MILLION

Making children's mental health matter

October 2008

"The 11 MILLION children and young people in England have a voice"
Children's Commissioner for England, Professor Sir Albert Aynsley-Green

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1 Who are we?

11 MILLION is a national organisation led by the Children's Commissioner for England, Professor Sir Al Aynsley-Green. The Children's Commissioner is a position created by the Children Act 2004.

The Children Act 2004

The Children Act requires the Children's Commissioner for England to be concerned with the five aspects of well-being covered in *Every Child Matters* – the national Government initiative aimed at improving outcomes for all children. It also requires us to have regard to the United Nations Convention on the Rights of the Child (UNCRC). The UNCRC underpins our work and informs which areas and issues our efforts are focused on.

Our vision

Children and young people will actively be involved in shaping all decisions that affect their lives, are supported to achieve their full potential through the provision of appropriate services, and will live in homes and communities where their rights are respected and they are loved, safe and enjoy life.

Our mission

We will use our powers and independence to ensure that the views of children and young people are routinely asked for, listened to and that outcomes for children improve over time. We will do this in partnership with others, by bringing children and young people into the heart of the decision-making process to increase understanding of their best interests.

Our long-term goals

1. Children and young people see significant improvements in their wellbeing and can freely enjoy their rights under the United Nations Convention on the Rights of the Child (UNCRC).

2. Children and young people are more highly valued by adult society.

For more information

Visit our website for everything you need to know about 11 MILLION: www.11MILLION.org.uk

2 Introduction

The Children's Commissioner considers that there is a demonstrable and urgent need for comprehensive and fully resourced child and adolescent mental health services (CAMHS). Alongside this must be a recognition that mental health promotion is the responsibility of all those working with children.

It is estimated that, in Great Britain, one in ten children and young people aged 5-16 in have a mental disorder that is associated with 'considerable distress and substantial interference with personal functions', such as family and social relationships, their capacity to cope with day to day stresses and life challenges and their learning[1]. Mental health disorders become more common in older children, and are more common in boys than girls. Although the latest figures (2004 survey) show no increase since 1999, the proportion of children with mental health problems is higher now than it was 30 years ago[2]. There is an even greater prevalence of mental health problems in children and young people within certain groups, including those in the youth justice system[3] and those in care, of whom an estimated 45 per cent have an identifiable mental health problem[4]. That there are such high numbers of children and young people with mental health problems is a serious concern in itself. It is clear that, despite the additional investment in this area in recent years, the needs of many of these young people are not being met sufficiently, at the right time or, in some cases, at all.

This report considers some of the key areas of concern in relation to the level and quality of care and support given to children and young people with mental health problems in England. It builds upon work that 11 MILLION has carried out in this area, particularly our work with VIK (Very Important Kids)[5] and YoungMinds. It reflects on the issues raised by children and young people who experience mental distress, as well as by individuals and organisations with an interest in the mental health of children and young people.

While there has been a significant improvement in the planning and provision of mental health services for children and young people, there

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[1] CAMHS Review, Improving the mental health and psychological well-being of children and young people, National CAMHS Review Interim Report, 29th July 2008 www.dcsf.gov.uk/CAMHSreview referring to: Office for National Statistics Survey of the mental health of children and young people in Great Britain, 2004 www.statistics.gov.uk/cci/nugget.asp?id=1229

[2] Report of the Implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services November 2006, page 8

[3] See: Youth Justice Board, *Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community,* 2005, Trust for the Study of Adolescence, *Key Data on Adolescence,* 5th edition 2005; Briefing by Department of Health: *'Mental disorder among young offenders',* October 2000; Office of National Statistics, Psychiatric Morbidity among Young Offenders in England and Wales, 2000;

[4] The Children's Plan: Building Brighter Futures; Department for Children, Schools and Families (2007), TSO, paragraph 1.32.

[5] Set up in June 2007, VIK is a group of 15 children and young people aged between 5 and 25, from across England, who have had experience of emotional support across tiers 1-4 of CAMHS.

is no room for complacency. There is still much to do. Many children and young people are benefiting from the positive changes, but many others are not[6]. Further investment and effort is needed if this is to be remedied. In *The Children's Plan, Building brighter futures* ('the Children's Plan') published in December 2007[7], the Government committed to setting-up an external review of Child and Adolescent Mental Health Services (CAMHS). An interim report, *'Improving the mental health and psychological well-being of children and young people, National CAMHS Interim Report'* ('the CAMHS Review Interim Report') was published in July[8], and the final report is expected in the autumn[9].

Failing to respond appropriately, or at all, to the needs of children and young people with mental health problems has wide-ranging and serious consequences. These failings can also be considered in the context of the United Nations Convention on the Rights of the Child (UNCRC) in order to show how they are also likely to infringe the human rights of children and young people and even, in some cases, may give rise to serious violations of their rights.

The United Nations Convention on the Rights of the Child (UNCRC)

The UNCRC is an international human rights treaty that sets out a comprehensive range of rights that apply to all children (defined as individuals aged less than 18). While recognising that children need to have special assistance and protection, the UNCRC emphasises that children are individuals. Subsequently, as they get older, they will develop their own views and interests and should be able to exercise their rights.

The UK Government ratified the UNCRC in 1991. By doing so, it made a commitment to take steps to ensure that the rights set out in the UNCRC apply to all children and young people in the UK[10]. Additionally, the UK Government is required to produce periodic reports outlining progress made in implementing the UNCRC, and submit these to the Committee on the Rights of the Child (the body responsible for monitoring compliance with the UNCRC).

In its Concluding Observations to the UK Government's second periodic report, the Committee on the Rights of the Child noted that many children and young people in the UK suffer from mental health problems, and that the rate of suicide among this group is still high. The Committee recommended that the UK Government:

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[6] As highlighted in Department of Health Report on the implementation of Standard 9 of the National Service Framework (NSF) for Children, Young People and Maternity Services, November 2006.
[7] The Children's Plan, op cit.
[8] CAMHS Review, op cit .
[9] 11 MILLION submitted evidence to the Review. This can be found at: http://www.11million.org.uk/resource/cacz42xhtvud4dmd958ovome.pdf
[10] Although the UNCRC is not part of UK domestic law, it can be taken into account by national courts and the European Court of Human Rights when considering cases relating to children and young people.

'Take all necessary measures to strengthen its mental health and counselling services, ensuring that they are accessible and sensitive to adolescents, and undertake studies on the causes and backgrounds of suicides…'[11]

The UK Government's most recent periodic report was submitted to the Committee on the Rights of the Child in July 2007[12]. Although there is some discussion on the issues relating to children and young people with mental health problems, it is very limited. This is of serious concern. For the reasons set out in this report, greater attention must be given to the needs of children and young people with mental health problems.

The four UK Children's Commissioners submitted written evidence to the Committee in June 2008[13] and presented oral evidence in Geneva in July 2008. This contained a section on Basic Health and Welfare, which covered mental health across all four jurisdictions.

[11] www.everychildmatters.gov.uk/_files/354F02F166A13719177122513B25167B.pdf at paragraph 42

[12] Available at: www.everychildmatters.gov.uk/uncrc/

[13] UK Children's Commissioners' Report to the UN Committee on the Rights of the Child, June 2008 www.everychildmatters.gov.uk/uncrc/

3 The need to promote emotional wellbeing

More needs to be done to raise awareness of the issues contributing to the increase of mental health problems (in some cases resulting in self-harm or suicide) among children and young people. Raised awareness is also needed with regards to ways in which to address these issues in a way that children and young people find helpful.

Emotional wellbeing and the United Nations Convention on the Rights of the Child (UNCRC)

The importance of emotional wellbeing is reflected in the following UNCRC rights:

- *Article 6: the right to life and maximum survival and development*
  This right is one of the core principles of the UNCRC. It is broad, including the physical, mental, spiritual, moral, psychological and social development of the child or young person as well as suicide prevention. The Committee on the Rights of the Child expects to receive information from governments on the measures they have taken to prevent the suicide of children and young people and to monitor its incidence.

- *Article 19: protection from all forms of violence*
  This right includes a requirement that governments take steps to protect children and young people from self-harm and suicide.

- *Article 24: the right to the highest attainable standard of health*
  In its guidance on adolescents and the right to health, the Committee on the Rights of the Child has urged governments to *'make the community aware of the early signs and symptoms and the seriousness of these conditions, and to protect adolescents from undue pressures, including psychosocial stress'.* The Committee has also highlighted its serious concerns about the high and increasing prevalence of mental health problems among adolescents in many countries, and the increasing incidence of self-harm and suicide within this group. It comments:

  'In many countries symptoms such as depression, eating disorders and self-destructive behaviours, sometimes leading to self-inflicted injuries and suicide, are increasing. They may be related to, inter alia, violence, ill-treatment, abuse and neglect, including sexual abuse, unrealistically high expectations, and/or bullying or hazing [ridicule or abuse] in and outside school. States parties should provide these adolescents with all the necessary services.[14]

[14] Adolescent health and development in the context of the Convention on the Rights of the Child: 01/07/2003. CRC/GC/2003/4. (General Comments) at paragraph 22

Importance of emotional wellbeing and *Every Child Matters*

Emotional wellbeing is a core feature of all five of the Government's intended outcomes for children and young people in its *Every Child Matters* programme[15]. The Government's aim is for every child, whatever their background and circumstances, to have the support they need to:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being

Emotional well-being can have a direct impact on children and young people's social, physical, cognitive and educational development[16]. For example, promoting good mental health can encourage children and young people to realise their potential, whilst providing the right support to children and young people who experience mental distress can help them understand their feelings and fears, as well as develop their own ways of dealing with them. A wide variety of factors are known to affect children's wellbeing, including environment and nutrition[17].

Emotional wellbeing: areas of concern

International Comparison

The *Innocenti* report[18], published by UNICEF in February 2007, provides a stark reminder that more must be done to improve outcomes for all children and young people. The report shows that the wellbeing of children and young people in the UK compares poorly to those in other countries in the developed world. Although the report noted that all countries have weaknesses that need to be addressed, the UK (along with the United States) is in the bottom third of the rankings for five of the six dimensions reviewed[19]. Of particular relevance to children and young people's mental health and emotional well-being are the findings in relation to the sixth measurement, young people's own subjective sense of well-being, which asked children and young people about their health, school life and personal well-being. The UK ranked last.

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[15] Every Child Matters: Change for Children, www.everychildmatters.gov.uk/aims/

[16] See for example, *National Service Framework for Children, Young People and Maternity Services, Standard 9: The Mental Health and Psychological Well-being of Children and Young People*, Department of Health, October 2004, paragraph 2.1, page 6. Also, The Children's Plan, op cit, page 33.

[17] Children and Young People Today: Evidence to Support the Development of the Children's Plan. Department for Children, Schools and Families (2007).

[18] An overview of child well-being in rich countries: A comprehensive assessment of the lives and well-being of children and adolescents in the economically advanced nations: www.unicef-irc.org/presscentre/presskit/reportcard7/rc7_eng.pdf

[19] These were: material well-being, health and safety, education, peer and family relationships, behaviours and risks, and young people's own subjective sense of well-being.

Stigma and discrimination

Recognising the significance of the negative attitudes towards people with mental health problems, the Committee on the Rights of the Child has urged governments '*to combat discrimination and stigma surrounding mental disorders, in line with their obligations under article 2 [right to non-discrimination].*[20]

The stigma associated with 'mental illness' continues to be a problem within our society. This has a negative impact on children and young people and often deters them from seeking help, as well as impacting on their own attitudes towards mental illness in adult life. There is also strong evidence of children and young people with a wide range of health problems or disabilities, including mental health problems, being twice as likely as their peers to become targets of bullying[21].

The setting in which mental health services are delivered is thought to impact on the decision to access services[22]. Co-location of services may help in reducing stigma for some children and young people, though others prefer being seen away from settings where they might meet friends and peers[23]. Although much work is in progress to improve psychological wellbeing, particularly in schools and other educational settings[24], 11 MILLION is concerned that not enough is being done to raise young people's awareness of mental health problems.

High incidence of suicides and self-harm

The numbers of children and young people who engage in self-harm or seek to take their own life is of serious concern. A survey of around 6,000 young people (most aged 15 and 16) undertaken in 2000-2001 found that 1 in 10 of these young people had self-harmed at some point in their teenage years[25]. The report comments:

'Self-harm is a clear sign of distress. Unfortunately it is one which is often repeated, with some 10 to 15 per cent of self-harmers harming themselves again within a year. What is more, adolescents who self-harm are far more likely than other adolescents to go on to die by suicide.'

A two year inquiry into self-harm, focusing on children and young people aged 11-25 years concluded that self-harm among young people

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[20] Adolescent health and development in the context of the Convention on the Rights of the Child: 01/07/2003. CRC/GC/2003/4. (General Comments) at paragraph 29.
[21] The research evidence is reviewed in Carter, B. and Spencer, V. 2006. 'The Fear Factor: Bullying and Students with Disabilities.' International Journal of Special Education, 21, No 1:11-23.
[22] Standard 9 of the Children's National Service Framework, Department of Health (2004) page 15.
[23] CAMHS Interim Review, page 16.
[24] See, for example, the Interim Report of the CAMHS Review, op cit, page 12.
[25] Samaritans & Centre for Suicide Research, University of Oxford (2002) *Youth and Self-harm: Perspectives,* Samaritans

is a 'significant and growing public health problem'[26]. The inquiry report, published in 2006, suggests that one in fifteen young people self-harm, and that the rates of self-harm in the UK are higher than anywhere else in Europe. The inquiry found that there was a lack of awareness and understanding about self-harm amongst school staff and others who work with children and young people who self-harm. It also found that the response to self-harming was often inappropriate, focusing on the self-harm itself rather than the underlying causes. The report makes a series of recommendations geared towards establishing a comprehensive self-harm strategy that promotes positive well-being and provides appropriate information, training and intervention. The report states:

'The key message from young people is that they need preventative measures that are non-judgmental and respectful. Equally important, school staff and others must reach out to young people – rather than expect young people to come forward – and provide opportunities for them to discuss problems before they turn to self-harm as a way of coping.'

Although the Government's report to the Committee on the Rights of the Child identifies the improvement of *'the physical, emotional and psychological health of children and young people'* as a priority, the lack of detail on how it intends to address the levels of suicide and self-harm within this group suggests otherwise. Despite the concerns expressed by the Committee on Human Rights about the high levels of suicide among adolescents in the UK, and the request that the Government undertake studies of the causes and background to suicide, the Government provides the following single paragraph in relation to its work in this area in England:

'In September 2002, the Government published the National Suicide Prevention Strategy for England. The strategy supports the Government target to reduce the death rate from suicide and undetermined injury by at least 20% by 2010. The National Service Framework contains important recommendations to address this[27].'

The National Suicide Prevention Strategy applies to all age groups. Since its introduction, the overall rate of suicide has fallen. In 2005, the rate was at its lowest throughout the period 1991 to 2005, at 17.5 suicides per 100,000 in the UK[28]. In relation to the suicide rate for young men in the 15–24 age group, the rate has fallen from 18.1 per 100,000 in 1998 (when the rates were at their highest) to 11.9 per 100,000 in 2004. For women in this age group, the rate has fallen from 4.5 per 100,000 in 1998 to 3.6 per 100,000[29]. The suicide rate for children aged

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[26] Camelot Foundation & Mental Health Foundation (2006) *Truth Hurts: Report of the National Inquiry into Self-harm among Young People*.
[27] UK Government, *The Consolidated 3rd and 4th Report to the UN Committee on the Rights of the Child,* 2007, page 94.
[28] National Statistics, February 2007, www.statistics.gov.uk/cci/nugget.asp?id=1092
[29] Babb, P.', Butcher, H., Church, J., et al (2006) Social Trends, No 26. London Palgrave (figure 7.2) at:

5 -14 shows the UK rate to be very low in comparison with other developed countries[30]. Whilst these figures are encouraging, there is little information on what specific work, if any, is being done to address the high numbers of children and young people who attempt suicide or self-harm.

Working in schools

11 MILLION welcomes the Government's commitment to fund schools to work with mental health practitioners to improve the emotional well-being of pupils. The provision of such services in schools has real potential to improve outcomes. They may be less stigmatising than mental health services provided elsewhere, particularly where a 'whole school' approach is taken and mental health workers function as part of a multidisciplinary team including all the staff who come into contact with the children and young people at the school. They have a key role in supporting all staff to understand and address mental health problems including behavioural disorders.

However, this additional investment should be seen in the context of a severe shortage of school nurses who would be instrumental in supporting young people experiencing problems. The Government should ensure that the recommended minimum of one full-time school nurse in every secondary school and its cluster of primary schools is achieved[31]. It is hoped that this will be addressed in the context of the current review of the health of school-aged children.

www.statistics.gov.uk/downloads/theme_social/Social_Trends36/Social_Trends_36.pdf

[30] Children and Young People Today, op cit, page 19.

[31] National Service Framework for Children, Young People and Maternity Services, Core standards; Standard 1, pages 37 and 41; Department of Health (2004).

4 Continued problems in access to mental health care

Some children and young people continue to face problems in accessing appropriate mental health services. Further work is required in order to ensure that all children and young people with mental health problems have access to services that are responsive to their needs.

Access to mental health care and the UNCRC

Article 24 (right to health and health services) is of direct relevance to children and young people's access to mental health services. It provides for:

'...the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health'.

Article 24 also requires that States '*strive to ensure that no child is deprived of his or right to access to health care services'.*

There are other UNCRC rights that are relevant to accessing mental health care. For example:

- The rights set out under Article 24 must be applied to all children without discrimination in accordance with Article 2 (non-discrimination).

- Article 23 (rights of disabled children) makes clear that disabled children (including those with mental health problems) have an equal right to the highest attainable standard of physical and mental health.

Developments in Child and Adolescent Mental Health Services (CAMHS)

In its latest report to the Committee on the Rights of the Child, the Government states that every child and young person in the UK *'is entitled to an adequate standard of health and welfare'*. Sadly, this is not the case for all children and young people with mental health problems.

There has been considerable improvement in the provision of mental health services for children and young people since 2002, when Professor Sir David Hall, then President of the Royal College of Paediatrics and Child Health, informed the Joint Committee on Human Rights that:

'... child and adolescent mental health services in this country are a total disgrace. There are many places where the waiting list is 18 months or more. If that were an adult service there would be a public outcry but

this is just accepted as being the situation.'[32]

In addition to the resources being made available to child and adolescent mental health services *(*CAMHS) over the past few years, the Government has set targets and standards to deliver a comprehensive service. The goal was that '*all patients who need them have access to a range of services to tackle mental health problems and emotional well-being by 2006.'*[33]

The evidence currently available suggests that, while there has been much progress towards achieving a comprehensive CAMHS, the pace of change differs across the country and there is still much work to be done to achieve this goal[34].

Over the last two years, 11 MILLION has received some information about cuts in services and clinical posts being reduced. While some of these may be due to restructuring of services, anecdotal evidence suggests that, in some areas, CAMHS are suffering as a result of the financial problems within the NHS. There is concern that the good work to date risks being undermined by under-investment and poor planning in some areas. There is some evidence of this in the CAMHS Review Interim Report:

'The mapping of CAMHS tiers 2-3 suggests some slow down in service development, relative to previous years, and a mixed pattern of both improvements and slight reductions in some services across the country….[35]:

…there are some emerging concerns in some area[s] about disinvestment in some areas and shifts in funding to meet national priorities…[36]*.'*

Mental health care: areas of concern

Waiting lists, referrals and geographical variations

While progress is being made in meeting the demand for CAMHS, this is not necessarily meeting the actual need for such services. In other words, not all children and young people who should be are being referred to CAMHS. One of the means of reducing demand is by having high waiting times, which deter many referrals. It is very difficult to get firm evidence on these issues, but it is an area that merits further attention.

Concern about lengthy waiting times was raised in the Government's report on the implementation of Standard 9, published in November

[32] www.publications.parliament.uk/pa/jt200102/jtselect/jtrights/160/2061005.htm
[33] UK Government's Third Periodic Report 6.29
[34] See for example, Department of Health and Department for Education and Skills, *Report on the Implementation of Standard 9 of the NSF for Children, Young People and Maternity Services* November 2006
[35] Interim Report of CAMHS Review, op cit, page 11
[36] Op cit, page 13.

2006. This report found that some children and young people have to wait over six months to see a CAMHS professional, and that '*only 25% of children with a diagnosable psychiatric disorder were accessing mental health services over a 3 year period*.' It also raised concerns that there are geographical variations in the availability of services, reflecting the different levels of investment in different parts of the country so that access to services depends on which part of the country the child or young person lives[37]. The responses to the recommendations set out in the Children's Commissioner's report, *Pushed into the Shadows: young people's experience of adult mental health facilities* (referred to in this report as 'Pushed into the Shadows')[38] confirm that such problems continue to exist in different parts of the country[39]. This undermines the Government's contention that 24 hour cover is available across the country for urgent needs, and that specialist assessments are undertaken within 24 hours or during the next working day[40].

The CAMHS Review Interim Report refers to variability in access across the country:

'There are still areas where for many children and families access to services is confusing and takes too long. There are areas where services are provided only in a crisis[41].'

Furthermore, a survey carried out by the Royal College of Psychiatrists Research Unit raises concerns about the inequitable distribution of CAMHS in-patient services. It identified not only an increased inequity in provision of CAMH in-patient services, but also a reduction in the number of units that admit children under the age of 14[42].

These issues are of considerable concern to the Children's Commissioner, who would like to see that all those children and young people who need it receive high quality, evidence-based care from appropriately qualified staff.

The importance of early intervention

There are numerous examples of children who would benefit from early intervention, but are not receiving it. This means that some children and young people have to reach a crisis point before their mental health needs are addressed. This was the experience of a number of the young people in *Pushed into the Shadows.*

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[37] Department of Health and Department of Education and Skills, *Report on the Implementation of Standard 9 of the NSF for Children, Young People and Maternity Services,* November 2006

[38] Office of the Children's Commissioner, January 2007, see: http://www.11million.org.uk/resource/m8vtedhs9cbqx3aid5stkdrk.pdf

[39] See Out of the Shadows? A review of the responses to recommendations made in "Pushed into the Shadows: young people's experience of adult mental health facilities", 11 MILLION October 2008.

[40] Available at: www.everychildmatters.gov.uk/uncrc/

[41] CAMHS Review Interim Report, op cit, page 14.

[42] O'Herlihy, A., Lelliott, P., Bannister, D., Cotgrove, A., Farr, H. and Tulloch, S., Psychiatric Bulletin (2007), 31, 454 - 456

There is a strong correlation between school exclusion and young people becoming involved in the criminal justice system, and strong evidence of a link between offending behaviour and mental health problems, as well as learning disabilities. Pupils with special educational needs (who include a higher proportion of those with mental health problems than their peers) are more likely to be excluded than those without[43]. Although it is difficult to ascertain which is cause and which is effect, this is clearly an important link. Finding alternatives to school exclusion might help to maintain engagement with education and prevent a young person from getting into trouble with the law. Early intervention for those with emotional or mental health problems is significant in improving all five *Every Child Matters* outcomes for children, but may be particularly significant in preventing later involvement in crime. Evidence submitted to the current review of CAMHS found that families place particular emphasis on early intervention to avoid crises, and that *'there is concern that interventions can stop too abruptly, leading to further problems[44].'*

While early intervention is important and necessary, there will always be some children and young people who will need specialised services from within tiers 3 and 4. Establishing and maintaining the range of services and support across the CAMHS tiers with smooth transitions between them must be a key objective for the planning and development of CAMHS.

Lack of emergency provision

Pushed into the Shadows, published in January 2007, showed that, despite the national policy objectives that seek to end such practices, children and young people were still being admitted on to adult psychiatric wards. One of the major factors that lead to children and young people in need of in-patient care being admitted to adult psychiatric wards was the lack of sufficient specialised CAMHS in-patient units. A particular concern was that services are not able to respond to emergencies.

Various reports on CAMHS provision have highlighted similar concerns. For example, a 2005 survey of all adolescent in-patient psychiatric units in England and Wales showed that 72% of referrals for emergency admission were turned away[45]. An analysis of the regional reviews of tier 4 Child and Adolescent Mental Health Services (CAMHS) that have been undertaken in England over the last couple of years found that the capacity to admit emergencies varies depending on bed availability, staffing levels and the level of disturbance on the unit[46]. The responses

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[43] Children and Young People Today, op cit, page 69: In 2005/06, 39 in every 10,000 pupils with statements of SEN and 43 in every 10,000 pupils with SEN without statements were permanently excluded from school. This compares with 5 in every 10,000 pupils with no SEN.

[44] CAMHS Review Interim Report, op cit, page 16.

[45] Cotgrove, A., McLoughlin, R., O'Herlihy, A. & Lelliott, P. (2007) 'The ability of adolescent psychiatric units to accept emergency admissions: changes in England and Wales between 2000 and 2005', Psychiatric Bulletin **31**, 457 - 459.

[46] Dr. Zarrina Kurtz, *Regional Reviews of Tier 4 Child and Adolescent Mental Health Services, Summary and Comment,* Care Services Improvement Partnership (CSIP), December 2007 paragraph 1.6

to the recommendations made in *Pushed into the Shadows,* received from Primary Care Trusts and mental health trusts across England, indicate that there continue to be delays in accessing emergency in-patient facilities.

11 MILLION is aware that, in many parts of the country, work is being undertaken to both increase the availability of in-patient provision, including facilities that are able to accept emergencies and out of hours referrals, and to develop community-based services with the aim of reducing the need for admission to in-patient facilities. The national CAMHS mapping (see below) for 2006 found that there were more services providing alternatives to in-patient care on an intensive outreach basis[47]. It is not yet clear writing whether this trend is likely to continue, nor what the implications are for the quality of services. It is very important that such work is planned and implemented proactively and jointly between commissioners and providers, both in adult mental health services and CAMHS. Whilst we are aware that spot purchasing for individual patients is used in some instances, this should not be relied on as a matter of course and is no substitute for longer term commissioning based on a comprehensive assessment of need.

Service mapping

Since 2003, the Government has established a comprehensive exercise to map child and adolescent mental health services[48]. This is now being extended to, and integrated with, other health services for children and young people which is a positive development. This should now be used to identify and address inequalities in provision, and to improve the quality of needs assessment to drive the commissioning of integrated services.

Specific groups of children and young people

11MILLION has particular concerns about the access to mental health care for the following specific groups of children and young people.

- Infants: infant mental health is known to be a highly important predictor of future wellbeing. There is growing evidence of the effectiveness of interventions to address poor infant mental health, which is likely to be associated with weak attachment due to parental problems like poor maternal mental health or substance misuse. 11 MILLION would like to see additional investment in this area to enable specialist services to deliver evidence-based interventions at an earlier stage in the child's life than is currently common practice.

- 16 and 17 year olds: although the provision of age-appropriate services to this age group has been improved, there are still areas of England that have yet to include this age group in CAMHS. The Report on the implementation of Standard 9 of the NSF (published in November 2006), 78% of PCTs were commissioning services for 16

[47] Cited in the CAMHS Review Interim Report, page 11.
[48] See www.childhealthmapping.org.uk

and 17 year olds[49]. Furthermore, there are problems when these young people move from CAMHS at around 18 and require ongoing support, as they are sometimes told that they do not meet the criteria for adult mental health services. There is evidence that *'smooth transitions to young adulthood are still not being achieved…..This includes transitions to a range of services, including adult mental health services'.*[50]

- Children and young people with learning disabilities and mental health problems: the incidence of mental health problems amongst children with learning disabilities is four times higher than for other children (and higher still for those with a severe learning disability[51]). However, whilst much has been improved, mental health services for this group are not yet available equally across all parts of England.

- Children and young people from black and ethnic minority groups: issues of concern include whether these young people are gaining access to services that meet their needs. Information from the Mental Health Act Commission suggests that there is a greater proportion of black and ethnic minority groups detained under the MHA 1983.

- Children and young people who have been abused: it is clear from data collected on 'historic abuse' (i.e. those adults who report that they were abused as children) that many children and young people who are abused during childhood do not report it. There is strong evidence that many will suffer as a consequence of the abuse, and that appropriate, evidence-based therapeutic interventions would go some way to improving their emotional and mental health. As far as sexual abuse is concerned, many children and young people are not accessing appropriate support. Related to this are the needs of young people who display sexually harmful behaviour. They require specialist support which addresses the underlying causes of their offending behaviour. Evidence of the gap in services for these groups is difficult to come by, and more work is needed to assess the needs of these children and young people in order to commission and provide the services required.

- Children and young people within the youth justice system: the very high numbers of children and young people with mental health problems within the youth justice system is also of particular concern[52]. For many of these young people, their mental health needs are met inadequately and, inevitably, their problems continue after leaving custody. In addition, there are some young people with

[49] Report on Standard 9 of the NSF, op cit, page 16.
[50] CAMHS Review, op cit, page 14.
[51] Report on Standard 9, op cit, page 20.
[52] See: Youth Justice Board, *Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community,* 2005, Trust for the Study of Adolescence, *Key Data on Adolescence,* 5th edition 2005; Briefing by Department of Health: *'Mental disorder among young offenders',* October 2000; Office of National Statistics, Psychiatric Morbidity among Young Offenders in England and Wales, 2000;

serious developmental disorders and/or challenging behaviour for whom current provision is insufficient. A small number of high profile cases in recent years have highlighted the serious consequences for these young people. Since 1990, thirty young people under the age of 18 have died in custody: all except two deaths were classified as 'self-inflicted' and died by hanging. 11 MILLION is of the view that the number of children and young people in custody is too high, and that incarceration is unnecessary and inappropriate for some children. The poor mental health of this group needs to be addressed as a high priority - Lord Bradley's current review into the mental health of offenders of all ages may help to show how this can best be achieved.

- Asylum seekers: asylum-seeking children and young people, both those in families and those who are unaccompanied, are known to have a high prevalence of mental health problems[53]. Issues of particular concern to 11 MILLION include those in immigration detention since detention is known to have an adverse impact on their mental health and emotional wellbeing.

These concerns must be addressed if the Government's vision of greater equity of access to CAMHS for all children and young people in all parts of the country is to be achieved. They are also relevant to the Government's obligation under Article 24 of the Convention to strive to ensure no child is deprived of the right to access these mental health care services.

[53] Hodes, M, Jagdev, D et al, Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents. Journal of Child Psychology and Psychiatry (2008).

5 Need to ensure safe and supportive in-patient environments

The Government's commitment to end the inappropriate admission of all children and young people to adult wards by April 2010 is of huge importance. However, in order to realise this commitment, it is essential that Primary Care Trusts and mental health trusts act now to put the necessary measures in place.

There have been significant positive changes to the Mental Health Act 1983, for example the duty to provide an age appropriate hospital environment for patients aged under 18. However, many children and young people will not benefit from the safeguards in this Act as they will be admitted to hospital informally (for example, on the basis of parental consent).

Care and treatment in hospital and the United Nations Convention on the Rights of the Child (UNCRC)

The following articles are of relevance to the care and treatment of children and young people who are admitted to hospital for treatment for their mental health problems. There are particular concerns about young people being admitted to adult psychiatric wards, a focus of the Children's Commissioner's attention during the last three years. For many young people, this can be a frightening and negative experience:[54]

- *Non-discrimination (Article 2):* States must ensure that the UNCRC rights are available to all children without discrimination of any kind.

  The Mental Health Act Commission's report, *Safeguarding children and adolescents detained under the Mental Health Act 1983 on adult psychiatric wards,* based on 18 months of data collected from April 2002, found that 26.8% of the young people detained on adult wards were from ethnic minorities. Although Black Africans and Caribbeans make up just 2.7% of the youth population in England, they accounted for 13.1% of the young people detained on adult wards[55].

- *Respect for the views of the child (Article 12):* States must ensure that children who are capable of forming their views have the right to express those views freely in all matters affecting them, and that their views are *'given due weight in accordance with the age and maturity of the child'*. This is closely connected to *Right to freedom of expression (Article 13).* This Article (13) requires States to ensure that children have the right to freedom of expression. This includes the right to receive and share information. The provision of information is a prerequisite to children and young people's

[54] See for example, Pushed into the Shadows
[55] Mental Health Act Commission , 2004

participation in decision making – they must be appropriately informed about the circumstances and the options[56].

Pushed into the Shadows highlighted numerous incidents where the need to involve and inform the young people was disregarded by staff. Many young people commented that they had little or no involvement in their care planning and were provided with very little explanation of their rights (in particular regarding the use of the MHA 1983); only a very few were told about access to advocacy support.

- *Right to protection from all forms of violence (Article 19):* States must take measures to protect children from *'all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse'*.

  Young people in *Pushed into the Shadows* described feeling unsafe on adult psychiatric wards; some were harassed by other patients with little or no attempts by staff to address this. Others felt threatened or intimidated by staff.

  Article 19 also includes a requirement to take measures to protect children from suicide and self-harm. Some of the young people in *Pushed into the Shadows* stated that they were able to engage in harmful practices, such as misusing drugs or self-harming, whilst on the ward. These incidents suggest that staff lacked training in, and/or experience of, working with children and adolescents.

- *Right to periodic review of treatment (*Article 25): where a child or young person has been *'placed by the competent authorities for the purpose of care, protection or treatment of his or her physical or mental health',* there must be *'a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement'.*

  The Committee on the Rights of the Child highlighted the importance of this article in its *General Comment on Adolescent Health and Development* in the context of the UNCRC:

  'In accordance with article 25 of the Convention, States parties should undertake periodic review of the placement of adolescents in hospitals or psychiatric institutions.'[57]

- *Right to education (Article 28):* States must ensure that there is equal access to education. This applies to all children, including those in detention. The Committee on the Rights of the Child has stressed that, in all cases of deprivation of liberty:

[56] See UNICEF, Implementation Handbook on the Convention on the Rights of the Child, United Nations Children's Fund, 2002 166-7

[57] Adolescent health and development in the context of the Convention on the Rights of the Child: 01/07/2003. CRC/GC/2003/4. (General Comments) at paragraph 29

'Every child of compulsory school age has the right to education suited to his/her needs and abilities, and designed to prepare him/her for return to society; in addition, every child should, when appropriate, receive vocational training in occupations likely to prepare him/her for future employment'.[58]

This was another issue of concern raised by *Pushed into the Shadows*. One of the young people stayed on an adult ward for seven months but, during that time, no action was taken to help her continue with her education.

Some of the Primary Care Trusts and mental health trusts who responded to the recommendations in *Pushed into the Shadows* indicate that education will not be a crucial consideration because the young person will be transferred from the ward within a few days. 11 MILLION considers that, even where the intention is for young people to be placed on adult wards only for a short time, a member of staff should be responsible for maintaining links with the young person's existing place of education. In addition, procedures must be in place to cater for the situations where the young person's stay on the adult ward is longer than a few days. The Government has proposed an extension of the compulsory participation age which, if introduced, would require arrangements to be made for those up to the age of 18[59].

- *Protection for children deprived of their liberty* (Article 37(c)): Article 37 requires that every child or young person deprived of their liberty *'is treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes account the needs of persons of his or her age.'* It also states, '*every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so'*

  We are aware, from the responses to the recommendations set out in *Pushed into the Shadows,* that there is a considerable amount of work to do in order to achieve the goal of ending the inappropriate admission of young people to adult psychiatric wards and ensure that measures are in place to safeguard those young people who are admitted to adult wards.

Care and treatment in hospital: areas of concern

Ending inappropriate admissions to adult wards

Pushed into the Shadows showed that, not only were children and young people being admitted to adult psychiatric wards where services were not geared towards their needs, but the level of care offered to many of those young people was unsatisfactory - poorly planned,

[58] UN Committee on the Rights of the Child, General Comment No 10 (2007), Children's Rights in Juvenile Justice, paragraph 89.
[59] Education and Skills Bill

unsafe and inadequately monitored. 11 MILLION is therefore delighted that the Government has made a commitment to end the inappropriate admission of **all** children and young people on to adult wards by April 2010[60]. We also welcome the Care Services Improvement Partnership's extensive work plan to implement section 31 of Mental Health Act 2007 section 131A Mental Health Act 1983. This provision requires the managers of hospitals to ensure that the environment of the hospital in which the young person is to be admitted is suitable for that young person[61].

Whilst it is clear that concrete action is being undertaken to avoid the inappropriate admission of children and young people to adult wards in some areas, much more work is required to achieve this goal across the country. Such work is necessary to ensure compliance with the duty to set out in section 31 of the Mental Health Act 2007. By April 2010, when this provision comes into force, children and young people admitted to hospital for treatment for mental disorder must be accommodated in an environment that is suitable for their age and individual needs. In order to achieve this, 11 MILLION considers that the following areas will need to be addressed:

- Achieving a comprehensive CAMHS so as to prevent inappropriate admissions to adult wards.
- Establishing a system for the national collection of data to identify how many young people are admitted to adult wards and the length of their stay.
- Establishing robust safeguards for young people on adult wards.

Out of the Shadows[62]*,* includes suggested 'markers of good practice' in the areas set out below. These can be used by PCTs and mental health trusts when developing their policies and protocols to safeguard young people on adult wards, as well as in the planning, commissioning and delivery of mental health services for children and young people:

- A safe and supportive environment
- Provision of age-appropriate information
- Involvement in care planning
- Access to independent advocacy
- Access to education
- Involvement in daily activities
- Opportunities for meaningful participation

[60] Letter from Alan Johnson, Secretary of State for Health, to the Children's Commissioner, September 2007.
[61] See: www.mhact.csip.org.uk/workstreams/the-mental-health-act-amendment-workstreams.html
[62] Out of the Shadows? a review of the responses to recommendations made in Pushed Into The Shadows: young people's experience of adult mental health facilities, 11 MILLION (October 2008). See: http://www.11million.org.uk/resource/lokotpjr40iak1voug7z7ejn.pdf

Care and treatment in CAMHS in-patient facilities

Through our work with VIK (Very Important Kids) and YoungMinds, our visits to various CAMHS units in England, and consultations with practitioners working in this area, we are aware that the level of quality of care in CAMHS in-patient facilities varies widely across the country.

We are concerned that, where there is poor practice, children and young people may not have the support they need to raise their concerns and/or pursue a complaint. Anecdotal evidence suggests that there is a lack of independent, age-appropriate advocacy for children and young people in CAMHS units. Advocates also have an important role in enabling children and young people become involved in their own care-planning. The importance of access to advocacy is discussed below.

At the end of this section we set out below VIK's[63] 'Top Tips' for all tier 4 CAMHS in-patient units.

Changes to the Mental Health Act 1983

The Mental Health Act 2007 will introduce some significant positive changes in relation to the treatment and care of children and young people with mental health problems. As highlighted above, the duty to provide age appropriate accommodation is an important and essential step towards ensuring that the rights children and young people requiring in-patient treatment for their mental health problems are respected. However, we have the following outstanding concerns:

- *Complexity on the law relating to care and treatment:* there has been a long-standing consensus that the law relating to the care and treatment of children and young people is overly complex and requires clarification. The changes introduced by the Mental Health Act 2007 will clarify the situation for 16 and 17 year olds (if they have capacity to make decisions about their admission to hospital, their decision cannot be overridden by parental consent). The Code of Practice, Mental Health Act 1983, 2008 advises against relying on parental consent to override the decision of a child under 16 who is considered 'Gillick competent'[64] who refuses admission to hospital for treatment for mental disorder. In such cases, practitioners will need to

[63] Very Important Kids – see note at footnote 5.

[64] This term derives from the case of Gillick v West Norfolk and Wisbech Area Health Authority [1986] A.C. Paragraph 36.38 of the Code of Practice, Mental Health Act 1983 explains: 'In the case of Gillick, the court held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the competence to consent to that intervention. This is sometimes described as being "Gillick competent". A child may be Gillick competent to consent to admission to hospital, medical treatment, research or any other activity that requires their consent.

consider whether the criteria for detention under the Mental Health Act 1983 are met[65].

However, the situation for children and young people who are unable to make decisions about their admission to hospital for mental disorder is less clear. Young people aged 16 or 17 may be admitted under the Mental Capacity Act 2005 if this applies to their individual circumstances and is considered to be in their best interests. Alternatively they can, like children under 16 who are not considered Gillick competent, be admitted on the basis of parental consent if this is within the 'zone of parental control'. This is a new concept, introduced by the Code of Practice to the Mental Health Act 1983[66]. There is no precise definition of the zone of parental control. Although the Code gives some guidance for practitioners in determining what might fall within this zone, this is likely to cause further confusion to an already uncertain area.

Children and young people who are admitted informally do not have the protections afforded by the Mental Health Act 1983. The key consequences of this are discussed below.

- *Lack of advocacy for informal patients:* the provision requiring independent mental health advocacy to be made available to all patients who are detained under the Mental Health Act 1983 (due to come into force in April 2009) is very welcome. However, unlike their peers who are admitted under the MHA 1983, children and young people who are admitted informally will not have the right to support from Independent Mental Health Advocates (IMHAs) apart from in limited circumstances (such as if ECT (electro-convulsive therapy) is proposed[67]. IMHAs are specialist advocates trained specifically to work within the framework of the Mental Health Act 1983 to meet patients' needs[68].

  It is of concern that this statutory requirement to make advocacy services available does not apply to all children and young people receiving mental health services. This is particularly as many children and young people are likely to be admitted informally, for example on the basis of parental consent. The Department of Health has made clear that advocates trained to work with children and young people, and in mental health legislation, should be available to young people admitted to adult wards[69]. However, we consider that such advocates should be available to all under-18s receiving in-patient mental health care, whether or not they are detained.

[65] The Code of Practice, paragraph 36.43
[66] See the Code of Practice, paragraphs 36.9 – 36.15
[67] See section 130C(3)
[68] See the Code, Chapter 20.
[69] See appendix 6 of *Out of the Shadows* (2008).

Furthermore, given the complexity of the decision-making process for admission to hospital, we consider that advocates should also be available when admission to hospital for treatment for mental disorder is being considered. The independent mental health advocate would be able to ensure that the child or young person understands what is happening, and can be supported during the mental health assessment.

- *Lack of monitoring of care and treatment:* the Mental Health Act Commission (MHAC) has an important role in this area. It is responsible for safeguarding the interests of detained patients (of all ages), and keeping the operation of the Mental Health Act 1983 under review. Detained patients can also meet privately with the MHAC. However, the MHAC does not have a remit in relation to those patients admitted informally, and will therefore not be accessible to those children and young people who admitted on the basis of parental consent or (in the case of 16 and 17 year olds) in accordance with the Mental Capacity Act 2005. Whereas patients compulsorily admitted, detained under the Mental Health Act 1983, can request that the Tribunal (formerly known as the Mental Health Review Tribunal) reviews the continued need for their detention, patients who are informally admitted to hospital have no right to an independent review of the need for their continued in-patient care.

  11 MILLION considers that all children and young people who are admitted to mental health facilities should have their treatment and care monitored in accordance with Article 25 UNCRC. As a step towards this, we recommend that the monitoring role of the MHAC should be extended so that it keeps under review the care and treatment of children and young people who have been admitted to any hospital for treatment for their mental disorder (whether or not detained under the Mental Health Act 1983).

Tier 4:
VIK's Top Tips for CAMHS In-Patient Facilities

- Every unit should be linked to local children and young people's services.
- Children and young people's advocacy should be signposted on the ward to let young people know that advocacy is "their right", and it should be accessible without explicit permission from staff.
- Children and young people should receive user friendly information about every step of their treatment in an in-patient unit. This should be delivered in ways that they can access, and at various points so that they can take the information in (maybe

through a computer programme/game/leaflets/DVD etc).

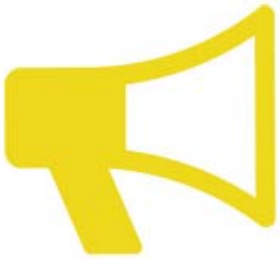
- Dignity nurse – there is now a 'dignity nurse' role at each hospital. This person should visit the psychiatric ward and have direct contact with patients through an available free phone on the ward.
- Key workers should have time to talk to children and young people about their care plans.
- Children and young people should be given allocated time to talk about their care plans (can be with a named person).
- Ward managers/dignity nurse/advocates should collate feedback from patients regularly. This should be through a range of methods (and enabling respondents to maintain their anonymity if they so wish), such as:
  - through a suggestion box
  - comments that can be sent to an email address
  - regular visits.
- Time during ward rounds should be dedicated to the child or young person so that s/he can ask questions or resolve queries. There must be enough time to do this.
- If agency staff are required, they must be CAMHS trained.
- There should be guidance for agency staff regarding appropriate training/policies and procedures on the ward.
- Adult mental health services should be linked to CAMHS so that children and young people can be supported in the transition to adult services (similar to the way in which children and young people are supported from primary to secondary school). For example, staff visiting CAMHS wards, provision of a link worker, education and occupational therapy staff working together.
- Pre discharge – staff from the next team should come to the current ward/clinic to meet with the child/young person, so as to provide familiarity during the hand over period.
- The most appropriate bed should be given to the child/young person, for example those of higher risk should be the nearest to the nurses' station.

6 Conclusion

In recent years, much progress has been made in improving the psychological wellbeing of children, and young people and in recognising that this is the responsibility of everyone who works with children. There has also been considerable investment in mental health services. This has led to a more strategic approach to the commissioning and delivery of mental health services for children and young people, informed by a comprehensive analysis of needs.

However, there is still a need for more concerted action focusing on effective prevention strategies, as well as for earlier and more sustained interventions, and more comprehensive and equal access to high quality evidence-based treatment. To achieve this will require sustained investment across children's services, closer alignment with adult services and an even greater focus on commissioning services jointly within children's trust arrangements.

This briefing shows that more needs to be done to ensure that the rights of all children and young people with, or at risk of, mental health problems are met, and that all children are able to fulfil their potential.



"The 11 MILLION children and young people in England have a voice"
Children's Commissioner for England, Professor Sir Albert Aynsley-Green

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