Transforming children and young people's mental health provision

A response from the Partnership for Wellbeing and Mental Health in Schools, the Fair Education Alliance and the Children and Young People's Mental Health Coalition

About this response

Membership of these three coalitions includes leading charities, professional and provider associations from across the education, health and social care sectors, and the voluntary and community sector. This response reflects the consensus identified following two national consultation events held with over 50 of our members in December and January. These are listed in Annex A.

Introduction

Members of these three coalitions strongly support the Green Paper's intention to continue the transformation of children and young people's mental health provision. The Green Paper's proposals have the potential to both amplify and strengthen the direction already set by Future in Mind. We therefore hope that current and future work under the Green Paper's proposals build on the principles already set, and agreed, in Future in Mind. Government reassurance that Future in Mind will continue to provide the foundations for the long-term strategy required to tackle the inequalities in meeting children and young people's needs is crucial if national and local partners are to deliver on the vital improvement required.

Whilst we particularly welcome the collaborative approach between health and education in some aspects of the Green Paper's proposals, there is a wider challenge of developing the long term strategic and sustainable approach to improving children and young people's mental health and

wellbeing. We are very supportive of the Green Paper's proposals to raise the profile of children and young people's mental health and wellbeing in schools and colleges. We are concerned, however, that without a more holistic and systemic approach, the preventative measures set out will be undermined by the absence of wider social and community-based support.

We believe there needs to be a wider strategy that focuses on tackling the major determinants of poor mental health - poverty, social inequality, poor housing and degraded communities, as evidenced in successive recent studies of children's mental health and well-being, Millennium Cohort Studies, (2016, 2017, 2018). Without a long-term sustainable plan that includes the whole system and its workforce, there is a danger that the Paper's key three proposals will flounder. If there is continued poor access to the wider support children, young people and their families require, the consequences will be the risk of worsening mental health and wellbeing for children and young people, rather than the laudable improvement the Government wishes for all. A range of evidence-based actions have already been recommended in a report[1] commissioned by Public Health England, and a plan to enable their implementation would go a long way to enabling the Green Paper's proposals to take root.

1. Schools and colleges

1.1 We warmly welcome the Green Paper's recognition of the need to promote whole school and college approaches to children and young people's mental health and wellbeing. In building schools and colleges' commitment to deliver the proposals, we believe it will be important they are offered opportunities to see how a whole organisation approach can bring benefits to both staff and students and their families and carers.

1.2 We also believe that a careful balance needs to be struck in terms of the Green Paper's worthy intentions to ensure more prevention and early intervention within schools and colleges and their wider purpose. Schools and colleges should be expected to be communities that understand the importance, value and cost benefits of developing good mental health. They should also be expected to provide good quality teaching and learning about positive mental health, emotional resilience and life skills. However, there is a risk that the Green Paper's ambitions may feel overwhelming if not implemented and managed well.

[1] https://www.mentalhealth.org.uk/sites/default/files/mental-health-and-prevention-taking-local-action-for-better-mental-health-july-2016.pdf.

1.3 It is also important that these proposals are not interpreted as shifting the balance of responsibility for children and young people's mental health and wellbeing into schools and colleges. This may be a risk unless the support from Mental Health Support Teams, and perhaps more importantly the wider system of services for children and young people is properly strengthened. Without this, these proposals may leave schools and colleges simply feeling further burdened at a time when they are already facing considerable budgetary and other pressures.

1.4 Many schools and colleges are already doing a considerable amount of positive work in supporting whole-school approaches to mental health and wellbeing. While this can be built on to support the Green Paper's further ambitions, other schools may need to be convinced of the value of the approach. Encouraging schools and colleges to adopt whole school approaches on the basis, for example, of 'nudge theory' principles may be the best approach.

1.5 **The Green Paper's proposals must make clear that they are intended to cover the needs of all school-age children and young people.** This importantly includes ensuring those <u>not</u> in mainstream schools, e.g. pupil referral units, alternative provision and special schools benefit equally from local implementation. Consideration should also be given to those who are home-schooled. Improving access to prevention and early intervention for some of the most vulnerable will be a key test of whether all aspects of the Green Paper's proposals are effective.

1.6 Providing incentives to appoint Designated Senior Lead (DSL) for Mental Health is a positive step, and there may be a case for the role to become a statutory responsibility for schools and colleges in the longer term. This would be subject to the role being shown to be effective and if additional resources could be made available to schools and colleges. However, **a whole school approach goes beyond one person.** In our view it also requires:

- Strong senior leadership, including governors.
- The promotion of an asset-based, rather than a deficit model of mental health and wellbeing
- The involvement of children, young people and parents/carers
- Wellbeing and mental health embedded in both the PSHE curriculum, and the broader curriculum;

- A focus on staff wellbeing;
- Policies and procedures that both model and reinforce the approach
- Strong links with external specialists and wider services in the community.
- Ongoing access to relevant training for all staff

1.7 The question of who, and which level of staff should be appointed to take on the role of a DSL should be determined by individual schools and colleges. **The success of the DSL role is more likely if taken up by someone committed to championing the agenda within the organisation.** The DSL remit will also need to be as much about promoting good mental health and championing ideas that everyone in the school community can practically implement, as it is about being the key link for those children and young people needing more targeted support.

1.8 While there is a strong overlap between the DSL remit and that of the SENCO and safeguarding lead, and these staff will need to work closely together, we are generally of the belief that this role should not be added to these other roles. However, we recognise that the size and make-up of a school/college will have some bearing on this decision. Whatever local decisions are made about who leads responsibility, it is very important that there is a **more explicit recognition of the links and crossovers between the SEND, safeguarding and mental health and wellbeing agendas. This is as important at national level, as it is at the local area and individual institution level.** Further guidance about how these agendas should work together to ensure that children and young people with overlapping needs are supported appropriately and not bounced between different responsibilities would be welcomed.

1.9 There must also be **greater recognition of the interaction between the Green Paper's main proposals and social care, particularly existing duties** on health services, education services and local authorities **under the Children Act 1989, Care Act 2014 and Children and Families Act 2014**. Both DSLs and the Mental Health Support Teams are likely to have to support

compliance with these duties and the delivery of certain rights under the current legislation.

1.10 **The DSL should bring not just additional skills and knowledge into schools and colleges, but also additional capacity**. This will help to ensure there is time and space to implement change across the whole school. Without this additional capacity, there is a real risk that the ambitions set will flounder in many schools and colleges.

1.11 While new staff may benefit from the welcome changes in teacher training, there is also a **need to ensure longstanding staff have the opportunity to develop their skills and knowledge**. Ensuring a widening of skills and knowledge across the workforce will also help to ensure the sustainability of the DSL role and their work when staff changes occur. While widening the skills and knowledge base of the teaching workforce will be helpful, further clarity is required about how schools will sustain the DSL role in the inevitable turnover of staff. **Ongoing resources must be available to schools to enable them to have continued access to the DSL training programme.**

1.12 The training offered to DSL's and other staff should include a focus on developing a shared language framework, as well as skills and knowledge. There needs to be a balance between developing good mental health, as well as an understanding of mental health problems. The latter should, for example, include awareness of those with learning disability and autism, those with Developmental Language Disorder and other speech, language and communication needs with mild to moderate mental health needs, together with an understanding of the factors that may leave some children and young people vulnerable to mental health problems issues. **The training should also support DSLs to become better equipped with strategies for targeting support on the more vulnerable before mental health issues become a problem.**

1.13 We also believe some consideration might be given **to placing responsibility for mental health and wellbeing on a par with safeguarding.** This would ensure that everyone shares responsibility for changing the culture of schools.

1.14 The Green Paper makes assumptions about the place of school and college in young people's lives. While some children, young people and parents and carers will see school as a safe and

non-stigmatising place, for others this will not be the case. **No child or young person should be deterred from seeking and getting help because they are led to believe that school is the best/only place where they can be seen**. The voice and choice of children and young people regarding who and where they are seen must remain at the heart of service delivery, as must their views (based on their capacity to consent) of how, when and sometimes whether their families are involved. If schools are unable to accommodate young people's wishes in this respect – and when they are offered help during school time, this is often the case - then young people must be given clear information about how they can access help outside the school.

1.15 It is also important that **where access to further help is identified with children, young people and/or their families, this must not become limited by the school gate and term times.** We do not for example want to see mental health support replicating the 'Holiday Hunger' issues for those taking up free school meals!

1.16 As Future in Mind recognised, children and young people's mental health services (CYPMHS) depend upon a whole-system approach. **If schools and colleges are to meet the challenges set in the Green Paper then this will only be feasible if the rest of the system of support for children and young people is also functioning well.** To support schools and colleges and in particular the DSL, to fulfil their responsibilities, it is essential that the expertise of the whole children and young people's workforce is harnessed to both identify and respond appropriately to the totality of needs affecting mental health. The Government should clarify how the expertise of the wider health and wellbeing workforce is going to be used to support schools and colleges.

1.17 Continued and sustained investment in local community-based CYPMHS and wider services for children and young people is imperative. **A strong local network of CYPMHS and other services through a range of provide**rs will best ensure schools/colleges have fast and easy access to consultancy and advice they need, as well as opportunities to refer children and young people to a wide range of interventions and other support both in school and/or the local community. Local Primary Mental Health workers, alongside others are an important element of the local network, and how their role works with the DSL (MH) role, and

how their roles complement one another, should be considered as part of the Trailblazer evaluations.

1.18 While we recognise the Green Paper's intention to cover colleges and schools, clearly differences in the college curriculum, the age and range of the student population present some very different issues from those of schools. **Further discussion with the further education sector would be very useful to ensure that the Green Paper's proposals can be better shaped to reflect and meet the college context**. The university sector would also benefit from further discussion in this area too (in addition to the proposals on 16-25 year olds). Student Mental Health Services in Higher education institutions (HEI) and apprenticeship schemes should for example establish coordinated working relationships with local NHS mental health services. The form that this should take will depend on local need and context.

2. Role of Mental Health Support Teams

2.1 Given the widespread recognition of the current lack of capacity to meet demand in CYPMHS, we welcome the potential investment signalled by the introduction of Mental Health Support Teams (MHST). The proposal offers the potential to provide an accessible, 'school centric' service, which, when appropriate, could provide a smoother transition to CAMHS. We also believe that decisions regarding the role, skills and remit of MHSTs should rightly be considered in the context of best evidence about the level of need and what is likely to work best in responding to these needs.

2.2 Appropriately skilled and experienced clinicians must be involved in the oversight of the teams. Children and young people and their families and carers are entitled to expect high standards of mental health care whether in schools and colleges or in NHS settings. It is vital that CAMHS are embedded into the MHSTs. While the form this takes may vary depending on local context, it must be made explicit so that all stakeholders understand how the relationship works. Attention must also be paid to ensuring a common language between the health and education sectors, as well as the wider system of social care and other services for children and young people.

2.3 The current evidence about the scale of mild to moderate mental health problems is limited. However, many children and young people with these needs are already being seen both within schools and in NHS and voluntary sector CYPMHS. There is also evidence of good outcomes for children and young people through the implementation of nationally validated tools. **It is crucial that MHSTs are secured in a way that helps to expand and complement, not displace the current workforce, including Primary Mental Health Workers.**

2.4 We understand the training and employment of MHSTs is likely to be at least informed by the experience of the Child Wellbeing Practitioner role. We would welcome further clarity regarding the value of this role, as currently we are unsure how a decision to invest in this, rather than for example a range of other therapeutic trainings, is the best approach. **We would welcome more information about how the current training and deployment of Child Wellbeing Practitioners is being evaluated.**

2.5 There is also **some concern that staff in the MHSTs will be less experienced** (potentially newly-graduated). While graduates clearly have much to offer and it is important to encourage new and younger people into the workforce, MHSTs must include **sufficient numbers of senior and qualified practitioners able to offer advice and supervision and ensure access to the range of expertise required.**

2.6 Schools have also expressed concern that very experienced (and relatively well paid) teaching staff may be turning for additional advice and support from less inexperienced staff in MHSTs. If this is the case, then the credibility of MHSTs as an additional resource for schools is likely to be compromised from the outset. Many schools, particularly those that invest considerably in their support of students, will often turn to outside help only when they have exhausted all the other strategies available to them. **Schools will therefore want to know that they are referring on to someone who can bring an additional level of expertise and experience.**

2.7 A further point has also been made about the need to ensure sufficient time for staff from all sectors to liaise with each other, and share information generally, as well as to seek advice about specific children and young people. **Information sharing between the**

education, health and social care sectors (with due regard to the rights of children, young people and families) may be an area that needs further exploration in the implementation of the MHSTs.

2.8 **If the MHST training is limited to new entrants into the workforce, the costs of the programme are likely to become very costly and thus unsustainable very quickly**. Younger and less qualified staff in MHSTs are for very good reasons likely to want to move on rapidly to further their careers – often by engaging in further therapeutic trainings. **A high turnover of MHST staff will not only be costly, it will also be detrimental to children and young people in providing the continuity of care they often need.** It will also make it harder to affect a transformative cultural shift within schools towards mental health literacy and a whole-school ethos that is supportive and responsive to mental health need.

2.9 We would like to understand whether **the option of drawing in more recently qualified people from other therapeutic backgrounds has been considered** e.g. various counselling, drama, arts and play therapies? Offering people with existing training and qualifications a short training based for example on the CYP IAPT Enhanced Evidence Based Practice programme could provide both the additional skills required, as well as the continuity of help and support required by children and young people. This would also help to meet schools and colleges' demand for access to more help, and their ability to provide a greater variety of evidence-based therapies. Such an approach would also ensure a more sustainable and stable workforce, since they will already be equipped to work with children and young people.

2.10 We hope the planned local trailblazer sites will offer a diversity of service, workforce and other characteristics in which MHSTs will work. **Assessing which organisations are appropriate to host and manage MHSTs should be judged on whether they can meet a necessary set of functions and competencies.** The experience of the CYP IAPT programme for example demonstrated that the capacity to offer these functions and competencies could be available in some voluntary sector provision.

2.11 We also wish to highlight the following points regarding the role and training of MHSTs:

- Best practice in assessing children and young people should rely on skilled and experienced practitioners. It is currently unclear which staff in the MHSTs will be expected to undertake assessments, including risk assessments and how the necessary skills and experience will be built into the Teams. One person offering supervision and assessments across a number of schools scattered across a wide geographic area is unlikely to be sufficient.

- Equally important is the need for a clear directive about how MHSTs will work with other practitioners in schools and colleges, for example Educational Psychologists and counsellors.

- Those working in the MHSTs should be familiar with the teaching and learning on mental health and wellbeing available to children and young people. Helping children and young people to make links between any current/emerging needs and the tools and strategies they may already be aware of can be helpful in reminding and reinforcing how they can make use of what they are learning.

- Any entry requirements for training to be a member of a MHST should demand staff have some prior experience of working with either children or young people.

- The MHST workforce should also have knowledge of the wide range of bio-psychosocial risk factors impacting on children and young people's mental health and wellbeing. This includes for example poverty and neglect, as well as Developmental Language Disorder and other speech, language and communication needs alongside many other factors.

- There is a need to **recognise the different age range these Teams may work with i.e. 5-25 years**. Opportunities to specialise in work with younger children and/or young people should be considered within the Teams.

- We would also want opportunities to **include training in interventions beyond those such as CBT.** Whilst CBT clearly has a place and value, the evidence from the CYP IAPT programme is not conclusive[2]. We believe more weight should be

[2] http://www.corc.uk.net/media/1544/0505207_corc-report_for-web.pdf

given to interventions which have been part of good quality evaluations and the results of practice demonstrated through the implementation of nationally validated measures. The absence of RCT-based evidence should not be a barrier to providing the services that children and young people are positive about and which have evidence of good outcomes.

- While there is no mention of the use of routine outcome measures (ROMs) and on-going evaluation of the effectiveness of the services offered by a MHST, we support and endorse their use. Data gathered through ROMs will be an important part of the overall evaluation of the role and work of MHST and they should therefore be fully trained in their implementation

- The MHST's focus seems to be on early identification and prevention, but equally important is wellbeing. Likewise**, a more proactive response to addressing the social determinants of mental health would also be a useful part of the MHSTs' remit.**

- There is also a need to consider **how the MHSTs will potentially work with adult mental health services.** If MHSTs operate in colleges, then they will inevitably come into contact with 18-25 year olds and the potential need to work with a range of adult services. It is also the case that children and young people's mental health can be affected by their parents' mental health problems.

- Concern has also been expressed about **the issue of consent and confidentiality when working with the different ages.** The opportunity to place staff from the MHSTs in different settings will mean different organisational policies impacting on consent and confidentiality. Schools are likely to require parental consent regardless of age and the competency of a young person, while voluntary sector services with due regard to the legal framework, generally take a more flexible and needs focused-approach.

2.12 Given the current crisis in Child and Young People Mental Health Services (CYPMHS) - with around 75% of CYP with significant mental health needs not currently able to access treatment - to what extent will an investment in MHST address this issue? There is a risk that rather than helping to reduce need, MHSTs may simply add to the level of demand. If MHSTs

successfully reach and identify CYP whose needs are beyond their remit, what will happen to these CYP if the specialist capacity is not available? It is therefore imperative that **sufficient local capacity for those with more serious and complex mental health issues is included in the implementation of these proposals.**

2.13 Currently there is a lack of clarity about who will be responsible for identifying and supporting children and young people with significant mental health needs**.** If the MHST's role is limited to responding to mild to moderate mental health problems and largely aimed at those with depression and anxiety, then greater clarity is required about their role in relation to those whose needs fall outside these areas. **How will the system be properly equipped to ensure MHSTs are not left to hold and manage more serious and complex issues?** In the implementation of these proposals, sufficient care should be taken to ensure the availability and capacity of clinicians and services with a range of seniority and experience and that these are effectively mapped into the MHSTs. The right level of skills and experience to pro-actively identify and respond to these needs is imperative within the MHSTs.

2.14 It is also clear that **children and young people with mild to moderate mental health needs may have other complex needs** e.g. due to neglect, abuse, long term physical health, special educational needs and disabilities, such as speech, language and communication needs or other social and family problems. If MHSTs are to be effective, it is essential that they have access to the expertise of the wider children and young people's workforce. This is particularly important given the Government see MHSTs as having a referral and assessment function.

2.15 Clarity is needed on how the social care sector and other local authority-led services, such as Early Intervention Services, as well as the wider Health sector, such as Paediatricians and GPs, and speech and language therapists being informed and prepared for a potential increase in demand as a result of the introduction of MHSTs? We are particularly concerned about the lack of reference to the role of local authorities, especially social care provision in the Green Paper's proposals, particularly since many children and young people with mental health issues live in families that need, but cannot or do not access social care provision.

2.16 The introduction of **MHSTs, alongside the proposals for training a wider range of education and other staff requires**

further thought about wider workforce development and the setting of core competencies. This includes ensuring that **mental health professionals also benefit from specific training to become familiar with the school context**

2.17 While the NHS will need to update its own pathways to include the MHSTs and their role in meeting the needs of mild and moderate mental health needs, we question whether this is the most accessible format for schools/colleges and others? **Schools/colleges and others will need accessible information to enable them to make sense of the wide range of therapeutically trained professionals. It is equally important that information is accessible to children and young people and their families.** This should help to clarify who offers what and how it may be appropriate to particular needs and how different professional trainings and qualifications potentially work together.

3. Children and Young People

3.1 The Paper's proposals must work well for the most vulnerable. Local Transformation Plans should already have identified these groups and be working to develop local strategies to further identify and meet their needs. We believe access t**o good mental health and wellbeing is an important social justice issue** and hitherto fairness and equality have too often been absent in current responses to children and young people's mental health.

3.2 **Prevention, protection, care and compassion for all, but particularly the most vulnerable should be a critical and explicit feature to testing whether the proposals are working well**. Delivered through a human rights framework and based on a partnership between different sectors, those experiencing the most challenges and adverse circumstances should be a key target for the proposals. This includes for example those in temporary and unsuitable housing, those where domestic violence is identified, those with a range of disabilities, young carers, those in the care system, refugees and LGBT young people etc..

3.3 Identification, assessment and the support of these groups will depend on good local partnerships between schools/colleges and wider services, as well as appropriate levels of information sharing. For some of these young people their **mental health and wellbeing will only improve if other factors in their lives is improved e.g. their housing and other social and care needs**

3.4 There is also a need for **more emphasis on the role and relationship with parents and carers, both within and outside of the school context**, and especially with those in the most challenging and adverse circumstances. Given that research shows that family relationship problems are the biggest presenting issue for children and young people in CAMHS[3], (although this may not be true for older adolescents see in voluntary sector CYPMHS[4]), schools and colleges, as well as the MHSTs will need to have capacity to ensure they can work appropriately and sensitively with parents/carers. Such approaches are more likely to contribute to the best and ongoing support of children and young people by their families.

3.5 We are disappointed by **the absence of any reference to early years**. There is a need to ensure the mental health needs of 0-5 year olds as they enter nursery (and other childcare) settings are considered more explicitly in the implementation of the Green Paper's proposals. This includes the training of early years staff in developing their awareness of mental health prevention and early intervention, including an awareness of parental/carer mental health and wellbeing. **Nurseries attached to schools should be included in the school's wider approach, but independent nursery provision needs further thought and engagement with this sector would be useful.** The Government should also consider further investment in perinatal mental health services.

3.6 We are however **very pleased that the specific needs of 16-25 year olds have been singled out** for attention through the set-up of a 'strategic partnership'. There is a longstanding body of evidence concerning the problems of access to services and the funding of provision for 16-25 year olds.

3.7 However, we are concerned that despite recognition of the difficulties faced by this age group, there is **a lack of urgency in the proposals and little focus on those outside Higher Education settings.** While there is an urgent need to attend to the needs of students in HEIs, there is an equal need to include the most vulnerable and deprived young people, including those with lower educational attainment. The housing, financial, and other

[3] http://pbrcamhs.org/final-report/

[4] http://www.youthaccess.org.uk/downloads/ypimtheyoungpeople.pdf

social, health, care, and SEND needs of this group must be included in the work of the 'Partnership'.

3.8 The **focus must also go beyond the problems of 'transition,'** which is too often narrowly defined within the mental health sector as the gap between CAMHS and adult mental health services for those young people already in the mental health system. The Partnership must **consider the needs of young people who are not able to, or choose not to access, NHS services** if it is truly tackle the gaps in services and needs of this group.

3.9 Equally important is consideration of the geographical transitions created through the relocation of young people. This includes university students, as well as those moving home due to work and other reasons. The **impact of repeatedly moving between home and university support services is particularly detrimental to student mental health and their access to and the maintenance of good and continuing care and support.**

3.10 It is vital the Partnership is a jo**int enterprise between those responsible for youth and adult policy and commissioning.** The adult sector holds the bulk of the resources available for this group and while there are theoretically few barriers to focusing the resources specifically on meeting the distinct needs of this group, in practice this rarely happens. To date the adult sector has shown little interest in catering specifically to the needs of this group.

3.11 Equally important is that **adult policymakers/commissioners learn from those practitioners and providers in the youth sector and young people themselves** and build on this work by developing more flexible age-appropriate provision. Young people must be directly involved in co-producing the work under the 'Strategic Partnership'. Despite the challenges, there is good practice that can be built on with many examples of good practice[5]. as well as provision in the voluntary sector such as Youth Information, Advice and Counselling Services (YIACS) as recognised in Future in Mind.

3.12 The 'Strategic Partnership should also consider the following:

[5] http://www.studentminds.org.uk/studentvoices

- MHSTs' role in supporting transitions from CAMHS to adult services.
- the integration of Early Intervention Psychosis into the new model of services
- an increase in funding for Early Intervention services for young adults need to ensure the continuation of interventions and services
- further development and funding of Student mental health services at both Furher and Higher education levels

4. Waiting time standard

4.1 We are **pleased to see the proposal to test the implementation of a new waiting time standard** for CYPMHS. Given the challenges this is likely to present to local areas, the testing of the standard is entirely appropriate. However, there needs to be a **sufficient number of sites to ensure the robustness of the learning**. The Green Paper seems only to propose trialling the standard in some trailblazer areas and we question whether this will offer sufficient diversity of contexts in which to understand how best to secure an effective national roll-out.

4.2 As is widely recognised, CYPMHS demands a whole-system approach and there are often complex local funding and commissioning arrangements. We would like to see **local sites bringing a whole-system approach to testing the standard.** This will hopefully enable learning about the whole of a child/young person's potential journey to 'treatment' i.e. the first point of contact, access to information and advice; assessment and the jointly agreed outcome of any assessment - whether this results in a specialist intervention or something else.

4.3 We would like to see local areas in the pilot sites conducting **a brief audit of where and how these different functions** i.e. local contact, information/advice, assessment, ongoing "treatment" are performed across all local services, together with the competencies of staff in a range of settings.

4.4 The testing of a waiting time standard must **go beyond NHS directly provided services (CAMHS) to include, as a minimum, other services provided under NHS-contracts and**

funding. (The ideal would be to test the standard against services funded through the multiple funding and commissioning arrangements for CYPMHS e.g. local authority, schools-funded provision.) Understanding children and young people's journey and response times across all stages and services (especially those that contribute to reducing some of the risk factors that impact on children and young people's mental health) is critical to improving both the management of demand/appropriateness of referrals, as well improving response times at all stages. It will also help to ensure that funding is targeted at the key services used by children and young people, and enable better decisions to be made about where to deploy resources to have the greatest impact.

4.5 Good data collection will be crucial to testing the standard. Ease of data collection must be considered to minimise the risk of this becoming a bureaucratic burden. We believe some further support and investment is likely to be required if all relevant agencies are to have the capacity to contribute effectively. This means **resources to ensure access to good IT and training for relevant staff.**

4.6 Of concern are voluntary sector (VS) agencies operating NHS contracts, and also meeting the multiple demands of other significant funders with different data requirements. Simply demanding NHS-contracted VS provision implements a system designed for the NHS will not work. We would urge **further thought about how an investment in IT solutions can be made available to ensure data can flow usefully between different systems and providers**. We hope that a lack of resources does not deter the inclusion of VS providers in the testing sites, as this will cause a clear loss of good data about children and young people's journey to help and support.

4.7 For the target to be implemented satisfactorily, there must be additional clinical staff employed in front-line services. If the four week target is introduced without sufficient support, it will mean children will potentially have quicker assessment but then wait even longer, than current waits, for intervention/treatment.

4.8 We also believe that the selected **testing sites must operate in the 'real' context** - not skew delivery by re-deploying resources at the expense of other provision or at the cost of children and young people themselves. Children and young people must continue to have a choice about where they are seen and for

how long. Commissioners must not arbitrarily set limits on the amount of treatment offered to meet a target. As with other areas of health, we believe the principle of children and young people's choice together with clinical judgement remain paramount.

5. Implementation and Evaluation

5.1 We welcome the willingness of government to ensure the proposals are properly tested and evaluated and to be willing to offer a degree of flexibility to local areas, so that responses are shaped in accordance with local needs. However, it is **disappointing that the ambition across the proposals is limited.** Coverage of just 1/5 – ¼ of the country by 2023 is nearly a decade since the Taskforce was set up that led to the publication of Future in Mind.

5.2 As a consequence, **most children and young people in education today are unlikely to benefit** from a change in the culture and curriculum of schools and colleges and the many good intentions of the Green Paper. The absence of any commitment to implement the waiting time standard nationally will continue the postcode lottery in access to help. In some areas, there is a risk that access to services may worsen given the funding levels, despite the best intentions of policy. And for 16-25 year olds, unless the proposed 'strategic partnership' is tasked with the production of a clear and urgent plan for action, there is a risk nothing will happen within the life of this Parliament and a good chance it will slip off the agenda again.

5.3 We welcome the commitment to **ensure robust evaluation.** As stated during evidence to the Health and Education Sub-Committee what we want to see above all else is "a rapid, iterative, well-evidenced and outcome-focused response" across all the proposals. It is unclear whether the resources identified thus far will be sufficient to meet both the demands of the evaluation and the implementation of proposals across a five-year period.

5.4 Whatever the level of investment made to deliver across all the Green Paper's proposals, **safeguards must be put in place to ensure this new funding is protected and does not displace existing resources for CYPMHS or wider Health and other children and young people's services.** From the experience of

the CYP IAPT programme, the agreement of local commissioners to maintain local investment in services whilst benefiting from national investment programmes proved no guarantee. In the roll out of these proposals, there needs to be a **strong mechanism or consequence in place to deter any displacement of existing funds** for local service delivery.

5.5 The evaluation must be designed at the outset of the implementation process – ideally from the point of the site recruitment and selection process. **It is also crucial that those directly involved in the work should be co-producers in the evaluation's design.** This includes children and young people, school staff, local authority, wider Health and voluntary sector, as well as mental health service providers and practitioners and professional bodies. It is particularly important that those organisations that support particular vulnerable groups such as young carers, LGBT young people and others are actively included in evaluating the effectiveness of the proposals in meeting the needs of the some of the most vulnerable children and young people.

5.6 In addition to supporting the collection of evidence through ROM, we would also want to see as a minimum better recorded data across all parts of the system regarding referral rates, service take-up and drop out, as well as the level of 'DNAs'. This will add to a better understanding of both how to improve services, as well as to improving investment in effective services that children, young people and their families and carers value.

5.7 **Regular interim reports of the findings** should be published and where emerging good practice is identified, this should be readily disseminated to other areas (in and out of the selected sites) to ensure **opportunities to build a movement for change across the country as rapidly as possible.**

We would also recommend that the evaluation tracks those areas that apply to become sites, but are not selected, since the coming together to bid for inclusion in the process may yield some wider changes in practice that it would be useful to capture and learn from.

5.8 We share government's view for trailblazer sites to offer a diverse mix of local population and geographical characteristics, alongside a mix of schools e.g. mainstream, special schools and

colleges. On balance, and given the potential limitations of resources, we suggest **areas selected might initially include those where some investment has already occurred.** For example, the schools link pilot sites, where it is hoped there will be some effective partnership work built between schools and local CYPMHS provision could offer a fruitful basis for more rapid implementation of the proposals.

5.9 Other evidence that might also be considered in terms of site selection could come from local Headstart areas, the review of CYPMHS by CQC, as well as any analysis of Local Transformation Plans (LTPs). **We would expect that any areas selected as Trailblazer sites to integrate this development into their existing Plan.**

5.10 Finally, without a clear and robust plan for the recruitment and retention of a multi-professional workforce, including child and adolescent psychiatrists, nurses, psychologists, allied mental health, including a range of therapeutically trained practitioners and other health professionals and social workers, the Green Paper's ambitions and those of Future in Mind will not be realised. We urge Government to ensure that it takes steps to ensure the resources are available to develop and implement such a plan.

APPENDIX I

CONTRIBUTING ORGANISATIONS

Action for Children
Action for Happiness
Association for Child and Adolescent Mental Health
Association for Young People's Health
Association of Educational Psychologists
Association of School and College Leaders
Barnardo's
Beat
Bethlem and Maudsley Hospital School
British Association for Counselling and Psychotherapy
British Psychological Society
Canterbury Christ Church University
Carers Trust
Cathy Street, Consultant
Centre for Mental Health
Children's Society
Coram Life Education

Evolve
Family Action
Family Links
Girl Guiding
Harmless
Hear4You, Metanoia Institute
Hilary Emery
How to Thrive
Matthew Elvidge Trust
Mental Health First Aid
Mental Health Foundation
MindEd
National Association of Head Teachers
NSPCC
PSHE Association
Rethink
Roots of Empathy
Royal College Speech and Language Therapists
Royal College of Nursing
Royal College of Psychiatrists
Royal College Paediatrics and Child Health
Royal Society of Arts
Samaritans
SEBDA / Oxford Brookes University
Step Up to Serve
Student Mind
Tavistock Relations
The Mix
The Nurture Group Network
The Tomorrow Project
The People's Project
Universities UK
University of Sussex
Young Minds
Youth Access