

CentreForum Commission on Children and Young People's Mental Health:

State of the Nation



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CENTRE:FORUM

About the authors

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Emily has also worked for the Prison Reform Trust on support for people with mental health problems in the criminal justice system, and the Driver Youth Trust on support for children with special educational needs. From 2005 to 2009, she was External Affairs Manager for Turning Point, the social care organisation which provides services for people with a substance misuse problem, a mental health problem or a learning disability.

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About

CentreForum is an independent think tank which develops evidence-based research to influence both national debate and policy making.

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Foreword

By Rt. Hon. Norman Lamb MP



In my time as Minister for Mental Health I was appalled by the institutional bias against mental health within our NHS. This has existed for decades and is intrinsically linked to the stigma and discrimination faced by people with mental health problems.

Child and adolescent mental health services are often described as the ‘Cinderella of the Cinderella service’, receiving less than 1% of NHS funding. I was determined to change this, so launched *Future in Mind* in March 2015, a plan to transform services around the country. This was accompanied by £1.25bn investment over five years to increase access to the right treatment, in the right place, at the right time.

I was delighted that CentreForum invited me to chair this Commission to understand and explore progress since the publication of *Future in Mind*. This, our first report, charts where we are now, and describes the scale of the transformation process that is needed to achieve the vision set out in that document. It tells a story of children and young people who are denied timely access to the treatment they need or who are treated in the wrong place.

This is not about blaming services, or those who commission them. It is a highly complex problem which has existed for decades. Those who work in services are all too aware of the lack of equality for mental health care. Transforming services will take time and sustained commitment. This Commission seeks to understand the problem as it exists across the country so that we can work together to find a lasting solution.

Executive summary

One in 10 young people have a mental health problem. That's the equivalent of three in every classroom¹. **This means there are around 720,000 children and young people aged between 5 and 16 experiencing a mental health problem in England²**. CentreForum analysis suggests that there has also been a significant rise in children's mental health problems over the last five years.

In the context of this rising prevalence, Centre Forum's new research for this report reveals serious concerns over access to treatment:

- : **CentreForum research has revealed that child and adolescent mental health services (CAMHS) are, on average, turning away nearly a quarter (23 per cent) of children referred to them for treatment** by concerned parents, GPs, teachers and others. This was often because their condition was not considered serious enough, or not considered suitable for specialist mental health treatment.
- : CentreForum's new analysis of providers' eligibility criteria indicates that this access problem could be because services are putting in place high thresholds for treatment. Something has to go drastically wrong before some services will accept a referral; the antithesis of an early intervention approach. For example, in one area the criteria states that for a referral to be accepted, the condition must have *"a major impact on the child's life such as an inability to attend school or a major breakdown in family relationships"*. Another suggests that those hearing voices should seek specialist help only if they *"heard voices that command particular behaviours"*. One service would not accept those who had expressed a desire to commit suicide unless this had happened on more than one occasion.
- : The median waiting time for all providers was one month for a first appointment and two months until start of treatment. There was wide variation in average waiting times for different providers, from two weeks in Cheshire to 19 weeks in North Staffordshire. The average waiting time in Gateshead is five times as long as for those in nearby Tyneside. Similarly, waits in London vary widely from two months in Kensington and Chelsea to nearly six months in neighbouring Brent.
- : This average waiting time conceals longer 'hidden waits'. CentreForum has uncovered that the median of the maximum waiting times for all providers was 26 weeks (6 months) for a first appointment and **nearly ten months (42 weeks) for the start of treatment**. Some providers did not measure waiting times at all, meaning that some patients could even be waiting longer than this.

CentreForum also analysed existing data sources for this report. This uncovered concerning trends:

- : Our analysis of NHS Benchmarking data finds that the average of the maximum waiting times for all providers has more than doubled since 2011/12.
- : CentreForum examined NHS England data on expenditure. Our analysis finds wide variation in expenditure on children's mental health by region. There is a higher level of expenditure in the North compared to the South and East of the country, which contrasts with the higher prevalence indicated in the South and East and the potential capacity problems uncovered in the South. For example, since April 2015 there were over 50 days on which no beds were available in the whole of the South West.

Mental health problems are linked to premature mortality and can also be life-limiting. Young people with an emotional disorder are more likely to smoke, drink and use drugs than other children³; more

1 According to the most widely used prevalence data: Mental health of children and young people in Great Britain, Office of National Statistics, 2004 <http://www.hscic.gov.uk/catalogue/PUB06116/ment-heal-chil-young-peop-gb-2004-rep2.pdf>

2 9.6 per cent of 7.5m children aged 5-16 in England- Population Estimates, Office of National Statistics, 2014 <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland>

3 Mental health of children and young people in Great Britain, Office of National Statistics, 2004

likely to have time off school and fall behind in their education; and are more likely to earn less money as adults or to experience unemployment⁴. As well as the personal cost, the estimated long term cost to the economy of mental health problems is £105bn a year⁵.

Despite this significant impact, children and young people face substantial difficulties in getting help. **Only 0.7 per cent of NHS funding is spent on young people's mental health**, and only 16 per cent of this funding is on early intervention.

This report demonstrates a stark inequality within the NHS where, unlike those who are physically ill, children and young people with mental health problems are still not always getting the right treatment, at the right time, in the right place. While this issue has become a policy priority in recent years (as outlined below), there is still a long way to go before there is equality for mental health in the NHS in England.

CentreForum's Commission will seek to explore the risks and barriers to effective implementation of the current policy agenda and then to make recommendations to government and local commissioners in order to support the process of transformation over the next five years.

4 Childhood mental health and life chances in post-war Britain Insights from three national birth cohort studies, Richards et al, 2009: [http://www.rcpsych.ac.uk/pdf/life_chances_summary%20\(2\).pdf](http://www.rcpsych.ac.uk/pdf/life_chances_summary%20(2).pdf)

5 The Five Year Forward View for Mental Health, NHS England, 2016 <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

Introduction

CentreForum has established a Commission chaired by former Mental Health Minister Rt. Hon. Norman Lamb MP on child and adolescent mental health. The Commission aims to understand and explore progress in transforming children and young people's mental health care in England since the publication of *Future in Mind*, a government strategy to improve services published in March 2015, alongside a commitment to invest £1.25bn over five years.

Members of CentreForum's Commission

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

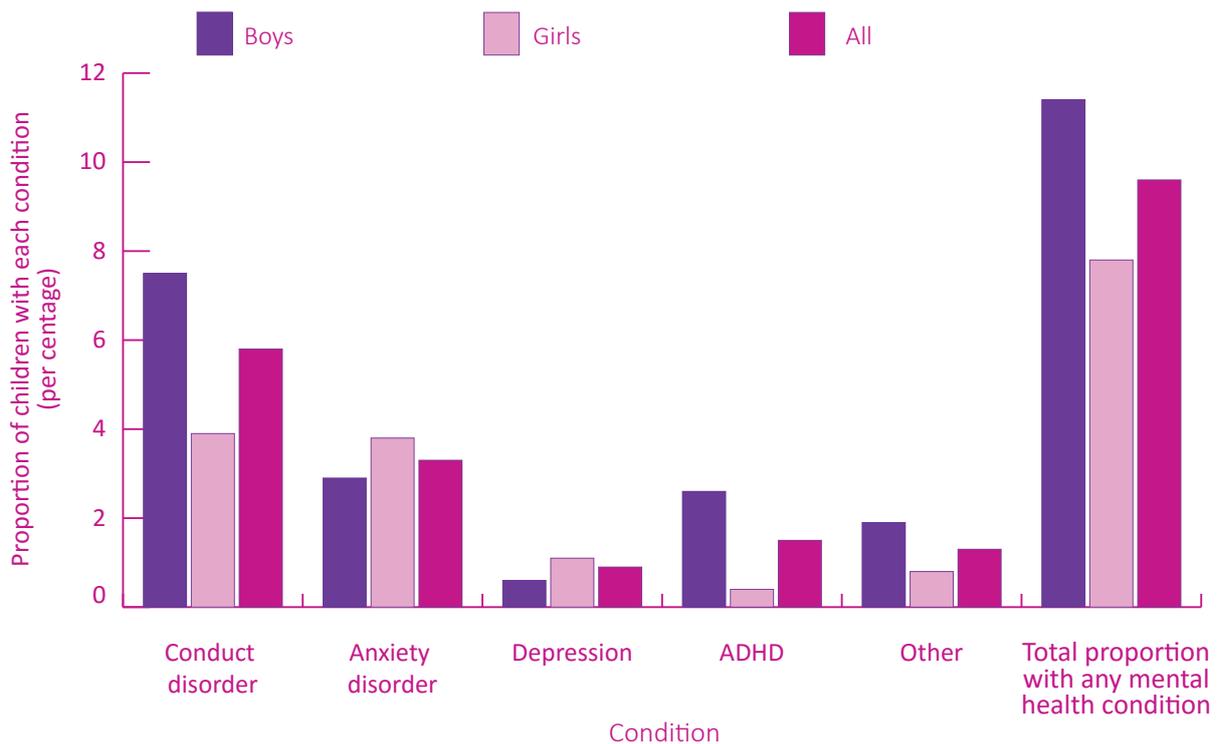
This report explores the issue of child and adolescent mental health in England. It sets out the latest available data on prevalence and trends over the last five years, and in the process highlights the fractured and inconsistent nature of the data available on this issue. This research identifies a significant 'treatment gap', where children and young people are unable to get the help they need; have to wait months for treatment; or are treated in the wrong place. The report also provides a brief synopsis of recent policy developments to address these issues.

Prevalence

Around one in 10 young people aged between 5 and 16 have a mental health problem. That’s the equivalent of three in every classroom⁶. This means there are around 720,000 children and young people experiencing a mental health problem in England⁷.

There is some evidence of gender differences, with boys more likely to ‘externalise’ problems (conduct disorder or ADHD) and girls experiencing ‘internalised’ conditions such as depression and anxiety⁸.

Figure 1: Prevalence of mental health conditions among children aged 5-16



All this information is from the most widely used prevalence data, based on research published in 2004. The government has commissioned a new prevalence survey, but new data will not be available until 2018. This lack of up to date information has a serious impact on the ability of commissioners and providers to understand the current prevalence in their areas. For example, each local area has been instructed to develop a local transformation plan on children’s mental health, but these are based on data that is over ten years out of date. Given the evidence cited in this report of an increase in prevalence, such as the rise in admissions to A&E, this will significantly undermine the ability of the transformation plans to increase access and reduce waiting times.

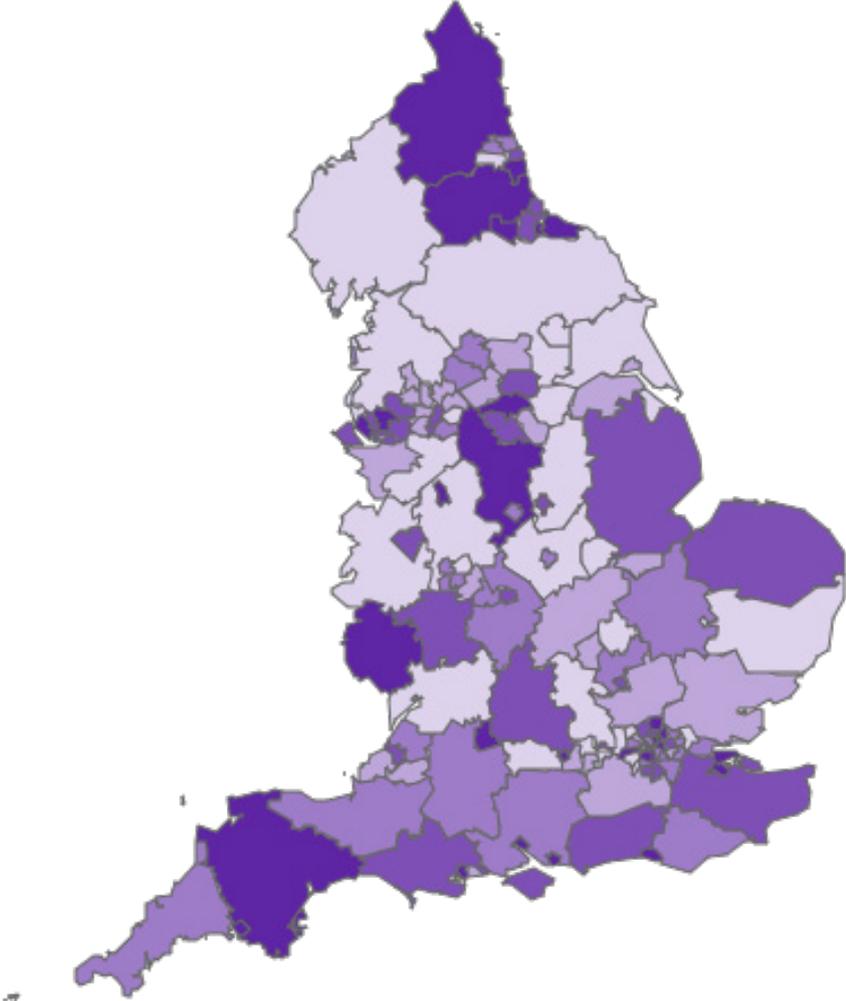
There is also a larger group of young people without a specific mental health diagnosis, but who nevertheless experience low levels of wellbeing. For example, just under one in five young people experience high levels of anxiety⁹. In a 2015 international comparative study by York University as part of the Children’s Worlds project, England ranked 14 out of 15 for children’s satisfaction with life

6 According to the most widely used prevalence data: Mental health of children and young people in Great Britain, Office of National Statistics, 2004 <http://www.hscic.gov.uk/catalogue/PUB06116/ment-heal-chil-youn-peop-gb-2004-rep2.pdf> 2004
 7 9.6 per cent of 7.5m children aged 5-16 in England 2014, Population Estimates, Office of National Statistics, 2014 <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwales-scotlandandnorthernireland>
 8 Also from Green et al 2004
 9 Measuring National Well-being: Insights into children’s mental health and wellbeing, Office of National Statistics, 2015 <http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/children-and-young-people-s-well-being-in-the-uk--october-2015/index.html>

as a whole¹⁰. The survey presented findings from over 30,000 children aged 10 to 12 years old in 15 countries across four continents. It looked at a range of measures, including family composition and material possessions. Three measures of wellbeing were used – positivity about the future; happiness over the last two weeks and satisfaction with life as a whole. The UK ranked in the lower half of the table on all three measures. On the index of satisfaction with life as a whole, it ranked below Poland and Nepal and above only South Korea.

Latest data from the Department for Education shows variation across the country in the prevalence of social, emotional and mental health needs in schools.

Figure 2: Pupils with social, emotional and mental health needs, percentage of school pupils¹¹



This data highlights patches of higher prevalence in the South and East of England, although there is not a wide variation in prevalence.¹²

10 Rees, G. & Main, G. (eds) (2015) Children’s views on their lives and well-being in 15 countries: An initial report on the Children’s Worlds survey, 2013/14. York, UK: Children’s Worlds Project (ISCWeB) http://www.isciweb.org/_Uploads/dbsAttachedFiles/ChildrensWorlds2015-FullReport-Final.pdf

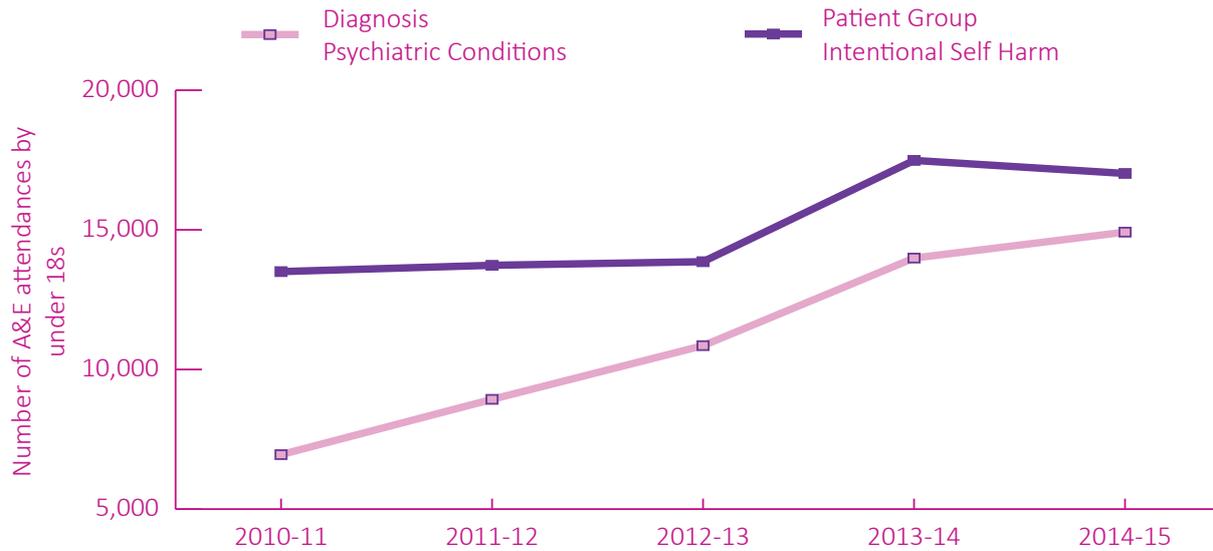
11 Department for Education special educational needs statistics 2016 <https://www.gov.uk/government/collections/statistics-special-educational-needs-sen>

12 Variation from 0.3 per cent to 3.9 per cent prevalence

A growing problem?

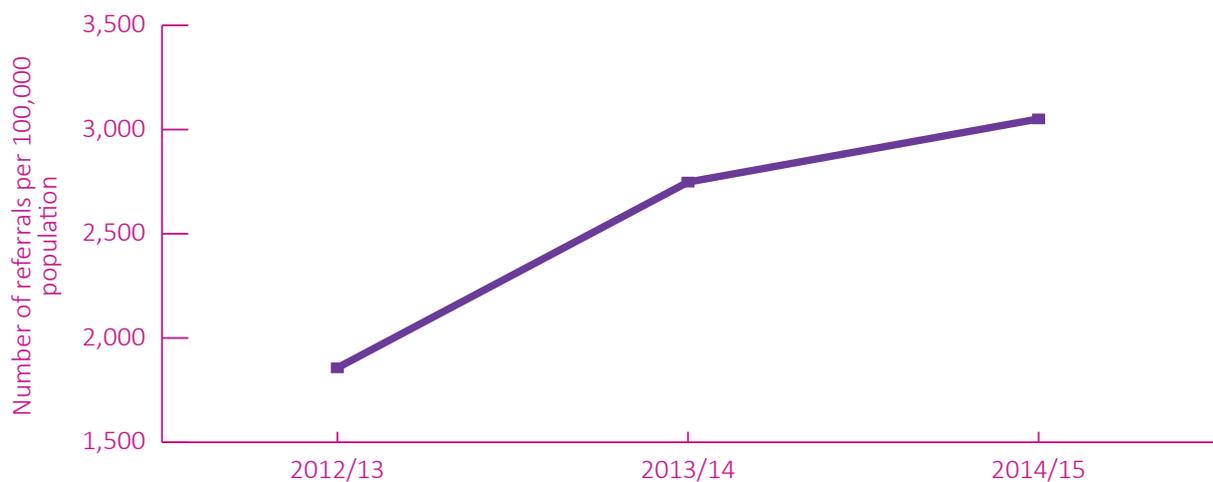
An in-depth understanding of trends in child and adolescent mental health is hindered by the lack of up to date, high quality data and access standards, as outlined above. Nevertheless, there is some evidence of a significant rise in children’s mental health problems over the last five years. For example, the number of young people attending A&E because of a psychiatric condition has more than doubled since 2010¹³.

Figure 3: A&E attendances by under 18s: Primary diagnosis of psychiatric conditions or intentional self-harm



Referrals to specialist mental health services have also increased - by 64 per cent over the last two years to 2015 according to the NHS Benchmarking Review (an optional benchmarking system for providers)¹⁴.

Figure 4: Referrals to community CAMHS services per 100,000 population



Source: NHS Benchmarking of UK wide services NB: The increases in referrals may be reflective of the different mix of providers taking part in the different years, as well as an overall increase in demand and service provision for CAMHS. However, the data does suggest that the referrals have increased from 2013-2015.

13 House of Commons Written Answer <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2016-02-01/25146>

14 NHS CAMHS benchmarking review for 2014/15 published in November 2015

Moreover, a British Psychological Society survey of mental health providers found that 89 per cent of respondents said there had been an increase in referrals in the two years leading up to 2014; percentages ranged from 20-70 per cent¹⁵.

Reasons for such large increases in referrals could include a reduction in stigma which is encouraging young people and their parents to seek help, a higher awareness of mental health problems in the wider community, or a higher prevalence of certain conditions, for example self-harm. The lack of updated prevalence information complicates any analysis of the reasons for this increase.

15 Health Select Committee report on children's mental health, 2014 <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34205.htm#a11>

Risk factors

Mental health problems, like physical health problems, have a complex range of causes, biological, psychological and social, which are not yet well understood. Some people may be at greater risk due to underlying inherited predisposition or significant risk factors in childhood. Research by the Mental Health Foundation¹⁶ has identified certain risk factors that make some children and young people more likely to experience problems than other children. These include:

- : having a long-term physical illness;
- : having a parent who has had mental health problems, problems with alcohol or has been in trouble with the law;
- : experiencing the death of someone close to them;
- : having parents who separate or divorce;
- : having been severely bullied;
- : having been physically or sexually abused;
- : living in poverty or being homeless;
- : experiencing discrimination, perhaps because of their race, sexuality or religion;
- : acting as a carer for a relative, taking on adult responsibilities;
- : having long-standing educational difficulties.

Social disadvantage and adversity increase the risk of developing mental health problems. Children and young people from the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes¹⁷. Almost three quarters (72 per cent) of children in residential care experience some form of emotional and mental health problem¹⁸. Evidence has also linked mental health problems in boys to the absence of a father or significant male attachment figure¹⁹.

Research shows the high levels of mental health problems in young people involved in gangs, with one UK study finding 34 per cent of gang members had considered suicide, and a quarter had experienced psychosis. The study found gang membership was associated with an increased risk of mental ill health even when associated demographic factors were taken into account²⁰.

Nevertheless, anyone can experience a mental health problem, no matter what their background or life experience. In fact, recent research has shown evidence of a link between affluence and problems such as substance misuse, depression, and eating disorders²¹.

The recent rise in popularity of social media and the phenomenon of 'cyber-bullying' have been linked in the media to adolescent mental health problems, but the evidence on this point remains inconclusive. Office for National Statistics data suggests a correlation, though not necessarily a causal link between the use of these sites and those experiencing mental health problems. While 12 per cent of children who spend no time on social networking websites have symptoms of mental ill health, the

16 Mental Health Foundation <https://www.mentalhealth.org.uk/a-to-z/c/children-and-young-people>. Accessed March 2016

17 Annual Report of the Chief Medical Officer 2013 <https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health>

18 Sempik, J. et al. Emotional and behavioural difficulties of children and young people at entry into care. 2008. *Clinical Child Psychology and Psychiatry*. 13 (2). Pages 221-233

19 The causal effects of father absence. McLanahan et al, *Annu Rev Sociol.* 2013 Jul; 39: 399-427 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3904543/>

20 Coid et al 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398674/The_mental_health_needs_of_gang-affiliated_young_people_v3_23_01_1.pdf

21 Suniya S. Luthar, Samuel H. Barkin and Elizabeth J. Crossman (2013). "I can, therefore I must": Fragility in the upper-middle classes. *Development and Psychopathology*, 25, pp 1529-1549. doi:10.1017/S0954579413000758

figure rises to 27 per cent for those who are on the sites for three hours or more a day²². Nevertheless, social media and the internet more widely have also been shown to have a beneficial effect for young people experiencing mental health problems,²³ who can connect with other teenagers going through the same experiences or access digital apps and other support online. More research is clearly needed into the relationship between young people's mental health and social media.

22 Measuring National Well-being: Insights into children's mental health and wellbeing, Office of National Statistics, 2015 <http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/children-and-young-people-s-well-being-in-the-uk--october-2015/index.html>

23 E-mental health: what's all the fuss about?, NHS Confederation Mental Health Network, 2013 <http://www.nhsconfed.org/resources/2013/01/e-mental-health-whats-all-the-fuss-about>

Impact

Suicide is the most common cause of death for boys aged between 5 and 19, being the cause of 14 per cent of deaths in this age group²⁴, and the second most common for girls of that age (9 per cent), after land traffic accidents. Recently, data has been collected on suicides for those aged under 14 for the first time. This shows that nearly 100 children aged 10 to 14 killed themselves in the UK in the past decade²⁵.

Even where child and adolescent mental health problems have less immediate tragic consequences, they can still be life-limiting. People with a severe mental health problem die on average about 15–20 years earlier than people without mental illness²⁶.

Child and adolescent mental health problems are also associated with poorer outcomes later in life, such as: poor academic attainment, an increase in economic inactivity and criminal activity²⁷. Young people with an emotional disorder are more likely to smoke, drink and use drugs than other children²⁸; more likely to have time off school and fall behind in their education²⁹; and are more likely to earn less money as adults or to experience unemployment³⁰.

Over half of all mental ill health starts before the age of fourteen years, and seventy-five per cent has developed by the age of eighteen³¹. Recent research has identified the neuro-plasticity of the brain in this adolescent period³², indicating that intervention at this age could prevent problems getting worse in adulthood. As well as the personal cost, the estimated long term cost to our economy of mental health problems is £105bn a year³³. Research indicates that early intervention with social and emotional learning programmes for children has a return on investment of £84 for each £1 spent³⁴.

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- 24 What do we die from? Part of Mortality Statistics: Deaths Registered in England and Wales (Series DR), 2014 Release, 17 December 2015. Cause of death listed as 'suicide or poisoning of undetermined intent' <http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2014/sty-what-do-we-die-from.html> 2015
- 25 Suicides in the United Kingdom: 2014 registrations <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations#methodology>
- 26 Annual Report of the Chief Medical Officer 2013, <https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health>
- 27 Childhood mental health and life chances in post-war Britain Insights from three national birth cohort studies, Richards et al, 2009: [http://www.rcpsych.ac.uk/pdf/life_chances_summary%20\(2\).pdf](http://www.rcpsych.ac.uk/pdf/life_chances_summary%20(2).pdf)
- 28 Mental health of children and young people in Great Britain, Office of National Statistics, 2004
- 29 Mental health of children and young people in Great Britain, Office of National Statistics, 2004
- 30 Counting the true cost of childhood psychological problems in adult life, 16 March 2015 <https://www.ioe.ac.uk/newsEvents/112000.html>
- 31 Murphy M and Fonagy P (2012). Mental health problems in children and young people. In: Annual Report of the Chief Medical Officer 2012. London: Department of Health
- 32 [Development of the adolescent brain: implications for executive function and social cognition](#), SJ Blakemore, S Choudhury Journal of child psychology and psychiatry 47 (3-4), 296-312 2006
- 33 The Five Year Forward View for Mental Health, NHS England, 2016 <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf> 2016
- 34 Mental health promotion and mental illness prevention: The economic case, Martin Knapp, David McDaid and Michael Parsonage (editors) Personal Social Services Research Unit, London School of Economics and Political Science April 2011 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf

The treatment gap

CentreForum’s analysis finds that current service provision is patchy and highly variable in terms of access, availability and quality of mental health treatment. Many children and young people simply get no treatment at all:

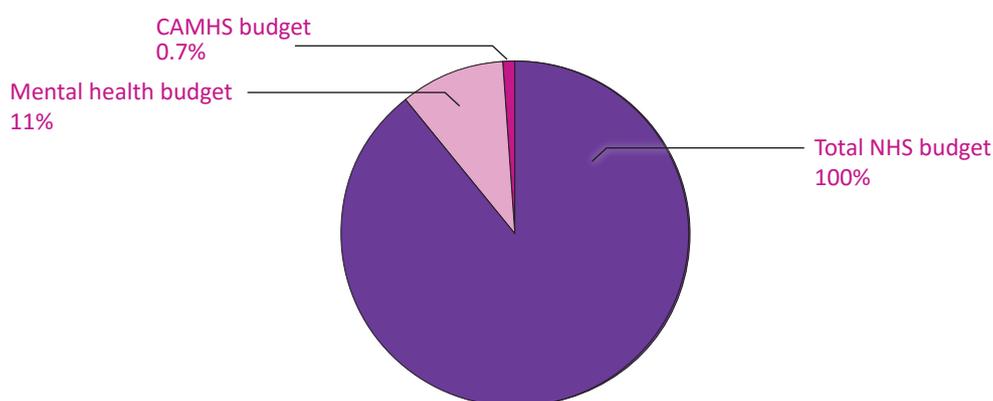
- : 75 per cent of people with mental health problems may not get access to the treatment they need³⁵.
- : More than three quarters of GPs surveyed in 2010 said they could rarely get access to psychological therapy needed for their young patients³⁶.
- : A headteacher survey in 2016 found that over half felt that CAMHS services were poor; 65 per cent struggled to get mental health support for pupils, and 8 out of 10 wanted CAMHS provision to be expanded³⁷.

One reason for lack of access to treatment is that the stigma surrounding this issue can often prevent families seeking help. According to a survey by Place2Be³⁸ more than one in five parents said concerns that their own behaviour would come under scrutiny or that they would be judged means they would persuade their child to wait and see if things got better on their own. This was particularly true for fathers: more than a third of fathers said they would not want their child receiving counselling or other treatment and would try to prevent it. One in three said they would be deeply embarrassed if anyone found out their child had an emotional or mental health problem. When families do seek help, often when things have reached crisis point, they often face significant difficulties in accessing support and long waits for treatment.

Funding

In 2012/13 £704m was spent on CAMHS³⁹, the equivalent of about 6 per cent of the total mental health budget, or around 0.7 per cent of the total NHS budget⁴⁰.

Figure 5: CAMHS expenditure



35 Annual Report of the Chief Medical Officer 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf

36 London School of Economics. How mental illness loses out in the NHS. London: London School of Economics; 2012 <http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf> (accessed March 2015)

37 Keeping young people in mind – findings from a survey of schools across England, Association of School and College Leaders, 2016 <http://www.ascl.org.uk/utilities/document-summary.html?id=D91C5B0A-72A6-4117-96A9B343E51FB296>

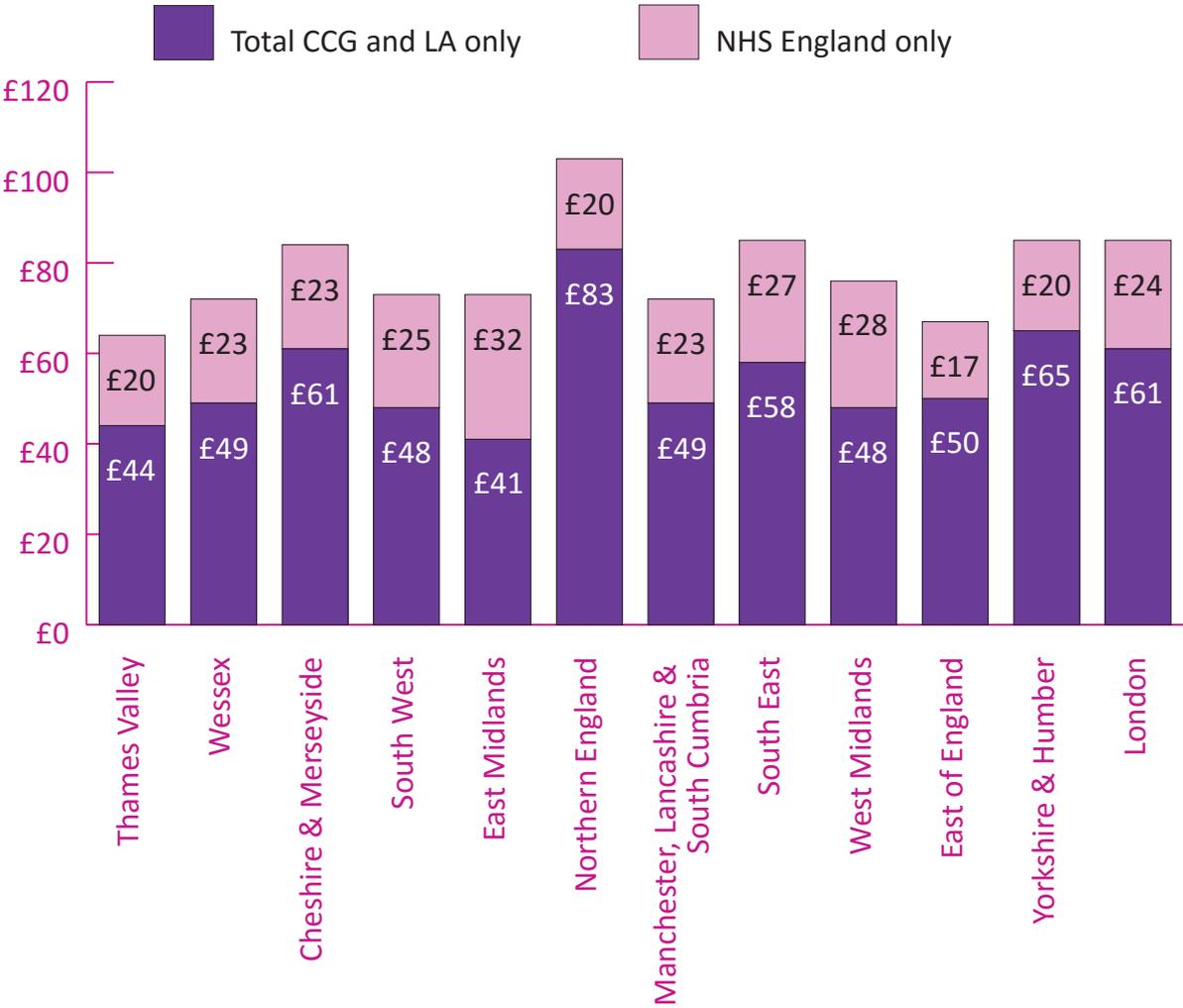
38 The Times, 14 February 2015, <http://www.thetimes.co.uk/tto/health/child-health/article4354031.ece>

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

40 NHS England evidence to the Health Select Committee enquiry into children’s mental health, 2014 <http://data.parliament.uk/written-evidence/committeeevidence.svc/evidencedocument/health-committee/childrens-and-adolescent-mental-health-and-camhs/written/7703.pdf>

It is very difficult to analyse trends in funding of CAMHS because there is no transparency in the way that data is collected. A parliamentary written answer appears to show a reduction in real terms funding from 2010/11 (£751m) to 2012/13 (£717m)⁴¹ but this does not cover all expenditure and is not directly comparable across years. A freedom of information request by Young Minds in 2015⁴² found that £35m had been cut from services over the last year with 74 out of the 95 Clinical Commissioning Groups that responded having frozen or cut their budgets. NHS England recently completed analysis of local areas plans for children’s mental health, which indicated a slightly higher level of funding including local authority expenditure, of £900m⁴³. This can only be seen as a broad estimate of expenditure, given it is not a nationally assured data collection, and is not comparable over time. The analysis was, however, broken down by region, giving an indication of the variation in funding at a local level.

Figure 6: Approximate expenditure on children and young people’s mental health per child⁴⁴ by region



41 Real terms 2013/14 prices, House of Commons Written Answer, 16 December 2014 <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2014-12-16/218865/>

42 Community Care Magazine, January 2015, <http://www.communitycare.co.uk/2015/01/09/real-terms-funding-cut-childrens-mental-health-services-revealed/>

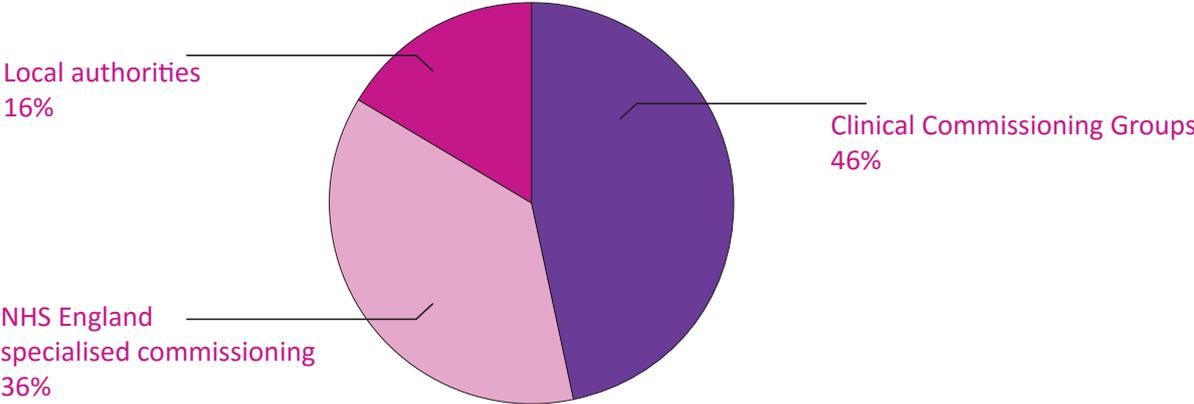
43 2014/15 expenditure. Children and Young People’s Mental Health Services Baseline Report, Local Transformation Plans Review 2015, NHS England, March 2016 <https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/08/nhse-camhs-baselining-summary1.pdf>

44 Based on expenditure in thousands of pounds per thousand 0-17 population.

This figure shows there is wide variation in expenditure on children’s mental health by region, from £41 per child in the East Midlands to £83 in Northern England. There is a higher level of expenditure in the North compared to the South and East of the country, which could be associated with the capacity difficulties experienced in the South of England identified elsewhere in this report. There is less variation by region in specialised inpatient commissioning (which is expected given there is now more national coordination of this expenditure). The two regions with the highest level of expenditure on specialised care are also areas with low levels of spending by local commissioners (the East and West Midlands). In the North West, however, there are high levels of community and specialised expenditure.

The NHS England analysis also looked at where the money was being invested. It found that almost half of funding comes from Clinical Commissioning Groups (local health commissioners). 36 per cent of expenditure came from NHS England, which means it was spent on specialised inpatient services. Only 16 per cent was invested by local authorities, showing that the **smallest proportion of the budget was spent on community based early intervention support.**

Figure 7: Approximate average annual CYP mental health spending by funding source



There is evidence that this imbalance in funding is linked to health and care commissioners not prioritising mental health in their planning. According to an analysis of key strategies by the Children and Young People’s Mental Health Coalition in 2013, two thirds of Joint Strategic Needs Assessments did not measure children and young people’s mental health, and one third of Joint Health and Wellbeing Strategies did not prioritise children and young people’s mental health⁴⁵.

Funding more effective treatments

Another area of significant funding inequality is in medical research. A major concern in mental health is how little we understand the causes and manifestations of mental illness, and the limited availability of effective treatments for every condition. The inequality faced by mental health in the NHS is reflected in the funding of scientific research in this area. Only 5.8 per cent of total UK health research spend is invested in mental health, falling significantly short of the amount which would more fairly reflect the 23 per cent burden of disease⁴⁶. If resources were allocated in proportion to the disease burden, mental health research would get almost four times its current share of total UK health research spending. In response to a recent Freedom of Information request, the MRC revealed that it spent £21.8m on research directly relevant to mental health in 2014/15. This amounts to less than 3% of its

45 Children and Young People’s Mental Health Coalition. Overlooked and forgotten: a review of how well children and young people’s mental health is being prioritised in the current commissioning landscape. 2013
 46 MQ statement on new 10-year analysis of UK health research, August 2015 <http://www.joinmq.org/news-opinion/entry/mq-statement-on-10-year-analysis-ukcr>

total research spend of £801.4m in that year⁴⁷. For every £1 spent by the Government on mental health research, the general public gives just 0.3p. The equivalent general public donation for cancer is £2.75. Approximately £9.75 is invested in research per person affected by mental illness – over 100 times less than the amount spent on cancer research per patient (£1,571)⁴⁸.

Treatment in non-specialist settings

The provision of mental health treatment and support for children and young people outside of specialist CAMHS services is even more of a data desert. GPs sometimes employ their own mental health nurses and acute hospitals often have liaison psychiatry departments which can work with children in paediatric wards or A&E departments. This provision is highly variable at present.

For school age children, many schools offer school-based counselling, although this provision is patchy. School based counselling⁴⁹ is one of the most prevalent forms of psychological therapy for children and young people, with around 70-90,000 cases seen a year across the UK as a whole in secondary schools alone⁵⁰. Around two thirds of primary schools (65 per cent) report that their pupils currently do not have access to a school-based counsellor. The schools reported that financial constraints and a lack of services or qualified professionals locally were the key barriers to putting in place such support. Of those primaries who do have access to a counsellor, 59 per cent are on-site for one day a week or less. 84 per cent are fully or partly funded by pupil premium funding⁵¹. The Department for Education's Teacher Voice survey⁵² found a higher level of support, with 52 per cent of primary schools and 70 per cent of secondary schools offering some counselling support.

Access to specialist treatment

A consequence of increased demand in some areas has been increased referral thresholds, meaning services are now accepting fewer referrals, prioritising those with the highest levels of need. CentreForum has undertaken a freedom of information request to 78 providers to understand this situation across England. We received comparable responses from 35 providers, a response rate of 46 per cent. We found that, on average, child and adolescent mental health services were turning away nearly a quarter of children referred to them for treatment (23 per cent). Our research found that this had increased slightly since 2011/12 (the earliest year for which there is comparable data):

47 Freedom of Information request by Adrian Stott, board member of the Mental Health Foundation and the MindED Trust, February 2016: <https://normanlambdocs.files.wordpress.com/2016/03/jeremy-hunt-re-mrc-mental-health-research-spending.pdf>

48 Mental Health Research Funding Landscape Report, April 2015 <http://www.joinmq.org/pages/mental-health-research-funding-landscape-report>

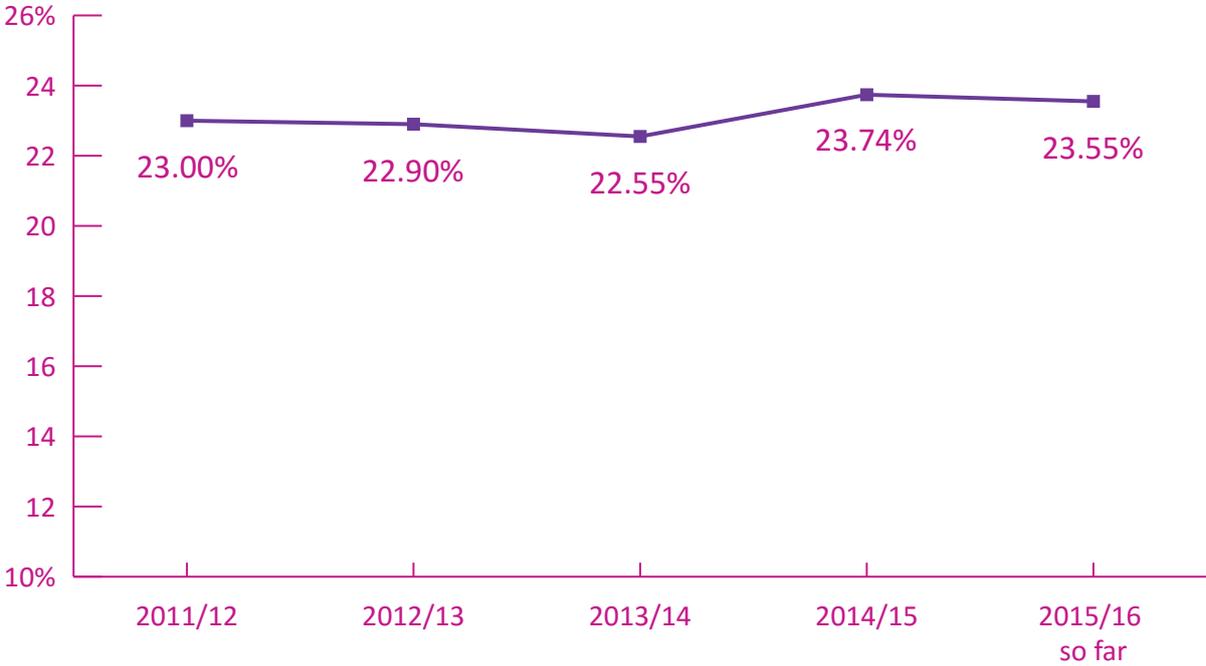
49 Counselling in schools: a blueprint for the future Departmental advice for school leaders and counsellors, Department for Education, February 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497825/Counselling_in_schools.pdf

50 School-based counselling in UK secondary schools: a review and critical evaluation, Mick Cooper, University of Strathclyde 19th January 2013, <http://iapt.nhs.uk/silo/files/school-based-counselling-review.pdf>

51 Place2Be and NAHT survey, February 2016

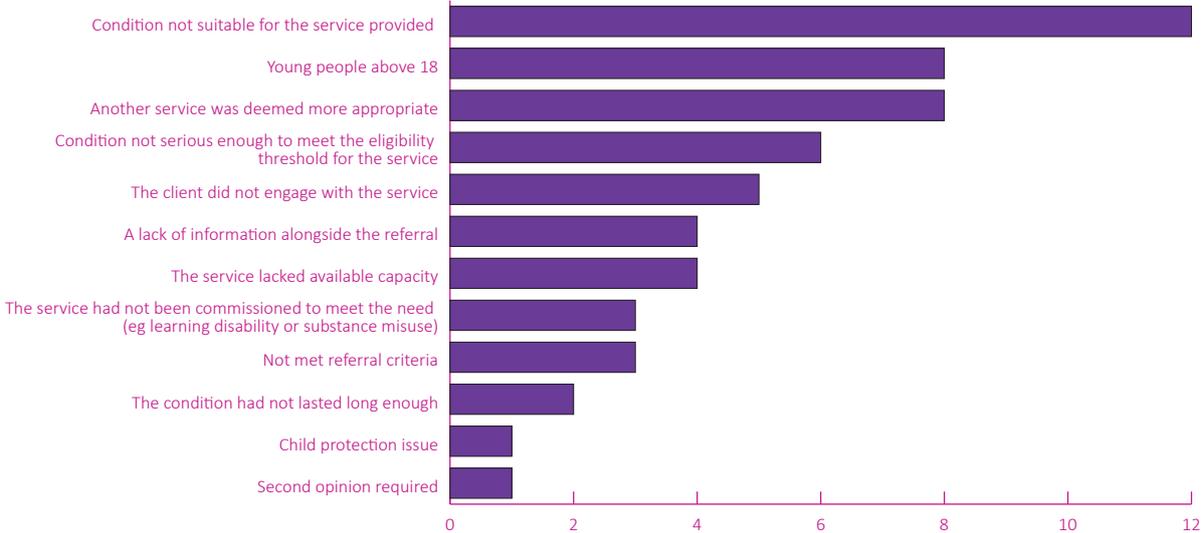
52 Teacher voice omnibus: June 2015 responses, Department for Education, December 2015 <https://www.gov.uk/government/publications/teacher-voice-omnibus-june-2015-responses>

Figure 8: Mean percentage of referrals returned by providers



The rates of referrals deemed ‘inappropriate’ ranged from negligible in some trusts to 49 per cent in one. Providers were asked to list the main reasons they returned referrals. The most common responses were:

Figure 9: Reasons for referrals returned by providers



It is important to recognise that there are sometimes legitimate reasons for referral to an alternative service. For example, a generic CAMHS service may refer a young person onto a more specialist eating disorder service. Nevertheless, these high and rising rates of referrals not being accepted by services raise questions about the capacity of local services, the limitations placed on services by commissioners, and the interface between the service and those agencies referring to them, for example schools, social workers and GPs.

CentreForum analysed the referral criteria documents used by local CAMHS providers to filter referrals. This research showed that many services are clearly limited in their scope due to pressures on their capacity and are introducing high threshold rates for access to their care. This directly contradicts the strong evidence in favour of early intervention⁵³. Examples of exclusion criteria found by CentreForum research include:

- : Services asking for evidence that a child has received support from schools, GPs or the voluntary sector before being referred to the service.
- : Services only accepting referrals from listed professionals, e.g. GPs and not teachers.
- : Support for anorexia being denied unless a young person is under a certain BMI threshold.
- : Referrals not being accepted unless the young person's condition has reached a high level of severity, e.g. *"Having a **major** impact on the child's life such as an inability to attend school or involving a **major** breakdown in family relationships"*. Another service would refer people to more generic support unless they had *"enduring suicidal ideation"* (i.e. they had felt they wanted to commit suicide on more than one occasion).
- : Referrals not being accepted if they are not overly complex, i.e. they only have one condition. For example Cambridgeshire and Peterborough did not recommend referral to CAMHS for young people who were not attending school and having panic attacks unless they also were self-harming or had other symptoms impacting on daily life. The same service would recommend those *"Hearing voices in the context of mild anxiety, low self-esteem or low mood"* should see their GP or voluntary sector counselling service and only be referred to CAMHS if they *"heard voices that command particular behaviours"*.
- : Many services had strict guidelines for the age of clients, not accepting referrals after an 18th birthday.
- : Some services would not accept referrals from young people where the problem appeared to be *"entirely school-related"*. Given that in this case the referral would have come from the school this indicates that no suitable support would be available. Similarly, exclusion criteria often ruled out support for those showing a 'normal' reaction to bereavement, but it is not clear what support would be available for those children. There is a risk that the high thresholds for care apparent in these criteria mean that young people need to wait until their problems get worse before they can get help.

The criteria also highlighted the inequality of access to appropriate crisis support. For example, one included the note:

"The [out of hours] phone will have a message facility and will advise that if the call is not answered, and the matter is of an urgent nature the child/young person or family should not wait for a response but attend their local A&E department".

The direction to A&E represents a better situation than providing no advice on where to access help. Nevertheless, the fact that this 'out of hours' phone line would be unstaffed demonstrates the inequality faced by those experiencing mental health problems. This would not be the case for those with a physical health problem - the 111 phoneline or a local community out of hours service would never be unstaffed in this way. In some areas of the country, there is a strong focus on integrating out of hours provision and ensuring appropriate mental health support in A&E, but progress continues to be patchy.

⁵³ There is a wealth of evidence supporting early intervention, eg: Investing in Children, Centre for Mental Health, February 2015 <http://www.centreformentalhealth.org.uk/investing-in-children-report>

Inpatient services are only appropriate for those with the most severe level of need, and therefore are more likely to have very high threshold criteria. There are, however, signs that some services are increasing their thresholds simply due to a lack of capacity. One service would rarely accept young people unless they had two or more conditions and a number of 'risk factors':

“Therefore, Tier 4 must deal not only with a diagnosis of mental health disorder but also with children who, in real life, more often than not, have two or more co morbid conditions, such as a learning disability and a mental health disorder, or depression and a conduct disorder, as well as a number of risk factors.”

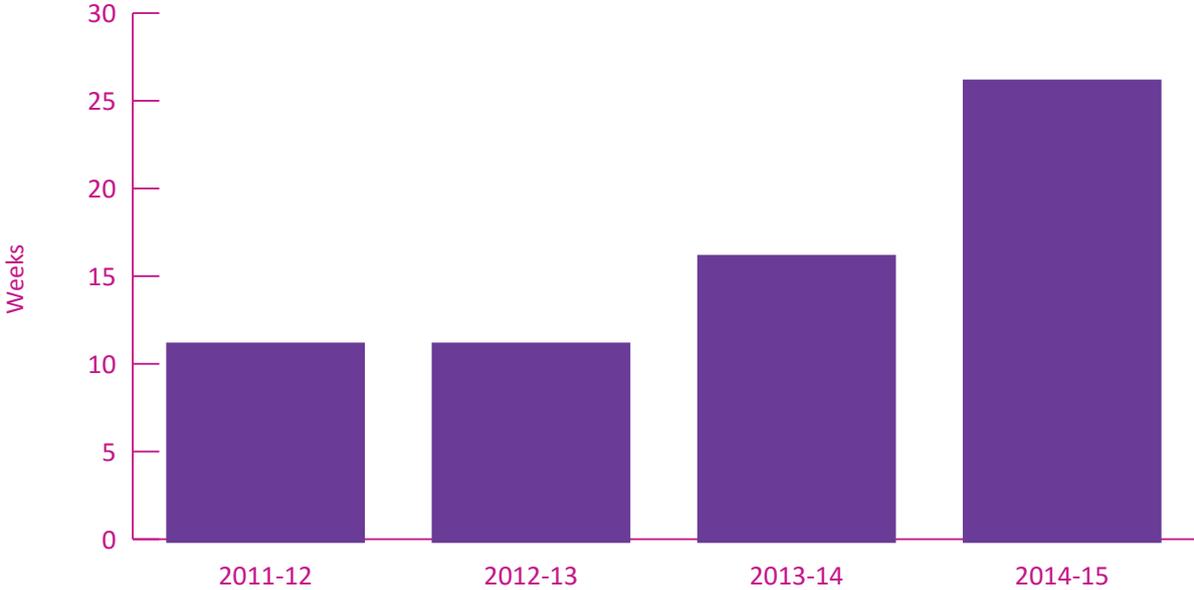
These factors include having a history of abuse or living in local authority care. There is a risk that young people from more mainstream backgrounds may not get access to support even where their mental health condition is severe.

This is not about placing blame on providers. These criteria are put in place in order to cope with rising demand and inadequate funding. There are also different viewpoints as to the nature and role of specialist mental health services and a need for more preventive services in the community. There were some good examples of services changing these rigid criteria or which had already adopted a different approach. For example, some services had introduced a Single Point of Access so that young people, or their parents or teachers could get the right help by coming to one place for a range of levels of service. CentreForum's commission will explore these issues in more detail in our subsequent reports, identifying the reasons behind the difficulties in access to services and highlighting positive practice and potential solutions to these complex problems.

Long waiting times

Even when children do get access to treatment, they may wait a long time. Data from the NHS Benchmarking Report (a voluntary data-sharing programme for mental health providers)⁵⁴ found that the average maximum waiting times for all providers in the benchmark is now 26 weeks, more than doubled since 2011/12. The average wait to access urgent specialist treatment was three weeks.

Figure 10: Maximum waiting times for a routine appointment (average of all providers)



Source: NHS Benchmarking review of UK wide services. The increases in waiting times may be reflective of the different mix of providers taking part in the different years, as well as an overall increase in demand and service provision for CAMHS. However, the data does suggest that the waiting times have increased from 2013-2015.

CentreForum also asked child and adolescent mental health providers for data on their waiting times. We received comparable responses from 52 providers, a response rate of 67 per cent. Our research uncovered that the median waiting time for all providers was 4 weeks for a first appointment but the wait for treatment to begin was two months (8 weeks). While it is not ideal for someone to have to wait two months for their treatment to begin, the median waiting times do not indicate severe access problems. There is, however, no current standard on how long patients should wait for the start of treatment, and so these average times can often mask long waits.

CentreForum therefore also looked at the maximum waiting times for each provider and calculated the average of these (using the median). The median of the longest waiting times⁵⁵ for all providers was 26 weeks (6 months) for a first appointment (which is consistent with the published benchmarking data) and nearly ten months (41 weeks) for the start of treatment. There was wide variation in waiting times for different providers: the longest waiting time for start of treatment was 31 months (over two and a half years).

This data has to come with a number of caveats. Maximum waiting times can only give an indication of capacity problems. In some cases providers gave reasons for long waits, e.g. patients cancelling appointments multiple times. Nevertheless, the data indicates that far too many patients face 'hidden waits' for treatment.

One service told us: *“Waiting times have grown within the service due to a significant increase in demand without an increase in resource/capacity to meet demand in a timely way”.*

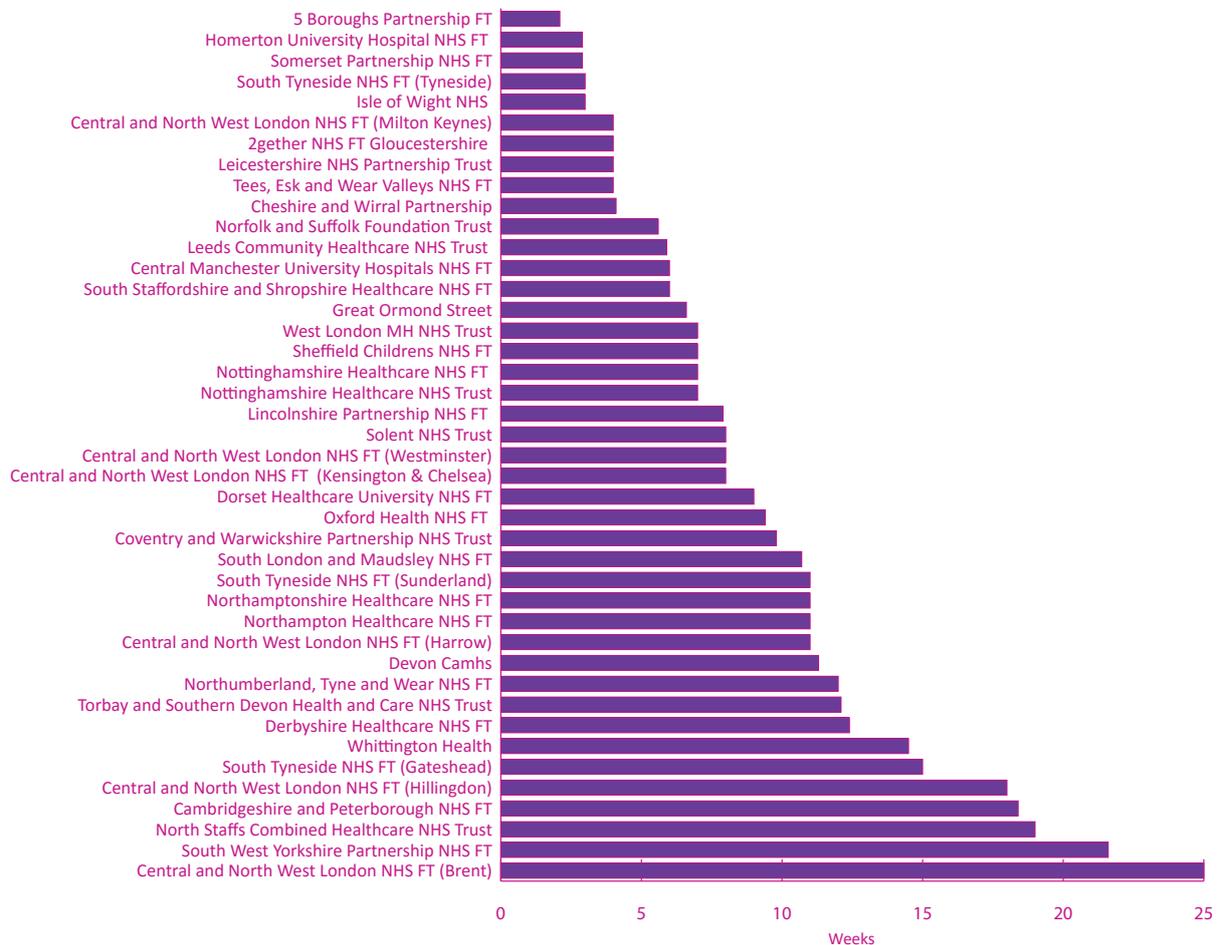
A maximum waiting time standard would involve consistent data collection on all waiting times. This would prevent the current situation of hidden waits. There would also be a uniform and evidence-based approach to situations where it was appropriate for the ‘clock’ to stop and start, where there was a legitimate reason for treatment to be delayed.

The fairest way to compare performance across providers with the current limited data is by comparing median waits. While not all services are directly comparable as they operate differently and have a

⁵⁵ This was calculated as the median due to the existence of outliers

different client base, the variation in median waiting times is significant. For example, the median waiting time in Gateshead is five times as long as for those in nearby Tyneside. Similarly waits in North West London vary widely from two months in Kensington and Chelsea to nearly six months in Brent.

Figure 11: Median waiting times by provider (weeks)



Crisis and inpatient care

There are also severe access problems for those experiencing a mental health crisis. According to a survey by the Royal College of Psychiatrists, 20 per cent of respondents said that they did not have an out of hours service⁵⁶. Almost two thirds (64 per cent) of 96 providers surveyed for the NHS England inpatient care review said they did not have an intensive outreach team⁵⁷.

This lack of crisis care in the community creates pressure on inpatient beds. According to NHS England, bed occupancy rates rose between 2012 and 2013⁵⁸. This can lead to situations where there are no beds available for a child or young person to be admitted, so that they have to travel miles away from home, or are treated in an inappropriate setting such as a police cell or an adult mental health ward.

56 Royal College of Psychiatrists evidence to the Health Select Committee 2014

57 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, July 2014 <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

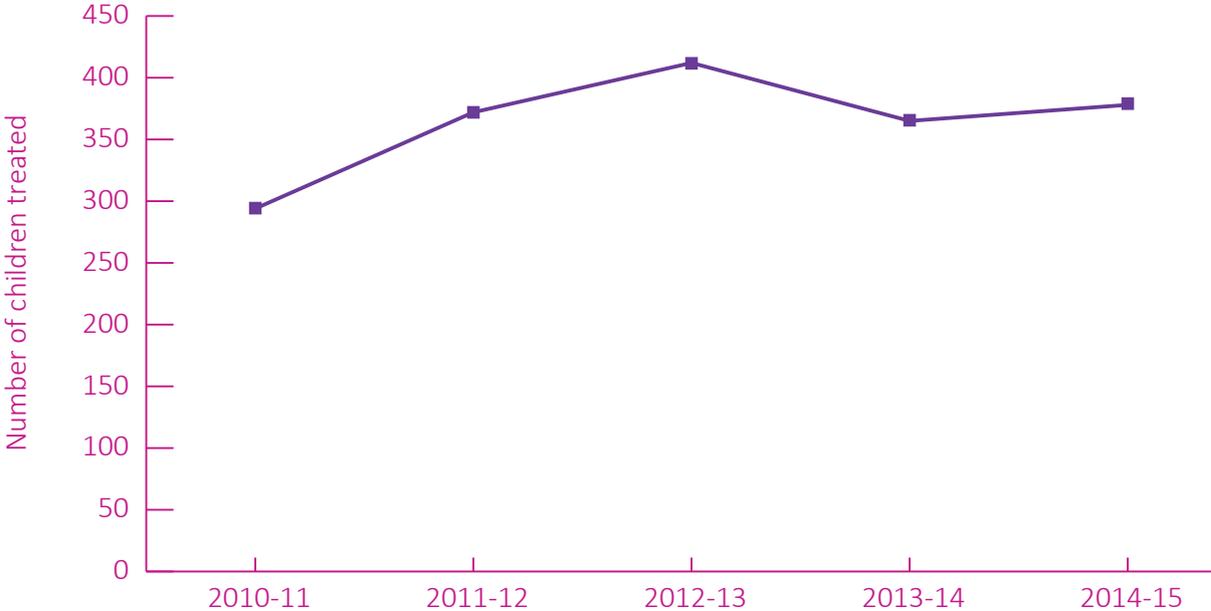
58 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, July 2014 <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

Research for this Commission has uncovered that since April 2015 there were 26 days when no beds were available in the South East and 52 days when no beds were available in the South West⁵⁹. In such cases, young people are more likely to have to travel further for treatment, or be treated in an inappropriate setting. In all other regions there were no days when no beds were available, but this data indicates clear concerns over access to inpatient care in the South.

Out of area treatments

Research by the BBC and Community Care Magazine found that of 18 trusts that provided out-of-area placement data, 10 had sent children more than 150 miles away for care. The furthest distance was from Sussex to Bury, Greater Manchester, a distance of 275 miles⁶⁰. A parliamentary answer from Mental Health Minister Alistair Burt MP in February 2016 revealed that nearly 1000 under 18s (979) were treated outside of their own local NHS area in 2014/15. While the number of 16-18 year olds treated out of area had remained relatively stable over the last five years, the number of under 16s treated out of area had risen 28.6 per cent since 2010⁶¹:

Figure 12: Children treated out of area

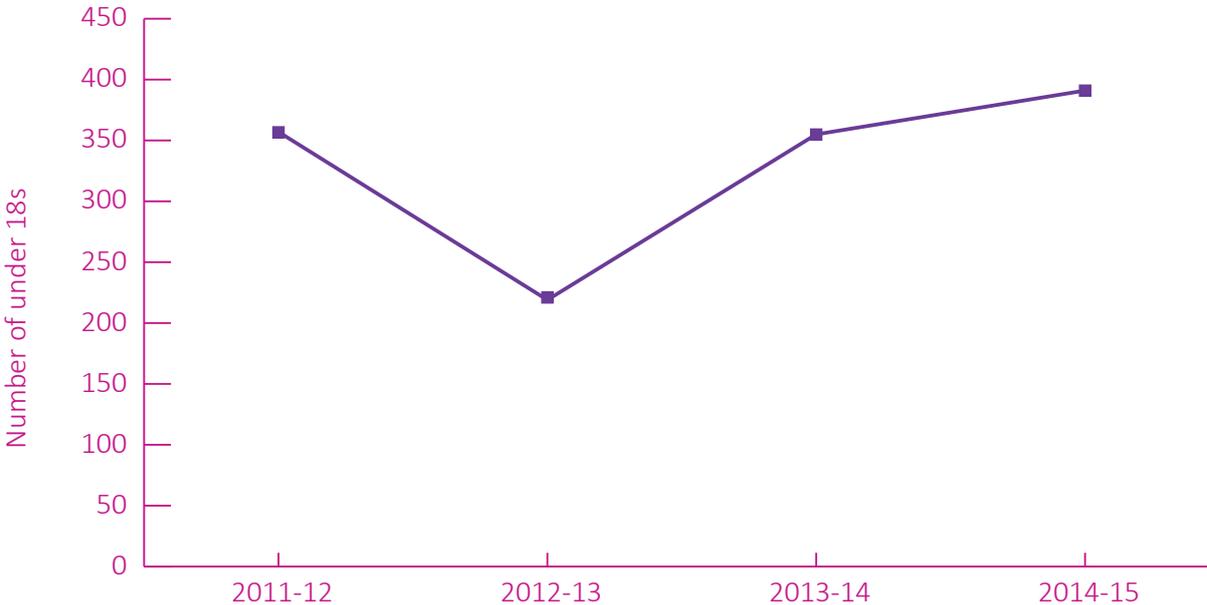


Adult wards

There were 391 children aged under 18 treated in adult mental health wards last year, a 10 per cent increase on the year before⁶². In 2010, the government created a new duty under the Mental Health Act 1983 that young people should not be treated on adult wards⁶³. This, in addition to changes in data collection, is likely to have led to the reduction seen in 2012/13 (see Figure 13 below). The duty alone, however, has clearly not been enough to change practice, which is affected by wider pressures on inpatient and community treatment.

59 House of Commons Written Answer, February 2016 <http://www.theyworkforyou.com/wrans/?id=2016-02-01.25026.h>
 60 FOI request by Community Care Magazine and the BBC, February 2014
 61 House of Commons Written Answer, February 2016 http://www.theyworkforyou.com/wrans/?id=2016-02-23.27918.h&s=speaker_per_cent3A11878#g27918.q0
 62 House of Commons Written Answer, February 2016 <http://www.theyworkforyou.com/wrans/?id=2016-02-01.25027.h>
 63 A Briefing on the Responsibilities of NHS Trust Boards under Section 131A of the Mental Health Act 1983, due to come into force on 1st April 2010, Young Minds http://www.youngminds.org.uk/assets/0000/1233/Age_appropriate_duty.pdf

Figure 13: Under 18s treated in adult inpatient settings



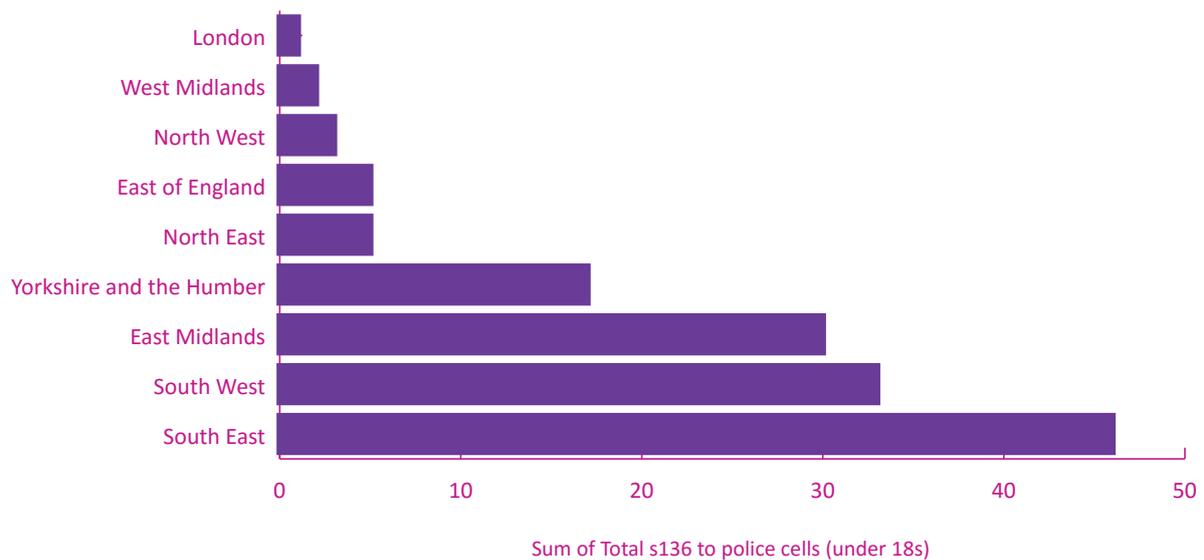
Police Cells

Another example of severe capacity problems is the issue of young people being detained in police cells under s136 of the Mental Health Act 1983. There are only 161 places of safety in England, many of which can only accommodate one person at any one time and a third of these places do not take under-16s⁶⁴. Therefore, not only is there a severe lack of facilities and accommodation available but many of these facilities do not accept children and young people. Many trusts are refusing to admit children into their places of safety, arguing they are not age appropriate. This means adults may be held in a specialist facility but a police cell is used as a default place of safety for children⁶⁵.

In 2014/15 145 children and young people were taken to police cells as a place of safety⁶⁶. This has substantially reduced in recent years: there has been an almost 50 per cent reduction in the number of times police cells were used as a place of safety in England and Wales between 2011/12 and 2014/15. There is, however, still wide variation across the country, and as the following figure shows, there appears to be a particular capacity problem in the South of England:

64 Right Here, Right Now: Mental Health Crisis Care Review, Care Quality Commission, June 2015 <https://www.cqc.org.uk/content/thematic-review-mental-health-crisis-care>
 65 Emergency provision for children in mental health crisis, Howard League for Penal Reform, September 2014 <http://www.howardleague.org/emergency-provision-for-children/>
 66 National Police Chiefs’ Council Lead for Mental Health, 2014/15 http://www.npcc.police.uk/documents/edhr/2015/Section_per cent20136_per cent20MHA_per cent20201415_per cent20Data.pdf

Figure 14: Under 18s in Police Cells 2014/15



The Policing and Crime Bill, which had its second reading on 7 March 2016⁶⁷, has the potential to ban this practice. Nevertheless, this will not be effective unless more appropriate places of safety are created. A parallel can be drawn here with the trend in children being admitted to adult wards since the introduction of the duty in 2010. In that case, a new duty did not have the desired impact.

It is clear that until capacity in the child and adolescent mental health system is increased, changes in legislation will not have the desired impact on children seen in police cells or on adult wards. In fact, the drive to stop the use of police cells may actually be leading to an increase in the number being treated on adult wards.

While children with a mental health problem should not be held in a police cell or on an adult ward, more inpatient care is not the solution to this problem. Inpatient bed numbers have risen from 844 in 1999 to 1264 in January 2014⁶⁸. The pressure on inpatient provision could be caused by the lack of appropriate care outside of hospital. More investment in community provision would enable early intervention to prevent people reaching crisis point, and is therefore a more appropriate model of care. More services in the community would also enable more people to be discharged from inpatient care. Data from NHS England indicates that between November 2015 and February 2016 there were 1,834 bed days relating to delayed discharges, where a young person was in hospital when they could have been discharged into the community if the right care had been available⁶⁹. This indicates a lack of appropriate community services for young people with mental health problems.

Quality of treatment

As well as problems in accessing treatment, there are also issues with the quality of care provided. It is difficult to get a clear picture of the quality of provision, as there is limited nationally collated data on the experience of people using CAMHS services. Nevertheless, some voluntary information is available via the NHS Benchmarking report. This identified some improvements in 2014/15 in terms of quality. Staffing levels in community settings have increased by around two per cent, and by three per cent in inpatient settings. Bed occupancy is 76 per cent, lower than most adult bed types. Most quality

67 Home Office, February 2016 <https://www.gov.uk/government/news/restricting-the-use-of-police-cells-for-those-experiencing-a-mental-health-crisis>

68 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, July 2014, <https://www.england.nhs.uk/2014/07/camhs-report/>

69 House of Commons Written Answer, February 2016 <http://www.theyworkforyou.com/wrans/?id=2016-02-01.25029.h>

measures have improved (e.g. reduced levels of violence, ligature incidents, and prone restraint). However, concerns remain that some services are stigmatising and inaccessible to young people. For example, in spite of pockets of good practice, providers often do not understand how to co-produce services with young people so that the services are designed around young people's needs, therefore being easy to access and improving the quality of what is provided.

There are also no nationally available data on the outcomes of care for CAMHS services. Anecdotally, some providers report reductions in quality over the last five years due to funding pressures, and there is acknowledged inconsistent use of evidence-based treatment within services.

The use of evidence-based treatment is, however, gradually being addressed through the roll out of the Children and Young People's Increasing Access to Psychological Therapies (CYP IAPT) programme. The programme works to transform existing services by:

- : using regular feedback and outcome monitoring to guide therapy;
- : improving user participation in treatment, service design and delivery;
- : improving access to evidence-based therapies by training existing staff in an agreed, standardised curriculum of NICE approved and best evidence-based therapies;
- : training managers and service leads in change, demand and capacity management, and
- : improving access through self-referral.

This programme does not create standalone services, but works to embed the above principles into existing services providing mental health care to children and young people. The programme currently covers 68 per cent of CAMHS providers and is working to achieve 100 per cent coverage by 2018.

Transition

For those young people who do manage to access mental health support, it is widely acknowledged that transition to adult services is a serious concern: *"For a significant number ... transition is poorly planned, poorly executed and poorly experienced"*⁷⁰. A 2008 study of local providers found that⁷¹ not all areas had transition protocols, and of those that were in existence, not all met the requirements set by government policy. The estimated annual average number of cases considered suitable for transfer to adult services per CAMHS team was greater than the annual average number of cases actually accepted by adult services, meaning that some people simply no longer received services at all even where their current service provider felt they needed them. The study found that a major omission from protocols was procedures to ensure continuity of care for patients not accepted by adult services. This gap is of great concern given that mental health problems often emerge in late adolescence and young people are losing touch with services or having their care disrupted at a crucial point where early intervention could make a significant difference to their future health and wellbeing⁷².

70 Closing the Gap, Department of Health, 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

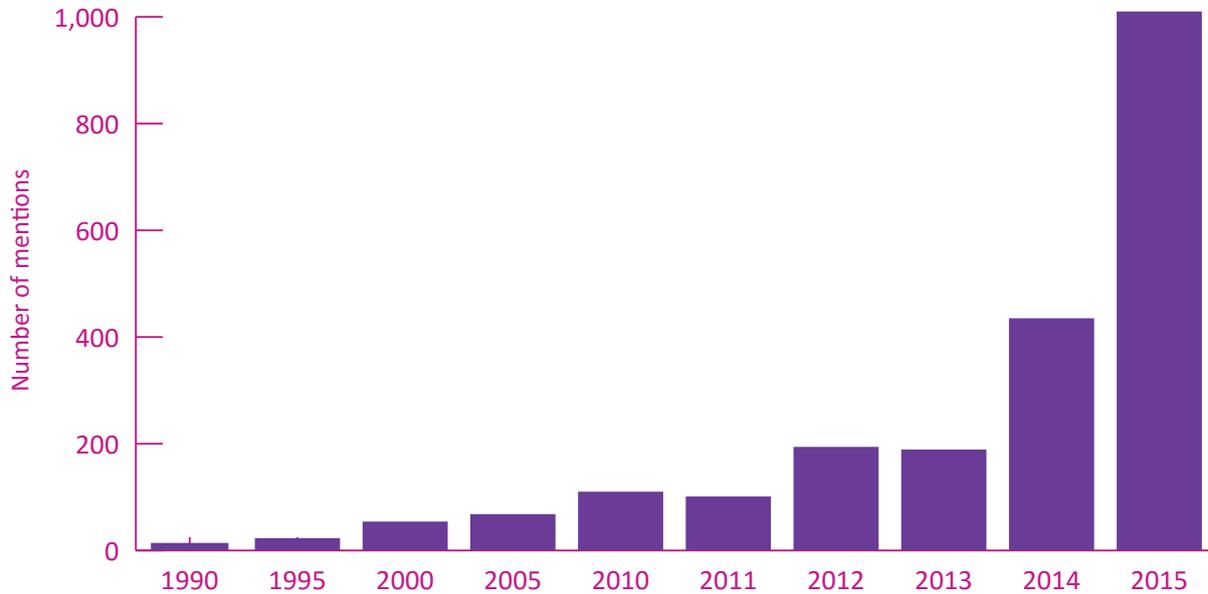
71 Singh, Swaran P., Paul, Moli, Ford, Tamsin, Kramer, Tami and Weaver, Tim. (2008) *Transitions of care from child and adolescent mental health services to adult mental health services (TRACK Study) : a study of protocols in Greater London*. BMC Health Services Research, Vol.8 . Article 135. ISSN 1472-6963 <http://wrap.warwick.ac.uk/201/>

72 Birchwood, M. J. and Singh, Swaran P. (2013) *Mental health services for young people : matching the service to the need*. The British Journal of Psychiatry, 202 (Supplement 54). s1-s2. ISSN 0007-1250 2013 <http://wrap.warwick.ac.uk/58774/>

Recent policy developments

In recent years the inadequate state of child and adolescent mental health services has risen up the political agenda. As some of the stigma surrounding mental health has diminished, stories of long waiting times and funding cuts are being reported more frequently.

Figure 15: Media mentions of children’s mental health in UK newspapers



Source: NHS England analysis

The Chief Medical Officer chose to make mental health the subject of her annual report in Autumn 2014⁷³. This was followed by a critical House of Commons Select Committee report in October 2014⁷⁴, which concluded that:

“There are serious and deeply ingrained problems with the commissioning and provision of children’s and adolescents’ mental health services. These run through the whole system from prevention and early intervention through to inpatient services for the most vulnerable young people”.

Earlier in 2014, faced with stories of children travelling miles for a bed, NHS England commissioned a review of inpatient services. The review raised serious concerns about inadequacy of provision in inpatient settings, but also in community services which had led to further pressure on beds. In response, 50 new beds were commissioned and NHS England implemented immediate actions to improve the management of inpatient services across the country.

Future in Mind

The concerns raised both externally and as a result of the inpatient review coincided with mental health being a key priority for the Coalition Government. Then Mental Health Minister, Norman Lamb MP established a children’s mental health taskforce to tackle these deeply ingrained issues of access and quality. The taskforce report, *Future in Mind*, was published in March 2015 and contained a series of recommendations for changes in the way services are commissioned and provided, such as tackling stigma, introducing access standards and moving away from a ‘tiered’ system⁷⁵.

73 Annual Report of the Chief Medical Officer 2013 <https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health>

74 House of Commons Select Committee inAquiry into child and adolescent mental health 2014 <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34202.htm>

75 CAMHS services have historically been structured across four tiers, with the first being preventative, non-specialist support and tier four meaning inpatient services

Future in Mind was accompanied by the announcement of £1.25bn investment over five years (£250m per year) in the last budget before the 2015 general election. With previously announced investment in eating disorder care⁷⁶, this is a total of £1.4bn additional investment by 2020.

Progress since *Future in Mind*

In 2015/16 only £143m of the proposed £250m funding was allocated. A departmental spokesperson explained that this was to ensure that the money was properly invested given the significant uplift in funding this represented. The government has reiterated that the total amount over the next five years will still reach £1.25bn⁷⁷. This funding **has not been ring-fenced** and from 2016/17 it will be part of the CCG's baseline allocation. There is, therefore, a substantial risk that it could be siphoned into other priorities for investment, or used to back-fill cuts from local authority investment in children's mental health. Given the government's objective of improving child and adolescent mental health care, this investment will need to be carefully monitored over the next five years to avoid this risk.

In order to gain access to this investment at a local level, each area has been asked to produce and publish a 'transformation plan'. These plans have been assured by NHS England in the process of allocating funding to local areas. In future years, plans will be included in each area's five year strategy for health and assurance of progress will be mainstreamed into the wider annual assurance process for local health commissioners. It is essential that this mainstream assurance process remains robust to ensure successful delivery of the transformation process.

Other positive changes since *Future in Mind* include:

- : a new section of the *NHS Choices* website on youth mental health, which includes advice and self-help apps for young people looking for support;
- : a government backed national anti-stigma campaign for teenagers and parents, launched in November 2015;
- : with the Health and Social Care Information Centre, the Department of Health is commissioning the first national survey of children and young people's mental health since 2004. The final results are expected in 2018.

In February 2016 NHS England published a *Five Year Forward View for Mental Health in England*⁷⁸. This adopted a 'life course' approach to mental health, covering care for new families, through the early years, school, adulthood and older age. Nevertheless, given the focus on children in the last parliament, this report inevitably covered adult care in more detail. On child and adolescent care, it endorsed the direction of travel outlined in *Future in Mind* and recommended additional measures including:

- : the development of an access and waiting time standard for child and adolescent mental health services in 2016/17;
- : mental health support in A&E departments with extended opening hours to treat children and adults;
- : the development of appropriate community based crisis support for children and young people;
- : a pilot of specialist inpatient care for young people aged 16 to 25, recognising that this age group

⁷⁶ In December 2014 the government announced £150m over five years to improve care for those with eating disorders. A new Access and Waiting Time Standard for Children and Young People with Eating Disorders has been devised which states that National Institute for Health and Care Excellence (NICE)-concordant treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases. In the case of emergencies, the eating disorder service should be contacted to provide support within 24 hours. This will be rolled out with the aim of 95 per cent of cases meeting this standard by 2020

⁷⁷ Alastair Burt MP, Mental Health Minister, House of Commons Hansard 3 Dec 2015, column 606

⁷⁸ The Five Year Forward View for Mental Health, NHS England, 2016 <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

has fallen through the gaps in care in the past;

- : a review of the mental health needs of vulnerable groups, including looked after children;
- : an end to out of area placements, where people are forced to travel miles from home for inpatient treatment.

Future in Mind and the *Five Year Forward View* have set out a clear pathway for the transformation of child and adolescent mental health services at a local level. There is, however, real uncertainty as to whether the additional funding will result in sufficient, genuine extra investment. Moreover, given the current treatment gap, the lack of available data and the variation in access and quality, there is a long journey ahead before services meet the standards which are taken for granted in the rest of the NHS.

Education policy

The Department for Education has also taken a number of actions to improve mental health support in schools. New guidance has been produced for school counselling services⁷⁹. Updated guidance has been published on mental health and behaviour⁸⁰, and on children with physical and mental health conditions⁸¹. In August 2015, the first ever mental health champion for schools, Natasha Devon, was recruited to help raise awareness and reduce the stigma around young people's mental health.

The Department for Education is investing £3m with NHS England to pilot joint training for designated leads in CAMHS services and schools; £5m in 'character education' including peer mentoring; and nearly £5m for grants for organisations that work with vulnerable children and young people, such as funding for a comprehensive directory of all mental health services for schools.

In March 2016, the Department launched a call for evidence to gather views on what support could be offered to encourage peer mentoring in schools⁸².

In spite of pressure to introduce mandatory mental health education as part of PSHE, following a consultation 2013, the Department of Education confirmed in February 2016 that it would remain optional. Instead, to improve teaching about mental health the department funded the PSHE Association to produce guidance and lesson plans to support teachers to deliver age-appropriate lessons on mental health in PSHE education. The Department has also commissioned a survey to provide nationally representative estimates of what provision schools and colleges offer for mental health and character education⁸³.

The recent Carter Review of Initial Teacher Training (ITT)⁸⁴ recommended that in future, training should provide new teachers with a grounding in child and adolescent development, including emotional and social development, which will underpin their understanding of issues like mental health. The Department for Education has established an independent group of experts to build a better shared understanding of what elements good ITT courses include and to develop a framework of core ITT content. The group will consider the Carter Review recommendations on emotional and social development⁸⁵. In advance of further formal training support, the Department of Health funded MindED website⁸⁶ is an invaluable resource for all professionals, including those in the education sector, on young people's mental health care.

79 Counselling in schools: a blueprint for the future Departmental advice for school leaders and counsellors, Department for Education, updated February 2016 <https://www.gov.uk/government/publications/counselling-in-schools>

80 Mental health and behaviour in schools, Department for Education, updated March 2016 <https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2>

81 Supporting pupils at school with medical conditions, Department for Education, December 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/484418/supporting-pupils-at-school-with-medical-conditions.pdf

82 Children and young people's mental health: peer support, Department for Education, February 2016 https://consult.education.gov.uk/children-and-young-people2019s-mental-health-team/peer-support-for-children-and-young-people-s-menta/consult_view

83 House of Commons Written Answer, March 2016 <http://www.theyworkforyou.com/wrans/?id=2016-03-16.31291.h&s=Men-tal+Health+Services+Young+People#g31291.r0>

84 Carter Review of Initial Teacher Training (ITT), Sir Andrew Carter OBE, Department for Education, January 2015

85 Government response to Youth Select Committee, para 37: http://www.byc.org.uk/media/279518/ysc_report_response_cleared.pdf January 2016

86 <https://www.minded.org.uk/>

Conclusion

In this, our first report, CentreForum's Commission has analysed the existing treatment gap for children and young people with mental health problems. Those who work in the sector are, in the vast majority, committed to delivering good care, and good practice does exist. Nevertheless, too often young people are not getting the help they need; are having to wait for months for care; or are treated in entirely inappropriate settings.

This issue has risen up the political agenda in the last couple of years but there is still a long way to go to raise standards to the levels that people with physical health problems are used to. The direction of travel outlined in *Future in Mind* and the *Five Year Forward View*, with additional funding, has been widely welcomed. CentreForum's Commission will explore the barriers and risks which could hinder progress in the months and years ahead and will then seek to identify solutions to support successful implementation of this transformation. We will also endeavour to shine a spotlight on those areas which are moving further and faster. We will propose a series of measurable goals for child and adolescent mental health to move towards a more equal and accessible system. These will cover the following key areas:

- A maximum access and waiting time standard across all of child and adolescent mental health pathways. NHS England's taskforce report proposes such a standard be introduced in 2016/17. Our Commission will seek to identify what such a standard should look like.
- Quality of services: the Care Quality Commission is changing the way it regulates mental health services. We will explore whether a goal should be set on the proportion of providers receiving a 'good' inspection.
- CentreForum's Commission will investigate the most appropriate ways of measuring outcomes in child mental health services, and propose a specific outcomes goal.
- Appropriate mental health support should be a priority for the education system. This Commission will also explore the most effective levers or mechanisms to get all schools engaged in building resilience and providing better preventive support

CentreForum will work to define specific goals in the above four areas. We would welcome views on this approach and the best ways of defining such goals in the months ahead (see contact details overleaf). Any such measurable goals will be dependent on the collection of clear and consistent data on access, quality and outcomes of treatment. This report has highlighted the paucity and inconsistency of data in child and adolescent mental health and a key recommendation of this Commission will be for sustained progress to be made in this area.

Over the course of the Commission's work we will seek to ensure that the vision outlined in *Future in Mind* is delivered, including a decisive shift towards early intervention and building resilience. We will assess how far the 'treatment gap' which has been clearly identified in this report is closing, and if successful service transformation is achieved. Our vision is for a system where no child is turned away without help, or has to wait months for their condition to get worse before they can get the support they need.

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