Transforming Children and Young People's Mental Health Provision: a Green Paper

North Somerset COUNCIL

Agreed response from a group of North Somerset Councillors:
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1. North Somerset welcomes the Government's Green Paper on children and young people's mental health with its recognition of the important role that schools and colleges can play in a whole system approach to early intervention. There are three main policy initiatives: a Designated Senior Lead for Mental Health (DSLMH) in every state school; Mental Health Support Teams (MHSTs); reduction in waiting times for specialist Child & Adolescent Mental Health Services (NHS CAMHS).

2. Through its work on the Local Transformation Plan, North Somerset has recognised its own responsibility as part of the wider range of CAMHS services: Mental health is everybody's business. Children and young people do not always choose or have access to more formal mental health services and it is important that all workers are confident that they can address emerging mental health needs and know how to signpost to other agencies, whether statutory or voluntary, and how to make appropriate referrals to NHS CAMHS.

3. The evidence that half of all diagnosable mental health conditions are established before the age of 14 supports mental health provision at primary school age and earlier. We would appreciate confirmation that all primary as well as all state secondary schools will be encouraged to appoint a DSLMH and will have access to any resources provided to support schools.

4. The Green Paper does not address the gap between the 'first postnatal year' and the age when a child starts school. Mental health provision is also needed for families with pre-school children, and we would advocate for work with Local Authority Early Years teams to understand and scope the support needed in this phase.

5. We are concerned that the DSLMH role is considered voluntary and fear that this may mean inequitable access to support for children and young people within local authority areas or in different phases of education. Many children and young people live in one local authority but attend school in a different local authority; their needs should supersede any geographical boundaries.

There are also many children who do not attend state schools, for example, those who are home schooled; those who have been excluded and those who attend other forms of Alternative Provision. We would urge a clearer expectation on all schools to create DSLMH roles across both the primary and secondary phases. Equity of access is essential.

6. To meet the needs of our children and young people, partnership working is crucial and evidence from the *Mental Health Services and Schools Link Pilot* has highlighted the importance of having a lead in each school and mental health service. We are delighted that North Somerset is in the second phase of the Schools Link programme. We hope that schools and mental health services will still be motivated to attend and that successful outcomes are maintained without the additional funding for schools and mental health services offered during in the pilot. We are very concerned about the capacity of schools to take on all of the duties contained in the role of DSLMH.

The role of the local authority

7. There is little reference to local authorities either in the Green Paper or in the Consultation Questions. As part of wider CAMHS, the local authority commissions and delivers mental health support and needs to be included in this transformation. The merging of the Department of Health and Social Care emphasises the importance of health and social care working together and we would like this reflected in the Green Paper.

8. The Joint Strategic Needs Analysis (JSNA) is a statutory process which analyses the current and future health and care needs of the local population, including children and young people's mental health, to inform and guide the planning and commissioning of health, well-being and social care services and is evidence of the need for joined-up thinking and working. We believe the local authority's responsibility to assess this need and publish its analysis also underpins the important role councils have to play in delivering these initiatives.

9. The Local Authority is Corporate Parent to children in care and has a statutory duty in the *Children and Social Work Act, 2017* to '*promote the physical and mental health and well-being*' of looked after children and to help them '*gain access to, and make best use of, services provided by the local authority and its relevant partners.*'

10. It is also the lead body for other vulnerable groups, for example, young offenders; and children and young people with a disability. It also commissions services for other identified, vulnerable groups where there is a higher incidence of mental health, for example, substance misuse services;

children and young people affected by domestic abuse; and young carers. As stated in parts of the Green Paper, mental health is influenced by the wider contexts in which children and young people live. An holistic view of the child or young person is essential to their wellbeing which means training all services in basic children and young people's mental health, including adult services such as Adult Mental Health and the Police.

11. We think it is essential that these initiatives and activities are carefully coordinated to ensure they achieve their aims, and we believe that the local authority is best placed to provide this overview and coordination. There is a danger that the system will become more fragmented as individual schools or academy chains take up new opportunities, eg. mental health awareness training (Youth Mental Health First Aid). There is currently no national or local database showing which schools have taken advantage of these new programmes and other mental health training. This makes robust monitoring, effective joint working and multi-agency workforce planning more complicated.

Effective partnership working

12. We believe the most effective way of meeting children and young people's needs is to form closer working relationships through multi-agency training. This is particularly important given that help must be available to children and young people and their families outside school hours and school terms. The Safeguarding model, with strong local, multi-agency training and accountability is one that could be followed.

13. We would wish to ensure that the Police are included in the training provided. They are often the 'first responders' when a child or a family with children experiences a crisis outside school hours, and their links with the wider range of support services across the system including in schools, are crucial to effectively supporting children and young people. In North Somerset, colleagues from Avon & Somerset Constabulary are already linked into safeguarding training and we would wish to see this extended to cover issues of mental health and associated trauma.

14. Likewise we recognise the importance of linking closely with GPs in delivering effective mental health services to children and young people. We believe that schools should be encouraged to form links with local practices, in order that children can access primary care which supports and works effectively alongside the support which the Green Paper advocates developing in schools. Equally, the importance of maintaining robust health records for children and young people as they move through the system and between services is essential in coordinating support.

15. The focus of Public Health England is on the wider determinants of health. Public Health could have a more prominent role in the proposed transformation, collating useful information for parents/carers, working with young people to determine what would help them cope with mental health issues, and publicising and disseminating new self-help initiatives, for example, NHS Apps and MindEd.

Providing and maintaining resources to effect genuine change

16. Only 6.7% of mental health spending is currently spent on children and young people's mental health services. The Government has pledged £1.4b over five years to transform wider CAMHS. It is intended that an additional 70,000 children and young people will receive support by 2020-2021. This would increase the number from 1:4 to 1:3 children and young people being seen by a specialist service in spite of the Government's commitment to parity of esteem. The LTP funding is not ring-fenced and the full amount is not reaching the frontline.

17. On this basis, we feel that funding provided to support the developments outlined the Green Paper must be ring-fenced to ensure that it is spent according to the proposals. North Somerset would recommend that is held in one organisational budget but monitored by the multi-agency boards overseeing the Local Transformation Plans, with full accountability by Health and Wellbeing Boards.

18. It is difficult to comment further on the sufficiency or suitability of the approach in the Green Paper without clarity on the level of funding available, on what basis it will be distributed and how local areas will be prioritised for access to this funding. We would hope that mechanisms for allocation and distribution would be transparent and equitable, and that they would not unduly delay funds from reaching recipients.

Capacity and deliverability

19. We are delighted that positive mental health will be incorporated into the OfSTED inspection framework and that there is a commitment that 'every child will learn about mental wellbeing' but Relationship and Sex Education and wider PSHE are non-statutory parts of the curriculum, with no consistency of approach across schools. We understand from the Green Paper that Relationship and Sex Education guidance will go out to consultation soon. It is important that this process is completed before the first DSLMHs and MHSTs are operational in 2019.

20. The Green paper states that NHS CAMHS receives 460,000 referrals per year, with 200,000 going on to receive treatment. Based on current estimates,

there are a further 650,000 children with a diagnosable mental health need (para 2) who need treatment.

21. The Impact Assessment (page 22) is predicated on the MHSTs seeing approximately 325,000 children and young people with a diagnosable condition plus children and young people who require 'non-specialist treatment'. This implies that a further 325,000 children with a diagnosable condition will not be offered a service by these teams. The national increase in demand for NHS CAMHS suggests that this number may rise further before the work of MHSTs have an effect. The results of the new prevalence survey must be taken into account when updating the estimate of children and young people with a diagnosable mental health problem.

22. It is also proposed that MHSTs will have a role in training staff from other agencies. We recommend that 'champions' or 'ambassadors' from other disciplines are invited to share the initial training of MHSTs so that the learning can be disseminated more widely to ensure as many young people as possible are being reached in a variety of settings and services.

23. Is there any contingency in place should the MHSTs uncover evidence of greater than expected 'hidden' need in schools as a result of their learning?

Scope of support and Equality of Access

24. We look forward to a more detailed description of the training and support which will be provided for teachers and for any newly appointed mental health staff, and would wish if possible to be involved in influencing this offer. In particular we are concerned to ensure that current thinking around the impact of trauma and Adverse Childhood Experiences (ACEs) are key to the model of training used.

25. The paper reflects a medical model while a psycho-social model is necessary. It defines 'trauma' variously. There is now sound evidence that developmental trauma, experienced in infancy and early childhood, needs a very different approach from common behavioural and social learning models. If a child is living with neglect and/or abuse, their behaviour and emotional presentation are forms of communication of distress which will not be alleviated by a focus on their specific behaviour or mental health presentation, for example, anxiety or depression. The problem lies not within the child but within their environment. A systemic response is crucial and the involvement of families is essential, working with fathers as well as mothers. We would welcome a stronger emphasis on working with parents and carers whether in supporting their children or their own needs which impact on their children's mental health.

26. MHSTs would benefit from being a multi-disciplinary team with mental health training so that all aspects of the child or young person's life can be addressed, for example, the team will need expertise in safeguarding, substance misuse, developmental trauma, domestic abuse, youth offending etc. One model could be seconding experienced members of staff from across teams, with backfill into their substantive roles, to ensure strong networking and an holistic approach. We agree that MHSTs will be made even stronger through close working relationships with other professionals but many local authorities now have varied staffing and outsourcing arrangements and may not have easy access to school nurses and Educational Psychologists.

27. We feel it is essential that the impacts of domestic abuse and drug misuse on children's mental health are recognised in the support developed in schools, both in terms of their own experiences and the trauma experienced in family settings. Where support is provided based on issues of domestic abuse it is important that it recognises the need to support all genders equally, and also provides support to young perpetrators as well as young victims on the basis that this behaviour is evidence of underlying environmental trauma.

28. We were concerned that using schools to deliver these important services presented a risk that some children and young people will not be able to access support. In particular we are concerned that Gypsy and Roma traveller families are often disengaged from the school system especially after primary stage. Children who may experience trauma as a result of issues such as forced marriage, child sexual exploitation, modern slavery and female genital mutilation are also often absent from the school system. This support cannot be the only support available to extremely vulnerable children and young people, and a sufficiently funded CAMHS with capacity to support local need is essential.

29. The existing NHS CAMHS provision is under severe pressure, both locally and nationally. Releasing a member of staff at Band 7/8 to supervise the new MHSTs will be extremely challenging in a time of national shortage of mental health staff. While funding for early intervention is welcome, this must be balanced by continued, assured funding for NHS CAMHS, especially in the short-term while these new teams prove their effectiveness.

30. There are many counsellors already trained in working with children and young people. We would recommend that each secondary school would benefit from a counsellor with the qualifications, knowledge, skills and experience of working with the appropriate age range. There should be a central register of these counsellors, with qualified clinical supervisors

providing reflective supervision individually and/or in groups. These counsellors should have direct links to NHS CAMHS, with training to make appropriate referrals to specialist treatment. With the new funding, this could be achieved immediately across the country and it is in line with the Government's recommendations in *Counselling in Schools: A blueprint for the future*. These counsellors could become part of the MHSTs as they are rolled out.

31. Primary schools also need mental health workers but those who are confident in working work with families, as well as with individual and groups of children. Family counsellors could work effectively with a cluster of primary schools.

32. It is unclear from the Green Paper how young people leaving secondary education and moving into Further Education will be supported between the ages of 16-25. Access to adult mental health services can be problematic for this group, and there is a lack of transitional planning and support across the system. Careful consideration should be given to ensure that leaving school does not create a new 'cliff edge' in support for young people. It is essential that Colleges of Further Education are also supported by the initiatives in the Green Paper.

33. MHSTs and DSMLHs must be equipped to manage issues around gender identity and LGBTQ issues which impact on children and young people's mental health, and must be able to support colleagues throughout school in developing strategies to manage these impacts.

Pace of change

34. The pace of change outlined in the Green paper is too slow. Some areas will not have a Mental Health Support Team until 2027-2028. Children currently experiencing trauma and poor mental health could be adults before MHSTs are in place. The timescale for investment in training mental health staff and establishing MHSTs should be more urgent and ambitious and should recognise the current recruitment challenges.

35. The roll out of the new approach, including Designated Senior Leads for mental health in schools, creating Mental Health Support Teams and reducing waiting times, to at least a fifth to a quarter of the country by the end of 2022/23 is not sufficiently aspirational and there is no guaranteed funding beyond 2020-2021 despite evidence of a growing problem.

36. We would welcome further detail on how the 'Trailblazers' will be chosen and whether there will be transparency in this process? North Somerset is keen to consider being part of the first wave of MHSTs on the basis of the approaches

we have already taken to working across partners and disciplines in the area of children's mental health.

37. We are pleased that each area's specific circumstances will be taken into account when designing a model to meet the needs of children and young people. However it is important that there is robust evaluation with some core routine outcomes measures (ROMs) which can be monitored across different models and collated centrally so that different models and different populations can be compared and best practice shared effectively. For example, by using CORC/CYP IAPT *Current View,* data would be available for different cohorts with provisional problem descriptions, selected complexity factors, contextual problems and Education difficulties. NHS CAMHS data could be compared with MHST data by using the Mental Health Services Data Set (MHSDS).

38. Some of the MHST trailblazer areas will also be piloting a reduction in waiting times to NHS CAMHS to four weeks. The Green Paper does not clarify whether this is four weeks until the first appointment or until treatment. Clarification on this would be welcome.

39. Long waiting times in NHS CAMHS indicate a service under pressure. While it is hoped that earlier intervention will eventually relieve the pressure, NHS CAMHS will still need adequate funding until the full roll-out of the MHSTs in 2027-2028 evidences a reduction in the number of referrals.