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National Children's
Bureau

Transforming Mental Health Provision for Children and Young People

Summary findings of consultation events with
children's sector practitioners and parents

April 2018

About this report

In December 2017, the Department for Education and the Department for Health and Social Care launched the green paper, Transforming Children and Young People's Mental Health Provision. A public consultation ran for three months, ending on 2 March 2018.

As part of the consultation process, the Departments commissioned the National Children's Bureau to run consultation events for professionals and parents. Two events were held - in London on 19th February 2018 and in Leeds on 6th March 2018. There were over 80 participants in total, including representatives from:

- Schools and colleges
- Clinical commissioning groups
- The social care sector
- Educational psychology
- Health services
- The voluntary and community sector
- Headstart, the Big Lottery funded projects
- Parents and those with a lived experience of mental health services.

This report summarises the views of these participants. It is structured broadly in line with the questions in the public consultation.

General response to the proposals in the green paper

The green paper proposals were broadly welcomed by those in attendance at the events. Participants welcomed the overall direction of travel, and particularly the focus on support available in schools and colleges.

Participants did identify gaps where they felt the green paper did not sufficiently reflect their concerns. They suggested that further consideration should also be paid to:

- Ensuring children in the early years develop well emotionally and are prepared for the transition into school;
- Support and advice for parents, children and young people;
- Better continuity of care for young people with mental health conditions transitioning to adult services;
- Greater emphasis on wellbeing and good mental health. Participants felt that the language and proposals in the green paper were more focussed on mental ill health rather than prevention.
- The negative influences within the education system which can adversely affect children and young people's mental health and which undermine the promotion of good emotional well-being – with particular reference to exam stress and the focus on academic standards over other measures of success.

Designated Senior Leads for Mental Health

General points

The proposal to incentivise schools and colleges to identify a Designated Senior Lead for Mental Health was supported by virtually all participants. There was also universal support for the green paper's recognition of the importance of 'whole school/college approaches' to wellbeing and mental health. DSL's were seen as one element within the wider context of promoting whole school/college approaches, and participants felt that the emphasis of the role should be more overtly focussed on promoting positive wellbeing as well responding to need.

In general, participants were concerned about whether a member of staff could be expected to fulfil this role on top of existing workloads and questioned, if not, where this additional resource would come from. School and college representatives in particular felt that, while training for DSLs was welcome, the lack of funding for additional staff capacity would be major barrier to some schools identifying a DSL.

The subheadings below refer to the key factors which participants felt were necessary to enable the Designated Senior Leads (DSLs) to carry out their roles effectively.

The knowledge and skills for promoting good mental health across the school

Participants believed that anyone undertaking the DSL role, as set out in the green paper, would need significant knowledge and skills development. The DSLs would need to understand trauma in children, the wide variety of issues that can affect a child's emotional wellbeing, how these can be addressed in a school setting and more general behaviour management expertise. They would also need an understanding of how the culture and policies within a school can contribute to resilience and wellbeing. In addition, it was stressed that leading a whole school approach would require significant interpersonal skills and the ability to communicate well with children, young people and their parents and carers.

The breadth, depth and status of the training to be made available to DSLs was seen as of significant importance. A number of participants identified the legally mandated Masters level qualification for SENCos as a positive example of how roles can be given value and status through the requirements of their training. The National Award for Special Educational Needs Co-ordination was seen as crucial in enabling SENCos to prioritise their CPD and that something similar might be considered for the DSL in the longer term.

A wider school team that understands and prioritises emotional wellbeing

It was felt that the DSL's ability to lead a whole school approach would be very dependent on buy-in from colleagues at all levels. There was widespread, but not universal, support for the DSLs being part of their school's senior leadership team. There were suggestions about how to ensure all schools take mental health seriously, including the potential for Ofsted to focus on this issue more, or a national prioritisation of emotional wellbeing within the curriculum similar to that achieved with regards to numeracy and literacy.

It was felt that the wider teaching staff should also be part of the whole school approach. Participants suggested all staff should receive at least a basic level of training to understand mental health and the role of the DSL (and mental health support teams). Support should be in place to promote good mental health among staff themselves, and opportunities provided with, and for, DSLs for reflective supervision about how mental health cases are being addressed.

Capacity and sustainability

There was widespread concern that the proposed list of responsibilities for the DSL would be challenging for any individual to carry out alongside a full-time teaching role. Concerns

about capacity are potentially made even more critical given the additional areas that were thought to need a DSLs attention as part of a whole school approach (see above).

It was stressed that the role would need dedicated, funded time. However it was also noted that having a significant teaching role would help the DSL to maintain authority with other staff, as has been the experience with SENCOs. It was suggested that the DSL could delegate some of the work associated with their responsibilities to other staff.

Concern was raised about the prospects of the DSL role being sustainable beyond the trailblazer phase of the reforms. Participants were also keen that there was provision to maintain the role in the event of the trained staff member within a school moving on. It was suggested that the following may help:

- Funding for capacity and supervision of the DSL on an ongoing basis
- Making the DSL role statutory (like a SENCO or designated safeguarding lead)
- Training for, and some delegation to, other staff
- Smaller schools being able to 'cluster' to deliver the role.

Mental health support teams

General thoughts on the proposed approach

Proposals for support accessible in schools were largely welcomed. There was a general belief, however, that the creation of a new workforce to deliver this was not the best option. This was partly because participants thought that existing (already trained and experienced) professionals could make a more effective contribution more easily. It was suggested that cuts to provision of educational psychology and occupational therapy in some areas meant that professionals who are trained in these roles were not being deployed accordingly. There was also concern about the level and breadth of experience that recent graduates might have (see below).

More clarity was sought on what was meant by 'mild to moderate' mental health needs. There was a concern that children who need support may end up having their problems over-medicalised, particularly given the expectation that the teams will be made up of health professionals. It was suggested that the teams should be renamed 'wellbeing support teams' and that particular attention be paid to ensuring that accessing support was not stigmatising.

Those attending the consultation events felt quite strongly that it was not realistic to expect the introduction of mental health support teams (MHSTs) to reduce demand on existing CAMHS services. This is partly due to a concern that the gap between demand and capacity is too great to be closed by such interventions, but also an expectation there would be greater identification of need. The Behaviour Improvement Programme in the mid-2000s, for example, was said to lead to increased CAMHS referrals. There were also mixed views on whether it was appropriate to try to reduce demand – with some concerned that the new service would create a 'buffer' that prevented children from getting the specialist support they needed

What knowledge and skills will the teams need?

There was concern that newly qualified professionals would not have the breadth of experience to understand the wide range of causes of mild mental health problems and the wide range of options for addressing them. Parallels were drawn with the primary CAMHS and CYPIAPT programmes which offered a very specific course of treatment from recently

trained professionals who generally had no wider experience. In particular it was felt the teams would need:

- Experience of working with children and young people
- Experience and training in family work
- Understanding of poverty, disability, social care needs, exam pressures and other ways in which children's mental health may be impacted
- Be multi-disciplinary – drawing on the skills of occupational therapists and educational psychologists as well as clinical psychologists
- A mix of junior and more senior roles
- Clinical supervision from CAMHS (supported by extra capacity in this service) in relation to any treatment they are providing.

Who should run the teams?

In line with the desire for the teams to be multi-disciplinary, the only widespread view on who should set up the teams was that this should be done in partnership across several organisations. It was suggested that there should be some requirement or accountability for joint working. This might include, for example, only awarding funding to consortia or to statutory bodies who could demonstrate that they are part of established partnership arrangements.

Who should the teams forge links with?

There was generally a strong feeling that teams would need to work with a wide range of professionals and services. Suggestions reflected but also went beyond those listed in the consultation document. They are listed in figure 1.

Figure 1: Suggestions for who MHSTs should work with

Educational Psychology	Speech and Language Therapy	SEND services	Social care
Therapists and counsellors (e.g. Place2BE)	Creative therapy (e.g. art, drama, music)	Existing CAMHS	Voluntary sector
Occupational therapy	Schools and colleges	Parents	Early years settings
Youth Information Advice and Counselling Services	School nurses	Health visitors	Family therapists

How can the teams support vulnerable groups of children?

Those at the consultation events suggested that vulnerable groups of children would benefit from:

- MHSTs being aware of the particular issues that may impact on their mental health – children in care may be recovering from past trauma, those with sensory impairments may have difficulties relating to social isolation

- Options for accessing support in different settings, including more home visits and outreach work – with safety of professionals who are lone-working being properly considered
- Links with other services relevant to the child in question – inclusion of MHST in the local SEND offer and links with SEND resource hub, involvement of school nurses for those with physical health conditions, family therapy for children in need
- Particular attention to portability and communication between different local areas – this is particularly important for children looked after or adopted 'out of area' and those 'stepping down' from inpatient mental health services.

Waiting time standards

There were mixed views as to whether the proposed waiting time standards were a good idea. Whilst there was a general consensus that children were often not getting support as quickly as they should, there was also concern that any rules or targets could risk unintended consequences. These concerns were amplified by a view that the NHS is under exceptional pressure at the moment, and scepticism about MHSTs' potential to help reduce demand. The particular risks identified were:

- An inadequate service being offered, such as a single appointment followed by a further wait or a very short intervention which is not evidence-based
- Assessments being rushed and not involving all the professionals and family members that they should in order to properly understand the child's needs
- Services raising their thresholds for accepting referrals – it was suggested that targets to provide support within 18 weeks had already increased thresholds for referrals being accepted in some areas
- The application of spurious criteria for accessing the service – an example of a current practice was given of children with autism not being able to access CAMHS because they were accessing a separate autism service
- A postcode lottery of waiting times and criteria – with poorer access outside trailblazer areas.

It was felt that, because of these challenges, the trailblazers would need to look at waiting times particularly carefully. It was also suggested that attention should be paid to any support and advice that could be provided to children and their families whilst they waited for specialist treatment to begin.

Implementation

General thoughts

Participants suggested attention would need to be paid to four particular issues as more detailed plans for the trailblazers are developed:

The need for clear purpose and guidelines – it was suggested that there would need to be clear aims for the trailblazers in terms of any outcomes they were intended to improve. A clear framework for implementation across sites would also make it easier to begin delivery sooner, avoiding spending too long working out what to do and how. It was suggested that any variation in approaches taken should be informed by an assessment of the needs of local children.

Opportunities to share practice and interim learning – as trailblazers look to tackle similar challenges any insight they can share with each other on successful approaches could help to maximise impact.

Ensuring all required activity is resourced – it was stressed that establishing and maintaining joint working arrangements costs money (for example, time taken for meetings). As stated above, there was also a strong view that time to carry out the DSL role would need to be funded. It was suggested that the Teaching and Leadership Innovation Fund was not a suitable mechanism for doing this and additional money would be needed. Once the scope of activity and resource required is properly scoped, it was suggested that money could be ring-fenced to ensure that it is spent how intended.

Selecting trailblazer areas

There was general support for having a good geographic and demographic spread (e.g. deprivation, region). It was also suggested that different types of school should be included: academies and maintained schools, faith schools and a mix of Ofsted judgments. Participants agreed that the extent to which different agencies' boundaries aligned could be an important factor in how they work together so there should be diversity amongst the trailblazers in this regard.

It was suggested that there should be some key principles for all trailblazers to follow (see general thoughts, above) but that there may be value in some areas having a particular focus e.g. eating disorders, autism, looked after children etc.

There were mixed views on whether there should be some requirement for areas to have existing good practice in children and young people's mental health in order to become a trailblazer.

Evaluation

Participants made a number of suggestions of issues and outcomes to explore through the evaluation and measures which could be used. These are set out in figure 2, below.

Figure 2: Suggestions for the evaluation

Relevant outcomes	Potential measures and indicators	Practice issues to explore	Things to avoid
Social interaction	Existing local surveys e.g. Cambridgeshire's health behaviours survey	How joined up are services?	Judging success based on number of contacts with CAMHS
Self Esteem	Outcomes Rating Scale	Are referrals to CAMHS appropriate?	Blanket administration of the Strengths and Difficulties Questionnaire
School staff wellbeing	Session Rating Scale	Does support unnecessarily pathologise children?	Inflexible targets for good individual mental health (as they could discourage work with the most
Mental health and wellbeing change over time	Reduced demand for CAMHS	What are the common factors across trailblazers that are having an impact?	
	School attendance	How is referral for Education, Health and Care plans affected?	
	Exclusions		
Academic attainment	Views of parents and carers, particular for children with additional needs	Where has a whole school approach been achieved?	

	Tailored measures e.g. for children not attending school, affected by gang violence or affected by child exploitation.	How have public health services been involved?	vulnerable children)
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