Health Select Committee Inquiry: Children's and adolescent mental health and CAMHS

NCB Written Submission
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Summary

- Children and young people's mental health had not received the financial and political priority it deserves
- There is a lack of clarity on responsibility and accountability for the effective commissioning of CAMHS. This is reflected in concerns raised by health professionals (including through a survey we ran on child health services last year). There is a need an up to date strategy and clearer guidance.
- Data on the mental health needs of children and young people is inadequate and is not effectively deployed in the commissioning process. A revised, effective data infrastructure is needed to ensure that national and local priority setting can be based on evidence of need, and at the heart of this should lie a new extensive national prevalence study.
- A significant proportion of young people say that they experience stress on a daily basis and common causes of this are school work, social life and family relationships
- A significant proportion of young people say that they experience bullying (including physical and cyber bullying). Those that have experienced this report an impact on their mental wellbeing and many feel that they do not receive enough support and understand from school.
- High quality mental health support is critical to ensuring that mother and baby develop healthy attachments. The important role that parant-infant mental health services can play needs to be recognised as well as the capacity of universal services to identify problems and make referrals.
- Bereaved children have specific mental wellbeing needs and are more likely to develop diagnosable mental health problems. We refer the Committee to the submission from the Childhood Bereavement Network, which is based at NCB, for further information on this particular topic.

About NCB

The National Children's Bureau is a leading research and development charity that for 50 years has been working to improve the lives of children and young people, reducing the impact of inequalities. We work with children, for children to influence government policy, be a strong voice for young people and front-line professionals, and provide practical solutions on a range of social issues.

For more information visit www.ncb.org.uk

1. Introduction and overview of the current state of CAMHS

1.1. Mental health services for children and young people have long been seen as a Cinderella service that is poorly funded and never given the priority it should. Half of life time mental illness (excluding dementia) starts by 14 years old.[1] Failing to offer appropriate and timely care not only greatly increases the chances becoming complex and spreading into all domains of a child or young person's life (e.g. their peer relationships, family life, schooling and education), it also makes it more likely they will last into adulthood. These facts alone should justify investment early in the life course

1.2. It is clear, however, that children and young people's mental health services face a double lack of parity, both with services for physical health and with services for adults. It is alarming enough to see reports that NHS England and Monitor have proposed to reduce the tariff for mental health services by 20%[2], but set against the fact that only 6 per cent of spending on mental health goes to services aimed at children and young people[3], it is hard to overstate the lack of priority this area suffers from. We find it very telling that in the Department of Health's latest strategy document on mental health figures are given for the number of adults receiving access to improved psychological therapies but not for children.

1.3. We are aware of evidence that point to this being an area of the health service that is failing. It is estimated that only around a quarter of 5-15 year olds with anxiety or diagnosable depression are in contact with CAMHS.[4] Amongst services that have volunteered to join a benchmarking network, the average maximum waiting time has increased consistently since 2011 to 15 weeks, with the maximum waiting time in some areas at over 40 weeks.[5]

1.4. There are fundamental problems with the system such as gaps in prevalence and outcomes data and a lack of clarity about responsibility for securing a children and young people's mental health service that is fit for purpose. These flaws make it easier for local and national commissioners to cut funding for these vital services and harder for society at large to hold decision makers to account

1.5. What is needed is a clear delivery action plan on children's mental health that is backed up by resource commitments and takes a whole system approach across all services. This action plan needs to establish clearer accountabilities and needs to be based on evidence, not just evidence of what works, but of the level of need and the resource needed to meet that need. We should be able to expect local commissioning decisions to be based on the same logic.

1.6. The remainder of our submission gives more detail on two systematic problems: The lack of clarity of responsibility on CAMHS (drawing on evidence from a recent survey of health professionals); and flaws in the availability and use of data. We also offer, based on our extensive and wide-ranging work with children and young people, and the many difficult practitioner networks supported by NCB (for example through our Early Childhood Unit, the Council for Disabled Children and the Anti-Bullying Alliance) evidence on prevalence and causes of stress in young people, on the impact of bullying on mental health, and on infant and perinatal mental health. We also refer the

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[1] Kesler, et al (2007) Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative, *Word Psychiatry*, Volume 6, October 2007

[2] Letter to the Guardian 12 March2014 http://www.theguardian.com/society/2014/mar/12/risks-deep-cuts-mental-health

[3] Kennedy (2010) *Getting it right for children and young people - Overcoming cultural barriers in the NHS so as to meet their needs*

[4] Ford et al (2005) Service Contacts Among the Children Participating in the British Child and Adolescent Mental Health Surveys (pages 2–9), *Journal of Child and Adolescent Mental Health*, volume 10, issue 1

[5] Data from the NHS Benchmarking Network

Committee to a submission from the Childhood Bereavement network, based at NCB, which focuses on the mental health and wellbeing needs of bereaved children.

2. Planning and commissioning of CAMHs in the reformed NHS

2.1. It is clear to us that there is a damaging lack of clarity on responsibility and accountability for the effective commissioning of CAMHS. An up to date strategy, grounded in the realities of the pressures facing public services and recent reforms is needed. Better guidance for local agencies is needed to ensure roles and responsibilities are clear

2.2. Responsibility for commissioning CAMHS across tiers 1-4 is spread across a range of agencies. Our understanding is that tier four inpatient services are the responsibility of NHS England, while Clinical Commissioning Groups, local authorities and schools are all involved in tiers 1-3, with variation in who commissions various services locally. While such partnership working may help the targeting of services and the a more holistic approach for those who are receiving support, it may be unclear where responsibility lies for ensuring a basic level of service at all times.

2.3. In autumn 2013 the National Children's Bureau (NCB) worked with NHS Confederation to carry out an independent survey of those directly involved in the commissioning, management and delivery of health and related services.[6] The aim of this survey was to monitor the impact of the health reforms on provision for children and young people. When we asked an open question seeking responds views on what challenges were facing the sector, many expressed concern about the fragmentation of commissioning responsibilities for children's services in general and several gave CAMHS as an example.

2.4. The lack of clarity in responsibility is perhaps well illustrated by two particular responses to this question. While one (describing the fragmentation of commissioning) said that tiers 2 and 3 were "with CCGs" another complained of cuts to local authority funding to tier 2 services.

2.5. As highlighted by the submission from the Childhood Bereavement Network, several targeted childhood bereavement service staff have raised concerns that specialist CAMHS tended to refer any bereaved child or young person to them, regardless of any other mental health issues of concern. Reasons given for this included

- Underfunding of specialist CAMHS meaning they were keen to refer as many children on as possible
- An acknowledgement within specialist CAMHS that they were not the 'experts' around bereavement and loss.

2.6. The spread of commissioning responsibilities can also lay the system vulnerable to further confusion from interaction between several strands of public service reform. For example local authorities have previously been encouraged to invest in services such as targeted mental health in schools by allocation by central government of the sure start grant, and later the early intervention grant, which has now been rolled into other funding streams. Meanwhile the relationship local authorities have with many schools has been changed by the Academies programme, at the same time at which the Health and Social Care Act 2012 has given them responsibility for public health (including 'public mental health' and school nurses). One respondent to the survey we carried out with NHS Confederation called for a "requirement for all types of school to fund access to a school nursing service."

[6] For detail on methodology etc see NCB and NHS Confederation (2013) *Child Health in the NHS Results of a survey by the National Children's Bureau and the. NHS Confederation* www.ncb.org.uk/media/1100604/**child_health**_survey_report_final.pdf

2.7. We also asked direct questions about the impact of the health reforms on services for children, the answers to which may raise further concerns about the ability of the reformed health system to foster the partnerships necessary to arrange services such as CAMHS. For example, when we asked *How much do you think the reforms have removed structural barriers to integrated commissioning of health, social care and other children's services?,* 75% responded "not much" or "not at all". A similar response was received when we asked about integrated *delivery* of services. When we asked about the advice and guidance that has been provided to enable local services to work together in the context of the reformed health system to meet children's needs 20% said they would describe it as "never adequate" and 55% said it was only "sometimes adequate".

3. Data on children and young people's mental health

3.1. There is not enough good quality population-level data on the mental health needs of children and young people and the information that is available is not deployed as effectively as it could be to inform the commissioning of services. A revised, effective data infrastructure is needed to ensure that national and local priority setting can be based on evidence of need, and at the heart of this should lie a new extensive national prevalence study.

3.2. Although there is a CAMHS secondary uses data set scheduled to go live in 2014, this will not harness information from non-specialist CAMHS services. This means, crucially, that it will not take up evidence of unmet need that often presents in GP surgeries, youth offending teams, schools and voluntary sector services, the latter in particular being widely acknowledged as key providers of mental health support services to children and young people and yet also, facing significant cuts in funding in recent years. The new dataset will only record information about children and young people who have reached a critical level of ill mental health and who have reached the threshold for intervention. Only an estimated 24% of children aged 5 to 15 with anxiety or diagnosable depression are in contact with mental health services.[7] Admissions and referral data are sometimes used locally to inform commissioning. These systems are subject to same flaws.

3.3. Another way of assessing need is to extrapolate what is known about the prevalence of mental health and its relationship with demographics and risk factors nationally and map this on to what is known about the local population to make a prediction about the level of need. The most recent major study of the prevalence of mental health problems in children and young people was published in 2005, using data that is now ten years old.[8] It is likely that prevalence and risk factors have developed and changed significantly in the last ten years.

3.4. As set out by the submission from the Childhood Bereavement Network, No data is collected each year on the number of children and young people experiencing the death of a parent, sibling or someone else close. Estimates suggest that around 3.5%

[7] Ford et al (2005) Service Contacts Among the Children Participating in the British Child and Adolescent Mental Health Surveys (pages 2–9), *Journal of Child and Adolescent Mental Health*, volume 10, issue 1

[8] Green et al (2005) *Mental health of children and young people in Great Britain, 2004,* Office for National Statistics

of 5-16 year olds (or 1 in 29) have been bereaved of a parent, brother or sister[9]. Approximately 33% of those bereaved of a parent will reach clinical levels of emotional or behavioural difficulties at some point over the two years following the death.[10]

3.5. As the available evidence can only give a partial or rough picture, it is good practice for those planning health services to use several sources of information to inform their decisions. The Children and Young People's Mental Health Coalition found in 2013 that over two fifths of joint strategic needs assessments (JSNAs) only used one source of information to estimate need.[11] More alarmingly, they found that one third of JSNAs did not make an estimate of mental need amongst local children and young people at all.

3.6. The vast majority of JSNAs will include some information on risk factors associated with mental health problems in children and young people. The national roll out of the young people's health and wellbeing survey in 2015 will make a significant addition to the information available to local commissioners on such issues. The Children and Young People's Mental Health Coalition found, however, that 78 per cent of JSNAs, despite including information about known risk factors, did not make a link between these risk factors and what this might mean about the mental health needs of children and young people experiencing them.

4. Trends in children and young people people's mental health – self reported stress and common causes

4.1. In January 2014 NCB worked with Channel 5 and polling company One Poll to survey 1500 11 to 15 year olds on the issues affecting young people today. 18.5% of respondents to this survey said they felt stressed every week and 10% said they felt stressed every day

4.2. 40% of respondents to this survey said it was school results that was made them most stressed, followed by friendships (22.5%) and family relationships (19.8%). In terms of causes of stress we received similar results from smaller scale online survey of 11-19 year olds that NCB carried out in collaboration with 4 children and young person's website b-live. School work/exams (61%), friends (32%) and family relationships (31%) where common causes of stress, although physical appearance (35%) and future career(39%) where also significant.

5. Bullying and support from schools

5.1. Bullying is a challenge and a mental health risk factor affecting a significant proportion of today's children and young people. Around 1 in 7 (14.5%) respondents to our survey with Channel 5 and One Poll said that they were bullied at school or college at least once a week. Around 1 in 12 (8.6%) said they were experiencing cyber-bullying at least once a weak. 10% of young people aged 11-19 responding to our 2011 survey identified bullying as something that had made them feel stressed in the last week.

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[9] Fauth, B., Thompson, M. and Penny, A. (2009) *Associations between childhood bereavement and children's background, experiences and outcomes. Secondary analysis of the 2004 Mental Health of Children and Young People in Great Britain data*, London: NCB.

[10] Worden, W. J. (1996) *ibid*

[11] Olivia and Lavis (2013) *Overlooked and forgotten: A review of how well children and young people's mental health is being prioritised in the current commissioning landscape*

5.2. During July and August 2013 the Anti-Bullying Alliance, part of NCB, ran a series of discussion groups with young people to explore the issues surrounding bullying and mental health.[12] One of the key messages from the young people was that bullying has a significant effect in children and young people's mental health, emotional well-being and identity. Young people talked of taking out their frustrations on family members, self harm, eating disorders and turning to drink and drugs as a result of being bullied. One young person described the effect of bullying thus "Wears down their confidence, their self-esteem, until they're quite depressed, low. And also it leaves them feeling very isolated. Which is why people don't reach out for help with bullying."

5.3. Feedback from the young people also suggests that schools are not primed to make the best contribution they should to their pupils' mental wellbeing. Many felt that there is a lack of teaching and learning about bullying or mental health and emotional well-being. Many children and young people also talked of receiving little or no support for their mental health support needs in school. These messages are corroborated by the NCB and NHS Confederation's 2013 survey of those working in the health service which found that the 89% felt the potential of schools for supporting health is not being fully realised.

6. Perinatal and infant mental health services

6.1. NSPCC has found that perinatal mental health issues affect at least 10% of women according to[13]. When mothers have mental health needs, it increases the likelihood that their children will experience behavioural or social/emotional issues, develop special educational needs or fail to fulfil their potential.

6.2. High quality mental health support is critical to ensuring that mother and baby develop healthy attachments. Young mothers will need timely access to CAMHS and in all families with young children the mental health needs of parents should be considered alongside the mental health needs of the child. This will sometimes be through a parent-infant service as part of CAMHS. Some parent infant psychotherapy programmes such as Oxford Parent Infant Partnership (OXPIP)[14] and Northamptonshire Parent Infant Partnership (NORPIP)[15] give specialist support to parents struggling with the demands of a new baby to develop healthy attachment. There is potential for learning to be cascaded from these services to other areas developing their approach to supporting mental health in the early years.

6.3. According to *All Babies Count*, effective prevention, identification and treatment of mental health disorders could have a positive impact on tens of thousands of families across the country. Universal services, including health visiting, GPs and midwifery, are often the primary route for early identification, highlighting the importance of these professionals having adequate training in mental health. The capacity of CAMHS and adult mental health services themselves is of course also crucial to ensuing that fast referrals are made available to perinatal and infant mental health support.

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[12] NSPCC (2013) *All Babies Count: spotlight on perinatal mental health*

[13] NSPCC (2013) All Babies Count: spotlight on perinatal mental health https://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/spotlight-mental-health-landing_wda96578.html

[14] http://www.oxpip.org.uk/

[15] http://www.norpip.org.uk/