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Health and Social Care Committee

Children and young people's mental health

Eighth Report of Session 2021–22

Report, together with formal minutes relating to the report

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Health and Social Care Committee

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Introduction

According to NHS data, the mental health of children and young people in England has worsened since 2017.[1] Even before the pandemic, children and young people were facing a mental health crisis. Although children and young people under 25 have always had to deal with personal identity issues in formative years, risks to mental health have been greatly exacerbated by heightened academic expectations and the ubiquity of social media.

Three lockdowns and the social distancing requirements of the pandemic have made the situation worse. Children and young people have struggled with the loss of normal social structures, being unable to socialise in person with peers and not being able to attend school or university. The need for teaching and assessment to take place virtually led to further stress because of the uncertainty it created about people's futures.[2] Research from the Centre of Mental Health shows that, in England, 1.5 million children and young people under 18 will need new or additional mental health support as a direct consequence of the coronavirus pandemic.

We are very grateful to everyone working in children and young people's mental health who, even prior to the pandemic, were experiencing high levels of work-related stress and burnout. We heard from one clinician during our inquiry that staff are "constantly firefighting"[3] in order to meet the increased need in the population and although this report is not primarily about workforce pressure we reiterate our previous findings that it is not sustainable for NHS staff in mental health or indeed any specialty to face the pressure of permanent staff shortfalls.

We received over 100 written submissions to our inquiry. In addition to this, we held four oral evidence sessions and carried out an in-depth anonymous roundtable with children and young people's mental health clinicians and practitioners. We are especially grateful to the participants of this roundtable. Their insights on how children and young people's mental health has changed over time, and the challenges that NHS staff are facing as they try to address this crisis were invaluable to our inquiry. Their passion for supporting and caring for children and young people during the most difficult year for the NHS was clear and worthy of commendation.

We are also extremely indebted to the two young people who gave oral evidence to our inquiry, Lucas and Hope. We thank them for the clarity and courage they demonstrated whilst giving highly personal accounts of their own experiences with mental health conditions. Their accounts are a stark reminder that beyond the statistics there are children and young people across the country who are facing unimaginable struggles with their mental health.

1 NHS Digital, Mental Health of Children and Young People in England, 2020. October 2020.
2 YoungMinds (CYP0066)
3 Health & Social Care Committee, Transcript from Roundtable with children and young people's mental health practitioners, May 2021.

Executive Summary

1. The mental health of children and young people has worsened in the pandemic. As well as research from the Centre for Mental Health showing that in England 1.5 million children and young people under 18 will need new or additional mental health support, data from NHS Digital shows that in 2020 potentially one in six young people had a diagnosable mental health disorder, up from one in nine in 2017.[4] This is placing a massive additional strain on already stretched children and young people's mental health services.

2. Notwithstanding such pressures, the Department of Health and Social Care and NHS England have made progress in expanding the provision of children and young people's mental health services in recent years, with significant additional funding.[5] However, we are deeply concerned that the pressure created by fighting a pandemic and dealing with the backlog it creates is leading to a neglect of long-standing mental health priorities. We are also worried that a sufficient proportion of the additional funding from the health and social care levy has yet to be allocated to mental health in a way that is consistent with repeated commitments to parity of esteem.

3. In priority areas such as eating disorders, our independent Expert Panel rated as 'Good' overall the commitment that 95% of young people should access treatment within 1 week (urgent cases) and 4 weeks (routine cases), although they expressed concerns that the level of treatment was not always appropriate

4. We also note the progress towards the implementation of proposals and ambitions laid out in the 2017 Green Paper *Transforming children and young people's mental health provision* and the *NHS Long Term Plan* that will see 47% of school children able to access new Mental Health Support Teams by 2023–24.[6] This recognises the vital need to make schools equal partners in identifying mental health needs and securing access to services.

5. However, whilst new NHS ambitions to increase access rates and decrease waiting times are welcome as far as they go, even after those ambitions are met far too many children and young people will be unable to access the care that they need. Half of all mental health conditions become established before the age of 14, so whilst it is progress that the number of young people receiving treatment has risen from just 25% to around 40% of those with a diagnosable condition pre-pandemic, it is not acceptable that more than half of young people do not receive the mental health support they need. There are also doubts about the commitment to ensure at least 70,000 additional children and young people receive evidence-based treatment every year, which our Panel rated as requiring improvement overall and which needs to be more ambitious, not least because the proportion accessing adequate care has gone into reverse because of the pandemic.

6. The combination of this unmet need prior to the pandemic and additional needs created by the pandemic means that the scale and speed of improvements planned by the NHS are simply not sufficient for the task at hand. Significantly more ambition is needed and without urgent action there is a risk of provision slipping backwards.

4 NHS Digital, Mental Health of Children and Young People in England, 2020. October 2020.
5 See paragraph 23.
6 Q 210

7. In schools, the new Mental Health Support Teams represent a valuable opportunity to identify and support children and young people who are beginning to experience problems with their mental health. However, no funding to roll them out nationally has been identified in the recent Spending Review settlement and even currently planned timescales lack ambition. Given the significant impact of the pandemic on children and young people's mental health, it is vital such funding is identified and that these teams can be rolled out to every area of the country as soon as staff can be trained and recruited to run them.

8. Smaller problems too often escalate to the point of crisis because of long waiting times and high access thresholds, but crisis care too is fraying at the edges and only receives a 'Requires Improvement' rating overall from our Panel. We therefore support setting up a national network of open access hubs to offer earlier intervention for young people without the need for a referral. This could be modelled on the approach taken by organisations like headspace in Melbourne or offered alongside the new Mental Health Support Teams.

9. It also remains the case that there are too many children and young people in inpatient units subject to inappropriate care: far from home, without adequate understanding of their rights, and subject to restrictive interventions. In the vast majority of cases, the most appropriate and most compassionate care for children and young people will be in their community near their families. It is essential that the new Integrated Care Systems come up with plans jointly with the social care system in the next year to ensure such care is provided seamlessly and locally. That will only be possible if the social care system is adequately funded and we are concerned the currently planned allocation from the health and social care levy will not make that possible.

10. Mental health services in general - and children and young people's mental health services in particular - have been disappointingly overlooked in the recent Spending Review. Commitment to parity of esteem requires action not just words, but when we wrote to the Secretary of State setting out our concerns, he told us that "a detailed financial planning exercise would take place to determine the precise allocation of extra resource spending that will be spent on mental health, including children and young people's mental health."[7] It is extremely disappointing that even two months after the announcement of the health and social care levy the level of mental health spending has not been finalised.

11. We welcome the significant increase in the mental health workforce in recent years. But we remain concerned that further vital expansion will not be possible without a funded increase in the budgets for training both medical and non-medical staff. The budget for Health Education England has not been settled, and further delay seems likely given the proposed merger with NHS England. We are concerned that it may not make any provision for increasing the number of mental health staff being trained and retained, but without such increases we do not believe it will be possible to deliver even the modest ambitions to which the Government is signed up.

12. Parity of esteem between mental and physical health is a vitally important step forward that was being addressed by the Mental Health Investment Standard (MHIS). However, we are concerned that the principle embodied in the new standard will be breached following the implementation of the health and social care levy, even though

7 *Ibid.*

the backlog of mental illness cases is as severe as that for physical illnesses. We note that the Secretary of State remains committed to the need for parity of esteem between mental and physical health, which he said "has never been more important"[8] but this needs to be demonstrated in action as well as words, including maintaining the MHIS, without which such commitment will lose all credibility. Mental health must also remain a core priority for the new Integrated Care Boards.

13. ***Children and young people's mental health is an all-society issue. The problems discussed in this report can only be addressed by Government departments, local government and the health system acting together to promote good mental health and prevent new crises emerging. We recommend setting up a Cabinet sub-committee to bring together different departments to make sure this happens.***

8 Letter from the Secretary of State for Health and Social Care, 18 November 2021

1 The scale of the problem

Background and current context

14. Children and young people's mental health is an area where a gap has long existed between the underlying need for treatment and the availability of services. NHS Digital conducted major surveys of the mental health of children and young people in England in 1999, 2004, 2017 and 2020. The 2017 report, which included the first prevalence data in more than a decade, confirmed that approximately one in nine children and young people in England had a diagnosable mental illness. This shows an increase in underlying prevalence compared to one in ten children and young people in 2004.[9] In 2020, NHS Digital conducted a follow-up survey. This research found that rates of children and young people with a probable mental disorder in England had risen to one in six.[10]

15. There has been overwhelming consensus in the oral and written evidence to this inquiry that the mental health of children and young people has worsened in recent years. For example, Mark Rowland, CEO of the Mental Health Foundation, a leading UK mental health charity, told us:

> In our own study, we have been tracking the mental health of the population. We see thoughts of suicide in our young people at almost double the rate of the adult population, as well as rates of loneliness and hopelessness. The flashing red lights are there; this is a situation that needs attending to.[11]

16. Emma Thomas, CEO of YoungMinds, a mental health charity for children and young people, similarly expressed concern that the pandemic was affecting not only those with existing mental health needs but was also causing a second cohort of children and young people to begin to experience early struggles.[12] YoungMinds reported that 80% of children and young people they interviewed said that the covid-19 pandemic was having a detrimental effect on their mental health.[13]

The impact of rising demand

17. The implications of this rise in mental ill health among children and young people have been laid bare by the sharp increase in demand for, and referral rates to, mental health services:

- In 2019/20, 538,564 children were referred to children and young people's mental health services. This represents an increase of 35% on 2018/19, and nearly 60% on 2017/18.[14]
- Current modelling by The Centre for Mental Health suggests that 1.5 million children and young people in England will need either new or additional mental health support as a result of the pandemic.[15]

9 NHS Digital, Mental Health of Children and Young People in England, 2017. November 2018.
10 NHS Digital, Mental Health of Children and Young People in England, 2020. October 2020.
11 Q167
12 Q1
13 YoungMinds (CYP0066)
14 Children's Commissioner, The state of children's mental health services 2020/21. January 2021.
15 Centre for Mental Health (CYP0037)

18. Furthermore, stakeholders have raised concern about how effectively the increase in demand for mental health services can be met. In May 2021, we conducted a roundtable with children and young people's mental health practitioners. Many of the practitioners stated that they were already unable to provide the appropriate level of care and support to children and young people due to the sharp increase in demand. One nurse told us "we're not able to always provide the care that we need to, because of that dramatic increase in referral rates".[16]

19. Others told us that they had seen not only an increase in demand for services, but in the severity and acuity of the cases that were being referred:

> I think what we know is that we are seeing increased presentations at A&E, we're seeing increases in self-harm, and we're seeing increases in acuity in terms of the presentations. Psychosis, I think we're seeing a lot more of that then we were maybe 10 years ago as well.[17]

20. Overall, this increase in demand has put a huge pressure on already stretched NHS children and young people's mental health services. NHS Providers reported to us that even prior to the pandemic "services were at full stretch and access thresholds in many places were too high, creating long waits and contributing to deteriorating mental health".[18] Ahead of our 25 May oral evidence session, NHS Providers commissioned a survey of all their mental health trust leaders. Saffron Cordery, Deputy Chief Executive of NHS Providers told us that:

> Of those we surveyed, 100% said that demand for treatment had increased over the last six months, and 84% said that waiting times had worsened. A large majority told us that they could not meet demand for eating disorder services; children and young people needing community support; and in-patient care.[19]

Eating Disorders

21. Throughout our inquiry, stakeholders have raised concern about the sharp rise in the number of children and young people suffering from eating disorders, particularly among teenage girls. In correspondence with us in August 2021, Claire Murdoch, National Mental Health Director and Professor Tim Kendall, National Clinical Director for Mental Health at NHS England & Improvement stressed that the NHS "is now treating more CYP [children and young people] with an eating disorder than ever before".[20] But they were not complacent about the challenge, particularly given data they provided showed that during 2020/21 the NHS saw an 83% increase in demand for urgent eating disorder services and a 41% increase for routine services.[21]

16 Health & Social Care Committee, Transcript from Roundtable with children and young people's mental health practitioners, May 2021.
17 *Ibid.*
18 NHS Providers (CYP0068)
19 Q129
20 Correspondence from Claire Murdoch and Professor Tim Kendall to Rt hon Jeremy Hunt MP: 17 August 2021.
21 *Ibid.*

22. Sophie Corlett, Director of External Relations at the charity Mind, specified that by monitoring children and young people's mental health during the pandemic, they had observed that "a high proportion of people in the 18 to 24 age group - 71% of that group - told us that they were either eating more or eating less".[22] Dr Lynne Green, Chief Clinical Officer at Kooth, speculated that the pandemic had exacerbated this problem:

> In terms of the Covid-19 pandemic per se, for all of us our sense of control has been threatened. Control and sense of control is generally central to people with eating difficulties. For the young people who are coming to us, that has been pivotal […] Are they going to get their exams? Are they going to get to college? All those sorts of things have exacerbated eating difficulties.[23]

23. In March 2021, the Department of Health and Social Care announced funding of £79 million to boost mental health support for children and young people. This funding included a commitment for eating disorder services to be accessible to an additional 2,000 children and young people.[24] In addition to this, an extra £40 million was allocated to children and young people's mental health in June 2021, partially to address the increasing demand for the treatment of eating disorders.[25] However, the May 2021 survey conducted by NHS Providers found that 85% of NHS Trust leaders could not meet demand for children and young people's eating disorder services-- the highest result across all services.[26] When we questioned Rt Hon. Nadine Dorries MP, then Minister of State for Patient Safety, Suicide Prevention and Mental Health, about this she acknowledged that eating disorders had been "our biggest issue recently" and this had come "to a crisis point during lockdown".[27]

Who has been most impacted?

24. It has been well-documented that the impact of the pandemic, and the longer-term trends in mental health have not hit all groups of children and young people equally. We heard specifically that children and young people from ethnic minorities, poorer socioeconomic backgrounds and those in the LGBTQ+ community have faced the largest impact on their mental health. Sophie Corlett, of Mind, outlined the specific inequalities in who had been most affected:

> People who already had a mental health problem were really affected. Children from households with lower levels of income, but also young women, were seemingly more affected than men. Across the piece, we found that people from black, Asian and minority ethnic communities were more affected.[28]

22 Q2
23 Q10
24 Department of Health and Social Care, £79 million to boost mental health support for children and young people. March 2021.
25 NHS England, Funding boost for young people's mental health services. June 2021.
26 NHS Providers, Children and young people's mental health services survey. May 2021.
27 Q187
28 Q2

25. Even prior to the pandemic, it was well-established that certain groups of children and young people face a higher risk of mental ill health. Recent research from the University College London has confirmed that children and young people from lower socioeconomic backgrounds are more likely to face mental distress.[29] Several written submissions to our inquiry also emphasised the stark inequalities by sexuality in mental health.[30] For example, the National Children's Bureau pointed out that LGBTQ+ teenagers were twice as likely as their heterosexual peers to report serious mental distress (41% compared to 16%) and self-harm (56% compared to 24%). LGBTQ+ teenagers were also found to be three times more likely to report self-harm with suicidal intent.[31] The submission from the charity Mermaids also highlighted that transgender, non-binary and gender diverse children and young people experience disproportionately high levels of mental ill health, with 92% of transgender young people reporting having thought about taking their own life in 2017.[32]

26. In addition to facing higher risk of poor mental health, there are certain groups of children and young people who face higher barriers to accessing support than others. The Centre for Mental Health outlined that young Black men are often marginalised by support services. For these young people, help is "less welcoming, less understanding and less accessible".[33] Julie Bentley, CEO of Samaritans, explained:

> Young people from LGBT communities are struggling to access services and face real barriers around those services. We know that that community of young people are really affected by self-harm. There are higher rates of self-harm, and they often face discrimination, both in their sexuality and in their gender identity. That is a real barrier for them. We already know that structural inequalities in the design of services mean that young people from black, Asian and minority ethnic backgrounds often struggle to access the services, particularly young black men.
>
> We have a huge amount to do to make sure not only that we have the services for all young people, but that we have thought about specific and cultural needs so that no young person is left out in the cold from services.[34]

27. When asked about how these inequalities could begin to be addressed, Mark Rowland, CEO of the Mental Health Foundation, told us that having public access to better data would be an important step. This could enable improved understanding of which groups of children and young people are facing specific risks and support a targeted strategy to increase the protective factors around those groups.[35]

28. **Although the full long-term impact of the coronavirus pandemic on the mental health of children and young people under the age of 25 is as yet unknown, it is already clear that the mental health needs of these groups have been much exacerbated by the pandemic. This has been supported by NHS data from July 2020 which shows that one in six young people now have a probable mental health disorder. But the impact of**

29 University College London, Mental ill-health at age 17 in the UK. November 2020.
30 See, for example: The Children and Young People's Mental Health Coalition (CYP0043); National Children's Bureau (CYP0079)
31 National Children's Bureau (CYP0079)
32 Mermaids (CYP0097)
33 Centre for Mental Health (CYP0037)
34 Q176
35 Q177

this has not been even across different children and young people, with older teenage girls, for example, particularly affected by the rise in eating disorders. In order to understand the level of need in children and young people's mental health as well as the inequalities that continue to exist, more regular and accurate prevalence data is urgently needed.

29. ***The gap between the 2004 and 2017 NHS Digital Mental Health Surveys was too long, and this must not be repeated. We recommend that NHS Digital regularly collect and publish robust prevalence data for mental health conditions every three years, starting from the end of 2021 disaggregated by age, ethnicity, sexuality, gender, and condition, alongside a plan to address any disparities uncovered. Such a study should also examine both unmet need and the risks of overmedicalisation of minor issues.***

Promotion, prevention, and early intervention

30. YoungMinds highlighted that half of all mental health problems manifest by the age of 14, and 75% by the age of 24.[36] Unfortunately, research has shown that on average, children and young people go 10 years between their symptoms first arising and receiving the support that they need.[37] In order to deliver sustainable improvements to these outcomes for children and young people, many submissions called for Government to adopt a whole-system, preventative, public health strategy that should "span all departments and address young people's mental health in health services, from infancy to adulthood, in education, in welfare, housing, employment, criminal justice, immigration, leisure and culture".[38] While the role of treatment is vitally important, the evidence we have received has been clear that, in order to address the growing problem of mental ill health among children and young people, it is necessary that there is a change in focus towards meeting the needs of this group before they reach the point of requiring clinical care. This is a theme we return to repeatedly in our report.

31. Organisations such as The Mental Health Foundation have long been calling for a "proportionate universalism approach" which would embed policies which promote good mental health and mitigate risks to individuals' mental health across all departments as well as in local government, the education system and the care system.[39] Such an approach would not simply include traditional 'mental health' policy interventions, but would also address the material, social and economic conditions in the wider environment, that we know have an impact on children and young people's mental health. Several witnesses have argued that a society-wide preventative approach should also provide targeted interventions for those children and young people that we know are at higher risk.[40]

32. The most important determinants of children and young people's mental health remain social, economic, and environmental factors. Written evidence to our inquiry has suggested a number of areas for public health intervention:

- Economic inequalities: Findings have consistently demonstrated that socio-economic circumstance are strongly predictive of children and young people's wellbeing. Findings from the UK Millennium Cohort Study, conducted by

36 YoungMinds (CYP0066)
37 National Children's Bureau (CYP0079).
38 The Centre for Mental Health (CYP0037).
39 The Mental Health Foundation (CYP0061)
40 Q164

University College London, show that having severe mental health difficulties was strongly related to family income. In particular, the most disadvantaged 40% have almost twice the rates of attempted suicide (almost 12%) when compared with those with higher family incomes (around 6%).[41] A large number of written evidence submissions stressed that directly addressing these inequalities would be central to making progress on children and young people's mental health.[42]

- Mental Health literacy: Mark Rowland, CEO of The Mental Health Foundation, called for "universal mental health literacy" to decrease the stigma associated with mental health and improve children and young people's understanding of mental health problems and health seeking behaviours.[43] For children and young people this could be achieved through building on the existing mental health content in the Health Education and Relationships and Sex Education Curriculum, as part of a wider whole school approach.

- Reducing online harm: while witnesses to our inquiry acknowledged that online mental health support is a valuable resource to many children and young people, we heard that the online environment also makes harmful content available to children and young people. In correspondence with us on 15 June 2021, Julie Bentley, CEO of Samaritans, told us that the Government should strengthen the Draft Online Safety Bill to ensure that harmful content around suicide and self-harm is removed from all platforms.[44]

33. While population-wide preventative approaches are valuable, they are not all that is necessary. For those children and young people who do struggle with poor mental health, we have heard repeatedly that early intervention in the course of their illness is key. For example, The Children and Young People's Mental Health Coalition, which represents over 200 organisations, stressed that early intervention is "crucial in identifying needs early and providing preventative and low-level mental health support and advice, reducing referrals to more costly specialist services".[45]

34. **During the pandemic, children and young people's mental health has significantly worsened and the scale of the backlog mean that the NHS will not be able to treat its way out of this crisis. The need for early intervention and prevention in children and young people's mental health has been consistently overlooked by successive governments and although there has been a significant expansion of services recently the pace of change has not been keeping up with increases in demand. Still today too many children and young people are reaching the point of crisis before they can access any mental health support. This compounds stress not only on the individuals affected, but across society more widely. The lack of adequate protective support and early intervention create unnecessary pressure across the entire healthcare system, from GP appointments to A&E presentations and NHS inpatient services.**

41 University College London, Mental ill-health at age 17 in the UK. November 2020.
42 See, for example: The Centre for Mental Health (CYP0037); The Children and Young People's Mental Health Coalition (CYP0043); The Mental Health Foundation (CYP0061); YoungMinds (CYP0066)
43 Q177
44 Correspondence from Julie Bentley to Rt hon Jeremy Hunt MP: Letter from the Chief Executive of Samaritans on the issue of online harms, 15 June 2021.
45 The Children and Young People's Mental Health Coalition (CYP0043).

35. ***The Department of Health and Social Care—in partnership with the Department for Education and all other relevant Government departments—must take radical steps to shift the focus in mental health provision towards early intervention and prevention. This must ensure that all children and young people under the age of 25 can receive mental health support as early as possible and no young person is turned away from mental health support for not being ill enough. The Department must focus its attention on:***

a) ***the faster roll out of Mental Health Support Teams, as detailed in Chapter 3 of this report;***

b) ***a network of community hubs based on the Youth Information Advice and Counselling service model detailed in Chapter 4 of this report and;***

c) ***digital support, as detailed in Chapter 4 of this report.***

36. ***We expect a full and comprehensive update from the Department on what measures it will implement, how this work will be funded and a timeframe for key outcomes relating to increased early intervention and prevention. We expect this information by the end of January 2022.***

Spending Review and funding

37. On 27th October 2021, while our Report was in preparation, the Chancellor of the Exchequer presented his Budget and Spending Review to Parliament. We were concerned that there was a lack of clarity about what the settlement meant for mental health and wrote to the Secretary of State for Health to ask what assessment he had made of how much of the £44 billion extra resource spending allocated to the NHS by the end of the Parliament would be spent on mental health, and to children and young people's mental health in particular. We also asked what assessment he had made of the adequacy of the capital spending allocated to mental health over the Spending Review period, and of whether there was adequate funding to deliver the NHS Long Term Plan commitment of expanding the mental health workforce. Finally, we asked, how much of the funding to tackle the NHS elective care backlog would be allocated to mental health services.

38. On 18th November 2021, the Secretary of State replied and told us that there would be a detailed financial planning exercise to "determine the precise allocation of extra resource spending that will be spent on mental health, including children and young people's mental health."[46] He commented: "The settlement does provide funding for the pipeline of trained mental health professionals supporting the ambitious goal of the NHS Long Term plan to expand mental health workforce." He confirmed that there was a capital budget of £448 million until 2025 for mental health and noted that this included "the remaining £298m needed to finish the job of eradicating mental health dormitories" and "a new allocation of £150m aimed at better mental health facilities linked to A&E and enhancing patient safety in mental health units." On the funding to tackle the elective care backlog, he commented that the Government was working with the NHS "to allocate the headline budgets allocated at the Spending Review, before funding is made available in April 2022." He stated that "a focus on preventing and treating poor physical health can help prevent mental health problems", but added: "I do also expect some of the funding

46 Letter from the Secretary of State for Health and Social Care, 18 November 2021

for COVID impacts and the recurrent funding will go towards funding growth for mental health services." There remains considerable uncertainty about how much of the headline budgets will be allocated to mental health. It is crucial that the financial planning exercises to which the Secretary of State refers ensure that the funding allocated to mental health reflects its parity with physical health. Otherwise, we will not see an improvement in the mental health of England's children and young people.

2 Increasing access to mental health services

39. Successive governments have made commitments to increase access to clinical support for those children and young people who need it. The *NHS Long Term Plan*, published in January 2019, made a number of commitments relating to children and young people's mental health. This included investment in eating disorder services, creating a comprehensive offer for 0–25 year olds, the expansion of crisis support, and a goal to "ensure that 100% of children and young people who need specialist care can access it" through NHS-funded mental health services and Mental Health Support Teams.[47]

40. During our inquiry we have heard that children and young people often face high access thresholds and rejected referrals, followed by long waits if they do get accepted into services. In this chapter we consider how access to support can be improved so that children and young people can receive the help that they require efficiently and, in a way which works best for them. This chapter addresses the barriers that children and young people face in trying to access specialist NHS support including long waiting times, high thresholds, and a drop in support at age 18.

41. The independent Expert Panel evaluated the Government's progress against its commitment that "at least 70,000 additional children and young people each year will receive evidence-based treatment–representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions." The Expert Panel found that, overall, this commitment required improvement. The Panel concluded:

> progress on this commitment has been good, yielding positive impacts for children and young people who have been able to access treatment for their mental health. However, our evaluation has found that this commitment was not ambitious enough to start with and scope must be widened to support a greater proportion of children and young people with a mental health diagnosis.[48]

42. The independent Expert Panel also evaluated the Government's progress against its commitment to establish a crisis response that meets the needs of children and young people and again found that, overall, this commitment required improvement. The Expert Panel noted that "progress in setting up crisis support lines was accelerated due to the COVID-19 pandemic", but stated that there were other elements of the crisis response, such as intensive home treatment services aimed at children and young people who might otherwise require inpatient care, that were not on track to be operational by 2023–24.[49]

47 NHS England, Long Term Plan. 2019.

48 Health and Social Care Committee, Second Special Report of Session 2021–22, *The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England*, HC 612, page 32.

49 Health and Social Care Committee, Second Special Report of Session 2021–22, *The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England*, HC 612, page 46.

Rejected referrals

43. We have heard that too many children and young people are not receiving the much-needed support they require. Although there has been significant progress in the number of children and young people accessing mental health services, approximately 60% of children and young people are currently unable to access mental health services, partly due to a high rate of rejected referrals.[50] The Care Quality Commission, in a 2018 review of children and young people's mental health services, found that "too often" rejected referrals were due to inappropriately high eligibility thresholds that can create a barrier preventing children and young people accessing the right support before they are "at the point of crisis".[51] Currently, the number of children and young people being referred to mental health services is exceptionally high as the pandemic has driven an increase in demand for support. We believe that this highlights the urgent need for a significant boost in the capacity of services so that children and young people are not turned away unnecessarily.

44. Hope, who struggled with an eating disorder as a teenager, explained to us the damage that being turned away from services due to high thresholds can do. Hope explained to us that:

> With my eating disorder, and for a lot of other people, it takes time to fall into the underweight category. You are then constantly being pushed back from services. When you are told, in essence, that you are not thin enough for treatment, your brain goes into turmoil. You feel like a fraud and a fake.[52]

45. Furthermore, the issue of children and young people being rejected from mental health services has not been felt equally across the country. We have heard that access to mental health services remains a "postcode lottery".[53] This was stressed to us by the Children's Commissioner, Dame Rachel de Souza, who told us that "different local areas are spending very differently on mental health services for children".[54] Since 2017 the Office of the Children's Commissioner has produced an annual briefing on the state of children's mental health services which assesses the provision of NHS children's mental health services. The latest briefing, published in January 2021, found that there were "enormous levels of variation" between different local areas.[55] This was particularly the case for the percentage of children and young people whose referral was closed before accessing treatment (a rejected referral). The report found that in 2019/20, 70 local areas in England were closing 30% or more of their cases before children access support. In only nine areas was this number below 10%.[56]

46. We also heard that children below the age of three are often rejected from services. The Parent-Infant Foundation reported that in 2019 children and young people's mental health services in 42% of areas in England did not accept referrals for children in this age group, despite the service nominally covering 0–18 year olds.[57] Given the breadth of

50 Q194
51 The Care Quality Commission, Are we listening? March 2018.
52 Q77
53 National Children's Bureau (CYP0079)
54 Q25
55 Children's Commissioner, The state of children's mental health services 2020/21. January 2021.
56 *Ibid.*
57 The Parent-Infant Foundation (CYP0050).

research which shows that the first 1001 days from pregnancy are crucially important to a child's emotional wellbeing and development, it is highly concerning that this group is being shut out from services.

Waiting times

47. Under proposals set out in the 2017 Green Paper on *Transforming Children and Young People's Mental Health*, the Government committed to trialling a four-week waiting time for access to specialist NHS children and young people's mental health services.[58] This is in addition to the existing waiting time standards for children and young people with an eating disorder. These standards set the objective that by 2020, 95% of young people in need of an eating disorder service will be seen within one week for urgent cases and four weeks for routine cases.[59] Stakeholders have told us that the introduction of waiting time standards that set clear expectations around access to treatment has been generally welcome.[60]

48. However, we have heard that waiting times for those who are able to access services remain too long and present a further challenge to children and young people accessing the mental health support they require. We heard first-hand the impact that being unable to access support due to long wait times can have on a young person. Lucas, who is now 21 years-old and an activist for the charity YoungMinds, told us that "the main barrier" to accessing mental health support when he needed it was the two-year waiting list. Lucas described the impact this had on his mental health:

> It kept escalating until I was about 14 or 15, when I got admitted to A&E after very serious self-harm. I then went under the crisis team for CAMHS [children and adolescent mental health services]. Initially, I was told that the waiting list in my trust was about two years long. I didn't have any help before that, so things just kept escalating. I struggled with the self-harm, with anxiety and with intrusive thoughts. Eventually, it escalated to the point that I struggled with suicidal thoughts. I was making plans and things. I was really struggling, and it was just escalating very dramatically.[61]
>
> […] Obviously, the main barrier was the two-year waiting list. A big barrier was also places like school. They thought that because I was on the waiting list that was all that they would concentrate on. When we were talking about difficulties and stuff, they said, "It's okay, we will just wait for CAMHS to come through. You are on that waiting list." But they did not always mention, "Yes, you are on that waiting list but it's two years long." That was quite a barrier.[62]

58 Department of Health & Department for Education, Transforming Children and Young People's Mental Health Provision: a Green Paper. December 2017.
59 Department of Health and Social Care (CYP0116).
60 Children and Young People's Mental Health Coalition (CYP0043)
61 Q72
62 Q74

49. While there has been a general downward trend in the waiting time to treatment since 2015, according to the Education Policy Institute, even prior to the pandemic, average waiting times for treatment consistently "far exceed the government's goal of a four-week standard laid out in the 2017 green paper":[63]

- In 2019, the median wait time to treatment was 56 days, or two months.[64]
- While national averages in waiting times have been reduced, there is significant variation in performance against waiting time standards. The Children's Commissioner found in 2019/20 that average waits across England ranged by area from 8 days to 82 days.[65]
- In eating disorder services, where NHS England & Improvement have stated that they were on track to meet the Waiting Time Standard[66] there was also a high degree of local variation. Beat, the UK's eating disorder charity, pointed out that in 2019/20, 94% of routine cases in the North West NHS region started treatment within the target of four weeks, in contrast to just 74% in the South East.[67]

50. The independent Expert Panel evaluated the Government's progress against its commitment to "Achieve 2020/21 target of 95% of children and young people with eating disorders accessing treatment within 1 week for urgent cases and 4 weeks for routine cases." The Panel commented:

> Prior to the COVID-19 pandemic, the NHS was on track to meet the 2020/2021 target of 95% of children and young people with an eating disorder accessing treatment within 1 week for urgent cases and 4 weeks for routine cases. However, the pandemic has significantly impacted progress against this target, with the prevalence of eating disorders increasing during the pandemic. As such, the latest data suggests that progress on this commitment has not been met by the deadline stipulated in this commitment.[68]

However, the Panel rated the commitment as good overall, commenting that the impact on those children and young people who were able to access eating disorder services was likely to be good and noting: "Due to the significant negative impacts of eating disorders on children and young people, the ambitious target set out in this commitment was an appropriate one."[69]

63 The Education Policy Institute (CYP0078).
64 The Education Policy Institute (CYP0078).
65 Children's Commissioner, The state of children's mental health services 2020/21. January 2021.
66 NHS England, Children and young people's eating disorders programme. 2021.
67 Beat (CYP0110)
68 Health and Social Care Committee, Second Special Report of Session 2021–22, *The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England*, HC 612, page 39.
69 Health and Social Care Committee, Second Special Report of Session 2021–22, *The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England*, HC 612, page 45.

51. The CQC has raised concern that children and young people do not have appropriate access to information and support while they wait for an appointment with mental health services. The 2018 report *Are we listening?* found examples of poor communication with people who were waiting for care. Children and young people were not signposted to other forms of help while they waited "and as a result their mental health deteriorated".[70]

52. In addition to the devastating impact that long wait times for treatment can have on the mental health of the individual, there is also a wider cost to the health system as a whole. YoungMinds pointed out that because of inadequate access to early intervention, some young people like Lucas turn to A&E for support. They stated that NHS data shows a tripling of A&E attendances by young people aged 18 or under with a recorded diagnosis of a psychiatric condition between 2010 and 2019.[71] During our roundtable with clinicians, one participant explained the strain this can create on services:

> Parents lead with an awareness that the system is very busy, and they are aware of that, and almost becoming quite apologetic or disempowered about being able to access the system, or parents telling us that they've been advised by another professional just to take their child to A&E so they can rush an assessment. And they're coming through to us wanting an immediate psychiatric assessment. Our service is not able to provide that, and as identified by my colleagues the system in itself is not able to meet the demands.[72]

Impact of the pandemic on waiting times

53. The full impact of the pandemic on waiting times going forward has not yet been understood. Claire Murdoch, National Mental Health Director at NHS England & Improvement noted that due to an increase in referral rates, particularly in the eating disorder field, there has been "a slight increase in waiting times". However, NHS Providers, in its written evidence painted a more concerning picture:

> Prior to the pandemic, services were at full stretch and access thresholds in many places were too high, creating long waits and contributing to deteriorating mental health for many individuals. Eight out of 10 trust leaders told us they were not able to meet demand for community CAMHS and over half of trusts reported that waiting times for community CAMHS were increasing. Three out of 10 trusts also told us they were not able to meet demand for inpatient CAMHS.[73]

54. Eating disorder services have been particularly affected, as we noted above. Prior to the pandemic, 80.5% of urgent eating disorder cases started treatment within the standard of 1 week from referral.[74] However, by May 2021, several trust leaders reported to NHS Providers that waits for eating disorder services had deteriorated in their trust, resulting in them missing the national standard.[75] In correspondence to us on 17 August 2021,

70 The Care Quality Commission, Are we listening? March 2018.
71 YoungMinds (CYP0066)
72 Health & Social Care Committee, Transcript from Roundtable with children and young people's mental health practitioners, May 2021.
73 NHS Providers (CYP0068).
74 Correspondence from Claire Murdoch and Professor Tim Kendall to Rt hon Jeremy Hunt MP: 17 August 2021.
75 NHS Providers, Children and young people's mental health services survey. May 2021.

Claire Murdoch and Professor Tim Kendall reported that the most recent data shows only 61% of children and young people starting treatment within the one week standard for urgent cases.[76] Claire Murdoch told us that this was due to the "phenomenally" higher demand for services during the pandemic.[77]

55. **Commitments in the 2017 Green Paper and the NHS Long Term Plan have been taken seriously by NHS England and led to a significant expansion of provision. We are, however, concerned that many commitments may not yet be ambitious enough to ensure every young person with a diagnosable mental health condition can access care. Currently, waiting times for accessing children and young people's mental health services remain far too long, and too many referrals to specialist services are inappropriately rejected. We are also concerned that, despite the NHS Long Term Plan committing to improve access to specialist support for all children and young people aged 0–25, children below the age of three have largely been overlooked to date. The Early Years Health Development Review provides an opportunity for Government to ensure a more consistent offer for families to help strengthen parent-infant relationships which are a key foundation for good mental health.**

56. ***We recommend that NHS England & Improvement set out a clear action plan including key milestones, deadlines, and funding for how they will meet their target set out in the NHS Long Term Plan of 100% access to specialist support for all children and young people aged 0–25 by 2029, without raising the already high thresholds for accessing support.***

57. ***We further recommend that NHS England & Improvement hold Clinical Commissioning Groups, which have consistently failed to meet national expectations, to account on key measures such as expenditure, waiting times and access rates. National ambitions should be raised in line with the best performing areas so that best practice becomes universal practice. This is essential to ensuring that provision of children and young people's mental health services does not remain a 'postcode lottery'.***

58. ***We welcome and support the proposals in the recent access and waiting times consultation that concluded on 1st September, including crisis response times and a four-week waiting time limit for children and young people, and call on NHS England to publish a detailed roadmap as to how it will be delivered including the additional funding requirements.***

Access during the transition to adulthood

59. Many evidence submissions expressed longstanding, significant concerns about the support that is provided to young people between the age of 18 and 25 when they are required to transition from children's to adult mental health services.[78] Evidence to our inquiry has suggested that up to a third of young people are 'lost from care' during this transition period, with an additional third experiencing an interruption in their care.[79] Lucas, who transitioned from child to adult services while he was in inpatient care, nevertheless described the drop in support that he faced after being discharged at age 18:

76 Correspondence from Claire Murdoch and Professor Tim Kendall to Rt hon Jeremy Hunt MP: 17 August 2021

77 Q214

78 See, for example: Centre for Mental Health (CYP0037); Children and Young People's Mental Health Coalition (CYP0043); Mind (CYP0054); Samaritans (CYP0060); Royal College of Psychiatrists (CYP0090).

79 YoungMinds (CYP0066).

> When I was discharged, there was a massive difference between community CAMHS and community adults. With the therapy that I finally managed to get, they just went, "Oh, we have to put you back on the list now." That was when I was 18. I turned 21 this year and I still have not had any therapy on the NHS since coming out of hospital. My mental health has worsened. What I am constantly told by adult services and my psychiatrist is, "You need therapy. You cannot rely on meds. We cannot do all of that." I turn round and go, "Okay, give it to me then, please." They still have not. I have been told that I am at least six months off the list, as it is now.[80]

60. Witnesses have also made it clear to us that a sharp transition to adult services at age 18 does not make sense from a neurodevelopmental perspective. Professor Pat McGorry Professor of Youth Mental Health at the University of Melbourne, told us:

> The transition to adult is very different from what it was 40 years ago. It takes a longer period of time. It is much more complex and fragile. As he said, you are supposed to be an adult at 18, but you are probably not an adult until you are in your mid to late 20s these days in many respects, especially if you have had mental health problems.[81]

61. Claire Murdoch agreed with this, telling us that she viewed the cut off at 18 as a "purely arbitrary historical figure" which was "not needs based".[82] The NHS Long Term Plan made a commitment to try and mitigate these issues by creating "a comprehensive offer for 0–25 year olds that reaches across mental health services for children, young people, and adults."[83] Despite this commitment, evidence to our inquiry has been clear that progress on this ambition has been slow and too many young people still experience an unacceptable disruption to their care.[84]

62. **It is clear that young adults between the ages of 18 and 25 face some of the widest gaps between the support that they need and the support that is available to them. We welcome NHS England & Improvement's commitment to shift away from the current model of care towards one that provides for those aged 0–25. However, we have heard progress on this has been slow, with large variation between areas on what age services are commissioned to. Lucas's story provided a stark reminder that the transition to adult services remains poor for many children and young people, with high rates of drop-out from services in this period. It is essential that young people do not experience a sudden drop in their support at the age of 18.**

63. ***NHS England & Improvement must accelerate the implementation of the 0–25 offer in every local area as a national priority so that young people do not continue to face a cliff edge in accessing the care they require as they transition from children to adult services.***

80 Q85
81 Q94
82 Q66
83 NHS England, Long Term Plan. 2019.
84 Mind (CYP0054)

Workforce pressures

64. We have heard that issues with workforce skills, capacity and morale have exacerbated issues relating to the delivery of mental health services. In particular, witnesses have told us that the ability of services to meet the ambitions of the 2017 Green Paper and the NHS Long Term Plan, as well as the forecasted additional mental health need among children and young people as a consequence of the pandemic, is limited by long-term shortages in the children and young people's mental health workforce. We recognise the significant increase in the mental health workforce in recent years and believe that demonstrates it is considered an attractive sector in which to work. But we also note that even after such increases, NHS Providers describe workforce shortages as a key, longstanding reason why services have struggled to meet demand.[85] This was echoed by participants in our roundtable with children and young people's mental health practitioners, who emphasised that this problem had existed prior to the pandemic, but had only been exacerbated over the last year:

> we had staff shortages way before the pandemic[…] So yes, everywhere is short staffed- everywhere- and it was before. It worries me because it almost seems like people kind of feel that this resilience to keep going, but actually I think people need to stop.[86]

65. There has been a growth in the NHS children and young people's mental health workforce in recent years, with research from Health Education England showing that vacancy rates decreased between 2016 and 2019.[87] However, there are still large workforce shortages in a number of key specialities. The Royal College of Psychiatrists point out that while Health Education England estimated children and young people's mental health services would need to recruit an extra 100 consultant psychiatrists by March 2021 in order to expand access, the actual number of psychiatrists has decreased in this time.[88] Data from April 2021 shows that there were 19 fewer consultant psychiatrists than in March 2017.[89] There are also current and predicted shortages in the workforce necessary to support the mental health needs of the youngest children. The Children and Young People's Mental Health Coalition report that, despite parent-infant teams being crucial for providing therapeutic support when young children are most at risk, there are fewer than 40 of these specialised teams in the UK.[90] Worryingly, given the growing demand for eating disorder services, the Royal College of Psychiatrists reported in their 2019 workforce census that almost 16% of consultant eating disorder positions were unfilled.[91]

66. In order to retain the existing children and young people's mental health workforce as well as recruit the necessary additional staff, the high levels of work-related stress and burnout in the workforce must be addressed. Prior to the pandemic, the 2019 NHS Staff Survey found that 40.3% of respondents had reported feeling unwell as a result of work-

85 NHS Providers (CYP0068).
86 Health & Social Care Committee, Transcript from Roundtable with children and young people's mental health practitioners, May 2021.
87 Health Education England. Children and Young People's Mental Health Services Workforce Report. July 2019
88 Royal College of Psychiatrists (CYP0090).
89 NHS Digital, NHS Workforce Statistics- April 2021. July 2021.
90 Children and Young People's Mental Health Coalition (CYP0043).
91 Royal College of Psychiatrists (CYP0090).

related stress that year. During the pandemic, this number rose to 44% of respondents.[92] One participant during our roundtable explained the impact of this burnout that she had seen among her co-workers:

> I've dealt with nurses in the last year that have had quite severe mental health concerns and I've supported staff who have attempted suicide because actually nobody wants to go off. Nobody wants to let their team down. Nobody wants to kind of step away at a time where it's just so busy and there's so much going on.[93]

67. **One of the largest barriers to increasing access to mental health provision for children and young people remains the size of the mental health workforce. We have seen that children and young people's mental health practitioners face staff shortages, increasing demand and high levels of work-related stress which in turn leads to more part-time work and increased early retirement. We have already made recommendations to the Department on providing mental health and wellbeing support to NHS staff in our previous Report into workforce burnout and resilience in the NHS and Social Care. In particular, we are clear that:**

a) ***Integrated Care Systems (ICSs) must be required to facilitate access to wellbeing support for NHS and social care workers across their systems, and that they are accountable for the accessibility and take-up of those services. (Workforce burnout and resilience in the NHS and Social Care, Second Report of Session 2021–2022, Paragraph 39); and***

b) ***the level of resources allocated to mental health support for health and care staff must be maintained as and when the NHS and social care return to 'business as usual' after the pandemic; and that the adequacy of resources allocated to that support be monitored on a regular basis. (Workforce burnout and resilience in the NHS and Social Care, Second Report of Session 2021–2022, Paragraph 40).***

68. ***In addition, it is paramount that a plan is implemented to increase the size and wellbeing of the children and young people's mental health workforce based on independently verified estimates of the number of people needed in different disciplines and the training places required to deliver them. The strategy should include an assessment of how the skill mix of the workforce can be developed to include other expert professionals such as speech and language therapists, social workers, youth workers and the importance of a diverse workforce in improving outcomes for minority ethnic groups. The Department of Health and Social Care should work with Health Education England to develop this plan to build on the steps already taken to expand the workforce and enhance the skills of the wider workforce.***

92 NHS Staff Survey Co-ordination Centre, NHS Staff Survey: national results briefing, accessed 5 August 2021.

93 Health & Social Care Committee, Transcript from Roundtable with children and young people's mental health practitioners, May 2021.

3 Mental health support in schools

69. Children and young people spend a significant proportion of their time in education, whether this is school, college or university. Schools in particular are a universal provision for children and young people and because of this, the availability of mental health and wellbeing support in schools can have a profound impact on a child or young person. This chapter addresses how mental health provision based in schools can work to support children and young people with mild to moderate mental health difficulties, as well as promote earlier identification of pupils who may be at risk. In particular, we examine the value that Mental Health Support Teams and Designated Senior Leads for mental health (as set out in the 2017 Green Paper *Transforming children and young people's mental health provision*), can add to mental health support in schools.

A whole school approach

70. A great deal of evidence we received called for a "whole school approach" to mental health. The whole school approach to mental health focuses on creating the conditions that are conducive to good mental health and wellbeing through all aspects of school life. A whole school approach involves the universal and continuous promotion of good mental health across all parts of the school including the curriculum, the school leadership and staff-student relationships. It is not only about preventing mental ill health but about the promotion of positive mental health and wellbeing being integrated into a normal school day, while reducing stigma and encouraging openness around mental health. A whole school approach to mental health should also involve a targeted element, by making sure that teachers and other staff can recognise pupils with emerging mental health needs and provide early support to these pupils, including through referral to specialist support and treatment if necessary.[94]

71. Many of our contributors also called for the universal availability of school counsellors, as part of the whole school approach. The Children and Young People's Mental Health coalition suggest that counselling in schools "can reduce psychological distress, help manage emotions and improve relationships."[95] Dr Aleisha Clarke, Head of What Works, Child Mental Health & Wellbeing at the Early Intervention Foundation, told us:

> I think school counsellors have a role to play as part of a whole-school approach in addressing the needs of individual pupils. There is no silver bullet. There is no one evidence-based intervention or approach that will be the one that we should roll out across all schools. We need a collection of support.[96]

72. We heard that this kind of universal approach to mental health and wellbeing support in schools can create positive outcomes for children and young people's mental health. This is evidenced by a review conducted by the Early Intervention Foundation (EIF) of 35 systematic reviews and 98 primary studies over the last decade. The review found that school-based universal interventions "have good evidence of enhancing young

94 Anna Freud National Centre for Children and Families, Mentally Health Schools: Whole-school approach. Accessed 19 July 2021.

95 The Children and Young People's Mental Health Coalition (CYP0043)

96 Q123

people's social and emotional skills and reducing symptoms of depression and anxiety".[97] In commenting on this, Dr Aleisha Clarke told us that most importantly "it is not about bringing in an intervention as a one-off event in a school on borrowed time. It is much more about the adoption of a whole-school approach".[98]

73. The Department for Education and the then Public Health England have identified a whole school approach as an important tool for promoting good mental health in children and young people.[99] In 2017, the then Government's Green Paper, *Transforming Children and Young People's Mental Health Provision* also acknowledged that "a whole school approach, with commitment from senior leadership, and supported by external expertise, is essential to the success of schools in tackling mental health".[100]

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

74. To support the delivery of the whole school approach, the 2017 Green Paper made a number of specific proposals and of the three key proposals, two related directly to mental health provision in schools:

- To incentivise every school and college to identify and train a Designated Senior Lead for Mental Health with a new offer of training to help leads and staff to deliver whole school approaches to promoting better mental health. To support every school and college to do this, the Green Paper committed to rolling out training to all areas by 2025; and
- To fund new Mental Health Support Teams (MHSTs) to provide specific extra capacity for early intervention and ongoing help, supervised by NHS children and young people's mental health staff, whose work will be jointly managed by schools and the NHS. They will provide interventions to support those with mild to moderate needs and support the promotion of good mental health and wellbeing.[101]

75. The Green Paper committed to rolling out these proposals incrementally, with both Designated Senior Leads and Mental Health Support Teams being rolled out to "at least a fifth to a quarter of the country by the end of 2022/23."[102] These commitments were largely welcomed in the sector at the time, and this support was reflected during our inquiry. In particular, several witnesses acknowledged that the reforms are likely to expand system capacity across England, resulting in an increase in access to early intervention support in schools.

97 Early Intervention Foundation, Adolescent mental health: A systemic review on the effectiveness of school-based interventions. July 2021.
98 Q113
99 Public Health England, Promoting children and young people's emotional health and wellbeing: a whole school and college approach. February 2021.
100 Department of Health & Department for Education, Transforming Children and Young People's Mental Health Provision: a Green Paper. December 2017.
101 *Ibid.*
102 *Ibid.*

76. However, at a time when the pandemic has had such a clear impact on the mental health of children and young people, we received evidence expressing fear that the current timeframes for the roll out of the Mental Health Support Teams and Designated Senior Leads would leave too many children and young people many unable to access support.[103] For example, the National Association of Head Teachers (NAHT) explained their position:

> Even at that time NAHT was very concerned by the scale and pace proposed by the green paper… the coronavirus pandemic will have impacted on those timescales, pushing back the vital improvements needed to support children and young people's mental health.[104]

77. Mind expressed a similar concern:

> We are concerned that the long timeframes involved in establishing MHSTs will leave many children and young people unable to access this support, at a time when the impact of the pandemic is having a significant impact on many children and young people's mental health.[105]

Mental Health Support Teams

78. To deliver the programme of Mental Health Support Teams, the Department of Health and Social Care and the Department for Education created a new professional role, the Education Mental Health Practitioner (EMHP). EMHPs deliver "evidence-based early interventions for children and young people and parents/carers in educational settings in England".[106] In correspondence to us on 17 August 2021, Claire Murdoch, National Director of Mental Health, and Professor Tim Kendall, National Clinical Director for Mental Health at NHS England & Improvement, explained that EMHPs are "the core" of Mental Health Support Teams' workforce, with their training designed to equip them to identify and understand common mental health problems, as well as provide support for children and young people with lower-level mental health needs.[107] However, they also stated that they are not trained "to provide clinical interventions to more complex issues like eating disorders".[108]

Speed and scale of roll out

79. The current roll out of Mental Health Support Teams is proceeding at an impressive pace which surpasses the aims set out in the 2017 Green Paper. In correspondence with us on 7 May 2021, Claire Murdoch, National Director of Mental Health, and Professor Tim Kendall, National Clinical Director for Mental Health at NHS England & Improvement, informed us that "over 180 Mental Health Support Teams are operational across 3,000 schools and colleges and 15% of pupils".[109] Their letter also set out that the current trajectory of the rollout "surpasses our previous targets", with the expectation that MHSTs

103 See, for example: The Centre for Mental Health (CYP0037); Children and Young People's Mental Health Coalition (CYP0043); YoungMinds (CYP0066) .
104 National Association of Head Teachers (CYP0024).
105 Mind (CYP0054)
106 Anna Freud National Centre for Children and Families, About the Education Mental Health Practitioners programme. Accessed 24 August 2021.
107 Correspondence from Claire Murdoch and Professor Tim Kendall to Rt hon Jeremy Hunt MP: 17 August 2021.
108 *Ibid.*
109 Correspondence from Claire Murdoch and Professor Tim Kendall to Rt hon Jeremy Hunt MP: 7 May 2021

will reach "a national coverage of 30% by 2023". This is a year ahead of the stated aim of reaching a fifth to a quarter of the country by the end of 2022/23. In June 2021 Claire Murdoch stated that, at the current rate of increase in the number of Educational Mental Health Practitioners coming through training, NHS England & Improvement expect to reach 47% coverage by 2023/24.[110] This is a welcome improvement on the original aims in the Green Paper, but the fact that only around half of pupils will be able to access the new teams by the end of this parliament also demonstrates why the original ambition was too low.

80. To inform the formulation of the Green Paper, *Transforming children and young people's mental health provision*, the then Government asked Professor Tim Kendall, Professor Peter Fonagy and Professor Steve Pilling, of the National Collaborating Centre for Mental Health (NCCH) and University College London (UCL), to undertake a systematic review of the evidence relating to the mental health of children and young people. Professor Fonagy, explained to us why the roll out of MHSTs had not been faster:

> Of course, it would be fantastic to be able to roll it out faster[…]. The kind of person that Shanti talked about who goes into school and is able to help does not just suddenly pop out of the ground. They have to be trained. What is perhaps currently a rate-limiting factor is the rate at which we can train people.[111]

81. Professor Fonagy also warned that accelerating the roll out of Mental Health Support Teams and Designated Senior Leads too fast could be "counterproductive".[112] He instead underlined the importance of the rollout taking place "thoughtfully and deliberately" to ensure that while Mental Health Support Teams are fully staffed, this is not achieved by destabilizing other services through drawing staff away from other mental health provisions.[113]

82. Rt Hon. Nadine Dorries MP, then Minister for Patient Safety, Suicide Prevention and Mental Health, agreed with this, stressing the difficulty of accelerating roll out of these services with limited personnel.[114] The Minister made it clear to us that she did not view funding as a rate-limiting factor in the expansion of Mental Health Support Teams, saying that she had "no barrier when I request money for mental health from Treasury".[115] Instead, she regarded training as the fundamental issue, telling us that "we need the people to provide the services" but "traditionally no one wanted to work in mental health as an area".[116] When questioned on the issue of training the Minister was optimistic about the future, telling us that there had been a 141% increase in the number of people coming through mental health training, but cautioned that "it takes time to train people."[117]

110 Q210
111 Q110
112 Q121
113 Q119
114 Q182
115 Q193
116 Q182
117 Q192

The impact of Mental Health Support Teams

83. At present, there is little to no publicly available data on the impact that existing Mental Health Support Teams have had on the mental health of children and young people who are accessing them. This point was raised early in our inquiry by Sophie Corlett, Director of External Relations at the charity Mind:

> Also, for mental health support teams, we are still waiting for the evaluation. We know that they are being rolled out. We would like them to be rolled out beyond the 35% of areas. We need to know whether they are working, and whether they are working for all groups. As Lynne was saying earlier, some groups of people are less likely to approach services, so we need to know that those services are reaching some of the groups who often do not approach services.[118]

84. While this data is not publicly available on a national scale, Professor Peter Fonagy shared the results of a pilot programme in London and the South East being monitored by University College London. He explained that "around 60% of the children seen [by mental health support teams] recovered from depression or anxiety."[119] We also heard from Tim Bowen and Shanti Johnson, respectively Head and Deputy Head Teacher at Maple Primary School, St Albans. Mr Bowen told us that working with Mental Health Support Teams meant that staff in the school had a direct contact they can reach out to if they are concerned about a child's wellbeing. In the past, he explained that they would have said "you might want to consider going via your GP".[120] Shanti Johnson, Deputy Head Teacher at Maple Primary, also pointed to the training available for staff as a particular positive of the programme, saying that she now feels "able to support children and to help identify where there might be particular needs".[121]

85. For Tim Bowen, the most important benefit of working with MHSTs was their impact on the culture of the school at large, by supporting staff to adopt a whole school approach:

> One of the most positive things in this for me is that the culture in the school over the last couple of years since it became involved in the pilot has changed. We have adopted a whole-school approach to talk positively about children's emotional and mental health and wellbeing, and also that of staff. For me, as a headteacher, that is crucial, although it was set up primarily to support the children. The culture in the school is that it is not just acceptable but a really positive healthy thing to be talking about ways of looking after yourself and your emotional and mental wellbeing.[122]

86. **We have seen that Mental Health Support Teams, where they have been rolled out, are well-placed to facilitate early intervention for children and young people as part of a whole school approach. They appear to have delivered positive outcomes for children and young people where they are up and running. We welcome the fact that under the current trajectory the commitment of 20% to 25% coverage will be delivered a year ahead of schedule and we welcome the commitment that the Government and**

118 Q16
119 Q109
120 Q103
121 Q104.
122 Q116

NHS England & Improvement have shown to deliver this roll out. But reaching only around half of children by the end of this Parliament shows the original ambition is too low and it should be increased, at a minimum, to reaching two thirds of schools by the end of the Parliament if we are to reduce referrals for severe conditions by as much as needed.

87. ***We therefore recommend that the Department of Health and Social Care fully fund and scale up the roll out of Mental Health Support Teams to cover two thirds of schools in England by 2024/25 and 100% by 2027/28.***

88. ***Furthermore, in light of the rise in both prevalence and severity of children and young people's mental health difficulties, the training of Education Mental Health Practitioners should be reviewed to integrate their skills into a new psychological professions structure. This must include training experienced practitioners in more sophisticated psychological therapy so that they can work with more complex cases such as eating disorders and self-harm.***

Designated Senior Leads for Mental Health

89. The second key element of the 2017 Green Paper was the roll out of a Designated Senior Lead for Mental Health in every school and college, supported by high-quality training.[123] The Green Paper proposed that the roles for these Designated Senior Leads would include:

- oversight of the whole school approach to mental health and wellbeing;
- supporting the identification of at risk children and children exhibiting signs of mental ill health;
- working with clear links into children and young people's mental health services to refer children and young people into NHS services where it is appropriate to do so; and
- support to staff in contact with children with mental health needs to help raise awareness and give all staff the confidence to work with young people.[124]

90. To achieve these objectives, the Green Paper proposed a training fund that would "allow schools to choose an appropriate training course" for a senior member of staff.[125] However, many written evidence submissions to our inquiry expressed concern that the training for Designated Senior Leads had not yet been rolled out.[126] Emma Thomas, CEO of YoungMinds, told us that this training had been paused in January 2020, due to the covid-19 pandemic, but it is not clear what had caused the delay prior to this.[127] In June 2021, the Department for Education published the Learning Outcomes for this training and announced that it was offering a grant for senior member of schools and colleges to take it up. The announcement included sufficient funds to offer a grant to "around a

123 Department of Health & Department for Education, Transforming Children and Young People's Mental Health Provision: a Green Paper. December 2017.

124 *Ibid.*

125 *Ibid.*

126 See, for example: The Centre for Mental Health (CYP0037); Mind (CYP0054); National Children's Bureau (CYP0079); Royal College of Psychiatrists (CYP0090).

127 Q15

third of all state schools and colleges between September 2021 and March 2022."[128] The Learning Outcomes for Designated Senior Lead training include supporting mental health leads in "identifying need" among pupils, as well as providing "targeted support and appropriate referrals" and "creating an ethos and environment that promotes respect and values diversity".[129] Given the sharp rise in eating disorders among children and young people, we asked Professor Tim Kendall to clarify if the training for these Senior Leads for mental health would cover eating disorders specifically. In correspondence sent to us on 17 August 2021, Claire Murdoch and Professor Kendall explained that the training is "likely to include eating disorders".[130]

91. **A whole school approach to mental health and wellbeing should include the promotion of good mental health as well as the early identification of those who are at risk of mental health difficulties. Designated Senior Leads for mental health can have an extremely important role in overseeing and leading this whole school approach but they need to be adequately trained, particularly in how to identify and intervene in emerging cases of mental health problems. Given the worrying signs that more children and young people are turning to self-harm as a coping mechanism and more are struggling with eating disorders, it is extremely concerning that training for Designated Senior Leads appears to have been paused and has not yet been rolled out four years after the Green Paper committed to do so.**

92. ***It is vital that the Department rolls out the training for Designated Senior Leads to all schools urgently with a commitment to completing the roll out before the end of the current Parliament. Moreover, given the worrying trends in self-harm and eating difficulties among children and young people, it is essential that this training includes sufficient training specifically for the early identification of self-harm and eating disorders as well as mild to moderate mental health problems generally. We expect a comprehensive update on work towards this ambition by the end of December 2021.***

93. ***Whilst Mental Health Support Teams and Designated Senior Lead training is being rolled out, the Department of Health and Social Care and the Department for Education should work closely together with all schools to ensure that they have the support they need in order to offer a whole school approach, including: access to digital self-help support; school counselling for every child who needs it; and good guidance on best practice for staff on how to provide the most appropriate support in schools.***

128 Department for Education, Senior mental health lead training, 22 June 2021.
129 Department for Education, Learning outcomes for senior mental health leads in schools and colleges. June 2021.
130 Correspondence from Claire Murdoch and Professor Tim Kendall to Rt hon Jeremy Hunt MP: 17 August 2021.

4 Importance of community-based and digital mental health support

94. While a focus on providing mental health support in schools and in a clinical setting is crucial, it is important to note that for many children and young people these are not the easiest or most accessible places to access support. This chapter will examine alternative offers of support for children and young people including:

- the adequacy of current levels of community provision as well as the opportunities provided by open-access drop in hubs for children and young people; and
- the expansion of a digital offer for children and young people to access mental health support.

Community-based support

95. Throughout our inquiry we have heard that there is a need for a comprehensive expansion of the early intervention support available in communities.[131] Emma Thomas described early intervention community support as the "missing third" that is necessary to complement the support available in clinical NHS services and in schools.[132] This view was echoed in a number of written evidence submissions to our inquiry, including from the National Children's Bureau, which explained the advantages of situating early support in the community:

> Place-based, whole-system approaches are most effective at meeting children and young people's needs, particularly for those with complex, multiple and long-term needs. Services delivered in the community provide flexible and cost-effective support while reaching underserved communities due to their universal, non-stigmatising and culturally responsive approach.[133]

96. Existing community services play a crucial role in offering preventative and early intervention support that can promote good mental health and reduce problems by acting in everyday settings for children and young people before they ever reach the stage where they require specialist NHS support. However, funding pressures have meant that budget holders have been forced to focus on those children and young people facing the most immediate and urgent difficulties. The Local Government Association explained:

> Councils have to make extremely difficult decisions about how to allocate increasingly scarce resources, and youth services have seen their funding reduced as councils are forced to prioritise urgent help for children at immediate risk of harm.[134]

97. As a result, many local areas have reduced funding for low level, early intervention mental health support for children and young people. A 2019 Children's Commissioner report showed that 60% of local authorities had seen a real-terms spending fall on low-

131 Children and Young People's Mental Health Coalition (CYP0043).
132 Q20
133 National Children's Bureau (CYP0079).
134 Local Government Association (CYP0041).

level mental health services between 2016/17 and 2018/19.[135] Wider support—such as youth services and children's centres—has also reduced. Analysis by YMCA showed that by 2019, spending on youth services in England had reduced by £959 million in real terms since 2010. This is equivalent to a 71% cut.[136]

98. Many in the sector have advocated, during our inquiry and separately, for the rolling out of open-access, drop-in 'hubs' to help fill this gap. These services, would operate on a self-referral basis and increase access to early intervention support and prevent escalation to more serious mental ill-health.[137] The Children's Society explained how open-access hubs work:

> Open access hubs are designed to offer easy-to-access, drop in support on a self-referral basis for young people with emotional health and well-being needs, up to age 25. These services can be delivered through the NHS, in partnership with local authorities, or through the voluntary sector. A mix of clinical staff, counsellors, youth workers and volunteers provide a range of support on issues related to well-being, while a range of services can be co-located under one roof; offering wrap-around support across, for example, psychological therapies, housing advice, youth services, employment support and sexual health.[138]

99. Many contributors to our inquiry cited the Australian approach to community-based open access mental health support as an example of good practice (see Box 1).

Box 1: The Australian Model: headspace

The headspace model in Australia provides "a youth-friendly service for young people (aged 12–25) to access a range of mental health programmes, including primary care, psychological support, vocational and educational support and drug and alcohol services" based on a one-stop shop model.

The first one-stop shop headspace centres opened in 2007 and as of 2020 there are 140 across Australia, with headspace having strong brand awareness among young people. An overview of the services that headspace has delivered in the financial year 2019–20 has shown the impact that it can have on communities:

- As of June 2020, 62% of young people experienced reduced distress and/or improved functioning while at headspace.
- After accessing headspace services, 89% said that they understood better how to manage their mental health.
- 88% of young people and 93% of parents said that headspace is a vital community service.

100. We heard from Professor Pat McGorry, Professor of Youth Mental Health at the University of Melbourne and a founding board member of headspace, who told us that it is crucial to identify and treat mental illness among children and young people as early as possible:

135 Children's Commissioner, Early access to mental health support. April 2019.
136 YMCA, Out of Service: A report examining local authority expenditure on youth services in England & Wales. January 2020.
137 See, for example: The Children's Society (CYP0048); Youth Access (CYP0085); YoungMinds (CYP0066).
138 The Children's Society (CYP0048).

> Nearly every potentially serious mental illness that affects adult life—whether it is anorexia, as you have heard, mood disorders, anxiety, substance misuse, or personality disorders, especially borderline personality, which is a very destructive illness—begins in the period following puberty, quite often on the back of adverse childhood experiences[…]
>
> That means that if you want to capture the full spectrum of early intervention that is possible, and mitigate the very disabling, destructive and economic effects of poorly treated mental illness across the decades of adult life, you have to focus on the transitional period from puberty through to the mid-20s.[139]

101. Professor McGorry further stressed the damage that high thresholds and long waiting times for specialist services can do:

> It is absolutely devastating, as Cassandra was saying, for the young people. They have put their hands up and tried to get help, and it is amazingly invalidating to be told that. It is intensely frustrating. It causes a moral injury in the practitioners as well, I think, because they cannot actually do what they know they should do. Other doctors do not have that problem. In cardiovascular and cancer medicine, you do not have that moral injury, but in mental health you do because you cannot do what you know is needed for the patient.[140]

102. A model of community-based, open access hubs has already been established in England through the Youth Information Advice and Counselling services (YIACs). These services are run by Youth Access, which currently have a network of 160 services rooted in communities across the country to "provide free, easily accessible and age-appropriate support to young people aged 11–25 with a wide range of issues".[141] The Government recognised the value of this style of open access services in the 2015 paper *Future in Mind.* The paper proposed that by 2020 mental health support would be "more visible and easily accessible for children and young people".[142] This would be delivered by "every area having 'one-stop-shop' services" based on the existing network of YIAC services.[143] However, this ambition has not yet been realised.

103. One advantage of services like these is that they are perceived as highly accessible by children and young people. In particular, evidence submissions stressed that the drop-in nature of these hubs, combined with their operation on a self-referral basis means that young people can access support when they need it, without the high thresholds and long waiting times associated with NHS services.[144] We have also heard that these open-access style community hubs could play a valuable role in helping to address the inequalities of access discussed earlier in this report. Cassandra Harrison, Chief Executive of Youth Access, explained that these services have the ability to reach a more diverse group of young people, including those who may traditionally struggle to access CAMHS:

139 Q87
140 Q97
141 Youth Access (CYP0085).
142 Department of Health, Future in Mind. 2015
143 *Ibid.*
144 The Children's Society (CYP0048).

> We know that our members have better reach to young people of colour, LGBTQ young people, young refugees and young people who have experience of the justice system. Those are the groups of young people who access our services. Our services are reaching them to a greater degree than CAMHS.[145]

104. As well as providing an accessible model of support for children and young people, Cassandra Harrison stressed that these open-access services were also highly effective and "achieve clinical outcomes that are comparable to CAMHS and schools-based counselling".[146] A 2018 study by the British Association of Counselling and Psychotherapy with Youth Access observed that open-access services delivered "statistically significant reductions in psychological distress" that were "comparable to those reported in school-based and statutory mental health services in the United Kingdom".[147]

Funding challenges

105. Despite this, we have heard that these services continue to be undervalued. Cassandra Harrison described that Youth Access' members were having to "battle" to keep their services running by "patchwork[ing] together bits of funding, which are often very limited and very short term".[148] Written submissions have stressed that the lack of a dedicated funding stream for local areas to provide services of this kind has meant that access to these open access hubs has also become a postcode lottery, with the service available depending on where a young person lives. Whilst some areas have invested in this kind of provision, it is far from standard.[149]

106. There is widespread consensus in the sector that investment in these kinds of services is needed. Cassandra Harrison told us:

> With the right kind of backing, funding and support, these services could play an even greater role in transforming young people's mental health provision and moving things away from crisis to earlier intervention and prevention.[150]

107. Rt Hon. Nadine Dorries MP, then Minister of State for Patient Safety, Suicide Prevention and Mental Health, told us that community-based open access hubs were something that "we will be keeping a very close eye on".[151] She said that it was her hope that:

> 10 years from now, all our mental health services will be delivered via an infrastructure in the community and looking something like an open-access hub, where young people can just walk in. They will not need to be referred. They can just walk in off the street and receive the support and mental health support they need.[152]

145 Q96
146 Q91
147 Counselling for young people and young adults in the voluntary and community sector. *Psychology and Psychotherapy: Theory, Research and Practice.* 2018, vol 93 (1): pgs36–53.
148 Q93
149 Mind (CYP0054).
150 Q93
151 Q250
152 Q250

108. **For some children and young people where schools are not their preferred place to access support, drop-in hubs that operate on an open access, self-referral basis provide a valuable alternative opportunity to access help. We have heard that the large-scale roll out of a similar style system has improved outcomes for children and young people in Australia. Where these hubs already exist in the UK, based on the Youth Information Advice and Counselling model, they fill a vital gap in the health system and are perceived as accessible to young people. They are also capable of reaching those who may be less able to access traditional services. However, while these have been rolled out in some areas of the country, we have heard that this is subject to local funding priorities and is far from a standard provision. Access to these drop-in services should not be dependent on where a young person lives but should be available nationally.**

109. ***We recommend that the Department of Health and Social Care fund and roll out open access models to every area across the country so that there is a consistent, comprehensive community offer to complement available school-based and clinical support across England. The hubs should also offer outreach support to vulnerable groups and should be integrated with specialist children and young people's mental health services with a clear step down/step up relationship. National standards for the provision of support should be published so hubs adhere to clinical standards.***

110. ***The social care sector is essential to the provision of mental health services to children and young people and it is essential that it is funded to do so as part of the forthcoming social care white paper.***

111. ***Equally vital is the role of the new Integrated Care Systems and it is essential they publish detailed plans with timescales as to how community provision for the mental health needs of children and young people will be improved working jointly with the local social care system.***

Digital mental health support

112. Some children and young people may prefer accessing support through digital means, as they can do so easily and anonymously. Given the need to maintain social distancing during the pandemic, digital mental health support has seen a surge in prominence. For some children and young people, being able to continue accessing digital support during the pandemic was a lifeline, particularly for those who live in remote areas, who may face accessibility issues, or those who experience stigma or shame related to their mental health.

113. YoungMinds have stated that a whole-system strategy to children and young people's mental health must include clinical, community-based, school-based and digital support.[153] During our inquiry, we heard from Dr Lynne Green who is the Chief Clinical Officer at Kooth, which is one of the UK's leading providers of digital mental health support. It is an online, anonymous service which offers online counselling services with human practitioners through either a booked or drop-in session available 24/7, 365 days a year. The service also offers messaging, live and static forums, discussion boards, mood trackers, goal setting and interactive activities.[154] Dr Green explained the importance of digital support being part of the offer for children and young people:

153 YoungMinds (CYP0066).

154 Kooth, Letting children and young people thrive. Accessed 29 July 2021.

> Many young people feel more comfortable talking about difficult psychological issues in an online, digital environment. We were seeing gradual increases in demand for our service prior to the pandemic. Of course, due to some of the logistical issues that some of my colleagues have already mentioned, we have seen an increase as a result of the Covid-19 pandemic.[155]

> As I said previously, it is about choice. It is so important that we enable easily accessible services in the way that people want them. We know from many years of working with children and young people, not just during the pandemic, that choice is important, and that digital and anonymous access is really important to them. When we survey children and young people, the No. 1 reason that always comes to light about why they like our digital service is its anonymity.[156]

114. Particularly for children and young people who experience shame or stigma around their mental health, the guarantee of anonymity that some digital services offer can remove an important barrier to early intervention. Research from the Education Policy Institute has shown that children and young people really value the anonymity that digital platforms such as Kooth can provide as it "enables them to open up about intimate or taboo issues."[157] This view was supported by Emma Thomas, who told us that digital mental health support "plays a key role" in supporting children and young people's mental health, particularly in "those kind of midnight moments when they are on their own".[158]

115. While digital support for children and young people's mental health has played a vital role, particularly during the pandemic, in ensuring that access to services has been able to continue, there was also a great deal of consensus in the evidence to our inquiry that digital support options should be supported and expanded in a way that is complementary to existing face-to-face options, not as an alternative.[159] One of the most important reasons for this is that some children and young people may experience difficulty accessing the appropriate technology. Digital exclusion makes it harder for children and young people who live in poverty to access this kind of support. The Prince's Trust cited research that "approximately one million children and young people do not have adequate access to a device or connectivity at home."[160] They point out that if digital support has limited accessibility, with only those children and young people who have appropriate technology able to access it, then it is likely that those children and young people who need support the most are the ones who are slipping through the gaps.[161] Emma Thomas stressed to us the importance of children and young people having access to the option of a face-to-face service:

> In the adoption of digital, we have seen the NHS roll out virtual counselling very quickly, and access to the 24/7 crisis helplines. It is important to understand that for many young people what we saw was that those virtual sessions, as opposed to face to face, were not appropriate, given data access

155 Q5
156 Q8
157 Education Policy Institute, Online mental health support for young people. November 2017.
158 Q8
159 Mind (CYP0054).
160 The Prince's Trust (CYP0091).
161 *Ibid.*

> or privacy problems. Young people need to be able to have the choice of face to face that might work for them, with a trusted adult and an ongoing service.[162]

116. Additionally, some children and young people simply find it harder to build relationships when support is being accessed virtually. Against the assumption that almost all young people would prefer to access services online, Mind point out that in a survey of 16,000, young people were nearly twice as likely as adults to say that they feel uncomfortable using technology to access mental health support. Almost a third of young people (30%) who accessed or tried to access support said that the technology was a barrier to doing so.[163]

117. **For those children and young people who prefer accessing help online, digital services can be an important way of reducing barriers to access so it is important that a digital offer should be available for all young people. To prevent over-medicalisation of mental health conditions this should include self-help options as well as digital counselling offers. However, digital support options are not appropriate for all children and young people, and in fact can pose barriers and exacerbate inequalities for some. Therefore, targets for improving access to services should not be met by over-reliance on digital support. These models should complement, rather than replace the existing in-person offers.**

162 Q8
163 Mind (CYP0054).

5 Inpatient care

118. This chapter reviews and addresses how the care provided to children and young people in inpatient settings can be improved. The chapter explores how children and young people currently experience inpatient care and the extent to which this is the most appropriate setting for treatment. We consider the safeguards in place to ensure that children and young people are aware of their rights and how these can be strengthened or expanded. We also address the concerning use of restrictive practices in these settings.

119. The Government has made a number of commitments to improve the experiences of children and young people in inpatient settings in recent years, but the most significant of these are:

- The NHS Five Year Forward View for Mental Health which committed that "by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements".[164]
- The Mental Health Units (Use of Force) Act 2018, which is designed to "set out the measures which are needed to both reduce the use of force and ensure accountability and transparency about the use of force in our mental health units".[165]
- The Independent review of the Mental Health Act, which in 2018 recommended that "every inpatient child or young person has access to an advocate and to a personalised care and treatment plan"[166] and The White Paper on Reforming the Mental Health Act, 2021, which builds on the recommendations made in the Independent Review, accepting "the vast majority" of its recommendations for change.[167]

120. Throughout our inquiry, there was clear consensus that in the vast majority of cases, it is better for a child or young person to receive treatment at home or in their community, close to home. This point was reiterated to us by Rt Hon. Nadine Dorries MP, then Minister for, Patient Safety, Suicide Prevention and Mental Health, who said that "community—close to home, friends, family and work—is where mental health services are better delivered".[168] Professor Tim Kendall, National Clinical Director for Mental Health at NHS England, added that inpatient care is "extraordinarily expensive" and "often harmful".[169] However, despite this, we heard that currently too many children and young people remain in inpatient settings for too long, far from home, subject to inappropriate use of restrictive interventions and unaware of their rights.[170] The *Mental Health Act 1983* acknowledges that if inpatient detention is necessary it should be delivered as close as reasonably possible to a location that the patient would like to be close to (e.g. their home or close to their family).[171] Yet, NHS Providers raised concern that NHS Trust leaders,

164 NHS England, Mental Health Delivery Plan 2018–2019. February 2018.
165 Department of Health & Social Care, Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England and police forces in England and Wales – draft for consultation. May 2021.
166 Article 39, A safe space? The rights of children in mental health inpatient care. November 2020
167 Department of Health & Social Care, Reforming the Mental Health Act, January 2021.
168 Q189
169 Q230
170 Children and Young People's Mental Health Coalition (CYP0043).
171 Department of Health, Mental Health Act 1983: Code of Practice. 2015

despite being acutely aware of the impact that out of area placements (OAPs) have on the overall quality of care, are having to do this as a last resort because of a lack of inpatient mental health beds in their local area.[172] NHS Providers reports that six out of 10 trust leaders are having to resort to OAPs for those children and young people with the most serious mental health conditions.[173]

121. There was also significant consensus among our witnesses that a lack of available adequate social care placement was contributing to this inappropriate care, including children and young people facing long stays in adult wards or wards far from home. In May 2021, we held a private roundtable meeting with CAMHS practitioners. During that meeting, we heard that inadequate social care provision was a significant barrier for clinicians to be able to offer the appropriate level of support. One participant (a Head of Nursing and Quality) told us:

> I think probably one of the other barriers as well is thinking about how social care links in. I think, particularly where I've been in adult, the real difference that I sort of see between adult and CAMHS is actually that as a health care provider, we quite often end up filling a gap for social care. And particularly when you think about our inpatients and delayed discharges it's quite often because there isn't an appropriate placement available for them to go to, or we've got somebody for a prolonged period of time in A&E being quite distressed where they don't need an impatient mental health admission, but there isn't a social care placement for them to go to. So actually in turn, then their mental health deteriorates, and we end up getting into a situation where they do get admitted, but actually it's not the right care and treatment for that young person.[174]

122. Other clinicians agreed with this assessment, emphasising that low availability of social care placement was a large contributor to delayed discharges for children and young people on inpatient wards. For example, during the roundtable, we also heard from a Consultant child and adolescent psychiatrist who stressed:

> I don't want to repeat what has been said, but I have a couple of things that I would add. One is in terms of real numbers around the need for social care placement. So we've got eleven young people on the ward at the moment, nine of whom are not going back home, and so a lot of those are awaiting some kind of social place. And in terms of delayed discharges we've got two that have been delayed for over 2 months while social care are looking for placement, so obviously in terms of providing appropriate treatment and care, we're not the right place for them, we recognised that over two months ago.[175]

123. Dr Bernadka Dubicka, Chair of the Child and Adolescent Faculty at the Royal College of Psychiatrists, told us that this can create real moral injury among clinicians and practitioners, who recognise when inpatient care is no longer appropriate but do not have a fitting place to discharge to:

172 NHS Providers (CYP0068).
173 *Ibid.*
174 Health & Social Care Committee, Transcript from Roundtable with children and young people's mental health practitioners, May 2021.
175 *Ibid.*

> [investment in social care] is absolutely essential. I cannot tell you how heartbreaking it is to look after somebody in an inpatient unit when you cannot find anywhere for them to go in the community. They stay for months on end. They should have been discharged ages ago, but there is a lack of specialised placement.[176]

124. During our inquiry into the *Treatment of autistic people and individuals with learning disabilities*[177] we heard that the Trieste model of care—which is characterised by simplified and quicker admissions to and discharges from inpatient facilities; limited number of individuals in inpatient facilities for lengthy durations; and emphasis on well-resourced community support—presents a clear alternative to the model of care currently in place in England.[178] Many witnesses to our inquiry indicated their support for a similar model of care for children and young people's mental health. Professor Tim Kendall explained the principles behind this model:

> I will be completely honest. I am a big fan of the Trieste model. […] What they have effectively done is reverse things. If you go back 10 years, we were spending about 20% of our budgets on community services and 80% on in-patient services. They have, effectively, reversed that. Back in 1978 when they closed the asylums, in places where they had great community services such as Trieste it worked fantastically.[179]

125. Claire Murdoch similarly indicated her support for the model, saying that she is "a very big fan and advocate" of the system.[180]

126. However, witnesses also expressed caution about a sudden transition to a Trieste-style system in which admissions are very short term. Professor Kendall, National Clinical Director for Mental Health, expressed cautious support for the principles of the model, and called for an "evolutionary approach to reducing our bed base and increasing our community services … in much the way that Trieste has done".[181] In the short term, as this evolutionary shift takes place, Professor Kendall pointed to the work of provider collaboratives as a "really important step".[182] The Provider Collaborative programme—NHS-led groups of providers of specialised mental health, learning disability and autism services working together to improve their local care pathways—has been piloted for two years across 15 pilots.[183] Claire Murdoch echoed support for this model and told us that in her view, "provider collaboratives will be a really important part of the answer."[184]

127. **Inpatient units have a role to play in treating some of the most severe and complex mental health conditions, especially those that are resistant to community treatment. However, in most cases the most compassionate and effective care for children and**

176 Q135
177 House of Commons Health and Social Care Committee, Treatment of autistic people and individuals with learning disabilities, HC 21
178 House of Commons Health and Social Care Committee, Treatment of autistic people and individuals with learning disabilities, HC 21, para 54.
179 Q54
180 Q55
181 Q230
182 Q242
183 Correspondence from Claire Murdoch and Professor Tim Kendall to Rt hon Jeremy Hunt MP, Letter from the National Mental Health Director and National Clinical Director for Mental Health, NHS England on Children and young people's mental health, 7 May 2021.
184 Q61

young people is provided in the community–and increasing its provision must be the overall aim of the Department and NHS England & Improvement. We have set out the benefits of Trieste model of care in more detail in our report into *The treatment of autistic people and individuals with learning disabilities*. We believe that the principles of this model of care are also appropriate for children and young people's mental health treatment.

128. ***We therefore recommend that the Department accelerates the shift towards increased community-based provision and a reduced inpatient bed base as a national priority to ensure that children and young people with the most complex needs receive good quality care in a setting that is right for them. A national strategy should be set out to establish jointly commissioned health and social care services. To ensure children and young people are not 'parked' in inappropriate in-patient care, an independent psychiatrist should sign off the need for inpatient provision on a monthly basis for all young people who have stayed for longer than three months in a mental health hospital. This should be backed up by legislative changes. It should equally apply to those with a learning disability, autism, or both.***

129. ***In order to achieve this shift towards community-based care, every area should have a community service for children in crisis which is available 24 hours a day, seven days a week. A clear map is needed of where current gaps in this provision are and a plan should be in place to ensure these services are available in every area. This should include 24/7 all age liaison psychiatry in hospitals, crisis services in the community, and 24/7 crisis support teams in all areas. These should have specialist expertise in preventing admissions and supporting children and young people with autism, a learning disability or both.***

130. ***For those children and young people for whom inpatient admission cannot be avoided, a continued focus is needed to increase the quality of this care. As well as much improved data collection, this should include access to therapies, activities and education, including from private sector providers. It should include a stronger voice for children, young people and their families through access to advocacy for all children and young people.***

Safeguarding children and young people in inpatient care

131. The Mental Health Act 1983 lays out the clear rights, processes and safeguards for those who are detained.[185] Sections 130 and 132 of the Act give the individual concerned the right to understand the basis of their detention, which section of the Act they are detained under, and the right to access support from an Independent Mental Health Advocate.[186] Research undertaken by the Children's Commissioner in November 2020 into *Children's experiences in mental health wards* found that for many children and young people these safeguards were a valuable opportunity to raise concerns.[187] In particular, Kamena Dorling, Head of Policy and Advocacy at the charity Article 39, explained the "fundamental" role that Independent Mental Health Advocates have in supporting children in hospital:

185 Article 39, A safe space? The rights of children in mental health inpatient care. November 2020
186 Mental Health Act 1983, sections 130A and 132.
187 Children's Commissioner, Children's experiences in mental health wards. November 2020

> They can help them understand their rights. They can help them participate meaningfully in decision-making processes. They have a key role in supporting children to communicate their wishes and feelings to medical professionals to shape their care and treatment plans, challenge detention and plan for leaving hospital.[188]

132. However, successive CQC reports[189] and written evidence submitted to our inquiry expressed concern at the differing experiences between children admitted formally (under the Mental Health Act 1983) and those admitted 'informally' (through their consent or the consent of a parent).[190] Witnesses told us that the safeguards contained in the Act do not automatically apply to patients who are informally admitted to inpatient facilities. This is despite the fact that these children and young people are often living in the same conditions as those who have been formally detained under the Mental Health Act 1983. In commenting on this issue, Kamena Dorling explained her concerns to us:

> One of the real concerns that came out was about children who are informal patients, in that they are not detained under the Mental Health Act but are there on the basis of their consent or their parents' consent. They do not have the same rights as children detained under the Mental Health Act. They do not have the right to advocacy, for example, yet many of the people we talked to expressed the point that these young people are living in exactly the same conditions as those who are detained under the Mental Health Act, but they do not understand their rights and have the sense that if they, in some way, break the rules they will end up being sectioned.
>
> There is a real question about whether we have a section of children who are unlawfully deprived of their liberty and are not having the same kinds of protections and safeguards as other children.[191]

133. The concern that children and young people who are detained informally may not have a full understanding of their rights and feel "coerced into consenting"[192] by threat of being sectioned was also raised by the Office of the Children's Commissioner. Consequently, they call for guaranteed advocacy for all informal patients.[193]

134. The *2018 Independent Review of the Mental Health Act* commissioned by the Government recommended that "the statutory right to an Independent Mental Health Advocate should be extended" to include all informal patients.[194] These provisions were regarded as essential to ensuring that "informal admission is truly voluntary".[195] There was also support for this from other stakeholders. When we questioned Claire Murdoch, National Director for Mental Health at NHS England & Improvement, about this she told us that "the best ones [inpatient units] will always have independent advocates available"[196]

188 Q131
189 CQC Monitoring the Mental Health Act: 2011–12; 2012–13; 2013–14; 2014–15.
190 See, for example: Children's Commissioner for England (CYP0109); Children and Young People's Mental Health Coalition (CYP0043).
191 Q131
192 Children's Commissioner for England (CYP0109).
193 *Ibid.*
194 Gov.UK, Final report of the Independent Review of the Mental Health Act 1983, pg.94. December 2018.
195 Gov.UK, Final report of the Independent Review of the Mental Health Act 1983, pg.109. December 2018
196 Q233

but that "we should see it universally".[197] In correspondence to us on 20 July 2021, the then Minister for Patient Safety, Suicide Prevention and Mental Health agreed that Independent Mental Health Advocates are "well placed to support informal patients to understand their rights".[198] However, the Government's White Paper, *Reforming the Mental Health Act*, states that expanding the statutory duty to all inpatients would create "an additional burden" on the system and "will therefore be subject to future funding decisions".[199]

135. **It is disappointing that the Government's 2021 Mental Health White Paper leaves expanding the legal right to support from an advocate to all children and young people subject to future funding availability. There is a compelling case that Independent Mental Health Advocates have a valuable role in helping inpatient children and young people understand their rights and raise any concerns that they may have. It is nonsensical that this resource is denied from children and young people admitted informally, who are often living under the same conditions as those admitted formally.**

136. ***The Department should commit to expanding Independent Mental Health Advocates support so that all children and young people admitted to hospital informally have the same legal right to an Independent Mental Health Advocate as those admitted under legislation without qualification. This advocacy should all operate on an opt-out basis.***

Restrictive practices

137. *The Mental Health Act 1983: Code of Practice* describes restrictive interventions as deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- end or reduce significantly the danger to the patient or others.[200]

138. Restrictive interventions in inpatient units can include manual physical restraint, mechanical restraint, chemical restraint as well as observation, segregation and seclusion.[201] Restrictive interventions can also include prone restraint, which is defined as a person being "forcibly laid on their front".[202] Prone restraint is a particularly dangerous form of restraint that NICE has reported "can, and has, caused death after as little as 10 minutes".[203] *The Mental Health Act 1983: Code of Practice* is clear that restrictive interventions "should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation".[204]

139. The use of restraint against children and young people can be humiliating and cause unnecessary distress. The Mental Health Foundation described the use of such practices

197 Q234
198 Correspondence from Rt hon Nadine Dorries MP to Rt hon Jeremy Hunt MP, 20 July 2021.
199 Department of Health & Social Care, Reforming the Mental Health Act. 24 August 2021
200 Department of Health, Mental Health Act 1983: Code of Practice, 2016
201 Mind, Restraint in mental health services. 2015.
202 *Ibid.*
203 NICE guideline, Violence and aggression: short-term management in mental health, health and community settings. May 2015.
204 Department of Health, Mental Health Act 1983: Code of Practice, 2016

as "fundamentally a result of not meeting the needs of the child".[205] Nevertheless, we have heard that the use of restrictive practices, including restraint, remains high in children and young people's mental health services. The Royal College of Psychiatrists has stated that the use of restraint on children and young people is on average "over 5 times higher than the adult equivalent."[206] Kamena Dorling, Head of Policy and Advocacy at Article 39, raised concerns that in children and young people's inpatient services, restraint is "almost seen as the norm in reacting to challenging behaviours".[207] During our roundtable with child and adolescent mental health practitioners, we heard that as the acuity of presentation among children and young people has increased, it can be more difficult for staff to make decisions about the appropriate techniques to use or for de-escalation to take place. One participant told us:

> When we're trying to manage very severe episodes of self-harm and you've got a young person that's very traumatised, you're really stuck as a staff team between kind of going OK do you go for a prolonged period of holding somebody which if they've had previous trauma, is incredibly traumatic for them. Or do you put them in a seclusion room, which again is also very traumatic. So there's some quite difficult decisions to be made. I think we are looking at our sort of seclusion use years and how we can reduce that and what we can do. One of the challenges for that at the moment for our wards is the environment […] And you know, we can think about sort of de-escalation spaces, but you've got to have the estates around that to be able to do that. At the moment, our general adolescent units don't lend themselves to the acuity, I think, of the young people that we're managing at the moment.[208]

140. According to NHS Digital datasets, in 2019–20 almost 2,500 children and young people under 24 were subject to a restrictive intervention.[209] Notably, over a third of these restrictive interventions (897) were prone restraint, despite the fact that section 26 of the 2016 *Mental Health Act 1983: Code of Practice* recommends that "there must be no planned or intentional restraint of a person in a prone position" unless there are cogent reasons for doing so.[210] This point was emphasised by Professor Tim Kendall who told us that "risk of dying is really significant" after ten minutes in this position.[211]

141. The use of restraint while a young person is in transit is also a cause for concern. Serenity Welfare has stated that "organisations that provide transportation and welfare services for children are not legally obliged to report incidents of handcuffing, or other methods of restraint."[212] This is at odds with the requirement on children's homes to report incidents of restraint, allowing a data gap to emerge.

142. For children and young people, the experience of restrictive intervention is often traumatic. This is particularly the case for those children and young people with learning

205 The Mental Health Foundation (CYP0061).
206 Royal College of Psychiatrists (CYP0090).
207 Q140
208 Health & Social Care Committee, Transcript from Roundtable with children and young people's mental health practitioners, May 2021.
209 NHS Digital, Mental Health Bulletin 2019–20 Annual report. January 2021
210 Department of Health, Mental Health Act 1983: Code of Practice, 2016
211 Q241
212 Serenity Welfare (CYP0022)

disabilities and/or autism, as we have previously set out in our report into *The treatment of autistic people and people with learning disabilities*.[213] Data from NHS Digital shows that in April 2021 a total of 2,275 restrictive interventions were used against children and young people under the age of 24 with learning disabilities or autism. 210 of these involved the use of prone restraint.[214]

143. NHS Providers have stated that the importance of the right training and of staff having the time for "supervision and reflective practice" to reducing the use of restraint and other restrictive practices.[215] The SafeWards programme, which has been used nationally within adult inpatient settings with positive outcomes, has focused on reducing restraint as a benchmark measure. The Royal College of Psychiatrists reported that this programme has resulted in "significant decreases in restraint and particularly prone restraint for adults".[216] Professor Kendall agreed with this, telling us that the programme is "a good evidence-based approach to reducing the use of restraint".[217] Such programmes are likely to deliver similar improvements to the children and young people's mental health estate.

144. While the clinicians who took part in our roundtable welcomed the provision of training, they stressed the need for this to be evidence based. In reflecting on this matter, one roundtable participant said:

> I think training is important, but the challenge is what we train people in. Because we want to use the evidence base, but the evidence base isn't there. There's a dearth of research on effective alternative to restrictive practice in CAMHS and how young people experience restrictive practice. And I know this is come up before, but I think there's a real need for sort of a rapid expansion of the research base to be able to inform the training and the policies. Because when you look into it, the research isn't there.[218]

145. In 2018 The Mental Health Units (Use of Force) Act received Royal Assent. The aim of the Act is to "clearly set out the measures which are needed to both reduce the use of force and ensure accountability and transparency about the use of force in our mental health units."[219] The Act, which has not yet been brought into force by Government, sets out that each mental health inpatient unit must nominate a "responsible person" who should:

- Publish a policy regarding the use of force by staff who work in that unit;
- Publish information for patients about their rights with regard to use of force;
- Provide training for staff that relates to the use of force; and
- Keep a record of any use of force by staff who work in that unit.

213 House of Commons Health and Social Care Committee, Treatment of autistic people and individuals with learning disabilities, HC 21
214 NHS Digital, Learning Disability Services Monthly Statistics, Mental Health Services Dataset. July 2021.
215 NHS Providers (CYP0068).
216 Royal College of Psychiatrists (CYP0090).
217 Q241
218 Health & Social Care Committee, Transcript from Roundtable with children and young people's mental health practitioners, May 2021.
219 Department of Health and Social Care, Open consultation: Open consultation Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England and police forces in England and Wales – draft for consultation, 25 May 2021.

146. The Act also imposes a new statutory duty on the Secretary of State for Health and Social Care to ensure that statistics regarding the use of force are published annually. This report must include analysis of the patient's personal characteristics, details of why restraint was used, and the type of restraint used.[220]

147. Speaking to our inquiry into *the treatment of autistic people and individuals with learning disabilities*, Julie Newcombe, Co-founder of the charity Rightful Lives, stressed to us how important the implementation of the Mental Health Units (Use of Force) Act 2018 was to understanding where and how often restraint is being used:

> We are still waiting for Seni's law. It was approved by Parliament two years ago, but it has not been enacted in law yet. First of all, we need to start doing that and make sure that it gets made into law. It is about monitoring it. […] We already know that a lot of hospitals do not always report all the incidents of restraint and segregation that they are supposed to report. The numbers are probably higher than you see in the reports.[221]

148. On 25 May 2021, the Government announced the launch of their consultation on the statutory guidance for the Act and their intention to publish the final statutory guidance and begin commencement of the Act in November 2021.[222] When questioned about the delay to the consultation process, the then Minister told us that the covid-19 pandemic had forced the delay.[223]

149. **We welcome the Government's commitment to reducing the use of seclusion, segregation and restraint for children and young people in inpatient units and the Mental Health Units (Use of Force) Act in particular. However, we have heard that restrictive interventions, and particularly restraint, are still used excessively and avoidably against children and young people in inpatient settings and in transit. We are particularly concerned about the continued use of prone restraint on children and young people, despite guidance stating that prone restraint should be avoided due to the increased risk of death from this position. It is extremely worrying that restraint, and particularly prone restraint, is being used on children and young people at a much higher rate than in adult services.**

150. ***In addition to our recommendations on the use of restraint that we set out in our report on the treatment of autistic people and people with learning disabilities, the use of prone restraint on children and young people should be banned in all inpatient settings and in transit. Further action should be taken with all inpatient and transport providers to minimise restrictive practice by sharing best practice from programmes such as the SafeWards approach with all children and young people's inpatient units nationally. In line with requirements to report incidents of restraint in inpatient settings and children's homes, all organisations involved in the transportation of children should be required to report such incidents so that these can be monitored and acted upon where necessary.***

220 Mental Health Units (Use of Force) Act 2018

221 Health & Social Care Committee, oral evidence: Q33- inquiry into Treatment of autistic people and individuals with learning disabilities, HC1195 [9 February 2021]

222 Hansard, Consultation on Use of Force in Mental Health Units, vol 696, 25 May 2021 [debate]

223 Q237

Quantifying children and young people's experiences in inpatient settings

151. We have heard that when it comes to children and young people's experiences within inpatient settings, the data available is incomplete and unreliable, making it very difficult to understand what children and young people are experiencing on a day-to-day basis and in which units. This is especially the case for patients admitted informally who do not have the same statutory right to certain safeguards and processes. Currently, there is no publicly available data on how many children and young people are admitted to inpatient units on an informal basis: that is, on the basis of their own or their parent/carers consent. Kamena Dorling, Article 39, explained the significance of this to us:

> Currently, we do not even have published figures on the number of children who are in mental health in-patient care on an informal basis. We do not have access to information on the grounds for their admission, whether it is by their consent or their parents' consent. I think we should have that data. It should be publicly available.
>
> We also do not have data on access to advocacy services for children and young people in in-patient care[…] The data just is not there.[224]

152. When she was questioned on this issue, Claire Murdoch, National Mental Health Director at NHS England, told us that "virtually all, or the vast majority" of children and young people who are in inpatient care are there under the Mental Health Act and would therefore "trigger the right to formal advocacy".[225] However, according to data provided to the Children's Commissioner by NHS England nearly a third of children in mental health wards were there informally in March 2020. Of the 944 children living in inpatient units, 544 were detained formally under the Mental Health Act. The remaining children were either detained on an informal basis (296), or the basis of their admission was not recorded (104).[226] The significant gaps in this data makes monitoring whether children and young people's rights are being upheld extremely challenging.

153. We are also concerned that the Office of the Children's Commissioner found that data available on the use of restraint against children and young people is of "very poor quality."[227] The statistics currently available on the use of restraint and other restrictive interventions likely underestimate the true picture, because many services do not submit data to the Mental Health Services Data Set, where restrictive interventions are recorded.[228] NHS Digital have said that they "hold limited information" on the exact number of providers who do not make submissions.[229]

154. **It is vitally important to be able to monitor the experiences of children and young people in inpatient care, particularly how often restraint is used in each setting and whether there is appropriate access to advocacy. This is key to ensuring individuals in inpatient care are receiving quality support and treatment, and to avoid the lowering of the standard of care. It is therefore highly concerning that the data currently**

224 Q138
225 Q233
226 Children's Commissioner, Who are they? Where are they? 2020. November 2020.
227 *Ibid.*
228 NHS Digital, Mental Health Services Data Set (MHSDS) submission update. Accessed 27 July 2021.
229 NHS Digital, Mental Health Bulletin, 2019–20 Annual Report. January 2021.

available on the use of restraint in inpatient settings is incomplete and of very poor quality, while there is no publicly available data at all on how many children and young people have a legal right to an advocate. Failure to understand the current experiences of children and young people in inpatient units only provides a further hindrance to the Government's and NHS England and Improvement's plans to improve the care provided in these settings. Higher national standards in data collection should be set by NHS England and Improvement and services that consistently fail to meet these standards should face greater accountability.

155. ***In addition to the recommendations on data we set out in our report on the treatment of autistic people and people with learning disabilities, we further recommend that NHS England and Improvement regularly collect and publish high quality data including from private sector providers on:***

- ***the basis of children and young people's admission to inpatient units;***
- ***the number of children and young people not accepted into units;***
- ***the waiting list for children and young people waiting for adequate community provision;***
- ***the number of children and young people receiving advocacy support;***
- ***the number of children placed out-of-area; and***
- ***the length of their stay in inpatient units.***

6 Self-harm and suicide prevention

156. This chapter addresses the distressing and sensitive issue of self-harm and suicide among children and young people. We consider the worrying trends in self-harm and suicide that existed among this age group prior to the pandemic and focus on the steps that need to be taken to address these. This includes providing access to earlier support for children and young people who self-harm, and also developing a wider suicide prevention strategy.

157. We have heard concerns from a number of witnesses about the rising rate of self-harm and suicide among children and young people. Although predicting suicide is extremely difficult, and most people who self-harm do not go on to take their own lives, self-harming behaviour in children and young people is a sign of serious emotional turmoil and can be a strong risk factor for future suicide. The charity Barnardos highlighted that during the pandemic they were working with more and more children and young people who self-harm. Of their staff who reported increases in mental health issues due to covid-19, nearly a third (32%) reported increases in self-harm among children, and nearly a quarter (23%) reported increases in suicidal thoughts or attempts.[230] Samaritans volunteers reported a similar rise in callers struggling with self-harm as a coping mechanism. Julie Bentley, CEO of Samaritans, told us that this problem seemed to be more significant among younger people—in the past year, 35% of callers to Samaritans under 18 discussed self-harm compared to just 7% of adults.[231] However, despite these concerns, early work by the National Confidential Inquiry into Suicide and Safety in Mental Health, led by Professor Louis Appleby, found that there was no evidence of the large national rise in suicide during lockdown that many had feared.[232]

158. Professor Appleby made it clear to us however, that while the pandemic did not seem to have resulted in a stark increase in suicide among children and young people, the rate had already been increasing year-on-year:

> The suicide rate for young people in this country is going up. Let's take the under-20s, for example. The rate in the under-20s has been rising for about 10 years. That runs counter to the pattern in the general population, for all ages. It is a distinct pattern in young people[…]
>
> It is particularly true in females, where the rates are at historical high levels at the moment. One of the reasons for that is that women have lower suicide rates. The baseline is much lower, so a rise has a bigger effect proportionally. The situation is problematic for young people, to put it mildly. It is reflected also in self-harm rates, which are more difficult to measure because they depend largely on hospital attendance. Those rates are going up in young people as well and have been going up for probably about 20 years.[233]

230 Barnardo's (CYP0088).

231 Correspondence from Julie Bentley to Rt hon Jeremy Hunt MP: Letter from the Chief Executive of Samaritans on the issue of online harms, 15 June 2021.

232 Louis Appleby et al, Suicide in England in the COVID-19 pandemic, April 2021.

233 Q158

159. Other witnesses echoed this point. Julie Bentley, Chief Executive Officer at Samaritans, stressed that self-harm is an issue that came up "tremendously" on their helplines, with young people increasingly seeing it as a coping mechanism.[234] Prior to the pandemic, rates of self-harm among young people had been steadily increasing for the past two decades. This increase has been particularly pronounced in young women from 7% to 20% between 2000 and 2014.[235] This, she said, was one of Samaritans key concerns because of the "link to suicidality in relation to that".[236] Indeed, we have heard that the link between self-harm and potential future suicide is very clear. Professor Louis Appleby explained:

> It [self-harm] is one of the strongest indicators for subsequent suicide. It is a very important risk indication. It is probably the most important statistically.[237]

160. This view was supported by Professor Tim Kendall, National Clinical Director for Mental Health at NHS England and Improvement, who stated:

> You are quite right to say that self-harm has a very important link with later suicide. It is probably the most important link we have. If people self-harm and they come to the attention of services, we need to take it very seriously.[238]

Preventing suicide

Early intervention in self-harm

161. It is because of this strong link between deliberate self-harm and later potential suicide that many of our witnesses stressed the importance of early intervention when self-harm becomes a possibility for a child or young person. Professor Appleby told us that in his view, self-harm services have the "most important" part to play in the broader task of suicide prevention.[239] Samaritans, the UK's largest suicide prevention charity, have made one of their key calls to Government "a new system of early intervention" to support children and young people who self-harm.[240] Julie Bentley, their CEO, explained to us why this was needed:

> Our real concern is that young people are simply not having access to help early enough. We know that they are being moved from pillar to post. They are being ping-ponged. They tell us that themselves. They are not able to get support until they are absolutely at crisis point. We are very much of the view that we need to make sure that services can get to young people much, much sooner and long before they reach crisis.

162. Although the challenges of long waiting lists and high thresholds to access the services and support they need impact all children and young people struggling with their mental health, Samaritans has found that there are additional barriers to support that are unique

234 Q175
235 Samaritans (CYP0060).
236 Q162
237 Q169
238 Q258
239 Q169
240 Samaritans (CYP0060).

to those dealing with self-harm.[241] Samaritans reported that self-harm is "often ignored or even banned by mental health services" as children and young people who self-harm are excluded from primary support services on the basis of being 'too high risk' while being deemed not ill enough for secondary mental health services. In fact, self-harm is one of the key reasons that a quarter of referrals to children and young people's mental health services are rejected.[242]

163. We also heard the impact that this kind of delayed treatment can have on a child or young person from Lucas, who struggled with self-harm as a teenager. Lucas started self-harming at the age of 13, and was told that the waiting list for treatment was two years long. He explained to us that providing early intervention for children and young people dealing with self-harm is "massively" important and that if he had been able to access support earlier he "might not have escalated as much as I did".[243] As well as the clear human cost of late intervention in self-harm among children and young people, the financial motivation to move from a system focused on crisis intervention to one that prioritises prevention and early intervention is clear. Samaritans estimated that the average overall hospital cost per episode of self-harm is £809. This equates to approximately £162 million per year spent on hospital management of self-harm.[244]

164. The national suicide prevention strategy, *Preventing Suicide in England*, was first published in 2012. In 2017 it was amended to include addressing self-harm, as a key indicator of suicide risk, as an issue in its own right.[245] The 2017 progress report acknowledged that "there is currently a lack of high-quality self-harm services across the country."[246] The evidence submitted to our inquiry suggests that this remains the case for too many children and young people.

165. **We are deeply concerned about the increasing numbers of children and young people who experience self-harm and suicide and the quality of care they are able to access. Much more needs to be done to tackle suicide and self-harm amongst children and young people. In particular, given the link between self-harm in children and young people and later suicidality, any suicide prevention strategy must include improving the support available to those who self-harm. We have heard that too often, children and young people's mental health services are not commissioned with self-harm in mind. It is essential that self-harm is not used as a reason to reject referrals to mental health services. While we welcome the inclusion of self-harm in the National Suicide Prevention Strategy, we are clear that support must be available earlier to these children and young people, before they reach a crisis point.**

166. ***We recommend that the Department implement a new system of early intervention to support children and young people who self-harm and are at risk of committing suicide. Educational settings, as a universal provision, can have an important role to provide effective early intervention to pupils who may be struggling with self-harm before the mental health need becomes more acute. Mental Health Support Teams are well placed to deliver these interventions and an accelerated roll out of these teams***

241 Samaritans (CYP0060)
242 *Ibid.*
243 Q75
244 Samaritans (CYP0060).
245 Department of Health, Preventing suicide in England. September 2012.
246 Department of Health, Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives. January 2017

would increase the capacity of schools and colleges to support those children and young people who may be struggling. Education Mental Health Practitioners must be trained in self-harm and suicide prevention specifically.

167. ***For those children and young people for whom school is not the most accessible place to seek support, there must also be a community-based offer. This could be based on the network of drop-in hubs outlined in Chapter 4 of this report, which provide open-access mental health support without the requirement for a referral or high thresholds for access.***

A public health approach to suicide prevention

168. A number of witnesses to our inquiry also called for self-harm and suicide prevention to be addressed as part of a society-wide public health strategy. This is a point that was made powerfully by Steve Mallen, who co-founded the Zero Suicide Alliance after the loss of his 18 year-old son, Edward. Mr Mallen stressed to us that "self-harm and suicide prevention is obviously a pan-society issue. It is everybody's business."[247]

169. That increasing numbers of children and young people are reaching the point of crisis without being able to access support is perhaps the most tragic expression of the gap between the level of need and the provision of support in children and young people's mental health services. According to the Mental Health Foundation, who have a specific focus on mental health as a public health issue, there are a number of public health interventions that could help to reduce and prevent self-harm and suicide.[248] In particular, they pointed out that interventions in the online space, including ensuring that technology companies act to control the spread of information which glamourises self-harm, would be an effective protective measure.[249]

170. The Mental Health Foundation have called for the Government to take a "proportionate universalism" approach across all Departments to tackling self-harm and suicide.[250] A large part of this includes reducing the stigma that remains attached to mental health problems, and suicide in particular. Mark Rowland, CEO of the Foundation, told us:

> It is really clear that we must take every step we can as preventive action. It is why we are calling for this really ugly term—proportionate universalism. It is important. In order for stigma and for problems to be prevented, and for early intervention, you need mental health literacy. We need to understand our inner worlds much more effectively—our emotions and what triggers them. This is stuff we were not taught at school. It needs to be part of how we educate children and parents.[251]

247 Q155
248 The Mental Health Foundation (CYP0061)
249 The Mental Health Foundation (CYP0061)
250 *Ibid.*
251 Q167

171. When we questioned the then Minister for Patient Safety, Suicide Prevention and Mental Health about this, she expressed support for such an approach. The Minister told us that supporting the mental wellbeing of children and young people, as a whole, should be a "cross-governmental" priority rather than sitting solely with the Department of Health and Social Care.[252]

172. **Preventing the worst mental health outcomes means first creating the conditions across society that are conducive to good mental health and wellbeing. We welcome the support provided by the former Minister for Patient Safety, Suicide Prevention and Mental Health to a 'cross-governmental' strategy to prevent the worst mental health outcomes for children and young people as well as her recognition that mental health should not be only the concern of the Department of Health and Social Care. The complex, multifaceted nature of the causes of suicide and self-harm necessitates a public health approach to suicide prevention that involves cooperation between Government departments, local government, education and the care sector. Given that self-harm is often used as a coping mechanism for other forms of severe emotional distress, the wider points made on public mental health in Chapter 1 of this Report will also help to prevent it.**

173. ***We recommend that each Government Department, led by the Department of Health and Social Care should set out specific, measurable objectives for mental health promotion in each policy area. This should include policies that aim to build mental health resilience in the population as a whole, as well as specific interventions targeted at those who have the greatest mental health need.***

252 Q247

Conclusions and recommendations

The scale of the problem

1. *Children and young people's mental health is an all-society issue. The problems discussed in this report can only be addressed by Government departments, local government and the health system acting together to promote good mental health and prevent new crises emerging. We recommend setting up a Cabinet sub-committee to bring together different departments to make sure this happens.* (Paragraph 13)

2. Although the full long-term impact of the coronavirus pandemic on the mental health of children and young people under the age of 25 is as yet unknown, it is already clear that the mental health needs of these groups have been much exacerbated by the pandemic. This has been supported by NHS data from July 2020 which shows that one in six young people now have a probable mental health disorder. But the impact of this has not been even across different children and young people, with older teenage girls, for example, particularly affected by the rise in eating disorders. In order to understand the level of need in children and young people's mental health as well as the inequalities that continue to exist, more regular and accurate prevalence data is urgently needed. (Paragraph 28)

3. *The gap between the 2004 and 2017 NHS Digital Mental Health Surveys was too long, and this must not be repeated. We recommend that NHS Digital regularly collect and publish robust prevalence data for mental health conditions every three years, starting from the end of 2021 disaggregated by age, ethnicity, sexuality, gender, and condition, alongside a plan to address any disparities uncovered. Such a study should also examine both unmet need and the risks of overmedicalisation of minor issues.* (Paragraph 29)

4. During the pandemic, children and young people's mental health has significantly worsened and the scale of the backlog mean that the NHS will not be able to treat its way out of this crisis. The need for early intervention and prevention in children and young people's mental health has been consistently overlooked by successive governments and although there has been a significant expansion of services recently the pace of change has not been keeping up with increases in demand. Still today too many children and young people are reaching the point of crisis before they can access any mental health support. This compounds stress not only on the individuals affected, but across society more widely. The lack of adequate protective support and early intervention create unnecessary pressure across the entire healthcare system, from GP appointments to A&E presentations and NHS inpatient services. (Paragraph 34)

5. *The Department of Health and Social Care—in partnership with the Department for Education and all other relevant Government departments—must take radical steps to shift the focus in mental health provision towards early intervention and prevention. This must ensure that all children and young people under the age of 25 can receive mental health support as early as possible and no young person is turned away from mental health support for not being ill enough. The Department must focus its attention on:*

a) *the faster roll out of Mental Health Support Teams, as detailed in Chapter 3 of this report;*

b) *a network of community hubs based on the Youth Information Advice and Counselling service model detailed in Chapter 4 of this report and;*

c) *digital support, as detailed in Chapter 4 of this report. (Paragraph 35)*

6. *We expect a full and comprehensive update from the Department on what measures it will implement, how this work will be funded and a timeframe for key outcomes relating to increased early intervention and prevention. We expect this information by the end of January 2022.* (Paragraph 36)

Increasing access to mental health services

7. Commitments in the 2017 Green Paper and the NHS Long Term Plan have been taken seriously by NHS England and led to a significant expansion of provision. We are, however, concerned that many commitments may not yet be ambitious enough to ensure every young person with a diagnosable mental health condition can access care. Currently, waiting times for accessing children and young people's mental health services remain far too long, and too many referrals to specialist services are inappropriately rejected. We are also concerned that, despite the NHS Long Term Plan committing to improve access to specialist support for all children and young people aged 0–25, children below the age of three have largely been overlooked to date. The Early Years Health Development Review provides an opportunity for Government to ensure a more consistent offer for families to help strengthen parent-infant relationships which are a key foundation for good mental health. (Paragraph 55)

8. *We recommend that NHS England & Improvement set out a clear action plan including key milestones, deadlines, and funding for how they will meet their target set out in the NHS Long Term Plan of 100% access to specialist support for all children and young people aged 0–25 by 2029, without raising the already high thresholds for accessing support.* (Paragraph 56)

9. *We further recommend that NHS England & Improvement hold Clinical Commissioning Groups, which have consistently failed to meet national expectations, to account on key measures such as expenditure, waiting times and access rates. National ambitions should be raised in line with the best performing areas so that best practice becomes universal practice. This is essential to ensuring that provision of children and young people's mental health services does not remain a 'postcode lottery'.* (Paragraph 57)

10. *We welcome and support the proposals in the recent access and waiting times consultation that concluded on 1st September, including crisis response times and a four-week waiting time limit for children and young people, and call on NHS England to publish a detailed roadmap as to how it will be delivered including the additional funding requirements.* (Paragraph 58)

11. It is clear that young adults between the ages of 18 and 25 face some of the widest gaps between the support that they need and the support that is available to them.

We welcome NHS England & Improvement's commitment to shift away from the current model of care towards one that provides for those aged 0–25. However, we have heard progress on this has been slow, with large variation between areas on what age services are commissioned to. Lucas's story provided a stark reminder that the transition to adult services remains poor for many children and young people, with high rates of drop-out from services in this period. It is essential that young people do not experience a sudden drop in their support at the age of 18. (Paragraph 62)

12. *NHS England & Improvement must accelerate the implementation of the 0–25 offer in every local area as a national priority so that young people do not continue to face a cliff edge in accessing the care they require as they transition from children to adult services.* (Paragraph 63)

13. One of the largest barriers to increasing access to mental health provision for children and young people remains the size of the mental health workforce. We have seen that children and young people's mental health practitioners face staff shortages, increasing demand and high levels of work-related stress which in turn leads to more part-time work and increased early retirement. We have already made recommendations to the Department on providing mental health and wellbeing support to NHS staff in our previous Report into workforce burnout and resilience in the NHS and Social Care. In particular, we are clear that:

    - *Integrated Care Systems (ICSs) must be required to facilitate access to wellbeing support for NHS and social care workers across their systems, and that they are accountable for the accessibility and take-up of those services. (Workforce burnout and resilience in the NHS and Social Care, Second Report of Session 2021–2022, Paragraph 39); and*

    - *the level of resources allocated to mental health support for health and care staff must be maintained as and when the NHS and social care return to 'business as usual' after the pandemic; and that the adequacy of resources allocated to that support be monitored on a regular basis. (Workforce burnout and resilience in the NHS and Social Care, Second Report of Session 2021–2022, Paragraph 40). (Paragraph 67)*

14. *In addition, it is paramount that a plan is implemented to increase the size and wellbeing of the children and young people's mental health workforce based on independently verified estimates of the number of people needed in different disciplines and the training places required to deliver them. The strategy should include an assessment of how the skill mix of the workforce can be developed to include other expert professionals such as speech and language therapists, social workers, youth workers and the importance of a diverse workforce in improving outcomes for minority ethnic groups. The Department of Health and Social Care should work with Health Education England to develop this plan to build on the steps already taken to expand the workforce and enhance the skills of the wider workforce.* (Paragraph 68)

Mental health support in schools

15. We have seen that Mental Health Support Teams, where they have been rolled out, are well-placed to facilitate early intervention for children and young people as part

of a whole school approach. They appear to have delivered positive outcomes for children and young people where they are up and running. We welcome the fact that under the current trajectory the commitment of 20% to 25% coverage will be delivered a year ahead of schedule and we welcome the commitment that the Government and NHS England & Improvement have shown to deliver this roll out. But reaching only around half of children by the end of this Parliament shows the original ambition is too low and it should be increased, at a minimum, to reaching two thirds of schools by the end of the Parliament if we are to reduce referrals for severe conditions by as much as needed. (Paragraph 86)

16. *We therefore recommend that the Department of Health and Social Care fully fund and scale up the roll out of Mental Health Support Teams to cover two thirds of schools in England by 2024/25 and 100% by 2027/28.* (Paragraph 87)

17. *Furthermore, in light of the rise in both prevalence and severity of children and young people's mental health difficulties, the training of Education Mental Health Practitioners should be reviewed to integrate their skills into a new psychological professions structure. This must include training experienced practitioners in more sophisticated psychological therapy so that they can work with more complex cases such as eating disorders and self-harm.* (Paragraph 88)

18. A whole school approach to mental health and wellbeing should include the promotion of good mental health as well as the early identification of those who are at risk of mental health difficulties. Designated Senior Leads for mental health can have an extremely important role in overseeing and leading this whole school approach but they need to be adequately trained, particularly in how to identify and intervene in emerging cases of mental health problems. Given the worrying signs that more children and young people are turning to self-harm as a coping mechanism and more are struggling with eating disorders, it is extremely concerning that training for Designated Senior Leads appears to have been paused and has not yet been rolled out four years after the Green Paper committed to do so. (Paragraph 91)

19. *It is vital that the Department rolls out the training for Designated Senior Leads to all schools urgently with a commitment to completing the roll out before the end of the current Parliament. Moreover, given the worrying trends in self-harm and eating difficulties among children and young people, it is essential that this training includes sufficient training specifically for the early identification of self-harm and eating disorders as well as mild to moderate mental health problems generally. We expect a comprehensive update on work towards this ambition by the end of December 2021.* (Paragraph 92)

20. *Whilst Mental Health Support Teams and Designated Senior Lead training is being rolled out, the Department of Health and Social Care and the Department for Education should work closely together with all schools to ensure that they have the support they need in order to offer a whole school approach, including: access to digital self-help support; school counselling for every child who needs it; and good guidance on best practice for staff on how to provide the most appropriate support in schools.* (Paragraph 93)

Importance of community-based and digital mental health support

21. For some children and young people where schools are not their preferred place to access support, drop-in hubs that operate on an open access, self-referral basis provide a valuable alternative opportunity to access help. We have heard that the large-scale roll out of a similar style system has improved outcomes for children and young people in Australia. Where these hubs already exist in the UK, based on the Youth Information Advice and Counselling model, they fill a vital gap in the health system and are perceived as accessible to young people. They are also capable of reaching those who may be less able to access traditional services. However, while these have been rolled out in some areas of the country, we have heard that this is subject to local funding priorities and is far from a standard provision. Access to these drop-in services should not be dependent on where a young person lives but should be available nationally. (Paragraph 108)

22. *We recommend that the Department of Health and Social Care fund and roll out open access models to every area across the country so that there is a consistent, comprehensive community offer to complement available school-based and clinical support across England. The hubs should also offer outreach support to vulnerable groups and should be integrated with specialist children and young people's mental health services with a clear step down/step up relationship. National standards for the provision of support should be published so hubs adhere to clinical standards.* (Paragraph 109)

23. *The social care sector is essential to the provision of mental health services to children and young people and it is essential that it is funded to do so as part of the forthcoming social care white paper.* (Paragraph 110)

24. *Equally vital is the role of the new Integrated Care Systems and it is essential they publish detailed plans with timescales as to how community provision for the mental health needs of children and young people will be improved working jointly with the local social care system.* (Paragraph 111)

25. For those children and young people who prefer accessing help online, digital services can be an important way of reducing barriers to access so it is important that a digital offer should be available for all young people. To prevent over-medicalisation of mental health conditions this should include self-help options as well as digital counselling offers. However, digital support options are not appropriate for all children and young people, and in fact can pose barriers and exacerbate inequalities for some. Therefore, targets for improving access to services should not be met by over-reliance on digital support. These models should complement, rather than replace the existing in-person offers. (Paragraph 117)

Inpatient care

26. Inpatient units have a role to play in treating some of the most severe and complex mental health conditions, especially those that are resistant to community treatment. However, in most cases the most compassionate and effective care for children and young people is provided in the community–and increasing its provision must be the overall aim of the Department and NHS England & Improvement. We have

set out the benefits of Trieste model of care in more detail in our report into The treatment of autistic people and individuals with learning disabilities. We believe that the principles of this model of care are also appropriate for children and young people's mental health treatment. (Paragraph 127)

27. *We therefore recommend that the Department accelerates the shift towards increased community-based provision and a reduced inpatient bed base as a national priority to ensure that children and young people with the most complex needs receive good quality care in a setting that is right for them. A national strategy should be set out to establish jointly commissioned health and social care services. To ensure children and young people are not 'parked' in inappropriate in-patient care, an independent psychiatrist should sign off the need for inpatient provision on a monthly basis for all young people who have stayed for longer than three months in a mental health hospital. This should be backed up by legislative changes. It should equally apply to those with a learning disability, autism, or both.* (Paragraph 128)

28. *In order to achieve this shift towards community-based care, every area should have a community service for children in crisis which is available 24 hours a day, seven days a week. A clear map is needed of where current gaps in this provision are and a plan should be in place to ensure these services are available in every area. This should include 24/7 all age liaison psychiatry in hospitals, crisis services in the community, and 24/7 crisis support teams in all areas. These should have specialist expertise in preventing admissions and supporting children and young people with autism, a learning disability or both.* (Paragraph 129)

29. *For those children and young people for whom inpatient admission cannot be avoided, a continued focus is needed to increase the quality of this care. As well as much improved data collection, this should include access to therapies, activities and education, including from private sector providers. It should include a stronger voice for children, young people and their families through access to advocacy for all children and young people.* (Paragraph 130)

30. It is disappointing that the Government's 2021 Mental Health White Paper leaves expanding the legal right to support from an advocate to all children and young people subject to future funding availability. There is a compelling case that Independent Mental Health Advocates have a valuable role in helping inpatient children and young people understand their rights and raise any concerns that they may have. It is nonsensical that this resource is denied from children and young people admitted informally, who are often living under the same conditions as those admitted formally. (Paragraph 135)

31. *The Department should commit to expanding Independent Mental Health Advocates support so that all children and young people admitted to hospital informally have the same legal right to an Independent Mental Health Advocate as those admitted under legislation without qualification. This advocacy should all operate on an opt-out basis.* (Paragraph 136)

32. We welcome the Government's commitment to reducing the use of seclusion, segregation and restraint for children and young people in inpatient units and the Mental Health Units (Use of Force) Act in particular. However, we have heard that

restrictive interventions, and particularly restraint, are still used excessively and avoidably against children and young people in inpatient settings and in transit. We are particularly concerned about the continued use of prone restraint on children and young people, despite guidance stating that prone restraint should be avoided due to the increased risk of death from this position. It is extremely worrying that restraint, and particularly prone restraint, is being used on children and young people at a much higher rate than in adult services. (Paragraph 149)

33. *In addition to our recommendations on the use of restraint that we set out in our report on the treatment of autistic people and people with learning disabilities, the use of prone restraint on children and young people should be banned in all inpatient settings and in transit. Further action should be taken with all inpatient and transport providers to minimise restrictive practice by sharing best practice from programmes such as the SafeWards approach with all children and young people's inpatient units nationally. In line with requirements to report incidents of restraint in inpatient settings and children's homes, all organisations involved in the transportation of children should be required to report such incidents so that these can be monitored and acted upon where necessary.* (Paragraph 150)

34. It is vitally important to be able to monitor the experiences of children and young people in inpatient care, particularly how often restraint is used in each setting and whether there is appropriate access to advocacy. This is key to ensuring individuals in inpatient care are receiving quality support and treatment, and to avoid the lowering of the standard of care. It is therefore highly concerning that the data currently available on the use of restraint in inpatient settings is incomplete and of very poor quality, while there is no publicly available data at all on how many children and young people have a legal right to an advocate. Failure to understand the current experiences of children and young people in inpatient units only provides a further hindrance to the Government's and NHS England and Improvement's plans to improve the care provided in these settings. Higher national standards in data collection should be set by NHS England and Improvement and services that consistently fail to meet these standards should face greater accountability. (Paragraph 154)

35. *In addition to the recommendations on data we set out in our report on the treatment of autistic people and people with learning disabilities, we further recommend that NHS England and Improvement regularly collect and publish high quality data including from private sector providers on:*

    - *the basis of children and young people's admission to inpatient units;*
    - *the number of children and young people not accepted into units;*
    - *the waiting list for children and young people waiting for adequate community provision;*
    - *the number of children and young people receiving advocacy support;*
    - *the number of children placed out-of-area; and*
    - *the length of their stay in inpatient units. (Paragraph 155)*

Self-harm and suicide prevention

36. We are deeply concerned about the increasing numbers of children and young people who experience self-harm and suicide and the quality of care they are able to access. Much more needs to be done to tackle suicide and self-harm amongst children and young people. In particular, given the link between self-harm in children and young people and later suicidality, any suicide prevention strategy must include improving the support available to those who self-harm. We have heard that too often, children and young people's mental health services are not commissioned with self-harm in mind. It is essential that self-harm is not used as a reason to reject referrals to mental health services. While we welcome the inclusion of self-harm in the National Suicide Prevention Strategy, we are clear that support must be available earlier to these children and young people, before they reach a crisis point. (Paragraph 165)

37. *We recommend that the Department implement a new system of early intervention to support children and young people who self-harm and are at risk of committing suicide. Educational settings, as a universal provision, can have an important role to provide effective early intervention to pupils who may be struggling with self-harm before the mental health need becomes more acute. Mental Health Support Teams are well placed to deliver these interventions and an accelerated roll out of these teams would increase the capacity of schools and colleges to support those children and young people who may be struggling. Education Mental Health Practitioners must be trained in self-harm and suicide prevention specifically.* (Paragraph 166)

38. *For those children and young people for whom school is not the most accessible place to seek support, there must also be a community-based offer. This could be based on the network of drop-in hubs outlined in Chapter 4 of this report, which provide open-access mental health support without the requirement for a referral or high thresholds for access.* (Paragraph 167)

39. Preventing the worst mental health outcomes means first creating the conditions across society that are conducive to good mental health and wellbeing. We welcome the support provided by the former Minister for Patient Safety, Suicide Prevention and Mental Health to a 'cross-governmental' strategy to prevent the worst mental health outcomes for children and young people as well as her recognition that mental health should not be only the concern of the Department of Health and Social Care. The complex, multifaceted nature of the causes of suicide and self-harm necessitates a public health approach to suicide prevention that involves cooperation between Government departments, local government, education and the care sector. Given that self-harm is often used as a coping mechanism for other forms of severe emotional distress, the wider points made on public mental health in Chapter 1 of this Report will also help to prevent it. (Paragraph 172)

40. *We recommend that each Government Department, led by the Department of Health and Social Care should set out specific, measurable objectives for mental health promotion in each policy area. This should include policies that aim to build mental health resilience in the population as a whole, as well as specific interventions targeted at those who have the greatest mental health need.* (Paragraph 173)

Formal minutes

Tuesday 30 November 2021

Members present:

Jeremy Hunt, in the Chair

Lucy Allan

Dr Luke Evans

Barbara Keeley

Sarah Owen

Ms Anum Qaisar

Dean Russell

Laura Trott

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

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

Executive summary agreed to.

Paragraphs 1 to 173 agreed to.

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

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

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

Adjournment

Adjourned till Tuesday 7 December 2021 at 9.30 am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 23 March 2021

Lynne Green, Chief Clinical Officer, Kooth; **Emma Thomas**, Chief Executive, Young Minds; **Sophie Corlett**, Director of External Affairs, Mind Q1–23

Dame Rachel de Souza, Children's Commissioner for England, Office of the Children's Commissioner for England; **Martin Lennon**, Head of Public Affairs, Office of the Children's Commissioner for England Q24–36

Tim Kendall, National Clinical Director for Mental Health, NHS England and NHS Improvement; **Claire Murdoch**, National Mental Health Director, NHS England Q37–71

Tuesday 20 April 2021

Lucas, Activist, Young Minds; **Hope, Easting Disorder advocate** Q72–86

Professor Pat McGorry, Professor of Youth and Mental Health, University of Melbourne, Director of Orygen Youth Health, Oregen Youth Health Research Centre in Victoria, Australia; **Cassandra Harrison**, Chief Executive Officer, Youth Access Q87–101

Professor Peter Fonagy, Head of the Division of Psychology and Language Sciences, University College London; **Dr Aleisha Clarke**, Head of Child Mental Health and Wellbeing, Early Intervention Foundation; **Tim Bowen**, Head, Maple Primary School, St Albans; **Shanti Johnson**, Deputy Head, Maple Primary School, St Albans Q102–129

Tuesday 25 May 2021

Kamena Dorling, Head of Policy and Advocacy, Article 39; **Saffron Cordery**, Deputy CEO and Mental Health Lead, NHS Providers; **Bernadka Dubicka**, Chair of the Children and young people's faculty, Royal College of Psychiatrists Q130–154

Julie Bentley, CEO, Samaritans; **Steve Mallen**, Co-founder, Zero Suicide Alliance; **Louis Appleby**, Professor of Psychiatry and National Confidential Inquiry into Suicide and Safety in Mental Health, University of Manchester; **Mark Rowland**, CEO and member of National Suicide Prevention Strategy Advisory, Mental Health Foundation Q155–181

Tuesday 22 June 2021

Professor Tim Kendall, National Clinical Director for Mental Health, NHS England; **Claire Murdoch**, National Mental Health Director, NHS England; **Ms Nadine Dorries**, Minister of State for Mental Health, Suicide Prevention and Patient Safety, Department of Health and Social Care Q182–272

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

CYP numbers are generated by the evidence processing system and so may not be complete.

1 APPG for Strengthening Couple Relationships and Reducing Parental Conflict (CYP0113)

2 Agenda Alliance (CYP0102)

3 AiMH UK (CYP0083)

4 Association of Directors of Children's Services (ADCS) (CYP0062)

5 Association of Educational Psychologists (CYP0103)

6 Association of Play Industries (CYP0084)

7 Association of Youth Offending Team Managers Ltd. (CYP0044)

8 Bailey, Mrs Fran (BSc Occupational Therapy Student and National Teaching Advisory Service teacher and caseworker., University of Essex and NTAS) (CYP0004)

9 Barnardo's (CYP0088)

10 Beat (CYP0110)

11 Blackpool Centre for Early Child Development (CYP0064)

12 British Association for Counselling and Psychotherapy (CYP0081)

13 British Psychological Society (CYP0021)

14 CLIC Sargent (CYP0028)

15 Cattanach (CYP0099)

16 Caudwell Children (CYP0012)

17 Centre for Mental Health (CYP0037)

18 Centre for Suicide Research, University of Oxford (CYP0007)

19 Children's Commissioner for England (CYP0109)

20 Conn, Dr Rory (Consultant Child and Adolescent Psychiatrist, Devon Partnership Trust) (CYP0009)

21 Conti, Dr. Gabriella (Associate Professor in Economics, University College London); Dow, Abigail (Research Assistant, University College London); and Johnson-Watts, Ella (Research Assistant, Institute of Fiscal Studies) (CYP0057)

22 CUSP (CYP0105)

23 Davies, Dr Virginia (CYP0013)

24 Education Policy Institute (CYP0078)

25 Families Need Fathers - because both parents matter (CYP0108)

26 Hart, Professor Angie; Brinton-Clarke, Louise; Dunham, Vicki; Flegg, Mirika; Hill, Harvey; Jones, Lindsay; and Rathbone, Anne (CYP0059)

27 Health Action Campaign (CYP0011)

28 Home-start UK (CYP0053)

29 Horsham & Crawley Counselling Group CIC (CYP0025)

30 Hospital Trusts (CYP0106)

31 Howells, Dr Kristy (Reader, Canterbury Christ Church University) (CYP0014)

32 Humphrey, Professor Neil (Professor of Psychology of Education, The University of Manchester) (CYP0036)

33 Hunter, Benny (Project Coordinator, Da'aro Youth Project) (CYP0121)

34 Institute for Mental Health and Institute for Policy and Engagement (Uni of Nottm) (CYP0086)

35 Institute of Health Visiting (CYP0051)

36 Intergenerational Foundation (CYP0015)

37 KidSafe UK Children's Mental Health & Safeguarding (CYP0039)

38 Kinsler, Peter (CYP0118)

39 Kraemer, Dr Sebastian (Honorary Consultant Child and Adolescent Psychiatrist, Tavistock & Portman NHS Trust) (CYP0082)

40 Lancashire Emotional Health in Schools and Colleges, within Lancaster University (CYP0069)

41 Layard, Professor Lord Richard (Emeritus Professor of Economics, London School of Economics) (CYP0045)

42 Leeds Beckett University (Carnegie Centre of Excellence for Mental Health in Schools) (CYP0031)

43 Lewis, Mrs Terry Alice (Franchise Owner, Tots Play Bexhill and Hastings West) (CYP0010)

44 Lewis, Ms Hannah (PHD Student, Queen Mary University of London) (CYP0111)

45 Local Government Association (CYP0041)

46 MRC/CSO Social and Public Health Sciences Unit, University of Glasgow (CYP0075)

47 Mental Health Foundation (CYP0061)

48 Mental Health Network, NHS Confederation (CYP0020)

49 Mermaids (CYP0097)

50 Mind (CYP0054)

51 Mortal Fools (CYP0107)

52 Mughal, Dr Faraz (GP and National Institute for Health Research Doctoral Fellow, School of Medicine, Keele University) (CYP0047)

53 NAHT (CYP0024)

54 NHS Providers (CYP0068)

55 NIHR MindTech MedTech Co-Operative, University of Nottingham (CYP0114)

56 National Association for Therapeutic Education (CYP0001)

57 National Children's Bureau (CYP0079)

58 National Education Union (NEU) (CYP0071)

59 Nottingham Centre for Children, Young People and Families, Nottingham Trent University (CYP0055)

60 Our Time (CYP0100)

61 Outdoor Play and Learning (OPAL) CIC (CYP0072)

62 Oxford Health Foundation Trust (CYP0067)

63 Rufus, Kate; and Catterall, Zoe (CYP0046)

64 Parent Infant Foundation (CYP0050)

65 Parenting Apart (CYP0065)

66 Place2Be (CYP0076)

67 Reading, Claire (Parliamentary Clerk, Department for Health and Social Care) (CYP0116)

68 Royal College of Nursing (CYP0074)

69 Royal College of Psychiatrists (CYP0090)

70 Samaritans (CYP0060)

71 Serenity Welfare (CYP0022)

72 Small Steps Big Changes (CYP0087)

73 Square Peg (CYP0093)

74 Teenage Cancer Trust (CYP0094)

75 The All-Party Parliamentary Group on a Fit and Healthy Childhood (CYP0115)

76 The Children and Young People's Mental Health Coalition (CYP0043)

77 The Children's Society (CYP0048)

78 The National Counselling Society (CYP0018)

79 The National Lottery Community Fund (CYP0063)

80 The Prince's Trust (CYP0091)

81 The Royal College of Emergency Medicine (CYP0112)

82 The William Templeton Foundation for Young People's Mental Health (CYP0073)

83 Townsend, Professor Ellen (Professor of Psychology, Self-Harm Research Group, School of Psychology, University of Nottingham) (CYP0030)

84 Tredget, Mrs Emily (Co-founder, Happity) (CYP0017)

85 Triple P UK (CYP0070)

86 UCL Institute of Education (CYP0038)

87 Understanding Society, Institute for Social and Economic Research, University of Essex (CYP0023)

88 University of Roehampton (CYP0019)

89 Wave Trust (CYP0027)

90 Winship, Dr Gary (Associate Professor, School of Education, University of Nottingham) (CYP0077)

91 Young Epilepsy (CYP0117)

92 YoungMinds (CYP0066)

93 Youth Access (CYP0085)

94 The Actors' Children's Trust (CYP0089)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and individuals with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311
1st Special	Process for independent evaluation of progress on Government commitments	HC 633
2nd Special	Delivering core NHS and care services during the pandemic and beyond: Government Response to the Committee's Second Report of Session 2019–21	HC 1149
3rd Special	Drugs policy: Government Response to the Committees First Report of Session 2019	HC 1178