



House of Commons
Health Committee

Children's and adolescents' mental health and CAMHS

Third Report of Session 2014–15



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to the report*

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The Health Committee

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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Summary

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.

The Committee draws conclusions and makes recommendations for action in the following areas:

Information

- The lack of reliable and up to date information about children's and adolescents' mental health and CAMHS means that those planning and running CAMHS services have been operating in a “fog”.
- Ensuring that commissioners, providers and policy makers have up-to-date information about children's and adolescents mental health must be a priority for the Department of Health/NHS England taskforce.

Early intervention

- Compelling arguments have been made to this inquiry that the focus of investment in CAMHS should be on early intervention—providing timely support to children and young people before mental health problems become entrenched and increase in severity, and preventing, wherever possible, the need for admission to inpatient services. However in many areas these are suffering from insecure or short term funding, or being cut altogether.
- Health and Wellbeing Boards, and the transfer of public health budgets to local authorities, both represent significant opportunities for health issues to receive higher priority within local authorities. We have been told of some areas where these opportunities are beginning to be exploited, but this is patchy and progress remains slow. We have also heard that in times of financial constraint, some local authorities do not consider CAMHS early intervention services as “core business”.
- We recommend that, given the importance of early intervention, the DH/NHS England task force should have an explicit remit to audit commissioning of early intervention services in local authorities, and to report on how best to improve incentives in this area. They should also look at the best mechanisms to provide stable, long term funding for early intervention services.

Outpatient specialist CAMHS services (Tier 3)

- Providers have reported increased waiting times for CAMHS services and increased referral thresholds, coupled with, in some cases, challenges in maintaining service quality. In the view of many providers, this is the result of rising demand in the context of reductions in funding. Not all services reported difficulties—some state that they have managed to maintain standards of access and quality—but overall there is unacceptable variation.
- Young people and their parents have described “battles” to get access to CAMHS services, with only the most severely affected young people getting appointments; they also described the devastating impact that long waits for treatment can have. Even amongst those providers implementing quality and efficiency improvement programmes there was concern that improvements were being stalled or even reversed because of increasing demand and reduced funding.
- While demand for mental health services for children and adolescents appears to be rising, many CCGs report having frozen or cut their budgets. CCGs have the power to determine their own local priorities, but we are concerned that insufficient priority is being given to children and young people’s mental health. We recommend that NHS England and the Department of Health should monitor and increase spending levels on CAMHS until we can be assured that CAMHS services in all areas are meeting an acceptable standard, and for NHS England to give CAMHS further monitoring and support to address the variations in investment and standards that submissions to this inquiry have described. Service specifications for Tier 2 and 3 services should set out what reasonable services should be expected to provide, and NHS England and the Department of Health should carry out a full audit to ensure all services are meeting these. We welcome recent funding announcements for mental health services, but we remain concerned and recommend that our successor Committee reviews progress in this area.
- In addition to the universal concerns expressed about CAMHS services, written submissions highlighted problems with CAMHS for children and young people suffering from particular conditions, or from especially vulnerable groups of society. We recommend that the DH/NHS England taskforce takes full account of the submissions we have received detailing these problems.
- Transition from CAMHS to adult mental health services has been described by NHS England as a “cliff edge”, and the stories we heard from young people bear this out. We plan to review progress in this area early in 2015.
- As well as the transition to adulthood, a crucially important time for promoting good mental health is the perinatal and infant period, but there is unacceptable variation in the provision of perinatal mental health services, and we recommend that this is addressed urgently.

Tier 4 inpatient services

- There are major problems with access to Tier 4 inpatient services, with children and young people's safety being compromised while they wait, suffering from severe mental health problems, for an inpatient bed to become available. In some cases they will need to wait at home, in other cases in a general paediatric ward, or even in some instances in an adult psychiatric ward or a police cell. Often when beds are found they may be in distant parts of the country, making contact with family and friends difficult, and leading to longer stays.
- The Committee is particularly concerned about the wholly unacceptable practice of taking children and young people detained under s136 of the Mental Health Act to police cells, which still persists, with very few mental health trusts providing a dedicated place of safety for children and young people. In responding to this report we expect the Department of Health to be explicit in setting out how this practice will be eradicated.
- Alongside problems with access, we also heard from young people and their parents, as well as those who work with them, of quality concerns in some inpatient services; NHS England reported that over the past year some inpatient services have in fact been closed owing to quality concerns.
- Concerns have also been raised about the quality of education children and young people receive when they are being treated in inpatient units. It is essential that clear standards are set for the quality of education provision in inpatient units, and that there is clear accountability and ownership for ensuring that these standards are upheld. As a first step towards this, we recommend that OFSTED, DFE and NHS England conduct a full audit of educational provision within inpatient units as a matter of urgency.
- Despite the move to national commissioning over a year ago, we have been told that NHS England has yet to 'take control' of the inpatient commissioning process, with poor planning, lack of co-ordination, and inadequate communication with local providers and commissioners. NHS England is now recruiting more case managers. However, while many of the difficulties NHS England is now seeking to address may be a legacy from previous arrangements, we are disappointed that during its first year as a commissioner of inpatient services, many of the perceived benefits of national planning have not been realised, and we intend to review NHS England's progress addressing these problems early in 2015. In particular, we recommend that NHS England should introduce a centralised inquiry system for referrers and patients, of the type that is already in operation for paediatric intensive care services.
- NHS England has announced 50 extra inpatient CAMHS beds, but by its own admission, it is not clear how many beds are needed to provide sufficient Tier 4 capacity. It is essential that the extra beds are commissioned in the areas which need

them most, and are supported by an improved system of case management.

Bridging the gap between inpatient and community services

- Out-of-hours crisis services, paediatric liaison teams within acute hospitals, and Tier 3.5 assertive outreach teams can have a positive impact, including reducing both risk and length of inpatient admission; however availability of such services is extremely variable. The experience of care reported by those young people suffering a mental health crisis remains extremely negative.
- Perverse incentives in the commissioning and funding arrangements for CAMHS need to be eliminated to ensure that commissioners invest in Tier 3.5 services which may have significant value in minimising the need for inpatient admission and in reducing length of stay. The Department of Health and NHS England must act urgently to ensure that by the end of this year all areas have clear mechanisms to access funding to develop such services in their local area, where this is appropriate. A key responsibility for the newly set up task force will be to determine a way in which commissioning can be sufficiently integrated to allow rational and effective use of resources in this area, which incentivises early intervention. The Government has recently announced extra funding for early intervention in psychosis services and crisis care; we recommend that the Government ensures that a substantial proportion of this new funding is directed towards services for under-18s.

Education and digital culture

- We heard from young people that while some teachers and schools provide excellent support, others seem less knowledgeable or well trained, and can even seem 'scared' of discussing mental health issues. The launch of MindEd, together with new guidance for schools on mental health, are both welcome steps towards addressing this. However, with both of these, the onus is on individual schools and teachers to find time to prioritise this, and within a sea of competing priorities, it may be difficult to ensure that all schools and teachers use these tools.
- We recommend the Department for Education looks to including a mandatory module on mental health in initial teacher training, and should include mental health modules as part of ongoing professional development in schools for both teaching and support staff. We also recommend that the Department for Education conducts an audit of mental health provision and support within schools, looking at how well the guidance issued to schools year has been implemented, what further support may be needed, and highlighting examples of best practice. OFSTED should also make routine assessments of mental health provision in schools.
- It is clear that education about mental health could and should contribute to prevention and support for young people. We recommend that the Department for

Education consult with young people, including those with experience of mental health issues, to ensure mental health within the curriculum is developed in a way that best meets their needs.

- For today's children and young people, digital culture and social media are an integral part of life; whilst this has the potential to significantly increase stress, and to amplify the effects of bullying, the internet can also be a valuable source of support for children and young people with mental health problems. We have not investigated the issue of internet regulation in depth. However, in our view sufficient concern has been raised to warrant a more detailed consideration of the impact of the internet on children's and young people's mental health, and in particular the use of social media and the impact of pro-anorexia, self-harm and other inappropriate websites, and we recommend that the Department of Health/NHS England taskforce should take this forward in conjunction with other relevant bodies, including the UK Council for Child Internet Safety.
- Children and young people also need to know how to keep themselves safe online. It is encouraging that e-safety will now be taught at all four key stages of school education. We recommend that as part of its review of mental health education in schools, the Department for Education should ensure that links between online safety, cyberbullying, and maintaining and protecting emotional wellbeing and mental health are fully articulated. We recommend clear pathways are identified for young people to report that they have been sent indecent images of other children or young people, and that support is provided for those who have been victims of image sharing. Pathways should also be established for children and young people who have experienced bullying, harassment and threats of violence.
- CAMHS providers may also need further support—both in helping the children and young people they treat to cope with the challenges of online culture and manage the impact it might have on their mental health - and so that they themselves are better able to use online means of communication for reaching out to young people. We recommend that the Department of Health/NHS England taskforce should also investigate and report on the most effective ways of supporting CAMHS providers to do this.

GPs

- We have heard that many GPs currently feel ill-equipped and lacking in confidence in dealing with mental health issues in children and young people, and that their current training does not prepare them adequately for this. We therefore ask HEE together with the GMC and relevant Royal Colleges to provide us with a full update on their plans to enhance GP training in children's and adolescents' mental health.

National priority and scrutiny

- It is clear that there are currently insufficient levers in place at national level to drive essential improvements to CAMHS services. These have received insufficient scrutiny from CQC and we look to review progress in this area following their new inspection regime. The Minister has argued that waiting time targets will improve CAMHS services but we recommend a broader approach that also focuses on improving outcomes for specific conditions in children's and adolescents' mental health.
- We therefore recommend the development, implementation and monitoring of national minimum service specifications, together with an audit of spending on CAMHS. We recommend that the Department of Health/NHS England taskforce look to remove the perverse incentives that act as a barrier to Tier 3.5 service development and ensure investment in early intervention services. There must be a clear national policy directive for CAMHS, underpinned by adequate funding.

Introduction

1. Autumn 2013 saw reports both in the media and in Parliament of young people with mental health problems having to travel across the country to receive inpatient treatment, in some cases hundreds of miles from their homes, families and local communities.² In October 2013 the Chief Medical Officer also took children's health as the focus of her annual report, devoting a specific chapter to mental health.³ The Committee announced its inquiry into Children's and Adolescents' Mental Health and CAMHS in February 2014; aware that problems between different parts of CAMHS services were likely to be interlinked, we did not confine the inquiry to inpatient (Tier 4) services, but launched the inquiry with terms of reference covering CAMHS services more broadly.⁴

2. The inquiry received 237 written submissions; the most the Committee has received for any inquiry it has held this Parliament. As well as professional groups, interest groups, charities and statutory bodies, we received evidence from individual service users and their parents. Clinicians and other professionals working in this area from across the NHS, voluntary and private sectors also sent submissions. The prevailing picture was of CAMHS commissioners and providers struggling with increasing demand and reducing resources. However, we also heard evidence of good and innovative practice within CAMHS services, and evidence from both CAMHS providers and commissioners expressed the strength of feeling and commitment to change within this sector. As well as CAMHS services, we asked for views on the quality of information about children's and adolescents' mental health; and the role of digital media, online culture and schools.

3. Over the course of five meetings, we took oral evidence from the Chief Medical Officer; YoungMinds; Youth Access and the Children and Young People's Mental Health Coalition; Royal College of Psychiatrists; the British Psychological Society; the Royal College of GPs; the CYP-IAPT programme; Place2Be; Beatbullying; providers and commissioners of CAMHS services; NHS England; the Department of Health; and the Minister of State for Care and Support. Dr Peter Hindley, Sarah Brennan, and Professor Tanya Byron also attended an informal seminar with the Committee.

4. We also held an informal private meeting with young people with experience of using CAMHS services from across England.

5. We are extremely grateful to all those who contributed to this inquiry. We are particularly indebted to the young people who travelled in some cases long distances to meet us and who described their experiences, which had often been difficult ones, so frankly and articulately. The session added considerably to the Committee's understanding of CAMHS, and raised new and important issues that had not previously been brought to

2 ['NHS investigates CAMHS beds shortfall as MPs warn of appalling care'](#), Community Care, 23 Oct 2013

3 Department of Health, [Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays](#) (October 2013)

4 Health Committee, [Terms of Reference – Children's and Adolescents' mental health and CAMHS](#), 14 February 2014

our attention. We are also grateful to the individual service users and parents of service users who submitted written evidence to the inquiry describing their personal experiences.

6. In July, shortly before our concluding evidence session with the Minister and NHS England, NHS England published a long-awaited review into Tier 4 inpatient CAMHS services, a review originally announced in October 2013. During that session, the Minister of State for Care and Support told us that there was “a long overdue need for a quite thorough review of CAMHS”, and that this would be carried out by a joint NHS England and Department of Health taskforce.

7. 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. We welcome the announcement of the joint NHS England /Department of Health Children and Young People's Mental Health and Wellbeing Taskforce, as it endorses one of our central conclusions, that problems with CAMHS are broadly based and not simply confined to inpatient Tier 4 services. Many of the recommendations in this report are therefore directed towards this taskforce as it begins its work. In addition to this, we recommend that the taskforce takes full account of the wealth of information contained in the written submissions received by this inquiry, including, in particular, submissions from service users, from their parents and representatives, from individual clinicians working in CAMHS, from provider organisations and from commissioners. We plan to review the progress of the taskforce early in 2015.

1 Information

Children's and young people's mental health in 2014

8. One of the most frequent observations made to this inquiry from its outset has been the lack of reliable data about the state of children's and young people's mental health in 2014. The most recent figures for prevalence of common mental health problems in children and young people date from the 2004 ONS prevalence study, a study which up until 2004 had been conducted on a five-yearly basis. The recent NHS England review is still based on this out of date information:

The best available estimates of the prevalence of mental disorders amongst children and young people are those from the Office for National Statistics surveys in 1999 and 2004. These found one in ten children aged between 5 and 16 years has a mental disorder. About half of these (5.8%) have a conduct disorder, 3.7% an emotional disorder (anxiety, depression), 1–2% have severe Attention Deficit Hyperactivity Disorder (ADHD) and 1% have neurodevelopmental disorders. The rates of disorder rise steeply in middle to late adolescence and the profile of disorder changes with increasing presentation of the types of mental illness seen in adults.⁵

9. The Chief Medical Officer's annual report for 2012, published last autumn, highlighted the need for a repeat of the ONS survey; it also cited other evidence suggesting a rise in levels of psychological distress in young people, and in particular increasing rates of self-harm:

Self-harm rates have increased sharply over the past decade, as evidenced by rates of hospital admission and calls to helplines, providing further indications of a possible rise in mental health problems among young people. However, in the absence of up to date epidemiological data, it is uncertain whether there has been a rise in the rates of mental health problems and whether the profile of problems has changed⁶

10. The CMO also highlights the strong links between mental health problems and social disadvantage, with children and young people in the poorest households three times more likely to have mental health problems than those growing up in better-off homes.⁷ Public Health England provide the following observations on young people's mental health and wellbeing drawn from other research:

Analysis of the British Household Panel and Understanding Society survey [2011–12] shows that the rise in children and young people's wellbeing from 1994 to 2008 has curtailed and may be in reverse. Peak onset of mental ill

5 NHS England, [Child and Adolescent Mental Health Services \(CAMHS\) Tier 4 Report](#), 10 July 2014, p14

6 Department of Health, [Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays](#) chapter 10 p3

7 Department of Health, [Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays](#) chapter 10 p2

health is 8 to 15 years. 10% of children have a mental health issue and half of lifetime mental ill health starts by age 14.

The Health Behaviour of School-Aged Children Survey [2009–10] (HBCS) found that around 30% of English adolescents reported a level of emotional wellbeing considered as (sub-clinical) “low grade” poor mental health, that is they regularly (at least once a week) feel low, sad or down. This is higher among girls than boys...

... Lesbian, gay, bisexual and transgender young people (aged 16-25 years) report higher levels of mental health problems, self-harm and suicidal thoughts. They experience more verbal, physical and sexual abuse and feel less accepted by their community.

The Understanding Society survey results for 2011–12 suggest 85.5% of children belong to a social networking site. In England, the proportion of young people playing computer games for two hours or more a night during the week increased from 42% to 55% among boys and 14% to 20% among girls between 2006 and 2010. The same survey suggests 12.1% of children have been bullied four or more times in the last six months. In some areas more than 10% of children reported being bullied. Data from the Tellus survey stated one-third of pupils do not think their school is managing the problem well. Childline has reported an 87% rise in contacts related to online, cyber- bullying.⁸

Problems caused by lack of prevalence data

11. The British Psychological Society is amongst many organisations to highlight the problems caused by the lack of comprehensive national data on the prevalence of mental health problems:

We do not know the scale of the problem ... we simply do not have accurate information from which to gauge the state of children and young people's mental health nationally. Information from ChiMat Intelligence Network March 2014 notes, *“In summary the ability to provide robust national data to support local service planning is at best limited and planned improvements to this position have suffered from significant delays”*⁹

12. Observations from CAMHS service providers strongly suggest that they are now operating in a considerably changed environment from the 2004 prevalence data, with many reporting dramatic increases in demand for their services:

Demand continues to increase - 89% of respondents said there had been an increase in referrals over the last 2 years; percentages ranged from 20-70%.

8 Public Health England [\[CMH0085\]](#) paras 3.1-3.8

9 British Psychological Society [\[CMH0133\]](#) p3

Many respondents noted a change in the mix of referrals seeing an increase in self-harm, complexity and severity.¹⁰

Partnerships are reporting rising numbers of both routine and emergency presentations. Partnerships suggest an average increase of 25% in referrals to CAMHS tiers 2/3 since 2012, possibly due in part to the impact of regional and local cuts on community based services and third sector services.¹¹

13. The Committee's witnesses on 1st April reiterated these impressions, noting increasing rates of self-harm, eating disorders, depression, conduct problems and autistic spectrum disorders¹².

14. The lack of up-to-date information about the prevalence of mental health problems is not simply an academic issue - information about how many children and young people may be affected is essential for healthcare planning. The lack of information is causing significant problems for commissioners seeking to plan, improve and fund services in this area. Derbyshire County Council and North Derbyshire CCG stated in their written evidence that "we need to have reliable and up to date prevalence data" and that "the data gap is impacting on strategic decisions and planning."¹³ The Minister agreed that prevalence data was "horribly out of date".¹⁴ During the course of our inquiry, the Government announced that it had identified funding to repeat this survey, and the Minister repeated this commitment in oral evidence to us. Work will begin in the autumn, although the project is not likely to be completed until 2016.¹⁵ While the Minister could not commit future governments to funding the survey on a continuing basis, he told us that in his view a long gap between surveys should in future be avoided, in order to "maintain a current understanding of the scale of the problem".¹⁶

Information about CAMHS services

15. The shortfall of information in this area is not confined to data on the prevalence of mental health problems amongst children and young people, but extends into information about service provision as well, including levels of demand, access and expenditure. The CMO recommends an annual audit of services and expenditure¹⁷, and the NHS England report also highlights this—the best available national data on access times is provided by the CAMHS Benchmarking consortium, a voluntary network which does not include all

10 British Psychological Society ([CMH0133](#)) p4

11 Professor Peter Fonagy ([CMH0216](#)) p4

12 Q3-4

13 Derbyshire County Council ([CMH0192](#)) Executive Summary

14 Q337

15 Q340

16 Q340

17 Department of Health, [Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays](#) Chapter 1 p9

providers, and the best available data on expenditure is from a recent Freedom of Information request made and analysed by a mental health charity:

There is no recent data on estimated levels of need for the different elements of CAMHS including Tier 4 services. This depends not only both on prevalence but also other factors including the range of alternative services.¹⁸

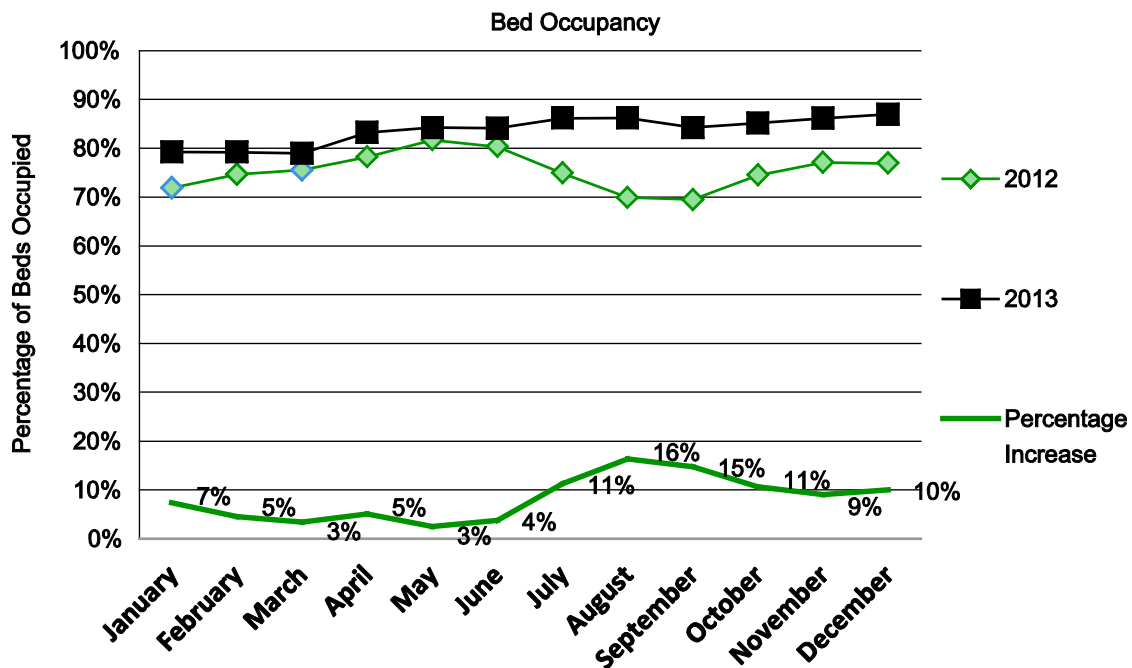
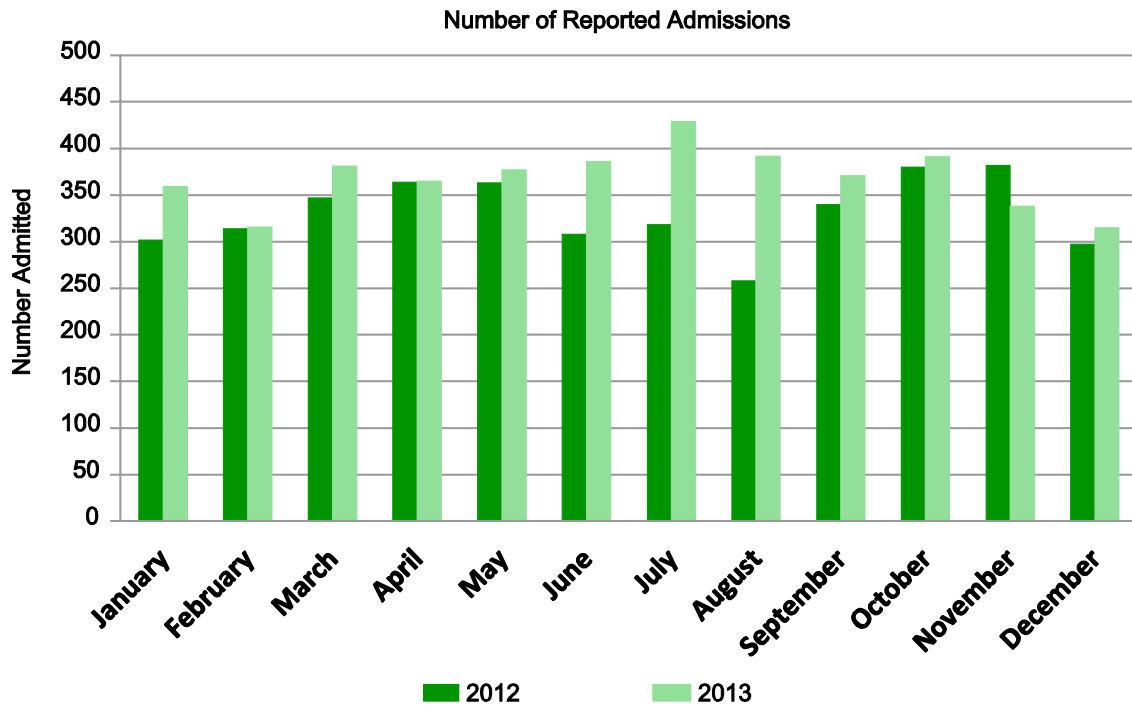
Information on access times for treatment in community CAMHS is not currently systematically available at a national level though it is understood that there is considerable geographical variation. Data from the NHS Benchmarking Report CAMHS (NHS Benchmarking Network, 2013) found that in 2012/13 amongst its members the maximum waiting times for specialist CAMHS Tier 3 average 15 weeks across the participating providers. This has increased from 14 weeks recorded in 2011/12. Waiting times for accessing urgent CAMHS Tier 3 had a 3-week median wait. This should also be seen in the context of the lack of crisis response services in CAMHS, with less than 40% of CAMHS in the benchmarking offering rapid access through crisis pathways.¹⁹

16. NHS England were able to provide more information in relation to Tier 4 inpatient services, reporting that both bed occupancy rates and numbers of reported admissions to Tier 4 units increased between 2012–2013, and that there was a rise in the number of inpatient beds available from 1,128 in 2006, to 1264 beds in January 2014.²⁰

18 NHS England, [Child and Adolescent Mental Health Services \(CAMHS\) Tier 4 Report](#), 10 July 2014, p15

19 NHS England, [Child and Adolescent Mental Health Services \(CAMHS\) Tier 4 Report](#), 10 July 2014, pp15-16

20 NHS England, [Child and Adolescent Mental Health Services \(CAMHS\) Tier 4 Report](#), 10 July 2014 p86; admissions, p46; occupancy, p52



17. National data published in March by the HSCIC reveals that the number of children and young people being treated in adult mental health facilities is rising:

In 2011–2012, 357 under-18s were treated on adult mental health wards in England, which went down to 219 in 2012–13. However, between April and November 2013 alone, the figure reached 250.²¹

21 [‘Children admitted to adult mental health wards ‘rising’](#), BBC news website, 11 March 2014 (accessed October 2014)

18. The number of young people being detained in police cells under s136 of the Mental Health Act 1983 remains high, with 263 detained in police cells in 2012-13.²²

Improvements to data on CAMHS

19. Again, data about CAMHS is a fundamental requirement for the safe and effective planning and delivery of healthcare, and lack of data causes problems for commissioners. Members of the Mental Health Commissioners Network described the lack of data as 'scandalous', and went on to argue that "the lack of current, good quality data means that commissioners and providers are working blind".²³ The Minister used a similar analogy, telling us that lack of data meant that "We have operated in many respects in mental health in a bit of a fog. We have not had access to the data—the information that other parts of the health system benefit from."²⁴ He went on to say

Information drives change. If you have an understanding of what is actually happening across the system, rather than the fog we have worked in up until now in mental health, you can start to put pressure on the system to change.²⁵

20. As well as recommending repeating the national psychiatric morbidity survey and the What About Youth? Survey, Public Health England make the following recommendations to "strengthen the collection, availability and use of data and intelligence to better inform local authorities, health services":

- The Maternity and Children's Dataset should be implemented as soon as possible. This will provide a robust flow of data on referrals, activity, assessments, treatments and outcomes from CAMHS
-that work is undertaken to determine the optimum way of collecting CAMH service and expenditure/budget mapping data
- there is a need to triangulate the data on wellbeing, mental illness, self-harm and suicide to better understand the national picture and effectively target resources. The National Mental Health Intelligence Network should start to address this.²⁶

21. Planned improvements in this area have been subject to delays, as David Wells, the Associate Director of the National Child and Maternal Health Intelligence Network explained:

Historically more detailed information was available about activity and services from the Children's Services Mapping project which was

22 [New map of health-based places of safety for people experiencing a mental health crisis reveals restrictions in access for young people](#), CQC news release, 16 April 2014 (accessed October 2014)

23 Mental Health Commissioners Network ([CMH0122](#)) 6f

24 Q368

25 Q445

26 Public Health England ([CMH0085](#)), para 4.8

discontinued in 2010 on the basis that the data collected would be replaced by the secondary user CAMHS dataset.

There have been significant unexpected delays in the flow of the data from the secondary users dataset which was originally expected in 2012. The present position is that data collection commenced in sites from April 2013 and funding was identified for the necessary hardware to enable data flow to the HSCIC.

Procurement of the hardware lies with NHS England and HSCIC. The last published date for data flow to commence was Summer 2014 and first reports should have been available from Autumn 2014 though this is now subject to further potential delay.

In summary the ability to provide robust national data to support local service planning is at best limited and planned improvements to this position have suffered from significant delays.²⁷

22. The HSCIC website now states the following information in relation to this:

On 11th July, HSCIC obtained high level agreement from NHS England to fund the infra-structure required for the Maternity and Children's Data Set, which includes the CAMHS data set, as well as Maternity and Child Health data sets. We hope to procure the required hardware soon, and are currently in the process of re-planning go-live dates. We will advise on the CAMHS go-live date once it is confirmed.²⁸

Conclusions and recommendations

23. **The Committee is deeply concerned that the most recent ONS data on children's and young people's mental health is now ten years old, as up-to-date information is essential for the safe and effective planning of health services. We welcome the Government's commitment, made during the course of this inquiry, to fund a repeat of the ONS prevalence survey. It is essential that this survey is not a one-off, but is repeated on an ongoing basis. We recommend that the Department of Health/NHS England taskforce adds the issue of the quality of ongoing data to its terms of reference.**

24. **Not only is there a lack of data on children and young people's mental health, but also a worrying lack of comprehensive and reliable information about children's and adolescents' mental health services, including referrals, access and expenditure. In the words of the Minister, CAMHS services have been operating in a "fog", and efforts to improve data availability have been subject to delays. This is unacceptable. Ensuring that commissioners, providers and policy-makers have access to up-to-date**

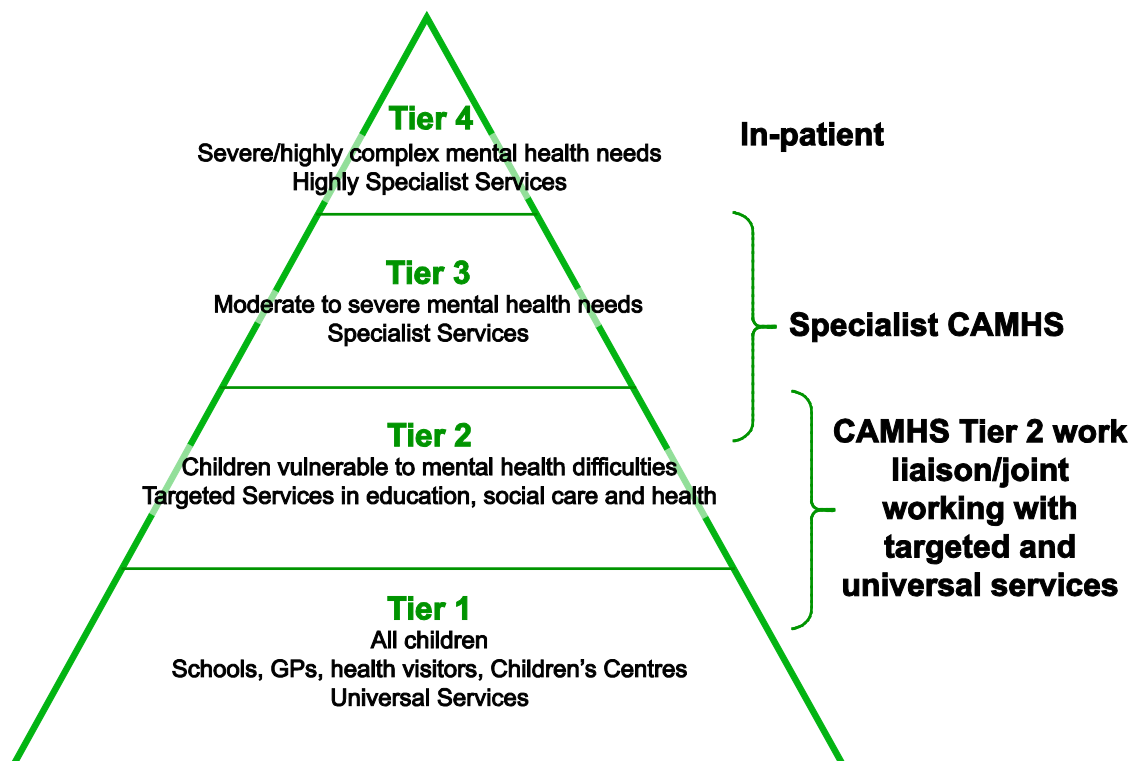
27 The Royal College of Psychiatrists [\[CMH0173\]](#) Annex D

28 [Child and Adolescent Mental Health Services Data Set](#), HSCIC website, (accessed 6th October 2014)

information about all parts of CAMHS services—from early intervention up to inpatient services—is essential. We recommend that this is a priority for the Department of Health/NHS England taskforce.

2 CAMHS as a whole system

25. CAMHS services have historically been conceptualised as a 4-Tier model, as follows²⁹:



26. Some have argued that this model is now outdated and unhelpful, reinforcing distinctions between different types of services when an integrated service structured around the needs of children and young people would be more effective.³⁰ Integrated service models are discussed in chapter 4.

27. This inquiry was prompted by concerns about access to Tier 4 inpatient treatment, for the most severely affected children and young people. But as with all parts of the healthcare system, Tier 4 inpatient services do not operate in isolation from other parts of the CAMHS system, but are linked to specialist outpatient services, to targeted early intervention services, and to universal services, such as support provided by schools and general practitioners. Throughout this inquiry, witnesses have emphasised the crucial role played by early intervention services in preventing mental health problems from escalating, minimising the need for inpatient care. Many suggested that this, in fact, is where the focus for investment should be. Dr Rao, a Consultant Psychiatrist from the Black Country Partnership Foundation Trust, told us:

29 Source - YoungMinds

30 See, for example, North West London Commissioning Support Unit ([CMH_0211](#)) Executive summary; University of Reading ([CMH_0135](#)), para 7

I do not think the solution is just tier 4 beds. If you create more beds, there will simply be more children perhaps inappropriately there. It needs perhaps a plan or a basic template for the commissioners on how to build a service, for example, with the tier 3+, with links and collaboration with tier 4.³¹

28. Michael Upsall, a commissioner from Derbyshire, put the argument in financial terms:

For the weekly cost of a bed in a tier 4 placement, we could be talking somewhere between £5,000 and £7,000 a week—£25,000-plus a month. You can provide a lot of bespoke services in the community with a lot less funding than that ... If local commissioners had easier access to that funding earlier, we could make the money go a lot further to prevent—or at the very least delay and shorten—the amount of time that a small number of young people end up in tier 4.³²

29. Many submissions received by the Committee also linked increased demand for more specialist Tier 3 and 4 services with reductions in early intervention services, arguing that when children and young people cannot access services at an early stage, they become more unwell, and need more specialist care. One CCG which carried out a review of its services identified this as a contributory factor to increasing pressure on Tier 3 services:

Reductions in Tiers 1 and 2 provision largely as a result of budget reductions leading to a lack of early intervention. Hence children and young people were tending to access services at too late a stage hence they required more complex and time consuming interventions to address their presenting challenges.³³

30. Another trust stated that:

In order to manage demand, teams may be left in a position of turning an opportunity for preventative psychologically based work away. This means a young person and their family have been turned away from early help only to return when their condition has become more challenging to work with or, distressingly, requires admission to T4 in patient services.³⁴

31. The relationship between the different Tiers of care also operates in reverse—as children and young people recover from more serious periods of mental ill health, they may need ongoing care from a lower Tier service. A provider of Tier 4 services argued that when these lower Tier services are lacking, the result may be delayed discharges and repeat admissions:

Our services have young people who wait protracted periods of time to move down the care pathway. Often, local services are fearful of the young person

31 Q169

32 Qq 235-236

33 Clinical Commissioning Groups within Staffordshire and Staffordshire County Council ([CMH0134](#)) para 2.3

34 Central and North West London NHS Foundation Trust ([CMH0132](#)) para 2

moving back to the community because of the extreme crisis under which they were originally referred to hospital. Local services are stretched and there is often no appropriate provision for the young people to move to. We have experienced young people waiting up to two years for an appropriate placement after they have recovered ...

... Young people can often become 'revolving door' patients. They are admitted to hospital, they recover and then on discharge, without as much support as they need, they quickly deteriorate and become a re-admission.³⁵

32. One of the best illustrations of the importance of early intervention, lower tier services, and the damaging impact when such services are lacking, was given by a young person:

If funding was increased, trained CAMHS staff could begin to tackle the problem in schools...this will greatly increase awareness of mental health in general and encourage help to be sought before crisis is reached... my lack of awareness led to my problems escalating until I was considered 'high risk' to myself and even then, I was on a waiting list. It reached a point where I was hurting myself daily to be finally be picked up by the CAMHS service. At this point I required a high level of support from services (possibly increasing expense)³⁶

Conclusions and recommendations

33. **Whilst most attention has so far centred on problems in accessing inpatient treatment, compelling arguments have been made to this inquiry that the focus of investment in CAMHS should be on early intervention—providing timely support to children and young people before mental health problems become entrenched and increase in severity, and preventing, wherever possible, the need for admission to inpatient services. It is clearly unacceptable if a child or young person cannot access a Tier 4 service close to their home, but for every child in this position, a further question needs also to be asked - has everything possible been done to prevent that child from becoming so unwell that they needed admission to inpatient services? The evidence we have received suggests poor provision of lower tier services may be increasing the number of children and young people requiring admission to inpatient services. This situation must be addressed by the Taskforce.**

35 Alpha Hospitals Ltd ([CMH0068](#)) para 2 viii, x

36 GIFT Partnership ([CMH0159](#)), para 3

3 Early intervention mental health services (Tier 2)

34. Early intervention mental health services at Tier 2 can be delivered by CAMHS, voluntary sector providers or other agencies. These provide mental and emotional health services for children and young people who require support, but who do not require more highly specialised Tier 3 services.

35. Liverpool CAMHS Partnership have adopted a comprehensive pathway approach for their CAMHS service, with a focus on early intervention and prevention; they report that this approach has helped them achieve reduction in specialist CAMHS (Tier 3) referrals in 2011/12 and 2012/13 and Tier 4 (although there has been a slight rise this year).³⁷ Several areas described Primary Mental Health Worker services providing early intervention, including Tees, Esk and Wear Valleys NHS Foundation Trust:

Via Primary Mental Health Workers (PMHWs) we have embedded links in education, training programs in our partner agencies, open access and consultation and liaison. All our clinical pathways include early detection and early intervention. We now have a Social and Emotional Wellbeing pathway which covers short term interventions and where indicated entry into other diagnostic pathways. Notably we are integrating our crisis work with our early intervention/prevention services.³⁸

36. However, many organisations submitting written evidence gave examples of early intervention services in their areas that had been cut or reduced:

Birmingham has traditionally had a strong ethos of early intervention and prevention work, much of this has been developed on a multiagency basis through initiatives such as the Children's Fund, Birmingham Brighter Futures, Sure Start, TAMHs and more recently the Big Lottery. The focus of this work has been on improving parenting skills and developing emotional resilience in children. These traditions have been difficult to maintain for CAMHS over the last three years ... In particular the reductions in funding have significant impact on the Primary Mental Health Worker Service where there have been reductions in staff. There has also been a reduction in the number of children under 5 who are seen by CAMHS in contrast with provision ten years ago when there was a strong emphasis on pre-school work and early intervention resulting from reductions in ABG funding. The shift in emphasis to severe and complex work can result in the late offer of CAMHS being too little too late.³⁹

37 Liverpool CAMHS Partnership ([CMH0139](#)), p2

38 Tees, Esk and Wear Valleys NHS Foundation Trust ([CMH0170](#)) para 12.1

39 Birmingham Children's Hospital NHS Foundation Trust ([CMH0130](#)), para 28

37. Derbyshire Healthcare NHS Foundation Trust argue that in their locality, there has been a direct link between the loss of their Primary Mental Health worker scheme and a recent increase in referrals to Tier 3 services.⁴⁰ Solihull report that funding cuts have resulted in disbanding of an infant mental health service and discontinuation of early intervention service to 0-8yr olds who have witnessed domestic violence.

These changes have been pushed through despite an overwhelming body of evidence to support intervening early in a child's life to minimise risks to both physical and mental health and its impact on the child's ability to achieve his/her potential and become productive individuals.⁴¹

38. Berkshire Healthcare NHS Trust reports that it has been informed by all but one of the six local authorities that provide Tier 2 services that there will be a reduction either in funding or in the services they offer:

At the most extreme this has involved the loss of a gold standard 'tier 2 hub' providing integrated primary mental health workers, psychologists, therapists and family intervention workers with a jointly funded social care/CAMHS worker. This has not been replaced and tier 2 services in that area are now limited to counselling, services, a small parenting team and the behavioural support provided by schools.⁴²

39. In oral evidence Jane Lunt of Liverpool CCG described voluntary sector services as "absolutely integral" to the success of their approach: "without their input and their flexibility in the way they can work with families and children, we would not be in the place we are in."⁴³ At our session with young people, we also heard from many voluntary sector early intervention providers. They described extremely fragile funding arrangements and increasing uncertainty about their future sustainability. London and South East CYP-IAPT Learning Collaborative provided a stark example from its patch:

One Voluntary Sector organization within the Collaborative is facing potential Local Authority disinvestment this year that amounts to 44% of its annual income. Given a number of staff are voluntary, the overheads for the service are small, and its approach to care unique in the local area. It may not retain its CYP IAPT trained CBT therapist.⁴⁴

Commissioning early intervention and voluntary sector services (Tier 2)

40. The evidence we have received in the course of this inquiry has been unanimous in emphasising the importance of early intervention services, many of which are delivered by

40 Derbyshire Healthcare Foundation NHS Trust [\[CMH0191\]](#) pp7-8

41 Solihull CAMHS [\[CMH0066\]](#) pp2-3

42 Berkshire Healthcare NHS Trust [\[CMH0049\]](#) p2

43 Q303

44 London and South East CYP-IAPT Learning Collaborative [\[CMH0155\]](#) para 4.1.2

voluntary sector providers. The Chief Medical Officer's report gives the example of the cost savings associated with parenting programmes as an early intervention:

NICE guidance recommends the use of evidence-based parenting programmes as a secondary prevention measure for parents of children who have been identified as at high risk of developing oppositional defiant disorder or conduct disorders, or who already have these disorders. Costs of group parenting programme delivery have been estimated to range between £670 and £4,100.97, Bonin et al. modelled the likely long-term savings to society of implementing an evidence-based parenting programme for the prevention of persistent conduct disorders, estimating that this could result in savings of about £17,500 per family (2012 prices) over 25 years (compared with a cost of £1,016–£2,218).⁴⁵

41. Early intervention services can be commissioned and funded by a variety of different bodies—mainly local authorities, but in some instances by individual schools or by CCGs. The role of schools and services provided within schools is discussed in the next chapter.

42. While the importance of such services has been repeatedly emphasised, the Committee has heard many reports of early intervention services being an 'easy target' for cuts during these current times of financial constraint within local authorities. Youth Access provides the following information about cuts in funding experienced by its membership of voluntary sector organisations:

Since 2010, most YIACS have reported reduced funding. In 2010, 86% of providers reported reductions, although only 22% said this in 2013. YIACS have always been vulnerable, largely because they sit between a wider system of young people's services and statutory mental health. A lack of ownership and ambivalence, despite often representing the most significant resource alongside CAMHS in meeting mental health needs, has allowed YIACS to be easy targets for cuts. Over the years, individual services have set up and closed, including some closures over the past four years. With national policy stressing the importance of mental health and better early intervention and prevention, these cuts make no sense at all.⁴⁶

43. Data obtained and published by YoungMinds suggests that 60% of local authorities responding have either cut or frozen their CAMHS budgets since 2010–2011, and 55% of local authorities that supplied data have cut, frozen, or increased their CAMHS budgets below inflation between 2013–14 and 2014–15.⁴⁷

44. Local authorities and clinical commissioning groups (CCGs), as members of Health and Wellbeing Boards, jointly prepare Joint Strategic Needs Assessments (JSNAs) for their

45 Department of Health, [Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays](#) (October 2013) Chapter 3 p19

46 Youth Access ([CMH0092](#)) para 3

47 YoungMinds [media release](#), 21 June 2014

local area; these are supported by Joint Health and Wellbeing Strategies (JHWS), which are strategies for meeting the needs identified in JSNAs.⁴⁸ In December 2013 the Children and Young People's Mental Health Coalition conducted a review of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) and found that two thirds of JSNA did not measure children and young people's mental health, and one third of JHWSs did not prioritise children and young people's mental health. They argue that "this is of grave concern as these documents influence local commissioning strategies."⁴⁹

45. Commissioners giving evidence to the inquiry described the difficulties faced by commissioners in prioritising CAMHS early intervention services:

I think it is about sustainability of funding at a time when the organisations contributing to the pot are having to focus on core business, and it is sometimes difficult to argue that that is core business. You are not inspected on that. You don't fail inspections on that, and that is the harsh reality certainly for local authorities and for health services as well.⁵⁰

46. One witness argued that the biggest challenge to running integrated services was not funding, but in achieving proper ownership across agencies. He described an autism service in his area, which at one point was declared a beacon site, now struggling because it is "nobody's child".⁵¹ North West London Commissioning Support Unit described fragmentation of funding for early intervention work, and the problems this causes:

...Funding for mental health prevention or emotional well-being is now fragmented between Public Health, Schools and Academies and Education. Links between national and local prevention initiatives are unclear as are relationships between, prevention campaigns and local CAMHS.⁵²

47. The Committee did hear evidence that in some areas integrated working was working well, and that Local Authority directors of Public Health and Health and Wellbeing Boards were positive developments:

...Our JSNA does have children's information in it. It has CAMHS information in it. We have Councillor Robathan in Westminster council, a talented, passionate local politician, who tasked me to do a task and finish group on CAMHS and report to her in September. She came to the launch. With people like that in local authorities, health and wellbeing boards are in good hands. Maybe we are fortunate, but that kind of process has made quite a difference. She was very involved, and she expects a report back in a

48 Department of Health, [Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies](#), March 2013

49 Children and Young People's Mental Health Coalition ([CMH0153](#)), para 3.3

50 Q292

51 Q172

52 North West London Commissioning Support Unit ([CMH0211](#)) p4

month's time; I shall be talking to her about this. It works. It is an enormous agenda; maybe we are fortunate.

.....Most of the funding of the third sector that was in health was in Public Health, so that has now moved into the local authority. It is ring-fenced in Public Health and they would be part of driving JSNAs and making sure information is better. Public Health is a real asset for local authorities to exploit, I think. But local authorities, of course, as I mentioned before, are subject to austerity, and the very same money you might want to use to grow your third sector—voluntary organisations—will be under scrutiny in terms of reductions.⁵³

48. However Central and North West London NHS Foundation Trust argued that recently reorganised Public Health Services are “only partially engaged in looking at these trends and influencing the strategic commissioning of services”⁵⁴, and Staffordshire commissioners raised concerns that since the shift of public health into local authorities they have placed ‘limited priority’ on children’s and young people’s mental health.⁵⁵ One witness suggested that transitional funding would be helpful to get early intervention services started:

The one thing that would make a difference would be if there was some transitional funding that would help us to put in place, get up and running and get started some of the early intervention initiatives, some of the things that we know the voluntary sector can do very well but we don't have the money to give them to get started. If they apply to Children in Need or for lottery funding, it is time-limited; it is going to run out. We have to find the money to keep it going ... Once the savings are made at the higher end, it will become self-financing. It is how you get it started that we are struggling with.⁵⁶

49. Witnesses also described how the pathway approach, discussed in more detail in the next chapter, as a useful means of improving quality and efficiency, could also be helpful in terms of securing funding for early intervention services:

If we are looking to fund the pathways—integrated pathways starting in universal services, in communities where needs present—the role of the third sector is clearer. It is harder to ignore the contribution that they can make if you are looking to fund the whole pathway; they are there. We have some examples in Derbyshire where we are able to do that ... It is something we

53 Q285, q288

54 Central and North West London NHS Foundation Trust ([CMH0132](#)) para 2

55 Clinical Commissioning Groups within Staffordshire and Staffordshire County Council ([CMH0134](#)), para 2.2

56 Q288

would like to take forward, but it is not an easy climate within which to do that.⁵⁷

Conclusions and recommendations

50. Early intervention services, including those delivered by voluntary sector organisations—whether these are drop-in services offering support to young people, parenting support programmes, or school-based interventions, can make a crucial contribution to preventing mental health problems from developing or escalating. However we have heard evidence of significant disinvestment in such services, despite evidence of their importance. Where they have been able to sustain services, some voluntary sector organisations report very fragile funding arrangements and great uncertainty over their future sustainability, despite evidence of growing demand for their services.

51. Health and Wellbeing Boards, and the transfer of public health budgets to local authorities, both represent significant opportunities for health issues to receive higher priority within local authorities. We have been told of some areas where these opportunities are beginning to be exploited, but this is patchy and progress remains slow. We have also heard that in times of financial constraint, some local authorities do not consider CAMHS early intervention services as “core business”. **We recommend that, given the importance of early intervention, the DH/NHS England taskforce should have an explicit remit to audit commissioning of early intervention services in local authorities, and to report on how best to improve incentives in this area. They should also look at the best mechanisms to provide stable, long term funding for early intervention services including those provided by voluntary sector partners.**

4 Outpatient specialist CAMHS services (Tier 3)

52. Outpatient specialist CAMHS services are community mental health services for children and young people with more severe problems who need more specialist treatment than can be provided by Tier 2 services.

The view from CAMHS services

53. Many providers of CAMHS services described the situation in their own areas with great honesty and frankness. We are including a selection of quotes from these descriptions not with the intention of singling out any particular Trusts for criticism, but as a means of illustrating the present difficulties facing CAMHS services and the variation around the country. Dr Myers of Cornwall Partnership NHS Foundation Trust gave the following account of Tier 3 CAMHS services in Cornwall:

Over the last five or six years, since we have been collecting records, our referral rates have gone up approximately 20% year on year to the extent where we are currently commissioned to see around 2,000 referrals, but we have 4,000 a year. This has meant that we are necessarily having to prioritise those who have the most urgent and pressing need, and we have no capacity for earlier intervention and very little capacity for seeing those perhaps with the less life-threatening or urgent risky presentations but for whom we could also do very useful pieces of work, such as those with neurodevelopmental disorders. It has also meant that the staff are feeling extremely run-ragged. There is increasing sickness, a lot of burn-out and we absolutely recognise that there are increasing waits. It is not okay. We do not want that for our children and young people, but we have to just keep prioritising. So there are cancellations and times when at any one time we might be trying to manage situations where there is a need to have an in-patient bed but there aren't any. That takes us away from more of the front-line work that could possibly be preventing admissions.⁵⁸

54. Barnet Child and Adolescent Mental Health Service reported an average 26.5% increase in all referrals to CAMHS services, and a 45% increase in self-harm rates⁵⁹, and Derbyshire Healthcare NHS Foundation Trust stated that “the service has experienced a huge increase in referrals they receive and accept into service”⁶⁰ Warwickshire County Council report that

58 Q148

59 Barnet Child & Adolescent Mental Health Service ([CMH0142](#))

60 Derbyshire Healthcare Foundation NHS Trust ([CMH0191](#)), p7

Overall referral rates are increasing: from April 2014 to November 2014 these increased further by over 500 from 3,100 to 3,621.

Rates of Self-harm have increased substantially over the last two years. At Q2 in 2012/13 rates of self-harm were at 107 for the year to date. By Q2 in 2013/14 rates of self-harm were already at 231 for the year to date.

ASD (autism spectrum) assessment referrals are reported to be increasing year on year. Data is unavailable due to difficulties in recording.⁶¹

55. Discussing the impact of increased demand, Black Country Partnership NHS Foundation Trust argues that meeting demand within the context of a “significant shortfall in funding” leads to long waiting times, and interventions being shorter than required:

There is a significant shortfall in funding for specialist CAMHS services at all levels to deliver the required activity and meet the demand placed on it. This leads services to provide within the available resource, often leading to long waiting times which impacts on accessibility into the service, shorter than required interventions and without a developed skill mix and workforce.⁶²

56. Cornwall Partnership NHS Foundation Trust give a similar picture:

Due to a change in the case mix referred i.e. more risky and unwell youngsters, there has been a knock-on effect on the ability to assess and treat non-urgent cases (mainly neurodevelopmental disorders such as autism, ADHD). This has led to an increase in internal waiting times.⁶³

57. A further impact 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:

There has been a clear increase in the threshold for access. This has been monitored through the common point of entry team (developed 2 years ago) which has demonstrated that as referrals increase, the number of referrals signposted to alternative services has also increased.⁶⁴

Many services report continuously increasing complexity of cases arriving at CAMHS, including higher levels of self-harm. Combined with reduced staffing and disinvested services, this is driving up thresholds for acceptance of referrals and resulting in junior staff holding increased levels of clinical risk.⁶⁵

61 Warwickshire County Council [\[CMH0182\]](#) para 3.1

62 Black Country Partnership NHS Foundation Trust [\[CMH0166\]](#), para 7

63 Cornwall Partnership Foundation NHS Trust [\[CMH0189\]](#), para 6

64 Berkshire Healthcare NHS Trust [\[CMH0049\]](#) p2

65 London and South East CYP-IAPT Learning Collaborative [\[CMH0155\]](#) para 4.1.7

Birmingham has mainly managed the overall increase in referral rates by tightening referral criteria and signposting less serious cases to other services, only accepting more serious presentations. Our referral acceptance rate has reduced from 75% to 65%.”⁶⁶

58. Barbara Rayment of Youth Access, which represents voluntary sector providers, told us of an extreme example, where “in some areas, it has been reported that CAMHS will not see any young person unless they have attempted at least one suicide.”⁶⁷ The British Psychological Society state that 71% of professionals responding to their survey said that their service had tightened its acceptance criteria for a referral to the CAMHS services, and “even more concerning was that 88% said there were insufficient other services to signpost non-accepted referrals to.”⁶⁸

59. Problems described in our submissions were not confined to difficulties in accessing services, but also to quality. Birmingham Children’s Hospital NHS Foundation Trust report that while its membership of QNIC (Quality Network for Inpatient CAMHS) and QNCC (Quality Network for Community CAMHS) gives it regular peer reviews of the quality of its service and “review reports are generally very good”, they are “becoming increasingly challenged to maintain quality given workload and complexity.”⁶⁹ Solihull argue that in the course of the last decade, funding increases, some of them ringfenced “led to clear improvements in service delivery and outcomes”, with many CAMHS teams becoming NICE guidelines compliant. However, they go on to argue that “Over the last 3 years, we have lost most of the gains we had made”:

The improvements in quality measured through NICE guideline compliance, post interventional outcomes and patient satisfaction surveys seem to indicate either a stalling in quality improvements or deterioration. Although the principle of expecting increased efficiency, and productivity in a business is a good one, blanket application of recurrent efficiency savings of 5% or more on an underdeveloped service like CAMHS, with its areas of unmet and partially met need- like that of looked after children, impact of parental mental illness, offending and substance misuse, needs of ethnic minority and hard to reach populations has caused significant damage to developing services.⁷⁰

The view from service users

60. Unsurprisingly, children and young people and the parents of service users provided a similar view on the state of Tier 3 services. In written evidence to us one parent described

66 Birmingham Children’s Hospital NHS Foundation Trust ([CMH0130](#)), para 21

67 Q5

68 British Psychological Society ([CMH0133](#)) p4

69 Birmingham Children’s Hospital NHS Foundation Trust ([CMH0130](#)), para 12

70 Solihull CAMHS ([CMH0066](#)) p1

the profound impact that a long wait to access services can have on a young person and their family:

From initial referral to concluding interview was 8 months. Combined with the previous wait for Family Therapy and CBT, a whole school year had now been missed. We would now struggle to get the 5 GCSE's that would open the doors to further education. It seems that these waiting times are not unusual, and yet the impact on people's lives seems forgotten. 13 weeks waiting is a full school term. For a child with ADHD, this means a term of disrupted classroom, a term of a teacher stressed, 30 other children suffering in the classroom. And at home, the parent is suffering, endlessly trying to support the child, apologising for problems caused, trying to protect the rest of the family, exhausted, unable to go out to work. For a teenager, a term is more GCSEs lost, more friends lost.⁷¹

61. At their meeting with the Committee, young people raised the following issues relating to CAMHS Tier 3 services:

Tightened referral criteria meaning mental health problems have to escalate to serious levels before help is given;

The importance of ownership of treatment and choice, which is not always given;

Insufficient information for young people about CAMHS services and mental health more generally, including online;

Specific examples of poor service provision including lack of respect, privacy, and continuity of carer, and lack of regular medication review.

62. In the written submissions received from individual parents, carers and service users, poor access to service, unclear referral thresholds and long waiting times were frequently raised as issues. Further, parents and carers stressed that because of the length of waiting times for an assessment, the child's or adolescent's problems generally became more entrenched and harder to treat, families were under sustained pressure, and it shifted the focus of care to crisis management, rather than preventative measures. Overall, key criticisms centred on:

Confused access and pathways and excessive waiting times

Lack of understanding of the needs of children and their families, including insufficient specialist expertise to recognise complex comorbidities

Lack of multiagency communication and administrative failures

Limited availability of appropriate treatment and support, including inpatient treatment and specialist interventions for treating complex comorbidities

Abrupt transition to adult services

Low awareness about mental illness in young people.⁷²

63. The majority of submissions from parents and carers raised issues about the referral process for CAMHS, how decisions were made about who was accepted by CAMHS, and where they could go if they were not referred for an assessment. Many reported having been initially refused for an assessment, and offered no other form of support; their child's mental health problems had subsequently escalated.⁷³ Seeking care was often described as a battle: one parent wrote that

My experience of having a child with mental health issues is that as well as battling with the pain and stigma of having a mentally ill child, it is also a draining and difficult battle to try and get the right help.⁷⁴

64. Parents also felt that they themselves were given very little guidance or support by CAMHS services about how best to help their child.⁷⁵

65. Jody Tranter, inclusion manager at a London primary school, gave the following overview:

The CAMHS service is buckling under an ever-increasing demand for its services

As a result, most referrals result in an assessment which almost always results in the case being closed

It would appear that only the most disturbed children are eligible for any sort of intervention from CAMHS

There is a large and significant gap in the mental health provision for distressed, disturbed and unhappy children.⁷⁶

66. Drawing on their engagement work with young people, Dr Cathy Street and Dr Yvonne Anderson made observations about young people's comments about CAMHS staff, both positive and negative:

72 Personal Experiences of CAMHS, [written evidence](#) p 2

73 Personal Experiences of CAMHS, [written evidence](#) p3

74 Personal Experiences of CAMHS, [written evidence](#) p2

75 Personal Experiences of CAMHS, [written evidence](#) p5

76 Jody Tranter [\[CMH0147\]](#) Executive summary

...large numbers of young people continue to report unhelpful attitudes from some CAMHS staff and some report quite worrying behaviours from their therapists.

“It would be great if the workers at CAMHS would actually help, listen to me and respect me. Not treat me like I'm a mental idiot, I hate CAMHS for the way I have been treated. I haven't been given much of a choice in my treatment and it seems it was all made behind my back. Overall, everything needs improving.” Young person: Puzzledout

Of course children and young people also have many good things to say about CAMHS.

“The workers are very understanding, and listen to everything you say, which is something I really appreciate.” “I have had a lot of people involved, from nurses and doctors on the wards, to now in the local CAMHS team. They have been all as helpful as possible and always willing to listen” Young people: Puzzledout⁷⁷

67. Dr Street and Dr Anderson also describe research they have published in this area showing that children and young people find it hard to complain about poor experiences of CAMHS

that children and young people are afraid or reluctant to complain about poor service from CAMHS. They understand the culture of the NHS is not positive regarding negative feedback and they do not wish to cause trouble. In cases where a young person is motivated to complain, the process may be opaque and obstacles placed in their way. We question how services are ever to improve in such a climate.⁷⁸

68. They also describe access problems, arguing that feedback from young people has been the same for the past ten years:

Hundreds of children and young people have given their feedback to local services via Puzzledout since it was launched in 2011. In reviewing this feedback the most striking feature was that they are saying the same things they were saying ten years ago. Children and young people want better access, services that are more acceptable and appropriate for them and greater involvement in their own care. It is sad and inexcusable that we are still hearing the same views and still failing to act on even the most simple of them—such as extending opening hours or redesigning waiting areas.⁷⁹

77 Dr Cathy Street and Dr Yvonne Anderson, The GIFT Partnership [\(CMH0178\)](#) p3

78 Dr Cathy Street and Dr Yvonne Anderson, The GIFT Partnership [\(CMH0178\)](#) p4

79 Dr Cathy Street and Dr Yvonne Anderson, The GIFT Partnership [\(CMH0178\)](#) p3

69. Young sessional workers from the GIFT partnership (a group which has been commissioned by NHS England to support the participation of children and young people in the CYP-IAPT programme) highlighted the difficulties that young people may find in accessing CAMHS services:

Honestly, for young people who may be reliant on their working parents or public transport, the service offers help in places that cover a whole area where some people struggle to access it. This could potentially make a huge impact on whether the young person goes to treatment or feels it's too much effort, as much as they want help. For example, a YP has to ask one of their parents to take time off work to take them to a session, or a YP has to travel for quite some time to their nearest service.⁸⁰

70. Healthwatch Northamptonshire report that they recently ran an engagement campaign with children young people and families to inform plans to redesign CAMHS in their area, and describe some of the issues raised by young people and families:

Access is a problem: We heard very widespread concern about the limited availability of Child and Adolescent Mental Health service in Northamptonshire. People said services are usually good once they have been able to access the service, but the issue is getting access. Many people said that waiting times for CAMHS are unacceptable. While waiting times in Northamptonshire may be average (according to the local Clinical Commissioning Groups), the sense is from the people we spoke to that this can feel like a very long time when there are urgent health mental health needs. This was a view echoed by nearly all the children and young people who spoke to us about CAMHS. For some this has resulted in having to seek diagnosis privately.

“Everywhere I go there is a long waiting list and it's hard to cope with when I am suffering from depression”

Problems with access to counselling services and early intervention/preventative services: Children and young people are not aware of where to go to for support. Children and young people with urgent needs talked to us about being turned down or contact with services not being followed up. Several people talked about a lack of continuity of care. We heard from one young woman who had 12 counsellors in 4 years.

Many children and young people told us that they don't get the right support at the right time—not just CAMHS, but other services. Several young people and parents described the “struggles” or “fights” they have had to get services. Many people talked about the high level of need they have to demonstrate in order to get any support. The impact this has on the lives and wellbeing of children, young people and families is significant, at times overwhelming,

and makes it difficult to plan for independence and is life-limiting in the long term.⁸¹

Improving Tier 3 services

71. Some provider organisations described efforts to redesign services to improve quality and efficiency which had led to improvements, but often they argued that these improvements have been limited by, or are under threat from, continuing increases in demand and funding constraints. Birmingham Children's Hospital NHS Foundation Trust report that by implementing a service transformation model called CAPA (Choice and Partnership), they have in fact successfully reduced waiting times since 2010:

In 2010 like many other CAMHS we had long waiting lists, up to 1000 patients waiting for treatment with approximately 450 waiting over 18 weeks. Only 55% of our patients were seen for treatment in 18 weeks. We have successfully implemented CAPA (Choice and Partnership Approach) to manage capacity, demand and flow through the system of referrals. Now 100% of patients are seen within 18 weeks with a 4 week average for first appointments (Choice) and an 11.4 week average for commencing treatment (Partnership).

72. However they go on to state that they “are at risk of losing some of the gains we have made and increased workloads are impacting on staff.”⁸²

73. Berkshire Healthcare NHS Trust report that it has redesigned its services to develop specialist pathways for ADHD, ASD and Anxiety and Depression, and has increased its efficiency to allow it to see more young people this year than last year. However there has still been a significant increase in waiting times over the past 3 years, with over 700 young people waiting more than 12 weeks for a treatment intervention, although referrals are triaged on receipt and urgent cases seen within 24hr and high risk cases seen within 1-3 weeks.⁸³

74. North East London NHS Foundation Trust report that despite ‘unparalleled’ increase in referrals, their threshold for access has remained unchanged:

We maintained waiting lists within the national targets and we managed the increase in referrals by increasing throughput through services, adopting briefer therapies and by bringing in triage functions to teams. We also make more use of parenting groups and ADHD follow-up clinics which are not run by consultants in order to reduce the consultant work load. However, we are at stretch point and would not be able to accommodate further increases in

81 Healthwatch Northamptonshire ([CMH0212](#)) pp1-2

82 Birmingham Children's Hospital NHS Foundation Trust ([CMH0130](#)), para 7

83 Berkshire Healthcare NHS Trust ([CMH0049](#)) p1

demand in the context of reduction in income without having to cut some of the services we deliver⁸⁴

75. NHS England state it is developing a waiting times project to deliver its Mandate objective on parity of esteem to bring waiting times for those with mental health issues in line with those in other services,⁸⁵ a point the Minister reiterated during oral evidence.⁸⁶ Barbara Rayment of Youth Access felt that such a target could help, were it accompanied by the resources needed to achieve it.⁸⁷ However, Peter Hindley of the Royal College of Psychiatrists said that he would be wary about waiting time targets, as they can create perverse incentives including internal waiting lists, and felt that it might be better to introduce targets for commissioners aimed at lowering the prevalence of specific conditions.⁸⁸

76. Specialist treatment pathways and clinics for specific conditions were cited as a helpful approach, though not without problems:

The development of specialist clinics as a QIPP⁸⁹ has been an attempt to maintain high quality care that meets NICE guidance. This has been achieved within the pathways. However this has been at the expense of greater waiting times of non-urgent cases as referral numbers increase. There is concern that the focus on the specialist pathways /clinics has left the locality community teams which manage the most complex and risky young people under resourced, with less contribution to joint agency work from Local Authority agencies. There is a danger that overall the service provided to these people reduced. There has for example been a decrease in the number of clinicians involved with each young person.⁹⁰

77. Liverpool CAMHS partnership has developed a “comprehensive CAMHS pathway” which attempts to bring better integration between the Tiers, and reports positive outcomes both in terms of reduced referrals to higher Tier services, and in outcome and satisfaction measures.⁹¹ North East London report that they are currently integrating CAMHS and community paediatric services:

Our CAMHS services and community paediatric services are presently undergoing integration. Pathways like the neurodevelopmental pathway will comprise of complete joint working between paediatricians and CAMHS clinicians. Integration also means greater joint working with the primary workforce such as health visiting and school nurses. This creates the

84 North East London NHS Foundation Trust [\(CMH0037\)](#) p1

85 NHS England [\(CMH0193\)](#), para 17

86 Q388

87 Q21

88 Q26

89 Quality, Innovation, Productivity and Prevention initiatives

90 Berkshire Healthcare NHS Trust [\(CMH0049\)](#) pp2-3

91 Liverpool CAMHS Partnership [\(CMH0139\)](#) pp1-2

opportunity for up skilling of the Tier 1 workforce. Primary mental health workers work with health visitors and school nurses to enable them to be more able to accurately identify mental struggles in their client groups but also to intervene early as well as having clear referral routes into CAMHS.⁹²

78. Many organisations also reported contributing to the CORC programme. The Child Outcomes Research Consortium (CORC) is a not-for-profit learning collaboration dedicated to finding the best ways to collect and use outcome data to create the highest quality services for children, young people and their families. CORC report that

Membership now includes members from over half of UK NHS CAMHS, with an increasing cohort of voluntary sector members. Members collate outcome information from children and their families, primarily from self-report questionnaires (patient reported outcome measures- PROMS) focused on symptomology, general wellbeing, impact and patient reported experience measures (PREMS) focusing on therapeutic relationships, access and satisfaction with service. Members send aggregated pseudonymised data to the CORC central team once a year to allow the team to produce a report that compares their outcomes with those of relevant others in the consortium⁹³

79. A strongly positive development within CAMHS in recent years has been the introduction of the Improving Access to Psychological Therapies programme (CYP-IAPT), described by the Government as a 'transformational programme' to improve access to psychological therapies within CAMHS services:

The programme does not create separate services, but seeks to transform existing services by making a modest investment in infrastructure including IT, participation and in workforce, training service leaders in best practice demand management systems, and training a number of supervisors and therapists in each partnership in evidence based treatments for self-harm, depression, anxiety, eating disorders and conduct problems. It mandates the collection of routine outcome monitoring.⁹⁴

80. CYP IAPT currently works with services covering 54% of the 0-19 population with a target of working with services covering 60% by 2015. It is the Government's aim that all of England will be involved by 2018.⁹⁵ While CYP IAPT has been widely welcomed as a positive step, written submissions to the Committee suggest that this programme does not represent a total solution to current issues within CAMHS, and that some areas implementing the programme are struggling to deliver improvements in the context of increased demand and reduced funding, as NHS England acknowledges:

92 North East London NHS Foundation Trust [\(CMH0037\)](#) p2

93 Child Outcomes Research Consortium (CORC) [\(CMH0141\)](#) Para 2.3-2.4

94 NHS England [\(CMH0193\)](#) para 18

95 Department of Health [\(CMH0154\)](#) Para 16; NHS England [\(CMH0193\)](#) para 18

Some services are already able to demonstrate improved efficiency through using CYP IAPT methodology. However, it is important to note that the programme is being put in place during a time of cuts and cost improvement plans for CAMHS by both local authority and NHS which is impacting on the ability of some services to take full advantage of the programme ...⁹⁶

81. Central and North West London Foundation Trust report that services have benefited from the CYP-IAPT over the past two years, but argue that this is “limited” and “comes with its own challenges particularly around data.”⁹⁷ Professor Peter Fonagy, National Clinical Lead for the CYP-IAPT programme, states that:

Cuts to CAMHS budgets at CYP IAPT partnerships since 2010 include Hackney (76% reduction), Derby (41% reduction), Bedford (27% reduction), Redcar & Cleveland (27% reduction), Ealing (19% reduction), Kensington and Chelsea (19% reduction), Westminster (19% reduction), Durham (13% reduction), Newcastle (13% reduction), North Somerset (10% reduction), and Leeds (9% reduction)^[i]. One CYP IAPT site has reported a reduction in a fifth of staff due to cuts. Another site has reported that all the staff trained in Parenting through the CYP IAPT programme have been made redundant due to cuts. Another Trust has reported having to adjust to the cuts by reducing numbers of experienced staff and replacing them with more junior staff.

... Some services have responded to budget cuts by raising thresholds, meaning that a child or young person is only seen if their mental health problem is judged to be at a raised level of severity. This increased threshold also compromises the ability of services to accept self-referral.

Capacity is limited by Clinical Commissioning Groups wanting to manage referral rates and impose Quality, Innovation, Productivity and Prevention targets.

However well we deliver the CYP IAPT programme, existing services still need experienced, evidence-trained, and appropriately supervised staff on the ground.⁹⁸

Commissioning specialist outpatient CAMHS services (Tier 3)

82. Tier 3 services are commissioned by CCGs, and NHS England have a responsibility for assuring and supporting CCGs.

83. In their written submission to the inquiry, NHS England state that “only 6% of Mental Health Spend is on Children and Young People (Kennedy, 2010). CAMHS is under

96 NHS England [\(CMH0193\)](#) para 18

97 Central and North West London NHS Foundation Trust [\(CMH0132\)](#) para 4

98 Professor Peter Fonagy [\(CMH0216\)](#) para 4

resourced. According to research only 25% of children with a diagnosable mental health problem receive a specialist service.”⁹⁹ YoungMinds have recently published data obtained through Freedom of Information requests suggesting that 77% of CCGs which submitted data have frozen or cut their CAMHS budgets between 2013–14 and 2014–15. (34 reported having cut their budgets, and 40 reported having frozen their budgets).¹⁰⁰ Evidence of disinvestment in recent years is also borne out in the NHS Benchmarking Review of CAMHS 2013 (NHS Benchmarking Network, 2013).¹⁰¹ Discussing funding for CAMHS in general terms, North West London Commissioning Support Unit argue that “CAMHS is usually a small part of a large Adult Mental Health and the operational, contractual and funding requirements are too easily overlooked”¹⁰²:

It is overlooked and neglected not by intention but because it is mostly bundled with adult mental health services. Our adult mental health services have enormous volumes, enormous difficulties and their own possible inquiry into the problems they have in relation to budgetary considerations and providing safe treatments and places for people. Children, I think, in the health service traditionally have been brought somewhat belatedly to the table ... The agenda in health is enormous. Unless you have people banging on about children and their mental health needs—and indeed other needs—they do not get heard, if I am frank.¹⁰³

Historically, CAMHS has always been the poor relation to adult mental health. For example, in adult mental health we have had adult mental health tsars and more ministerial ambassadors, but that has not really been reflected in the children’s world.¹⁰⁴

84. Solihull provided the following view:

For those of us working in Child and Adolescent Psychiatry, and being witnesses to this unfolding crisis, the first step is to stop further deterioration in the situation. This is only possible if we can have certainty about CAMHS funding structures and amounts. Commissioning arrangements regarding all tiers of CAMHS have to be clarified. The quick way to give some financial certainty would be to ring fence CAMHS budgets again, so that they are not an easy target for cash strapped local councils and acute trusts.¹⁰⁵

85. Witnesses also referenced changes to the tariff deflator as further evidence of a lack of parity of esteem. The Chief Medical Officer argued:

99 NHS England ([CMH0193](#)) para 3

100 YoungMinds [media release](#), 21 June 2014

101 NHS England, [Child and Adolescent Mental Health Services \(CAMHS\) Tier 4 Report](#), 10 July 2014, p14

102 North West London Commissioning Support Unit, ([CMH0211](#)) pp2-3

103 Steve Buckerfield, Q251

104 Barbara Herts, Q251

105 Solihull CAMHS ([CMH0066](#)), p4

Everything is a question of prioritisation. I am told that Monitor and NHS England have said that the tariff next year should be minus 1.5% for the acute sector and minus 1.8% for the mental health sector, and the difference relates to the need for £150 million for the acute sector to address the Francis inquiry issues. That ignores the Winterbourne View issues or the Francis issues in mental health, let alone a historical lack of focus in the area.¹⁰⁶

86. Norman Lamb agreed that mental health and CAMHS in particular faced funding problems:

I think there are funding issues. I have made it pretty clear, I think, in the time I have been Minister, that there is an institutional bias against mental health, and it has not had its fair share of funding. Within mental health there is a big question mark as to whether children's mental health gets its fair share ... Is it really rational that 6% of the mental health budget is applied to children and young people when we know that a very significant proportion of mental health problems start in the teenage years?

The other thing is that we have to address the imbalance in levers and incentives in the system that always disadvantage mental health. If you have a very potent 18-week waiting time standard in physical health but nothing in mental health, that will dictate where the money goes from the local CCGs.¹⁰⁷

[Resourcing] In my view, it is very variable around the country, and I think this is what was exposed superbly by the YoungMinds survey. It is great that they did it, because we have to identify which areas are doing it well and which are doing it badly. That survey revealed that there are loads of areas around the country that are increasing investment in children's mental health services, but there are far too many that are reducing funding for an area that, to me, ought to be seen in every area as a priority. That view and the evidence from the survey apply both to CCGs and to local government.¹⁰⁸

There is an issue about ring-fencing here. I have not reached any conclusion, but I think ring-fencing was withdrawn in 2008. Question: do we need to look at that?¹⁰⁹

Challenges for commissioners

87. The opening chapter of this report discussed the difficulties commissioners currently face because of the lack of up to date information. The complexity of current commissioning arrangements for CAMHS has also been described as a problem:

106 Chief Medical Officer, Q30

107 Q387

108 Q417

109 Q456

The disaggregated CAMHS commissioning arrangements have increased the risk of fragmented service delivery, conflicting commissioning intentions, post-code lottery of provision, confusing communication for providers, and poor value for money. Locally this is being addressed for tiers 1-3 through a CAMHS commissioning project.¹¹⁰

88. Many commissioning and provider organisations argue that the restructuring of the NHS in 2013 has made arrangements even more complex, and while some, including Derbyshire Healthcare NHS Foundation Trust and Staffordshire commissioners, report robust efforts to improve joint commissioning,¹¹¹ the prevailing picture is one of complexity and difficulty, as Islington CAMHS describe:

Located between local authority, education and health commissioners, CAMHS runs a tightrope of fragile commissioning arrangements so that initiatives are too often short term, with an uncertain funding base and reliant on collaborations between commissioning agencies who themselves have cost pressures which they are often unable to control. The time and energy spent by CAMHS service leaders in negotiating and securing funding for services from a wide range of stakeholders is extraordinarily wasteful of expertise that should be used on more direct project work within the services they manage and supervise.¹¹²

89. Central and North West London NHS Foundation Trust argue that they are “experiencing a concerning and damaging breakdown in structures, processes and communication and a clear message that our CAMHS experience and expertise is no longer valued in commissioning and planning”, and that the issues they identify are resulting in “collective confusion, duplication of work and are compromising the quality and safety of services”.¹¹³

90. North West London Commissioning Support Unit raise the shortness of CAMHS contracts as a difficulty for commissioners and for providers:

Currently CAMHS contracts are very short with an annual re-negotiation which consumes vast amounts of staff resources, both for providers and commissioners. New service specifications and performance frameworks barely have time to be constructed before they are subject to review and further change.¹¹⁴

We have a floor of people endlessly going round this contracting round... It is important to get it right, but you end up being a contracting person rather

110 Warwickshire County Council ([CMH0182](#)) para 6.1

111 Clinical Commissioning Groups within Staffordshire and Staffordshire County Council ([CMH0134](#)), para 2.2; Derbyshire Healthcare Foundation NHS Trust ([CMH0191](#)), p12

112 Islington CAMHS ([CMH0077](#)) p1

113 Central and North West London NHS Foundation Trust ([CMH0132](#)) para 3

114 North West London Commissioning Support Unit, ([CMH0211](#)) p3

than somebody commissioning services for children who have mental health problems. They should run for two or three years and then you might have some chance to see what works.¹¹⁵

91. However Jane Lunt of Liverpool CCG felt that it was possible to work around this:

You just renew your annual contracting process and refresh your key performance indicators, outcomes, quality schedule and so on. Within that, the key specification could be for three years ... We try not to allow the contractual process to become the commissioning process. The commissioning process is a cycle that includes the contractual process, but that is just a nuts-and-bolts function. Your commissioning process is understanding your local needs assessment, looking at what services you have—where your gaps and strengths are—and then commissioning and determining what you need as services to meet the needs of your population.¹¹⁶

Monitoring the performance of CAMHS services

92. CCGs have an important role in monitoring the performance of CAMHS services and ensuring they are delivering high quality, value for money services within their own areas. Central and North West London NHS Foundation Trust argue that in their view “performance management meetings are inconsistent. In some areas we have none and therefore no formal ways to raise difficulties and concerns and seek support/partnership solutions.”¹¹⁷ In oral evidence, Steve Buckerfield of North West London Commissioning Support Unit described quarterly performance meetings with providers and stated that they currently receive data on volume of patients, types of treatments and waiting times, and that each year they are adding more questions about treatments and evidence base, but whilst attempting to keep the information burden manageable.¹¹⁸ Steve Buckerfield also argued for the importance of securing feedback from children and young people, and went on to point out that CCG patient committees often do not have young people included on them, and that in his view local authorities and CCGs should collaborate better on this.¹¹⁹

93. Despite the progress that has been achieved in this area through initiatives such as CYP-IAPT and CORC, North West London Commissioning Support Unit also argue that “the adoption and performance reporting of outcome focused practice across CAMHS has been slow and would benefit from significant encouragement”.¹²⁰ The Evidence Based Practice Unit argue that “safety as an aspect of CAMHS has been largely overlooked and

115 Q258

116 Qq 333-334

117 Central and North West London NHS Foundation Trust ([CMH0132](#)) p4

118 Q274

119 Q278

120 North West London Commissioning Support Unit, ([CMH0211](#)), Executive Summary

needs to be better built into recording systems and performance management.”¹²¹ Dr Jenny Taylor of the British Psychological Society agreed that there was a greater need to focus on outcomes in CAMHS, to ensure that services are actually making a difference to children and young people’s mental health:

We are talking a lot about access to services, but we also need to make sure that the services we are delivering are effective and making a difference ...we have not spoken about as much is ensuring that the interventions that we offer when children and young people do come to our services make a difference to whether or not they return and deliberately self-harm or whether they actually attempt suicide.

We have, for example, a lot of NICE guidance about children’s and adolescent mental health services. One of our colleagues who spoke earlier talked about the need for commissioning groups to ensure that there were certain provisions. That would be a starting point, making sure that CAMH services are providing, at the least, what the NICE guidance recommends needs to be provided, as opposed to emphasising needs for numbers of staff, for example, or particular disciplines ... We are collecting far more of that sort of data than we have done previously, but still in many trusts the data they are required to provide to the commissioners is not that data: it is how quickly they are seeing people and how many people they are seeing, which, as a colleague said to me the other day, is a bit like simply looking at whether the post office are picking up letters very quickly and how many they are picking up, but not checking where they are going.¹²²

Improving CCG commissioning

94. When asked how effectively they felt CCGs were performing in their functions, neither NHS England nor the Department of Health raised concerns:

CCGs are just over a year old. My personal view—I know it was David Nicholson’s view as he left NHS England—is they have done remarkably well in their first year. Of course, across 211 or 212, there is a variation in terms of level of performance, but I genuinely believe that having general practitioners driving CCGs, collaborating with local authorities and other partners, has made a real difference in terms of some of the big decisions that needed to be made around changing commissioning patterns within localities. I think that is very exciting and welcome. That is the good news.

There clearly is variation in terms of the extent to which CCGs are prioritising mental health, and, within that, children’s mental health. That

121 Evidence Based Practice Unit (EBPU) ([CMH0161](#)), para 4.4.3

122 Qq188-189, Q197

has to be addressed through the assurance relationship between NHS England and CCGs over a period of time.¹²³

95. Professor Sir Bruce Keogh told us he had “very little to add” to Mr Rouse’s assessment, and that “clearly you would expect there to be some variation, because CCGs are, in the grand scheme of things, still relatively immature; they are forming.”¹²⁴

96. However, North West London Commissioning Support Unit argued that “expertise in CAMHS commissioning is in very short supply with as a result service development, innovation and invest to save activity, significantly under-represented in the sector.”¹²⁵ Essex County Council state that it has become increasingly hard for commissioners to find out about best practice since the abolition of the CAMHS national support service, and state that in redesigning their service they have expended considerable effort in contacting other areas for information, which could have been reduced if there were national opportunities for this.¹²⁶ She even stated that it had been very valuable to look at the written evidence submitted by different areas to this inquiry.¹²⁷

97. While there is already a wide range of NICE guidance relevant to CAMHS services, covering treatments for different conditions, witnesses suggested a need for further guidance setting out “at least a bare minimum” of what a CAMHS service should provide. Dr Myers stated that in her view,

It would be helpful if there was absolute national guidance on at least a bare minimum that you are meant to provide because, locally, commissioners can make a choice about what to invest in or not to invest in. So, for me, there needs to be an absolute bottom line, “You must get this level.”¹²⁸

In specialised commissioning, there are service specifications that provide exactly that sort of guide to the local area teams as to what to commission. I do not see the same for CCG commissioning, where it very much depends upon the CCG’s own professional knowledge of the sorts of services available. I think one of the solutions is to provide that sort of guidance, so not to break up the service. I do not think CCGs are failing us and there are many very good examples, but I do not think they have enough guidance ... It should come from the NHS and there should be discussion then about how best to allocate resources. Resources per head of population should be tied into acuity, complexity and dependencies. There is quite wide variation at the moment.¹²⁹

123 Q422

124 Q422

125 North West London Commissioning Support Unit, [\[CMH0211\]](#), p3

126 Essex County Council [\[CMH0078\]](#) para 3.4

127 Q265

128 Q184

129 Q184

98. At our oral evidence session the Minister told us that he planned to develop a programme of CAMHS “exemplar” sites, from which examples of best practice could be disseminated.¹³⁰ NHS England also sent us further information about the CCG mental health leadership programme, run by NHS England, which includes a day’s learning on commissioning CAMHS, with best practice examples. They also mentioned the Mental Health Intelligence Network, which there is an ‘ambition’ to extend to children’s and young people’s services.¹³¹ In their memoranda, NHS England also state that the CYP-IAPT programme is currently working on developing a new Tier 2 and Tier 3 service specification:

The Children’s and Young People’s Improving Access to Psychological Therapies team in NHS England (CYP IAPT) is working with partners to support improved commissioning framework for Children and Adolescent Mental Health Services (CAMHS) framework which facilitates closer working together of all commissioners–NHS England, CCGs, Local Authorities (including social care and education). The programme is creating a new Tier 2 and 3 specification to support commissioning of evidence-based, outcomes-focussed CAMHS. This work will take into account the outcome of the Tier 4 review. The CYP IAPT Programme is developing resources to support better integrated working across counselling and Tier 3.¹³²

Problems with specific aspects of Tier 3 CAMHS

99. Our inquiry received over 200 submissions of written evidence, and the breadth of issues covered in these provides an excellent illustration of the complexity of CAMHS services and the different problems faced by the children and young people who use them. We received submissions from many different professional groups, some advocating for specific therapeutic approaches. We also received submissions covering a wide range of specific mental health and neurodevelopmental problems; and highlighting a number of different groups who are particularly vulnerable to mental health problems. Within the limited time available to this inquiry, we have not been able to address the all the specific challenges and problems raised in the written evidence relating to individual conditions and specific vulnerable groups, or different therapeutic approaches; but in this section we provide an overview of some of the issues raised, and we recommend that the Department of Health/NHS England taskforce address these more fully.

100. We received written evidence describing problems with services for CAMHS children and young people specific conditions including Autistic Spectrum Disorders (ASDs), ADHD, Obsessive Compulsive Disorder, learning disabilities and other disabilities, and

130 Q342

131 Additional written evidence submitted by NHS England ([CMH0233](#))

132 NHS England ([CMH0193](#)) Para 6

Eating Disorders.¹³³ Concerns that were frequently raised included delays in diagnosis; access problems and lack of sufficient specialist knowledge of specific conditions within CAMHS.¹³⁴ Several groups highlighted the importance of condition-specific pathways as a means of improving access and standards.¹³⁵ Submissions from parents frequently raised similar problems, and written evidence from provider organisations agreed that long delays were often occurring in the assessment and treatment of children and young people with neurodevelopmental disorders.¹³⁶

101. Our written submissions, and our discussions with young people themselves, also highlighted the specific groups of children and young people who are particularly vulnerable to mental health problems, but whose needs may not currently be being adequately addressed by CAMHS services. These included children and young people in the care system, and those who have been adopted or fostered;¹³⁷ homeless young people;¹³⁸ asylum seekers and recent immigrants;¹³⁹ and lesbian, gay, bisexual and transgender young people.¹⁴⁰ Submissions were also received outlining the particular needs of bereaved children.¹⁴¹

Transition

102. Difficulties with transition from CAMHS to adult mental health services was raised both in the Committee's session with young people, and in the written submissions received from individual parents, carers, and service users. The GIFT young sessional workers made the following observations:

Focusing just on transitional period between CAMHS to adult mental health services for me was traumatic. I felt like there wasn't a solid structure of guideline to ensure despite my age there was a service that enabled me to not slip back into crisis. I'm not sure what can realistically be done to tackle this issue but maybe something along the lines of a merge between services or a specialist link worker role to make the transition smoother and less detrimental.

133 See for example, Act Now For Autism ([CMH0205](#)), National Autistic Society ([CMH0163](#)), UK ADHD Partnership ([CMH0048](#)), Educational Rights Alliance ([CMH0117](#)), OCD Action ([CMH0152](#)), Can't Go Won't Go ([CMH0168](#)), Contact a Family ([CM0148](#))

134 *ibid*

135 See, for example, OCD Action ([CMH0152](#)), Act Now For Autism ([CMH0205](#)), National Autistic Society ([CMH0163](#)),

136 See for example, Hampshire Parent Carer Network ([CMH0149](#)), Wiltshire Parent Carer Council ([CMH0184](#)), Kent Parent Carer Forum ([CMH0095](#)), Black Country Partnership NHS Foundation Trust ([CMH0166](#)), para 17-18, Cornwall Partnership Foundation NHS Trust ([CMH0189](#)) para 6-7

137 See for example, Derbyshire County Council Children Younger Adults Dept. ([CMH0192](#)), TACT ([CMH0055](#)), British Association for Adoption Fostering ([CMH0082](#)), Adoption Leadership Board ([CMH0231](#))

138 See, for example, Centrepoint ([CMH0061](#))

139 See, for example, Barnet Child & Adolescent Mental Health Service ([CMH0142](#))

140 See, for example, Jan Bridget ([CMH0014](#)), METRO ([CMH0156](#))

141 Childhood Bereavement Network ([CMH0150](#)), Shirley Potts, Director of Regional Development for Child Bereavement UK ([CMH0100](#))

Upping the age is something a lot of young people would agree needs to be done. Although the transition is smooth, adult services are very different from children's services. At 18, YP should be treated as a young adult, not an adult.¹⁴²

103. Young people from the Surrey County Council Youth Advisors group also described issues in this area:

All the young people who had transitioned to Adult Services reported needing more information on the differences between CAMHS and Adult Services, especially surrounding the different thresholds, and the support that could be provided if thresholds were not met. One member reported a very good transition where he kept his CAMHS worker for a couple of months to enable the transition to be smoother. However he also said that the turnover of staff in adult services was very high and had not had the opportunity to develop any relationships with them.

One particularly shocking story was reported of a young person who was an inpatient on her 18th birthday and was made to move from the Children's ward to the adult ward on that day.¹⁴³

104. The young people the Committee met with also described problematic experiences with transition, particularly for those young people for whom it coincided with moving away from home to university. The CYPMHC describe transition from CAMHS to Adult mental health services (AMHS) as a "perennial problem", which features in all of the previous reviews of CAMHS.¹⁴⁴ The Royal College of Psychiatrists report that "transition from CAMHS to AMHS continues to be an issue of concern in many areas."¹⁴⁵ NHS England state that "transition from child centred to adult services is currently poorly planned, poorly executed, and poorly experienced. This can lead to the "cliff edge" where support falls away, the young person disengages, and may present as their first episode of transition acutely in crisis to an adult Emergency Department."¹⁴⁶ *Closing the Gap: Priorities for essential change in mental health*, identifies transition from CAMHS to appropriate adult services as a priority for action, and NHS England state that they will be developing a transition service specification for CCGs and Local Authorities.¹⁴⁷

Perinatal mental health services

105. As well as problems for young people reaching adulthood, a strong theme we heard throughout this inquiry was the importance of early intervention to support mental and

142 GIFT Partnership ([CMH0159](#)) para 4

143 CAMHS Rights and Participation Team ([CMH0069](#)) p2

144 Children and Young People's Mental Health Coalition ([CMH0153](#)) para 6.5.1

145 The Royal College of Psychiatrists ([CMH0173](#)) para 38

146 NHS England ([CMH0193](#)) para 41

147 Department of Health, [Closing the Gap: Priorities for essential change in mental health](#), January 2014, p26

emotional health in the perinatal and infant period. The Children's and Young People's Mental Health Coalition was one of many organisations to highlight this:

The first 1,001 days of a baby's life are critical and this developmental window is the best time to help parents and carers support their baby and help ensure healthy brain development. If necessary put in place interventions that help ensure that babies are securely attached and get off to the best start in life.

Infant mental health provision has historically been very patchy with some areas having good provision, and others having virtually nothing. About 1 in 10 women suffer from post natal depression, which can impact on the mother's ability to become securely attached to their child; but provision for these women is very poor.

Like CAMHS, infant mental health provision requires different levels of service. It should include universal services that promote healthy parent-infant interactions; services for infants who are displaying early signs of mental health problems, and specialist perinatal mental health provision which supports both mothers with mental illnesses and their babies.¹⁴⁸

106. Dr Amanda Jones of North East London NHS Foundation Trust argued that “perinatal Services are rare in the UK and, where available, often small and poorly resourced.”¹⁴⁹ In oral evidence, Dr Jones went on to argue that such services should be seen as an essential part of healthcare, in the same way that specialised physical health services are:

Someone needs to say that the services have to be there, just like you expect an A and E to be available if you have a car accident or you expect a neonatal intensive care unit to be available if you have a premature baby. You should say, “I expect in this area that to be available.” If you have bipolar affective disorder and you are at risk of breaking down very quickly after birth, you don't want just to be with ordinary adult mental health; you want to be with a specialist perinatal psychiatrist who knows about the medication and has managed that during your pregnancy, who knows about what to do if you need admission. You need specialist knowledge, not just general psychiatry.¹⁵⁰

107. In addition to the written submissions we received from charities and interest groups focused on this area¹⁵¹, the lack of perinatal and infant services was identified by many CAMHS service providers as a problem. The Black Country Partnership NHS Foundation

148 Children and Young People's Mental Health Coalition ([CMH0153](#)) para 6.1

149 Amanda Jones, ([CMH0221](#)) p5

150 Q221

151 See, for example, All Party Parliamentary Group for Conception to Age 2 ([CMH0214](#)), Maternal Mental Health Alliance ([CMH0076](#)), Association of Infant Mental Health ([CMH0101](#)), Bliss ([CMH0046](#))

Trust state that there is no perinatal or infant mental health service provision in their area,¹⁵² and Cornwall Partnership FT have highlighted perinatal and infant mental health as a service for which they have been unable to secure funding.¹⁵³ Central and North West London NHS Foundation Trust state that they have “major concerns” about the “lack of coherent commissioning and specific funding for early infant and perinatal mental health”, and go on to say that “we have cases where under 5s are already struggling in the environment of nursery or school and have limited access to services that may be able to help.”¹⁵⁴ Derbyshire Healthcare NHS Foundation Trust told us:

There is no Infant Health Service locally despite increasing evidence regarding the impact of early environment, attachment difficulties, domestic abuse and parents struggling with mental health problems on their children. Previously successful projects such as Building Bridges lost funding and whilst Family Nurse Partnership and increased numbers of Health Visitors are to be welcome they may not have knowledge regarding infant mental health. Our CAMHS CYIAPT Parenting Therapy groups and others with training in attachment, Theraplay and skills in working with Parents with Mental Health problems are not being utilized yet in developing Services further for families of young children.¹⁵⁵

108. According to the Maternal Mental Health Alliance, Pregnant women and new mothers across almost half of the UK do not have access to specialist perinatal mental health services, potentially leaving them and their babies at risk.¹⁵⁶ When we discussed perinatal and infant mental health with the Minister, he agreed that “there is nothing more important” than this.¹⁵⁷

Conclusions and recommendations

109. Providers have reported increased waiting times for CAMHS services and increased referral thresholds, coupled with, in some cases, challenges in maintaining service quality. In the view of many providers, this is the result of rising demand in the context of reductions in funding. Not all services reported difficulties—some state that they have managed to maintain standards of access and quality—but overall there is unacceptable variation.

110. Young people and their parents have described “battles” to get access to CAMHS services, with only the most severely affected young people getting appointments; they also described the devastating impact that long waits for treatment can have.

152 Black Country Partnership NHS Foundation Trust ([CMH0166](#)), para 11

153 Cornwall Partnership Foundation NHS Trust ([CMH0189](#)), para 8

154 Central and North West London NHS Foundation Trust ([CMH0132](#)) para 5

155 Derbyshire Healthcare Foundation NHS Trust ([CMH0191](#)) p7

156 <http://everyonesbusiness.org.uk/>

157 Q434

111. We heard many positive examples of efforts within CAMHS to improve efficiency and quality—these included the Choice and Partnership approach, the introduction of pathways for managing specific conditions, and development of more integrated services. The CYP-IAPT programme was also highlighted as a positive development in improving access and quality. However, even amongst those providers implementing quality and efficiency improvement programmes, there was concern that improvements were being stalled or even reversed because of increasing demand and reduced funding.

112. Whilst demand for mental health services for children and adolescents appears to be rising, many CCGs report having frozen or cut their budgets. CCGs have the power to determine their own local priorities, but we are concerned that insufficient priority is being given to children and young people's mental health. We recommend that NHS England and the Department of Health monitor and increase spending levels on CAMHS until we can be assured that CAMHS services in all areas are meeting an acceptable standard. We welcome recent funding announcements for mental health services but we remain concerned and recommend that our successor committee reviews progress in this area.

113. CCGs are responsible for commissioning Tier 3 services. Evidence to our inquiry has detailed numerous difficulties facing the commissioners of CAMHS services. These include the annual contracting rounds, which some argued was a distraction from more strategic commissioning; the lack of reliable and up-to-date information on children's and adolescent mental health services and CAMHS; and the complex web of different organisations involved in the commissioning and provision of CAMHS. A particular complaint was the lack of guidance available on best practice.

114. We have heard that a stronger focus on evidence-based practice and outcome measurement, including safety, is needed. Collaborations such as CYP-IAPT have driven improvements in this area, but commissioners must take a stronger lead in ensuring that services are actually making a measurable difference to children and young people's mental health, and in ensuring that this focus is not overlooked in the drive to improve access.

115. Commissioners of CAMHS services undoubtedly face a difficult task in collaborating across a complex web of other commissioners, and overseeing a varied patchwork of different types of providers to attempt to commission a seamless CAMHS service. They also face challenges in securing sufficient funding for this sadly de-prioritised service. However, CCGs hold ultimate responsibility for commissioning community CAMHS services, and we feel that there is a clear need for CAMHS commissioners to be given further monitoring and support from NHS England to address the variations in investment and standards that submissions to this inquiry have described. We recommend NHS England provides an action plan detailing how it plans to do this.

116. We heard from witnesses that national service specifications are required, to set out minimum acceptable levels of community CAMHS services, and we understand

that Tier 2 and 3 service specifications are now being developed. We recommend that these specifications should set out what reasonable services should be expected to provide. They should cover specific clinical areas including ASDs, perinatal mental health, and eating disorders, as well services which currently fall between the Tiers, including out-of-hours, outreach and paediatric liaison. We recommend that the taskforce should carry out and publish an audit of whether services are meeting these minimum standards.

117. We welcome the Minister's commitment to establishing 'Pioneer sites' of best practice within CAMHS, and we again urge the taskforce to consider the evidence submitted to this inquiry in helping to identify high performers. In our view supporting other commissioners and providers to improve will require more than simply holding up examples of good practice. Detailed analysis should be undertaken to establish how these areas have managed to secure these improvements, in order to make these approaches easier to implement in other areas, and pioneer sites should make an explicit commitment to evaluate and share their learning.

118. In addition to the universal concerns expressed about CAMHS services, we also received written submissions highlighting problems with CAMHS services being experienced by children and young people suffering from particular conditions, or from especially vulnerable groups of society. Specific conditions included OCD, ASDs, ADHD and Eating disorders; vulnerable groups included children and young people in the care system, and those who have been adopted or fostered; homeless young people, asylum seekers and recent immigrants; lesbian, gay, bisexual and transgender young people; and bereaved children and young people. The breadth of different conditions and different populations covered in our written submissions is indicative of the complexity but also the importance of the task facing CAMHS services. This inquiry does not have the scope to consider all of these issues individually, but again we recommend that the Department of Health/NHS England taskforce takes full account of the submissions we have received, and the wealth of information they contain.

119. Transition from CAMHS to adult mental health services has been described by NHS England as a "cliff edge", and the stories we heard from young people bears this out. We are encouraged to see that the Government is taking steps to address this by identifying transition as a national priority, and by supporting the development of a national service specification for transition. We will seek an update on progress towards this in six months.

120. As well as the transition to adulthood, a crucially important time for promoting good mental health is the perinatal and infant period. The Minister agreed that "nothing is more important than this". However, while the written submissions we received suggested that while some areas are providing good services for parents and babies, many are not. **There is unacceptable variation in the provision of perinatal mental health services, and we recommend this is addressed urgently. Service specifications should make clear that these services must be available in every area.**

5 Inpatient CAMHS services (Tier 4)

121. Inpatient Tier 4 services are inpatient services for the most unwell children and young people whose mental health problems cannot be managed on an outpatient basis. Our submissions have described difficulties in accessing inpatient care for children and young people who have been assessed as requiring admission to hospital, with, in many cases, no beds being immediately available. When this happens, alternative arrangements have to be made to care for the child or young person until a CAMHS Tier 4 bed becomes available, which can often give rise to dangerous situations, as shown in the following stark examples from the Royal College of Psychiatrists:

‘Bipolar high risk patient had to be managed by parents at home went missing for a week because they couldn’t look after her’

‘Anorexia patient lost further 10% body weight waiting for bed’

‘Risky situations arose in acute paediatric ward when numerous patients with mental health difficulties on ward at same time and 'ganged up' to confront nursing staff. Indirectly related to nursing staff not having training or skills to manage mental health needs of these patients.’

‘paed bed bay unsafe w access to glass, ligature points and barricading possibilities. Attempted ligature. Restraint by 5 man hosp security team and IM tranquillisation [age 14]. Another, police involved and prolonged handcuffs also age 14’

‘Young person (aged 15) on Section 136 in the police cell. It took 18 hours for the police surgeon to see her and then when the psychiatrist saw her it was not until 38 hours after admission to the cells that a bed was found for a section 2 in a distant city’

‘Admission to adult ward while awaiting bed has resulted in adverse experiences for some YP despite best attempts to provide appropriate care e.g. witnessing successful suicide attempt, assaulted by adult patient.’¹⁵⁸

122. Inappropriate admission of young people to acute paediatric wards was raised as a problem by many of those submitting evidence, including Birmingham Children’s Hospital NHS FT:

Currently there are 4 Birmingham young people on paediatric wards awaiting a Tier 4 bed. We understand there are a further 14 across the region waiting for beds. These are the young people at most risk of suicide and we believe the current level of risk in the system is unacceptable.¹⁵⁹

158 The Royal College of Psychiatrists [\[CMH0173\]](#) Annex B, pp33-34

159 Birmingham Children’s Hospital NHS Foundation Trust [\[CMH0130\]](#) para 8

123. Worcester County Council state that “first and foremost, the most serious current issue in Worcestershire is the risk to children and young people's safety as a result of the national crisis in access to CAMHS Tier 4 in-patient facilities”:

The growing problem manifested itself over the last few months when our Acute Hospitals Trust raised major safety concerns when several CAMHS patients were kept inappropriately in an acute paediatric ward whilst waiting for a Tier 4 bed.¹⁶⁰

124. An alternative to an inappropriate admission to a paediatric ward is for a child or young person to receive more intensive CAMHS support in the community whilst awaiting a bed, but this too can lead to unsafe situations:

Other children and young people have been supported intensively in the community for long periods whilst on the waiting list for a Tier 4 bed. The longest delay to date has been 4 weeks, but CAMHS have recently been told that a child on the waiting list will have to wait for 6-8 weeks for a bed. This puts tremendous strain on the child, their family and the clinicians caring for them, who have to try to manage the child's condition and the significant risks to their safety that result from the lack of an appropriate safe clinical environment for their treatment.

The Worcestershire health economy is being forced to make less than ideal provision for these children and young people who are not receiving the right care in the right place at the right time and we are very well aware that at any point we could be faced with a child death that could have been prevented if there had been ready access to Tier 4 in-patient care.¹⁶¹

125. Another outcome of the absence of appropriate CAMHS Tier 4 beds may be the inappropriate admission of children and young people to adult mental health wards. Data published in March by the HSCIC reveals that the number of children and young people being treated in adult mental health facilities is rising:

In 2011–2012, 357 under-18s were treated on adult mental health wards in England, which went down to 219 in 2012-13. However, between April and November 2013 alone, the figure reached 250.¹⁶²

126. Finally, if suitable inpatient beds are not available locally, children and young people may have to be admitted to a CAMHS Tier 4 bed elsewhere in England, which in some cases may be hundreds of miles from their homes:

There have been occasions, and they seem to be increasing, when no Tier 4 bed was available in either private or NHS units across the country or the closest bed to London was in Edinburgh¹⁶³

160 Worcester County Council ([CMH0160](#)), para 3

161 Worcester County Council ([CMH0160](#)), para 4

162 [‘Children admitted to adult mental health wards ‘rising’](#), BBC news website, 11 March 2014 (accessed October 2014)

An audit over 5 months in 2012 showed that ... Children travelled to London, Birmingham, Berkshire, Norfolk - all hundreds of miles away ... Over the past year, this trend has continued. The distances involved are frequently more than those highlighted in the media recently, with Cornish youngsters being admitted to units in the private sector, which the local CAMHS have no links to, and often staying there for several months.¹⁶⁴

127. This causes great difficulties for families and friends visiting, and can also lead to longer stays in hospital as there are no links with local community CAMHS services to facilitate a swift discharge back home.

This has led to financial and emotional hardship for families, increased lengths of stay and challenges in providing optimal treatment.¹⁶⁵

128. This is not just a problem in rural areas, or areas that have limited CAMHS provision within their own region. A witness from Birmingham told us that although they in fact have sufficient local Tier 4 capacity to meet the needs of children and young people in their area, this capacity is now frequently being filled by children and young people from other parts of the country, forcing them to admit their children to units in other areas:

We are a net importer of patients from other regions. As a result, some completely ridiculous things happen. Recently, for example, we had a 15-year-old girl who came from Birmingham as a new presentation and she had to go to Newcastle for a bed, while at the same time we had someone from Newcastle being admitted to one of our beds. The lack of co-ordination is completely outrageous.¹⁶⁶

Use of police cells

129. A separate but related issue concerns the use of police cells for the accommodation of children and young people under Section 136 of the Mental Health Act. Section 136 give the police a power to remove from a public place any person an officer believes is suffering from mental disorder and who may cause harm to themselves or another and take them to a designated place of safety for assessment under the Act.¹⁶⁷ People who have been detained by the police under Section 136 of the Mental Health Act must be taken immediately to a safe place where a mental health assessment can be undertaken. This should be a 'health-based place of safety', located in a mental health hospital or an

163 Barnet Child & Adolescent Mental Health Service ([CMH0142](#)) para 4.1

164 Cornwall Partnership Foundation NHS Trust ([CMH0189](#)) p5

165 Cornwall Partnership Foundation NHS Trust ([CMH0189](#)) p5

166 Q156

167 HM Government, [Crisis Care Concordat](#), February 2014, p22

emergency department at a general hospital. They should only be taken to a police station in exceptional circumstances.¹⁶⁸

130. Growing concern about people in crisis being taken to police cells instead of health based places of safety has prompted the Government to state that each local area, as part of its own Mental Health Crisis Declaration, should commit to reducing the use of police stations as places of safety.¹⁶⁹ This will be monitored by the Department of Health, with the expectation that the use of police cells as places of safety should fall rapidly, dropping below 50% of the 2011/12 figure by 2014/15.¹⁷⁰ With regard to children and young people specifically, the Crisis Care Concordat specifies that local protocols should ensure that police custody should “never” be used as a place of safety “except in very exceptional circumstances.”¹⁷¹

131. However, figures from the Association of Chief Police Officers estimate that, in 2012/13, 580 children and young people under the age of 18 were detained under Section 136. Of those, it is estimated that 263 (45%) were taken to police custody. The CQC believes that the restrictions on access for young people to health-based places of safety in some areas are a key reason for this. A recent survey carried out by the CQC as part of its thematic review of mental health crisis care found that, while all but one upper tier local authority (county or municipal borough) area is served by a health-based place of safety, over 20% of these areas are not served by a place of safety which accepts young people under the age of 16. CQC found that 35% of the 161 health-based places of safety do not accept young people under the age of 16, and 17% do not accept young people aged 16-17.¹⁷²

132. Young people who we met with described being held in police cells as a hugely frightening and negative experience, and others argued that there was a need for police officers to be better trained in understanding and managing young people with mental health problems. Research from the Howard League estimates that nearly 74% of mental health trusts do not provide a specialised place of safety for children:

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-16s. 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

168 [New map of health-based places of safety for people experiencing a mental health crisis reveals restrictions in access for young people](#), CQC news release, 16 April 2014 (accessed October 2014)

169 HM Government, [Crisis Care Concordat](#), February 2014, pp10-11

170 HM Government, [Crisis Care Concordat](#), February 2014, p24

171 HM Government, [Crisis Care Concordat](#), February 2014, p24

172 [New map of health-based places of safety for people experiencing a mental health crisis reveals restrictions in access for young people](#), CQC news release, 16 April 2014 (accessed October 2014)

be held in a specialist facility but a police cell is used as a default place of safety for children.¹⁷³

133. They go on to argue that:

Under no circumstances should a child experiencing a mental health crisis be taken to a police station. A commitment to public safety means treating these children as vulnerable children, making sure they get the help they need, and not locking them away in a police cell. Resources need to be prioritised and in place to receive children under section 136 in specialised health-based settings to be able to assess these children quickly. Better still would be the removal of police stations as a place of safety under the Mental Health Act at least for children.¹⁷⁴

134. Drawing on a survey of their membership, the Royal College of Psychiatrists reported that:

Faculty members reported very variable experiences of S136 for children and young people. The majority reported an increase in the use of S136, including one who reported a 6 year old detained under S136. Several experienced consultants commented on the relatively recent use of S136 with the under 18s. Some described arrangements for young people, with young people admitted to adult 136 suites where staff are now enhanced CRB checked and able to manage under 18s. Others described unsatisfactory arrangements such as places of safety located in council offices or children and young people being held in Police cells for extended periods of time.¹⁷⁵

135. Oxford Health NHS Foundation Trust provided details of the collaborative work they have done with the police service and local adult mental health services:

Oxford Health NHS FT have worked with Police colleagues across all counties in which we work to ensure appropriate care for young people. For example the joint work we have done with police in Swindon, Wiltshire and BaNES to implement a policy to ensure police officers can get quick advice from CAMHS about young people they have concerns about. This has reduced use of section 136 in Swindon and Wiltshire and ensured YP get the correct assessments at the right level and kept children out of police cells.

Oxford Health NHS FT does not provide adult mental health services in Swindon Wiltshire and BaNES and so it has been particularly important to work with commissioner's adult provider (Avon and Wiltshire Partnership NHS Trust), to get access to 136 suites for under 18s who do get detained under sec 136 in that area to ensure such children are not detained

173 Howard League [\(CMH0232\)](#) p4

174 Howard League [\(CMH0232\)](#) p5

175 The Royal College of Psychiatrists [\(CMH0173\)](#) para 35

inappropriately in police cells. Where the Trust provides Adult Mental Health Services (Oxfordshire and Buckinghamshire) this has been managed in house.¹⁷⁶

136. The Crisis Care Concordat was launched by Government in February 2014, with the aim of improving crisis care in mental health:

Our Mental Health Crisis Care Concordat, launched on 18 February, makes it clear that all services should work together to minimise the chance of young people with mental illness ending up in a police cell. The Concordat builds on the objective we have given the NHS in the Mandate that every community should have plans to ensure no-one in crisis will be turned away. Unless there are specific arrangements in place with CAMHS, a local place of safety should be used, and the fact that such a unit might be attached to an adult ward should not preclude its use for this purpose.¹⁷⁷

137. However, we saw little evidence that it has yet made an impact on crisis care for children and young people, with few references to it in the written evidence we received from commissioners and providers. One witness, when asked if she felt confident that progress was going to be made with the Crisis Care Concordat, replied that, although she was about to attend a meeting about implementing it, she still did not feel confident about its impact.¹⁷⁸

Reasons for problems with Tier 4 access

138. The submissions received by this inquiry suggest that a range of factors may be contributing to the current difficulties in accessing beds. In a survey carried out by the Royal College of Psychiatrists, over 40% of respondents believed that each of the following issues were significant:

Increase in referrals, decreased capacity of social care, decreased inpatient capacity, decreased community CAMHS capacity, changes in commissioning arrangements, change in clinical need / complexity of cases.¹⁷⁹

139. In oral evidence, witnesses highlighted rising demand, new commissioning arrangements disrupting local networks that had previously worked to minimise the need for admissions, and reductions in some of the wider support systems that previously enabled young people with mental health problems to be managed in the community.¹⁸⁰ They also pointed out pre-existing problems with the distribution of Tier 4 services around

176 Oxford Health NHS Foundation Trust ([CMH0230](#)) para 42-43

177 Department of Health ([CMH0154](#)) para 34

178 Q167

179 The Royal College of Psychiatrists ([CMH0173](#)), para 14, reasons listed in order beginning with the factor that most respondents indicated

180 Q11

the country.¹⁸¹ John Rouse argued that current problems have their history in the previous commissioning system, where PCTs were variable in their approach to commissioning inpatient care:

The point about “This has never been got right” is really important, because the system we had before 1 April 2013 had different but equal problems. One of the reasons why we are in the situation we are, in terms of tier 4 beds and disparate geography, is because PCTs took very different approaches to those responsibilities. Some really got their act together, formed regional groupings and worked with their strategic health authority; places like the west midlands and the north-west had really good strategies and adequate beds, part of which are now filled from other parts of the country. Other PCTs did their own thing, did not make proper provision, and in those areas we have insufficient beds. At the very least, by bringing that all together under NHS England, we can see the problem as a whole piece and plan on a national basis, working through the 10 area teams.¹⁸²

140. Since April 2013, Tier 4 inpatient services have been commissioned on a national basis by NHS England. Following its review of Tier 4 services, NHS England has announced 50 new beds will be commissioned, to add to the 1,264 currently available in England.¹⁸³ The Minister was clear that “there have to be beds available for those who need them, and they should not be, unless it is a particular specialty, a long way away from home.”¹⁸⁴ He went on to say that NHS England plans for each area to be “self-contained” in respect to access to beds, “so that each area can be confident that they have the beds for children and young people in their area and we end this unacceptable shunting of people around the country.”¹⁸⁵ However, the NHS England review does not provide a conclusive answer on the reasons for the current problems, nor on whether there are sufficient beds:

Commissioners were requested to offer a view about whether “in theory” there were sufficient beds to meet local demand both before and after April 2013. Responses were mixed; some said theoretically there were sufficient beds locally and others had a clear view that there were not, whilst some described a mixed picture across their geography. Most noted an increase in demand since April 2013 and therefore a current insufficiency of beds.

It appears that the current difficulties being experienced are the consequence of a range of factors which adversely affect capacity. It is therefore impossible to conclude definitively whether the current level of bed provision is sufficient to meet the need. Variations in practice around admission

181 Q11; Q155

182 Q360

183 NHS England takes action to improve access to specialised mental health services for children and young people, NHS England [media release](#), 10 July 2014

184 Q341

185 Q349

protocols, approvals, availability of intensive community services and management of delayed discharges compound the picture as do bed closures and staffing problems. Some controls that were in place pre-April 2013 have been discontinued. Equally however, difficulties that were previously experienced at a local level are now seen nationally for the first time.¹⁸⁶

Quality

141. NHS England note in their written submission that they and the Care Quality Commission (CQC) had closed admission to some Tier 4 units as a result of quality concerns, and on occasions units were closing to admission due to staff shortages.¹⁸⁷ When the Committee met with young people, some described their negative experiences in Tier 4 services, which included lack of choice of treatment and of carers, feelings of isolation, a sense of 'blame' for being there, and difficulties making the transition out of hospital.

142. In the written evidence received by the Committee from individual parents, carers and service users, about a quarter of submissions referred to inpatient care, and of these, a mixture of concern and praise were noted. Some of these highly praised specialised inpatient care for the difference it had made to their lives. For example, one adolescent and her parents were highly impressed at the care and support she had received in a specialised unit, including the treatment itself, the manner of the staff, the environment and the support of a charity to enable the parents to stay near the unit at the weekends free of charge. However, both the adolescent and her parents had been deeply concerned at the insensitive and abrupt manner in which discharge was handled and the lack of continuity of care, which was reflected in submissions by other parents and carers.¹⁸⁸

143. A few parents and carers raised concerns about the lack of inpatient care locally, making it difficult and expensive for family to visit and support the child, and leading to a lack of continuity of care. One parent raised serious concerns about the practices of a particular residential unit to which his daughter had been admitted under section following extreme self-harm and a suicide attempt.¹⁸⁹

144. NYAS is a charity providing advocacy services for young people. NYAS make the following observations about the quality of care in Tier 4 inpatient units based on their work with young people:

The calibre of staff therefore is critical. Children and young people often talk to advocates about issues with staff rather than complain about what is happening. We have examples from young people which include asking the advocate to support them to raise concerns about staff attitudes which they were experiencing as punitive. In one case NYAS contributed to a resignation

186 NHS England, [Child and Adolescent Mental Health Services \(CAMHS\) Tier 4 Report](#), 10 July 2014 p86 - 87

187 NHS England ([CMH0193](#)) para 8

188 Personal experiences of CAMHS, [written evidence](#), p9

189 Personal experiences of CAMHS, [written evidence](#), p10

after which the young people reported that they were experiencing a more open and responsible culture and one in which they had more trust and confidence.

The role of unit staff is critical in affecting a positive culture. Across all tier 4 advocacy services, attitudes of staff and in particular bank staff and staff working at night are a feature of concerns raised. In one setting, young people reported to the NYAS advocate the noise being made by night staff behaving irresponsibly which affected the sleep of young people on numerous occasions. Young people often feel that they wait too long for someone to talk to them. Decisions which should be discussed and agreed with young people sometimes are not. We have examples of a points system being introduced for the tidiest bedroom with a score board visible for all staff. Another example involved young people writing on the board outside their room what time they wanted to be woken up the following morning. If one young person failed to awake at the specified time, all young people would be woken up an hour earlier the next day as a result. It is also a concern that staff are unaware of the rights of children and young people. Effective training is essential for all staff about how to communicate with children and young people, how to treat them with dignity and respect even when their behaviour is challenging. They need to be aware of the rights and entitlements which includes the legislative framework.

Food and the quality of it is a recurring theme across all the tier 4 services in which NYAS provides an advocacy service.

It is critical to the recovery of children and young people that tier 4 settings do not fall back into institutionalising the staff and the patients. Responses from tier 4 managers of these settings to issues raised by advocates on behalf of children and young people is constructive but the actions they need to make take a long time.

We also have positive feedback from children and young people about their experiences of tier 4 settings, including having a say in the décor of the unit.¹⁹⁰

Commissioning inpatient CAMHS services (Tier 4)

145. In April 2013, NHS England took over commissioning of Tier 4 inpatient services. Fifteen months later, in July 2014, they published a review of inpatient services, and announced the commissioning of 50 extra inpatient beds, with further beds moved according to need.¹⁹¹ As mentioned in the previous chapter, the move to national

190 NYAS ([CMH0081](#)) pp3-5

191 NHS England takes action to improve access to specialised mental health services for children and young people, NHS England [media release](#), 10 July 2014

commissioning replaced the system of local commissioning by PCTs, which had reportedly led to geographical variation, as described by this provider organisation:

In the past these services were patchy and there was considerable variation across the country with some areas having little or no access to beds. As a result, the move to national commissioning seemed like a good idea...¹⁹²

146. Some written evidence we received was positive about the new commissioning arrangements:

The structure of NHS England with a single Account Manager and supporting Local Area Teams works extremely well. This is the most cohesive commissioning and management structure that the NHS has had. As an independent sector operator, Alpha Hospitals has found working with NHS England to be hugely supportive. NHS England drives tangible improvements in the quality of care that they commission. They get to know services inside out and work in total partnership with services to drive forward the patient experience and the quality of the service.¹⁹³

147. Even some witnesses who were critical about how the new arrangements were working remained supportive in principle of national involvement in commissioning.¹⁹⁴ However, our evidence highlighted a number of problems with NHS England's commissioning. Central and North West London NHS Foundation Trust raised the following issues:

We have received no communication regarding access and discharge arrangements since the move to National Commissioning. We co-ordinate the North West London Out of Hours Emergency CAMHS response which makes this particularly concerning ... We have been unable to engage NHS England in discussions regarding the current lack of in-patient beds and have therefore no agreed contingency plans to manage this. We have been left to negotiate with our local paediatric and adult ward bed managers with no support from the responsible commissioners ... We are being asked for data regarding admissions and discharge data by local CCGs/CSU because it is not forthcoming from NHS England ... No analysis of trends (and therefore barriers/problems) is being undertaken (or if it is then it is not being shared) to support understanding, planning and solutions.

This is all having a significant impact on our ability to meet the needs of our service users and deliver our contracted services effectively and safely. Prior to the move to NHS England local CAMHS commissioners played a significant role in supporting and brokering partnerships between health, education and social care services to support discharge and avoid delays. This

192 Barnet Child & Adolescent Mental Health Service ([CMH0142](#)), para 4.1

193 Alpha Hospitals Ltd ([CMH0068](#)), para 4i

194 Steve Buckerfield, Q255; Dr Diwakar, Q161

support is no longer available and this may go some way to explaining the huge problems we now face in accessing appropriate in-patient beds.¹⁹⁵

148. Steve Buckerfield of North West London Commissioning Support Unit also described difficulties in collaborating with NHS England:

That is probably not because they are unwilling but because they are currently too consumed with their own process. They explain they are still trying to find the contracts, and they do not understand how it works with their area teams and specialist teams. You remain sympathetic, but then you go back and they will not tell me who is in hospital. I used to know all the children who were in hospital; now I don't—they tell me to go and ask my provider. That lack of exchange of information with clinical commissioning groups is ridiculous. That is the bad side, I would say, and the answer is to force people to collaborate.¹⁹⁶

149. Barnet, Enfield and Haringey Mental Health Trust put it in strong terms:

A considerable amount of clinical time is also being spent trying to track down beds as there does not seem to be any centralised information available For the Tier 4 situation to be alleviated, it is vital that NHS England take control of the inpatient commissioning process. There needs to be a centralised structure where the use of beds is approved, as was previously the case with local commissioners, but also monitors the bed availability and can advise the closest bed to the requestor.¹⁹⁷

150. Dr Diwakar of Birmingham Children's Hospital NHS Foundation Trust told us that in his view, the lack of effective national co-ordination of inpatient beds, which led to children being transported across the country, was 'completely outrageous'¹⁹⁸ Dr Diwakar also felt that in his view, there is insufficient co-ordination of the bed-finding and admission process by NHS England, and described paediatric intensive care as an example of a similar, highly specialised service which is better co-ordinated, with a single number that clinicians can call:

Families need to know what they have a right to expect, who is responsible for delivering it and what they can do if they don't get it. What I am not seeing at a national level for tier 4 is somebody who says, "It is my responsibility to get your young person admitted to the nearest tier 4 bed that can meet your needs."If I take the example of paediatric intensive care ... again you do get periods where the service is overwhelmed and children have to be transported across the country. But certainly what happens in the west midlands is that there is a single number that you can ring if you are a

195 Central and North West London NHS Foundation Trust [\(CMH0132\)](#) pp3-4

196 Q255

197 Barnet Child & Adolescent Mental Health Service [\(CMH0142\)](#), para 4.1-4.2

198 Q156

paediatrician wanting an intensive care bed ... there is a service that is extremely responsive to the needs of children who are critically ill. I think we should aim to get the tier 4 service into exactly the same state, where there is central co-ordination either at a regional or national level which allows families to know that there is a single person or team who is responsible for finding the most appropriate placement and you can give them a name so that they have an identity.¹⁹⁹

151. The press release accompanying the NHS England review notes “weaknesses in commissioning and case management”²⁰⁰; further detail is provided in the review report:

Whilst the new commissioning responsibilities since April 2013 have been perceived by some as the cause of recent difficulties, there are other factors around past variation in practice and provision which have significantly influenced the situation. Arrangements that may have been in place by previous commissioners to manage demand largely disappeared on 1 April 2013. There were few if any posts in specialised area teams to place, manage or monitor the use of CAMHS Tier 4 in the first 6 months from April 2013 (now some case managers in place temporarily). Specialised area teams inherited an arrangement whereby their CAMHS Tier 3 providers could place young people anywhere there was a bed available, without nationally agreed access criteria or funding flow arrangements being in place.

Areas which had previously worked to ensure sufficient capacity was available to them have expressed concern that the capacity in their area is now being used by other areas, for a variety of reasons, including insufficient provision elsewhere and lack of robust access assessment (which includes consideration of safe/effective alternatives to admission). This in turn impacts upon their ability to access local capacity for local young people. Thus the effects of shortfalls in provision in some areas are now over-spilling. The system put in place for commissioners to notify each other of a placement being made out of area was reliant on providers notifying commissioners of out of hour’s placement. This was not universally adhered to. Information systems to track patients were not in place. They have since been developed although implementation is hampered by capacity ...

... In addition, where there were excellent local commissioner and specialised commissioner relationships previously in place these have been affected due to changes in personnel, capacity and/or understanding of responsibilities. This situation needs to be addressed.²⁰¹

199 Qq 164-165

200 NHS England takes action to improve access to specialised mental health services for children and young people, NHS England [media release](#), 10 July 2014

201 NHS England, [Child and Adolescent Mental Health Services \(CAMHS\) Tier 4 Report](#), 10 July 2014, pp 20-21

152. NHS England report that they are now planning to recruit 10-20 new case managers to ensure that young people receive appropriate levels of care.²⁰² Kath Murphy told the Committee that “over the years we have found that having case managers, particularly in specialised commissioning, is very effective, because it keeps track of individuals”²⁰³

Education for children in inpatient CAMHS

153. A specific issue raised by young people the Committee met was that of poor educational provision in Tier 4 services, and the wider impact of mental health problems on young people's education. Young people argued that there was not enough time spent on education in Tier 4 inpatient units, and also that the quality of it was poor. This issue was also raised by NYAS: “Education, activities and the quality of them are not consistent. This makes a return to community education harder for some.”²⁰⁴

154. There is limited information available on education provision in inpatient CAMHS services, although in November 2013, OFSTED published a special report of an inspection of education provision for children and young people who do not, or cannot, attend full-time school education in the usual way, including, amongst other groups, those who have mental health needs and access Child and Adolescent Mental Health Services (CAMHS). The report, based on a sample of 15 local authorities, concluded that:

In too many of the local areas visited, provision was not flexible enough so that some children and young people had only a few hours of education each week. For example, those with the most significant mental health needs frequently had effective, full-time education in hospital or healthcare settings, but such provision was less frequent for those using community mental health services. Ofsted does not routinely inspect some of the education provision visited for this survey, because it is run as a local authority service or a health service rather than as a school.²⁰⁵

155. We raised this issue with the Minister, and he told us that “it is something that clearly has to change. You have identified a real problem”.²⁰⁶ However, representatives from NHS England suggested that even though they commissioned Tier 4 services, the education delivered to children within those services was not their responsibility:

It is an issue that has been raised, and it is my understanding—I am happy to be corrected—that it is education's responsibility to be providing education in those units, so we expect those units to discuss improving provision with the local education authority ... I cannot respond on the local education

202 NHS England takes action to improve access to specialised mental health services for children and young people, NHS England [media release](#), 10 July 2014

203 Q374

204 NYAS ([CMH0081](#))p4

205 OFSTED, [Pupils Missing Out on Education: Low aspirations, little access, limited achievement](#), November 2013, p8

206 Q395

authority not putting the education in. We can pursue it with that provider, but we need the area teams to pursue it. That is very much a local education authority responsibility.²⁰⁷

156. In a follow up response to our evidence session, the Minister stated that NHS England would, in fact, now be conducting further work in this area:

NHS England are liaising with OFSTED to identify Child and Adolescent Mental Health Services (CAMHS) in which educational provision has been identified as requiring improvement, or as inadequate. NHS England will be asking its Area Teams to engage at local level to understand the underlying issues in each case. This will include seeking to understand the working relationship both with the educational providers and with the Local Authorities that commission them. NHS England will be asking whether there are other ways in which it can use its influence as a CAMHS commissioner to facilitate the improvement of educational provision.²⁰⁸

157. We also asked the Secretary of State for Education for her view on this:

We recognise there are concerns around education provision and standards in Tier 4 CAMHS. Provision is made in a range of different ways. This can be necessary to provide for children with very specific circumstances, but can affect funding, commissioning and accountability for quality. We are working on with the Department of Health and NHS England to get better information on how provision is made and to identify whether further specific action is needed.

In terms of quality, Ofsted inspects hospital education when it is provided by a 'hospital school' and all registered alternative provision. But we know that in some smaller medical units, such as Tier 4 CAMHS provision, the education may be through an individually commissioned arrangement rather than a hospital school and hence not inspected by Ofsted. This is a particular area where we recognise we need better information to inform future activity.²⁰⁹

Conclusions and recommendations

158. It is clear that there are major problems with access to Tier 4 inpatient services, with children and young people's safety being compromised while they wait, suffering from severe mental health problems, for an inpatient bed to become available. In some cases they will need to wait at home, in other cases in a general paediatric ward, or even in some instances in an adult psychiatric ward or a police cell. Often when beds are found they may

207 Qq 394-95

208 Written evidence submitted by Rt. Hon Norman Lamb MP, Minister of State for Care and Support ([CMH0234](#)) pp1-2

209 Department for Education ([CMH0236](#)) p 3

be in distant parts of the country, making contact with family and friends difficult, and leading to longer stays.

159. Linked to this, the Committee is particularly concerned about the wholly unacceptable practice of taking children and young people detained under s136 of the Mental Health Act to police cells, which still persists, with very few mental health trusts providing a dedicated place of safety for children and young people.

160. It is wholly unacceptable that so many children and young people suffering a mental health crisis face detention under s136 of the Mental Health Act in police cells rather than in an appropriate place of safety. Such a situation would be unthinkable for children experiencing a crisis in their physical health because of a lack of an appropriate hospital bed and it should be regarded as a 'never event' for those in mental health crisis. In responding to this report we expect the Department of Health to be explicit in setting out how this practice will be eradicated.

161. Alongside problems with access to inpatient services, we also heard from young people and their parents, as well as those who work with them, of quality concerns in some inpatient services; NHS England reported that over the past year some inpatient services have in fact been closed owing to quality concerns.

162. Written submissions to this inquiry have described a situation where despite the move to national commissioning over a year ago, NHS England has yet to 'take control' of the inpatient commissioning process, with poor planning, lack of co-ordination, and inadequate communication with local providers and commissioners. While many of the difficulties NHS England is now seeking to address may be a legacy from previous arrangements, it has not, in our view, sufficiently prioritised these problems. We note that in addition to the new capacity that is being funded, NHS England is recruiting more case managers to give them better control over the commissioning process, but we are disappointed that during its first year as a commissioner of inpatient services, many of the perceived benefits of national planning have not been realised, and NHS England has instead presided over a system which has resulted in children being sent hundreds of miles to access care. We intend to review NHS England's progress addressing these problems early in 2015.

163. As a first step in improving its commissioning of Tier 4 services, we recommend that NHS England should introduce a centralised inquiry system for referrers and patients, of the type that is already in operation for paediatric intensive care services.

164. NHS England has announced 50 extra inpatient CAMHS beds, but by its own admission, it is not clear how many beds are needed to provide sufficient Tier 4 capacity. It is essential that the extra beds are commissioned in the areas which need them most, and are supported by an improved system of case management. We will seek an update on progress in this in six months.

165. As well as the well-publicised concerns relating to access to inpatient services, the young people we met with who had experience of inpatient CAMHS services gave us insight into a further problem, relating to the quality of education children and young people receive when they are being treated in inpatient units. We were very surprised when NHS England, which is responsible for commissioning inpatient services, stated that this was not its responsibility; since then, it appears that both NHS England and the DFE are taking steps to investigate this further.

166. We believe that education is crucial to protecting the life chances of the especially vulnerable young people who need inpatient treatment for mental health problems, particularly as in some cases these admissions may last many months. It is essential that clear standards are set for the quality of education provision in inpatient units, and that there is clear accountability and ownership for ensuring that these standards are upheld. As a first step towards this, we recommend that OFSTED, DFE and NHS England conduct a full audit of educational provision within inpatient units as a matter of urgency.

6 Bridging the gap between inpatient and community services

167. Intensive services provided in the community can act as a bridge between inpatient services and community services, with the aim of preventing the need for an admission, or facilitating more swift discharge back to the community. These services are variously described as 'Tier 3.5', 'Tier 3+', 'assertive outreach' or 'intensive community' CAMHS services. Out-of-hours and crisis services are also essential for responding to children and young people who need urgent assessment and treatment; paediatric liaison services, based within acute hospitals rather than CAMHS services, can also act as an important link, where they are available. The evidence we have received has described the important contribution these services can make, but has highlighted the fact that provision of such services is highly variable, and has suggested that this might be a more useful focus for investment than inpatient services.

Out of hours/crisis services

168. Peter Hindley told the Committee that young people “will not necessarily need to be admitted if they are assessed quickly and can be linked into appropriate community service. You can often avert a crisis with a good out-of-hours assessment.”²¹⁰ Dr Diwakar described the positive impact of an out-of-hours emergency response team which they have recently introduced in their area:

Yesterday I was in our main hospital operations centre and there were seven children waiting on various wards for gateway assessments, waiting for a bed in tier 4 or waiting for social support. When you present in crisis there does need to be 24/7 access to an emergency response team, which we again have. It has only gone in in the last year. That again for me, as a paediatrician, has been a fantastic addition to the service because one can now react quickly to children and young people, whereas, before we had that service, a child would be admitted and I, as a paediatrician, would go and see them the next day. I do not have a lot of mental health training and would have to say, “I am sorry, you have to wait for the psychiatrist,” ... Because they only came twice a week, this wasted an in-patient bed and also proved to be very frustrating for the young person, who would often try and take their own discharge. In my view, the response, in terms of an emergency response team that can go to local hospitals, is going to be absolutely essential.²¹¹

169. However, according to the Royal College of Psychiatrists written evidence, provision of out of hours care varies across the country:

²¹⁰ Q15

²¹¹ Q164

The CAMHS Benchmarking report says that less than 40% of services offer rapid access through crisis pathways. In our survey of access to inpatient services 20% of respondents said that they did not have an out of hours service.

Some areas were able to provide comprehensive out of hours services with CAMHS specialists providing first-line assessments but several reported difficulties in maintaining rotas of child and adolescent psychiatry higher trainees because of reduced numbers.²¹²

170. The Black Country Partnership NHS Foundation Trust told us that, while provision of 24 hour cover to A&E services was well supported in one of the boroughs they serve, in another, there was no provision.²¹³ North West London Commissioning Support Unit told us that in their view,

The very limited CAMHS available outside of office hours steers young people towards A&E and access to Out of Hours Service. Crisis or home treatment services for young people are not widely established with young people are being admitted to paediatric wards or CAMHS inpatient units. ... Significantly enhanced Out of Hours CAMHS would be in a much better position to provide support to young people and the Police facing a potential Section 136 detention.²¹⁴

171. Young people the Committee met with also described poor experiences of care in A&E departments—including poor knowledge of mental health, poor communication, lack of privacy, and lack of proper discharge arrangements - and on paediatric wards, including young people being cared for by security guards rather than clinicians. Discussing urgent out of hours care, young people from the Surrey County Council Youth Advisors group made the following observations:

All members reported that urgent out of hours care was a very de-personalised service, and consisted of being told to go to A and E. In A and E the young people reported being assessed very slowly with little mental health support. One girl said she had overheard nurses saying she was bed blocking and promises of a mental health nurse coming to sit with her were never followed through.²¹⁵

172. The GIFT partnership state that they have seen 'frustrations ... in getting services when in crisis. Most CAMHS do not seem to be set up to respond in a safe and timely

212 The Royal College of Psychiatrists ([CMH0173](#)) para 33-34

213 Black Country Partnership NHS Foundation Trust ([CMH0166](#)), para 38

214 North West London Commissioning Support Unit, ([CMH0211](#)) pp3-4

215 CAMHS Rights and Participation Team ([CMH0069](#)) p2

manner to crisis. These crises then escalate and can become very risky for children, young people and their families concerned, and any professional already working with them.”²¹⁶

173. In the written submissions received by individual parents, carers and service users, descriptions of crises formed a central part of the vast majority of submissions, and the complete absence of crisis support was highlighted as a key failing. Parents and carers reported being routinely advised to take their children to A&E in a crisis, which they regarded to be a wholly inappropriate environment for a distressed child. In many instances they had needed to call police and emergency care services for support. One parent highlighted that out-of-hours support in her area had been good until the 111 telephone helpline was introduced, after which point she had been unable to access suitable support.²¹⁷

Paediatric liaison

174. Paediatric Liaison teams, which consist of mental health professionals based within the paediatric teams of acute hospitals, can make an important contribution in this area, as Dr Sebastian Kraemer, a paediatric liaison psychiatrist at the Whittington Hospital described to the Committee:

Actually, where do you go in an emergency? You go to casualty. What happens in casualty if you are under 18? You go into a paediatric ward. If there is no mental health resource on that paediatric ward, then the child is an embarrassment, is frustrating paediatric staff, they are upsetting them and they are complaining. If there is a psychiatrist there—we have 24-hour-a-day psychiatry to the paediatric ward—they are grateful. They know it is part of their job to look after under-18s in crisis—deliberate self-harm and even psychosis. Some of them may need brain scans and the like, so they are in the proper place to be medically investigated. Then they will be pleased and they will do a good job. The paediatricians do a fantastic job in looking after seriously unhappy, disturbed young people because they have psychiatry on tap night and day. That is one point. That can only really survive if it is commissioned as part of a paediatric service. CAMHS is not going to provide this.²¹⁸

175. Paediatric Liaison teams play a broader role as well:

Paediatric liaison services are multi-disciplinary child and adolescent mental health services in the acute hospital setting. Their main focus is on: the acute management of psychiatric emergencies in the acute hospital (self-harm, delirium, acute disturbance of behaviour, acute psychosis); the identification and management of mental health problems in children with physical

216 GIFT Partnership ([CMH0159](#)) para 1.4

217 Personal experiences of CAMHS, [written evidence](#), p7

218 Q210

conditions (e.g. depression in the context of terminal illness such as cancer); the management of unexplained medical symptoms (e.g. conversion disorder, complex pain in the context of psychosocial difficulties); and the overall promotion of positive mental health in the acute hospital setting. Families may require help in coping with a newly diagnosed illness or managing a chronic illness. Mental health problems in parents interfere with parenting and may affect the mental health and coping of the children. (*Paediatric Liaison email group, 2014*). Identification of these issues early in the context of the medical treatment, significantly improves health outcomes and reduces costs. The RAID study demonstrated a saving of at least £4 for every £1 put into a liaison service for adolescents and adults (*Tadros et al, 2013*). Similar findings would be expected to be saved in a service aimed at children and adolescents.²¹⁹

176. Dr Isobel Heyman explained the importance of this:

Mental health disorders such as anxiety, depression and disruptive behaviour are much more common in children with long-term physical illnesses, such as diabetes or epilepsy, than in healthy children[4-7]. These mental health disorders impact significantly on children's development, functioning and quality of life, the implications of which persist into adulthood. Overall, mental illness has the same effect on life-expectancy as smoking, and more than obesity [8]. The mental health disorders often go unnoticed and untreated [9-11], and may also aggravate the physical health disorders. For example, depression in children with diabetes is associated with poorer control of blood sugar, increasing the risk for later serious complications such as loss of vision.²²⁰

177. However, while the Committee did hear of examples of good practice such as these, many highlighted the lack of paediatric liaison services. Sebastian Kraemer argues that “far too few paediatric departments have sufficient experience of timely and competent liaison. Despite a steady stream of national policy recommendations and research in the past decade there has never been a critical mass of first hand clinical knowledge of dedicated paediatric liaison teams in general hospitals.” He points out that Paediatric Liaison services are often ‘invisible’ because they do not fall clearly within any of the 4 Tiers, and suggests they could be categorised as “Tier 3 ¾”. Central and North West London NHS FT trust also highlight the difficulties around commissioning and funding such services:

There is a lack of clarity regarding who the responsible commissioner is for [Crisis Response and Paediatric Liaison] services and as such these areas are not well developed within CAMHS services. Expectations are high that services will adapt and provide interventions in these areas, however Trusts are often not specifically commissioned to deliver these interventions. The

219 Barnet Child & Adolescent Mental Health Service ([CMH0142](#)) para 2.1

220 Dr Isobel Heyman ([CMH0138](#)) para 2b

fact that they are delivered via hospital A&E and paediatric wards and therefore serve non local patients is an added difficulty that is not supported by clear specifications and charging policies ²²¹

Tier 3.5 assertive outreach/intensive community services

178. Tier 3.5 assertive outreach/or intensive community services provide enhanced support for children and young people on the boundary between needing Tier 3 and Tier 4 services, as described by a service in Oxford:

Provision of highly flexible and responsive community Outreach Service that provides a service 24/7.

Team prevent admission and facilitate discharge

Proactively 'tracking down' young people that are high risk but do not always attend appointments.

Has proven to shorten length of admission from over 120 days to 50-70 days

Provides stability to local placements for young people that are in care by working proactively with the Young person and wider care system by providing support, supervision and consultation to Children in Care Nurses, Social work staff, educational staff, residential care home staff.

Keeps people closer to home.

Diversion policy agreed with the police to ensure the prompt assessment of young people picked up by the police and reducing the need for mental health act assessments and holding in police stations. This has been seen a model of good practice and reduced the use of section 136 of the mental health act in under 18year olds in our area. ²²²

179. Derbyshire Healthcare NHS Foundation Trust gave further details of a successful pilot in their area:

Tier 3 Plus Service (CAMHS Crisis Home Treatment Service)

The PCT commissioned the Derby City Tier 3 plus pilot in 1st March 2011. The funding provided was £85k per year which supported the development and establishment of a pilot tier 3 plus intervention by two workers. The full evaluation report has demonstrated a significant reduction in Tier 4 placements though the provision of enhanced community interventions. For those requiring admission, it has been shown to have a significant reduction in the actual length of stay. Evidence based assessment tools such as CGAS

221 Central and North West London NHS Foundation Trust [\[CMH0132\].p6](#)

222 Oxford Health NHS Foundation Trust [\[CMH0230\]](#) para 21

and HONoSCA have shown significant improvement in the overall clinical functioning and clinical outcomes for the young people who had accessed the service (ref: Young Persons Specialist Service Evaluation Report–Pilot 3+ Project 2013 Scott Lunn).²²³

180. However, almost two thirds (64%) of 96 CAMHS providers surveyed for the NHS England review said they did not have an intensive outreach team.²²⁴ Derbyshire Healthcare NHS Foundation Trust report that their pilot has not received ongoing funding²²⁵.

Commissioning incentives for Tier 3.5 services

181. A strong theme emerging from our inquiry is the need, wherever possible, to prevent admissions to Tier 4 services by providing more intensive Tier 3.5 services in the community, which have proved to be effective. However the Committee has been told that since the division of commissioning responsibilities between NHS England (responsible for commissioning Tier 4 services) and CCGs (responsible for commissioning Tier 3) there are now no incentives to fund such services, and that there are also fewer incentives for Tier 4 providers to discharge their patients in a timely manner. Dr Rao explained how the change in commissioning arrangements has the potential to undermine progress in developing Tier 3.5 services:

Three years back, before the division from the CCGs and NHS England was brought about, the CCGs—then the PCTs—were asked to top-slice some amount of their budget to form a regional fund to create beds for the region because the demand was small but very intense. The idea then from that team, which provided the beds working along with the PCTs, was to create a tier 3+ model. It has been shown everywhere that it can decrease the amount of admissions to these in-patient beds. This was the same commissioning body which was proposing that we should work together with the PCTs to create a tier 3+ service, but, once this divide comes through from the CCG and NHS England, that same commissioning body will say that tier 3+ is a CCG problem and the CCG will say that a lack of beds is an NHS England problem.²²⁶

182. Worcester County Council describe an effective intensive community support service (Tier 3+) that they have worked hard to provide for young people on the threshold of needing inpatient services, despite the disincentives, but state that “It is unacceptable that

223 Derbyshire Healthcare Foundation NHS Trust ([CMH0191](#)) p5

224 [NHS England Report](#) pp129-130

225 Derbyshire Healthcare Foundation NHS Trust ([CMH0191](#)) p6

226 Q157

CCGs are carrying the risk both in terms of the management of the patient and the inevitable financial risk of the additional investments we have made.”²²⁷

183. Eating disorders provides another example of the difficulties in redirecting funding from inpatient to outpatient services. Dasha Nicholls, Consultant Psychiatrist at the Feeding and Eating Disorders Service at Great Ormond Street Hospital, states that “anorexia nervosa is the third commonest chronic illness of adolescence and has the highest morbidity and mortality of all psychiatric disorders”, and that “eating disorders is one of the, if the not the, commonest reasons for CAMHS inpatient admission”, but in fact “the best evidence based treatments are outpatient treatments”.²²⁸ South London and the Maudsley NHS Foundation Trust cite research suggesting that their eating disorder service, which results in some 68% of patients being well enough to be discharged after one year, in fact admits fewer than 10% of patients to inpatient care.²²⁹ Despite this, Dr Nicholls states that “the majority of resources for eating disorders are directed towards inpatient care and adult services, both in the NHS and independent sector.”²³⁰ In their written submission, Birmingham Children’s Hospital NHS FT describe an outpatient service they had planned for Eating Disorders, which has the potential to reduce demand on Tier 4 services, being ‘shelved’ because of the lack of a funding mechanism.

Our strategy for Eating Disorders had been to develop an outpatient model of Family Based Treatment which we have previously successfully trialled. This is shelved as there is no funding mechanism, but given its potential to reduce demand for inpatient admission this seems short-sighted in managing the system more efficiently and effectively.²³¹

184. Barnet Child & Adolescent Mental Health Service argue that the division of Tier 3 and Tier 4 commissioning may also contribute to delayed discharges:

Unfortunately, what has been lost was the cost of these beds being the responsibility of the PCTs, which means we have also lost the financial incentive to keep admissions short and return children to the community for their treatment. We have seen lengths of stay increase considerably as all Tier 4 units are paid to keep their beds full and so there is a perverse incentive to keep admissions longer and not admit new patients at the risk of increasing overall workload for no benefit.

Community services also don’t have the PCTs demanding they discharge the young person as this function so far has not been taken on by NHS England. As a result Tier 4 services, which were already a precious resource, are less available now than they were before and indeed there have been occasions,

227 Worcester County Council ([CMH0160](#)), para 11

228 Dr Dasha Nicholls ([CMH0105](#)), p1

229 South London and Maudsley NHS Foundation Trust ([CMH0227](#)) p4

230 Dr Dasha Nicholls ([CMH0105](#)), p1

231 Birmingham Children’s Hospital Foundation Trust ([CMH0130](#)) para 10

and they seem to be increasing, when no Tier 4 bed was available in either private or NHS units across the country or the closest bed to London was in Edinburgh.²³²

185. Priory Healthcare, an independent provider of inpatient mental health services make the same point:

Of additional concern to Priory is the lack of incentives for local trusts to facilitate early discharge. Local Tier 3 services were previously perceived as a re-investment of money and resource saved through reduced length of stay. Broadly speaking, however, such benefit is no longer being appropriately felt, with money following the patient through specialised commissioning, resulting in a rise in delayed discharge and bed blocking.²³³

186. The Minister told us that in his view, the current fragmented system of commissioning CAMHS was 'dysfunctional'²³⁴:

The fragmented commissioning, to me, makes no sense. We have commissioning from local authorities, from schools, from CCGs and from NHS England. That, ultimately, cannot make sense I am looking to find ways in which we can align commissioning—ideally, ultimately, to pool the budget as far as is possible ... There is an opportunity now to get a much more rational system, but I agree with your analysis.²³⁵

Conclusions and recommendations

187. We have heard that out-of-hours crisis services, paediatric liaison teams within acute hospitals, and Tier 3.5 assertive outreach teams can have a positive impact, including reducing both risk and length of inpatient admission; however availability of such services is extremely variable. The experience of care reported by those young people suffering a mental health crisis remains extremely negative.

188. It is clear from the evidence we have received that commissioning extra inpatient capacity alone will not be enough to alleviate the current problems being experienced in relation to Tier 4 services. Perverse incentives in the commissioning and funding arrangements for CAMHS need to be eliminated to ensure that commissioners invest in Tier 3.5 services which may have significant value in minimising the need for inpatient admission and in reducing length of stay. The Department of Health and NHS England must act urgently to ensure that by the end of this year all areas have clear mechanisms to access funding to develop such services in their local area, where this is appropriate.

232 Barnet Child & Adolescent Mental Health Service ([CMH0142](#)), para 4.1

233 Priory Healthcare, ([CMH0145](#)) para 4.3

234 Q445

235 Q342

189. Looking beyond this, we agree with the Minister that the current fragmented commissioning arrangements make “no sense”, and are “dysfunctional”. A key responsibility for the newly set up Taskforce will be to determine a way in which commissioning can be sufficiently integrated to allow rational and effective use of resources in this area, which incentivises early intervention. The Government has recently announced extra funding for early intervention in psychosis services and crisis care, which could include liaison services in A&E departments, and crisis resolution home treatment teams. We recommend that the Government ensures that a substantial proportion of this new funding is directed towards services for under-18s.

7 The role of education and GP services

Schools

190. CAMHS service providers, charities, voluntary sector organisations, commissioning organisations, and young people themselves have all agreed that schools have a crucial role to play in relation to children's and young people's mental health. This involves promoting good mental health and emotional wellbeing; detecting emerging mental health problems and supporting children with them, for example through in-school counselling services; educating children and young people about mental health issues; tackling bullying; educating children and young people about safety online.

191. At the Committee's meeting with young people on 11th June, the role of schools in mental health was frequently raised:

- Young people described some school support for young people with mental health problems as really good, for example specific supportive teachers, and non-stigmatising environments (such as a separate learning support block) where young people could access support for mental health issues
- But some young people felt that teachers were 'scared' of mental health issues, or lacked knowledge and ascribed problems to puberty or bad behaviour; improving teacher training was seen as very important. School nurses were also thought to require better training about mental health
- Young people also highlighted the lack of education for young people about mental health in schools; they said they received lots of information and awareness raising about sexual health, pregnancy, drugs and finances, but none on mental health. Educating children about mental health issues from a younger age was also seen as important.

192. The NCB presented a similar overview in its written evidence:

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.²³⁶

Support for young people with mental health problems within schools

193. Mick Cooper, Professor of Counselling Psychology, at the University of Roehampton, estimates that approximately 61-85% of secondary schools in England provide young people with access to counselling, meaning that between 50,000-70,000 young people attend school-based counselling per year in England, similar to the numbers in this age range attending specialist CAMHS. This makes school-based counselling one of the principal forms of CAMHS intervention in England.

Due to its short waiting times, convenient location, and broad intake criteria, school-based counselling is perceived by many stakeholder groups as a highly accessible intervention. It is able to offer a wide range of young people professional therapeutic support in a direct and immediate way. Indeed, there is evidence to suggest that young people may be as much as ten times more likely to access a school-based mental health service as compared with a non-school-based one. This means that school-based counselling may have the capacity to act as an effective early intervention: supporting young people to address their difficulties in a timely manner, with the possibility that this will then inhibit the development of more serious problems at a later date.²³⁷

194. However, many commissioning organisations described difficulties in getting schools to engage with mental health: Mental Health Commissioners Network argue that

... the multiple agencies involved in these children's lives seem to be increasingly focused on their own single issues—'we do education' or 'we do social work' for example. And increasing complexity in the education system is leading to further embedding of those silos, particularly amongst those types of schools specifically focused on academic attainment at the cost of the 'softer' personal support of pupils; leading, for example, to the exclusion of children displaying behavioural difficulties rather than referral to appropriate support.²³⁸

195. Other commissioners described a similar situation:

In addition and despite the very positive role of the BOND project, it is very difficult to fully engage schools as commissioners of CAMHS and EWB as they tend to see these issues as being the responsibility of the local authority and health commissioners. The engagement of schools in the commissioning of CAMHS is a critical factor in delivering early recognition and intervention.²³⁹

We have commissioned a CAMHS Tier 2 service which works with universal services to build their capacity to manage children and young people with

237 Professor Mick Cooper ([CMH0059](#)), paras 2.2, 3.4

238 Mental Health Commissioners Network ([CMH0122](#)), para 6c

239 Clinical Commissioning Groups within Staffordshire and Staffordshire County Council ([CMH0142](#)) para 2.2

emotional problems and emerging mental health difficulties. However, their challenge is made greater by current education policy which leads schools to prioritise academic achievement over emotional wellbeing needs and there is an expectation that CAMHS will deal with all emotional wellbeing needs.²⁴⁰

196. Dr Liz Myers of Cornwall Partnership NHS Foundation Trust described the impact that in her view this disengagement can have on CAMHS:

Part of our increase in referrals has been young people who really should have been dealt with at school and the problems should never have got to the stage they got to. But they are not getting picked up and they are not getting the support. I am not quite sure how we can change that, given the way that education is right now. It can only be done with a lot of very clear and quite directive instructions around collaborating together.²⁴¹

197. Jody Tranter of Christ Church Primary School described the picture from a school perspective, arguing that schools need better access to CAMHS services:

As a school it is our responsibility to teach the whole child, including his/her emotional health and wellbeing but we are not mental health professionals and cannot be given all the responsibility for working with very distressed, dysfunctional or damaged young children. In short, we need help: help that is effective, available and easy to access.

My recommendations would be thus:

A trial of a hub/school based access to lower-tier CAMHS provision

An increase of resources available to CAMHS in order to increase capacity and provision for children at risk of disengagement or exclusion

A re-thinking/re-classification of the boundaries of what qualifies as a mental health issue so that children that are violent and aggressive are not simply dismissed or forwarded to social workers or parenting groups who are not equipped or qualified to make mental health interventions²⁴²

198. We did hear examples of successful collaboration between schools and wider CAMHS services:

Schools are completely vital in identifying early signs of mental health or low-lying issues that might develop into something serious. The role of the school nurse is particularly important in supporting those young people. For instance, in Essex, a lot of counselling is taking place in schools. We have quite a mixture of services that are provided straight away when we identify

240 Worcester County Council ([CMH0160](#)) para 14

241 Q172

242 Jody Tranter ([CMH0147](#)) paras 4-5

self-harm or an eating disorder. We are trying to create a rapid response to a GP or to a psychiatrist when things get a little bit more serious. We do not want schools to feel that they are vulnerable and have to deal with some of these very difficult situations all on their own. I think it is about providing support to the school nurse and the teaching staff, and also doing a lot of training with the teaching work force on issues such as self-harm and eating disorders.²⁴³

In schools in Derbyshire, we are trying to roll out a model whereby networking of those services within the school provides a platform whereby the school can monitor what is happening, who needs help, who might be in trouble, who might be being bullied and who might be at risk of self-harm. They can respond and they can draw down help from specialist services like CAMHS, rather than exporting the problem and making a referral for somebody else to deal with—they can bring the services into the school and provide the help within the school. We have had examples where there has been a sharp increase in presentations of things like self-harm, and the school, with those services, puts on a series of information events for students and for parents, bringing in people from the safeguarding board and other services to talk about online security, and opening parents' eyes to what is actually going on—the bullying that can take place. They are providing that information so that the parents are getting help and the young people are getting information and help. That has shown that young people refer themselves for help; it is almost unprecedented within CAMHS, but they will do that in a school where there is a CAMHS presence. It can be done discreetly, in their lunch hour or after school, on their terms, the way they feel comfortable. Clinic-based services that are not integrated cannot deliver that; young people would not buy into it.²⁴⁴

199. However, we heard that the school nursing resource was “very thinly spread”, and also received descriptions of helpful services being removed or restricted:

That was delivered at schools. That was an excellent service and still is, but because of how it was restructured they simply turned round and said, “We will not see now any children below the age of 10.” So all the counselling services for all those below that age just disappeared...²⁴⁵

An example was the targeted mental health in schools programme, which was exactly that—putting service into the schools. It ran for a period of years and has come to an endIt built some awareness. Our experience is that it

243 Q294

244 Q296

245 Q170

has not made a huge difference. A service was there, was provided for a brief period and then it disappeared.²⁴⁶

Guidance and training for teachers

200. Along with the young people we met, several organisations and witnesses agreed on the importance of the inclusion of mental health issue in teacher training. Liverpool CAMHS Partnership suggested that

A clear recommendation for prevention and early intervention however is to ensure mental health and emotional wellbeing is a key component of teacher training and built into continual professional development of the children's workforce.²⁴⁷

201. Children and Young People's Mental Health Coalition state that

Teachers are often the first people young people will go to if they are experiencing mental health problems. However, teachers have little or no training in mental health and child development. We believe that these topics should be incorporated within their initial training and within Continuous Personal Development (CPD). We suggest that as a minimum, schools access e-learning via the MindEd e-portal.²⁴⁸

202. Catherine Roche, of Place2Be, developed this point further:

We need to train teachers and to build the understanding of school staff generally—teaching and nonteaching—around children's behaviour and what lies behind that behaviour, which is often just a manifestation of a child's mental health issue. Helping teachers understand and work with that is absolutely key. We have made numerous attempts to get something in there, but one of the challenges with teacher training is how packed the curriculum is. We have been doing some great work for newly qualified teachers, so that when a teacher has done their initial teacher training they can have some applied experience. They are in the classroom, beginning to experience some of those behaviours.²⁴⁹

203. During the course of this inquiry the Rt. Hon. Nicky Morgan MP was appointed as Secretary of State for Education; we wrote to her and asked for her to outline her views and policies regarding children's and adolescents' mental health. The written evidence submitted by the Secretary of State described the guidance issued to schools by her Department in June, stating that mental health is “an area where teachers and schools have said they would appreciate more guidance in order for them to ensure they have the right

246 Qq321-322

247 Liverpool CAMHS Partnership ([CMH0139](#)), para 4

248 Children and Young People's Mental Health Coalition ([CMH0153](#)) para 6.4.4

249 Q312

knowledge and skills". She also referenced MindEd, an interactive e-learning tool aimed at people working with children in universal settings and ACE-V, a tool developed by the BOND consortium to help voluntary and community sector organisations which provide mental health support to make better links to commissioners, including schools. She also mentioned reforms to processes around Special Educational Needs (SEN) and disabilities, pointing out that for the first time the new Code of Practice now recognises that possible mental health difficulties should be looked into, where a child or young person is displaying concerning behaviours.²⁵⁰

204. However, in the view of Anthony Smythe of BeatBullying, the DFE guidance falls short of providing a complete solution:

The Department for Education has just released guidance on how schools should deal with mental health. It touched on CPD, but it was disappointing that there was not more in there. We need a lot more investment. The Government is very good at saying what needs to be done, but more needs to be done on the how—the sharing of good practice and the teacher training part of it. If you take an issue like bullying, one of the reasons teachers do not intervene at the earliest opportunity is that they do not know how to, or are a bit nervous of what to do, who to talk to and how to have that discussion with young people. That will be the same across all of these issues. There is a job to do on building the capacity of teachers, so that they can recognise signs and symptoms and intervene at the earliest opportunity.²⁵¹

Education for children and young people about mental health

205. Although the Secretary of State for Education's written evidence referenced many initiatives aimed at improving teachers' and professionals' awareness of mental health issues, it did not include any reference to one of the key issues raised by the young people the Committee met - the need for children and young people themselves to receive better education about mental health issues in schools. A young person from the GIFT partnership described the importance of this:

If funding was to be increased, trained CAMHS staff, could begin to tackle the problem in schools. For example doing monthly classes or speaking in school assemblies. This will greatly increase awareness of mental health in general and encourage help to be sort before crisis is reached. During my own time at school, I began showing/having symptoms of anxiety, but I didn't even know what the term anxiety meant. I got to year 10, without being taught and therefore not having, any kind of awareness of mental health symptoms and problems. This is shocking. At school, we are all taught

250 Department for Education ([CMH0236](#))

251 Q311

if we have a physical injury to go to the hospital. Mental Health issues are not addressed.²⁵²

206. Both commissioner and provider organisations suggested that school curriculums should include emotional wellbeing and mental health²⁵³, and the Children and Young People's Mental Health Coalition argues that:

The Personal, Social and Health Education (PSHE) curriculum provides a good opportunity to help improve children and young people's understanding of mental health and wellbeing. However it isn't mandatory and we hear from young people that it isn't always well taught. Many young people believe that mental health should be on the curriculum. Two young women from North London have been campaigning to get mental health on the curriculum after one of them developed an eating disorder. Ofsted have reported that 40% of schools' PSHE provision required improvement or was inadequate. Ofsted also asked a panel of young people what they would like to learn about in school, but currently didn't. Young people told them that mental health issues were at the top of their list, with:

- 38% wanting to learn how to deal with bereavement;
- 33% wanted to know how to cope with stress and
- nearly a third wanted to know more about eating disorders such as anorexia.²⁵⁴

207. Anthony Smythe suggested that while progress has been made in adding cyber-bullying to the computer sciences curriculum, on more work is needed to clarify mental health's place in the curriculum:

In terms of the curriculum, there has been a good development in relation to cyber-bullying, which will be embedded in the computer science curriculum from September. On mental health, there is still a lot more work to do. A lot of it is down to PSHE, which is inconsistent. In terms of mental health provision in schools, we would like to see greater representation in the curriculum and for it to be a bit more concrete in terms of where it stands. In my view, what schools do to educate young people around mental health is inconsistent.²⁵⁵

208. Much of the Department for Education's recent focus in relation to mental health has been on providing guidance and education about mental health issues to schools and teachers. However, an equally important message to emerge from young people who

252 GIFT Partnership ([CMH0159](#)), section 3

253 For example, West Midlands ADCS ([CMH0115](#)); The Huntercombe Group ([CMH0179](#))

254 Children and Young People's Mental Health Coalition ([CMH0153](#)) para 6.4.6

255 Q310

contributed to this inquiry is that children and young people themselves want better education and awareness about mental health issues. This would encourage young people to look after their own mental and emotional wellbeing as well as their physical wellbeing; would help young people to recognise the signs of mental health issues and seek help sooner; would encourage peer support; and, crucially, would help normalise talking about mental and emotional health and wellbeing, and reduce the stigma attached to mental health issues.

Conclusions and recommendations

209. Schools have enormous potential to help address emerging mental health issues in children and young people. We heard many examples of good practice, where schools are able to act as a central 'hub' for the wider community based provision, as well as providing support themselves. But when we spoke to young people, we heard that while some teachers and schools provide excellent support, others seem less knowledgeable or well trained, and can even seem 'scared' of discussing mental health issues.

210. The need for better support and training for teachers about mental health was raised by many of those who gave evidence to this inquiry; the launch of MindEd, together with new guidance for schools on mental health, are both welcome steps towards addressing this deficit. However, with both of these, the onus is on individual schools and teachers to find time to prioritise this, and within a sea of competing priorities, it may be difficult to ensure that all schools and teachers use these tools. **We consider that awareness of mental health issues, including their relationship to normal child development, conduct issues, and impact on education, is important and we recommend the Department for Education looks to including a mandatory module on mental health in initial teacher training, and should include mental health modules as part of ongoing professional development in schools for both teaching and support staff.**

211. The evidence we have received suggests that in some areas schools are already working innovatively and collaboratively with their wider communities to offer good mental health support, but that this is not happening universally. **We recommend that the Department for Education conducts an audit of mental health provision and support within schools, looking at how well the guidance issued to schools this year has been implemented, what further support may be needed, and highlighting examples of best practice. OFSTED should also make routine assessments of mental health provision in schools.**

212. It is clear that education about mental health could and should contribute to prevention and support for young people. **We recommend that the Department for Education consult with young people, including those with experience of mental health issues, to ensure mental health within the curriculum is developed in a way that best meets their needs.**

Digital culture, social media, bullying and cyberbullying

213. Children and young people are now major users of computers and the internet, with some 85.5% of children belonging to a social networking site, and the proportion of young people playing computer games for two hours or more a night during the week standing at 55% for boys and 20% for girls in 2010.²⁵⁶ Public Health England cite research suggesting that increased screen time and certain internet activity can have a negative impact on young people's emotional wellbeing:

Increased screen time and exposure to media is associated with reduced feelings of social acceptance, and increased feelings of loneliness, conduct problems and aggression. Certain internet activity (social network sites, multi-player online games) have been associated with lower levels of wellbeing. The evidence suggests a “dose-response” relationship, where each additional hour of viewing increases the likelihood of experiencing socio-emotional problems²⁵⁷.

214. The NSPCC highlight its latest ChildLine report which outlines the potential negative consequences of digital media for young people:

Our latest annual ChildLine report highlighted the potential negative consequences of digital integration into young people's lives as in the past year there was an 87 per cent increase in the number of children contacting ChildLine about online bullying. From December 2012, ChildLine began to monitor instances when young people specifically mentioned bullying that related to social networking sites, chat rooms or gaming sites. From December 2012 to March 2013, ChildLine heard from 1,098 young people who mentioned these platforms.²⁵⁸

215. Dr Sebastian Kraemer provided a succinct overview on the impact that digital culture can have on children's and young people's mental health:

It makes intimidation more alarming and more chronic. You can be teased in the playground and it has gone with the wind, but if you have got your photograph on Facebook then it stays there for ever. I do not believe these children are any different from the children I met when I started in 1980, but they have different means of upsetting each other—girls in particular. The medium is not the cause, but it certainly facilitates different ways of harming each other, of abusing each other, and that is what young children do. Some of these girls have been bullied into a state of despair because their attachments at home are not strong enough, so they rely on their friendships to be a family for them, and when that family crashes they feel they haven't

256 Public Health England, [\(CMH0085\)](#) para 3.7

257 Public Health England, [\(CMH0085\)](#) para 3.7

258 NSPCC [\(CMH0136\)](#) para 16

got any, until family then appears like magic in the paediatric ward the next day and maybe some restoration can be created then.²⁵⁹

216. Mark Waddington, clinical lead at Thornby Hall, reports that “100% of the young people we have admitted over the last five years are reported to have had difficulties in the area of bullying predominantly as victim but also as perpetrator”, and that “66% of the young people we have admitted over the last five years are reported to have had difficulties that have arisen through the internet and mobile phones.”²⁶⁰

217. CAMHS provider organisations expressed similar concerns:

Deeply concerning is the proliferation of pro-anorexia websites on the internet, in addition to pro self-harm sites which offer information about how to successfully commit suicide. Pro-anorexia (or Pro-Ana) websites can negatively impact the eating behaviour of people with and without eating disorders. One study of individuals without eating disorders demonstrated that 84% of participants decreased calorific intake by an average of 2,470 calories per week after viewing pro-ED websites. We believe that more studies into the effect of these websites, and more control should be exerted over their availability online.²⁶¹

Considering what might have caused the increase in complexity of cases, there is some anecdotal and clinical evidence about the negative influence of the internet and wide use of mobile phones on young people. We have had a number of children who have befriended other young people in different schools over the internet and formed a network of children who self-harm. These young people are using web cams and phones to send friends photos of themselves self-harming, usually by cutting, and this is having a very negative effect on all the children concerned, particularly as some of the young people are not themselves self-harming. Mobile phones can also be used for relentless bullying through messaging. There is also actual and anecdotal clinical evidence of young children taking photos of themselves or other young children, some as young as 11 or 12 years old, performing sexual acts and then sending photos around the school, which this leads to the dilemma of both how to deal with children who have uploaded child pornography onto the internet and also how to treat children psychologically traumatised by mass shame and internet bullying. External pressures around body image can also lead to eating issues and self-harm.²⁶²

259 Q204

260 Mark Waddington ([CMH0088](#)), p3

261 The Huntercombe Group ([CMH0179](#)) para 3.3

262 Barnet Child & Adolescent Mental Health Service ([CMH0142](#)) para 1.3

218. However, YoungMinds suggest that it is unrealistic to limit young people's use of the internet and social media, and also suggest that the internet can be a positive source of support for young people:

The 24/7 online world has the potential to massively increase young people's stress levels and multiplies the opportunities for them to connect with others in similar distress. But the online world is where children and young people are and it is unrealistic to think we can suggest they limit their contact with social media. Websites like Tumblr where there has been a recent media focus on self-harm blogs must do all they can to limit triggering content and that which encourages self-harming behaviour. However young people we work with talk about all the help they've found from others online and that often this has been far more supportive than specialist services in the community. For every piece of triggering content there are young people online providing ongoing support to other young people in distress.²⁶³

Addressing the challenges of digital culture

219. We received many suggestions for addressing the challenges of digital culture. Anthony Smythe of Beatbullying argued that improved regulation was key:

A lot of work that has gone into safety has been looking at the child protection side of it—child pornography images and so on—which is understandable. The Government have invested a lot in filter systems and parent filters, which is good ... but there is a danger that it provides a false sense of security ...

If we do not get regulation, we will look to industry to regulate themselves. That is what they said they would do. I have been working on this since 2008, both in Government and doing my job in the charitable sector. My view is that industry has failed miserably. What they pass off as self-regulation is by and large self-assessment. Occasionally they will get in a peer to do some peer review. That peer tends to be pretty friendly. I say to industry, "If you want to self-regulate, you are only going to be as strong as your weakest member." There are some very weak members in that sector, and that is not being addressed.²⁶⁴

220. Mr Smythe also argued that there was a 'lack of leadership' from Government in this area:

The problem with that in terms of cyber-bullying is that it is fast becoming nobody's responsibility—everyone is pointing at one another. As I mentioned earlier, somebody somewhere needs to pick this up and lead.²⁶⁵

263 YoungMinds ([CMH0169](#)), pp3-4

264 Q328

265 Q330

221. Beyond the high-level issue of internet regulation, we also heard that CAMHS services need to update their practice to ensure they are able to help children and young people manage the challenges posed by the online culture and social media, and also to ensure that they themselves are better able to exploit the opportunities of web-based and mobile technology, to give children and young people better access to support. YoungMinds argue that “Many professionals feel completely out of touch with, even intimidated by social media and the net”, and that further support is needed:

Statutory mental health services providers and others need help to make sure they have readily available online content on all platforms young people access. Providers need to go to where young people are, not expect young people to go to them. They also need to stay up to date as technology and the platforms young people use move on. In order to reach young people online who are suffering and need support providers and charities should be bringing in the expertise and ideas of young people of the same age group as those they cater to so that online support services are relevant and accessible to young people. Support services also need to be funded so that they are available for young people 24/7 both on and offline so that early access to support is provided at all times.²⁶⁶

222. This view is echoed by those working in CAMHS. Liverpool CAMHS partnership state that “CAMHS needs to update their practice in relation to digital culture to engage more with c&yp [children and young people]. However there needs to be guidance on this specifically in relation to safeguarding and quality.”²⁶⁷ The University of Reading, which provide training to CAMHS staff as part of the CYP-IAPT programme, argue that “CAMHS staff appear to require specialist training in the assessment and management of risks posed by social media”²⁶⁸ Tavistock and Portman suggest a “whole systems” approach:

The internet has been used creatively by young people as a peer resource and there are opportunities to engage with young people therapeutically through the internet and social networking sites....CAMHS staff need to be aware of the centrality of digital lives to children and young people and to understand both the threats and opportunities the internet provides. This will need to be achieved through a whole systems approach, rather than individual trainings if CAMHS staff are to be able to engage with children meaningfully about their experience of the digital world.... It would seem that what we are witnessing now in terms of young people's online lives represents a fundamental change in human behaviour and enquiry about digital lives needs to become integrated into assessments including risk assessments.²⁶⁹

266 YoungMinds [\[CMH0169\]](#), p4

267 Liverpool CAMHS Partnership [\[CMH0139\]](#), para 2

268 University of Reading [\[CMH0121\]](#), para 4.3

269 Tavistock and Portman NHS Foundation Trust [\[CMH0074\]](#), para 2

Of topical concern is the impact of the internet on young people. This virtual world is an important part of most young lives in a way that would have been unimaginable for many CAMHS practitioners in their own youth.... There are a number of CAMHS initiatives, some associated with CYPIAPT providing psycho-education and information about services, however there is a potential gap to be filled by more specific health promotion material informed by the knowledge and skills available in CAMHS. The development would require creative commissioning investment and partnership with web designers, together with young people, who could, together produce age-appropriate material and training for staff.²⁷⁰

223. Leicester City Psychology Service describe innovations they are introducing:

The digital culture provides numerous benefits. Whilst the incidence of referral to our service where cyber bullying is less than 1.0 % we nevertheless have taken heed of national trends and been proactive and have set up a number of initiatives to address potential issues around cyber and other forms of bullying. The Text Someone anti-bullying system in schools allow pupils to anonymously report incidents of bullying. On the City Psychology guidance information leaflets are available for professionals, parents and children on dealing with bullying. We are embarking on undertaking a survey of bullying in schools using a web based questionnaire page so that schools and children are able to access this information much quicker than was previously the case using other methods.

We believe that the digital media is an area to embrace and are in currently setting up an online training programme for staff on recognising and dealing with an array of issues including self-harm, bereavement, and missing children.²⁷¹

224. Anthony Smythe emphasised the importance of educating children and young people about the risks posed by digital culture:

Continue to invest in the education programmes that exist out there. I mentioned earlier that the new curriculum for 2014 will have safety from key stage 1 upwards, which is a good development. We will be looking with interest at how schools implement that. We do not want education around safety to be about how you secure your bank details—or not about that alone. It needs to be peer on peer.²⁷²

225. The Committee also heard about the importance of parental awareness:

There is a role to build parents' understanding as well. Parents should recognise that the internet is there and that children of five or six are

270 Central and North West London NHS Foundation Trust ([CMH0132](#)), p6

271 Leicester City Psychology Service ([CMH0197](#)), p5

272 Q328

accessing it. Parents should not be afraid of that; they should embrace it and understand what it is about, so that as parents we can also help to direct and provide support for our children. Again I emphasise that, both offline and online, a child should be able to go and talk with a trusted adult, so that they can take responsibility for themselves, with help within families to provide that supporting network.²⁷³

It is about having discussions about risks that they face online, in the same way that you would have those discussions about offline risks, such as violence that you may come across or bullying at school—whatever the risk may be. To do that, parents need to be supplied with greater information. In saying that, I do not think we can say this is for parents to deal with alone; the issue is too big. It needs everyone rallying around the child; it needs a child-centred approach. There is an old line that came out of Government many years ago but is still true: tackling bullying is everyone's responsibility.²⁷⁴

Conclusions and recommendations

226. For today's children and young people, digital culture and social media are an integral part of life; whilst this has the potential to significantly increase stress, and to amplify the effects of bullying, the internet can also be a valuable source of support for children and young people with mental health problems.

227. We have not investigated the issue of internet regulation in depth. However, in our view sufficient concern has been raised to warrant a more detailed consideration of the impact of the internet on children's and young people's mental health, and in particular the use of social media and the impact of pro-anorexia, self-harm and other inappropriate websites, and we recommend that the Department of Health/NHS England taskforce should take this forward in conjunction with other relevant bodies, including the UK Council for Child Internet Safety.

228. We have heard that CAMHS providers may need further support—both in helping the children and young people they treat to cope with the challenges of online culture and manage the impact it might have on their mental health - and so that they themselves are better able to use online means of communication for reaching out to young people. **We recommend that the Department of Health/NHS England taskforce should also investigate and report on the most effective ways of supporting CAMHS providers to do this.**

229. Children and young people also need to know how to keep themselves safe online. It is encouraging that e-safety will now be taught at all four key stages of school education. **We**

273 Catherine Roche, Q329

274 Anthony Smythe, Q330

recommend that as part of its review of mental health education in schools, the Department for Education should ensure that links between online safety, cyberbullying, and maintaining and protecting emotional wellbeing and mental health are fully articulated.

230. We recommend clear pathways are identified for young people to report that they have been sent indecent images of other children or young people, and that support is provided for those who have been victims of image sharing. Pathways should also be established for children and young people who have experienced bullying, harassment and threats of violence.

General practice

231. Evidence submitted by the Jane Roberts of the Royal College of GPs argues that GPs need better training in dealing with young people with mental health concerns:

GPs are inadequately prepared for both consulting in general with young people and more specifically for addressing mental health concerns. This is reported in both the formal literature, from national surveys distributed through the RCGP and from the recent experiences of the RCGP Adolescent Health Group running national Master Classes with the BMJ and One Day Educational event at the RCGP.

There is scant coverage of adolescent mental health in undergraduate curricula which might now cover the growing field of adolescent neurodevelopment using functional imaging to demonstrate the neuroplasticity of the brain in the second and third decade of life.

A direct consequence of inadequate preparation is that GPs report feeling anxious and uncertain when faced with YP in distress. Professional competence is challenged when a GP is unsure how to proceed and young people may be aware of this in the clinical consultation thus compounding their feeling of isolation.²⁷⁵

232. Dr Roberts described the situation in stark terms:

We see an increasing number present with self-harm- cutting, alcohol abuse, exploratory behaviour associated with high risk such as driving whilst under the influence of alcohol , fighting, unprotected intercourse. There are higher rates of accidents When and trauma in poorer communities.... In a ten minute consultation it can feel overwhelming to open a 'pandora's box' and begin to look at what is troubling a young person and leading them to cut

repeatedly or drink to oblivion, especially if the options for referral seem limited and difficult to access.²⁷⁶

233. Dr Roberts went on to explain to the Committee that within the Quality and Outcomes Framework (QOF), which determines priorities within primary care, children and young people's health accounts for less than 3% of QOF indicators, "so it is on nobody's agenda to do anything about it."²⁷⁷

234. The Minister undertook to write to us about GP training.²⁷⁸ In his letter, he told us that Health Education England (HEE) will work with Royal Colleges and with professional regulators to seek to include compulsory work-based training modules in child health in GP training. HEE will also work with the Royal College of General Practitioners and the Royal College of Paediatrics and Child Health to develop a bespoke training course which will allow GPs to develop a special interest in the care of young people with long term conditions, which will be introduced by September 2015. HEE has also established a Mental Health Advisory Group to promote and enhance mental health training across the professions. The Minister writes that "there is already mental health experience included in GP training, and it may be that further modules are required to established GPs as part of their continuing professional development."²⁷⁹

Conclusions and recommendations

235. Like schools, GPs provide universal services which are open to all children and young people without prior referral, and because of this, they may be one of the first places children or their parents turn to when they are experiencing mental health problems. We have heard that many GPs currently feel ill-equipped and lacking in confidence in dealing with these issues, and that their current training does not prepare them adequately for this. We would like to seek further assurance that the issue of GP training in children's and adolescents' mental health specifically will be addressed by this work.

236. We ask Health Education England, together with the GMC and relevant Royal Colleges, to provide us with a full update on their plans for GP training in children's and adolescents' mental health. If children, young people or their parents turn to their GP for help with a mental health problem, they have a right to see a professional who has received sufficient training to be able to consult with them with confidence, and who is able to signpost them to other support, resources or more specialised services as appropriate.

276 Dr Jane H Roberts ([CMH0217](#)), p5

277 Q27

278 Q433

279 Written evidence submitted by Rt. Hon Norman Lamb MP, Minister of State for Care and Support ([CMH0234](#)) p4

8 National priority and scrutiny

237. Discussing the views we had heard on the current state of CAMHS services, the Minister responded as follows:

I would accept all the propositions that you put to me, that the system, to me, looks rather dysfunctional with all this different commissioning, that there have been poor decisions about funding in localities and that there needs to be a complete recognition across the whole system that mental health really must be treated equally—that parity of esteem is not just a bit of rhetoric but has to be delivered in practice. You cannot do that just by exhortation. You have to make sure that the levers deliver it. That is why I think it is so important that you get access to the data. Information drives change. If you have an understanding of what is actually happening across the system, rather than the fog we have worked in up until now in mental health, you can start to put pressure on the system to change. That has to be combined with standards of access and waiting times that exist in physical health but do not exist in mental health. That has to change, and it is starting next year.²⁸⁰

I cannot begin to justify failures of care that result in a youngster being sent off somewhere else around the country, or not getting access to early intervention in psychosis, or whatever the issue might be, so I have impatience about this, just as all of you do. It is complex. The problem has been made worse, in my view, by some fairly irrational decisions around the country about disinvestment in children's mental health, and indeed mental health more generally in some areas—not across the entire country, because there are areas that are doing, in my view, exactly the right thing. I think there needs to be a sense of a national imperative that this changes.²⁸¹

238. Many of our submissions agreed that CAMHS now needs to be given greater priority at a national level. According to the Tavistock Centre for Couple relationships

...The lack of centrally driven policy development, performance management and targeted funding together with funding reductions both as a result of the efficiency drive with the NHS and the reductions in local authority budgets are, we feel, to a large extent responsible for the current challenges and difficulties in service provision.

It is difficult therefore to imagine that improvements in children's mental health and psychological wellbeing and the services required to meet children's needs will not require a reiteration of the importance of CAMHS by central government, backed up by a new national programme of service

280 Q445

281 Q445

development that is adequately resourced and effectively performance managed.²⁸²

239. Birmingham Children's Hospital Foundation Trust state that there is a need for "a major rethink on the part of policy makers to make children's mental health the priority it needs to be." In their view, this should include:

Clear expectations and national standards for a 21st Century CAMHS

Levels of funding which reflect need.

Clarification and monitoring of levels of staffing and skills needed to provide services²⁸³

240. National minimum service specifications for Tier 3 services were recommended by several witnesses, and the Committee endorses this, alongside the need for thorough audit to ensure that CAMHS services are meeting these.

241. Turning to the Minister's focus on levers within the system to deliver improvement in CAMHS, it seems clear that the system's current levers for ensuring standards—including commissioners and the CQC—have not delivered improvements in CAMHS services in a consistent way. CCGs and Local Authorities manage their own spending priorities, and in the absence of national targets, guidance and service specifications, many LAs and CCGs have struggled to prioritise CAMHS within current financial constraints, with the resulting impact of worsening services, as described by both providers and service users submitting evidence to this inquiry. In the words of one commissioner:

It is sometimes difficult to argue that that is core business. You are not inspected on that. You don't fail inspections on that, and that is the harsh reality certainly for local authorities and for health services as well.²⁸⁴

242. NHS England told us that "with respect to the CCGs, it is more tricky because, in a sense, we cannot tell CCGs what to do in the world in which we work at the moment, but we have an assurance system which invites CCGs to consider mental health across the whole lifespan, and NHS England is now revisiting the financial levers that we have at our disposal."²⁸⁵ Several submissions call for improvements in consistency and accountability of CAMHS commissioning:

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

282 Tavistock Centre for Couple Relationships ([CMH0025](#)), para 2

283 Birmingham Children's Hospital NHS Foundation Trust ([CMH0130](#)), para 42

284 Q292

285 Q456

recent reforms is needed. Better guidance for local agencies is needed to ensure roles and responsibilities are clear.²⁸⁶

We recommend that ... a working party is set up to review current commissioning arrangements for all child mental health services to ensure sufficiently funded and resources services are providing effective delivery of evidence-based interventions.²⁸⁷

243. We were also told that “CAMHS receives very little if any scrutiny from the Care Quality Commission”²⁸⁸

I have never seen a CAMHS team inspected in the same way as I see other parts of the public sector inspected. We have concerns about our tier 4 providers. We are currently dealing with several complaints about them and we have shared them with NHSE, but we are the people writing the complaints letters and talking to the families; we are having the conversations behind closed doors about, “At what point do we go to the Care Quality Commission about a particular provider that we are concerned about?”²⁸⁹

Our experience in Essex is that we have not had much involvement from CQC in children’s mental health services. We have had more advice from our Ofsted colleagues, but really a very poor service from CQC. We have had to be very proactive ourselves in dealing with complaints to NHS England and sorting out the complaints and scrutiny ourselves ... We have detected that they do not see it as part of their brief.²⁹⁰

244. In response to this, the Minister told us that “the truth is that we do not have a full enough picture yet about the variability in quality around the country.”²⁹¹ However, he believed new arrangements at the CQC would be stronger:

It may well have been a fair assessment, but I think it is changing. Now that we have someone with a dedicated responsibility for mental health ... I do not think there is any risk that children’s mental health services will be ignored in the future. They are introducing a much more rigorous inspection regime ... That gives us an opportunity, as I indicated earlier, to put the spotlight on mental health and to really identify good practice, but also unacceptable practices, in a way we have never been able to do before.²⁹²

286 National Children’s Bureau ([CMH0146](#)) para 2.1

287 London and South East CYP-IAPT Learning Collaborative ([CMH0155](#)), para 6.2

288 North West London Commissioning Support Unit, ([CMH0211](#)) p3

289 Q277

290 Q278

291 Q389

292 Q425

245. The CQC have provided detail on their new inspection regime, which will from now on include an inspection of CAMHS services in all inspections of mental health trusts:

We began to pilot our new style inspections in NHS mental health services in January 2014, with a full roll-out from October 2014. The new style inspection defines core services for each type of organisation, which will always be inspected where they are provided. CAMHS has been designated as a core service for NHS mental health trusts. We have carried out twelve inspections using this new approach and will carry out a further four inspections this autumn.²⁹³

246. However, the CQC were not able to give us information on which CAMHS services, or how many, had been inspected between 2009 and 2013.²⁹⁴

247. It is also essential to put in place the right levers to prioritise early intervention in children's mental health, as Professor Dame Sally Davies, the CMO, explained:

I have seen the newspaper reports and I have heard the stories, and it is unacceptable for children who need secure accommodation to end up in police cells or even miles away. So that does need sorting. But that is a small problem ... if we did more at the preventive early end we wouldn't need so many beds. Some of this lack of beds is because the children are not being picked up and dealt with when they present, so they spiral downwards.²⁹⁵

.....anything that you can do to help shift the debate away from putting a sticking plaster on something that is wrong to moving to prevention and early intervention would be very welcome. We, as a nation, need to shift to that. I also welcome any support you can give to raising the children's agenda up the priority list because they are our future. Economically, we are sunk if we don't make sure that our children come through all right.²⁹⁶

248. Following the conclusion of our evidence sessions, in October this year the Department of Health published *Achieving Better Access to Mental Health Services by 2020*. This confirmed the Government's commitment to funding 50 new inpatient CAMHS beds, and announced further investment for early intervention services for psychosis, and for crisis services more generally, including liaison psychiatry in A&E departments for all ages, and crisis resolution home treatment teams. It also gives further detail on proposed access targets, which will include a target that 50% of those experiencing a first episode of psychosis will receive referral to a NICE-approved care package within two weeks of referral, 75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18

293 Additional written evidence submitted by Care Quality Commission [\[CMH0235\]](#) p1

294 Additional written evidence submitted by Care Quality Commission [\[CMH0235\]](#) p1

295 Q35

296 Q59

weeks of referral.²⁹⁷ However it is not clear how waiting targets will apply to CAMHS services more broadly, nor the extent to which funding for crisis services will apply to services for under-18s.

Conclusions and recommendations

249. It is clear that there are currently insufficient levers in place at national level to drive essential improvements to CAMHS services. These have received insufficient scrutiny from CQC and we look to review progress in this area following their new inspection regime. The Minister has argued that waiting time targets will improve CAMHS services but we recommend a broader approach that also focuses on improving outcomes for specific conditions in children's and adolescents' mental health.

250. We recommend the development, implementation and monitoring of national minimum service specifications, together with an audit of spending on CAMHS. We recommend that the Department of Health/NHS England taskforce look to remove the perverse incentives that act as a barrier to Tier 3.5 service development and ensure investment in early intervention services. There must be a clear national policy directive for CAMHS, underpinned by adequate funding.

297 Department of Health, [Achieving Better Access to Mental Health Services by 2020](#), October 2014

Recommendations

Introduction

1. 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. We welcome the announcement of the joint NHS England /Department of Health Children and Young People's Mental Health and Wellbeing Taskforce, as it endorses one of our central conclusions, that problems with CAMHS are broadly based and not simply confined to inpatient Tier 4 services. Many of the recommendations in this report are therefore directed towards this taskforce as it begins its work. In addition to this, we recommend that the taskforce takes full account of the wealth of information contained in the written submissions received by this inquiry, including, in particular, submissions from service users, from their parents and representatives, from individual clinicians working in CAMHS, from provider organisations and from commissioners. We plan to review the progress of the taskforce early in 2015.(Paragraph 7)

Information

2. The Committee is deeply concerned that the most recent ONS data on children's and young people's mental health is now ten years old, as up-to-date information is essential for the safe and effective planning of health services. We welcome the Government's commitment, made during the course of this inquiry, to fund a repeat of the ONS prevalence survey. It is essential that this survey is not a one-off, but is repeated on an ongoing basis. We recommend that the Department of Health/NHS England taskforce adds the issue of the quality of ongoing data to its terms of reference.(Paragraph 23)
3. Not only is there a lack of data on children and young people's mental health, but also a worrying lack of comprehensive and reliable information about children's and adolescents' mental health services, including referrals, access and expenditure. In the words of the Minister, CAMHS services have been operating in a "fog", and efforts to improve data availability have been subject to delays. This is unacceptable. Ensuring that commissioners, providers and policy-makers have access to up-to-date information about all parts of CAMHS services—from early intervention up to inpatient services—is essential. We recommend that this is a priority for the Department of Health/NHS England taskforce.(Paragraph 24)

CAMHS as a whole system

4. Whilst most attention has so far centred on problems in accessing inpatient treatment, compelling arguments have been made to this inquiry that the focus of investment in CAMHS should be on early intervention—providing timely support to children and young people before mental health problems become entrenched and increase in severity, and preventing, wherever possible, the need for admission to

inpatient services. It is clearly unacceptable if a child or young person cannot access a Tier 4 service close to their home, but for every child in this position, a further question needs also to be asked - has everything possible been done to prevent that child from becoming so unwell that they needed admission to inpatient services? The evidence we have received suggests poor provision of lower tier services may be increasing the number of children and young people requiring admission to inpatient services. This situation must be addressed by the Taskforce.(Paragraph 33)

Early intervention mental health services (Tier 2)

5. We recommend that, given the importance of early intervention, the DH/NHS England taskforce should have an explicit remit to audit commissioning of early intervention services in local authorities, and to report on how best to improve incentives in this area. They should also look at the best mechanisms to provide stable, long term funding for early intervention services including those provided by voluntary sector partners. (Paragraph 51)

Outpatient specialist CAMHS services (Tier 3)

6. Whilst demand for mental health services for children and adolescents appears to be rising, many CCGs report having frozen or cut their budgets. CCGs have the power to determine their own local priorities, but we are concerned that insufficient priority is being given to children and young people's mental health. We recommend that NHS England and the Department of Health monitor and increase spending levels on CAMHS until we can be assured that CAMHS services in all areas are meeting an acceptable standard. We welcome recent funding announcements for mental health services but we remain concerned and recommend that our successor committee reviews progress in this area.(Paragraph 112)
7. Commissioners of CAMHS services undoubtedly face a difficult task in collaborating across a complex web of other commissioners, and overseeing a varied patchwork of different types of providers to attempt to commission a seamless CAMHS service. They also face challenges in securing sufficient funding for this sadly de-prioritised service. However, CCGs hold ultimate responsibility for commissioning community CAMHS services, and we feel that there is a clear need for CAMHS commissioners to be given further monitoring and support from NHS England to address the variations in investment and standards that submissions to this inquiry have described. We recommend NHS England provides an action plan detailing how it plans to do this.(Paragraph 115)
8. We heard from witnesses that national service specifications are required, to set out minimum acceptable levels of community CAMHS services, and we understand that Tier 2 and 3 service specifications are now being developed. We recommend that these specifications should set out what reasonable services should be expected to provide. They should cover specific clinical areas including ASDs, perinatal mental health, and eating disorders, as well services which currently fall between the Tiers, including out-of-hours, outreach and paediatric liaison. We recommend that the

taskforce should carry out and publish an audit of whether services are meeting these minimum standards. (Paragraph 116)

9. In addition to the universal concerns expressed about CAMHS services, we also received written submissions highlighting problems with CAMHS services being experienced by children and young people suffering from particular conditions, or from especially vulnerable groups of society. Specific conditions included OCD, ASDs, ADHD and Eating disorders; vulnerable groups included children and young people in the care system, and those who have been adopted or fostered; homeless young people, asylum seekers and recent immigrants; lesbian, gay, bisexual and transgender young people; and bereaved children and young people. The breadth of different conditions and different populations covered in our written submissions is indicative of the complexity but also the importance of the task facing CAMHS services. This inquiry does not have the scope to consider all of these issues individually, but again we recommend that the Department of Health/NHS England taskforce takes full account of the submissions we have received, and the wealth of information they contain. (Paragraph 118)
10. There is unacceptable variation in the provision of perinatal mental health services, and we recommend this is addressed urgently. Service specifications should make clear that these services must be available in every area. (Paragraph 120)

Inpatient CAMHS services (Tier 4)

11. It is wholly unacceptable that so many children and young people suffering a mental health crisis face detention under s136 of the Mental Health Act in police cells rather than in an appropriate place of safety. Such a situation would be unthinkable for children experiencing a crisis in their physical health because of a lack of an appropriate hospital bed and it should be regarded as a 'never event' for those in mental health crisis. In responding to this report we expect the Department of Health to be explicit in setting out how this practice will be eradicated. (Paragraph 160)
12. Written submissions to this inquiry have described a situation where despite the move to national commissioning over a year ago, NHS England has yet to 'take control' of the inpatient commissioning process, with poor planning, lack of co-ordination, and inadequate communication with local providers and commissioners. While many of the difficulties NHS England is now seeking to address may be a legacy from previous arrangements, it has not, in our view, sufficiently prioritised these problems. We note that in addition to the new capacity that is being funded, NHS England is recruiting more case managers to give them better control over the commissioning process, but we are disappointed that during its first year as a commissioner of inpatient services, many of the perceived benefits of national planning have not been realised, and NHS England has instead presided over a system which has resulted in children being sent hundreds of miles to access care. We intend to review NHS England's progress addressing these problems early in 2015. (Paragraph 162)

13. As a first step in improving its commissioning of Tier 4 services, we recommend that NHS England should introduce a centralised inquiry system for referrers and patients, of the type that is already in operation for paediatric intensive care services.(Paragraph 163)
14. We believe that education is crucial to protecting the life chances of the especially vulnerable young people who need inpatient treatment for mental health problems, particularly as in some cases these admissions may last many months. It is essential that clear standards are set for the quality of education provision in inpatient units, and that there is clear accountability and ownership for ensuring that these standards are upheld. As a first step towards this, we recommend that OFSTED, DFE and NHS England conduct a full audit of educational provision within inpatient units as a matter of urgency.(Paragraph 166)

Bridging the gap between inpatient and community services

15. It is clear from the evidence we have received that commissioning extra inpatient capacity alone will not be enough to alleviate the current problems being experienced in relation to Tier 4 services. Perverse incentives in the commissioning and funding arrangements for CAMHS need to be eliminated to ensure that commissioners invest in Tier 3.5 services which may have significant value in minimising the need for inpatient admission and in reducing length of stay. The Department of Health and NHS England must act urgently to ensure that by the end of this year all areas have clear mechanisms to access funding to develop such services in their local area, where this is appropriate.(Paragraph 188)
16. Looking beyond this, we agree with the Minister that the current fragmented commissioning arrangements make “no sense”, and are “dysfunctional”. A key responsibility for the newly set up Taskforce will be to determine a way in which commissioning can be sufficiently integrated to allow rational and effective use of resources in this area, which incentivises early intervention. The Government has recently announced extra funding for early intervention in psychosis services and crisis care, which could include liaison services in A&E departments, and crisis resolution home treatment teams. We recommend that the Government ensures that a substantial proportion of this new funding is directed towards services for under-18s. (Paragraph 189)

Schools

17. We consider that awareness of mental health issues, including their relationship to normal child development, conduct issues, and impact on education, is important and we recommend the Department for Education looks to including a mandatory module on mental health in initial teacher training, and should include mental health modules as part of ongoing professional development in schools for both teaching and support staff.(Paragraph 210)

18. . We recommend that the Department for Education conducts an audit of mental health provision and support within schools, looking at how well the guidance issued to schools this year has been implemented, what further support may be needed, and highlighting examples of best practice. OFSTED should also make routine assessments of mental health provision in **schools**. (Paragraph 211)
19. We recommend that the Department for Education consult with young people, including those with experience of mental health issues, to ensure mental health within the curriculum is developed in a way that best meets their needs.(Paragraph 212)

Digital culture, social media, bullying and cyberbullying

20. We have not investigated the issue of internet regulation in depth. However, in our view sufficient concern has been raised to warrant a more detailed consideration of the impact of the internet on children's and young people's mental health, and in particular the use of social media and the impact of pro-anorexia, self-harm and other inappropriate websites, and we recommend that the Department of Health/NHS England taskforce should take this forward in conjunction with other relevant bodies, including the UK Council for Child Internet Safety.(Paragraph 227)
21. We recommend that the Department of Health/NHS England taskforce should also investigate and report on the most effective ways of supporting CAMHS providers to do this.(Paragraph 228)
22. We recommend that as part of its review of mental health education in schools, the Department for Education should ensure that links between online safety, cyberbullying, and maintaining and protecting emotional wellbeing and mental health are fully articulated.(Paragraph 229)
23. We recommend clear pathways are identified for young people to report that they have been sent indecent images of other children or young people, and that support is provided for those who have been victims of image sharing. Pathways should also be established for children and young people who have experienced bullying, harassment and threats of violence. (Paragraph 230)

General practice

24. We ask Health Education England, together with the GMC and relevant Royal Colleges, to provide us with a full update on their plans for GP training in children's and adolescents' mental health. (Paragraph 236)

National priority and scrutiny

25. It is clear that there are currently insufficient levers in place at national level to drive essential improvements to CAMHS services. These have received insufficient scrutiny from CQC and we look to review progress in this area following their new inspection regime. The Minister has argued that waiting time targets will improve CAMHS services but we recommend a broader approach that also focuses on

improving outcomes for specific conditions in children's and adolescents' mental health.(Paragraph 249)

26. We recommend the development, implementation and monitoring of national minimum service specifications, together with an audit of spending on CAMHS. We recommend that the Department of Health/NHS England taskforce look to remove the perverse incentives that act as a barrier to Tier 3.5 service development and ensure investment in early intervention services. There must be a clear national policy directive for CAMHS, underpinned by adequate funding.(Paragraph 250)

Glossary

CAMHS	Children's and Adolescents' Mental Health Services
CYP-IAPT	Children and Young People's Improving Access to Psychological Therapies programme
ONS	Office of National Statistics
CMO	Chief Medical Officer
CCG	Clinical Commissioning Group
HSCIC	Health and Social Care Information Centre
JSNA	Joint Strategic Needs Assessment
JHWS	Joint Health and Wellbeing Strategy
ASD	Autistic Spectrum Disorder
ADHD	Attention Deficit Hyperactivity Disorder
OCD	Obsessive Compulsive Disorder
QNIC	Quality Network for Inpatient CAMHS
QNCC	Quality Network for Community CAMHS
NICE	National Institute for Health and Care Excellence
CBT	Cognitive Behavioural Therapy
CAPA	Choice and Partnership Approach
QIPP	Quality, Innovation, Productivity and Prevention
CORC	Child Outcomes Research Consortium
PCT	Primary Care Trust
CQC	Care Quality Commission
NYAS	National Youth Advocacy Service
OFSTED	Office for Standards in Education
PSHE	Personal, Social and Health Education
HEE	Health Education England
GMC	General Medical Council

Formal Minutes

Tuesday 28 October 2014

Members present:

Dr Sarah Wollaston, in the Chair

Rosie Cooper
Andrew George
Barbara Keeley
Charlotte Leslie

Andrew Percy
David Tredinnick
Valerie Vaz

Draft Report (*Children's and adolescents' mental health and CAMHS*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 250 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 4 November at 2.00 pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at <http://www.parliament.uk/healthcom>.

Tuesday 4 March 2014

Question number

Professor Dame Sally C Davies, Chief Medical Officer, Department of Health, **Dr Claire Lemer** Consultant in general, paediatrics and service transformation, Evelina London Children's Hospital

Q1-62

Tuesday 1 April 2014

Dr Jane Roberts, Royal College of General Practitioners National Clinical Champion for Youth Mental Health, **Professor Peter Fonagy**, National Clinical Lead, Children and Young People's Improving Access to Psychological Therapies programme, **Dr Peter Hindley**, Chair of the Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists, **Sarah Brennan**, Chief Executive, YoungMinds, and **Barbara Rayment**, Chair, Children and Young People's Mental Health Coalition

Q63-146

Tuesday 10 June 2014

Dr Liz Myers, Consultant Child and Adolescent Psychiatrist/Clinical Director of Children's Services, CAMHS, Cornwall Partnership Foundation Trust; **Dr Vinod Diwakar**, Chief Medical Officer, Birmingham Children's Hospital NHS FT; **Dr Madhava Rao**, Associate Clinical Director for CAMHS, Black Country Partnership NHS Foundation Trust, **Dr Jenny Taylor**, British Psychological Society, **Dr Amanda Jones**, Professional Lead & Consultant Perinatal Psychotherapist, Perinatal Parent Infant Mental Health Service, North East London NHS Foundation Trust, **Dr Sebastian Kraemer**, Consultant Child and Adolescent Psychiatrist, Whittington Hospital

Q147-226

Tuesday 24 June 2014

Barbara Herts, Director for Integrated Commissioning and Vulnerable People, Essex County Council, **Steve Buckerfield**, Acting Head of Children's Joint Commissioning, North West London Commissioning Support Unit, and **Michael Upsall**, Children's Commissioning Manager for Derbyshire County Council, **Jane Lunt**, Head of Quality/Chief Nurse, Liverpool CCG, on behalf of Liverpool CAMHS Partnership, **Catherine Roche**, Chief Executive, Place2Be, and **Anthony Smythe**, Director, The BB Group/BeatBullying

Q227-335

Tuesday 15 July 2014

Norman Lamb MP, Minister of State for Care and Support, Department of Health, **Jon Rouse**, Director General of Social Care, Local Government and Care Partnerships, Department of Health, **Professor Sir Bruce Keogh**, Medical Director, NHS England, and **Kath Murphy**, Assistant Head of Specialised Services, NHS England

Q336-461

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at www.parliament.uk/healthcom. INQ numbers are generated by the evidence processing system and so may not be complete.

- 1 4Children ([CMH0176](#))
- 2 5 Boroughs Partnership NHS Foundation Trust ([CMH0067](#))
- 3 Act Now for Autism ([CMH0205](#))
- 4 Action for Sick Children ([CMH0075](#))
- 5 Adoption Leadership Board ([CMH0231](#))
- 6 Alpha Hospitals Ltd ([CMH0068](#))
- 7 Amanda Hayward ([CMH0090](#))
- 8 Andrew Gregory ([CMH0199](#))
- 9 Andrew Starr ([CMH0017](#))
- 10 Aspired Futures ([CMH0041](#))
- 11 Association of Child and Adolescent Psychotherapists (ACP) ([CMH0109](#))
- 12 Association of Educational Psychologists ([CMH0079](#))
- 13 Association of Infant Mental Health (AIMH UK) ([CMH0101](#))
- 14 Association of Primary Mental Health Work and Training CAMHS ([CMH0035](#))
- 15 Barnet Child & Adolescent Mental Health Service ([CMH0142](#))
- 16 Berkshire Healthcare NHS Trust ([CMH0049](#))
- 17 Black Country Partnership NHS Foundation Trust ([CMH0166](#))
- 18 Bliss ([CMH0046](#))
- 19 Bright Futures School ([CMH0012](#))
- 20 British Association for Adoption & Fostering ([CMH0082](#))
- 21 British Association for Counselling and Psychotherapy ([CMH0131](#))
- 22 British Psychotherapy Foundation ([CMH0107](#))
- 23 Brook ([CMH0194](#))
- 24 CAMHS Rights and Participation Team ([CMH0069](#))
- 25 Camilla Parker ([CMH0114](#))
- 26 CANDI ([CMH0112](#))
- 27 Cant Go Wont Go ([CMH0168](#))
- 28 Care Quality Commission ([CMH0218](#))
- 29 Centre For Mental Health ([CMH0108](#))
- 30 Centrepont ([CMH0061](#))
- 31 Cernis Limited ([CMH0178](#))
- 32 CFCS/CAMHS East London NHS Foundation Trust ([CMH0180](#))
- 33 Cheshire & Wirral Partnership NHS Foundation Trust ([CMH0104](#))
- 34 Child Outcomes Research Consortium ([CMH0141](#))
- 35 Childhood Bereavement Network ([CMH0150](#))
- 36 Children and Young People's Mental Health Coalition ([CMH0153](#))
- 37 Children's Commissioner for England/OCC ([CMH0038](#))
- 38 CNWL ([CMH0132](#))
- 39 Contact a Family ([CMH0148](#))

- 40 Cornwall Partnership Foundation NHS Trust ([CMH0189](#))
- 41 CQC ([CMH0235](#))
- 42 CYP IAPT North East Collaborative ([CMH0183](#))
- 43 Dasha Nicholls ([CMH0105](#))
- 44 David Samson ([CMH0120](#))
- 45 Department for Education ([CMH0236](#))
- 46 Department of Health ([CMH0154](#))
- 47 Department of Health - Rt Hon Norman Lamb MP ([CMH0234](#))
- 48 Derbyshire County Council Children & Younger Adults Dept. ([CMH0192](#))
- 49 Derbyshire Healthcare NHS Foundation Trust ([CMH0191](#))
- 50 Dr Deborah Judge ([CMH0033](#))
- 51 Dr Gwen Adshead ([CMH0208](#))
- 52 Dr Isobel Heyman ([CMH0138](#))
- 53 Dr Moira Mccutcheon ([CMH0060](#))
- 54 Dr Sebastian Kraemer ([CMH0031](#))
- 55 Dr Steve Kingsbury ([CMH0110](#))
- 56 Dr Varsha Joshi ([CMH0009](#))
- 57 Dr. Nik Johnson ([CMH0096](#))
- 58 Educational Rights Alliance ([CMH0117](#))
- 59 Enys Delmage ([CMH0022](#))
- 60 Essex County Council ([CMH0078](#))
- 61 Evidence Based Practice Unit ([CMH0161](#))
- 62 Faces in Focus ([CMH0045](#))
- 63 Foxhills Schools ([CMH0203](#))
- 64 GIFT ([CMH0159](#))
- 65 Hampshire Parent Carer Network ([CMH0149](#))
- 66 Healthwatch Northamptonshire ([CMH0212](#))
- 67 Helen Simpson ([CMH0024](#))
- 68 Howard League ([CMH0232](#))
- 69 Ian Michael Goodyer ([CMH0051](#))
- 70 Independent Mental Health Services Alliance ([CMH0207](#))
- 71 Islington CAMHS ([CMH0077](#))
- 72 Islington Community CAMHS ([CMH0091](#))
- 73 Jan Bridget ([CMH0014](#))
- 74 Jeannette Phillips ([CMH0016](#))
- 75 Jody Tranter ([CMH0147](#))
- 76 Kelly Mogano ([CMH0044](#))
- 77 Kent Parent Carer Forum ([CMH0095](#))
- 78 Keren Corbett ([CMH0130](#))
- 79 Lee.Bruce@Local.Gov.Uk ([CMH0128](#))
- 80 Leicester City Psychology Service ([CMH0197](#))
- 81 Liverpool CCG ([CMH0139](#))
- 82 London & South East CYP IAPT Learning Collaborative ([CMH0155](#))
- 83 Maple Ride School ([CMH0113](#))
- 84 Marie Johnson ([CMH0186](#))

- 85 Mark Waddington ([CMH0088](#))
- 86 Maryanna Schaefer/Lady Tavener ([CMH0157](#))
- 87 Maternal Mental Health Alliance ([CMH0076](#))
- 88 Mel Wood ([CMH0018](#))
- 89 Meningitis Research Foundation ([CMH0187](#))
- 90 Mental Health Foundation ([CMH0087](#))
- 91 Metro Charity ([CMH0156](#))
- 92 Michael Still ([CMH0056](#))
- 93 Mick Cooper ([CMH0059](#))
- 94 Mrs Henye Meyer ([CMH0047](#))
- 95 National Autistic Society ([CMH0163](#))
- 96 National Children's Bureau ([CMH0146](#))
- 97 NHS Clinical Commissioners Mental Health Commissioners Network (MHCN) ([CMH0122](#))
- 98 NHS England ([CMH0193](#))
- 99 NHS England ([CMH0233](#))
- 100 North East London NHS Foundation Trust ([CMH0037](#))
- 101 North East London NHS Foundation Trust Mental Health Services ([CMH0221](#))
- 102 North West London Commissioning Support Unit ([CMH0211](#))
- 103 North West London Division Of The London Perinatal Mental Health Network ([CMH0165](#))
- 104 Northern School of Child and Adolescent Psychotherapy ([CMH0143](#))
- 105 Northern, Eastern & Western Devon Clinical Commissioning Group ([CMH0198](#))
- 106 NSPCC ([CMH0136](#))
- 107 NYAS ([CMH0081](#))
- 108 OCD Action ([CMH0152](#))
- 109 Oxford Health NHS Foundation Trust ([CMH0230](#))
- 110 Paediatric Mental Health Association ([CMH0094](#))
- 111 Place2be ([CMH0164](#))
- 112 Pods Parent Carer Forum ([CMH0098](#))
- 113 Public Health England ([CMH0085](#))
- 114 Ralph Leavey ([CMH0005](#))
- 115 Roger Cook ([CMH0073](#))
- 116 Royal College of General Practitioners ([CMH0217](#))
- 117 Royal College of Nursing ([CMH0223](#))
- 118 Royal College of Paediatrics And Child Health ([CMH0174](#))
- 119 Royal College of Physicians ([CMH0118](#))
- 120 Royal College of Psychiatrists ([CMH0173](#))
- 121 Royal College of Psychiatrists ([CMH0229](#))
- 122 Sandwell Metropolitan Borough Council ([CMH0172](#))
- 123 Sheffield CAMHS ([CMH0195](#))
- 124 Shirley Potts ([CMH0100](#))
- 125 Siobhan Bryant ([CMH0027](#))
- 126 Solihull Child & Adolescent Mental Health Services, Hoeft ([CMH0066](#))
- 127 South East Staffordshire and Seisdon Peninsula CCQ ([CMH0134](#))

- 128 South London and Maudsley NHS Foundation Trust ([CMH0227](#))
- 129 South Staffordshire & Shropshire Healthcare NHS Foundation Trust ([CMH0171](#))
- 130 Steve Dexter ([CMH0013](#))
- 131 Stoke on Trent City Council ([CMH0050](#))
- 132 Sussex Partnership NHS Foundation Trust ([CMH0200](#))
- 133 Tact ([CMH0055](#))
- 134 Tavistock And Portman NHS Foundation Trust ([CMH0074](#))
- 135 Tavistock Centre for Couple Relationships ([CMH0025](#))
- 136 Tees, Esk And Wear Valleys NHS Foundation Trust ([CMH0170](#))
- 137 The Association for Family Therapy ([CMH0070](#))
- 138 The Association of Directors of Children's Services (ADCS) Ltd ([CMH0210](#))
- 139 The Beat Bullying Group ([CMH0228](#))
- 140 The British Psychological Society ([CMH0133](#))
- 141 The First-Tier Tribunal (Health Education and Social Care Chamber) Mental Health ([CMH0140](#))
- 142 The Huntercombe Group ([CMH0179](#))
- 143 The Priory Group ([CMH0145](#))
- 144 The UK ADHS Partnership ([CMH0048](#))
- 145 UCLpartners ([CMH0123](#))
- 146 UCLpartners ([CMH0124](#))
- 147 Uclpartners ([CMH0126](#))
- 148 UKCP ([CMH0084](#))
- 149 University College London ([CMH0216](#))
- 150 University of Reading ([CMH0121](#))
- 151 University of Reading ([CMH0135](#))
- 152 Walsall JCU ([CMH0167](#))
- 153 Warwickshire County Council ([CMH0182](#))
- 154 Wave Trust (on Behalf of The APPG for Conception to Age 2 - The First 1001 Days ([CMH0214](#)))
- 155 West Midlands ADCS ([CMH0115](#))
- 156 West Midlands CAMHS Learning Disability Psychiatry Peer Group ([CMH0106](#))
- 157 West Sussex County Council ([CMH0219](#))
- 158 Wiltshire Parent Carer Council ([CMH0184](#))
- 159 Worcestershire County Council ([CMH0160](#))
- 160 Youngminds ([CMH0169](#))
- 161 Youth Access ([CMH0092](#))

Unpublished evidence

The following written evidence has been reported to the House and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Parliamentary Archives (www.parliament.uk/archives), and are available to the public for inspection. Requests for inspection should be addressed to The Parliamentary Archives, Houses of Parliament, London SW1A 0PW (tel. 020 7219 3074; email archives@parliament.uk). Opening hours are from 9.30 am to 5.00 pm on Mondays to Fridays.

- 1 South London and Maudsley NHS Foundation Trust (CMH0071)
- 2 Buckinghamshire County Council (CMH0058)
- 3 Queen Mary University of London (CMH0125)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/healthcom.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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Second Report	Managing the care of people with long-term conditions	HC 401 (HC 660)
First Report	2014 Accountability hearing with the Health and Care Professionals Council	HC 339 (HC 731)

Session 2013–14

First Special Report	2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13	HC 154
Second Special Report	2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee's Tenth Report of Session 2012–13	HC 172
Third Special Report	2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee's Ninth Report of Session 2012–13	HC 581
First Report	Post-legislative scrutiny of the Mental Health Act 2007	HC 584 (Cm 8735)
Second Report	Urgent and emergency services	HC 171 (Cm 8708)
Third Report	After Francis: making a difference	HC 657 (Cm 8755)
Fourth Report	Appointment of the Chair of Monitor	HC 744
Fifth Report	2013 accountability hearing with the Nursing and Midwifery Council	HC 699 (HC 1200)
Sixth Report	2013 accountability hearing with the Care Quality Commission	HC 761 (HC 1218)
Seventh Report	Public expenditure on health and social care	HC 793
Eighth Report	Public Health England	HC 840
Ninth Report	2013 accountability hearing with Monitor	HC 841 (HC 511)
Tenth Report	2013 accountability hearing with the General Medical Council	HC 897 (HC 510)

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First Report	Education, training and workforce planning	HC 6-I (Cm 8435)
Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132 (Cm 8439)

Fourth Report	2012 accountability hearing with the General Medical Council	HC 566 (Cm 8520)
Fifth Report	Appointment of the Chair of the Care Quality Commission	HC 807
Sixth Report	Appointment of the Chair of the National Institute for Health and Care Excellence	HC 831
Seventh Report	2012 accountability hearing with the Care Quality Commission	HC 592
Eighth Report	National Institute for Health and Clinical Excellence	HC 782
Ninth Report	2012 accountability hearing with the Nursing and Midwifery Council	HC 639
Tenth Report	2012 accountability hearing with Monitor	HC 652
Eleventh Report	Public expenditure on health and care services	HC 651 (Cm 8624)
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First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)
Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and further issues	HC 1699
Sixteenth Report	PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)