CareQuality Commission

Review of children and young people's mental health services

Phase One supporting documentation:
Summary of recent policy and literature

Contents

1 Introduction

1a - Purpose of the review of the literature

The report summarises the findings, conclusions and recommendations of recent investigations, reviews, inquiries and policy relating to the system that responds to children and young people who experience mental health problems, or who are at risk on doing so. It also summarises what is known about the strengths and weaknesses of the current system, as well as enablers and barriers to change. It will focus on:

- What is everyone's role in the system now?

- How well is it working, in terms of quality, access and experience?

- What are the gaps, barriers and enablers to change?

Method

In order to understand the current state of knowledge, the problems and challenges facing children and young people's mental health provision and the impact of these on young people and their families, we reviewed of a range of secondary sources of information and material that had been published on this topic.

We included national policy and guidance documents and reviews, evidence to House of Commons submissions and publications by credible think tanks and non-statutory agencies. To ensure that the information was still relevant, we drew largely on documents published since 2014. We made exceptions for statutory guidance that, though published prior to 2014, is still current and for some important issues for which there is no more recent material – such as information about the use of medication in young people and allocation of funding.

We supplemented our own searches for relevant material by asking a range of experts in the field, including those represented on our Expert Advisory Group, to suggest sources that may be important and relevant to review.

1b - Summary of findings

There is a consensus that improvement in the promotion of mental health and the prevention, early identification, support, care and treatment of mental ill-health in children and young people must be a national priority. However, those individuals and agencies who work together in local areas face very substantial practical challenges and obstacles in bringing this about. These include:

- pressure on, and sometimes reduction in, funding at a time of increasing demand (across social care, health and education)

- wide geographical variation in the extent to which local areas have an adequate range of provision and accessible, high-quality services; in particular, many areas have seen a reduction in the availability of local authority services

- too few staff with the required skills and training

- services planned, commissioned, delivered and regulated across multiple different organisations, which do not always work together in a joined-up way

- poor infrastructure and IT systems to support integration of services and joint working

- lack of reliable and accurate data with which to monitor and assure the quality and outcomes of care.

Future in Mind and the *Five Year Forward View for Mental Health* set out the ambition for the future and their recommendations point the way.[1,2] A significant amount of work is already underway to improve the way services are planned, commissioned and delivered, improve the quality of data about services and review the funding of high-quality services. However, these are very early days and the transformation of children and young people's mental health care will take a long time to embed. Effective and sustained national and local leadership is required if the ambition is to be realised.

Local areas are at different stages of understanding their local population need, and planning and developing services that will effectively meet that need. With significant workforce and financial issues across the whole pathway, the literature reflects that many stakeholders are concerned about the sustainability of projects and pilots beyond the additional funding (following the *Future in Mind* report) from the government, as well as successfully implementing the change required across the whole system.[2,3]

2 Understanding the context

2a – Overview of national policy context

- *Five Year Forward View* – published in 2014[4]
- *Future in Mind* – published in 2015[1]
- Sustainability and Transformation Plans – announced in 2015
- *Five Year Forward View for Mental Health* – published in 2016[2]

Recent policy documents describe significant challenges in ensuring that services are effective and easily accessible to support children and young people with mental health problems. Rising demand for care, increasingly complex needs, workforce issues, lack of accurate data, and current constraints on budgets have all been identified as significant factors in challenges facing delivering effective and sustainable care. Lack of joint commissioning and planning has contributed to unclear care pathways and lack of appropriate services.

The loss of much of the prevention and early intervention provision generally provided by local authorities, in addition to specialist community children and adolescent mental health services (CAMHS) raising their thresholds and eligibility criteria to manage demand, as well as geographical variation in the availability of services, has led to increasing numbers of children, young people and families reaching crisis point. Consequently, children and young people's mental health has become a national priority, with government commissioning a number of key policies and reviews over recent years to shape the future of children and young people's mental health services at both a national and local level.

2a(i) Five Year Forward View

In October 2014, NHS England and other arms-length bodies[a] published the *Five Year Forward View*, which sets out a vision of how NHS services need to change to meet the needs of the population.[4] It places greater emphasis on prevention and integration of services. It proposes that through using a number of care models, adapted to meet local need, it will put patients and communities in control of their health. The overarching *Five Year Forward View* policy proposes to:

- drive improvements in health and care

- restore and maintain financial balance

- deliver core access and quality standards.[5]

2a(ii) Future in Mind

In 2014, the government established the Children and Young People's Mental Health and Wellbeing Taskforce. It was asked to identify and consider ways to make it easier for children and young people, their parents and carers to access help and support when needed and to improve how children and young people's mental health services are commissioned,

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[a] Care Quality Commission, Health Education England, NHS Improvement and Public Health England

organised and provided. The subsequent report, *Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing*, published in 2015, outlined the government's aspirations for children's mental health to be reached by 2020 and made a total of 49 recommendations, with five key themes:

- promote resilience, prevention and early intervention

- improve access to effective support – a system without tiers

- improve care for the most vulnerable

- ensure greater accountability and transparency

- develop a skilled and supported workforce.[1]

2a(iii) Local Transformation Plans

The government announced extra funding for the NHS to invest in transforming mental health services for children and young people in March 2015. This was set out as follows:

- £1.25 billion over five years for mental health and wellbeing services for children and young people

- £150 million over five years for community eating disorder services for children and young people up to the age of 18

- £75 million over five years to improve perinatal and antenatal mental health care.

The allocation of funding is managed by NHS England. Clinical commissioning groups (CCGs) secure funding from NHS England through the submission of a Local Transformational Plan (LTP). A recommendation from *Future in Mind* was that each local area must develop LTPs to improve mental health services for children and young people across the whole health, social, education, community and voluntary system. LTPs will outline how local areas will contribute to achieving the national ambitions and principles. Plans should meet the following key objectives:

- deliver parity of esteem between mental and physical health

- build capacity and capability across the whole system, including joint mental health training for the workforce

- continue with the roll-out of Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT)

- close the treatment gap so that more children and young people can access timely, high-quality and coordinated support

- improve perinatal care

- develop evidence based community eating disorder services for children and young people

- target distinct groups of vulnerable children and young people.[1,6]

2a(iv) Five Year Forward View for Mental Health

In 2016, NHS England published the *Five Year Forward View for Mental Health* in England, which outlines strategic planning to deliver mental health care across the lifespan (from infants through to adults and older age) and supports the recommendations made in *Future in Mind*. It sets out the actions required of commissioners and providers for the delivery of key objectives and outcomes anticipated by 2020. The *Five Year Forward View for Mental Health* focuses on delivering seven-day care and developing new models to improve outcomes through integrated services, developing step-down arrangements, standardising referral and discharge processes, and increasing investment in community care and crisis.[2] In July 2016, NHS England published *Implementing the Five Year Forward View for Mental Health.*[7] This sets out plans for the delivery of the recommendations over the coming years to 2020/21.

2a(v) Sustainability and transformation plans

Sustainability and transformation plans (STPs) were announced in NHS planning guidance published in December 2015. NHS organisations and local authorities, in different parts of England, will work together and develop 'place-based plans' for the future of health and care services in their local area. The development of STPs is central to the effective delivery of the *Five Year Forward View* ambition, providing a 'route map' for how local NHS and its partners can deliver the *Five Year Forward View* objectives.[5] STPs will encompass the financial, strategic, contracting and operational planning for all aspects of NHS provision from 2016 to 2021.[8]

2b - What is the aspiration for improving mental health services for children and young people?

Children and young people's mental health services comprise a system of services that have responsibility for assessing and supporting the mental and emotional wellbeing of children and young people. There is a shared vision from all stakeholders of the need to work together in planning and providing a better integrated model for responding to the mental health needs of children and young people that includes prevention, early intervention and intervention to enable recovery.

This vision has been articulated and supported by health commissioners (NHS England and clinical commissioning groups), NHS providers, independent health providers, local authorities, schools, colleges and the voluntary sector, in addition to national arms-length bodies, children and young people and their families. This may require changes in roles and responsibilities for many staff and organisations, and the continued development of innovative and person-centred services that are supporting children and young people to receive timely support, care and intervention.[1,2]

The *Future in Mind* report[1] outlines the government's aspirations for children and young people's mental health to be reached by 2020:

- Improved public awareness and understanding, so people think and feel differently about mental health issues for children and young people and there is less fear and stigma and discrimination are tackled.

- In every part of the country, children and young people have timely access to effective mental health support when they need it.

- A step change in how care is delivered, moving away from a system defined in terms of the services organisations provide (the tiered model) towards one built around the needs of children, young people and their families.

- Increased use of evidence-based interventions with services rigorously focused on outcomes.

- Making mental health support more visible and easily accessible for children and young people and their parents/ carers.

- Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible.

- Improving access for parents to evidenced-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.

- A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it.

- Improved transparency and accountability across the whole system, to drive further improvements in outcomes.

- All professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.

2c - What is mental health and wellbeing in children and young people and why does it matter?

The definition of mental health and mental health difficulties in children and young people is a widely debated topic with many interpretations and definitions. A commonly used definition of mental health and wellbeing is by the World Health Organization: "a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". [9]

This definition reflects that mental health and wellbeing is not simply the absence of mental illness.[10,11] It is influenced by an individual's experience, in addition to the circumstances they find themselves in, as well as the broader environment or society they live in. This is particularly relevant to children and young people, as experiences in childhood have been found to have a lasting impact on a child's development and mental wellbeing that can go on into adulthood.[12,13] A strong focus on children and young people's mental health can promote greater personal, social and economic benefits than intervention at other times in the lifespan.[1,7,9]

Mental health problems in children and young people are common and account for a significant proportion of the burden of ill-health in this age range, with estimates suggesting that mental health problems affect approximately one in 10 children. This is likely to be an

underestimate – this figure is from the 2004 ONS survey and was in reference to children and young people in the age range of five to 15. There is a new prevalence study due to report in 2018.[1,2]

Mental health problems in children and young people incur significant financial costs to health, social and other services such as schools and the criminal justice system.[12] There are significant personal and economic costs associated with not addressing issues early and mental problems continuing into adulthood. It is estimated that mental health problems across the country cost around £100 billion each year and it is the leading cause of sickness absence in the UK. Mental health problems are the largest cause of disability, representing a quarter of the national burden of ill-health[14] and linked to early mortality and health inequalities across all ages.[7]

Children and young people can experience a wide range of mental health problems. These include transient episodes of anxiety, behaviour problems, eating disorders and depression, severe and persistent conditions such as severe eating disorders, persistent self-harm and severe conduct disorder that can cause serious and long-lasting impact.[1] Half of those with lifetime mental health problems first experience symptoms by the time they are 14 and more than 75% of adults who access mental health services reportedly had a diagnosable condition before they were 18.[15]

Mental health problems in children and young people are associated with poor short and long-term mental and physical health, as well as negative educational, social and economic outcomes for the young people themselves and for their family and carers.[1,2,9]

2d - Which children and young people are affected by mental health issues?

The mental health and wellbeing of children and young people can be influenced by a variety of factors.[1,16] Risk factors can increase the likelihood of mental health problems, whereas protective factors can help reduce or moderate the negative effects of the risks. When risk factors and vulnerabilities outweigh factors that are protective, mental health problems can result.[11,17,18] Since risk factors for developing a mental health problem come from many different layers – individual, family, community and wider society – strategies need to be implemented that work at each level.[7,9] In particular, focusing on addressing wider determinants of health, building resilience, improving earlier recognition, timely access and better response for those young people who do experience mental health issues, can bring about positive change and reduce both the cost of future interventions and health inequalities.[1,13,19]

Some children and young people are more vulnerable to poor mental health and wellbeing due to their circumstances. These can include, for example:

- those who experience multiple complex life events, such as parental mental illness, substance misuse, poverty, neglect, abuse, domestic violence and sexual exploitation

- children and young people with disabilities, neurodevelopmental and long-term conditions (2.5% of children and young people in the general population has a learning disability and nearly 40% of this group will develop significant mental health needs)

- those in the criminal justice system (these include the children of parents who are prisoners)

- refugee and asylum-seeking children

- lesbian, gay, bisexual and transgender (LGBT) children and young people

- looked after children, care leavers and adopted children and young people

- bereaved children and young people – bereavement has been identified as a significant risk factor for mental health problems in children and young people and, although there is an absence of official data, estimates suggest that there are approximately 30,000 children under 18 bereaved of a parent every year

- young carers, who can be at risk of poor emotional and physical wellbeing due to the impact of caregiving and responsibility. It is recognised that only a small number of young carers are likely to be identified and assessed from support. Many young carers are reluctant to ask for help or don't know where to go.[2,19.20.21]

However, while it is important to understand the wider determinants that can influence a children and young people's vulnerability, it is critical to recognise that not all children who experience adverse life events and/or environments will develop mental health problems. In addition, mental health problems can occur in young people with no identifiable risk factors. Therefore, grouping children and young people only in terms of their vulnerability or circumstances potentially risks reducing equity of service to all children and young people, or missing early opportunities to prevent mental health problems developing in the wider population.

2e - Specific risks in children and young people's mental health: self-harm and suicide

Self-harm among children and young people is a significant concern, with rates appearing to be rising sharply.[22,23] Available data shows that rates of admission to hospital following self-harm have increased[24], as well as calls to helplines (such as Childline) reporting a significant increase in children and young people contacting them with issues around self-harm and suicidal thoughts.[25] LGBT children and young people are at significantly higher risk of depression, self-harm and suicide. This risk increases further in Black and minority ethnic (BME) LGBT young people.[26]

It is difficult to get a clear picture of the actual prevalence of self-harm, as many children and young people may not disclose self-harming behaviours to anyone.[20] Research carried out by the national suicide prevention strategy demonstrates links between deprivation, self-harm and suicide. The first study of suicide in children and young people showed that 54% of children and young people who died through suicide in England had previously self-harmed.[22]

Suicide is one of the leading causes of death in young people in the UK. Data has been collected on children and young people's suicides for the first time and the report was published in July 2017. This showed that there were 922 suicides and probable suicides by people aged under 25 in England and Wales, and 316 deaths in people aged under 20 in the two year study period (January 2014 to December 2015).[27] The study concluded that suicide

rates were greatest for young men (with 204 deaths, under 20 years old, by suicide) and rise sharply in late adolescence[28]; according to sources the suicide rate in 15-19 year olds has risen for the last three years.[29] The national suicide prevention strategy provides a national approach to suicide research and prevention and recommends the importance of improving mental health in specific groups who may be at increased risk, including:

- children and young people

- people who are especially vulnerable due to social and economic circumstances

- LGBT people

- Black, Asian and some minority ethnic groups.[29]

While there may be a number of factors that contribute to suicide in children and young people (such as mental health problems, substance misuse, deprivation, abuse, bereavement, bullying, family conflict and academic pressures)[13], it is suggested that a collective number of risks may lead to a 'final straw'.[27] All staff who work with children and young people, particularly those working with groups such as care leavers and young people in custodial settings, should have an understanding of potential cumulative risks and 'final straw' stresses that could contribute to suicide.[22]

In addition, the national suicide prevention strategy recommends improved training about self-harm and suicide is important for all services that work with children and young people and, in particular, that frontline staff working with high-risk groups of children and young people should receive specific training on assessment and management of suicide risk.

There is also a need to improve services for those children and young people who self-harm, and timely access to appropriate services are crucial.[30] It is important that all health providers have an agreed protocol for management of children and young people who may present to different areas following an episode of self-harm (for example, children and young people's mental health services, emergency department, paediatrics, general medical, substance misuse services, learning disability services), as well as individual care plans relevant to wider services working with the children and young people.

3 Who is involved?

3a - Role of partners in identifying and responding to the mental health and wellbeing needs in children and young people

A number of organisations have responsibility for commissioning, planning, delivering and monitoring a wide range of health, education and social services, at local and national levels. These include local authorities, clinical commissioning groups (CCGs), health, social care, education and voluntary organisations, all of whom have roles and responsibilities in providing and improving children and young people's mental health services across England. There are a number of challenges and competing pressures faced by education, health, social care, voluntary organisations, commissioners and national arms-length bodies; these will all impact on the provision and prioritisation of children and young people's mental health services at a local level.[31]

While service priorities and provision may vary according to local need and commissioning plans, the literature suggests that there needs to be agreed national priorities, as well as clear structures in place to establish consistently effective integrated working and reduce geographical variation.[7] National arms-length bodies such as the Department of Health, the Department for Education, Health Education England, NHS Improvement, NHS England, Public Health England, Ofsted and CQC, all have roles and responsibilities to agree national strategic priorities, commissioning, funding, service transformation, training and regulation.[1]

The Health Select Committee's Inquiry into CAMHS in 2014/15 found that there was a lack of accountability for ensuring effective funding and commissioning of services, in addition to a lack of national targets and service specifications leading to wide variation and gaps in care.[32] The *Five Year Forward View* proposes that by 2020 there will be a comprehensive set of access data and waiting time standards, data collection, payment models and commissioning frameworks to support addressing these gaps.[14]

There are a range of staff who work directly with children and young people in relation to their mental health and wellbeing, both in universal services and targeted mental health services:

- Universal settings include primary care services, early years provision and schools. Professionals that work in these services include teachers, health visitors and practice nurses, GPs and youth workers.[9]

- Targeted services include services such as paediatric psychologists working in acute hospital settings with children and young people with physical illnesses who may be at risk of or who have mental health problems, looked after children's teams, CAMHS professionals working in schools, community child health services providing care for children and young people with attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorder (ASD), and early help services such as parenting interventions provided by local authorities or schools.

A comprehensive specialist CAMHS service requires professionals with a range of skills and competencies to deliver varied interventions and are provided by a number of different

professional backgrounds such as social work, nursing, clinical psychology, occupational therapy and child and adolescent psychiatrist.[1] Voluntary and charity sector organisations have a key role in working with children and young people, particularly with some of the most vulnerable.[19]

Sources suggest that a shared understanding of roles and responsibilities between national and local leaders, and universal, targeted and specialist services, is necessary to ensure children and young people do not fall between the gaps in services, or in the transition between different services. This shared understanding of roles and responsibilities will help ensure information is shared effectively and resources used appropriately.[13,15,33] Clear understanding is also important due to the number of complexities involved in partnership working.

Potential barriers to effective partnership working between agencies/services include: overlapping geographical boundaries, different priorities, different governance, protocols and organisational structures, as well as variable working practices due in part to different cultures, different concepts and language used to describe mental health problems, organisations focusing only on their own perceived individual remit, and variation in the resources available to different parts of the system.[32,34] The Health Committee Inquiry 2014/15 highlighted the importance of ensuring there are improved assurance mechanisms put in place between NHS England, clinical commissioning groups (CCGs) and local authorities to help clearly establish responsibilities and address variation in how mental health needs of children and young people and their parents/carers is prioritised and resourced.[32].

An overview of the roles and responsibilities of each of the main partners involved in identifying and addressing children and young people's mental health needs, in addition to some of the specific challenges, are described below.

3b - Inspection and regulation

The Care Quality Commission (CQC) is responsible for monitoring, inspecting and regulating health and social care services. It also has a child safeguarding and looked-after children inspection programme. Her Majesty's Inspectorate of Probation is the independent inspectorate of youth offending and probation services in England and Wales. Ofsted is the office for standards in education, children's services and skills. They regulate services that provide care for children and young people and services that provide education and skills for learners of all ages. The Independent Schools Inspectorate is the body responsible for the inspection of schools that are members of the Independent Schools Council.

CQC, Ofsted and HMI Probation carry out specific thematic reviews across different parts of the health, social, justice and education sectors. These thematic reviews can be carried out by the individual inspectorates, or jointly with other organisations and other inspectorates.

NHS Improvement is a merger of previous regulators Monitor and the NHS Trust Development Agency, and is responsible for overseeing foundation trusts and NHS trusts from a finance, governance and leadership perspective.

Methods used by regulators to assess providers include routine visits by inspection teams, visits in response to specific concerns or intelligence, as well as reviewing information and self-assessments submitted by organisations. The inspections identify good and poor practice and both Ofsted and CQC use a rating system to help the public understanding of the quality of care or education delivered by each provider or service.

Regulation and inspection is viewed, by many stakeholders, as a key lever to drive quality, safety and improvement. However, many stakeholders have also highlighted that the legislative and regulatory framework underpinning mental health should be improved.[2] In particular, some sources argue there is a need to strengthen inspection and regulation of mental health support and psychological therapies in primary care and acute physical settings, which are not currently inspected but make up much of the mental health care provision. In addition, voluntary service provision and school counselling is not subject to inspection.[23]

There is debate about the best way of using inspection and regulation to improve quality, while ensuring that actions are proportionate and do not place additional burden on the providers, including excessive preparation ahead of planned inspections that can cause extra workload.[35,36] This can be exacerbated as some systems and services may have several different inspectorates regulating different aspects of provision.[37] For example, a young person in a youth offending institution, who self-harms, is likely to be in receipt of services that are regulated by at least three bodies (CQC, Ofsted and HMIP).

The impact of inspection and regulation heavily influences the behaviour of health, social and education providers. Concerns have been raised about inconsistency, bureaucracy and frequent changes to inspection frameworks and methodology, as well as too much reliance on externally monitored targets and performance, which can undermine organisations' efforts to bring about improvement internally.[35,36] In addition, enforcement and inspection activity can, for example, result in inpatient providers closing services to admission due to staffing shortages or serious concerns about the safety and quality of treatment, but this can in turn impact the whole local and national children and young people's mental health service pathway.[32]

Ofsted's new common inspection framework places greater emphasis on development, welfare and behaviour for children and young people, including emotional and mental health and wellbeing.[38,39] However, the research cited by YoungMinds suggests that this new approach is inconsistently implemented: a third of Ofsted reports reviewed did not make any reference to mental health and wellbeing.[40]

The Kings Fund highlight that CQC's inspection methodology focuses too singularly on one provider or aspect of a service, which does not reflect the complexity of the care pathway with multiple partners responsible for planning, commissioning or providing different aspects of care. This approach may inhibit the development of integrated models as individual providers, in order to meet the requirements of their regulators, focus on their own performance.[3]

A key recommendation from *Future in Mind* is that CQC should work with Ofsted to develop joint, cross-inspectorate view on how health, education and social care are working together to improve mental health of children and young people.[1] This approach would potentially ensure that regulators reflect more accurately the move towards a whole system approach

that is central to the transformation of care for children and young people with mental health problems.

3c - Commissioners

Commissioning of services is fragmented, with different responsibilities lying with different organisations including clinical commissioning groups, NHS England Specialised Commissioning, local authorities and health providers. Schools are also able to commission support services such as educational psychology, mental health support, including school counselling. As a result, the quality of local mental health commissioning and monitoring is variable.

The Health Select Committee Inquiry 2014/15 found that fragmented commissioning pathways and responsibilities have contributed to lack of incentives and accountability to fund and provide a range of services. The use of block contracts means that providers received a fixed payment regardless of how local needs are met or the quality of care provided. This has been compounded by national guidelines to monitor quality and outcomes being poorly implemented at local level. The NHS England review of submitted LTPs found that a third were reportedly planning to move towards an outcomes-based model of commissioning, with others looking at different payment systems to focus on achieving specific locally agreed outcomes.[6]

To help improve accountability of commissioners, CCGs are expected to report performance with the CCG Improvement and Assessment Framework (IAF), a tool that NHS England uses to measure progress on improving services for children and young people's mental health across a range of quality indicators. CCGs will also be expected to publish data on the levels of mental health spend in their annual report and accounts.[2] However, outcomes and indicators are still being developed and some sources express significant concern about variation between CCGs' spend, the additional funding not being ring-fenced, and ongoing difficulty in identifying how money has been spent. This could result in the additional money from the government to improve provision for children and young people's mental health being used to plug gaps in other services or make up for pre-existing shortfalls in funding.[34,41]

Commissioners with responsibility for commissioning services to improve children and young people's mental health within the local area will need to develop service specifications, developed on the basis of the joint strategic needs assessment (JSNA), which is based on specific needs of the local population and the national standards that exist. All service specifications should contribute to a number of strategic outcomes, taking into account a whole range of services for children and young people and their families that have been agreed both nationally and locally (such as the NHS Outcomes Framework, the Public Health Outcomes Framework, local Health and Wellbeing strategies).[42]

NHS England guidance states that service specifications should clearly set out what each provider is or is not responsible for and commissioned to provide. They should be developed with input from children, young people and their parents or carers and include outcomes that are important to children, young people and parents/carers. They should also include any specific protocols for children and young people with complex needs and vulnerable groups.[43] With the exception of services commissioned directly by NHS England, specific

models of care and service specifications will not be defined at national level. Best practice guidance will be shared to support the providers and commissioners in local areas.[1]

A more integrated approach to commissioning, contracting and payment arrangements is expected to form part of many sustainability and transformation plans (STPs). It is recognised that this will require significant work and development, and different STP 'footprints' are at different stages of developing and implementing their plans.[8] In addition, given that health and social inequalities contribute to poor mental health and vice-versa, the commissioning of services to meet the mental health needs will require a broader response than singularly focusing on children and young people's mental health services in order to avoid exacerbating existing inequalities. Commissioning for children and young people's mental health services will need to be aligned with a range of health and social care commissioning services for adults too (for example, mental health and housing), as well as commissioning of physical health services for children and young people.

3d - Local authorities

The Health and Social Care Act 2012 initiated a major reform of the health and social care systems in England. In particular, key duties and responsibilities for improving health and coordinating local systems to reduce health inequalities, promote and protect public health and wellbeing moved from the NHS to local authorities. Local authorities also have a duty to commission and provide a range of welfare and support services, such as children's services and residential accommodation, for those who have additional needs because of age, social/home circumstances, illness or disability.[44]

Local authority finances have come under significant budget restrictions, resulting in reductions in the funding and/or availability of non-statutory services such as early intervention services, housing and youth services, which can significantly increase pressure on the mental health services and funding of voluntary sector services. In addition, the *Five Year Forward View for Mental Health* policy document reflects that historic under-investment has resulted in fewer services available for children and young people's mental health.[2] Some concerns have been raised that this may continue to be a risk unless the funding for children and young people's mental health is ring-fenced.[34]

For the purpose of this review, the roles and responsibilities of local authorities will be discussed in relation to their role in supporting the wellbeing of people and communities. This includes, for example, their public health duties, their responsibilities to looked after children, their role in supporting families, and their role in schools improvement.

3d(i) - Looked after children and children whose circumstances make them vulnerable

Approximately 2.5 million children in the UK are living in difficult family circumstances, such as poverty, poor parental mental health, drug and alcohol addiction, homelessness and domestic abuse.[45] However, figures are likely to underestimate how many children and young people are actually living in difficult circumstances. For example, there is generally poor knowledge about the actual number of children and young people who live in with a parent who misuses substances.[20]

There are a number of processes in place to help identify how to meet the needs of vulnerable children and young people, such as the common assessment framework (CAF), 'team around the child' and the 'troubled families' programme. The literature described variation in how effectively and consistently these are implemented in different organisations.[1]

Some families in vulnerable circumstances will require specific support from the local authority. Children and young people may be taken into the care of the local authority due to significant neglect and abuse or because a parent is, for other reasons, unable to care for them.[46]

Local authorities have a duty under section 22(3)(a) of the Children's Act 1989 to safeguard and promote the welfare of the children they look after, including their mental health. Almost half of children in care have a diagnosable mental health disorder and two-thirds have a special educational need.[17] A review into CAMHS by the Children's Commissioner found there is a significant over-representation of children in care referred to CAMHS; while fewer than 0.1% of children in England are in care, 4% of those referred to CAMHS services were.[47]

The local authority has a statutory responsibility to arrange for looked after children and young people to have a health assessment within 20 days of the children and young people being taken into local authority care. This must be completed by a registered health professional and they are required to use a Strengths and Difficulties Questionnaire[b] to understand the emotional wellbeing of a looked after child (LAC).[17, 24] However, a review by Ofsted found that a significant number of local authorities fail to identify the mental health issues of children and young people in the care system, and most were unable to complete the initial health assessment within the statutory timeframe. Where the assessment had been completed, there was variability in quality.[48]

Statutory guidance for local authorities, CCGs, NHS England and the range of professionals working in these organisations sets out requirements to develop personal education and health plans for looked after children. Ofsted found these were often not adequate or up-to-date and lacked clear targets[45], and shortfalls were identified in the availability of effective CAMHS in a third of local authority areas reviewed.[46]

Guidance from health and wellbeing boards for looked after children recommends that they and care leavers are given priority access to CAMHS, but this is not in place consistently across England.[24] Looked after children who are placed in residential and/or foster care a distance from their previous home can have more difficulties accessing specialist mental health care due to lack of local capacity, poor communication and disagreements between the local authorities and CCGs about who is responsible for funding care. Some services would not see a child or young people unless they were in a permanent and settled placement.[48] However, where there is strong and active engagement from a wide range of agencies this has been found to make a positive difference to the planning of services, quality and extent of mental health support offered.[46]

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[b] The Strengths and Difficulties Questionnaire is a brief behavioural screening questionnaire about 3-16 year olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists.

The NHS England review of submitted LTPs showed that 85% of plans identified looked after children and care leavers as a priority group[6], which suggests that most local areas remain focused on identifying and meeting the mental health needs of this group of children and young people.

There are increasing and additional complex demands on local authority resources to support children in other vulnerable circumstances. For example, there has been a sharp increase in the number of unaccompanied minors who require being 'looked after' by local authorities: this has doubled in the past two years.[46, 49] This population may be particularly risk of mental health problems if they have experienced trauma and loss and as a result they may have complex mental health needs.

While these children and young people may require a range of specialist services, in relation to mental health, access to mental health support has been reported as problematic.[50] This could be because there is limited availability of culturally appropriate services, or lack of understanding among professionals working with this population group about refugee issues such as torture and war. The quality and availability of face-to-face interpreters varies across the country and the cost of interpreting services can be a particular challenge for services particularly voluntary services. There is lack of clarity about the extent of mental health need among refugee and unaccompanied asylum seeking children and young people populations in the UK due to poor quality data collection on health status and access[20]

3d(ii) - Public health

Public Health England was established in April 2013 to support local authorities in fulfilling their public health responsibilities. It provides national and local leadership in understanding and delivering a range of programmes to promote wellbeing across the lifespan. In 2014 it published the 'public health outcomes framework' (PHOF), which includes a range of outcomes and indicators used to measure improvements and set out how the public health system can help identify and respond to a range of health issues, including mental health.[51] This has been reflected recently by the inclusion of two new indicators for self-harm: attendances at A&E for self-harm per 100,000 population and percentage of attendances at A&E for self-harm that received a psychosocial assessment.[16]

Public Health England is responsible for supporting the effective delivery of many of the recommendations in recent national mental health policy, such as *Future in Mind* and *Five Year Forward View for Mental Health*[28,52] and is leading the development of the Prevention Concordat Programme for Better Mental Health with system partners. This aims to put in place joint plans to prevent mental illness, as well as promote and support better mental health and wellbeing, including specific parenting programmes, by 2017.[23]

Local authorities commission public health programmes, including those for mental health and wellbeing. The Healthy Child programme (2009) is a key public health programme for children and young people and their families, used in local area health planning and prioritising. It sets out a framework that brings together the health service, education services and other partners to focus on a universal preventative service around the whole spectrum of child health, wellbeing and parenting.[53] Importantly, the programme links in with a range of interconnecting policy areas, including *Future in Mind* and the *Five Year Forward View for Mental Health*.[54,55] Local health and care planning is channelled through health and wellbeing

boards that are established in all local areas, bringing together system partners across public health, health and social care, with an increasing inclusion of education services.[10]

It is critical to understand the wider determinants of health and mental wellbeing, such as: neglect, homelessness, poverty, domestic violence and parental use of drug and alcohol, in order to improve mental health services and develop integrated systems effectively.[48] Local areas do this through carrying out Joint Strategic Needs Assessments (JSNA), which use local data and insight to map out the health and wellbeing needs of the local population. Priorities and recommendations in the JSNAs are then delivered across health, social and education services.[10] Their effectiveness relies on comprehensive data and partnership working between all health, education, local authority partners (including early years organisations), and third sector (voluntary).[16]

A thematic review by Ofsted into the effectiveness of early help services for children and young people and families by partner agencies and local authority found a disconnect between statutory service provision and partners who provide early help for children and young people. Many JSNAs did not routinely identify known indicators for potential future child protection and mental health issues, such as prevalence of parental mental ill-health, substance use, domestic violence or how many children live in these difficult circumstances. Without comprehensive shared information, early intervention services cannot be targeted at the children in most need.[32,45]

3e - Prevention and early intervention services

Universal services such as health visiting, children centres, youth services, schools and primary care all play key role in prevention and early identification of mental health problems, and/or factors that may impact on the mental health and wellbeing of children and young people. They offer a range of advice, support and interventions to improve the emotional health, wellbeing and resilience of children and young people and their families.

Early intervention services can be commissioned, funded and delivered by a variety of different bodies, including schools, CCGs and NHS provider organisations, independent health providers, local authorities or the voluntary sector. If children and young people cannot access appropriate support and services at an early stage, they are more likely to become more unwell and require specialist care.[1, 23]

While national policy highlights the importance of mental health and better early intervention and prevention[24], these services have been targeted in many areas for funding cuts due to financial constraints.[1, 19] Significant concerns have been raised about the impact of funding reductions for early intervention services in place now and those planned for the future – in particular whether they will be at risk when the additional funding from the government ends in 2020.[34] Only 10% of local areas intended to commission a new service or review the current provision in relation to early intervention with families and young children in their LTPs.[6] In addition, concerns have been raised that specific clinical interventions may be prioritised over early intervention (for example, placing more importance on delivering a specified psychological therapy, over the provision of a drop-in centre for single parents).[20, 21]

Future in Mind set out that, if access and support are targeted too narrowly on clinical care and outcomes, ignoring the wider influences on mental wellbeing of children and young

people, demand will continue to rise and there is a risk of inappropriately medicalising children's mental health needs. This emphasises the importance of the whole system working together to ensure a balance between monitoring meaningful outcomes that ensure accountability, without focusing too singularly on diagnosis and clinical interventions.[1, 12]

Perinatal mental illness is a significant public health issue, with serious negative impacts on mothers, their infants and family, as well as the consequence on wider society.[55, 56] Mental health problems affect at least 10% to 20% of women during pregnancy, or soon after the baby is born, and this figure increases for teenage mothers.[57] A wide range of mental health problems can occur for women during pregnancy and the perinatal stage of their child's life, such as depression, anxiety disorders, post-traumatic stress disorder, panic attacks and postpartum psychosis. Suicide is one of the leading causes of maternal death in the UK.[2, 56]

Early intervention is vital. It is well recognised that experiences in early years can have a significant impact on lifetime wellbeing.[1, 54, 56] Recent policy developments, such as the *Five Year Forward View for Mental Health*[2], the *Maternity Review*[56] and *Future in Mind*[1] have emphasised the need for improved mental health services and timely access to services for women and their families during pregnancy and the first year of a child's life.

Teenage pregnancy is recognised as having an important impact on health outcomes and inequalities and is included as a key indicator for the public health outcomes framework (PHOF). One in 25 births in England are to young people under the age of 20, and teenage mothers are three times more likely to develop postnatal depression.[57] In addition, babies of teenage mothers are at increased risk of poor health outcomes.

Young people – including those who are, or are about to become, parents themselves – are less likely to seek help for fear of being judged negatively or of the effects of social services becoming involved. Often, they do not know how to access help.[57] The 'family nurse partnership' is a programme of intensive home visits by health visitors to provide additional support for first time mothers under 19, although this is not available in every area of the country. While an initial review of this programme showed little evidence of cost effectiveness and/or reductions in behavioural and mental health problems, it has been recommended that there should be a long-term 'life course' approach to research and evaluation of the outcomes for children and parents, to understand the effectiveness of the programme in reducing mental health problems.

Women with more severe mental health problems will need expert care from specialist community perinatal mental health teams and a small number will need admission to inpatient mother and baby units.[55] National policy has highlighted that there is unacceptable variation in access to perinatal mental health services[1], with an estimated 40% of women in England lacking access to specialist perinatal mental health services[56] and 85% of local areas reporting they do not have a specialist perinatal service, or the available service does not meet NICE guidelines.[2, 56]. The objective set out in the *Five Year Forward View for Mental Health* is that all women will be able to access specialist perinatal services by 2020/21.[7]

3f - Paediatric services (hospitals and community) and children and young people with complex needs

Paediatric health services are often used by children and young people who have experienced psychological and developmental difficulties, especially those with newly diagnosed illnesses, life-limiting illnesses, learning disabilities or a chronic health condition, (for example, diabetes).[58] Between 10% and 30% of children and young people have a chronic illness or other long-term physical health needs. These children can be four times more likely to experience mental health difficulties than their peers.[33] Children and young people with several specific physical, emotional and behavioural needs, or co-existing conditions, will have more complex needs and will need access to a range of services.[59]

Paediatricians, community nurses and allied health professionals all work with children and young people and their families who present with a range of mental health presentations, including behavioural challenges, neurodevelopmental disorders, eating disorders, mood disorders and anxiety.[32] The literature suggests that this is another area where lack of clarity about roles and responsibilities poses a challenge. Integrated and joint working arrangements between mental health and acute paediatric and community child health colleagues has been consistently highlighted as a priority area in a number of policy reviews. While this can vary in terms of implementation from one area to another, there remains lack of clarity at both local and national level in relation to who has responsibility for which aspect of a young person's care. This can be exacerbated where care may be provided by several different providers or commissioned by more than one CCG. These factors can mean that some children and young people fall through the gaps between services, with delays or failure to access the mental health care they need.[60]

Community child health services play a key role in the identification and assessment of children and young people with developmental disorders and, in some areas, provide specialist care for children and young people with ADHD.[60] Approximately half of children and young people with autistic spectrum disorders/conditions accessed special educational needs and disabilities (SEND) services in schools or specialist mental health services, and over a third accessed specialist physical health services.[20] Children and young people with a learning disability may be referred to a community learning disability team in addition to the paediatric service. This can be a challenge for families as there may be poor coordination of care across specialisms. Many families can struggle to access mental health support as there may be issues with eligibility, or people may be required to attend multiple locations and appointments that are difficult to fit in with the needs and commitments of the children and young people, such as education and physical health appointments.[21]

Where the system does not meet the needs of children and young people with learning disabilities and complex needs, there is an increased risk of social exclusion, prolonged admission to hospital and failure to access evidence based interventions. In addition, where services have a diagnosis-led approach, this can exclude complex cases where the children and young people may have multiple problems that do not meet threshold for a particular diagnosis but is nevertheless impaired, or where the diagnosis and treatment options are unclear.[60] There are many different views about using psychiatric diagnosis and whether this is a helpful way to understand distressing or unusual experiences and/or behaviours, in addition to making a judgement about what is considered 'normal'. Some people may find it helpful to have a diagnosis as it makes them feel less 'to blame' for their difficulties, or gives

them a better understanding of the options available to support them. Others may find it unhelpful, not accurately reflecting the underlying issues or stigmatising. Therefore, relying too singularly on this aspect of an individual's experience may not always be a helpful way of ensuring that people get the mental health support that they need. One doctor may have a different view to another, or to the patient and/or their family, about what the diagnosis and best treatment are.[61]

The Transforming Care programme aims to improve services and support for children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. In October 2015, the Local Government Association, the Association of Directors of Adult Social Services and NHS England published *Building the right support*, a national plan, across all ages, to reduce inpatient provision and improve community capacity for people with a learning disability and/or autism who display behaviour that challenges.[62] This is included in the NHS Operational and Contracting Planning guidance 2017 - 2019 as one of its nine 'must dos' to deliver actions set out in local plans to transform care for people with a learning disability.[5] Therefore, local transformation plans for this population need to also take into account the national plan and actions.

Some specialist paediatric services have embedded paediatric psychologists and other professionals who can meet the mental health needs of children and young people, but this is not the case in all paediatric services. Paediatric psychiatric liaison services usually consist of one or more mental health professionals, who may be based within the paediatric teams of acute hospitals or the local CAMHS community team. The main focus of this role is acute management of psychiatric emergencies in an acute hospital (such as self-harm, disturbance of behaviour or psychosis) and management of mental health problems associated with physical conditions. Sources suggest that having crisis support and/or psychiatric liaison within the acute hospitals and the wider community can have a positive impact on reducing the risk of admission and the overall length of stay in hospital.[30]

Commissioning and funding arrangements vary widely and this can lead to significant gaps in the availability of care, due in part to differing views on whose responsibility it is to provide specialist mental health support. In addition, care may be provided to children and young people who are from other areas (for example, those admitted via accident and emergency or for specialist paediatric care). However, there is no system in place that allows hospitals to claim back money for providing mental health care to paediatric patients from other CCG areas, in the same way that hospitals do for patients who receive medical treatment.[30, 58] The *Five Year Forward View for Mental Health* states that mental health liaison teams for all age groups will be in place by 2020/21.[2]

3g - Accident and emergency care

Evidence suggests that the number of young people attending accident and emergency (A&E) departments due to mental health problems has more than doubled since 2010. Many are directed there to access help out-of-hours due to the lack of effective alternative out-of-hours provision.[33] Staff at A&E have lead responsibility for initial assessment and treatment of children and young people who self-harm and present to A&E. NICE guidance

recommends that anyone attending A&E departments with self-harm should be offered a comprehensive assessment of physical, psychological and social needs.[30]

There can be long waiting times to see a mental health professional, particularly over a weekend. Concerns have been raised that acute and paediatric staff may not have the skills or training to assess and manage mental health needs effectively. Also, many A&E departments do not have a physical environment that can ensure privacy and safety of young people experiencing mental distress. Many have rooms that contain potential ligature anchor points or whose doors could be barricaded, and pressures on nursing staff and observation practice means that children and young people may leave the department unnoticed.[32] An admission to a paediatric ward may be required, until a full multidisciplinary team review can take place, in line with NICE guidance, or, if required, the identification of an appropriate mental health bed. This has an impact on both the children and young people, and also availability of beds on the paediatric wards.[30, 32]

3h - Primary care

Primary care services are accessible to all children and young people without prior referral and are likely to be one of the first places children and young people and/or parents turn to when experiencing mental health or behavioural problems.[15] Sources suggest that many GPs and practice nurses feel ill-equipped and lack confidence in assessing and managing these issues[32, 63], and reported that options for referrals to specialist services can be limited and difficult to access, leaving some primary care staff concerned about the level of risk they are carrying in the absence of support from specialist mental health teams.[64]

While several preventative mental health programmes are in place within primary care for adults (for example, social prescribing where GPs can refer people to exercise or social activities), these services are not in place for children and young people, although there may be access to other early intervention services, such as parenting groups, through the local authority.[63] Some GP practices have appointed/procured mental health workers to be formally attached to GP practices, offering patient appointments as well as liaison and consultation for primary care staff.[65] More generally, there is no nationally available data looking at the quality of mental health care in primary care settings.[2, 58] This, in addition to the lack of regulation of psychological therapies in primary care (for example, counselling) means there is very little objective oversight of the quality and/or outcomes of mental health care provided in the primary care setting.

Health outcomes for children in the UK are among the worst in Western Europe, and the lack of training in child health across the primary care workforce is viewed as a significant factor in failures to recognise or diagnose serious illness in children.[66, 67] The Primary Care Workforce Commission report for Health Education England sets out the need to focus on training and support in relation to child health for clinicians in primary care.[67] In addition, there are plans to ensure GPs receive mental health training by 2020. Health Education England has proposed that there will be a new role developed for GPs, with extended scope of practice in mental health to help.[2] However, there is wide recognition that GP practices are currently under considerable pressure due to workforce issues, increased demand for their services, and growing complexity in the needs of patients. Evidence suggests that people are finding it increasingly difficult to get GP appointments and/or in seeing the same GP. At the

same time, the government is also proposing a seven day a week, extended hours, GP service by 2020.[64]

Mental health services are often organised separately from wider universal primary care, community health and hospital services. This can be an additional barrier to easy access to mental health services from primary care. The new models of care programme in mental health aims to integrate children and young people's mental health services with the primary care and acute care system. An example of this is the 'vanguards' that join up GPs, hospital, community and mental health services[60], potentially improving access and coordination of mental health care.

Midwives and health visitors are the main professionals who deliver a range of preventative and early intervention support within the Healthy Child Programme 0–5 age range. They are in a key position to educate and support women about mental health and wellbeing during and after pregnancy, as well as to identify families in need of additional support, including those at risk of child abuse and neglect.[54, 56] A range of NICE guidance recommends the use of evidence-based nurturing and parenting programmes for families that need additional support, as well as for children who have been identified as being at increased risk of developing ADHD and/or conduct disorders. These evidence-based programmes all aim to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.[1, 54]

3i - Youth Offending Service and youth offenders

The Youth Offending Service (YOS) is a multi-agency partnership set up under the Crime and Disorder Act 1998, to prevent offending or re-offending by children and young people. National Standards for Youth Justice Services, published in April 2013, set out statutory responsibilities of the YOS and teams working within it.[68] Youth offending teams were created as multi-agency partnerships to help make sure services delivering care to youth offenders are joined up. There are a range of different disciplines employed in YOS healthcare teams, and different models of provision. Some teams are integrated with local mental health systems or have mental health workers embedded in them, but many do not.

Estimates suggest that a third of people in youth justice system have a mental health problem, although figures are likely to underestimate the prevalence and complexity of need that many young offenders experience. Young offenders may have experienced, for example, drug and alcohol misuse, homelessness, abuse and gangs.[69] Young offenders are at increased risk of mental health problems because the original risk factors that led them to offending and associated risk-taking behaviour itself may cause mental health problems. The experiences of the criminal justice system can also lead to developing, or worsening, mental health problems.[48]

Many offenders in the youth justice system have unidentified or unmet mental health needs. This includes young people with unrecognised neurodevelopmental disorders.[7] Children and young people in or on the edge of the criminal justice system have additional difficulties accessing mental health services and concerns have been raised that youth justice and mental health provision is not joined-up. Problems accessing support from mainstream specialist health and social care services can be due in part to inflexible exclusion criteria, failure to recognise complex safeguarding needs, and services lacking the skills and

experience to work with children and young people who are difficult to engage. For example, some services discharge people who do not attend appointments without necessarily seeking to understand if there is an important underlying reason for their failure to attend, or without reaching out to the young person to re-engage them in their care.[70]

There are some examples of successful outreach projects, which help children and young people with mental health problems in the youth justice system who have not been able to access specialist CAMHS. The Department for Education and Department of Health have pledged investment to develop evidence-based interventions for a range of vulnerable children, including those on the edge of custody.[1]

The Healthcare Standards for Children and Young People in Secure Settings (2013) state that there should be a clear pathway for prompt assessment of mental health needs and named points of contact with local services for children and young people who are detained within secure settings. In addition to an initial screening and risk assessment, all young people should receive a physical and mental health assessment within three days of arriving in detention.[71]

The Comprehensive Health Assessment Tool (CHAT) is a method of providing standardised holistic screening and assessment for all young people, with the aim of aiding early identification of needs. It was implemented after it was identified that the most common reason for unmet mental health needs in the youth justice system was a failure to adequately assess and identify them. Assessment should also take into account that the prison environment, isolation and lack of meaningful activity can worsen existing mental health problems.[69]

Sources reflect there are various continued concerns identified in relation to mental health provision in children's secure detention facilities, including over reliance on previous assessments, variability in individual practitioners skills and resource problems in delivering appropriate interventions.[69, 70]

Sources suggest that a lack of effective resettlement support can mean that when children and young people leave the youth justice system they have a range of education, social and housing issues in addition to health and wellbeing needs. In order to address high reoffending rates, access to effective mental health assessment and support, as well as the educational attainment and social needs of children and young people in this group, needs to be improved.[70]

3j - Schools and education for young people

3j(i) - Why are schools important?

Young people's experiences of school are important to their wellbeing and there is general agreement that schools are well placed to support children and young people with their social, emotional and mental wellbeing.[1, 18] Educational attainment is a strong predictor of good mental health and wellbeing, without timely intervention and support for mental health problems, many children cannot engage with learning effectively.[18, 72] While educational attainment is a strong indicator of good health and wellbeing, the literature suggests that

schools must ensure that pressure for high academic achievement does not have a detrimental impact on mental health.

The National Institute for Health and Care Excellence (NICE), Public Health England, the Department of Health and the Department for Education have produced a range of guidance documents about improving children and young people's mental health and wellbeing in schools. *Future in Mind* identifies the importance of developing whole-school approaches to promoting mental health and wellbeing and sets out recommendations to support education services to do so.[1] For a whole-school approach to be effective, senior leaders need to embed wellbeing throughout all aspects of school life.[7, 18] Strong engagement with parents and children and young people have all been shown to work well in promoting mental health and wellbeing in schools, in addition to anti-bullying and diversity policies.[1, 18, 73]

Schools have a major role in tackling bullying, including cyber bullying.[18, 73] Bullying at school is a strong predictor of mental health and wellbeing and is a significant risk factor in many instances of mental health problems in children and young people, including self-harm and suicide.[30, 39] It is also associated with increased anxiety, depression, self-harm and suicide in adulthood.[1, 18, 73] The vast majority of bullying occurs at school[11] and all schools are required to have a behaviour policy that includes actions around bullying.[73] In addition, the government is funding a £2.8 million programme from 2016 to 2019 specifically to focus on homophobic, bi-phobic and transphobic (HBT) bullying in schools.[29]

There is a strong association between poor mental health and special educational needs and disabilities (SEND).[74] The Children's and Families Act 2014 includes specific duties in relation to children and young people with special educational needs and disabilities. There have also been reforms to processes around SEND, including the new Code of Practice (CoP) that provides statutory guidance that health, education and social services must use. The CoP and the Department for Education guidance for staff relating to mental health and behaviour in schools, highlight that potential underlying mental health difficulties should be looked at if a child or young person is displaying concerning behaviours.[7, 73]

Good SEND practice includes clear systems in place to allow for effective identification of learning and mental health needs and appropriate support once need is identified.[13] To support this process, schools should have access to educational psychologists who can carry out a range of statutory and non-statutory work[75], focusing on helping improve learning, development and social outcomes for all children and young people, although much of their work is with the most vulnerable children and young people and supporting children and young people with special educational needs and disabilities, such as autism.[18, 76] There is geographical variation in the availability of educational psychologists and concerns have been raised about their capacity to fulfil their requirements under the amended SEND CoP.[77]

It is recognised in the literature that health and education services need to work together to provide effective mental health care and support.[1,18] While there are many examples of schools working collaboratively with wider communities to offer good mental health support and early identification, there are wide variations in the quality of these partnerships and this impacts on the timely provision of appropriate support for children and young people.[39] For instance, a survey of head teachers in 2016 reported that over half had found the response from specialist CAMHS services poor, with 65% having difficulties getting mental health advice and support for pupils.[78]

3j(ii) - Promotion of wellbeing in schools

Many schools have implemented programmes to promote pupils' mental wellbeing. This is mainly delivered through personal social health and economic education (PSHE), although PSHE is not mandatory. The PSHE programme aims to enable children and young people to look after their own mental health and wellbeing, recognise signs earlier and reduce stigma around mental health.[32]

In 2015, NHS England and the Department for Education jointly launched the mental health services school link project. The project aimed to evaluate whether introducing a single point of contact could improve joint working arrangements between schools and specialist CAMHS. The intended purpose of this approach was to improve the identification and knowledge of mental health problems and the quality and appropriateness of referrals to specialist services. The project included a number of different approaches, such as training, supporting named staff, improving clarity on protocols, direct work with children and young people and families, and developing pathways. Evaluation of the project was positive, although no single model was identified as most effective due to the influence of local need and resource availability. This appears to support the recommendation of *Future in MInd* that models of care need to be planned and delivered in response to local population needs. A lack of clarity remains on how the single point of contact model will be funded and continued beyond the pilot programme.[18].

Other school-based interventions include lunchtime nurture clubs (small group provision in primary schools, usually for children identified as having difficult behaviour, and/or traumatic early experiences, that require additional emotional support), pastoral care services that provide structure in supporting children and young people with identified mental health needs, peer support programmes, practical sessions about mindfulness, relationships and emotional wellbeing.[18, 73] The literature describes how, in order to help prevent significant mental health problems and promote good emotional health, there are some key skills that can improve the resilience of children and young people. These include developing good communication and problem-solving skills and also promoting the ability to seek help. Schools can be particularly beneficial in promoting resilience where the children and young people's home environment is less supportive.[73] As well as providing support within the school environment, schools can promote awareness and signpost to external services that are accessible to all, such as Childline.[74]

3j(iii) - The role of schools in early identification and support

The Healthy Child Programme for five to 19-year-olds is mainly delivered by primary care and school nursing teams. School nurses are well-placed to support children with a range of physical and mental health issues as well as broader welfare and wellbeing issues, including young people that may require additional support, such as children who identify as lesbian, gay, bisexual or transgender (LGBT), who are often less likely to seek help outside their schools and immediate support networks.[16] However, issues in accessing local systems (such as high referral thresholds in specialised mental health services) have meant that the school nurses are also more involved in complex safeguarding and mental health issues. This has the potential to impact on their preventative work and reduce the amount of contact they are able to have in identifying and supporting the wider range of mental health problems experiences by children and young people.[79]

School based counselling is one of the main forms of mental health intervention in schools in England and has the potential to act effectively as early intervention.[73, 74] It is regarded as a highly accessible intervention due to its broad intake criteria and accessibility; it can potentially offer a wide range of therapeutic support.[1, 73] School-based counselling is a statutory provision in Wales and Northern Ireland, but not in England. Sources suggest that this is likely to impact on equity of provision if schools have competing priorities for allocating funds. For example, some schools may choose not to provide counselling services at all if they need to allocate money elsewhere.[19] While the schools counselling strategy, developed by Department for Education, aims to encourage better use of counselling in schools, there is variability in pupil access to a counsellor, with approximately 70% of secondary schools and 52% of primary schools currently offering counselling services to their pupils.[74, 80] The quality of provision is variable, with school leaders reporting that they do not always have the experience, time or knowledge to be assured they are commissioning high-quality and effective school based counselling.[34] While 40% of LTPs referenced school counselling, just 3% of local areas had clear plans to commission this. In addition, within the LTPs, there is little information about specific need, current provision and individual school plans in relation to mental health and wellbeing in each school. Despite being central to the transformation of children and young people's mental health services, few schools have had input into developing the LTPs.[6, 81]

3j(iv) - Training, capacity and challenges for schools

Positive relationships between teachers and pupils are vital to promoting pupil wellbeing, as teachers are often among the first to notice there is a problem and they are one of the main professionals that children and young people will go to for help.[30, 39] However, many teachers report feeling unprepared to manage mental health issues and significant work is required so they can identify and respond to mental health problems at the earliest opportunity.[34, 39]

Schools are facing significant challenges to support the growing number of children with mental health issues, with continued funding reductions and increased pressure on teachers' workloads.[18, 39] School leaders reported that the cost of addressing the additional needs of pupils is a significant and increasing financial pressure. This in turn can mean that in-school mental health provision is vulnerable to cuts, as schools have to make difficult choices about competing priorities.[18, 78, 80]

In October 2014, the Secretary of State and Deputy Prime Minister launched the Department for Education's online Workload Challenge in order to understand causes of additional workload in schools: 34% of respondents stated that policy change at national level was a significant driver of their workload.[36] National policy, including *Future in Mind* and the *Five Year Forward View for Mental Health*, also has such direct workload implications on schools alongside educational reforms.

3k - Voluntary & third sector services

Voluntary organisations have a key role in providing prevention, early intervention services and other services, offering a range of vital support and signposting activities, in addition to working with children and young people in some of the most vulnerable and difficult-to-engage circumstances.[19] There is increasing recognition of the need to involve voluntary

organisations in developing effective mental health services. Many voluntary organisations run helplines and websites offering online support, as well as face-to-face interventions, often providing services that no other agencies offer for children and young people and their families.

Voluntary organisations deliver a range of evidence based interventions. For example, voluntary and third sector services are one of the main sources of specialist counselling services, such as those for bereaved children and children and young people who have experienced sexual abuse and/or sexual exploitation.[21] Voluntary organisations contribute a valuable source of information, particularly representing experiences of children and young people, which is being used increasingly to inform both local and national policy. For example, Childline provides a set of data, used by Public Health England, which provides insight into trends and challenges faced by young people.[13]

Around half of LTPs recognise that voluntary and third sector organisations can work flexibly within the community to support work, such as improving children's and young people's resilience.[6] Emerging models that demonstrate partnership-working across the system, led by a voluntary organisation, include youth services with different pathways for psychosis, developmental conditions and conduct disorders.[12] Some organisations have identified a lack of acknowledgement and respect of voluntary services as a barrier to effective partnership working with health and social services – even where they deliver evidence based interventions. While the role of voluntary organisation in joining up processes and pathways of care is important, voluntary sector providers are also often much more vulnerable to funding reductions and bureaucratic constraints.[21]

3I - Targeted and specialist mental health services

Targeted and specialist children and young people's mental health services are largely delivered by NHS and independent health providers. They incorporate a wide range of specialist services and are intended to meet the needs of children and young people with a wide range of emotional and psychological disorders, in addition to problems such as attention deficit hyperactivity disorder (ADHD) or autistic spectrum disorder (ASD). Specialist mental health teams play a significant role in liaising with and supporting a wide range of services including general practice, hospital and community paediatrics, education, social care and the voluntary sector, in addition to offering direct interventions and support to children and young people.[1]

Most providers of specialist children and young people's mental health services offer: mental health promotion, CAMHS outpatient and community services, family therapy, individual therapy, pharmacological treatments and group work, provision to specialist schools, support to youth offending teams, looked after children services, and eating disorder services. Services that are delivered inconsistently include: antenatal and postnatal support (including perinatal services), specialist BME services, forensic CAMHS, sensory impairment teams, and crisis intervention services.[82]

There are varying access thresholds, diagnostic criteria, conditions and treatment pathways in specialist CAMHS services across the country.[1, 2] A range of policy reports have identified a persistent gap between identifying the needs of children and young people and their access to timely, high-quality help and support.[30, 32] Stigma, fragmented commissioning,

funding, referral criteria, waiting lists and transitions have been identified as common issues in the provision of specialist mental health services.[83]

CAMHS provision in England is currently largely based on a model that divides service provision into four tiers, providing care and treatment depending on the severity and complexity of the problems, with children and young people being referred and/or transferred between the tiers.

The tiers model was highlighted in the *Future in Mind* report as "unintentionally creating barriers between services, embedding service divisions and fragmentation of care," [1] resulting in children and young people not receiving the care they need when they need it and poor transitions between services. Some areas in England are piloting or implementing different models of care that are more flexible, with services built around the needs of children and young people and their families, although these are in varying stages of development and evaluation.[6, 25] A number of projects and providers have been successful in securing funding for pilots, although it is not clear how sustainable many of these will be once the funding for the pilot ends.[34]

Models with an emphasis that moves away from understanding services in terms of severity or complexity[18] include:

- Choice and Partnership Approach (CAPA) – a systematic method of matching patient need to capacity of the service through a 'choice' appointment with a clinician.[83] CAPA is used in mental health services internationally.

- Thrive – a model for thinking about children and young people's mental health needs as four overlapping groups of need: coping, getting help, getting more help, getting risk support. The Thrive model, in particular, is being piloted in a number of local areas as iThrive, with a focus on developing flexible, locally led and evidence-based care; it relies on the availability of a range of community teams who are joined up and working collaboratively.[83] CAPA is embedded in iThrive.

- The Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) – a service transformation programme delivered by NHS England that aims to improve existing services through creating collaborative children and young people's mental health service partnerships across existing services provided by the NHS, local authority, voluntary and independent sector. CYP IAPT transformation includes training for staff and routine outcomes monitoring. Staff can access courses in various evidence based therapies, supervision and leadership. The programme aims to be in place in all local areas of the country by 2018.[2, 33]

3I(i) - Inpatient services specialist mental health services (Tier 4 CAMHS)

Within the inpatient element of 'Tier 4' CAMHS there are several different types of service including general adolescent units. These can include children's inpatient units, adolescent psychiatric intensive care units, low secure inpatient units, medium secure adolescent units, eating disorder services and inpatient learning disability services. The majority of Tier 4 CAMHS inpatient provision is in the form of general adolescent units and most young people admitted are in the 13-18 age range. Service specifications were developed for these services as part of the 2013/14 NHS standard contract. There are significantly more

independent sector providers of specialised inpatient mental health services than any other provider; they represent nearly 50% of provision.[84, 85]

Currently there is limited data on what the outcomes are from different interventions from inpatient services.[85] In addition, while some quality measures are voluntarily reported to the NHS Benchmarking Network, such as levels of violence, ligature incidents and prone restraint, this data is limited to the participating providers and relies on voluntary self-reporting from providers. Therefore, this data may not be representative of all providers, including voluntary sector, social care and independent organisations.[33] However, these caveats aside, the available data from 2016 submissions has shown that safety and quality measures submitted have reflected higher rates of violence, greater use of restraint and more ligature incidents in inpatient provision, compared with previous years. There could be a number of a different reasons for this, such as an increasingly complex and challenging patient cohort, changing profiles of services, workforce issues (such as lack of suitably skilled staff to manage the patient group), or increased reporting by providers.[82]

In April 2013, NHS England took over the commissioning of inpatient children's and young people's mental health services. Previously, these services had been commissioned mainly by clinical commissioning groups (CCGs). The CAMHS Tier 4 review was established due to concerns that emerged after NHS England took over the commissioning of inpatient services in 2013, including:

- quality concerns about a small number of services

- closure to admissions impacting on capacity (for example due to staffing shortages, the complexity of the needs of people currently using the service, or issues with the quality of care)

- problems in accessing beds when needed

- children and young people having to travel long distances to access a bed

- anecdotal information suggesting some reductions in NHS community or local authority children's services may be impacting on demand

- poor environmental standards in some services

- disparity in education input to children's mental health hospitals

- continuing inequity in provision across the country.[84]

It is widely acknowledged that the current geographical spread of inpatient provision does not meet the local population needs, and is a reflection of how services have been historically commissioned and developed across the country.[84, 85] There are concerns about a lack of locally available beds, including children and young people being admitted miles away from home, or other settings such as police cells and adult wards.[1] Closure of beds (by providers, commissioners or regulators) continue to be a necessary outcome of quality or safety issues, sometimes due to staffing problems, inappropriate facilities or unsafe care.[84, 85]

Admissions to inpatient units occur either as emergencies or as planned events; a Royal College of Psychiatrists' survey found there was significant difficulty in locating inpatient beds for young people in crisis.[86] The House of Commons Health Committee found that lack of

timely availability to a bed increases strain on families and community staff who have to manage increasingly unwell and risky children and young people at home.[32]

There are particular challenges for children and young people with the most complex needs, especially those with severe autism, learning disability and mental health needs. With few inpatient beds available, and none for children and young people with a learning disability living in London, south east or south west of England, concerns have been raised relating to children and young people's admission to residential schools in crisis and those services not adequately skilled or staffed to effectively meet needs.[60]

NHS England has proposed that by 2020/21 overall bed usage will have reduced and out of area placements will no longer be necessary.[7] NHS England has led another service review programme to understand local requirements for inpatient beds, and to improve local capacity and access to beds.[31, 85] Where geographical gaps in provision are significant, new service reconfiguration (including additional beds in some areas), will be required to improve the equality of distribution nationally and locally.[87]

The values-based child and adolescent mental health system commission reflect that to improve patient outcomes and quality of provision, as well as timely access to local beds, inpatient services need to be commissioned and delivered as part of a whole system, including a range of alternatives to admission[83], rather than have separate commissioning for inpatient and community services. The aspiration is that this will help ensure there is the right capacity to meet need and to ensure that children and young people can receive treatment as close to home as possible.[30, 31] *Implementing the Five Year Forward View for Mental Health* includes a commitment from NHS England to transform the model of commissioning. As part of this, NHS England has committed to trialling a new model of care that allows providers of mental health services to manage care budgets for inpatient and specialist services, with the overall purpose of supporting local areas to manage all of their specialist CAMHS services (inpatient and community), improving outcomes and reducing out-of-area placements.[2, 6] Sources suggest that the challenge will be in ensuring that they are appropriately designed, staffed and able to provide a therapeutic service, particularly given that workforce shortages are particularly problematic in inpatient services.[60, 85]

3I(ii) – Specialist community mental health services

A range of specialist mental health services provide community services, such as routine outpatient, assertive outreach and/or intensive services, with the overall aim to provide flexible and responsive care and support, prevent admission to hospital, or facilitate early discharge and pro-actively follow up children and young people presenting with high risk behaviour. Provision of the range of community mental health services is highly variable across the country.[14]

The NHS England review of the inpatient services in 2014 identified a number of significant concerns with the availability of community services. It concluded that the pressure on inpatient provision could be caused by lack of availability and investment in effective community provision. There is agreement that early intervention and crisis care provision would potentially reduce the number of children and young people reaching crisis point and potentially requiring admission. In addition it would enable people to be discharged more quickly.[84] There is variable evidence of good coordination between inpatient and community

services and commissioning – for example, maintaining regular contact between children and young people with community mental health teams to facilitate discharge.[6] The literature reflects that this will need to be addressed if children and young people and their families are to receive provide comprehensive care in the community and have better outcomes.

3I(iii) – Specialist crisis mental health services

The House of Commons Select Committee report 2014/15 concluded that that CAMHS in England have seen an increase in the demand to access services out-of-hours, urgent or emergency referrals.[32] Children and young people are turned away because mental health services are not available at weekends and as a result they do not receive adequate treatment and support early enough, including for children and young people with behaviours that challenge[1, 60], indicating the need for services to be commissioned to ensure a timely and responsive 'out-of-hours' provision.

The national crisis care concordat set clear expectations as to how mental health services should respond to people presenting in crisis and states every community should have plans to ensure no-one in mental health crisis will be turned away.[14] The police and other local public services work together as part of local area multi-agency response to plan services to meet demand related to mental health. Specifically, that local protocols should ensure police custody should never be used unless in exceptional circumstances.

However, nationally the police have raised significant concerns that they are increasingly being used to fill the gaps that other agencies are unable to provide for, being required to attend to people in mental health distress due to lack of mental health provision available to people in crisis.[88] Arguably, by the time the police have become involved, the opportunity for early intervention has been missed and the situation has already escalated.

This is further demonstrated by the number of young people detained in custody as a place of safety under section 136 of the Mental Health Act. Data from the National Police Chiefs Council Lead for Mental health showed that from April 2015 to March 2016, 1,124 children and young people were detained under section136, with 43 of those being held in police cells. Few mental health trusts have a dedicated health-based place of safety for children and young people, some do not accept admissions of under 16s and/or 18s, and many only accept one person at a time. This is compounded by staffing problems that in turn affects the capacity of some facilities, resulting in them being closed to admissions.[89] These factors can mean that young people are potentially taken into custody for safety, or experience long waits for a suitable place to go. The Policing and Crime Act 2017 proposes to ban the practice of holding young people in police cells. However, the Education Policy Institute draws parallels with the continued admission of children to adult wards, despite the duty introduced in 2010 to prevent this happening[33], suggesting that it may be difficult to implement unless appropriate places of safety and alternatives are available.

Some sources have proposed that new investment will be required to increase capacity of crisis teams and 'out of hours' provision; improve liaison with A&E and acute services and ensure local health-based places of safety are appropriate.[6] According to NHS England local performance benchmarking, data shows wide geographical variation both with current and planned crisis service, with less than a third of CCGs proposing a fully funded plan to improved crisis care.[34] NHS England are expected to work with CCGs and other

commissioners to deliver a shared goal of crisis services that are accessible and responsive at all times by 2020. NHS England are currently working with eight urgent and emergency care vanguards to fund and test different models of crisis and liaison mental health care for children and young people to help build the evidence base.[29]

4 Care and treatment

4a - Care and treatment options for children and young people with mental health needs

Transformation plans set out in *Future in Mind* and the *Five Year Forward View for Mental Health* are ambitious and will take time to implement. It is important to recognise that there are many examples of good practice, care and treatment, with literature describing a number of innovative models of care that are being developed to improve patient experiences.[2, 6, 87] There are non-mandatory service specifications and standards for community, inpatient and transition between child and adolescent and adult mental health services to support commissioners.

Future in Mind was clear in its recommendations that the focus must be on developing models of care that meet the needs of the local population. However, concerns have been raised that, without national mandatory minimum standards in place, there may be inconsistency for service transformation and improvement, such as the development of service specifications, standardised outcomes and ensuring equity of access to a full range of services.[34] It is proposed that through the expansion of access to services, including increased therapists, 70,000 additional children will receive evidence-based treatment – this will equate to meeting the needs of 35% of those with a diagnosable mental health condition by 2020.[7] However, this will require a significant increase in skilled staff in a climate where there are already existing serious workforce issues.

The literature highlights concerns about both capacity and quality of care and treatment available, not just waiting times, but also geographical variation, gaps in provision and the quality of interventions once the children and young people are receiving support.[21, 34] Children and young people's mental health services are currently commissioned by a number of different organisations, including schools, local authorities, CCGs and NHS England for specialist services such as forensic and inpatient care. Some areas have gaps in provision due to different commissioning practices and priorities, this impacts on what services are available to the local population. Services are delivered from a wide variety of service locations from hospitals, community health locations, primary care, schools and youth facilities.[33, 83] It is the perceived severity of the mental health problems, children and young people and family preferences, as well as referral criteria and availability of service, which may determine where the child or young person receives the care and treatment.

The most common mental disorders in children and young people are conduct disorders, attention deficit hyperactivity disorder (ADHD), emotional disorders (anxiety and depression) and autistic spectrum disorders.[16, 18] Current evidence supports a number of child and family focused therapeutic and psychological approaches that look at thinking and behaviour for children and young people, depending on their and their family's needs. NICE have produced guidance on a range of topics relating to mental health and wellbeing, with many programmes focused on helping the children and young people regulate behaviours and emotion.[20] Interventions include a range of evidence-based treatments such as talking therapy (for example CBT, DBT, problem solving, psychodynamic treatments or family therapy).

There is also a range of preventative programmes, working with parents by looking at behaviour and practical problem-solving; group parenting classes; individual parenting classes for small number of families who have very complex needs; family intervention, targeting children and young people who are at risk of, or already in the youth justice system – including family behaviour and problematic behaviours. Family work is central to the work in children and young people's mental health services, and difficulties in engaging families are one of the main reasons for interventions failing.[30, 81] Trauma related problems such as sexual abuse and exploitation require specialist interventions.[73]

Care and treatment for conduct disorders typically include behavioural therapies, parenting groups, social skills programmes and functional family therapy.[29, 67] In moderate to severe ADHD, medications can play a role. There is evidence that the use of medication where ADHD has been diagnosed is most effective when used in addition to parent education programmes.[25]

The links between mental health and substance misuse are well established. NICE guidance identifies that vulnerable and disadvantaged children and young people aged under 25, with pre-existing mental health problems, are more at risk of misusing substances. NICE recommends that prevention and treatment activities should be delivered through a range of services that have contact with children and young people (including opportunistic contacts such as GPs and A&E), as well as through specialist children and young people's drug and alcohol services.[90] The Drugs Strategy 2017, published by the Department of Health, sets out how the government and its partners will take action to tackle drug misuse and the harms it causes. It proposes a universal approach across the life-course, including specific needs of young people who misuse drugs.[91]

Eating and feeding disorders include a range of different conditions where an individual has problems with eating such that their growth, development or physical health is affected or they experience significant distress. These include anorexia nervosa, bulimia nervosa and avoidant restrictive food intake disorder. Anorexia nervosa is the third most common chronic illness of adolescence and has the highest morbidity and mortality of all psychiatric disorders. It is one of the most common reasons for admission to a Tier 4 CAMHS unit. The sooner someone with an eating disorder starts an evidence-based NICE approved treatment, the better the outcome.[92] In 2014, the government announced an additional £3 million recurrent funding over five years to improve support, care and treatment options for children and young people through the development of evidence-based community eating disorder teams. Commissioning guidance sets out new referral to treatment standards to be in place by 2020, with the emphasis on community and family based treatments.[6]

A range of common measures are used to inform care and treatment, or evaluated to monitor effectiveness.[93] These include the Revised Child Anxiety and Depression Scale (RCADS), parent/child SDQ, goal based outcomes, HONOSCA, and the Children's Global assessment scale (CGAS). Routine use from a wider range of measures that look at symptoms, functioning, experience and the relationship between the young person and the therapist are fundamental to the CYP IAPT transformation of services. It is anticipated that new national datasets will include information on diagnosis, intervention and outcomes, which will help develop evidence based care and treatment options, as well as understand gaps in provision.[2]

4a(i) - Medication

There is limited information available about prescribing patterns for children and young people's mental health. The publication of prescribing data is also very varied. While GP prescribing is published, in mental health trusts, information about what medicines are ordered in bulk is identifiable, but, unless that organisation has electronic prescribing, it is not easy to find any patient level data. In addition children and young people with ADHD (the most commonly prescribed-for disorder) may be treated by community paediatric services or specialist mental health services. The gap within existing literature suggests that this area requires focus.

There have been relatively few randomised placebo-controlled studies of the potential benefits and risks of psychotropic drug treatment in younger people, and little is known about the value of long-term treatment.[94] Psychosis is rare in children and young people and relatively few randomised controlled trials have been conducted in children and adolescents around the use of antipsychotics in the treatment of psychotic illness. This is in stark contrast to the extensive evidence base underpinning treatment in adults. Only a few antipsychotic medications are licensed for use in those younger than 18 years of age, meaning much of the prescribing is off-label. Nevertheless, according to a joint audit by the prescribing observatory for mental health-UK and the Royal College of Psychiatrists, antipsychotics are prescribed by a significant number of child and adolescent psychiatrists and community paediatricians in the UK.[95]

The use of antidepressants in children and young people continues to rise.[96] Evidence from Wales suggests that while antidepressant prescribing in primary care rises, conversely the number of depression diagnosis in under-18s is falling.[97] Additionally these new antidepressant prescriptions are more likely to be for citalopram rather than fluoxetine that is recommended as first line in national guidelines.[94, 98, 99]

Often medicines are used off-label in child and adolescent psychiatric disorders[100] (off-label prescribing occurs when medication use falls outside the scope of the marketing authorisation and often occurs in paediatric practice as many companies have not sought licences for this age group). A number of evidence-based resources are available to inform the use of medicines in children and young people, largely provided by NICE and the British Association of Psychopharmacology.[94, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108] There are also a number of resources to guide drug dosing in these patients including British National Formulary for Children (BNFc), Psychotropic Drug Directory and The Maudsley Prescribing Guidelines.[109, 110, 111]

In the report *The Safer Management of Controlled Drugs*, CQC recognises that prescribing rates of methylphenidate is increasing year on year.[112] This is the first line drug treatment for ADHD according to both NICE and BAP guidance.[104, 107] The report suggests that this is likely due to a greater recognition of ADHD by GPs, who will then refer to specialist services for assessment and diagnosis; however, the British Association for Psychopharmacology has in fact suggested that ADHD is still underdiagnosed in the UK.[107] CQC recognises that there may be some inappropriate prescribing and use over-prescribing of methylphenidate and commits to monitor this due to the potential for misuse.[112]

It has been nationally recognised that, across all age groups, there is a higher rate of prescribing in primary care of medicines associated with mental illness among people with a

learning disability than the general population. It was found that in the majority of cases this is with no clear justification.[113] In children and young people the relevant indications for drugs were less often recorded in relation to hypnotics, anxiolytics and antipsychotics.[113] The 'Stopping overmedication of people with a learning disability autism or both (STOMP)' is a national campaign bringing together professional and patient groups to stop the overprescribing of psychotropic medicines in this group of patient.

5 Barriers and enablers to high-quality, joined up care – themes identified across the system

5a - Overview of access and referrals

The *Five Year Forward View for Mental Health* states that from 2013/14 to 2014/15, referrals to CAMHS increased five times faster than the CAMHS workforce. Further to this, NHS England dashboard data showed that, across England from July to September 2016, 17,902 new children and young people were referred for treatment compared with 16,274 new children and young people referred from April to June 2016[114], an increase of just over 10% in six months, suggesting that referrals are continuing to increase.

There could be a number of reasons for increases in referrals. These include reduced availability of non-NHS services that support young people in local authorities and variation in what is available in schools, an increase of certain conditions such as eating disorders and self-harm, or a result of better awareness of mental health problems, and reducing stigma in accessing help.[32, 33]. Whatever the cause, the result is pressure on capacity and service provision issues, which impact on timely access and lead to a number of potentially negative outcomes for children and young people such as referrals not accepted, long waiting times, appointments being cancelled due to staff shortages, and a lack of skilled and experienced staff including trained therapists.[2].

The lack of available baseline data on referrals, waiting times and investment across the whole system was raised by a number of the local areas as a problem when developing the LTPs.[6] Quality of referral data collected and submitted by providers varied widely and data from the independent sector is limited despite providing a significant amount of children and young people's mental health services.[1] In addition, referral and access data about different services is not directly comparable as they may be configured and staffed differently, reflect historic capacity levels and varied thresholds for CAMHS in different areas.[82] Lack of up-to-date data will affect effective planning and delivery of services in relation to improving access and reducing waiting times although, moving forward, local areas will be carrying out new prevalence data and needs analysis that will identify current and future levels of demand. This can be used to provide evidence for increased service capacity or funding if required.[9]

5a(i) - Referral processes and criteria

There is wide variation in how effectively CAMHS services are set up to respond and meet the needs of children and young people in a timely way, with variations in practice and protocols relating to management of referrals, transitions and discharges.[1, 33] There is increasing recognition and concern that CAMHS providers are raising their thresholds and eligibility criteria to manage increasing demand and complexity, resulting in high eligibility criteria limiting services to those children and young people with the most severe symptoms or difficulties, reducing the opportunity for preventative work.[1, 15] As a result, it is estimated that only 25% of children and young people who need treatment are able to receive it.[28]

Whether a referral is accepted by a service or not is generally determined by local eligibility and exclusion criteria. Examples of exclusion criteria include age limits, limits on the

condition or problems that will be accepted, absence of evidence that support has already been tried, restrictions on which professionals are able to refer into the service. In addition, services may not be commissioned or available, which will restrict the ability to action the referral locally.

Health, education, social care and voluntary sector can each have a different culture and set of priorities and referral criteria. For example, community health CAMHS may only accept referrals of children who meet a high threshold of risk translating into perceived level of severity of risk or suicidality.[24] In contrast, many voluntary organisations accept self-referrals, meaning children and young people and/or their families can contact them directly. The literature also highlights concerns that children living in more challenging circumstances (such as looked after children) may face even higher thresholds to access services than other children.[33]

Differences in thresholds, referral criteria and access to services can lead to tensions in the system, poor communication and children and young people being constantly referred onto different parts of the system.[34] In this context, some children fall through the gaps between services and their needs are left unmet. For example, children and young people with learning disabilities and complex needs can find it difficult to access services. Even when they do access services, they may find that these services do not fully understand the complexity of their presentation, and require the collaboration of a number of services.[6] They can also face the challenge that there are some CAMHS who do not accept children and young people with a learning disability, while community children's health services do not consider themselves mental health professionals, and neither service considers they are the right service to deliver care for these children and young people. As a result, they fall through the gaps.[60]

Concerns have also been raised that health services, in particular, can focus too singularly on a child meeting a clinical threshold, looking for a diagnosis and receiving treatment. Diagnostic-led services can be a barrier for families and organisations supporting children and young people, as many difficulties may not fit easily into diagnostic criteria. For example, a child who has faced bereavement, abuse or another traumatic event may not be eligible for treatment until they reach a certain threshold or diagnosis.[19] An increasing number of children and young people without any specific mental health diagnosis may experience low levels of emotional wellbeing that would respond well to early intervention but if left, difficulties may become more entrenched and difficult to treat.[1] If a child is viewed as not meeting the service referral/acceptance criteria, they may be referred back to their school or GP for support. Deficits in activity data and intelligence from GPs and schools make it difficult to assess the types of activity and demand in relation to children and young people's mental health, in order to understand workload and capacity issues that may in turn be linked to the access and capacity issues in CAMHS.[64, 81]

5a(ii) - Waiting times

There are still significant and unacceptable delays and barriers to accessing mental health care and treatment and a lack of parity between mental health and physical health care.[14] The NHS Constitution for England sets out targets for access to physical health services and the aspiration is that these will be equally applied to mental health services. Most mental

health services are not currently subject to waiting time targets, although some have recently been introduced, in addition, commissioner contracts will include expected waiting times.

In April 2016 the first access and waiting time standard was introduced for people experiencing first episode of psychosis. It states that 50% of people should commence NICE concordant treatment within two weeks of referral.[23] Access and waiting times have also been introduced for children and young people presenting with an eating disorder, with four weeks for a routine referral, one week for an urgent and 24 hours for an emergency.[92] Standards for crisis and generic mental health problems are due out soon.

Without nationally agreed measurement for waiting and access times, it is difficult to benchmark performance and hold providers to account.[34] In addition, good data and national standards, including transparency about wait times, are necessary to allow people to make informed choices.[2]. While comparisons to the national average can help when tracking local progress against national trends, local knowledge is crucial when identifying and prioritising local action required to meet local population need. Literature suggests that access to accurate waiting time data at both local and national level, as well as understanding how these datasets interlink, is a critical component to planning and developing effective services.[9]

There is wide variation in average waiting times for both assessment and treatment from different providers across the country. Waiting times vary according to local processes, systems and perceived need. For example, if a child's or young person's need is deemed not to be urgent, or service availability is limited[47], then they may face an extended waiting time. Waiting time data has not been routinely collected, and many providers do not have easily accessible information about referrals and waiting times. Where data is available, it may not give a full understanding on capacity problems and waiting times. For example, providers may 'stop the clock' on waiting times when they do an initial telephone triage assessment, and they may not measure waiting times between initial assessment and the beginning of treatment.[33]

Nonetheless, it is important not to become too focused on waiting targets as a key indicator of quality as this can have unintended consequences that have an adverse impact on care quality. For example, waiting time targets may influence organisations to create internal waiting lists (following initial assessment the child or young person then waits on a different list to start treatment), thereby not addressing the capacity issues.[32] As part of the LTP process, providers have been encouraged to be transparent in providing their baseline information so that they can have a clear understanding of the true extent of their capacity issues, as well as review and improve their methods of data collection in order to get a clear picture of gaps.[6]

5a(iii) - 'Did not attend' processes

Children and young people whose circumstances make them vulnerable are less likely to access services. Children in these circumstances may not have support networks in place to encourage them to get help, or to transport them to appointments. They are also less likely to attend arranged appointments.[24] This can lead to children and young people continuing to have unidentified mental health needs, which risk getting worse and more entrenched. This can be compounded when services do not proactively try to engage children and young

people who fail to attend; including those children and young people who are excluded and/or who are difficult to engage.

The Children's Commissioner review found that 35% of CAMHS state that services would be withdrawn if a child or young person failed to attend between one and three appointments.[47] Poor communication and information sharing also contributes to children and young people falling through the gaps between referrals to different services. For example, different parts of the service may not realise another part has discharged them for not attending appointments. Therefore, 'did not attend' protocols should include joint agreements, clearly identifying how services will liaise with each other.[24] Some innovative models of holistic support are now developing to improve access for vulnerable groups who are difficult to engage, such as 'AMBIT' training provided by the Anna Freud Centre. It is a team approach for teams working with young people with severe and multiple needs, who do not tend to access mainstream services.

5a(iv) - Stigma

An additional reason for lack of timely access to treatment is stigma. As young people become adolescents, they are most sensitive to mental health stigma, or feeling they are not being taken seriously and least likely to seek help as a result. Families also reported that they were concerned that their own behaviour or parenting may be judged negatively.[20] These factors can prevent children and young people and/or their families seeking a referral, or they may not attend appointments when they are offered. Anti-stigma campaigns more generally have been focused on raising awareness and education for general public, with some local areas actively promoting peer support and youth-led programmes.[6] There have been a number of national initiatives such as Time to Change and Head Start to challenge attitudes[76] and there is evidence that mental health issues are discussed more widely among young people in addition to a wide range of information accessible through social media.[33] It is proposed that Time to Change local hubs will be developed by 2020/21, training people with lived experience to become mental health champions to challenge attitudes and stigma in local communities.[23]

Stigma has been identified as a major barrier to accessing services for children and young people from Black and minority ethnic (BME) communities. This could be in part due to cultural beliefs about mental illness, in addition to a mistrust of statutory services. The Equality Act sets out that providers have a responsibility to ensure services are available to all children and young people without regard to disability, gender, sexuality, religion, ethnicity, social, or cultural determinants. Despite significant demographic changes in recent years, which have seen the increases in the numbers of BME children and young people in the UK, there is little prevalence data on this group of children and young people, with few providers collecting data on protected characteristics such as ethnicity, disability and sexuality.[1, 2]

While adults from BME communities are over-represented in adult mental health services, children and young people are under-represented in CAMHS. This could suggest that some BME children and young people do not access early intervention or primary care services. While there are examples of voluntary organisations targeting outreach and anti-stigma campaigns with BME communities, these remain a minority of organisations.[115] It is essential that people from all backgrounds get early access to support they need, particularly those

who are under-represented by attendances to services (for example, BME people, LGBT people, people with a learning disability). Literature refers to the importance of commissioners ensuring that a range of age-appropriate and culturally-sensitive services are available to all children.[34]

Digital culture

While digital culture can be an important source of support and learning to children and young people with mental health problems, it can also be a source of great difficulty and increase stress for children and young people. Concerns have been raised that increased screen-time and inappropriate internet activity can have a negative impact on emotional wellbeing. For example, the long-lasting impact of the negative use of social media and online bullying. Concerns have also be highlighted about the impact of external pressures around body image and early sexualisation.[1, 19, 33]

In addition, concerns have been identified in relation to the potential impact of the internet on children and young people using inappropriate sites that may promote eating disorders, self-harm or other harmful behaviours, such as forming networks with other children and young people who self-harm and sharing information and pictures. The first study into children and young people's suicides highlighted that "internet safety is an important component of suicide prevention in young people, particularly under 20".[27] Literature indicates that more research is required to understand the link between internet use, social media and the phenomenon of cyberbullying and the potential impact on children and young people's mental health and wellbeing.[34]

Children and young people are major users of the internet and digital culture. Many children will not seek professional advice or help if they feel they are struggling, but will instead turn to friends and family, and websites and apps for information in the first instance. Online forums are an increasingly important part of young people's lives, and while there are numerous websites and apps available now aimed at supporting young people who may be experiencing mental health problems, issues around confidentiality and trust remain key. Certainly, young males have indicated in some studies a preference for online advice and counselling services over face-to-face options , and these can work well as an initial source of information and contact for some individuals, where they are deemed to be trusted sites, informed by knowledgeable professional information and can guarantee anonymity and confidentiality.

Enablers to improving access

The literature highlights several approaches that could support improving access to care and processes around this, including:

- developing individualised pathways

- clarity of access and eligibility criteria

- single point of access

- outreach programmes for excluded and hard to reach children and young people, including enhanced support for children and young people with complex needs and emerging personality disorders

- joint working – for example, mental health clinicians working with looked after children and being embedded in social care teams

- co-location – multiple services in one site

- shared strategic oversight and shared management structures across organisations

- shared protocols, including re-designing 'did not attend' policies, ensuring practice is in line with *Future in Mind* recommendations

- workshops and bespoke parenting programmes for members of BME and refugee communities

- develop local access and waiting time standards based on good practice examples from CAMHS nationally

- extend hours to provide weekend and evening provision and appointments, with the aim of reducing waiting times and improving timely access

- self-referral (central to the CYP IAPT transformation programme).

5b - Transitions

Problems surrounding transitions between CAMHS and adult mental health services have been highlighted in a range of reports and policy guidance. Specifically, there are serious concerns that children and young people are poorly supported when they are referred by CAMHS to adult services, particularly as they may move to adult services at an especially vulnerable point in their development.[15, 24] It is also a time that many children and young people may be leaving care, leaving school and/or beginning to live more independently.

Common issues with transition to adult services include inadequate planning, inconsistently followed protocols, different service structures and differences in culture and referral criteria. Poorly managed transitions of care can lead to break down in continuity of care, children and young people disengaging, or for some children and young people the end of any support. Young people with mental health problems whose needs have been met primarily by paediatric services, education or social care may find that there is no equivalent service for adults.[116]

Age of transition to adult services varies across the country and different organisations. In relation to CAMHS, many stipulate 17.5 to 18 years is the age for transfer to and/or referral to services for adults. There are some examples of service introducing an increased age range up to 25 years. The Children (Leaving Care) Act 2000 came into effect on 1 October 2001 and sets out local authority duties to young people when they leave care. This includes duties to 18 to 21 year olds if they are still in education or training. The Care Act and Children and Families Act (2014) both place duties on the local authority to promote choice and control over care and support from birth to 25, including at the point of a planned transition between services.[117] The Department of Health commissioned NICE to develop an evidence-based guideline and quality standard to improve practice and outcomes for young people using health and social care services and their families and carers, published in February 2016.

However, *Future in Mind* highlighted the importance of focusing on improving the transition arrangements rather than the age this happens, which should remain a decision for local providers to agree.[1] The NHS England review of LTPs found that 65% of the plans submitted,

looked specifically at improving transitions and suggests that to succeed, it is important that these LTPs consider and include the range of transition points that children and young people will encounter, such as moving between different schools (primary and secondary) and leaving local authority care.[6]

Strategies to improve transitions identified in the literature include:

- recommending that the local area joint strategic needs assessment reflects the best practice for transition and it is included in the contract between commissioners and providers

- NHS England and NICE have published best practice guidance for transitions and discharge protocols and it is included in the minimum standards for CQUIN (national Transition CQUIN)

- removing age-based criteria

- providing accessible information and improved signposting

- employing transition coordinators, personal advisors and peer support workers, establishing and following clear transition processes

- involving children and young people in decision-making, developing co-designed, individualised transition plans

- improving the communication and sharing of information, including written discharge summaries and follow up appointments after discharge

- benchmarking current provision against NICE and best practice guidance and quality standards.

5c - Data

National prevalence data for children and young people's mental health problems is based on research carried out in 2004. The government has commissioned a new prevalence survey, including information on eating disorders, the impact of social media and cyber bullying, although the data will not be available until 2018. In addition, the 2004 study only covered children and young people between the ages of five and 16 (up to 16th birthday so five to 15), meaning that there will still be a significant gap in the knowledge of the population over 16 years old. This is a concern, with approximately a quarter of mental health problems emerging in young people between 14 and 18 years and suicide risks rising steeply in late adolescence.[22, 34]

Lack of accurate, reliable and robust data has been persistently identified in the literature as having a significant impact on both national and local service funding and planning. Addressing this significant deficit in knowledge and improving the collection of reliable data on children and young people has been subject to delays and this issue continues to impact on the effectiveness of planning and pace of improvement in many local areas.[2, 6] Literature reflects that a key enabler to change in children and young people's mental health services across the whole system is developing high-quality information systems that collect accurate data.

While there is some good information emerging, it is inconsistent and is not always analysed effectively. In addition, routinely collected data may exclude some of the more vulnerable groups of children and young people within the population due to sample size or because the data does not identify children's circumstances (for example, homeless and LGBT children and young people).[9]

From December 2016, new data has begun to flow from the NHS Digital minimum data set. It is proposed this system will eventually include a range of data, including referral rates and waiting times, treatment outcomes. Early submissions of the datasets are experimental and not yet considered to be reliable.[1, 34] In addition, submissions of mental health data sets are not yet received from all NHS organisations and do not include children and young people who may be accessing support from independent health providers, voluntary organisations or schools.[31, 114]

The Mental Health Intelligence Network (MHIN), run by Public Health England and supported by NHS England and the Department of Health, are developing a range of indicators and using publicly available data to pull together wider social outcomes, such as abuse, neglect and housing. Public Health England have just launched their new Children and Young People's Mental Health and Wellbeing Profile Fingertips tool with the first round of data. Public Health England has published examples of case studies in local areas where local intelligence has been used to promote children and young people's mental health and wellbeing.[9]

The national Child and Maternal Health Intelligence Network is developing an interactive atlas of maps and data for child and maternal health indicators and statistics. The Child Outcomes Research Consortium (CORC) is a learning collaboration focused on finding the best way to collect and use outcome data to create the highest quality services for children and young people – while recognising that current data sets may not be reliable. Membership includes representatives from a range of health and voluntary providers.[32]

There has been no national system for reporting suicide, identifying trends or prevention strategies in young people.[22] As a result, there is very limited information available nationally on the number of children who have died (by any cause, including suicide) in mental health settings or while in receipt of mental health care. There are no published death rates, in individual units or by CCG area, or information about whether a death has occurred in the public, independent or voluntary sector. There is currently no independent pre-inquest process in place for investigating deaths under the Mental Health Act. All of these factors seriously impact on identifying national trends, learning and developing effective suicide prevention strategies.[2]

The Care Quality Commission reviewed how NHS trusts identify, report, investigate and learn from deaths of people using their services. This report was published in December 2016 and made recommendations for improving the way the NHS identifies, reports and investigates the death of any person in contact with a health service managed by an NHS trust, paying particular attention to how NHS trusts investigate and learn from deaths of people with a learning disability or mental health problem.[118]

5d - Quality measures and outcomes

Under parity of esteem, the same expectations and standards of high-quality should be applied in both mental health and physical health services.[119] Currently in children and young people's mental health services, however, there is no comprehensive set of quality standards or comprehensive pathways comparable to those in physical health.[2] NHS England has completed work to develop evidence-based care and treatment pathways for children and young people in community settings, across a range of settings, including health, social and education services, which is due to be published.[31]

It is proposed that national and local outcome measures, looking at a whole care pathway, should be used as part of a payment system that is established in a way that increases the provision of high-quality care and data. This approach should both encourage improvement and promote transparency.[2] The CCG Improvement and Assessment Framework (IAF) is a tool that NHS England uses to measure progress on improving children and young people's mental health services across a range of quality indicators. CCGs will also be required to complete a self-assessment, which includes a range of questions about performance[31, 114], although the range of national metrics and indicators are still being developed.[7]

The commissioning for quality and innovation (CQUIN) scheme is intended to deliver clinical quality improvements and drive transformational change and is linked to priorities identified in the *Five Year Forward View* and the NHS Mandate. A proportion of providers' income from commissioners will be conditional on demonstrating improvements in quality and innovation in specified areas of patient care. Two indicators relevant to children and young people's mental health have been included in the 2017-19 CQUIN guidance: 'Transitions out of children and young people's mental health services' and 'Improving services for people with mental health needs who present to A&E'.[120]

A new integrated dashboard for mental health was published by NHS England in October 2016. Indicators are being developed, to try to capture outcome measures to understand how public health programmes are improving mental health and it is proposed that this will assist in monitoring quality, as well as informing policy and planning future services.[23]

As part of the transformation of children's and young people's mental health services, commissioners need to focus on standardising and improving the frequency and quality of outcomes recording. However, it is recognised that many IT systems do not easily or effectively record outcomes, which makes recording and monitoring outcomes much harder. Some areas are developing local outcomes frameworks with local stakeholders, using a range of measures that are already available across the system[6, 16], such as:

- school readiness data (considered an important predictor of the likelihood of problems in school, as well as links with parental mental health problems)

- school nurse data (numbers of pupils accessing their support with emotional issues)

- patient reported outcome measures

- emotional wellbeing of looked after children

- troubled families outcome data

- pupil absence indicator

- referral data

- referrals to carers groups/carers assessments

- first entrants to youth justice system

- access to school counselling

- persistent absence from school.

It will be important that the agreed monitoring outcomes and methods for measuring them are relevant to all children and young people and families[6], with literature outlining that the main purpose of outcome monitoring must be to use this information to change and improve clinical practice and ultimately, the experiences of children and young people and their families.[121] There are a range of existing tools that can be used to routinely evaluate outcomes, measuring quality and effectiveness of treatment collated and centrally reported to the NHS England children and young people mental health team though the CYP IAPT programme. These tools generally evaluate outcomes from several different perspectives (usually the child, parent/carer and the professional working with them).

There is a growing interest in the potential of using subjective wellbeing measures and indicators to understand children and young people's mental health and wellbeing. For example, research is ongoing with the Office of National Statistics, Children's Society and Public Health England to understand how using indicators of wellbeing can contribute to measuring change in wellbeing, as a result of public health programmes.[9, 11]

Outcome measurement tools used by services range from simple feedback forms to validated measures that focus on both wellbeing and mental health. These tools can help a range of people working with children and young people to plan and respond effectively to children and young people's mental health needs, as well as monitor the effectiveness and quality of provision.[53] Commonly used tools include SDQ and the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). NICE guidance recommends using the common assessment framework (CAF) in circumstances where there is wider concern about children and young people's healthy development, welfare, safeguarding learning or behaviours.[24,73] Some areas are using or developing indicators and risk assessment tools to help identify risk of childhood sexual abuse and/or childhood sexual exploitation.[6] However, all of these tools are reliant on the skills and interpretation of those completing them, which means that there is likely to be significant variation in their use and in the quality of data gained from them.

It is generally agreed that NICE has an important role to play in developing quality standards, setting out cost-effective evidence based practice, as well as identifying priorities for improvement. It is important, however, to also monitor what may be barriers to effective implementation of guidance – including lack of availability of skilled staff or the commissioning arrangements. It will not be effective in understanding the challenges in services to simply assess whether a service is meeting NICE guidelines or not.

5e - IT systems and digital culture

Information sharing and information systems are among the key barriers to joined-up working across the system. Existing data demonstrates that bureaucratic information systems, concerns about sharing information, confidentiality and data protection laws can all pose a

challenge. Services and organisations use a range of different governance, patient recording and IT systems.

Common issues associated with IT systems include staff having to create duplicate records, and the risk of important information and decisions not being communicated effectively, which in turn leads to delays or mistakes in treatment. Organisations may not quickly identify issues (for example, safeguarding issues within the family) or anticipate problems, which would enable them to plan care effectively and prevent further escalation.[2] Many rely on packages designed for use in adult services or hospitals, which may not meet the needs of services working with children and young people or in the community.[31] In addition, many IT and patient record systems are not designed to gather information on outcomes, which makes it difficult for services to accurately reflect service requirements, how effectively they are meeting need, or submit required information for commissioners and the national datasets.

There are a number of ways services already use technology to engage with children and young people, such as using text messaging, social media platforms, email and forums; providing a range of accessible information about services and mental health issues. Many organisations are increasingly working with web designers and children and young people to produce age appropriate material, help with staff training and increase the availability of health information.[1] There is a national focus on developing and expanding online health applications and continued investment in digital mental health services, as well as improved and integrated IT systems.[23]

5f - Workforce

5f(i) - Challenges

Building and maintaining sufficient and skilled workforce of staff is one of the greatest challenges for implementing the transformation plans.[122] Numerous reports appear to reflect that there are problems at all levels of the care pathway and system – resulting in understaffing or ineffective staffing. The range of workforce issues go beyond ensuring the provision of future supply; they are compounded by funding pressures, increased demand and changing models of healthcare delivery. Effective support in relation to workforce planning, requires coordinated and collaborative action across the health and social care system and national bodies.[123] A significant point highlighted in the literature in relation to workforce planning across the whole system, is that all providers are competing for the same, limited pool of staff.

Sources reflect that mental health services have been persistently underfunded, resulting in numerous service restructures and the loss and/or downgrading of posts.[2] These changes in the mental health workforce have had a direct impact on quality of care, in particular the capacity to deliver services in line with NICE guidance and new access standards. Interventions need to be delivered by well trained and supervised staff who have access to appropriate clinical standards to ensure effective, high-quality care. The lack of availability of suitably skilled and qualified staff can mean interventions are often poorly targeted and ineffectively implemented.[76, 81] Some areas currently have limited provision of access and choice to evidence based interventions, such as family therapy and interpersonal

psychotherapy due to differences in what has been commissioned and availability of staff with the appropriate skills.[2, 20]

The publication of the *Five Year Forward View for Mental Health* sets a clear vision of significant changes to service delivery and ways of working.[123] Delivering the objectives of the *Five Year Forward View for Mental Health* will require significant increase in workforce numbers and skills across the system, from schools, to GP practices, to specialist CAMHS services in the community and on inpatient wards. It will also require staff to work in flexible roles to deliver care, including upskilling non-clinical staff to fulfil wider roles, including delivering therapeutic interventions. Literature clearly reflects that workforce planning in CAMHS is complex due to the fragmented provider network responsible for delivering care in different circumstances. Therefore, it is important to have an understanding of workforce requirements and challenges across the whole system, not just in specialist CAMHS.[124] Arguably, understanding and developing the whole workforce is perhaps the most important factor to transforming services for children and young people.

There are regional variations in recruitment and retention issues. Some reasons identified included high cost of living areas, high levels of staff retiring at the same time, lack of specific professions – mental health and learning disabilities nurses, as well as psychiatrists, were noted as the most difficult to recruit.[60] Providers are increasingly using temporary staff (agency and/or locums), which has implications on both quality and finances. In addition, interim or short-term positions can have a significant impact on how effectively providers are able to recruit into posts and plan future need.[34]

There are challenges with recruitment and retention of members of the primary care team. The role of the GP is key to the success of *Five Year Forward View* plans and there are serious workforce issues identified in relation to recruitment and retention, particularly recruiting in areas of greatest social deprivation.[123] Reportedly, many GPs are reaching the end of their careers or are choosing to retire early in response to workload pressures. Health Education England, NHS England, the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) have agreed a '10-point plan' to try and help address this shortage.[64] GP training numbers are still below target and unlikely to achieve the goal of ensuring the additional number of full-time equivalent doctors required.[122] Workload, recruitment and retention issues also affect education services, with a third of schools facing shortages of teachers.[125]

Significant problems in recruitment and retention mean that both the NHS and the social care system are heavily reliant on international recruitment, the current workforce implications of the UK leaving the EU are unknown.[122] The Migrant Advisory Committee has concluded that there is a significant national shortage of nurses, adding this occupation to the 'shortage occupation list' in 2015.[126] Contributing factors to shortages include: an ageing population of nurses who are moving towards retirement, low pay, recruitment and retention issues, budget restrictions on training places, changing roles of nurses meaning increased or decreased responsibility, increased demand for nurses due to national guidance on minimum staffing levels, and people leaving the profession for alternative careers.

There are concerns about the availability of psychiatrists to meet the increase in demand for the health service, with the majority of psychiatrist vacancies occurring in CAMHS, general and old age mental health services. In addition to recruitment issues, the Royal College of

Psychiatrists reports that psychiatry has the slowest rate of growth in new recruits and the highest drop-out rate of any clinical specialty in medicine.[127]

5f(ii) - Workforce plans and strategy

In 2013, the Department of Health set up Health Education England to have accountability for ensuring that future workforce of the NHS is the right size and has the right skills. National oversight bodies such as the Department of Health, the Department for Education, NHS England, NHS Improvement, CQC, Ofsted, Skills for Care, the Local Government Association and NICE all have significant roles in terms of understanding and supporting the workforce to develop, as well as ensuring that key policies and guidance clearly consider the workforce implications and financial impact arising from transformation of care models.[3] Nonetheless, the NHS and social care have no overarching strategy for their workforce and literature has highlighted this as an ongoing risk to understanding and ensuring sustainability in the workforce.[122]

The first comprehensive all-age mental health workforce strategy, published in 2017, states that by 2020/21, at least 1,700 more therapists and supervisors need to be trained and employed to meet predicted additional demand in CAMHS.[23] As part of the CCG IAF, local areas are required to produce joint workforce plans, working with Health Education England and the local education and training boards.[6] Concerns have been identified that workforce plans developed as part of the LTPs may not necessarily be translated into extra funding by commissioners for staff in the front line.[41] This will potentially cause more specialist posts to be lost or downgraded, and concerns have been raised that moving towards more generic mental health practitioner roles without appropriate training, support and supervision in place will impact the quality of care and treatment.[34]

Health Education England develops its national workforce plans by adding together local workforce plans submitted by individual trusts. There is currently insufficient accurate data available to give a clear national picture of vacancies across the whole system of health and social care. NHS Digital has recently begun to collect experimental vacancy data through the NHS jobs portal to help understand the extent of gaps in the workforce, although this only relates to NHS health providers.[123]

Workforce data is generally not gathered from GPs, local authorities, independent or voluntary sector organisations. In addition, financial and local pressures and targets may lead organisations to underestimate their projected workforce needs.[124] Integrated care systems are complex; workforce demands and issues may not be easily captured in the workforce plans.[128] These factors can contribute to workforce issues only becoming evident once there are significant problems, examples of this cited within the literature include the current shortage of GPs and increase in use of agency staff.[129] Therefore, while the workforce plans can be a useful guide to providers, commissioners and local education and training boards, it is clear from the literature that they are likely to have significant gaps in information and as such may seriously underestimate the workforce issues across the local areas.

5f(iii) - Training and support

The government mandate to Health Education England sets out the requirement to support local areas to understand the workforce training requirements in relation to children and young people, highlighting the importance of all health professionals understanding mental health conditions in reducing the disparity between mental health and physical health.[130] Therefore, professionals who work across the whole health, social and education system need to be trained to recognise and promote mental health and wellbeing in children and young people to prevent unnecessary escalation of problems and inequality in access[1, 7], including proposed increase in training levels for a number of specific professions. There is a drive to incorporate nationally provided training and support for universal service staff such as 'make every contact count' and MindEd within the local workforce plans.[6] It will be critical to also ensure that there is sufficient capacity for services to effectively support and facilitate trainers as well as those entering training.[131]

Schools can access e-learning from the MindEd portal (free online training, with advice and information for staff on a range of mental health issues) and it has been recommended that teacher training provides teachers with a good baseline understanding in child and adolescent development, mental health issues and social wellbeing.[1] Half of the LTPs have identified the need to train school staff and teachers in mental health.[6] Training for parents/carers is also important to help ensure problems are picked up at an early stage and support their own wellbeing in order that issues do not escalate and result in multiple agencies needing to be involved.[6]

The right workforce is a vital component of effective and high-quality care, this does not only relate to sufficient numbers, significant change in healthcare delivery and expectations on staff, presents challenges to employers to support staff effectively, ensuring new ways of working are implemented without negative impact on morale. Literature describes evidence that staff morale is a major concern across the system.[122] Currently morale, the availability of effective supervision and effective workplace support varies widely. Workload pressures, stress, staff shortages, lack of adequate support and supervision, have all been identified as contributory factors to poor morale, as well as difficulty recruiting and retaining staff.[2] Therefore, it is crucial that organisations incorporate valuing and keeping existing staff into workforce planning, as well as focusing on recruiting and training new staff.[131]

5f(iv) - Enablers to addressing workforce issues

A range of local and national organisations are trying a number of solutions to help address workforce and recruitment problems such as:

- looking at the workforce across the whole system, including flexible working across roles
- financial incentives to move to, or stay within, an organisation, access to funding for training, rotational posts
- improving e-rostering systems and local workforce strategies
- buddying systems with other organisations
- improving access to workplace support

- national strategies include – developing new professional roles, increasing the number of training places available for specific professions, fast track nursing course and simplifying return to nursing access, overseas recruitment

- NHS England has commissioned work on effective, safe and compassionate staffing in children and young people's mental health, due out at the end of 2017.[87]

5g - Integrated and partnership working

A major barrier to transforming and improving care and experiences for children and young people and their families is that they are currently delivered across multiple different organisations, which do not always work together in a joined-up way to provide care.[34] Literature reflects that the existence of poor or variable working relationships across different parts of the system negatively impact on children and young people's timely access to early intervention or specialist advice, as well as inefficiencies in the use of resources.

Tensions and confusion can arise from inconsistent responses to referrals, indirect or impersonal contact (for example, sending a generic email response), as well as poor communication about the outcomes of referrals or assessments.[18] For example, schools that do not have good links with CAMHS are likely to refer a child or young person to the GP. At that point, referral criteria for specialist services or other bureaucratic disputes (such as obtaining an additional parental consent form for sharing information) may leave the GP unable to take further action. This potentially leaves the children and young people without a plan or support.

There are also physical and geographical barriers to effective partnership working between school, local authority and health services. Currently, school boundaries may not match with NHS and CCG organisational boundaries, this issue may become more apparent with the introduction of sustainability and transformation plans (STPs). The STPs are developed across 44 geographical areas and referred to as 'footprints'. Although these footprints are based on the geographical boundaries of CCGs, they do not necessarily reflect organisational boundaries.[8] STPs are proposed to represent a different way of working, with partnership behaviours becoming the new norm.[5] However, nearly half of respondents in the NHS Providers annual report stated that they were concerned about the lack of priority given to mental health in STPs.[41] This will inevitably risk how effectively CAMHS transformation plans are prioritised and implemented, as part of the wider plans of the STP.[34]

It is important to recognise that there is no 'one size fits all' approach to partnership working, as local arrangements must reflect the particular circumstances of each local area. Nonetheless, there are some key aspects to integrated working that contribute to strong partnership working between health partners (primary and secondary, NHS and independent), local authority partners (including social care and early years partners), and third sector (voluntary) partners.

When they work well, local partnerships enable integrated planning, delivering, and monitoring of the LTPs, using local generated data from all the different parts of the system.[16] Some local areas are developing community hubs that include a range of locality-based services such as physical, mental health, social care and specialist treatments.[6] Co-locating is generally viewed as a positive arrangement that enables effective information-sharing and

helps to develop relevant skills and knowledge across disciplines. There are a few local areas highlighted where co-location has also included voluntary services. Increasingly, services are moving towards having single point of access, so that children and young people and their families do not experience multiple referrals to different parts of the system.[6] There are examples of multi-agency training and supervision to support the development of consistent evidence based interventions and safeguarding practices across the system.[16]

However, NHS England reported wide variation in local approaches, priorities and qualities of the LTPs submitted.[6] Most LTPs submitted were largely health led and there was wide variation in how involved other partners are. This means that plans may be too singularly health focused and not effectively take into account individual organisational plans in relation to mental health and wellbeing, or important wider community partners, such as the police.[25, 34] This may, in part, be addressed as part of the ongoing LTP refresh process, whereby local areas update their plans.

Differences in organisational culture, working practices and priorities will also present challenges in partnership working, influencing decision-making and behaviours, resulting in various parts of the system not thinking about the 'whole child' but focusing narrowly on their particular remit or service.[1, 21] Common barriers identified in the literature that contribute to tensions between agencies, included: lack of consistency of terminology and language, which leads to misinterpretation, perceived stigma associated with certain professions and a mismatch or unrealistic set of expectations about what particular services can deliver.

Agreeing a shared set of values, a view of 'what is important', have been found to be more successful in developing effective partnership working. These include examples where there are nominated lead contacts and they are flexible and proactive, willing to take time to understand the logistical and cultural differences between settings (for example, school and health).[24] The Values-Based Child and Adolescent Mental Health System Commission propose that values-based practice enables service providers, and people who use services, to understand and build on their own and others' good practice. They argue that this will be integral to improvement across the whole system.[83]

5g(i) - Enablers that support integrate working

Literature suggests that other important enablers include:

- joint working to build capacity in staff who work in universal services (such as identifying mental health leads to support GPs, teachers, health visitors) and reduce dependency on children and young people's mental health service specialists

- joint training, including specific training to meet local skill gaps or specific evidence based treatments

- shared care arrangements with primary care – providing whole person approaches to physical and mental health care

- employing specific professionals for liaison and case management particularly for complex cases

- establishing a joint approach to outreach work with parents who are difficult to engage

- developing a whole family approach (for example, identifying children and young people living with a parent with mental health or substance misuse problems)

- focusing on developing shared protocols that look at personalising care based on individual experiences, rather than service specification

- a commitment to multi-agency working, including the development and use of integrated multi-agency pathways, as well as integrated commissioning of services, this can help reduce uncertainties about the role of the lead professional and commissioner

- clarity of roles and responsibilities, with clear local leadership that is respected across the range of services and agencies

- promoting a shared value-based culture, involving children and young people and families in service design and delivery

- increasing awareness and reducing stigma around mental health.[6, 18, 76]

5h - Sharing good practice

Details about new models and emerging practice to share learning is available in a wide number of publications and websites, including NHS England, Public Health England and a range of non-statutory partners, such as the Children's Society and YoungMinds. NHS Benchmarking is an example of a national project that aims to document current approaches to delivering children and young people's mental health services, as well as identify ongoing good practice in its annual report.

The literature refers to a number of national learning systems established that local areas can, and should, become part of to support and share best practice and learning. These include:[132]

- The Choice and Partnership Approach (CAPA) is a well-developed approach that many areas have found can aid implementation of the key principles of shared decision making and clarity of choice. The alignment of CAPA to THRIVE is discussed in more detail in Thrive Elaborated available at:
https://www.google.co.uk/url?sa=t&source=web&rct=j&url=http://www.annafreud.org/media/4817/thrive-elaborated-2nd-
Information on CAPA is at www.capa.co.uk

- Children and Young People Improving Access to Psychological Therapy (CYP IAPT) is being rolled out across the country and seeks to combine evidence-based practice with user involvement and rigorous outcome evaluation to embed best practice in child mental health. www.cypiapt.org

- The Child Outcomes Research Consortium (CORC) learning collaboration can aid alignment and integration of data and outcomes across agencies and organisations, and is seeking to support areas to develop and embed cross-sector outcomes. www.corc.uk.net

- Peer-review networks such as those led by the Royal College of Psychiatrists – for example, the Quality Network for Community CAMHS and Quality Network for Inpatient

CAMHS (QNIC) can aid embedding and consideration of key elements of practice. www.rcpsych.ac.uk/quality/quality,accreditationaudit/communitycamhs.aspx

- iTHRIVE – Website for the accelerator sites (NHS Innovation grant funded originally). Active Community of Practice for a wider group than the accelerator sites. http://www.implementingthrive.org/implemented/ https://uclpartners.com/what-we-do/clinical-themes/mental-health/ithrive/

- Schools in Mind – hosted by the Anna Freud Centre, to support schools. http://www.annafreud.org/services-schools/schools-in-mind/

Clinical Networks, the local authority and local Public Health England and NHS England teams also play a key role in providing ongoing support to the whole system in local areas. It is important that there are representatives from all parts of the system, including voluntary and independent sectors, who have generally been under-represented in key health forums and groups. This will ensure that both challenges, and good practice, are effectively shared across the system and will help improve partnership working.[6]

Specific examples of sharing and developing good practice in local areas identified in the literature include:

- developing an induction programme for staff to consult on and that sets out the plans for a new model; in particular, bringing staff together who might normally never meet – for example, staff working in CAMHS, AMHS, education, the voluntary sector, youth services and employment and housing services

- setting up a 'buddying' programme for experienced and new team managers

- co-designing and delivering strategy development sessions

- running action learning sets with staff and service managers across the system

- specific partnerships working with schools to support integrated planning, delivery, monitoring and review of plans has worked to ensure that plans are not too singularly focused on health

- actively engaging with participation groups (children and young people and families)

- local inter-agency multi-disciplinary training can assist in sharing practice knowledge, facilitate discussion, solve problems and promote networking

- local professional networks to share best practice and joint learning

- improved training for staff, children and young people and families.

6 The views of children, young people, their families and carers

6a - How well do children, young people and their families and carers feel the system is working to provide access to high-quality care?

Literature reflects that the system is not consistently serving the needs of children and young people's mental health with high-quality care. Childline stated in their annual review for 2015/16 that calls related to mental health and wellbeing have increased significantly year-on-year: one in three Childline counselling sessions related to mental health and wellbeing; counselling about suicidal thoughts and feelings had reached their highest ever levels with 19,481 sessions; and there had been an 87% increase in counselling with young people who were experiencing difficulties in accessing local support services, including counselling. There was also a 34% increase in dissatisfaction with mental health support services, where these had been accessed. Mental health and wellbeing is now the top reason why children and young people call Childline.[133]

Policy and funding direction set out in *Future in Mind* is most welcome in defining a long awaited commitment to transform child and adolescent mental health services. However, according to the literature, many children and young people say it is often the simple things, done well, that can really make the difference to how they feel about themselves, their overall experience and whether or not they will access and continue to engage with services.

There are common themes that emerge on this subject, including the need for individual staff and settings to be welcoming, friendly and warm. There is a preference for individual staff and settings to be less clinical and not to be seen as authoritative. There is recognition that things work better when staff members are flexible and approachable, and adequate time is built in to develop a relationship and sense of trust and respect. Often some of the simplest things are key to improving the experience of children and young people during these difficult times in their lives. And when these positive attitudes and approaches are missing, it can really impact on a young person's willingness and ability to engage with the services that can improve their mental health.[134,135,136,137] This can be even more pronounced where the young person has complex and multiple needs and is faced with numerous interactions with many different professionals or services.[138]

Many children and young people view face to face support and information within the school setting as highly valuable, as long as it is set up and run effectively. Examples given in the literature include: being staffed properly with teachers (or other staff) with the right skills and information, accessible at flexible times to suit children's needs and preferences, and where the schools are well connected to the wider local mental health support network (for example with local GPs, charities or youth groups, CAMHS that can offer varying levels of support or treatment as required). A lack of support in schools is certainly one of the key issues identified in the literature that children and young people raise, especially as it is during these early years when mental health issues can commonly start to arise.

Some themes arising from work done with children and young people directly, include their call for earlier information and education about mental health generally, to help reduce

stigma and raise peers' as well as teachers' awareness and ability to identify early signs that may benefit from early intervention. Access to school based counselling services is widely mentioned, but with many saying that such support needs to be available in a more flexible way, perhaps outside of school times or in online formats for those who would prefer that, to avoid peer scrutiny but also to lessen the impact on education and learning opportunities. Other options such as peer support groups being developed inside and outside of schools have also been shown to be beneficial and welcomed by those who have experienced such projects.[135,136,139,140]

Delays in referrals to CAMHS, followed by delays in starting treatment or even rejections of the referral, is another area where young people have voiced clearly that the system is not working well for them. Childline's annual report presents the situation from the children and young people's perspective, reflecting an increase in calls where children and young people talked about difficulties accessing local services, lengthy waiting lists or being refused help completely. For those who were already engaged with CAMHS services, many voiced concerns about the quality of care – 'in some cases the young person was too scared to be entirely truthful about their symptoms, so their issues were not being addressed; in other cases they felt the treatment itself was not working'.[133] In terms of what could help make the system work better through improvements to CAMHS services, suggestions highlighted in the literature included – more availability of services; shorter waiting times; more flexibility in where and when services are delivered; and being listened to and respected.[137]

Families and carers voice many of the same concerns as the children and young people they support, but sometimes express more anxiety and frustration over how disjointed the system can be and the impact this can have on them and their child. In terms of the support available from schools, many parents have suggested that there are several things that really help, when they are available, but unfortunately they are not always present in all schools or all areas. Help from schools could include, for example, information about mental health and local services on a school intranet, evening sessions and classes for parents, lessons on mental health for their children at a young age, better signposting for parents on where else to go for more advice or support to help them manage their child's needs and family situation.[137]

Families and carers suggest that when the most common combination of local support works well together, such as schools, GP and CAMHS, then the need to rely on other crisis support and A&E services is reduced. However, in too many cases literature suggests that these services are not well aligned or integrated.[137] The lack of joined up working and poor information sharing between the range of agencies involved in the young person's care, is often a source of difficulty for the family or carer. There can be additional difficulties for the parent when their child might not wish for them to be kept fully informed, but the issues are more commonly to do with a general lack of communication and information sharing when different agencies or workers are involved or when new services become available in the local area.[134] This situation can be further exacerbated when the young person involved has multiple complex needs or is in a particularly vulnerable situation: "there can be a failure to keep the child or young person and their families informed as to what is happening; the lack of information sharing between agencies concerned with a vulnerable child or young person may have a significant impact and reduce the quality of care and their experience of services".[138]

It is widely recognised that involving children, young people and families in the design and development of local services can improve the quality of those services offered.[34] However, engagement can still too often be tokenistic and therefore does not reap the benefits it should. An early analysis of LTPs indicates that most areas are failing to adequately engage with their local communities to develop their plans for these services. Suggesting there is still a long way to go for some areas to truly involve children and families actively to help shape and improve services and culture.

Meaningful involvement of children and young people in decision about their service they are using is also vitally important and something that many young people feel still needs to improve. YoungMinds report on children, young people and family engagement (2014) highlighted numerous powerful examples of where this active engagement and decision making was sorely lacking:

> "…I wasn't going to 'click' with recovery unless I was able to have input into my own treatment to make it individual and realistic to be but this was ignored purely as I was an adolescent."

> "They didn't support me in the decisions I wanted to make. CAMHS could have listened to me and not spoke over me and tell me how I am feeling."

> "They should listen to young people instead of thinking they know what's best for you when they really don't."

Where LTPs have been recognised as excellent, a common feature has been "full and meaningful engagement with children and young people, both those using services and those not currently engaged". Indeed, the very act of being involved in planning and decision making can have a significant positive impact on young people's wellbeing, in addition to the end result service. Evidence from the Mental Health Foundation's Right Here programme, for example, highlights that meaningful participation is vital and must be factored in for successful and effective outcomes. Many young people "expect that their views will not be taken seriously and that they will have minimal influence over events and activities delivered to them". The very fact of involving and gathering their views and experiences to help shape what will be available for them is an empowering and enabling act. Working in a more collaborative and inclusive way not only seeks to improve the final design and culture of the service, but can also build social capital through friendships, peer support and mutual respect for those involved.

The fact that so many young people voice a desire for services to be more flexible in how they are delivered, may indicate that some providers often don't really understand how to co-produce services effectively, so they fail to be designed in a way that really fits around young people's needs. However, there are certainly some positive examples where actively listening to children and young people and acting on their involvement is key to service development and delivery. The expansion of the Children and Young People's Improving Access to Psychological Therapies (CYP CIAPT) programme[141] is a good example. It has, at its core, nine 'participation priorities', based on what children and young people have said about how best to involve them in extending and improving access to such therapies. These priorities embed commitment to participation and coproduction at the heart of the application process to become part of a CYP IAPT Collaborative and all sites must report on their performance against these nine benchmarks annually. This approach recognises that true

success rests on enabling children and young people to fully participate, that children and young people 'must be able to contribute in a meaningful way to how services are designed, delivered and monitored'.[142] Analysing a realistic picture of the quality of outcomes for young people using CAMHS is still difficult, however, due to the lack of nationally available data.[33]

7 Funding and expenditure

7a - How money is spent by, and on, the partners involved in supporting children and young people's mental health needs

While children and young people's mental health has certainly risen up the political agenda in recent years, there is still a very long way to go. The direction of travel and additional funding that has been promised must now start to build on years of under-funding and under-resourcing.

It is difficult to comment realistically and accurately on trends in spending on CAMHS and wider services because there has been little transparency or standardisation in the way data has been collected or shared so far. From the little that has been reported in the literature to date, for the 2012/13 period £704 million was spent on CAMHS, which was the equivalent of about 6% of the total mental health budget, and about 0.7% of the total NHS budget.[33] The general image of the trend in spending has not been positive. A freedom of information request by YoungMinds in 2015 found that, from 2013/14 to 2014/15, budgets had been cut or frozen in 75% of mental health trusts, 67% of CCGs, and 65% of local authorities. Therefore, more than one in five either froze or cut their CAMHS budgets every year since 2010.[143]

In March 2015, *Future in Mind* announced a much welcomed boost in funding for children and young people's mental health services of £1.25 billion over five years, equating to £250 million a year. However, it has been suggested that only £75 million of this was distributed to local health leaders in the first year.[34] Due to the poor data gathering and reporting still prevalent, it is not clear how much of this was given to or spent on front line services. One of the issues raised by commissioners about the first year of funding was that it was released so late in the financial year that it was hard to allocate and use meaningfully within the timescale allowed. This meant that commissioners could not plan how best to invest it. It is acknowledged that NHS England will be publishing a dashboard reflecting how much CCGs have spent so analysis should become easier in the future.

For the second period of additional funding, 2016/17, £119 million has been included in CCG baseline allocations. Concerns have already been raised, however, that this money is not ring-fenced and it may be too easily earmarked for other local priorities and demands, without frontline providers seeing any significant investment to help them identify and respond to the mental health needs of children and young people.[34]

Literature highlights that cuts in other spending areas may have a knock-on effect, especially as funding and investment in wider mental health support for children and young people, and their families, are not solely the responsibility of acute or mental health services. School-based counselling, for example, is often funded through schools' own budgets. In February 2017, the Department for Education announced that schools would receive an additional £415 million by way of a healthy pupil's capital programme, "to help improve facilities for children with physical conditions or support young people struggling with mental health issues".[144] However, this additional funding, which could have been used at a local level to help invest in much needed early interventions and support, might now be diverted. In July

2017 the Department for Education announced that £1.3 billion would be made available for schools' core budgets in 2018 and 2019. However, this will not be new money from the Treasury. Instead, it will be made available through efficiencies and savings made in other parts of the Department's budget, including the healthy pupil's capital funding.[145, 146, 147] With such funding streams under threat, further pressure could be added to the wider CAMHS system to pick up the increasing demand due to lack of early interventions. CQC has highlighted, in its submission to the Education Policy Institute's Mental Health Commission, that "reductions in funding, including to non-NHS services, has contributed to increased waiting times".

Funding on mental health generally, with children and young people's mental health included, has suffered lack of parity and under-resourcing: medical research. If we do not understand and cannot identify effectively the causes and presentations of mental illness, we cannot confidently offer effective treatments and support. "Only 5.8% of the total UK health research spend is invested in mental health".[33] Increased funding in this area is required to improve equality with research into physical health, to help lead us to new developments and improved outcomes for children and young people in the longer term.

Work on minimum data sets being gathered and shared by NHS Digital will hopefully result in better access to, and analysis of, a clearer picture on how much money is spent on, and by, the relevant partners within the system, as well as national level data on access and waiting times among other factors. However, this will still take a number of years to become established and for it to be viewed as robust and reliable usable data.

8   Discussion of findings from the review of literature and next steps

The literature reflects that many reports and reviews have looked at the systems and services that work with children and young people to identify and support mental health needs. All referred to a common set of issues that need to be addressed, specifically the need to:

- develop strong leadership

- establish clearer pathways and transition between services

- clarity of roles and responsibilities (across the system)

- workforce development

- focus on prevention and high-quality early intervention

- improve the quality of data

- increase participation

- implement evidence based treatment with measurable outcomes

- ensure effective funding, accountability and commissioning arrangements.

Current policy recognises that no single partner can meet all children and young people's mental health needs and that a multi-agency approach, based on shared values and commitment is required. There has been notable progress in collaborations between partners across the country, as well as significant service improvements in some areas. However, the literature highlights that the differences between service availability and delivery, at both local and national level, results in continued wide variations and gaps across the country. This is further compounded by: issues with funding, varied commissioning priorities, workforce issues, absence of reliable data and varied involvement in children and young people and families developing services. Unfortunately, this means that too few children and young people get timely access to appropriate evidence based interventions.

8a - Next steps

CQC will build on the findings of this review of the literature by producing a Phase 1 report that will summarise the current state of knowledge, the problems and challenges facing children and young people's mental health provision and the impact of these on young people and their families. In Phase 2, CQC will be visiting a number of areas to assess the availability and quality of provision for young people with mental health problems and the extent to which these support schools and other relevant local organisations and providers. This work will help further to identify the presence and impact of local and national enablers and obstacles to improvement.

We will share our findings and recommendations with our three main stakeholder groups (young people, families and organisations that represent young people and families) to check that it reflects their experiences accurately. While CQC's unique contribution will be from the

perspective of the services that it regulates, it will work in collaboration with other national system partners to extend the scope of the programme. There will be a final report published, bringing together all aspects of the thematic review, in March 2018. It will provide an overview of the evidence available to consider the question:

How can we ensure that all partners make their contribution and work together so that children and young people, and their families/carers, have timely access to high-quality mental health care?

References

1   Department of Health and NHS England, *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*, 2015

2   The Independent Mental Health Taskforce to the NHS in England, *The Five Year Forward View for Mental Health*, NHS England, 2016

3   The King's Fund, *Implementing the NHS five year forward view: aligning policies with the plan*, February 2015

4   NHS England, *Five Year Forward View*, October 2014

5   NHS England and NHS Improvement, *NHS Operational Planning and Contracting Guidance 2017-2019*, September 2016

6   NHS England, *Children and young people's mental health Local Transformation Plans - a summary of key themes*, July 2016

7   NHS England, *Implementing the Five Year Forward View for Mental Health*, July 2016

8   The King's Fund, *Delivering sustainability and transformation plans: From ambitious proposals to credible plans*, February 2017

9   Public Health England, *Measuring Mental Wellbeing in Children and Young People*, 2015

10   Department of Health, *Wellbeing: Why it matters to health policy*, January 2014

11   The Children`s Society, *The Good Childhood Report 2016*, 2016

12   Personal Social Services Research Unit and YoungMinds, *Youth Mental Health: New Economic Evidence*, January 2016

13   Royal College of Paediatrics and Child Health, *State of Child Health Report 2017*, 2017

14   Department of Health and NHS England, *Achieving Better Access to Mental Health Services by 2020*, 2014

15   Department of Health, *Closing the Gap: Priorities for essential change in mental health*, 2014

16   Public Health England, *School aged years 5-19, High Impact Area 1: Resilience and emotional wellbeing*, October 2016

17   Department for Education and Department of Health, *Promoting the health and well-being of looked-after children*, March 2015

18   Day L and others, *Mental Health Services and Schools Link Pilots: Evaluation report*, Department for Education, 2017

19   The Children's Society, *Children's mental health: Priorities for improving children and adolescent mental health services in England*, June 2015

20   Khan L, *Missed opportunities: A review of recent evidence into children and young people's mental health*, Centre for Mental Health, 2016

21   National Children's Bureau, *Delivering mental health transformation for all children: Findings from the engagement with the children and young people's voluntary sector in Autumn 2016*, 2016

22   National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Suicide by children and young people in England*, Centre for Mental Health and Safety, May 2016

23   HM Government, *The Government's response to the Five Year Forward View for Mental Health*, 2017

24   The Children's Society, *Access Denied: A teenager's pathway through the mental health system,* 2015

25   Institute for Public Policy Research, *Education, Education, Mental Health*, May 2016

26   Public Health England, *Preventing suicide among lesbian, gay and bisexual young people: A toolkit for nurses*, 2015

27   National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Suicide by children and young people in England*, Centre for Mental Health and Safety, July 2017

28   Public Health England, *The mental health of children and young people in England*, 2016

29   HM Government, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017

30   Royal College of Psychiatrists, *Managing self-harm in young people*, October 2014

31   NHS England, *Five Year Forward View for Mental Health: One Year On*, 2017

32   House of Commons Health Committee*, Children's and adolescents' mental health and CAMHS: Third Report of Session 2014-15,* 2014

33   Frith E, *Commission on Children and Young People's Mental Health: State of the Nation*, CentreForum, 2016

34   Frith E, *Progress and challenges in the transformation of children and young people's mental health care: a report of the Education Policy Institute's Mental Health Commission*, Education Policy Institute, 2016

35   The King's Fund, *Reforming the NHS from within: Beyond hierarchy, inspection and markets*, June 2014

36   Department for Education, *Government response to the Workload Challenge*, February 2015

37   Ofsted, *Integrated inspections: Consultation outcomes, learning from pilot inspections and next steps*, February 2015

38   Ofsted, *Better inspection for all*, October 2014

39   House of Commons Briefing Paper, *Children and young people's mental health – policy, services, funding and education*, April 2016

40   YoungMinds, *Wise up: prioritising wellbeing in schools*

41   NHS Providers, *The state of the NHS provider sector*, November 2016

42   NHS England, *Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)*, December 2014

43   NHS England, *Standard Contract for Tier 4 Child and Adolescent Mental Health Services (CAMHS): Children's Services*, 2013/14

44   House of Commons, *Local authorities' public health responsibilities (England)*, March 2014

45   Ofsted, *Early help: whose responsibility?* 2015

46   Ofsted, *Social care annual report 2016*, 2016

47   Children's Commissioner, *Lightning Review: Access to Child and Adolescent Mental Health Services,* May 2016

48   House of Commons Education Committee, *Mental health and well-being of looked-after children: Fourth Report of Session 2015–16*, April 2016

49   Association of Directors of Children's Services, *Unaccompanied Asylum Seeking and Refugee Children*, November 2016

50   Mind, *A civilised society: Mental health provision for refugees and asylum-seekers in England and Wales*, 2009

51   Department of Health, *Government response to the consultation 'Refreshing the Public Health Outcomes Framework (2015)'*, May 2016

52   Public Health England, *Best start in life and beyond: Improving public health outcomes for children, young people and families - Guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services*, January 2016

53   Public Health England and Children and Young People's Mental Health Coalition, *Promoting children and young people's emotional health and wellbeing: A whole school and college approach*, March 2015

54   Public Health England, *Rapid Review to Update Evidence for the Healthy Child Programme 0–5*, March 2015

55   Health Education England, *Specialist Health Visitors in Perinatal & Infant Mental Health*, March 2016

56   National Maternity Review, *Better Births: Improving outcomes of maternity services in England*, February 2016

57   Public Health England, Department of Health and Royal College of Midwives, *Getting maternity services right for pregnant teenagers and young fathers*, May 2015

58   Nuffield Trust, *The future of child health services: new models of care*, February 2016

59   National Institute for Health and Care Excellence, *Looked-after children and young people: Quality standard*, April 2013

60   Council for disabled children, *These are our children*, National Children's Bureau, 2017

61   British Psychological Society, *Understanding psychiatric diagnosis in adult mental health*

62   Local Government Association, Association of Directors of Adult Social Services and NHS England, *Building the right support*, October 2015

63   stem4, *"A Time Bomb Waiting to Explode": A Survey of GPs' Concerns about Mental Health Services for Children and Young People*, May 2016

64   The King's Fund, *Understanding pressures in general practice*, 2016

65   Mind, *Mental Health in primary care: A briefing for Clinical Commissioning Groups*, June 2016

66   Royal College of Nursing, *Inequalities experienced by children across the UK accessing the right care, at the right time, in the right place*, June 2016

67   Primary Care Workforce Commission, *The future of primary care: Creating teams for tomorrow*, July 2015

68   Youth Justice Board, *National Standards for Youth Justice Services*, April 2013

69   British Medical Association, *Young lives behind bars: The health and human rights of children and young people detained in the criminal justice system*, 2014

70   Taylor C, *Review of the Youth Justice System in England and Wales*, Ministry of Justice, December 2016

71   Royal College of Paediatrics and Child Health, *Healthcare Standards for Children and Young People in Secure Settings*, June 2013

72   Public Health England, *The link between pupil health and wellbeing and attainment*, November 2014

73   Department for Education, *Mental health and behaviour in schools: Departmental advice for school staff*, 2016

74   Department for Education, *Counselling in schools: a blueprint for the future: Departmental advice for school leaders and counsellors*, 2016

75   British Psychological Society, *Guidance for Educational Psychologists (EPs) when preparing reports for children and young people following the implementation of The Children And Families Act 2014*, July 2015

76   British Association for Counselling and Psychotherapy, *Psychological therapies and parity of esteem: from commitment to reality*, 2014

77   British Psychological Society, *HCPC registered Psychologists in the UK*, 2016

78   NAHT, *Breaking Point: A report of the school funding crisis in 2016/17*, 2017

79   Children's Commissioner, *School nurses: Children's access to school nurses to improve wellbeing and protect them from harm*, September 2016

80   Place2Be and National Association of Head Teachers, *Children's Mental Health Matters: Provision of Primary School Counselling*, 2016

81   Centre for Mental Health, *Investing in children's mental health: A review of evidence on the costs and benefits of increased service provision*, January 2015

82   NHS Benchmarking Network, *CAMHS Benchmarking Report 2016*

83   Values-Based Child and Adolescent Mental Health System Commission, *What Really Matters in Children and Young People's Mental Health*, Royal College of Psychiatrists, 2016

84   NHS England, *Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report*, July 2014

85   Frith E, *Inpatient Provision for Children and Young People with Mental Health Problems*, Education Policy Institute, July 2017

86   Royal College of Psychiatrists, *Survey of in-patient admissions for children and young people with mental health problems: Young people stuck in the gap between community and in-patient care*, March 2015

87   NHS England, *Next steps in the NHS Five Year Forward View*, March 2017

88   Her Majesty's Chief Inspector of Constabulary, *State of Policing: The Annual Assessment of Policing in England and Wales 2016*, 2017

89   Care Quality Commission, *People's experiences of help, care and support during a mental health crisis*, June 2015

90   National Institute for Health and Care Excellence, *Drug misuse prevention: targeted Interventions*, February 2017

91   HM Government, *2017 Drug Strategy*, July 2017

92   National Institute for Health and Care Excellence, *Eating disorders: recognition and treatment*, May 2017

93   NSPCC, *What works in preventing and treating poor mental health in looked after children?*, August 2014

94   Baldwin DS, and others, 'Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: a revision of the 2005 guidelines from the British Association for Psychopharmacology', Journal of Psychopharmacology, May 2014;28(5):403-39

95   James AC, 'Prescribing antipsychotics for children and adolescents. Advances in psychiatric treatment', Jan 2010;16(1):63-75

96   Bachmann CJ, 'Trends and patterns of antidepressant use in children and adolescents from five western countries, 2005–2012', European Neuropsychopharmacology, Mar 2016;26(3):411-9

97   John A and others, 'Recent trends in primary-care antidepressant prescribing to children and young people: an e-cohort study', Psychological medicine, Dec 2016;46(16):3315-27

98   National Institute for Health and Care Excellence, *Depression in children and young people: identification and management*, 2015

99   Cleare A and others, 'Evidence-based guidelines for treating depressive disorders with antidepressants: a revision of the 2008 British Association for Psychopharmacology guidelines', Journal of Psychopharmacology, May 2015;29(5):459-525

100   Sharma AN, and others, *BAP Position Statement: Off-label prescribing of psychotropic medication to children and adolescents*

101   National Institute for Health and Care Excellence, *Violence and aggression: short-term management in mental health, health and community settings*, 2015

102   National Institute for Health and Care Excellence, *Antisocial behaviour and conduct disorders in children and young people: recognition and management*, 2017

103   National Institute for Health and Care Excellence, *Bipolar disorder: assessment and management*, 2016

104   National Institute for Health and Care Excellence, *Attention deficit hyperactivity disorder: diagnosis and management*, 2017

105   Wilson SJ and others, 'British Association for Psychopharmacology consensus statement on evidence-based treatment of insomnia, parasomnias and circadianrhythm disorders', Journal of Psychopharmacology, Nov 2010;24(11):1577-601

106   Lingford-Hughes AR and others, 'Evidence-based guidelines for the pharmacological management of substance misuse, addiction and comorbidity: recommendations from the British Association for Psychopharmacology', Journal of Psychopharmacology, Sep 2004;18(3):293-335

107   Bolea-Alamañac B and others, 'Evidence-based guidelines for the pharmacological management of attention deficit hyperactivity disorder: update on recommendations from the British Association for Psychopharmacology', Journal of psychopharmacology, Mar 2014, 28(3):179-203

108   Goodwin GM and others 'Evidence-based guidelines for treating bipolar disorder: revised third edition recommendations from the British Association for Psychopharmacology. Journal of Psychopharmacology', Jun 2016;30(6):495-553

109   Paediatric Formulary Committee, *BNF for children 2016-2017*, 2016

110   Bazire S, *Psychotropic Drug Directory: The Professionals' Pocket Handbook and Aid Memoire: 2016*, 2016

111   Taylor D, Paton C and Kapur S, *The Maudsley prescribing guidelines in psychiatry*, John Wiley & Sons, 2015

112   Care Quality Commissio, *The safer management of controlled drugs: Annual report 2015*

113   Glover G, and others, *Prescribing of psychotropic drugs to people with learning disabilities and/or autism by general practitioners in England*, 2015

114   Frith E, *The performance of the NHS in England in transforming children's mental health services,* Education Policy Institute, 2017

115   Race Equality Foundation, *The importance of promoting mental health in children and young people from black and minority ethnic communities*, April 2014

116   Joint Commissioning Panel for Mental Health, *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services – Volume Two: Practical mental health commissioning*, February 2013

117   National Institute for Health and Care Excellence, *Transition from children's to adults' services for young people using health or social care services*, 2016

118   Care Quality Commission, *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*, December 2016

119   The King's Fund, *Mental health under pressure*, November 2015

120   NHS England, *Commissioning for Quality and Innovation (CQUIN): Guidance for 2017-2019*, November 2016

121   Law D and Jacob J, *Goals and goal based outcomes*, 2015

122   The Health Foundation, *Election briefing: A sustainable workforce – the lifeblood of the NHS and social care*, May 2017

123   Health Education England, *Workforce Plan for England: Proposed Education and Training Commissions for 2016/17*, 2016

124   Department of Health, National Audit Office, *Managing the supply of NHS clinical staff in England*, 2016

125   The Key, *State of Education Survey Report 2016 – Spotlight on schools: illuminating the challenges and priorities in school leadership today*, 2016

126   Royal College of Nursing, *Unheeded warnings: health care in crisis: The UK nursing labour market review 2016*, October 2016

127   Royal College of Psychiatrists, *Census 2015: Workforce Figures for Consultant and Staff and Associate Specialist Grade Psychiatrists*, 2015

128   Migration Advisory Committee, *Partial review of the Shortage Occupation List: Review of nursing*, March 2016

129   The King's Fund, *Workforce planning in the NHS*, April 2015

130   Department of Health, *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values - A mandate from*

the Government to Health Education England: April 2016 to March 2017, October 2016

131 Health Education England, *HEE commissioning and investment plan - 2016/17*

132 Thrive, *Thrive Elaborated*, November 2015

133 Childline, *Annual review 2015/16: It Turned Out Someone Did Care*

134 Healthwatch Leeds 2016

135 Department for Education 2017

136 www.mentalhealth.org.uk/projects/right-here

137 YoungMinds 2014

138 Children and Young People's Mental Health Taskforce, *Vulnerable Groups and Inequalities Task and Finish Group Report*, March 2015

139 Healthwatch Bromley and Lewisham 2016

140 Healthwatch Dorset 2016

141 www.england.nhs.uk/mental-health/cyp/iapt/

142 www.myapt.org.uk/

143 YoungMinds, *Annual Report 2015-16*

144 www.gov.uk/government/news/new-funding-to-boost-schools-facilities-and-healthy-lifestyles

145 www.bbc.co.uk/news/education-40634472

146 www.telegraph.co.uk/education/2017/07/17/extra-13bn-spent-schools-justine-greening-announces

147 www.theguardian.com/education/2017/jul/17/justine-greening-raids-free-schools-budget-for-education-bailout