.

5. Workforce Development

Our new research supported our previous findings that workforce difficulties are a key barrier to the implementation of the vision set out in *Future in Mind*. In addition to the recruitment problems outlined in our second report, a major finding of our research visits was that changing the culture in existing services, or with staff transferred from previous services, was a particular challenge and one which could benefit from further focus in the government's forthcoming workforce strategy.

6. Involving Children and Young People

The research visits enabled the Commission to identify some of the benefits of involving children and young people in service design and delivery as well as some of the key challenges to this involvement. Designing services in partnership with children and young people means that they are more likely to use the services and benefit from them. The process of involvement can also be beneficial to young people's wellbeing. Some of the challenges to this included barriers in communication across generations and the transient nature of children's lives. Commissioners sometimes struggled to involve young service users because they did not have access to them in the same way that providers do.

7. Education

Engagement with schools was a recurring concern within local services. There were a range of barriers to effective engagement, such as the recent changes to the education system, with a reduced role of local authorities and a proliferation of multi-academy trusts, each with different governance structures. This made it difficult for health staff to know how best to engage with schools. Nevertheless, we identified some examples of promising practice. For example, in Oxfordshire child and adolescent mental health workers run weekly sessions within all secondary schools.

8. Delivery

The research visits provided interesting insights into how local areas were ensuring progress on transformation. Access to good quality data and setting clear objectives were critical elements for successful teams. Those areas which had already been planning improvements before the publication of *Future in Mind,* had been able to progress more quickly. A recurring theme from the visits, however, was the length of time it takes to achieve change. Our analysis of local transformation plans in August 2016 highlighted that the level of ambition in local areas was highly variable. Data from NHS England's analysis also highlights this problem: one in five areas have or are extending online emotional support and counselling. In our research visits we identified some promising practice, such as Essex's development of a mental health app for service users. We also found that those areas who had very ambitious plans, emphasised the length of time it takes to embed new systems and working practices.

9. Transition

Many of the areas we visited were still challenged by the process of young people transitioning to adult services at the age of 18. While transition protocols were often in place, they were not always being followed and there was variable partnership working with adult services. In Birmingham, they had moved the age of transition to 25 but recognised that a smooth process was still important at the new transition point.

10. National Policy

Finally, our research explored the impact of national policy levers on the transformation process. **For example, we heard concerns that the decision not to ring-fence the funding for children's mental health, including it into wider health budgets, was putting the transformation process at risk.** This highlighted the importance of retaining children and young people's mental health as a national priority over the next five years and after 2020.

Policy Recommendations

In this report, the Commission on Children and Young People's Mental Health sets out its policy recommendations to improve the process of transforming services based on our research over the past year. The Commission proposes that the Prime Minister should announce a **National Challenge on Children's Mental Health**, making it a key priority of her administration. This would include:

1. Prevention

1. A sustained focus on **raising awareness and reducing stigma**.

2. An easy to understand web-based **parenting guide for all parents**.

3. The establishment of a **Mental Health Research Institute**[7] in order to fund research into understanding mental health, new treatments such as talking therapies or better medication, and develop the evidence base for effective interventions.

4. A strategy to **empower young people to live safe digital lives.** This should focus on developing young people's resilience and critical thinking skills in the face of online threats, given the impossibility of eliminating all online risk. It should cover threats such as excessive internet use, child protection, websites promoting suicide, self-harm or eating disorders (e.g. pro-ana and pro-mia sites that promote anorexia or bulimia[8]) and cyber-bullying.

2. Early Intervention

1. **Nationally kite marked,[9] easy to access[10] (by drop-in, or self-referral, with no thresholds) services in every area**.

2. A high profile, national government programme to ensure **a stronger focus on mental health and wellbeing within schools**. This should include:

7　The PM's Challenge on Dementia 2020 announced that an international dementia institute will be established in England – the Spending Review and Autumn Statement 2015 confirmed that up to £150 million will be invested to launch a competition for a Dementia Institute. The Australian government established a Centre of Excellence in Youth Mental Health with responsibility for research, training, skills and workforce and service development.

8　A 2006 survey of eating disorder patients at Stanford Medical School found that 35.5% had visited pro-ana web sites; of those, 96.0% learned new weight loss or purging methods from such sites. Wilson, Jenny; Peebles, Rebecka; Hardy, KK; Litt, IF; Wilson, J L (De-cember 2006), "Surfing for thinness: A pilot study of pro-eating disorder web site usage in adolescents with eating disor-ders", Pediatrics, 118 (6): e1635–e1643,doi:10.1542/peds.2006-1133, PMID 17142493

9　There is also good evidence on the real difference that can be made to children's life chances by intervening at the very first sign of deterioration, and on what has the best chance of improving outcomes for those who develop a diagnosable mental health problem (Patel, et al., 2007; Social Research Unit, 2013; Khan, et al., 2015).
See Australian Headspace model: Over half of adolescents (54.4%) with mental health problems had heard of it (based on national survey of young people). 65% of parents of those with mental health problems had heard of it. The programme supports a third of secondary schools in Australia. 80% of young people wait two weeks or less for help. Outcome data after two years includes 61% improvement, 50% 'reliable improvement' and 42% improvement over clini-cal threshold (recovery). Service has also been inde-pendently evaluated: https://headspace.org.au/assets/Uploads/Corporate/Publications-and-research/final-independent-evaluation-of-headspace-report.pdf
See also Jigsaw programme in Ireland. Early analysis indicates participants reported high levels of psychological distress pre-intervention and levels were sig-nificantly lower post intervention: https://www.cambridge.org/core/journals/irish-journal-of-psychological-medicine/article/description-and-outcome-eval-uation-of-jigsaw-an-emergent-irish-mental-health-early-intervention-programme-for-young-people/820D6F3F7845761D9711A9741C62FFEA
UK evidence from Youth Access: 17% of youth advice agenices had GHQ-12 scores that indicated severe mh issues (scores of 11 or 12), compared with 2.6% of the general population. The unit cost of youth advice services ranged from £61 to £120 per individual young person advised. Estimate dsavings in GP costs alone equate to £108,108 per 1000 clients or £108 per young person – exceed-ing the costs involved. Youth Advice: a mental health intervention? Youth Access, November 2012.

10　What good looks like in psychological services for children, young people and their families, The Child and Family Clinical Psychology Review, No 3 Summer 2015. Edited by Julia Faulconbridge, Duncan Law and Amanda Laffan. http://shop.bps.org.uk/publications/publication-by-series/child-and-family-clinical-psy-chology-review-no-3-summer-2015.html.

- **Evidence-based training for teachers[11]**
- A **trained lead for mental health and wellbeing in every school**, college and university.
- **Schools, colleges and universities adopting** the WHO recommended Whole School Approach model.[12]
- **Within its existing framework categories, Ofsted having regard to wellbeing in any inspection of a school or college**.
- **Mandatory updated high quality, statutory PSHE** in all schools and colleges, with dedicated time for mental health.

3. A clear strategy to improve access to the right care for young people with mental health problems from a variety of communities.

3. Delivering better treatment

1. **Areas should not receive their annual share of the additional £1.4bn unless** they can demonstrate that they have robust plans to improve care and all the additional funding is being spent on children's mental health and not offsetting cuts elsewhere. This should include an audit of progress in delivery of their initial local transformation plan and expenditure in 2015/16 and 2016/17.[13]

2. The strategy should **set a series of ambitious goals for care**, including that no one should wait more than eight weeks for routine treatment (the current average waiting time across services).

3. The Government's **Workforce Strategy** must be creative around workforce, exploring new ways of working and skills sharing.

4. **The practice of making a young person leave their support service on their 18th birthday must end.** Young people should be able to choose when to transition up to the age of 25[14] with support from their therapists and parents or carers.

The Commission has also identified a **checklist for local health and care leaders** based on what we have learnt about the best way to improve service provision. This covers: good commissioning practice; effective partnership working; early-intervention and engagement; workforce development and transition to adult services.

It is the Commission's objective that this report will support the government, and local health and care leaders, in the journey towards improving children and young people's mental health services over the next five years, reducing the 'treatment gap' that we have identified in our research.

---

11 Training for education staff is recommended by the National Institute for Health and Care Excellence: http://pathways.nice.org.uk/pathways/social-and-emotional-wellbeing-for-children-and-young-people#path=view%3A/pathways/social-and-emotional-wellbeing-for-children-and-young-people/social-and-emotional-wellbeing-in-secondary-education.xml&content=view-node%3Anodes-staff-training. In a large nationally representative study of children's mental health, the most commonly consulted professionals regarding children's mental health were teachers (Ford et al., 2007).

12 For more detail, see: Promoting children and young people's emotional health and wellbeing A whole school and college approach, Public Health England and the Children and Young People's Mental Health Coalition, March 2015: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf A US me-ta-analysis summarised research on 207 social and emotional interventions, and suggested that schools with effective programmes showed an 11 per cent improvement in achievement tests, a 25 per cent improvement in social and emotional skills, and a 10 per cent decrease in classroom misbehaviour, anxiety and depression. Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., and Schellinger, K. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. Child Development 82: 474-501. Schools provide a rare context within which universal programmes have been noted to result in moderately sized improvements to whole child population mental health, but with particularly notable gains for higher risk children (Weare & Nind, 2011). Proven programmes must form part of a Whole School Approach to promoting mental health and wellbeing and should be reproduced faithfully (not adapted or dipped into). Programmes should be delivered by well trained and supervised staff (Durlak & DuPre, 2008);

13 This expenditure is particularly at risk of cuts eg: Northamptonshire reviewing children's mental health services with aim to save £0.6m: http://bit.ly/2fj9EeS

14 Adolescents leaving mental health or social care services: predictors of mental health and psychosocial outcomes one year later. Jessica Memarzia1,2, Michelle C St Clair1,3, Matt Owens1,4, Ian M Goodyer1 and Valerie J Dunn1,2 Memarzia et al. BMC Health Services Research (2015) 15:185
What good looks like in psychological services for children, young people and their families, The Child and Family Clinical Psychology Review, No 3 Summer 2015. Edited by Julia Faulconbridge, Duncan Law and Amanda Laffan. http://shop.bps.org.uk/publications/publication-by-series/child-and-family-clinical-psychology-review-no-3-summer-2015.html

Introduction

This is the third and final report of the Education Policy Institute's Independent Commission on Children and Young People's Mental Health. Our first two reports provided analysis of the current prevalence and trends in access to treatment within the child and adolescent mental health system. This report complements that quantitative analysis with further qualitative evidence on the process of transformation from frontline service visits.

The report also includes our policy recommendations for government based on all the research the Commission has undertaken. We have also developed a checklist for local commissioners based on what we have learnt about how best to transform their local child and adolescent mental health system.

The Treatment Gap

Our first report, *Children and Young People's Mental Health: The State of the Nation* was published in April 2016. The report found that specialist child and adolescent mental health services are turning away, on average, nearly a quarter (23 per cent) of the young people referred to them for help. Our analysis of services' eligibility criteria showed that this is often because there are high thresholds for access to their services. Something has to go drastically wrong before some services will intervene; the antithesis of an early intervention approach. For example, one criteria suggests that those hearing voices should only seek specialist help if they "*heard voices that command particular behaviours*".[15] One service would not accept those who had expressed a desire to commit suicide unless this had happened on more than one occasion.

Once a referral is accepted, young people frequently have to wait many months for treatment. The median waiting time for all providers was one month for a first appointment and two months until start of treatment. There was wide variation in average waiting times for different providers, from two weeks in Cheshire to 19 weeks in North Staffordshire. The average waiting time in Gateshead is five times as long as for those just down the road in Tyneside. Similarly, waits in North West London vary widely from two months in Kensington and Chelsea to nearly six months in Brent.

This average waiting time conceals longer 'hidden waits'. The report uncovered that the median of the maximum waiting times for all providers was 26 weeks (6 months) for a first appointment and **nearly ten months (42 weeks) for the start of treatment**. Some providers did not measure waiting times at all, meaning that some patients could even be waiting longer than this.

---

15   Cambridgeshire and Peterborough NHS Foundation Trust

Progress and Challenges

Our second report, *Progress and challenges in the transformation of young people's mental health care* was published in August 2016. This focused on progress in transforming services since the publication of the Coalition Government's strategy, *Future in Mind*, in March 2015.[16] Accompanied by announced investment of £1.25bn over five years, *Future in Mind* set out a vision to improve the care offered to children and young people in England, by 2020. The Education Policy Institute conducted an analysis of the local transformation plans developed by local health and care leaders across the country. These set out each area's strategy for improving services in line with the vision of *Future in Mind* and were a condition of receiving the first year's tranche of the additional funding announced as part of the programme. Education Policy Institute analysis found wide variation in the quality of local delivery. Our analysis found that of the 121 published plans,[17] **only 18 areas (15 per cent) had 'good' plans. 58 plans (48 per cent) 'required improvement' and 45 plans (37 per cent) 'required substantial improvement'**.

The Education Policy Institute also identified six key barriers to the effective delivery of *Future in Mind*:

1. Workforce (both recruitment difficulties and training needs);
2. Funding;
3. Commissioning;
4. Data;
5. Fragmentation (the complexity and gaps between services);
6. Intervening too late.

In order to investigate the problems within the **workforce** in more detail, the Education Policy Institute sent a freedom of information request to CAMHS providers. The key findings were as follows:

- 83 per cent of trusts which responded stated that they had experienced recruitment difficulties.

- The same proportion had had to advertise posts on multiple occasions to fill roles.

- Mental health nurses were the most difficult profession to recruit, followed by consultant psychiatrists.

- These recruitment challenges had led to an 82 per cent increase in expenditure on temporary staffing in the last two years. In 2015-16 nearly £50m was spent on agency staff by 32 trusts, up from £27m in 2013-14.

On **funding,** the £1.25bn over five years announced in March 2015 equates to £250m per year. Only £143m was released in the first year, and of that only £75m was distributed to clinical commissioning groups (local health leaders). It is not yet clear how much of this has been spent on frontline services, but reports from mental health providers indicate that they have not yet seen this increased investment.

For 2016-17, £119m has been allocated to clinical commissioning groups, but this has been included in their total baseline allocation. The funding for children and young people's mental health has not been ring-fenced and so there is a risk that it will be spent on other priorities, such as those covered by national targets, like A&E waiting times.

It is also important to consider this additional investment in the wider context of funding for the whole system. Children's mental health services have been historically underfunded. In 2012-13 £704m was spent on CAMHS,[18] the equivalent of about 6 per cent of the total mental health budget, or around 0.7

---

16 Future in Mind, Department of Health and NHS England, March 2015: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

17 The plans have all, apart from one area (Greenwich) been published online. Some have only been published in summary form or do not include the background documents submitted to NHS England for assurance.

18 NB this does not include all investment in children's mental health, such as through public health or schools budgets. Due to the move to a new system of data collection, figures will not be made available for 2013/14. Figures for 2014/15 will be made available at a later date

per cent of the total NHS budget.[19] This is in spite of prevalence data showing that one in 10 children and young people experience mental health problems and that 75 per cent of young people experiencing a mental health problem are thought not to access any treatment.[20]

It is very difficult to analyse trends in funding of CAMHS because there is no transparency in the way that data is collected. A parliamentary written answer appears to show a reduction in real terms funding from 2010-11 (£751m) to 2012-13 (£717m)[21] but this does not cover all expenditure and is not directly comparable across years. A freedom of information request by Young Minds in 2015 found that £35m had been cut from services over the previous year.[22]

There is also widespread concern that reductions in local authority budgets have led to cuts in community mental health services (tier 2). Such reductions are hard to measure as there is little data collected on the availability of these early intervention services. However, the Children's Society and others found that, between 2010-11 and 2015-16, spending by local authorities on early intervention services for children, young people and families fell by 31 per cent in real terms. They estimate that the early intervention grant will see a 71 per cent cut by the end of the decade.[23] These wider financial challenges facing local authorities, including specific pressures and uncertainties about public health and social care budgets, will impact on child and adolescent mental health because these specialist NHS services sit within a wider framework of local authority funded early intervention support. The Care Quality Commission has found that reductions in funding, including to non-NHS services, has contributed to increased waiting times.[24]

19   NHS England evidence to the Health Select Committee enquiry into children's mental health, 2014 http://data.parliament.uk/writtenevidence/committeeev-idence.svc/evidencedocument/health-committee/childrens-and-adolescent-mental-health-and-CAMHS/written/7703.pdf
20   https://www.mind.org.uk/media/1113989/a-manifesto-for-better-mental-health.pdf
21   Real terms 2013/14 prices, House of Commons Written Answer, 16 December 2014 http://www.parliament.uk/business/publications/written-questions-an-swers-statements/written-question/Commons/2014-12-16/218865/
22   Community Care Magazine, January 2015, http://www.communitycare.co.uk/2015/01/09/real-terms-funding-cut-childrens-mental-health-services-re-vealed/
23   Losing in the long run: Trends in early intervention funding, Children's Society, Action for Children and the National Children's Bu-reau, 2016
24   Care Quality Commission submission to the Education Policy Institute Call for Evidence 2016

Further Evidence

In addition to the Education Policy Institute analysis, NHS England published their own summary of the local transformation plans. This supported our analysis that workforce and information technology are key barriers to progress across the country: "*Having IT systems that can record outcomes and bring real time feedback is one of the greatest challenges faced by services*".[25]

The NHS England summary also highlighted that:

- Only one in five areas have or are extending online emotional support and counselling. One factor which may be delaying progress in this area is concern over having the capacity or knowledge to commission these services effectively. National guidance would be one means to drive faster improvement.

- While the vast majority of plans involved young people in some way, only half of plans engaged with or collaborated with young groups or youth councils and 6 out of 10 did not evidence current or future plans for involving young people in decision making.

- Only 15 per cent of areas are committed to producing young people friendly versions of their plan.

- Approximately 40 per cent of plans referred to school counselling but only 3 per cent had plans to commission it. This figure may not take account of individual schools' plans as they were not always effectively involved in the local transformation plan process.

- New government guidance on eating disorders was released in July 2015, alongside the new investment in children's mental health.[26] The NHS England analysis of transformation plans found that only 16 per cent of areas currently have eating disorder services which met the new guidelines. Only 18 per cent of areas were meeting a 4 week waiting time for routine cases. Only 14 per cent of areas were meeting one week waiting times for urgent cases. This is a national focus for NHS England in guidance so this should be addressed over the course of the delivery of *Future in Mind*.

It is important to note that the NHS England review was based on submitted plans, and the Education Policy Institute analysis was of published plans. Local areas may have undertaken activity in addition to what was evidenced in their plans.

In September 2016, NHS Digital published the Adult Psychiatric Morbidity Survey.[27] This showed a marked increase in mental health problems for young women. In fact, one in four women aged 16-24 in the survey had self-harmed. The research also looked at access to treatment and supported the EPI Commission's findings on a treatment gap for young people. **For example, two thirds (66.9 per cent) of young people aged 16-34 who had attempted suicide had not subsequently received medical or psychological help.** The survey does not indicate the reasons for this, which could include a reluctance to seek help, but could also be due to the limited capacity of support services. Older age groups were more likely to receive help, for example the same figure for over 55s was 47 per cent.

The NHS England summary, the Annual Psychiatric Morbidity Survey and our analysis point to significant barriers to the delivery of effective mental health services for children and young people in this country and demonstrate the challenge ahead to tackle the treatment gap identified by our Mental Health Commission.

25   Children and young people's mental health Local Transformation Plans – a summary of key themes, July 2016, NHS England
26   https://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf
27   Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014, NHS Digital, September 29, 2016

Transforming child and Adolescent Mental Health Services on the Ground

In order to complement our analysis of the local transformation plans from *Progress and Challenges in the transformation of young people's mental health care*, the Education Policy Institute Commission spoke to a range of frontline experts and conducted four research visits in partnership with our Youth Reference Group. The areas visited were Barnsley, Birmingham, Essex and Oxfordshire. These were chosen based on our analysis of local transformation plans and on geographical factors (North/South, Urban/Rural). The choice of areas enabled us to investigate both promising practice and the challenges facing local services.

The research visits identified ten themes on progress and challenges in implementing the transformation process on the ground.

1. Prioritisation

One positive finding of our fieldwork was that children and young people's mental health was becoming a priority for a wider range of external local health organisations in many of the areas. For example, local healthwatch organisations were undertaking research into the quality of local provision and were considering inspection visits. Council Overview and Scrutiny Committees had also undertaken investigations in some areas. We also found that MPs had raised the issue locally, with responses to local transformation plan consultations or statements on their websites. This prioritisation should help to maintain focus on progress at a local level, which may drive improvement. For example, previous investigations by local healthwatch organisations has led to local action being taken in areas such as Barnsley prior to the national focus on this issue.[28]

At a national level, however, the policy focus has broadened from the delivery of *Future in Mind*, being overtaken by the *Five Year Forward View for Mental Health*[29] and the national programme for the development of Sustainability and Transformation Plans (STPs).[30] These plans were announced in NHS planning guidance published in December 2015, and will encompass the strategic planning for all aspects of NHS provision between 2016 and 2021.[31] The plans are being developed across 44 geographical areas in England, known as 'footprints'. These 'footprints' are based on geographical boundaries and local service use, but do not always map across with other organisational boundaries, for example Essex County Council is covered by three STPs, one of which links to Suffolk and the other to Hertfordshire.[32]

As part of this Sustainability and Transformation planning process, child and adolescent mental health, while highly complex, is a very small part of the overall budget. It is, therefore, often not prioritised (perhaps being given a small paragraph at most within the whole Sustainability and Transformation Plan) and there is a risk that the transformation process gets overlooked as a result. The overlapping 'footprints' of the different plans creates additional complexity, with the 122 local transformation plan areas not mapping easily across the 44 Sustainability and Transformation Plan 'footprints'. Another problem was that the timing of refreshed transformation plans (which had to be completed by 31 October 2016) is not synchronised with wider NHS planning, based on September planning guidance. This means that children's mental health risks being overlooked in wider plans. There were concerns raised during our fieldwork visits that CAMHS was not always being included within Sustainability and Transformation Plan discussions. In Oxfordshire, however, mental health commissioners, by persistent relationship building, were beginning to get a higher profile within the STP and mentioned that it was helping explore further integration with physical health and the acute hospitals.

28   See Barnsley local transformation plan 2015: http://www.barnsleyccg.nhs.uk/CCG%20Downloads/strategies%20policies%20and%20plans/Barnsley%20Future%20in%20Mind%20Transformation%20Plan%20November%202015.pdf
29   Five Year Forward View for Mental Health: A report from the independent Mental Health Taskforce to the NHS in England, February 2016: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
30   Sustainability and Transformation Plans are a 'route map for how the local NHS and its partners make a reality of the Five Year For-ward View, within the Spending Review envelope" NHS England Operational Planning and Contracting Guidance 2017-19 https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/
31   https://www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained?gclid=CIy1vea5jNACFcyRGwodQx8OIQ
32   https://www.england.nhs.uk/wp-content/uploads/2016/02/stp-footprints-march-2016.pdf

2. Rising Demand

The services we visited were experiencing rising demand. For example, in Essex referrals had more than doubled in a year, from 3,000 to 7,000 open cases. We were told that the complexity of referrals had also increased, with young people coming forward with more serious conditions or at a younger age. In Birmingham, the team had experienced unexpected high demand for inpatient beds. During our desk-based research we found further evidence of this trend in Barnsley: "*The Trust believes in the importance of early intervention, but the increase in emergency referrals for CAMHS has meant that opportunities for early intervention and outreach have been lost due to the demand in meeting emergencies. Unfortunately, other urgent work has to be prioritised over important planned work at a time of limited resources*".[33]

This highlights the importance of new prevalence data (new figures on the numbers of children and young people with each condition across the country will be available in 2018) and of commissioners conducting clear needs analysis (developing an understanding of local need based on existing data) to identify current and future levels of demand, which then provides the evidence for increasing service capacity accordingly.

3. Partnership working

One of the greatest challenges for all the areas we visited was integrating services to provide a seamless route for young people to access care quickly. This was true for different teams within services as well as between services, such as those provided by the voluntary sector and the NHS. It was also a challenge for mental health services to partner more effectively with support provided by GPs and schools and work being done by other agencies such as social care and the police. This was particularly the case when those services were going through their own changes, such as early intervention services being cut or retendered, or social care services being redesigned. This risks duplicating effort and young people falling through the gaps in provision

Our desk research in preparation for the research visits highlighted this lack of integration. For example, for some services, we found different versions of websites about the same service, provided by the local authority, the clinical commissioning group, and the provider themselves. In one area, the local police responded to a consultation on mental health plans, expressing concern about the lack of integration with the wider system: "*my overall observation is that it's completely health focused with minimal links to the wider partnership. There are clear opportunities for the Police to support the NHS that link to the main issues raised by service users*".

We were impressed by the many new initiatives in one area we visited, such as support within schools, and training of young commissioners but it was apparent that these workstreams are progressing separately from one another, with staff from one team not aware of the progress made by another service. Commissioners were concerned about this challenge of "*navigating an unfathomable system*" and were holding regular events with stakeholders from within existing services and the wider system, such as children's centres, GPs, local voluntary sector organisations and schools. These events were aimed at encouraging those working in different services to talk to each other and think about ways they could work together, such as providing support while young people were on the specialist CAMHS waiting list. Another solution being considered was a central support facility with a telephone helpline to help professionals referring young people between services.

One barrier to integrated services was where different elements of the service are commissioned separately, such as inpatient care which is commissioned by NHS England at a national level. In some areas, for example, councils commission lower level 'targeted' services, also known as tier two, and the NHS commissions specialist care. Some local areas had already joined these services together, but even

33   Barnsley all-age mental health and wellbeing commissioning strategy: 2015 – 2020. http://barnsleymbc.moderngov.co.uk/documents/s10452/All-age%20
      Mental%20Health%20Commissioning%20Strategy%202015%20-%202020%20-%20ADOPTED.pdf

these providers had points of interface with wider services, such as social care and GPs, so there was no perfect model where everything was provided under one roof.

Another challenge for services attempting to integrate more effectively was concerns over data protection. These concerns are often misplaced and arise from the complexity of data protection rules within the NHS. This prevented services working together to provide a seamless pathway of care for a young person because they did not know what support was being provided to that young person by local partners. NHS services in particular were concerned about sharing data and breaking confidentiality rules. Services that already provided early intervention or had redesigned the whole system were better able to tackle this; for example, Forward Thinking Birmingham, who had included a voluntary sector provider, the Children's Society, in their partnership, and had shared care records with the Children's Society's drop-in service, Pause. This enabled a smoother transition for young people between agencies and helped the team to track which people were using which service.

Even services which were providing care in partnership arrangements talked of the challenges of working together across organisational boundaries, with staff working to different protocols and training programmes and with different organisational cultures. Commissioning in partnership was hindered by different budget cycles, financial regimes, procurement procedures and organisational governance. For example, in Essex the partnership consists of a county council, two borough councils and seven clinical commissioning groups. Each organisation has their own decision-making process and protocols. In particular, the NHS governance regime and timetable is very different to that of local government. They spoke of the need to build strong relationships between leaders in different organisations to overcome these barriers.

We found that different parts of the system can behave territorially, not wanting to share information or resources with commissioners, or other providers, or blaming other services for gaps in provision. The importance of strong local charismatic leaders was a recurring theme of our research, particularly having visionary clinical leadership. Successful areas had spent time developing strong local partnerships. This was at risk when key local leaders moved roles and the process had to begin again.

4. Early Intervention

Our visits indicated that early intervention services were often still not a high priority within the transformation process. For example, we spoke to a voluntary sector provider who felt very positive about the process. They had also received support from a CAMHS psychologist within their service once a week under the plan. This had prevented some referrals to CAMHS. Unfortunately, however, the funding for this had since run out and it was at risk of being downgraded to a less specialist worker or discontinued. The voluntary service had also been told that they could not receive additional funding from CAMHS because they were able to fundraise separately. This service was only being funded under a four-year grant, and is therefore at risk of closure at the end of this time.

"It is important for sufferers or carers to know what options are available, not feeling as though they are having doors closed in their face. I think that more links need to be made with charitable and voluntary organisations for this to be highly successful, as these can also provide vital services for those in need".

Member of Education Policy Institute Youth Reference Group on fieldwork visit.

We have been impressed by many of the voluntary sector providers we have encountered during our research. For example, our Commission heard from the Holt Youth Project in Norfolk who were using a non-medical model of support for young people, including those with severe mental health difficulties and were able to achieve dramatic results, for example supporting a young man with mental health problems who spoke to the Commission. The young man had been severely socially isolated and unable

to engage with traditional mental health services until he joined the Holt Youth Project, which enabled him to build confidence and take part in group activities.[34]

Many areas we visited were beginning to recognise the need to involve voluntary organisations in the local area as well as statutory early intervention services, rather than expecting all support to be offered by the NHS. For example, the Commission was impressed by the services which had created integrated 'drop-ins' so that young people had a place where they could go without an appointment and in a convenient location.

Case Study: Pause, Forward Thinking Birmingham

Pause in Birmingham, run by the Children's Society, is part of the Forward Thinking Birmingham partnership and therefore integrated with specialist teams while providing a city centre, non-stigmatising, young people friendly environment. Crucially, shared care records enabled monitoring of access across the different levels of provision within the partnership, and better coordination of care. The staff had a range of mental health expertise and youth engagement skills. Young people had been central to their recruitment process as well as the design of the service and its building. The team had recognised that there is still a need to outreach and engage young people, so were developing a 'hub and spoke model' to provide drop-in sessions at other locations such as schools or local libraries.

Services still faced challenges in engaging vulnerable groups, those from BME backgrounds and the 'hard to hear' – young people with a range of low-level, inter-locking needs such as substance misuse, learning disability or those experiencing domestic abuse who do not always engage with traditional support. Approaches to address this included the Children's Society in Birmingham monitoring the demographics of service users and planning to use this data to outreach to groups who were not accessing support. For example, they had also developed a service directory including support organisations from different cultural communities in order to partner more effectively with them.

In our second report we highlighted the impact of national funding reductions for early intervention services on children and young people's mental health. The Children's Society and others found that, between 2010-11 and 2015-16, spending by local authorities on early intervention services for children, young people and families has fallen by 31 per cent in real terms. They estimate that the early intervention grant will see a 71 per cent cut by the end of the decade.[35] This was a constant concern expressed in our fieldwork. For example, in one area mental health providers were bracing themselves for the increase in referrals due to the cuts to local children's services. In another, the local transformation plan was enabling them to build back

"We have absolutely massive savings targets"
County Council commissioner

"We had lots of services six to eight years ago but now everything's gone"
Voluntary sector lead at a stakeholder event

"Everything's always pilots and short-term. It's difficult to evaluate and see what is working"
Health Commissioner

up some of the universal provision that had been cut. People expressed frustration at this cycle of new services with unstable funding.

---

34   http://www.holtyouthproject.org.uk/staff/
35   Losing in the long run: Trends in early intervention funding, Children's Society, Action for Children and the National Children's Bu-reau, 2016

One solution we encountered was building evaluation into all new models and service development, so that organisations are able to demonstrate what works and build an evidence base to protect early intervention support from future budget reductions. Better collection of data on early intervention support, and building it into the wider support offer also appeared to be a promising solution. The key challenge is to prevent this support being lost once the process of transformation has been completed: that it, in the words of one commissioner we spoke to: "*doesn't disappear when the money goes*".

5. Workforce Development

As identified in our second report, the areas we visited were all experiencing workforce challenges. For example, areas had experienced delays in implementing their plans because they had struggled to recruit posts or lost staff as other services expanded. Areas with a high cost of living and with proximity to London, such as Oxfordshire and Essex, explained that they faced particular recruitment difficulties.

The issue of temporary staffing, highlighted in our second report, also arose during the fieldwork visits. For example, locum staff in CAMHS did not have established local networks and awareness of other local support within education and social care, so struggled to refer people onto to appropriate wider support.

Services were adopting a variety of solutions to overcome recruitment problems, such as focusing on retention of existing staff, recruit-to-train models and attending local nursing fairs. Another solution was changing their skill-mix, for example adding youth support workers or peer support programmes. In London, MAC UK are piloting an innovative service delivery model called 'Integrate' which builds on the expertise of mental health professionals and youth workers to deliver mental health services in a highly adaptive and flexible way.[36] One area explained that their young service users had requested different types of roles. In Oxfordshire, specialist services were working with Barnardo's to provide 'buddies' to help navigate young people to the most appropriate care. Other approaches included bringing in external expertise to help with organisational redevelopment, creating new roles and upskilling existing staff. Local teams would like more support from Health Education England and local workforce support services, but these organisations were focused on wider Sustainability and Transformation Plans.

Another workforce challenge was culture change, in particular helping staff move through processes of change management. Many of the commissioners and providers we spoke to all recognised that major change programmes present a challenge for morale, with staff moving employers or having to adopt new ways of working.

It was recognised that this culture change takes time and leadership focus to be successful: "*If staff feel beleaguered, they can't take the message on but if you start seeing progress and the results are good then you can show the impact and change people's minds*". Large scale changes do not work for everyone and services were also faced with high turnover of staff during the process of implementation.

In Birmingham, we were told of the importance of local leaders having a strong vision for successful transformation and retaining this focus and leadership throughout the long process of operational changes. The partnership had developed a highly ambitious vision statement which they felt had focused all partners on the overarching objective of the transformation process. Other solutions included: an ambassadorial role for senior leaders, staff training, away days and focused performance management.

New ways of working also bring challenges such as the need to adopt new approaches to health and safety, for example with risks to staff safety of drop-in clinics or street therapy. Services are having to develop new protocols and risk sharing policies, an area which requires further support and the sharing of best practice.

---

36   http://www.mac-uk.org/integrate/the-integrate-model/

6. Involving Children and Young People

The areas we visited were involving children and young people in many aspects of their provision, from naming new services, to advising on location and décor, designing a website, advising on referral forms and many other approaches. For example, Barnsley had commissioned a voluntary organisation, Chilypep, to train young commissioners and audit current support. The commissioners will be undertaking peer research, helping to design service specifications and sitting on commissioning panels.

Challenges to effective engagement included timing meetings to be accessible for young people, such as after the school day, which meant events running after the working day, which made it difficult for staff to attend. Another challenge for commissioners was reaching out to young people with mental health problems locally. For example, one commissioner engagement team were not permitted to contact the providers' own participation group and did not have access to patient records so could not contact any current service users but had to advertise more widely to recruit young people. Tight timescales for commissioning decisions can also hinder involvement of young people or put pressure on those being involved. Engaging young people in service design involves changing ways of working and changing commissioner attitudes.

In addition, young people move on quickly into different stages in their lives. It is difficult to maintain continuity with participation groups when people move on to university or move home out of area, and this can prevent more long-term involvement in projects or hinder services' ability to feed back to the young people how their views have been taken on board. The nature of young people's mental health problems can also hinder engagement. One young person had explained "*I would love to join your participation group but I don't leave the house*". The service was therefore exploring the possibilities of arranging Skype meetings and engagement groups via social media, including the security and safeguarding issues involved. It is also important to recognise the barriers to communicating effectively with those of a different generation, for example understanding new ways of communicating in the digital era. This highlighted the value of employing younger people in staff roles or as volunteers to help facilitate engagement of other young people. In Essex, they are setting up a radio station called Reprezent where young people will run the radio and will discuss a number of mental health topics. This approach focuses on listening to young people discuss the subject with each other, rather than more formal engagement with adults in control of the conversation and aims to reach a wider group of young people than traditional engagement techniques.

The engagement leads we spoke to also felt that it was also important to recognise the variety of different conditions covered by child and adolescent mental health services. For example, one engagement lead was aware that her work could not be completely representative, she wanted to ensure that she had a range of young people involved of different ages, genders, backgrounds and conditions, for example not only reaching young white men with autistic spectrum disorder. These challenges demonstrate the need for children and young people's engagement activity to be well-planned, appropriately facilitated and integral to service provision, not just tokenistic. It was considered important for organisational leaders to support engagement activity: "*It comes from the top down*".

Young people can bring creativity and new ideas to service design, for example helping commissioners consider new approaches, such as partnership with the voluntary sector or involving peer support or youth workers rather than relying solely on professional workers. Formal professional clinics can act as a barrier to access for young people, who often prefer a more relaxed approach.[37]

Participation in commissioning decisions builds young people's confidence and also makes them more aware of the challenges faced by those running services. It can also benefit the young people's mental health. For example, Chilypep in Barnsley found that 100 per cent of the young people who had

---

37   https://www.mentalhealth.org.uk/projects/right-here

participated in their youth engagement work recorded higher levels of wellbeing.[38] Similarly, for MAC-UK in London, youth engagement forms part of the therapeutic offer as an integrated part of service delivery.

Our youth reference group volunteers felt that in spite of some of the barriers identified, involving young people was critical and would help to reduce anxiety about services. They also felt that it was also important to manage expectations if waiting times did not reduce: *"I thought that this (service open event) was a great idea in reducing children and parent's anxiety about the service. I also think it makes it seem more approachable and accessible, but this may be an issue if waiting lists are still going to remain as long. It may give the wrong impression and people will be disappointed that they still have to wait"*.

The youth reference group also raised concerns about peer mentoring schemes, particularly around trust and confidentiality for students who had experienced bullying. *"We have to remember that social media and cyber bullying is very prominent in society, and college is a time when this can be most troublesome"*.

7. Education

As part of our research we spoke to Dr Mina Fazel, Associate Professor at the Oxford University Department of Psychiatry. In her work, Dr Fazel has highlighted the importance of appropriate support for children and young people's mental health within schools because *"many children with emotional and behavioural difficulties never reach traditional mental health services, yet a substantial proportion of mental illness starts before the age of 18".[39]* Dr Fazel and colleagues have produced a series of articles for the Lancet Psychiatry on mental health support within schools, concluding that it *"can create a continuum of integrative care that improves both mental health and educational attainment for children. A robust research agenda is needed that focuses on system-level implementation and maintenance of interventions over time."[40]* Dr Fazel highlighted the importance, not only of provision being offered within schools, but also of rigorous simultaneous evaluation of interventions to build the evidence base on what works.

Nevertheless, there are barriers to effective partnership working between schools and health services. The areas we visited expressed difficulties engaging with the education sector and similarly the schools we spoke to expressed frustration at obtaining support for their pupils from specialist mental health services. Barriers included the fact that school boundaries do not easily overlap with NHS organisational boundaries. For example, one school may have to interact with several different mental health services depending on where their students live. Recent reforms to the education sector, such as the reduction of the role of the local authority and the proliferation of multi-academy trusts, have meant that in some areas it has become more fragmented and health partners struggled to know how to reach all local schools. Nevertheless, this problem existed before recent structural changes, and similarly, schools do not always have easy access to the NHS. For example, one commissioner told us that *"some schools don't even know who their school nurse is"*.

Another difficulty is the pressure that schools are under. Recent Education Policy Institute research has highlighted that teachers in England are working longer hours than in most other countries, and that this hindered teachers' access to continuing professional development.[41] One health leader explained that school staff would not attend their meetings. This highlighted the importance of outreach into school settings, given the pressures on school timetables and teacher workload.

---

38   This is based on a small sample size of those who regularly completed a 'participation spiderdiagram' designed based on the 'out-comes star', an evidence-based tool for recording and monitoring change: http://www.outcomesstar.org.uk/

39   https://www.psych.ox.ac.uk/team/mina-fazel

40   Mental health interventions in schools in high-income countries, Dr Mina Fazel, Prof Kimberly Hoagwood, PhD, Sharon Stephan, PhD, Prof Tamsin Ford, PhD. Lancet Psychiatry, October 2014: http://www.thelancet.com/series/mental-health-interventions-schools.

41   Teacher workload and professional development in England's secondary schools: Insights from Talis, Peter Sellen, Education Policy Institute, October 2016: http://epi.org.uk/report/teacherworkload/

Some areas had already developed such outreach models. For example, in Oxfordshire child and adolescent mental health workers run weekly sessions within all secondary schools. Having a CAMHS worker within all secondary schools was seen as a vital connection for those areas we had visited who had implemented this approach. Local leaders told us that the majority of school leaders were calling for further support from health providers, although a small minority of schools were resistant to engaging with health on this issue.

Those services that had already begun to engage more effectively with schools were recognising that this approach should be extended to further education colleges and to independent schools. For example, in Barnsley there was a strong health and wellbeing centre within Barnsley college and young people from the college were being trained as peer mentors.

Linking in with existing SEN and vulnerable learner networks within the council had proved successful for Oxfordshire, where the local transformation plan team had presented at a conference for SEN Coordinators and inclusion leads. These networks can help bring the two worlds of health and education together, removing the barriers caused by different jargon and priorities.

There were concerns from NHS providers around the quality of school based counselling and training, with educationalists not being bound by National Institute for Health and Care Excellence guidance on what is evidence-based treatment. School leaders often do not have the experience or the time to know how to commission high quality school-based counselling. Health professionals expressed concerns about the danger of harmful provision in an under-regulated sector. For example, counsellors do not have to be regulated by the Health and Care Professions Council. Oxfordshire is exploring the idea of a 'kitemark' for schools provision so that schools can be assured that their support is of good quality.

8. Delivery

Some areas we visited were already well ahead in planning changes to their services before the publication of *Future in Mind*. This has allowed them to progress further than those who had not had that preparation. Nevertheless, our fieldwork has shown that even these areas spoke of the significant time needed to develop tenders, recruit new teams or change their culture. In addition, changes to IT systems to provide better data capture or more flexible working are taking time to get right. There was a need to manage expectations because change takes time, and the upheaval impacts on performance, such as waiting times in the meantime. This highlights the need for a sustained focus on transformation in the five years to 2020 and beyond this point.

Some areas have yet to develop clear objectives and measures of success. It is therefore difficult for them to assess progress in transforming services in spite of the fact they have a number of positive initiatives in train. For other areas, having clear action plans with measurable objectives was vital to ensure safe and effective partnership working. This was an area we highlighted in our second report as one of the key indicators of a good plan. In future all areas should set clear measurable objectives and monitor progress, for example via a dashboard of key indicators.

Having good quality data to underpin this is important. For example, Forward Thinking Birmingham had involved Beacon UK in their partnership. Beacon UK are specialists in using clinical, financial and user experience data to provide predictive analytics and key insights to help managers understand how services were being used, reduce lengths of stay and provide the right care at the right time. At their Access Centre, they were beginning to be able to monitor the usage of services, identify bottle necks and aimed to use this analysis to improve the flow of patients between teams, reducing delayed discharges from inpatient care and more efficiently target their resources. While this work is at an early stage it could potentially be a powerful tool to enable better use of resource and to demonstrate the efficacy of early intervention, thereby protecting them from future budget reduction. For example,

analysis has indicated that one difficulty locally is access to housing for young people being discharged from inpatient care – giving evidence to commissioners about local pressure points in the system.

The level of ambition varied widely in our analysis of local transformation plans. Our fieldwork research highlighted that some areas still have a very traditional approach to managing referrals. For example, expecting people to ask their doctor to refer them via secure email, or sending a fax or letter. In other areas, self-referral was encouraged and there were a range of ways to access help, either online, by phone or via easy to access drop-in centres.

We saw examples of high thresholds still being in place: "*The level of difficulty the child or young person experiences will be significantly interfering with their ability to cope*", and of services stating their policy of removing people from the waiting list if they did not attend an appointment (in spite of research indicating that this is a common problem for young people who need the most help).

Where areas had adopted a more ambitious approach to redesign they were faced with the challenges of implementing major changes and all the upheaval that entails. This requires focused effort across human resources, IT and data, finances and communications to ensure safe and effective delivery while changes are underway. People spoke to us of the challenges of doing things differently, such as avoiding traditional procurement routes.

While our own previous research, and NHS England's analysis as outlined above, did not find a high level of innovation in online support, we found some examples of good practice. In Essex they are piloting an app called "My Mind", where service users can instant message their clinicians to book appointments or seek advice, with all the communications automatically uploaded to patient records. They can also access a range of online support in the form of blogs, factsheets and videos. In addition, the service ensures that all staff have mobile technology to see patients in any setting, such as GP surgeries, schools or a young person's own home. They have deliberately encouraged staff to work outside of traditional clinics: "*We took away the buildings… that encourages staff to work in other places and that's money we can spend on clinical staff instead of rent*".

9. Transition

The problem of young people having to move to adult services simply because they had reached their 18th birthday was frequently raised as part of our research. In our first report we highlighted the problem that as mental health problems often emerge in late adolescence, young people are losing touch with services or having their care disrupted at a crucial point where early intervention could make a significant difference to their future health and wellbeing.[42]

Areas spoke to us of the time taken to plan moves appropriately, and the challenge of engaging adult teams in this process. Barriers to smoother transition included the divide between the commissioning of adult and children's services as well as the splits between providers. Our research indicates a need for a further focus on improving transition procedures as part of wider CAMHS transformation.

10. National policy

Some local areas we spoke to felt very supported (by NHS England in particular) and the national focus on improving child and adolescent mental health. Others expressed frustration at some of the bureaucracy around the process, such as short timescales for writing plans and for spending additional money, or the strings attached to new investment, for example the additional £25m announced in September 2016 to be spent in 2016/17.[43] Areas also called for more control over budgets for inpatient services.

---

42   Birchwood, M. J. and Singh, Swaran P. (2013) Mental health services for young people : matching the service to the need. The British Journal of Psychiatry, 202 (Supplement 54). s1-s2. ISSN 0007-1250 2013 http://wrap.warwick.ac.uk/58774/
43   https://www.england.nhs.uk/2016/09/mh-cyp-ccgs/

There was concern about whether the additional funding would be spent on children's mental health. Local commissioners and providers were still unclear as to what proportion of funding they would receive this year: "*I really worry that the new money is not getting to the frontline – we need more transparency. A CCG in deficit could use the money to pay it off*". This was particularly frustrating for local authorities where local health commissioners had control over the budget as it was part of their baseline allocation. The pressure on local commissioners to move away from a focus on transforming child and adolescent mental health services was high given the financial difficulties many were experiencing: "*It's such a shame that the money isn't on a separate route any more. It's been virtually impossible to make the case for the money*". One area was told "*It will just depend on how firm the government are whether we spend it on CAMHS. If they don't make us, it won't happen*".

Another concern raised was the need to ensure all organisations across the NHS treat young people's mental health as a high priority and work in an integrated way. This includes arms length bodies and inspectorates such as Health Education England and NHS Improvement as well as NHS England.

Most importantly there were concerns that both the funding and the national prioritisation would slip over the next five years, especially given the time needed to implement real change. Services called for clear national standards and dedicated levers to improve policy: "*The Government must keep Future in Mind high on the agenda. Now that we've started we must not stop keeping that focus*".

Conclusions and Policy Recommendations

The Education Policy Institute's Independent Mental Health Commission has spent a year researching child and adolescent mental health services in England. We have explored prevalence and trends in levels of need, access to treatment and progress and challenges in transforming care. We have uncovered rising demand for services, with an increase in referrals of 64 per cent in the year to 2015. We have also identified a treatment gap, where 23 per cent of the children and young people referred to specialist services are being turned away. Our research has found that in many areas early intervention support for these children does not exist, or has been cut in recent years. Those whose referrals are accepted face a postcode lottery of waiting times.

The Coalition Government rightly identified children and young people's mental health as a priority, with announced investment of £1.4bn over five years, accompanied by a clear national strategy. Our Mental Health Commission has explored the progress in delivering this strategy and the barriers to implementation. We have demonstrated that while some progress is being made, not all the agreed funding is reaching the frontline, and that services are struggling to expand due to recruitment difficulties and high expenditure on agency staffing. Anecdotally, we have also heard that demand for these services continues to rise. This report has enabled us to complement our analysis of national data and policy with a more qualitative understanding of the progress and challenges in the transformation of child and adolescent mental health services.

Our research has enabled the Commissioners to shape the following recommendations to government and national system leaders as to what we feel would make the biggest difference to improving support for children and young people over the next five years.

A National Prime Minister's Challenge

The Prime Minister should announce a **National Challenge on Children's Mental Health**, making it a key priority of her administration. In her first speech as Prime Minister, Theresa May spoke of fighting 'burning injustices', including *"If you suffer from mental health problems, there's not enough help to hand"*. Children and young people's mental health services should be the focus of this prioritisation as the single most important health issue, with self-evident consequences for the long term economic social and political success of this country.

Learning from the level of ambition of the Dementia Challenge,[44] the Prime Minister's Challenge should cover research and prevention, early intervention and treatment. It should be a cross-government strategy, not just focused on the Department of Health,[45] given the importance of mental health within education, local authorities and the criminal justice system.

The Education Policy Institute has identified a 'treatment gap' where increasing demand for specialist services has led to high thresholds for access to care and long waiting times. The Challenge therefore needs to have a particular focus on earlier intervention and support across the wider system, including within schools. It must be a fully cross-departmental, nationally accountable strategy with all departments and arms' length bodies working together in a coordinated way. It should be designed in partnership with, and accountable to, children and young people and their families.

The Prime Minister also spoke of the burning injustice of the treatment of black people being treated more harshly by the criminal justice system, which is mirrored in the over-representation of black young people in inpatient and secure mental health services. The Prime Minister's Challenge must include the moral imperative of ensuring that people from all backgrounds get early access to appropriate support to tackle this 'burning injustice'.

---

44   https://engage.dh.gov.uk/dementiachallenge/custom_layout/homepage/

45   The World Health Organisation Action Plan recommends that countries integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age in order to improve mental health service delivery, promotion and prevention strategies: http://www.who.int/mental_health/action_plan_2013/en/

1. Prevention

The strategy should first focus on how to prevent mental health problems in children and young people. This should include:

1. A sustained focus on raising awareness and reducing stigma. This work would target parents and grandparents as well as young people, and include BME communities with awareness of cultural differences and language barriers. The challenge should set clear goals to **increase mental health literacy** as have been adopted in Scotland, Australia and Canada.[46] The Government should promote the uptake of evidence-based **Mental Health training**[47] (Psychological first aid was part of the World Health Organisation World Mental Health Day campaign in October 2016).[48] This would help young people access care as one of the biggest barriers is young people and their parents asking for help.[49]

2. The government commissioning an easy to understand web-based parenting guide for all parents. This would provide advice at the child's birth and at key transition points, such as the start of primary and secondary school. This would include information on mental health, including evidence-based advice on how to prevent problems occurring.[50]

3. The establishment of a **Mental Health Research Institute**[51] in order to fund research into understanding mental health, new treatments such as talking therapies or better medication, and develop the evidence base for effective interventions. This should explore research into what is leading to the increase in mental health problems amongst young people, such as the impact of social media. Despite the fact that 75 per cent of mental illness starts by the age of 18, less than 30 per cent (£26 million a year) of the total mental health research spend is put towards children and young people's studies in particular.[52]

4. A strategy to **empower young people to live safe digital lives.** This should focus on developing young people's resilience and critical thinking skills in the face of online threats, given the impossibility of eliminating all online risk. This could build on the review undertaken by Young Minds and Ecorys on this issue.[53] It should also explore the potential for positive benefits from

"Parent support and understanding is paramount, they are the ones who are there when you are back from hospital".
EPI Youth Reference Group member

"We need clear advice like '5 portions of fruit and veg a day'. I didn't realise that your physical health affected your mental health".
EPI Youth Reference Group member

---

46 The Scottish Government, 2003. Australian Department of Health and Ageing, 2009. British Columbia Ministry of Health Services, 2003. There is evidence from Australia that increasing mental health literacy through high quality web-based information can have a beneficial effect on symptoms in people with depression, producing effects equivalent to internet-based cognitive behavioural ther-apy. See Mental Health Literacy, Empowering the Community to Take Action for Better Mental Health, Anthony F. Jorm, University of Melbourne, American Psychologist, April 2012.

47 A Mental Health First Aid training course began in Australia in 2001. The aim of this course is to train members of the public in how to provide support to someone who is developing a mental disorder or in a mental health crisis situation until professional help is obtained or the crisis resolves (Kitchener & Jorm, 2008). Four randomized controlled trials have been carried out comparing the course with wait-list controls (Jorm, Kitchener, Fischer, & Cvetkovski, 2010; Jorm, Kitchener, O'Kearney, & Dear, 2004; Jorm, Kitch-ener, Sawyer, Scales, & Cvetkovski, 2010; Kitchener & Jorm, 2004). These trials have found improve-ments in knowledge, confidence in providing help, actual helping behavior, and stigmatizing attitudes. These changes are maintained for five to six months after course completion.

48 http://www.who.int/mental_health/world-mental-health-day/2016/en/

49 Missed Opportunities: A review of recent evidence into children and young people's mental health, Lorraine Khan, Centre for Men-tal Health, 7 June 2016.

50 Teenagers felt that parents were sometimes reluctant to acknowledge child and adolescent needs for fear of being criticised or blamed themselves (Chandra & Minkovitz, 2007; Hinshaw, 2005). Parenting has effects on the development of depression and anxiety in children (McLeod, Weisz, & Wood, 2007; McLeod, Wood, & Weisz, 2007). Although the effects of parenting are modest in size, there could be a substantial gain in population mental health if shifts in parenting behaviour occur across the whole community. (Mental Health Literacy, Empowering the Community to Take Action for Better Mental Health, Anthony F. Jorm, University of Melbourne, American Psychologist, April 2012).

51 The PM's Challenge on Dementia 2020 announced that an international dementia institute will be established in England – the Spending Review and Autumn Statement 2015 confirmed that up to £150 million will be invested to launch a competition for a Dementia Institute. The Australian government established a Centre of Excellence in Youth Mental Health with responsibility for research, training, skills and workforce and service development.

52 MQ: https://www.mqmentalhealth.org/news-blog/post/funding-gap-in-mental-health-research-leaving-generations-of-young-people-in-the-dark

53 Resilience for the Digital World: Young Minds and Ecorys, 2016. http://www.youngminds.org.uk/assets/0002/5852/Resilience_for_the_Digital_World.pdf

the internet and social media such as online counselling and support. It should cover threats such as excessive internet use, child protection, websites promoting suicide, self-harm or eating disorders (e.g. pro-ana and pro-mia sites that promote anorexia or bulimia)[54] and cyber-bullying. The strategy would be developed in partnership with the UK Council for Internet Safety and Childnet.

2. Early Intervention

Early Intervention in the community

A key finding of the Mental Health Commission's first report: *Children and Young People's Mental Health: The State of the Nation*, was that specialist services were turning away, on average, 23 per cent of the young people referred to them for treatment. The report identified that this was often due to high eligibility criteria that limited specialist services to those children and young people with the most severe symptoms. This limits the ability of services to intervene early before young people have reached crisis point, which is contradictory to the strong evidence base for early intervention.[55] This key problem of high thresholds for care needs to be addressed by the transformation process. The availability of early intervention provision to support young people who are turned away from specialist care is a critical part of the overall system.

1. As part of the Prime Minister's Challenge, with the additional funding under *Future in Mind*, every area should have **nationally kite marked**[56] **easy to access**[57] **(by drop-in, or self-referral, with no thresholds) services.** These services should be designed to help young people with a range of problems, including debt, sexual health[58] as well as mental health support. Early intervention services are not just the responsibility of the NHS and this is why a cross-government approach is needed.

    Every aspect of the services should be designed in partnership with young people.[59] "*Get young people, the experts, involved in services*".[60]

    - While the design of local services should be a matter for local areas, there should be a national set of standards for these agencies, and they should be registered with the Care Quality Commission.

---

54 A 2006 survey of eating disorder patients at Stanford Medical School found that 35.5% had visited pro-ana web sites; of those, 96.0% learned new weight loss or purging methods from such sites. Wilson, Jenny; Peebles, Rebecka; Hardy, KK; Litt, IF; Wilson, J L (December 2006), "Surfing for thinness: A pilot study of pro-eating disorder web site usage in adolescents with eating disor-ders", Pediatrics, 118 (6): e1635–e1643,doi:10.1542/peds.2006-1133, PMID 17142493

55 There is a wealth of evidence supporting early intervention, e.g.: Investing in Children, Centre for Mental Health, February 2015 http://www.centreformental-health.org.uk/investing-in-children-report. See also Patrick McGorry's work on early intervention in psychosis: Early intervention in psychosis, Swaran P. Singh, The British Journal of Psychiatry Apr 2010, 196 (5) 343-345; DOI: 10.1192/bjp.bp.109.075804

56 There is also good evidence on the real difference that can be made to children's life chances by intervening at the very first sign of deterioration, and on what has the best chance of improving outcomes for those who develop a diagnosable mental health problem (Patel, et al., 2007; Social Research Unit, 2013; Khan, et al., 2015).
    See Australian Headspace model: Over half of adolescents (54.4%) with mental health problems had heard of it (based on national survey of young people). 65% of parents of those with mental health problems had heard of it. The programme supports a third of secondary schools in Australia. 80% of young people wait two weeks or less for help. Outcome data after two years includes 61% improvement, 50% 'reliable improvement' and 42% improvement over clini-cal threshold (recovery). Service has also been inde-pendently evaluated: https://headspace.org.au/assets/Uploads/Corporate/Publications-and-research/final-independent-evaluation-of-headspace-report.pdf
    See also Jigsaw programme in Ireland. Early analysis indicates participants reported high levels of psychological distress pre-intervention and levels were sig-nificantly lower post intervention: https://www.cambridge.org/core/journals/irish-journal-of-psychological-medicine/article/description-and-outcome-eval-uation-of-jigsaw-an-emergent-irish-mental-health-early-intervention-programme-for-young-people/820D6F3F7845761D9711A9741C62FFEA
    UK evidence from Youth Access: 17% of youth advice agenices had GHQ-12 scores that indicated severe mh issues (scores of 11 or 12), compared with 2.6% of the general population. The unit cost of youth advice services ranged from £61 to £120 per individual young person advised. Estimate dsavings in GP costs alone equate to £108,108 per 1000 clients or £108 per young person – exceed-ing the costs involved. Youth Advice: a mental health intervention? Youth Access, November 2012.

57 What good looks like in psychological services for children, young people and their families, The Child and Family Clinical Psychology Review, No 3 Summer 2015. Edited by Julia Faulconbridge, Duncan Law and Amanda Laffan. http://shop.bps.org.uk/publications/publication-by-series/child-and-family-clinical-psy-chology-review-no-3-summer-2015.html

58 Several services visited by the Commission such as Axis@The Hive and the Mancroft Advice Project expressed the view that joining up mental health advice and support with other services reduces the stigma attached and makes people more likely to access sup-port.

59 What good looks like in psychological services for children, young people and their families, The Child and Family Clinical Psycholo-gy Review, No 3 Summer 2015. Edited by Julia Faulconbridge, Duncan Law and Amanda Laffan. http://shop.bps.org.uk/publications/publication-by-series/child-and-family-clinical-psy-chology-review-no-3-summer-2015.html

60 Education Policy Institute Youth Reference Group member

- The NHS is not the only part of the children's mental health system and cannot provide all this early intervention support alone. This should mean strengthening, and building on the (often voluntary sector) services that already exist (such as YIACS – Youth Information, Advice and Counselling Services).
- Outreach should be a key element of the support offer. The Integrate Movement is pioneering an outreach model called 'street therapy' where professionals offer therapeutic interventions in the community, in places such as housing estates, local cafes or parks.[61] Reaching out to meet young people in their own communities will enable services to reach young people who would not engage with traditional services and overcome barriers such as people's inability to travel or clinics not being culturally appropriate.
- This should be clearly linked into specialist services (e.g. easy referral routes, psychiatrists offering sessions within the drop-in). Specialist teams should also provide support for GPs including screening and advice/signposting.[62]

2. Every young person should be able to access accredited online information and counselling in addition to face to face support so it is their choice which to use (or they can use a combination).[63]

3. There should be a clear strategy to ensure earlier access to appropriate care for young people with mental health problems from all local communities, particularly those who are under-represented in services (e.g. those with learning difficulties, black and minority ethnic groups, LGBT young people, or others who may fall within one or more of the protected characteristic categories). Focus should also be given to those communities who are over-represented in inpatient and secure services as this is an indication that earlier intervention is not taking place. This should include collecting data in the mental health minimum dataset on a) the prevalence of conditions within these groups b) their access to services, including waiting times c) the quality of care received (e.g. incidents of restraint). This should be actively monitored and goals should then be set to improve the care offered. It is important to ensure that the care accessed is culturally appropriate and accessible to young people by working with young people and their communities to design appropriate support.

---

61 See MAC-UK model, evaluated by the Mental Health Foundation indicating significant engagement with hard to reach young people, including reductions in offending behaviour and links into further statutory support: http://www.mac-uk.org/wped/wp-content/uploads/2013/03/MC-Research-Website-PDF.pdf http://www.integratemovement.org/new-page

62 General practitioner experience and perception of Child and Adolescent Mental Health Services (CAMHS) care pathways: a multi-method research study, Hinrichs S, Owens M, Dunn V, et al. BMJ Open 2012;2:e001573. doi:10.1136/bmjopen-2012-001573
The US McPap programme - Massachusetts phone service run by psychiatrists for GPs. This helped upskill paediatricians and GPs and reduced referrals, with an increase in confidence and partnership. https://www.mcpap.com/About/OverviewVisionHistory.aspx UK based good practice includes Right Here Sheffield's pilots to join up primary care services with youth mental health voluntary sector support: www.youngpeopleshealth.org.uk/5/page/71/gp-champions-project

63 According to research from Young Minds, 63% of young people would seek help online, more than the 56% who would go to family or 54% who would go to a mental health service. Croydon's SkyCasts programme delivers interactive psycho-educational online groups for 14-25 year olds using webinars. Groups are facilitated by a counsellor and offer practical information, coping strategies and options for further support. Mental health outcomes measures and feedback are used to assess levels of need and to ensure high-risk young people are directly involved in the sessions through 'live chat', surveys and Q&A. Feedback since its launch in 2015 indicates that young people would recommend SkyLine because of its flexibility and accessibility, but it is being independently evaluated.

CASE STUDY: Axis @ The Hive

- Axis @ the Hive is a joint project funded by Camden Council and Camden Clinical Commissioning Group (CCG) to help bridge the gap between child and adult health and wellbeing services, particularly for young people who are currently not engaging with any services. Managed by Catch22 in partnership with local specialist organisations, Axis operates from a youth base called The Hive, which has been co-designed by young people. Axis grew from a number of conversations between commissioners, organisations and young people in Camden and beyond.

- Based at The Hive in Camden, Axis supports young people with education, employment, housing, sexual health, substance misuse and health and wellbeing. It targets 16 to 24-year-olds in Camden, North London. Young people can self-refer to Axis by contacting the service directly, and services are welcome to get in touch to discuss partnership working with young people.

- Axis employs a team of young people who are trained to help other young people in many areas of their lives and who can relate to the challenges that young people face on their journey to adulthood. All partners employ staff who are realigned (rather than just seconding them into one organisation), the governance is co-written and is everyone's responsibility (again, rather than just falling with one organisation). Young people shaped it from the beginning and authentically so.

- The Hive has been co-designed by young people to be a safe and welcoming place to relax, meet new people, take part in events and activities and get information about local services. It includes spaces for e-learning and personal study and will include a social enterprise where young people can obtain experience to help build their CVs.

Early Intervention in Education

The Prime Minister's Challenge should deliver a high profile, national programme to ensure a stronger focus on mental health and wellbeing within schools:

1. **Funded training for teachers**.[64] Ensuring that all teachers and other school staff know the basics of how to identify young people in need, provide the right early support and refer to specialist services where necessary. Teachers need to be equipped to learn what to do and what not to do in response to mental health problems that become apparent in their classes. Evidence-based mental health training needs to be part of **Initial Teacher Training**[65] **and continuous**

"Teachers see kids five times a week and are the most likely group to notice children who are potentially at risk. The school system should be involved in developing local plans as they provide the easiest point of outreach to young people. Furthermore, I feel school environments lack an awareness or visibility of mental health services available to young people.
EPI Youth Reference Group member

"We know that an awareness of our pupils' mental health is part of our job but that needs to be recognised externally".
Headteacher, Association of State Girls Schools at roundtable with the Education Policy Institute

---

64   Training for education staff is recommended by the National Institute for Health and Care Excellence: http://pathways.nice.org.uk/pathways/social-and-emotional-wellbeing-for-children-and-young-people#path=view%3A/pathways/social-and-emotional-wellbeing-for-children-and-young-people/social-and-emotional-wellbeing-in-secondary-education.xml&content=view-node%3Anodes-staff-training. In a large nationally representative study of children's mental health, the most commonly consulted professionals regarding children's mental health were teachers (Ford et al., 2007).

65   The Department for Education will base quality assessments of ITT training on: A framework of core content for initial teacher train-ing (ITT), July 2016. Stephen Munday, CBE. This includes recognition of the importance of mental health training. The Department should ensure that this process means that all ITT providers include high quality mental health training in their courses.

professional development along with child development, behaviour-management and SEND. This was a key recommendation of the Youth Select Committee inquiry into mental health in 2015:[66]

2. Schools should have an **obligation to provide the right levels of CPD training** in mental health for different staff, including basic training for all school staff, including lunchtime supervisors (who, for example, will be overseeing meal times for young people with eating disorders). There should be additional training for all teachers and TAs, and more detailed training for a mental health and wellbeing lead. Consideration should be given to amending the Teacher Standards on which ITT is based.

"Mental health training courses/training should be compulsory or at least encouraged for people in positions of responsibility who consistently come in contact with young people".
EPI Youth Reference Group member

3. There should be a **trained lead for mental health and wellbeing in every school**, college and university. This should be a member of the school or college Senior Leadership Team. There should also be a named link for every school within specialist CAMHS and these two leaders should be provided with joint training. The CAMHS schools link pilots are very promising and a national programme of integrated training with schools should be rolled out.[67] There should also be a **lead school governor** for wellbeing.

4. **Schools, colleges and universities should be mentally healthy environments.** They should adopt the WHO recommended Whole School Approach model).[68] This includes eight areas of focus:
   - Leadership and management that supports and champions efforts to promote emotional health and wellbeing
   - School ethos and environment that promotes respect and values diversity
   - Curriculum, teaching and learning to promote resilience and support social and emotional learning
   - Enabling student voice to influence decisions
   - Staff development to support their own wellbeing and that of their colleagues and their students
   - Identifying need and monitoring impact of interventions
   - Working with parents/carers
   - Targeted support and appropriate referral, with clear referral pathways for mental health as exist already for safeguarding.

5. Students need to be involved in the design of in-school support. This could include provision

---

66   Youth Select Committee report on mental health, 2015: http://www.parliament.uk/youthselectcommittee-2015
67   Mental health interventions in schools in high-income countries, Dr Mina Fazel, Prof Kimberly Hoagwood, PhD, Sharon Stephan, PhD, Prof Tamsin Ford, PhD. The Lancet Psychiatry, Volume 1, No. 5, p377–387, October 2014
68   For more detail, see: Promoting children and young people's emotional health and wellbeing A whole school and college approach, Public Health England and the Children and Young People's Mental Health Coalition, March 2015: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf A US me-ta-analysis summarised research on 207 social and emotional interventions, and suggested that schools with effective programmes showed an 11 per cent improvement in achievement tests, a 25 per cent improvement in social and emotional skills, and a 10 per cent decrease in classroom misbehaviour, anxiety and depression. Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., and Schellinger, K. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. Child Development 82: 474-501. Schools provide a rare context within which universal programmes have been noted to result in moderately sized improvements to whole child population mental health, but with particularly notable gains for higher risk children (Weare & Nind, 2011). Proven programmes must form part of a Whole School Approach to promoting mental health and wellbeing and should be reproduced faithfully (not adapted or dipped into). Programmes should be delivered by well trained and supervised staff (Durlak & DuPre, 2008);

of evidence based in-school counselling[69] and peer mentoring (but peer mentoring must not replace other support and should be optional given the associations between mental health and bullying). There needs to be clear guidance and national standards to ensure this support is evidence-based.

6. All schools should have a legal responsibility – in common with financial audit – to commission an independent annual safeguarding and well-being audit.

7. **Within its existing framework categories, Ofsted should have regard to wellbeing in any inspection of a school or college**. The Ofsted framework and the School Inspection Handbook should be revised to include more specific attention to mental health and wellbeing under the existing category of "personal development, behaviour and welfare". The Independent Schools Standards should also be strengthened.

8. **Mandatory updated high quality, statutory PSHE** in all schools and colleges with dedicated time. PSHE is not just about sex and relationships education. It needs to encompass a rounded approach to young people's physical and mental health. The updated curriculum needs to take account of online risks and help to build resilience in young people in the face of these challenges.

There is a growing attention from policy makers on how character and resilience can be developed for young people. The Education Endowment Foundation is exploring the evidence base behind how far character and resilience can be impacted by educational interventions.[70]

Mental health is an underpinning factor for several aspects of the education system. A good understanding of mental health and wellbeing can support a strong school ethos, a positive learning environment, effective behaviour management and the wellbeing of staff and students.

According to the Department for Education's own research, children with higher levels of emotional, behavioural, social and school wellbeing, on average, have higher levels of academic achievement and are more engaged in school, both concurrently and in later years. Children with better emotional wellbeing make more progress in primary school and are more engaged in secondary school.[71]

88 per cent of the cost of young people's mental health problems is borne by the education system.[72]

This is not about schools replacing support that should be offered by the health system: teachers are not, and should not be, mental health specialists. The point is to recognise the influence of schools on young people's wellbeing, such as through the school ethos and policies; building young people's resilience including ensuring a strong pupil voice within the school; addressing social and emotional wellbeing within the curriculum; supporting staff wellbeing; identifying those who may need further support; being aware of and supported by clear referral routes to targeted and specialist services and acting as system partners with the NHS to ensure a joined up approach.[73]

---

69 Counselling in schools has proven to be a highly effective support for tens of thousands of troubled children and young people who are experiencing emotional health difficulties. The Welsh Government's national school-based counselling strategy has been such an overwhelming success, that it is now a statutory service for Welsh secondary schools.
    The most recent Welsh Government statistics for 2014/15 show that of the 11,567 children and young people who received school counselling, 89% did not need any onward referral to more specialist treatments. Furthermore, the average improvement in the Young Person's Core Score (a measure of psychological distress before and after counselling treatment) was a decrease in 8.5 (Welsh Government, 2016). Counselling has been shown to bring about improvements not just in mental health and wellbeing but also yielding reduced levels of school exclusion by 31% and improved pupil attainment (Banerjee et al., 2014). Furthermore, school management have reported perceived improvements in attainment, attendance and behaviour of young people who have accessed school-based counselling services (Pybis et al., 2012). Emotional, behavioural, social and school wellbeing also predict higher levels of academic achievement and engagement in school (Gutman & Vorhaus, 2012). Source: British Association for Counselling and Psy-chotherapy response to Education Policy Institute Call for Evidence.
70 https://educationendowmentfoundation.org.uk/school-themes/character/
71 Gutman L and Vorhaus J (2012). The Impact of Pupil Behaviour and Wellbeing on Educational Outcomes. London: DfE
72 Knapp M, Ardino V, Brimblecombe N, Evans-Lacko S, Iemmi V, King D, Snell T (2016) Youth Mental Health: New Economic Evi-dence. LSE Personal Social Services Research Unit.
73 See Public Health England guidance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf.

3. Delivering better treatment

1. Local health leaders should not receive the additional *Future in Mind* funding each year unless they can demonstrate that they have robust plans to improve care and all the additional funding is being spent on children's mental health and in addition is not offsetting cuts elsewhere. Sustained investment needs to be focused on early intervention to reduce increasing demand for specialist support. This should include an annual audit of progress in delivery of their initial local transformation plan and expenditure including for 2015/16 and 2016/17.[74] In addition, there should be a fundamental reassessment of expenditure on child and adolescent mental health when new data on prevalence amongst young people is available in 2018. This should include an analysis of where investment is currently being spent (for example in expensive inpatient settings where appropriate support is unavailable within the community) and what savings can be released through a redesign of current service provision.

2. **The Prime Minister's Challenge should set a series of ambitious goals for care, including that no one should wait more than eight weeks for the start of routine treatment (the current average waiting time across services).[75]** There should be a four-hour maximum wait for an emergency, just as there is for physical health problems in A&E. National quality and outcomes goals should also be developed, building on work such as that of the Child Outcomes Research Consortium, and as robust data becomes available in the future. These standards should be underpinned by legal rights through the NHS Constitution.

3. **The practice of making a young person leave their support service on their 18th birthday must end.** Young people should be able to choose when to transition up to the age of 25[76] with support from their therapists and parents or carers. Those over 18 on referral would still for the most part be seen by adult services. Whenever transition occurs, there should be a smooth transition to adult services[77] and when young people move to college or university. Young people at university should be able to stay connected with their home CAMHS team and stay registered with their home GP if they prefer.

4. The Government's **Workforce Strategy** must be creative, developing new ways of working, and skills sharing across professional boundaries. For example, the strategy should explore how highly trained specialists are used most effectively, such as to initially diagnosis, triage and signpost young people to follow up treatment. There needs to be a **better skill mix** between staff with experience of engaging young people and more expensive clinical expertise. The strategy should look across the whole workforce, not just specialist NHS professionals. For example, it should explore how more trained counsellors, therapists, Psychological Wellbeing Practitioners and youth workers can bring additional support and expertise. NHS Digital should **collect data on the mental health workforce** with sufficient granularity – e.g. including retirement profiles. **Mental Health training** should be provided for all health and care workers, especially GPs as well as all teachers.

> *"Updated training is needed. Nurses who have been practising for a number of years had not been adequately trained on mental health conditions".*
> **EPI Youth Reference Group member**

---

74   This expenditure is particularly at risk of cuts eg: Northamptonshire reviewing children's mental health services with aim to save £0.6m: http://bit.ly/2fj9EeS

75   This was the average waiting time identified in our second report, Progress and challenges in the transformation of children and young people's mental health care, Emily Frith, Education Policy Institute, August 2016.

76   Adolescents leaving mental health or social care services: predictors of mental health and psychosocial outcomes one year later. Jessica Memarzia1,2, Michelle C St Clair1,3, Matt Owens1,4, Ian M Goodyer1 and Valerie J Dunn1,2 Memarzia et al. BMC Health Services Research (2015) 15:185
What good looks like in psychological services for children, young people and their families, The Child and Family Clinical Psychology Review, No 3 Summer 2015. Edited by Julia Faulconbridge, Duncan Law and Amanda Laffan. http://shop.bps.org.uk/publications/publication-by-series/child-and-family-clinical-psychology-review-no-3-summer-2015.html

77   Camden and Islington Mental Health Trust have a programme of support for young people transitioning to ensure young people have a smooth transition to adult services.

Sufficient training should be commissioned to meet increased demand for specialist mental health practitioners so that there are enough practitioners to fill all the posts that are needed. Retraining should be considered of untapped workforce – such as therapists and youth workers.

5. There needs to be a continued commitment to **increasing access to data** on referrals, access and waiting times and quality, covering the wider mental health system (not just specialist services). National cross-government focus should be given to analysing data on the risk factors which lead to, and the early indicators that can predict, mental health problems, and targeting early intervention resources accordingly. For example, there should be an integrated focus on those temporarily and permanently excluded from school.

Conclusion

The Education Policy Institute research has identified a significant rise in children and young people seeking help for mental health problems over the last five years. We have also uncovered a significant treatment gap, with young people turned away from services or waiting a long time for treatment.

Our research finds that some progress is being made to tackle these barriers, but we have uncovered a wide variation in local performance and a range of serious barriers to transformation, such as funding problems and recruitment difficulties. This research has shaped our national and local recommendations for action. The Mental Health Commission is clear that without a sustained commitment to address these barriers over the next five years and beyond, then the treatment gap will remain and children and young people will continue to struggle to access the help they need.

Appendix A: Checklist for Commissioners

As part of our research we have undertaken a literature review, a call for evidence and have analysed every local transformation plan and spoken to expert commissioners and providers across the child and adolescent mental health system. We have distilled our learning on the most effective commissioning strategies we have seen into the following checklist. Many areas may already be undertaking many of these actions but taken as a whole, they provide a comprehensive list of positive approaches to transforming provision.

Good commissioning practice

1. Appoint a champion to motivate and bring people together locally and drive change.

2. Base commissioning on evidence: good needs assessment and gap analysis and outcomes measurement. Undertake an annual audit of services, expenditure and outcomes. Benchmark yourselves against other local and national organisations. Use your Joint Strategic Needs Assessment to collect up to date information from local and national sources on the current and future prevalence of mental health problems by age, gender, tier and condition. Also collect information about dual diagnosis and other complex needs and risk factors. Specialist services should collect data on where referrals come from and this information can be used to support commissioning. Map the range of providers in your local area delivering mental health care support, including universal services such as GPs and schools, and understand what part they play – fill any gaps and ensure there are smooth pathways for people to move between services.

3. Work in partnership with young people: co-produce your support offer with them. Listen to their views on services – don't leave young people's participation to be the sole responsibility of providers. Involving young people does not have to be a tokenistic tick-box exercise – it can be very useful in shaping and influencing a service. Ensure young people help design and run your services, and continue to help design and run them. Involve young people in all aspects of the system – prevention (raising awareness, education), early intervention, access to treatment, service design & system governance. Don't just involve those young people who are already engaged, but also those who tried and haven't been able to access provision, and those who haven't even tried. Involve young people in a structured way so that involvement and young people's views are reviewed and evaluated regularly. System leaders need to listen to the views of young people and not leave participation to more junior staff.

4. Adopt Goals Based Outcomes designed with young people and their families or carers.

5. Ensure clinical involvement in the commissioning process, e.g. through a Clinical Reference Group. Ensure you have the knowledge and authority to positively challenge providers, to ask the right questions, to know and understand what is being done and at what cost.

6. Use evidence-based practice following NICE guidance.

7. Data on access and waiting times, young people's experiences and views of services and outcomes achieved should be routinely collected and published.

Partnership working

1. Think of CAMHS as a 'system' not a 'service' – think more widely than specialist mental health care to include effective links with schools, health visitors and GPs, e.g. Ensuring all GPs understand mental health needs and pathways. Implement effective joined up planning and commissioning of services across housing, social care, youth and adult providers, including mental & physical health, e.g. sexual health and substance misuse. There needs to be excellent communication and strong relationships between commissioners and providers across all these services, both early intervention and specialist support. Pool or align your budgets with partners across the wider CAMHS system, including social care, public health, schools and primary care.

2. Consider partnering with the voluntary sector[78] to co-produce services, including shifting resources towards this early-intervention approach. This can be as partners in commissioning, as potential providers and/or in the form of grant making support for, or more informal partnership with, smaller organisations. Include such providers in outcomes data collection, but without placing undue burden on them. Voluntary sector organisations who support vulnerable people should be able to refer directly to CAMHS, and CAMHS practitioners should be willing to go to these services to conduct assessments and consult. Avoid multiple assessments: work together with partners to enable data sharing with consent.

3. Hold events and meetings to mix workers from different teams together e.g. youth and adult services, teams for different conditions.

4. Support young people with a key worker or service navigator who is able to build a trusted relationship with the young person.

5. Ensure your services for mental health support for young people are integrated with your physical health support offer, e.g. in primary care and community and acute paediatrics

Early intervention and engagement

1. Commission accessible, integrated/multi-disciplinary, drop-in support, in young-people friendly settings, enabling self-referral without entry thresholds.[79] Ensure it is easy to access help – that young people and their families know how to find help. Commission mental health informed youth services that young people will engage with. Go to where young people are. Base your workforce in a youth centre. Visit schools and places in your community where young people naturally go.

2. Ensure your services are culturally sensitive and accessible for everyone, acknowledging barriers to inclusivity and reaching out to groups who may not automatically access treatment.

3. Commission integrated support for those with a range of low-level, inter-locking needs but who don't meet thresholds for specialist services. This should be co-commissioned with a lead agency. There needs to be smooth pathways into care and services need to be trauma focused.[80]

4. Harness new technology – ensure you have clear online communications and advice. Commission effective, youth focused online mental health support.

5. Commission evidence-based parenting programmes such as Circle of Security and Solihull, Triple P and Incredible Years.

6. Consider ways to decrease your Did Not Attend rate – e.g. text reminders, flexible appointments, meeting people outside of the clinic, active follow-up.

7. Provide support for parents and carers, e.g. online advice, drop-in clinics.

8. Work with local media organisations to raise awareness and increase mental health literacy, and ensure local people know what help is available for those with problems, or those at risk. Do this in partnership with communications departments of local providers. Local cinemas may also be willing to advertise services as part of pre-film advertising.

9. Ensure local specialist services provide consultation for referral to young people, their families and carers and the other professionals who deal with them, e.g. phone advice lines, drop-in clinics, visits to schools and GP surgeries.

---

78   Young People's Access to Advice – The Evidence, Kenrick, J.Youth Access, 2009.
79   'It takes a lot to build trust: Recognition and Telling: Developing earlier routes to help for children and young people, The Office of the Children's Commissioner for England, 2013; The outcomes and impact of youth advice – the evidence, Kenrick, J., Youth Access, 2011.
80   Beyond Adversity: Addressing the mental health needs of young people who face complexity and adversity in their lives, Young Minds, 2016: http://www.youngminds.org.uk/assets/0002/9221/Beyond_Adversity_-_YoungMinds.pdf

10. Work with providers to develop assessments that focus on the needs of each young person rather than strict referral criteria.

Workforce development

1. To improve your workforce, encourage training into the shortage professions or think about how to use staff more effectively – be clear about who you need in your team and if they have the right skills to undertake the roles you need them for - e.g. expert clinical professionals and youth workers.

Transition

1. Allow young people to choose when to transition to adult services and ensure the process of transition is smooth with clear policies in place and joint meetings to discuss transitions between CAMHS and adult services. Consider seconding staff between adult and children's services.

Children and Young People's Mental Health: Time to Deliver

This is the final report of the Education Policy Institute's Independent Commission on Children and Young People's Mental Health. It summarises the findings of the Education Policy Institute's research into the 'State of the Nation' in child and adolescent mental health.

It also outlines the progress and challenges in transforming the system since the publication of the government strategy, *Future in Mind*, which was announced alongside investment of £1.4bn over the five years to 2020.

This report complements these findings with additional research visits to frontline services. It also outlines the Commission's policy recommendations to improve the process of transforming services.

Finally, the report includes a checklist for local health and care leaders based on the most effective strategies the Commission has observed.