HOUSE OF COMMONS

Health Committee

Oral evidence: Child and adolescent mental health services: access and funding, HC 522

Tuesday 21 November 2017

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Dr Lisa Cameron; Rosie Cooper; Dr Caroline Johnson; Diana Johnson; Johnny Mercer; Andrew Selous; Dr Paul Williams.

Questions 1 -118

Witnesses

I: Anne Longfield OBE, Children's Commissioner for England; Paul Lelliott, Deputy Chief Inspector with lead responsibility for Mental Health, Care Quality Commission; and Professor Ursula Gallagher, Deputy Chief Inspector of General Practice (London) and Children's Health & Justice, Care Quality Commission.

II: Sarah Brennan OBE, Chief Executive, YoungMinds; James Kenrick, Chief Executive, Youth Access; and Professor Miranda Wolpert MBE, Director of the Evidence Based Practice Unit, University College London, Director of Innovation Evaluation and Dissemination, the Anna Freud National Centre for Children and Families, and Director of the Child Outcomes Research Consortium.

III: Jackie Doyle-Price, Parliamentary Under-Secretary of State for Health; Jonathan Marron, Director General, Community Care, Department of Health; Claire Murdoch, National Mental Health Director, NHS England; Tim Kendall, Mental Health National Clinical Director for NHS England and NHS Improvement; and Chris Roebuck, Head of Profession for Statistics, NHS Digital.

Written evidence from witnesses:

- Anne Longfield OBE
- James Kenrick
- Department of Health
- Chris Roebuck

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Examination of witnesses

Witnesses: Anne Longfield, Paul Lelliott and Professor Ursula Gallagher.

Q1 **Chair:** Welcome to our first panel in this afternoon's session looking at children and young people's mental health. The focus of today's session is primarily going to be on whether the promised action and funding for children and young people's mental health services is being delivered, but also it is an opportunity to look at how that is targeted. Thank you, Anne Longfield, for your updated submission. We are particularly interested as well to look ahead to the Green Paper. For those who are following the session from outside this room, can I start by asking you all to introduce yourselves, starting with you, Anne Longfield, please?

Anne Longfield: I am Anne Longfield, the Children's Commissioner for England.

Paul Lelliott: I am Paul Lelliott, the deputy chief inspector of the Care Quality Commission who leads on mental health.

Professor Gallagher: I am Professor Ursula Gallagher. I am also a deputy chief inspector at the Care Quality Commission, leading on primary care, children's health and justice, and safeguarding.

Q2 **Chair:** Thank you. There are many themes that come out of your submission and your report, Anne, looking at access to services, quality, poor data, variation, and also the issue of where we should focus our resources. Because I know you are keen to comment on what should be in the Green Paper, perhaps I could start by asking each of you to give us your thoughts on the key priorities for the Green Paper.

Anne Longfield: I am really grateful to have the opportunity to talk with you today and I will try to be to the point, because we do not have much time. The first thing to say is that people—parents, professionals and children themselves—have poured through my door from the first days I was in post, which is nearly three years ago now, to talk to me about mental health. It is the biggest issue that they raise. It was the biggest issue in the consultation on what should be in my work programme. I have had children who have told me how they have struggled for years to get help—and years to get help at different levels of treatment needed, from low-level mental health problems with anxiety, to depression and right up to high-level help and possibly in-patient help too.

The things they have always told me about, which I followed up with my Lightning Review last year, were that they found it very difficult to get access—difficult, first, to know where to go. That is the first point really—and I can come back to that—but, as a child, where do you go to get help?

It is difficult to get access, we know. The issues are shortages of provision and the fact that only one in four are getting treatment, but also the waiting times if they are accepted for treatment. Often children

will say they do not have any contact with anyone during that waiting time, which can be six months. Just a text would have helped during that period to make sure that they felt part of it. Again, if they have not turned up to the appointment once they have got it, often it is two strikes and they are out, and they go back to the start again. You have distinct problems around access and distinct problems around waiting times, but all of that is compounded by a system that is not child-friendly in any way at all.

Looking at what needs to be done about it, certainly I have looked at IAPT and I think there is an awful lot in the model that could be transferred and translated into an ambitious programme, and could really give the transparency and accountability that children are after. Looking at the roles of schools, certainly they are very keen to do things and desperate to get help; so, I am very keen to look at that. There needs to be much more of an emphasis on early intervention, but then, at each stage of that process, on increasing capacity over a relatively short period of time to get the ambitious change that I think children are not only crying out for but desperately deserve.

Q3 **Chair:** Paul and Ursula, do either of you want to come in on this to make a few opening points of emphasis?

Paul Lelliott: I can contribute from the perspective of the report that we published on the first phase of the thematic review that we are doing. It does resonate, I think, with Anne's comments. The most striking finding, which I do not think was a new one, is the fragmentation of the system. It is a very complex system, and whoever you are, whatever your role in the system is, it looks complicated. If you are a young person, or the family or the parent of a young person, understanding how the system hangs together is quite a challenge.

The provision is often quite disjointed. There are a whole range of agencies that provide support for children and young people locally, and they do not always work very closely together. The funding streams are complicated—the way the money comes down. It comes through a whole range of different agencies and commissioning bodies. I would also say, from the perspective of a regulator, that the regulatory system is quite complicated in this area. That was one of the major findings.

We also had concerns about the workforce, and that is both the general workforce and the wide range of professionals who interact with children and young people. Whether they are teachers, general practitioners, youth workers, substance misuse workers or people in the youth justice system, that broad range of professionals all need to have a general awareness of mental health issues so that they can recognise, detect and, if necessary, support and refer on young people with mental health problems.

There are also problems with capacity of the specialist workforce. We found shortages of staff in a number of units, both in-patient and

community, and that has an effect in community services of causing the service to raise thresholds or to have high caseloads, or, in in-patient services, it can lead to unsafe care. Those were our main findings and they do resonate, I think, with Anne's thoughts.

Professor Gallagher: I would add two other things to that. Often in these discussions, there is a discussion of accountability, so we are in a system that is already quite complicated. Therefore, as well as fragmentation, I think there is fragmentation of accountability and that leads to issues around transparency. We also found a lack of a level playing field for things such as information, data and definitions. Even in this area, I think, more than others, there are still some differences of clinical views about the sorts of definitions that we might be dealing with in terms of autistic and pathway spectrum disorders or ADHD. At a local level, that can make things quite difficult in terms of individual champions and how that competition plays out locally in the absence of some clear national frameworks.

Chair: Thank you. We are going to look at many of the issues you have all touched on in more detail, certainly starting with quality and access. Lisa, would you like to start?

Q4 **Dr Cameron:** It is a question to Paul Lelliott and Professor Gallagher initially. Why do you think that services are struggling to ensure the safety of children in their care, and how can the CQC ensure the immediate safety of these children?

Paul Lelliott: I can talk certainly from the perspective of the providers that we regulate, which are the specialist child and adolescent mental health services. Safety is a key question that we assess on every inspection. It is the one that we most commonly rate as other than good. For both types of services—in-patient and community—a common finding is that staff are not assessing or managing risks appropriately. Those are risks to individual young people who are accessing the services.

As I mentioned previously, we also find that staffing levels have an effect on safety, either by meaning that staff have to carry very high caseloads or in in-patient services it means that you do not have sufficient staff with the experience to keep people safe. Regarding in-patient services, we often have concerns about the environment. The facilities in which some in-patient units are housed are not really safe for young people. They have blind corridors and nooks and crannies, and also we found some wards, frankly, where there were not good hygiene standards. So, those are our main concerns around safety.

Professor Gallagher: I can add that part of it—what Paul is talking about in terms of the specialist services—is often issues that have happened quite downstream. The children and young people have become very ill in terms of needing some of those services. What also affects that in terms of safety, whether it is general practice, people in community services or schools, is being able to know who to talk to and

how to get help earlier before some of that risk and some of those safety issues become extreme. Certainly, not only children, young people and their families but also practitioners in those settings will describe themselves as sometimes feeling very isolated when faced with a problem in the classic quarter-to-five Friday evening surgery, which many of us will recognise, when a crisis emerges, and the system needs to make a seven-day, 24-hour response. They need to know how to get that sort of urgent help. Certainly, some of the things that we found around eligibility criteria for services meant that getting that response really quickly would keep children safe if we were able to intervene earlier. Paul has talked about the issues for that very small number of children and young people who need specialist and mostly in-patient care in that context.

Q5 **Dr Cameron:** Moving on from that, self-harm is an absolutely serious concern, but data released by the Health and Social Care Information Centre in 2014 showed that admission rates to hospital had increased 93% among girls and 45% among boys over a five-year period. What do you think is behind those figures? I also note that there is some information from the five year forward plan that almost half of services do not have crisis services available. Is admission appropriate? What is causing the admissions and how do we take that forward in the best way for the child?

Anne Longfield: Certainly, children report high levels of self-harm. I met with two groups on Friday and both talked at length without any prompting about self-harm being part of life. We know from ChildLine services that there are increasing numbers of children coming through with self-harm.

For me, this is the perfect support that schools are ready and able to help with, if they can get back-up. School teachers tell me that increasing amounts of time are being spent in the classroom dealing with things that happen outside school, over the weekend or over the school holiday period. Some of that they will put down to social media, with the pressures that that brings and the constant nature of communication and pressure on children; but children in that situation tell me that they would like to get help first and foremost from a trusted adult, probably around the school, someone they could get to know, someone who has specialist knowledge, but also someone who is accessible to them. That is the thing that schools are desperately keen to do but are often struggling to do with very limited budgets.

Q6 **Dr Cameron:** Do you have any comments on the admission figures?

Professor Gallagher: I completely agree with that. I would reiterate my point on some of the things that we might talk about later as to what might be in the Green Paper, in terms of that real primary prevention stuff—how, through schools and other resources in public health, we build resilience and mental health literacy in children and young people so that they are able to handle some of these really difficult emotional issues,

whether it is social media, pressure at school or many of the things that they are confronted with as young people today. Clearly, we have a cohort of children and young people we need to be able to support better through many of the things that we have already talked about, but we also need to think about the prevention agenda as well.

Paul Lelliott: There has been a great increase in the number of young people going to the accident and emergency department with a mental health problem, which includes having self-harmed. It is true that in many parts of the country there is not a specialist CAMHS worker on call out of hours to assess the person. There is a very limited range of options for that young person if they need further support. Quite often, people might be admitted to a paediatric ward, or even, if they are an older child, to an adult medical ward, which probably is not ideal.

Q7 **Dr Cameron:** I have a final question. In 2016, the report on suicide by children and young people found that around half—57%—of young people under the age of 20 who had committed suicide were known to services. What is the issue there? Is it that we are picking up people but not noticing the risk in crisis, and what is happening to the other 40% who are not being picked up at all? What should be happening?

Anne Longfield: On suicide, again on visiting a school quite recently, they told me that they had had five occasions of either attempted or threatened suicide in this year alone, and that was something that they would never have had five or six years ago. I was really shocked early on in this role when 13-year-olds told me that they understood that feeling suicidal would not get them treatment. To have attempted suicide was what they would need to do to get treatment. In my slight naivety, I thought that was quite shocking, but, as I asked others, it seemed to be the norm. That is something we have to take very seriously and understand that there are a number of children with life-threatening conditions who just are not getting the support they need. That is not to say there are not brilliant services for those who do get support, and there are brilliant workers there who are very skilled and committed, but none the less my priority and worries are about those who are not.

Q8 **Dr Cameron:** For those who slip through the net—the 40% who are not identified—what should be done?

Paul Lelliott: I would say that a high proportion of young people who commit suicide had self-harmed before. Fortunately, the great majority of young people who self-harm do not go on to commit suicide, but it is very important that, first, young people who have thoughts of self-harm are identified, that they are offered the help they need. I agree with Ursula that much of that help should be happening very close to the school or the young person's home. Those few where the self-harm is either an indicator of potential suicide risk or an indicator of a more serious mental health problem need to be detected. I think it links back to one of our findings that in quite a few community services we were not satisfied with the quality of risk assessment, which is about identifying the factors that

put certain young people at higher risk than others and then responding to those risks.

Chair: Before we go on any further, having chaired the inquiry in the last Parliament on suicide prevention, can we avoid the use of the term "commit suicide"? We would prefer to refer to people taking their own lives. Luciana has a brief follow-up question and then we are going to come on to the issue of access.

Q9 **Luciana Berger:** I have a brief question to Mr Lelliott. In your recent report on young people's services, you found that 42% of community mental health services and 35% of in-patient services for children and young people were either inadequate or required improvement when it came to safety. Is there any service across the whole of the NHS that has comparable low and worrying levels of safety?

Paul Lelliott: I am afraid there is. I can provide this information as we have a table that shows all the various core services that we inspect with the ratings that they have had; but, from memory, there are several core services, including acute wards for working-age adults, where a higher proportion of services are rated "requires improvement" or "inadequate for safe." But it still does not excuse the situation. It is still far from being good. If the Committee would like, I could provide you with that information about the relative ratings of different types of mental health service.

Chair: Thank you. We come on to the issue of access.

Q10 **Dr Williams:** I am going to take us back to suicide with a quote from a parent about their child "T", with which I am sure Anne will be familiar: "There were 18 months between them first asking for support and getting anything. CAMHS rejected T four times because he wasn't suicidal—although he'd said he didn't want to live any more and he didn't want to wake up in the morning. But because he hadn't attempted suicide—aged 10—he didn't hit their criteria for help."

In your CQC report you have described largely very caring services, when people get to access them, but young people are really struggling to access them. You described a few minutes ago that some of it is about the risk-assessment criteria. Why else are young people really struggling to access these services and how are you working with service providers to try to address this?

Paul Lelliott: We very often rate services as other than "good" for "safe," but for child community mental health services we also very often

[1] Mr Lelliott has supplied a correction to the transcript: We very often find services that miss their own targets for how long young people wait for assessment and treatment, and we also find services that fail to meet any acceptable yardstick for waiting for treatment.

rate them as "requires improvement" or "inadequate" for "responsive", which reflects this problem with waiting times.

We very often find services that miss their own targets for how long young people wait for assessment and treatment, and we also find services that meet any acceptable yardstick for waiting for treatment[1]. If you take the NHS Constitution target of 18 weeks, we find services that miss that target too.

We hear from services that it is very often staffing levels that they take to be the issue. We also find services that manage very long waits by raising the threshold for taking young people on. A number of services will review or triage referrals, and they will apply criteria and turn away referrals that they think do not meet their criteria for assessment. The risk there, of course, is that there might not be any other service in that local area that can pick up that unmet need.

Q11 **Dr Williams:** That is exactly what children and parents describe. We know that at least three out of four children with a mental health problem are not accessing services, but some of it is not because they are not trying. They are trying to access services but they are being rejected.

Anne Longfield: You have services that are a rarity. In some areas there is a very limited amount. You have a lack of join-up between different levels of treatment, so there is nowhere else to go, and certainly no route throughout the system. I went online and looked at the IAPT system as an adult, put in my postcode, and up popped six different places to go. It told me that 90% got seen in six weeks. It told me what the feedback was, and there was a little thing that said, "Press here for a self-referral." I went on to Google and did the same for children, and there were myriad organisations that might be doing very good things or might not, but I would have no idea. There certainly was not any framework to work through.

For me, that is a system or model that would be hugely beneficial for parents, teachers and children themselves. Teachers, I think, often are the ones who notice when there are problems developing with children. Many of the schools really are stretching every sinew to look at how they can get that first-stage help, but often they identify a gap between what they can do and then whether the specialist service is there or not. Acknowledging that there have been improvements and there is a plan under way, even when that plan has come to fruition five years on, it still means that only one in three children are going to get help rather than one in four who do now. It is that scale of change that I am so keen to ensure gets to children.

Paul Lelliott: Do I have time to follow up the second part of your question, which is what the CQC does about this?

Dr Williams: Yes, please.

Paul Lelliott: We certainly do take action, including enforcement action, against providers, but there is a challenge to that, which is that we regulate providers and it is not uncommon for our inspectors to be told that the problem here is commissioning—that, "We are commissioned to provide this level of service and we do what we can with the funding that we are given." That puts us in a difficulty because it means that we are holding providers to account for something that they are telling us is not strictly their responsibility, which is a challenge. I am not sure what the answer to it is. We tend to take the approach that one of our values is putting people who use services at the heart of everything we do, and if we are going to do that we need to call it how it is, which is to rate services based on what we see and not always on the factors that underpin that.

Professor Gallagher: The piece of work we do that contributes to that is our joint work with Ofsted in the joint area inspections—inspections for children who are looked after and the special educational needs inspections. Those are whole-system inspections under our section 48 powers where we are able to look at a whole system. Clearly, one thing that we critically identify there is the strength of the partnership working, the strength of the local leadership, and sometimes the extent to which people even know that they have eligibility criteria in operation that do not join up, and how that lens gets shone back.

The challenge for us then is linking that in, as Paul has said, to our individual regulatory action against providers, but, if you look at some of those reports, we have been able to highlight what some of those areas are. As we go around to places that we have not yet inspected, we know that people are looking at those reports and sometimes anticipating what some of these issues might be in preparation. I certainly think the way in which we think about the regulation of the systems of care is something that we need to continue to develop both in working with other agencies and in terms of what our powers are if we are to be able to really help address these issues.

Q12 **Dr Williams:** What I have heard from your answer is that, in order to stop children and parents having their referrals rejected and being bounced around the system all the time, not only does the amount of resource that commissioners are putting into the services need massively scaling up but the services need to be changed and made much less opaque—or much more transparent—to help people to understand thresholds, what services are available and what waiting times are.

Anne Longfield: After seeing the services, children cannot be expected to be the ones who navigate between different entry points. A single point of entry into a system that wants to help them get better whatever it takes would be the thing. I know that a lot of people are delivering great things in the services, almost despite the fragmentation, but the fragmentation needs to be back-room fragmentation, not something that users have to navigate.

Q13 **Chair:** One thing that you touched on in your report, which was a theme of our predecessor Committee, was the fact that it costs £5.08 per student to deliver an emotional resilience programme in school, but £61,000 for the average cost of an admission, and the question of where we are focusing our resources within the system. Is there anything else you would like to reflect on while you are here, Anne?

Anne Longfield: Clearly, if children need crisis care, they need crisis care. However, we know that so many of them are not getting the support they need early on, with the majority of the funding—85%—going to just over 2% of children, which means that so little is available for early intervention and prevention. I think there is a will and eagerness to take part in that. It means that there needs to be a different calibration of partnerships to make that possible, especially services working alongside schools and others. But if you look again at IAPT and the amount per head, which I calculated was about £400 per unit cost, you really are able to take a seismic leap there in the number of people who get treatment, and also the costs and the outcomes within it.

Q14 **Chair:** That is, treatment at a stage where they do not progress to the point of needing much more expensive interventions.

Anne Longfield: Yes. It is clearly not sustainable in economic terms to continue to allow anyone's condition to worsen if that can be prevented. There is a high cost with that, but also socially and morally it cannot be right that we are allowing children's conditions to worsen. We would not allow that for a child who had a broken leg, for instance. Teachers, social services and others would notice. We would not expect them just to hope it would get better. We should not do the same for mental health.

Professor Gallagher: The other thing to provide for, as to the SEND process, is the impact of this on other siblings, other family members and on relationships. There is a significant morbidity cost over and above the child that can also end up with people needing help and services.

Chair: Thank you for that point.

Q15 **Luciana Berger:** Anne, we were witness to the exchange between you and NHS England, the various questions that you posed and the responses that you received, and the most recent response from NHS England. Can you share with us what you feel in terms of if there are—and I use the word "if"—any outstanding issues, but particularly in relation to funding of children and young people's mental health services?

Anne Longfield: Not wanting to spend time talking particularly about that instance, if you like, clearly there were conversations at that time and there have been conversations since then, I have to say, of a positive nature. There are huge disparities in children's mental health compared with adult mental health that need addressing. We know that children's mental health gets about 6% of the mental health budget, despite the fact that 20% of patients are children.

We also know that there are great data gaps, which I think still remain around children's mental health. Again, for adult mental health we know that there is data on referral times, on outcomes for adults and on numbers of adults falling outside that programme, and we just do not have some of those for children. I want to know more about that.

There is some data that we have had that is experimental data, and it is good to see that. Clearly, that needs to run through over time, but if we are going to look at a new system, on which I am hopeful there will be a focus in the Green Paper, it does need to come with a robust framework not only of investment—I do not think money is the only thing that needs to happen—but also of transparency, accountability and benchmarks, which can really look at where this money is being spent and ensure that we get rigour throughout the system.

Q16 **Luciana Berger:** Are you confident from the work that you have done that the money that we have been told has been intended for children and young people's mental health services is actually reaching the services?

Anne Longfield: You will hear from others. I think it was Sarah Brennan at YoungMinds who said that 34% of the areas are the ones where money is getting through. At the moment, where we do not have ring-fencing, there are many incentives for the money not to go to the frontline. Clearly, I am aware of the worries about ring-fencing, but for an issue that is such a high political priority, but also a high priority for young people at this point, I do think that ring-fencing for a period of time is absolutely necessary.

Q17 **Dr Caroline Johnson:** You have talked a lot about schools and young people. We have briefly touched on families, because often the first people to notice that there is something wrong with a child will be their family— their siblings or parents—or other care givers. What role do you think they have in helping the young person or child to get better, and what information is available to parents who are concerned about that young person to access or perhaps put in place those very early interventions that might make a difference without needing mental health services?

Anne Longfield: We would all want parents to have the best possible chance of building resilience with their children and get help if they need it along the line. I am a big fan of parenting programmes and would want to see that built into the earliest levels of intervention. Parents will often tell me that they did not know where to go to get help. Again, they would do my kind of exercise of googling online, not knowing where to go. They might go to talk to the school and between them might be able to put together some kind of package, but I cannot overestimate the stress that a lot of schools are feeling about being inundated with increasing numbers of children with problems and having such limited budgets.

Parents generally will do their best at any time. Interestingly, when I talk to children, often they will say that they will not go and talk to their parents because they do not want to worry them. They will say, "Our parents wouldn't know what to do, and we don't want to worry them and put them under stress." They say they prefer to talk to an independent adult, possibly around the school. Clearly, I would want support for parents, good information for parents, and good online information too. Not all of this is high cost. Some of it is about getting the right information to those who can really help.

Q18 **Dr Caroline Johnson:** That would presumably include encouragement for the young person to talk to their parents.

Anne Longfield: Of course, yes. I would hope that a part of any discussion with a child would be about bringing their parents into that discussion.

Professor Gallagher: We discussed earlier some of the pressures that social media brings, but we also know that online programmes, for example particularly with young men, have proven to be very helpful, and again some use of that technology might help in raising their awareness and help them with signposting, but also help them to have conversations and to structure those conversations, whether it is with teachers or parents. There are some real opportunities in some of those new media. Anybody who knows me knows that I am a complete dinosaur, that six-year-olds can manage my iPhone better than I can, but we should maximise those opportunities.

Anne Longfield: I agree. We certainly should not be afraid of those just because we are worried about the negatives, and we should understand as well that there will be a lot of children who will not be sure of their particular condition. They might just not feel too good, want to know what that means, and be much more confident about going online and testing that out.

Chair: Thank you. Unless anyone has any further points, we will come to Diana and fragmentation.

Q19 **Diana Johnson:** Paul, you have already spoken about the very complex system that we have, disjointed and sometimes not working together very effectively. I want to ask about the current system of regulation and providing that effective and comprehensive oversight of children and young people's mental health services. Do you think that is happening at the moment?

Paul Lelliott: It is complex and our report flags that up. You have us as the regulator of health services; you have Ofsted as a regulator of schools; there is another regulator for independent schools; there are then a couple of criminal justice regulators; and then you have the professional regulators of nursing, medical and other professions. It is highly complicated. If you are going to have a system of provision and

commissioning that is joined up, you need a system of regulation that is more joined up. We do work with the other regulators, and Ursula can probably say more about that. One recommendation of the five year forward view is for some very specific investigations[2], but maybe I should hand over to Ursula at that point.

Professor Gallagher: As I indicated, the work of my team covers the broader range of children services. It is important to see what we are offering children and young people, mental health services being an aspect of that. It can present perhaps with a child who has cancer but who also has mental health needs around that diagnosis, so we need to keep the child and the young person at the centre of these conversations. We work very well with Ofsted and Her Majesty's Inspectorates of Prisons and Constabulary. We have to work under particular powers, and again we are matching up a statutory independent regulator with inspectorates, but I would certainly say in the past two or three years that those relationships and understandings, and the impact that we are having, have really developed. There are further opportunities for that and there are bits of the system again—for example, the public health end, which is now commissioned by local authorities following that transfer, and some of those primary programmes such as smoking cessation and mental health and wellbeing services, and how those work with schools—that are currently unregulated.

Structural changes can be a distraction when you are having those conversations about whether it is services or regulation, but I think it is about challenging us, working together at the limits of our powers creatively and well, and how we demonstrate we can do that. I certainly think that in the last 12 to 18 months, in terms of our joint work with Ofsted and the health and justice regulators, we are really being able to focus in on those issues around children and young people's services.

Q20 **Diana Johnson:** Are you working to the limits of your powers yet, or is there still a way to go?

Professor Gallagher: In terms of our regulatory powers, yes. There is certainly more capacity and focus on some of our thematic work, because our regulatory power only takes us back to being focused on providers. I think all the organisations involved would like to be able to do more of the thematic work that helps to describe systems and pathways, and really helps us to get underneath some of the fragmentation. If you ask us later about what we are doing around phase 2 of this work—for example, around the field work—there is some really good modelling about what we are doing within that field work to get that level below not only what is happening but why it is happening, and what is happening in

[2] Mr Lelliott has provided clarification on this point, noting: One recommendation of the five year forward view is for CQC to undertake Joint Targeted Area Inspections of how local services work together to improve children and young people's mental health outcomes.

the places where it is better that makes it better so that other places can learn, particularly focusing on our encouraging improvement brief as much as our regulatory brief at the poorer end of performance.

Q21 **Diana Johnson:** Would you like to say something, Anne?

Anne Longfield: I have seen some really good examples of where partners are working together. I visited West Berkshire some time ago and saw their joined-up work, the police, social services, schools and health to triage. It was around early intervention—an early intervention hub. It had been relatively cost-effective and was already bringing returns in terms of being up and running over three years. That had a CCG lead, and it was able to get over so many of the gaps that we see so often where children are starting to fall down between that fragmentation. Clearly, there are various partners in here with responsibilities and funding responsibilities within there too. We need to see a framework that allows them to operate seamlessly. I see very much a similarity to the issue of safeguarding with local authorities. Local authorities retain that clear lead, but expect other partners to work together around that. Some kind of requirement around co-operation I think is essential, but also a clear lead.

Q22 **Diana Johnson:** Finally, that should be the CCG with that clear lead.

Anne Longfield: I think it should.

Diana Johnson: Right. That is in your written evidence. Thank you.

Q23 **Chair:** Could you clarify where you saw that example of very good practice because I did not catch it?

Anne Longfield: It was west Berkshire.

Q24 **Chair:** One question that constantly comes up is that you have wonderful pockets of good practice, but why is that not happening everywhere? What is the barrier to that happening everywhere?

Anne Longfield: Absolutely, I know. What was interesting about that was that it was led by the lead professional at the CCG here, and I asked her why it happened. She said she had worked there for 25 years and there came a point where people acknowledged that change was needed. They spent six months talking to children, who had often fallen out of the system and had very difficult experiences, about how it needed to change. She said that was a six-month period of very difficult conversations—it was very difficult to hear—but they were reaping the benefits of that instantly.

I often go to see places where there are excellent examples, and you see it in schools and elsewhere, but I notice them because they are good and because it shows what can be. I am eager to talk about those, but I would really like to get to the point where that becomes mainstream and what we notice is when areas do not fulfil that potential. That is now that next stage—to get to the point where, frankly, children, wherever they

are, can have assurance that there is consistency in the treatment they are going to get.

Q25 **Chair:** Although undoubtedly there is variation in the way that mental health services are funded, sometimes you have systems that have similar levels of funding and challenge, but one manages them so much better than the other.

Anne Longfield: Absolutely.

Q26 **Chair:** What is the thing that works in spreading best practice? Have you seen examples of how it can be spread most effectively so that it happens in other areas?

Anne Longfield: Clear, central senior leadership is really important. If you look at what happened in the police's response to child sexual exploitation, you had a really swift change not only of mindset but of practice. It is not perfect, but, none the less, there was clear leadership from the top, from the PM at the time. There was a clear framework, clear targets and investment too. That leaves no room for manoeuvre, if you like, in terms of this being an option. It cannot be an option. It has to be something that is driven through the system. There is clear indication that it is possible, both in terms of what you can see with adult services and what you can see from the areas that are really able to deliver, but it needs to become something that is mainstream and something that is clearly part of the expectation.

Q27 **Chair:** Is that something that, within your role as Children's Commissioner, you are doing—going around and sharing best practice?

Anne Longfield: I am, but I think it has to go beyond me. I know there are lots of good people looking at the sharing of that, but it needs to sit within a transformational programme that takes the ambitious leap to a new level of operation. It is that urgency that will require places to move at a speed they have not before.

Q28 **Chair:** Going back to the point about the role of the CQC and regulators, do you need to have greater powers as regulators within the system to be able to force through that system change to say, "You are not delivering what an area in another part of the country is delivering"?

Paul Lelliott: On the question of how some people do it and some do not, that is something we are looking at very closely in the second phase of this review. We have visited 10 areas, and we are at least as interested in where it is going well, so that we can find out what has made this happen, as we are in what obstructs what we think should be happening. I certainly think we have a role of flagging up excellent practice and making a noise about it so that it attracts attention and hopefully spreads across the system.

As Ursula said, in terms of us having wider powers within the system, we acquire those powers under section 48, the section under which we are

undertaking this thematic review. That gives us the power to look at services and functions that we do not regulate, but it is not something that we have in our day-to-day inspection activities.

Q29 **Chair:** Thank you. Before we finish, can I return to the theme about the very earliest prevention and early intervention? It was another theme of our predecessor Committee's inquiry about the lack of long-term stable funding for the voluntary sector. Is that something that you would like to say anything more about in the run-up to the Green Paper?

Anne Longfield: If we were going to look to invest, clearly the area with the most uncertain funding at the moment and also the area that can bring the greatest cost-effectiveness and greatest numbers is early intervention. The schools I talk to are scrabbling around for money from local parish councils; they are offering one-day-a-week counselling support where they know there is enough demand for five; they do not know where the funding is coming from after the next six months. However good it is for that period of time, you need certainty and planning to be able to offer that level of support. I would very much like to see, both in the Budget and the Green Paper, a real investment in early intervention throughout the system.

Going back to the conversation we have just had about spreading good practice, I would like us to be really intolerant of anyone who did not strive to achieve and to get the best possible practice. I know incremental change is positive. However, we have gone beyond the position of incremental change being acceptable here. We have to look at targets around numbers of children, around a period of time and around ensuring access. We have a position that is not going to go away. Children really are carrying the brunt of that burden at the moment, and children with mental health problems will become adults with mental health problems very soon. So, it is a situation that we simply cannot on any basis ignore.

Q30 **Chair:** As you have put it in your report, given the level of unmet need, we need seismic and not incremental change.

Anne Longfield: Seismic change, yes.

Chair: Does anyone else have any points that they would like to add, and you, as members of the panel, are there any final points that you would like to make?

Q31 **Andrew Selous:** Can I ask one brief thing? On the prevention agenda, mental health keep-fit, trying to help our young people have good mental health—I am talking about all of us, before any of us have problems in families: everyone and young people—how can we spread that?

Anne Longfield: There are some great programmes. There are great programmes around school, around mindfulness, about getting out and being active. I have introduced something around a "digital five a day," which aims to get kids to have a healthy diet online. This needs to become part of the wellbeing agenda within schools, but it is also for

parents to use these tools, to be very aware of building their children's resilience to cope with everyday life. This, for me, is about positive parenting and also responsible time within schools. Certainly online, the broadcasters have a job here, schools have a job and parents do too.

Professor Gallagher: Can I add one point in case there was a misconception about our role in assessing and driving particularly some of the system leadership and strategic issues? Through both our SEND inspections and joint area inspections through Ofsted, there are powers to demand an action plan and to monitor change. There are clear recommendations, and, ultimately, there is an opportunity for the Secretary of State for Education to put areas into—I cannot remember what the phrase is now—their version of the special measures process if they are found to be significantly failing. It is not that those areas are without, but just that the profile and some of the issues around child and adolescent mental health services, as Anne has said, need to rise within the areas that we are able to look at, particularly on data and information.

Q32 **Chair:** Does it concern you, though, that Ofsted could do more to comment on mental health provision during their school inspections?

Professor Gallagher: So, a separate conversation about their school inspections—I think, yes. At the moment, they do not particularly focus on it in terms of what is happening in in-school provision and particularly the role of teachers. There are conversations to be had, as always, about what the scope of regulation is and its intensity. I am sure that it will be one of the issues that will be raised.

Q33 **Luciana Berger:** I have a short extension on Andrew's question. You pointed to lots of fantastic examples around the country of schools that are doing excellent things with mindfulness and so on, but it is not the norm. This is perhaps slightly outside the scope of the Health Select Committee, but do you think, as part of their curriculum, that all schools should have compulsory PSHE that covers these issues?

Anne Longfield: Yes. From the first day in post, I talked about the need for compulsory PSHE in school. Last week I was talking to the Education Select Committee about the need for schools to be judged on children's wellbeing as well as educational attainment. This is all part of the broad role of schools in supporting children as they grow up. There is so much more scope there, and I think schools understand that high wellbeing means high attainment too. They do not see these as different competing agendas necessarily. They can see that they are very linked. However, we have a Green Paper. I think the expectation or ambition is high, and the potential to really take us ahead in terms of what we offer children in this country is immense.

Chair: No doubt we will all be meeting again after the Green Paper is published. Thank you very much for coming to give evidence today.

Examination of witnesses

Witnesses: Sarah Brennan, James Kenrick, and Professor Miranda Wolpert.

Q34 **Chair:** Thank you very much to our second panel for coming this afternoon. For those following from outside the room, would you mind introducing yourselves, starting with you, James Kenrick?

James Kenrick: I am James Kenrick, chief executive at Youth Access.

Professor Wolpert: I am Miranda Wolpert. I am professor of evidence-based practice at UCL, with a special focus on child mental health, and, just to share with the Committee, I am also a part-time adviser in NHS England, particularly in relation to outcomes, but that is not the role in which I am here today.

Q35 **Chair:** Thank you. Can I ask you as well to speak up slightly because you are softly spoken and it might be difficult for people to hear? Thank you.

Sarah Brennan: I am Sarah Brennan, chief executive of YoungMinds.

Chair: Johnny is going to start the questioning.

Q36 **Johnny Mercer:** I listened with interest to that last session because in Plymouth—and I think country-wide—if you are looking at this with a fair wind, mental health practices for children are generally improving but the demand is extraordinary. What is the biggest challenge? You have to meet those two things together to get to a service that is something we can be proud of for our young people, and clearly we have work to do on both. What is the biggest challenge in improving the services? We will come on to demand in a minute.

James Kenrick: The biggest challenge at the moment is rebalancing the allocation of resources towards early intervention for those with emerging issues and to ensure that the needs of the most vulnerable and under-served groups of all, in which I would include young adults and those in vulnerable socioeconomic groups such as care leavers and young black men, are better met. We have seen some progress. We are certainly getting evidence from our members at local level that in relation to early intervention there is certainly reasonable progress in quite a few areas, but it is too slow; there is not enough progress.

However, in relation to young adults and provision for more vulnerable groups, we have not seen any progress at all, and we think there is a particular problem that is not being picked up and addressed through CAMHS transformation at the moment relating to young adults. One reason for that is that, although local transformation plans are very explicitly encouraged to cover from 0 to 25, the additional funding that has been given to CCGs is primarily for work with under 18-year-olds. There is not an incentive for commissioners to improve services for young adults as much as there should be.

Adult mental health commissioners are not picking up that responsibility either, even though, of course, if we are talking about young adults, 16 to 25-year-olds, the majority of that responsibility should lie with adult mental health commissioners. They are leaving young adults to CAMHS. There is a particular issue there. We are concerned that the failure to provide those vulnerable groups and young adults with access to mental health services when they most need them constitutes a breach of their human and legal rights and also their rights under the—

Q37 **Johnny Mercer:** This comes to the nub of the problem. In cities, I am sure, all over the UK and generally, how do we get earlier intervention where it is cheaper, chances of recovery are better and you can treat more people? You talk about people falling through the gaps there. How do we meet this challenge of people working outside their scope, whether it is public health or NHS England, to treat these people? Miranda, can I come to you for that?

Professor Wolpert: One of the things that we desperately and urgently need is a better evidence base for those sorts of interventions. There is a great consensus that we need earlier intervention and that there is lots more that can be done in schools, colleges and universities. There is less consensus on the best way of doing that and a clear evidence base of what will and will not help, so there is a real urgent need to do that.

There is a lot that the Department of Health and the Department for Education are doing in randomised control trials and things they are trying to put in place. While we are finding out those things, we still have to decide what to do. We have to have a rationale for how we decide what to do and have agencies that will work together. It is a bigger issue than just health. It is health, social care and education, working together and using a common measurement framework of what they are trying to achieve for their population and measuring that at the population level while you are doing these interventions to see what makes the most of it.

Q38 **Johnny Mercer:** Is this work going on now? While people like me and everyone on this panel will always ask for more money for health and mental health—and we have the Budget again tomorrow—those conversations around structural changes are for the NHS and the public health teams, and we have to drive that change faster as well as getting new money.

Professor Wolpert: I agree, and certainly, from my sense, around the country there are things happening. There is fantastic stuff happening in Greater Manchester, for example. There are fantastic instances of communities coming together to do exactly that, working with the public.

Q39 **Johnny Mercer:** Why, in your view, are we not taking best practice in some areas—we are doing the same in Plymouth as well—and having a strategic lead across the United Kingdom to roll this out so that we have a national mental health care service of which we can be proud? In your view, why is that not happening?

Professor Wolpert: There are a number of issues here. One issue is that it is difficult to know what is best practice—it really is. It is not dodging the question, but actually the evidence base for what sort of preventions are the best and where we should put our energies—

Q40 **Johnny Mercer:** Okay, so how do you judge outcomes then? What outcomes for young people should we expect from mental health services?

Professor Wolpert: The sort of outcomes that are really important to think about are what goals are important to that young person and their family. Clearly, for the vast majority of young people and their families, that will be symptom change and functioning, but for other people there will be a balance between how much they want to control symptoms and how much they want to do other things in their life. There is a range of measures around mental health and wellbeing that are not exactly the same, which people need to measure both at the community level and at the individual level of people seeing and accessing services.

Q41 **Johnny Mercer:** That is quite an intractable problem. If there are no measurables to come out of mental health treatment that you can then look at, take to Government and say, "You should invest in these because this is working," surely we need to come up with a bunch of measurable factors that we can prove as an evidence base.

Professor Wolpert: I completely agree. One thing we are involved in and people are involved in nationally is agreeing common measurement frameworks that people are using at population level. Exactly as the Children's Commissioner was saying, schools are now investing in measurement frameworks; they are measuring their populations year on year so that we can actually see what impact interventions are having. We are also trying to measure outcomes for individual children seen within the service.

Q42 **Johnny Mercer:** Sarah, what is the issue that young people most commonly raise with you when they talk about mental health services? We have talked about delays and things like that, and people not being contacted. What is the most common issue that you see?

Sarah Brennan: I would also like to feed back on that one, but it is often just the really basic things that we have been hearing. It is, "Where do I go to get help? Who can help me? Who do I talk to? Where can I go? I feel lonely. Who can help me? I am isolated. Where do I go? Can I talk to my mum and dad? Can I talk to my teacher—probably not? This is a bit scary." It is complete confusion about where to go, who can help and who is qualified to help. On top of that, there is, "What information can I trust? What information is out there?" It is really very basic. On top of that, when they are worried about their friend, it is, "What can I do to help them? What is going to make it worse or better?"

Q43 **Johnny Mercer:** Whose job is it to do that? If you were to transpose this, for example, into a veteran's case, it is exactly the same thing. You

do not know where to go or the quality of the care you are going to get. Whose responsibility is it in health, so that we can stand on the doorsteps and tell the people who vote for us? It is their public money that goes into this. Who is in charge? Who does that? Whose responsibility is that?

Sarah Brennan: You have been hearing that there are too many people in charge of too little bits. We are talking about measurements. For instance, schools have no responsibility for wellbeing, although some schools see that as core to their work, but we do not measure it. We do not have a national measure on our wellbeing. Schools are not expected to do that, so they cannot play their part. It is about how we streamline each part of the system so that they know what part they are playing, whereas at the moment everyone is groping their way about their particular part and the only people who are clearly pointed at are CAMHS. CAMHS, as we have again heard, is overwhelmed.

The other challenge is workforce. We have low morale in our CAMHS workforce. They are overwhelmed. They do not want to turn people away, but they have to—just to cope. We have real issues on recruitment into CAMHS. We have seen from the Education Policy Institute report very serious gaps in the workforce across the country. We have had a long history of short-term posts and fixed-term contracts, and people are not coming into the mental health workforce either. So, we have to do something to promote CAMHS as a place worth working in and say that this goes beyond the current pocket of money that we have at the moment so that people can see beyond 2020 that there will still be a worthwhile profession to be part of.

Q44 **Johnny Mercer:** I absolutely get that, and we must work on the offer, obviously. The other side of this is the education, is it not? If we do not wade through people self-diagnosing and things like that, we are never going to be able to reach those who are really poorly whom we have a duty to look after. What are your organisations doing around closing the other end of the divide? We have the service provision here, but the demand is huge. How do we reduce that demand through education? Is anyone, for example, doing any lobbying with the Department for Education on statutory requirements at school?

Sarah Brennan: YoungMinds has a campaign called Wise Up addressing exactly these issues, because schools have an important role to play, as we have been hearing, but we have to create an atmosphere where, first, there is reward for schools when they do this. We also have the healthy schools programme, but at the moment it is unclear whether it is going forward; it is only for primary schools, not secondary schools. There is no recognition for schools if they do well around wellbeing; if they are doing great stuff around how their young people are. We know wellbeing outcomes at age 16 are more important in terms of life outcomes than qualifications, but we need to balance this up so that there is a measurement that all schools are involved with.

The EPI report showed that only 30% of Ofsted reports even mentioned wellbeing or mental health within the schools, so what is being considered is very patchy and there is no encouragement for schools to do this. We heard in the commission that we carried out with the Royal College of Psychiatrists and the Children and Young People's Mental Health Coalition from head teachers saying—this is about values-based CAMHS—that they focused on wellbeing because they believed it was crucial, but they had no support from their local authority or from the DFE, and at times felt they were doing it at their own reputational risk. Unless that side of it is encouraged, unless it becomes a fundamental expectation of our education system that it will teach young people about themselves—it is more than just PSHE, it is about the whole-school culture, and it is more than just mindfulness—we are not evening up and enabling young people to have good mental health, and we are simply investing in poor mental health for the future.

Q45 **Johnny Mercer:** Briefly and finally, James, that seems pretty sensible stuff to do, but does it cost too much money or is there a lack of desire in the Government to introduce more statutory requirements? What is it at the moment?

James Kenrick: I would completely agree with Sarah. The issue comes back to what data everyone is required to keep, because if schools are not keeping data on their impact on preventing mental health problems, and if the mental health system is not counting that preventive work either, there is no incentive for either the providers or commissioners to ensure that that happens.

Professor Wolpert: There is a growing interest from schools in doing this. For example, we are involved in rolling out something called the wellbeing measurement framework, which, thanks to funding from the Big Lottery Fund, is freely available to schools. We have been oversubscribed by schools wanting to measure wellbeing and mental health in their schools. We have a Schools in Mind network organised by the Anna Freud National Centre for Children and Families to which schools are signing up. Schools are up for it in that they are struggling with their own competing demands.

Johnny Mercer: The Marine Academy in Plymouth has a day when the children leave the school and all the teachers from other schools come in and talk about mental health, but that is a leadership issue for local and national Government, I would suggest, rather than schools doing it off their own bat, because then you will not get that standardised care.

Chair: Diana wants to come in, and then we will come on to looking at data from that.

Q46 **Diana Johnson:** Do you all feel that there is a joined-up approach to this issue in Government? We have talked about education; we have talked about schools; we have the Department of Health and we have NHS England. Across Government, is there now a recognition of the need to

have a holistic approach to this issue and not just leave individual schools to flounder or do whatever they can?

Sarah Brennan: Certainly, and I think the Green Paper that we are anticipating with great excitement has demonstrated that there is a recognition across Government, certainly between Health and Education, that there is a joint agenda. There is a big fear at the DFE about increasing the burden on schools, and certainly we are concerned about what resource support might follow it as well; certainly schools are concerned about what is expected of them and how they fulfil that agenda. However, there has been a distinct shift in that those two Departments completely understand that there is a shared agenda here and we need to look at how we address this realistically.

The other part, though, is how the voluntary sector fits into this, because the voluntary sector is depended on both by education and by health to fill in the gaps. It would be good if there was a way of incorporating that. Some excellent partnership work has been done, both with schools and with the NHS, because, often, all these young people we are talking about who need early intervention work go to the voluntary sector, but the voluntary sector is so poorly funded and has been dependent on these other contracts, either with schools or the NHS, to survive. That is another key part that provides the glue in these arrangements.

James Kenrick: It goes much beyond just health in schools, because you have to look at youth services and their funding, and also housing support for young people. All these things are linked up and should all be looked at together. When it comes to joint planning and commissioning of services, there is a sort of will to do it, but it seems to be almost impossible to get it to happen at the local level. I think everybody recognises that all these issues are interrelated and there needs to be a much more holistic view of how you plan and commission services, but actually making it happen is a very different matter.

Professor Wolpert: I would agree with what people have said, but would add that colleges and universities often get overlooked in this, and they are increasingly interested in this agenda. I think it is important that those are also areas where young people are situated.

Q47 **Dr Williams:** Are we currently collecting data that captures young people's experience of mental health services and data that measures outcomes that are important to them?

Professor Wolpert: We are certainly trying our very best to do so. Yes, there has been a big push to do that and there is a whole range of measures, both for parents and young people themselves, that are completed both when they come into the service and then at various points throughout their contact. There are, I think, about 20 child measures, because you can think of the whole range of difficulties that are seen in child mental health services, and about 15 parent measures. They capture ranges of issues, from general wellbeing to specific

symptoms, to functioning, to relationship issues and the experience of the service. There is a struggle to get those data in the numbers we need to really understand what is going on and what that experience is, and we are all looking to see how we can help support people to do this.

Q48 **Dr Williams:** Is that being captured by individual services?

Professor Wolpert: Yes.

Q49 **Dr Williams:** I have been a commissioner of children's mental health services in the past, and in my experience it appeared very opaque. Even though it may well have been that the services were capturing the data, it was not necessarily available to other people.

James Kenrick: I would very much agree with that. That is certainly our experience and there needs to be far greater transparency in how that data is used. There is a lot of data that the voluntary sector, for example, collects but is never utilised by commissioners. It is often fed through to them, but then disappears. The rationale for commissioning decisions is not always that clear. We have increasingly good data on access outcomes and cost-effectiveness of voluntary sector services, and that should drive better commissioning, but those commissioning decisions do not always follow the needs of young people. The critical thing here is to make sure that young people are far more involved in the design of services and ensure that the allocation of resources follows their wishes and needs.

Professor Wolpert: A major challenge if people are going to feel there is more transparency is that we have to have a more realistic conversation about what we expect to be achieved in terms of measures and outcomes. Within wider society at large, because we care about children and about mental health, we can fall into a conversation that says services have to get everyone better or they are failing. Actually, we have to be more realistic. On diabetes services, we are happy with the fact that 24% of children are now managing their diabetes.

When we did our analysis of the best practice in child mental health services in England, we probably saw about a third being able to show reliable improvement on the measures that we have, which may be flawed in many ways, and that is pretty comparable with measurement that we see internationally. It is not that we are failing in some way internationally, but we need to start having those conversations more openly and be more open about what we are expecting to see. That needs to be contrasted with the nine out of 10 young people who felt they were moving some way towards achieving their goals and so were feeling very supported by services; but, until we have that more realistic conversation, it is very difficult for providers to feel safe enough when there are so few resources available to share what sort of outcomes they are finding.

Q50 **Dr Williams:** Where would you suggest that we have that conversation?

Where does that need to take place?

Professor Wolpert: One thing I think is best practice is where commissioners and providers are having that conversation up front, saying, "What are we expecting? What are the norms? What are the baselines?" The Child Outcomes Research Consortium published our findings—and I am happy to share them with you—last year from the children and young persons IAPT services saying what we thought might be a baseline[3]. It is based on very flawed data. There may be all sorts of errors in it, but at least it is a starting point for those sorts of conversations. It is a conversation to have up front so that, when people are collecting the data, they do not feel they are going to be held against some impossible standard.

Q51 **Dr Williams:** This is my final question. What I have heard from you is that a lot of information is being collected around experience and outcome. It sounds as though the voluntary sector may be leading the way in this. Is that the same for NHS services? Are NHS services collecting data that is really important?

Professor Wolpert: Both the voluntary sector and the NHS are trying their very best to collect these data. As James has said, the voluntary sector is more used to collecting these data because they have had to for all sorts of reasons. The statutory services are really trying, so it is in the mental health services dataset. It will be something that will be looked at, and we are looking at different ways of trying to support people to do it. There are many complexities and barriers to data collection that many of us spend much of our lives trying to work out how to address, but it is being collected. I would not say it is being collected in vast quantities yet. That is yet to come.

Q52 **Dr Williams:** The reason for collecting the data is to compare and hopefully drive improvements.

Professor Wolpert: There are two reasons for collecting the data. One is to be able to compare at the service level and drive improvements, but the other is to inform clinical decision making and support shared decision making so that you can talk with young people and parents about how you are doing and where we would expect you to be, and also to be more open and transparent about when we finish treatments as well as when we start treatments.

Sarah Brennan: I absolutely agree with everything Miranda has said. There is a huge amount of work going on around data, and it is new. The other side of it, I think, is that the challenges for the clinicians and people

[3] The Child Outcomes Research Consortium, CORC (www.corc.uk.net) analysed child- and parent-reported outcomes for those accessing child and adolescent mental health services across England (2011 - 2015). All services involved were part of the Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) http://www.corc.uk.net/child-and-parent-reported-outcomes-and-experience-from-child-and-young-peoples-mental-health-services-2011-2015/.

on the frontline are that they are having to complete data for all sorts of different purposes; they find it very challenging and go to different levels. Some will go nationally; others will go locally; some will go to their commissioners; some will go to their team. They themselves feel very frustrated by the systems they are using—I am sure you are aware of this—and find it very time-consuming, so that that makes the gathering of the data more challenging for the centre because it can feel as if you are trying to pull teeth. There are lots of challenges around it as well. That is all really, as a balance.

Q53 **Dr Cameron:** Earlier you said that there were some gaps in the outcome and the research evidence base. What are the significant gaps that you would like to see addressed?

Professor Wolpert: For me, the biggest gap is trying to know about the sort of support that can be provided that is not in a clinical context. We all believe in early prevention and early intervention, but we have lacked a really rigorous research base about the sorts of things people have talked about—exercise and things that people can do to manage their own health. This is not to say that you only need that and nothing else, but we need a more rigorous evidence base on that to be able to balance up what we should be providing and where we should be putting our energies.

Q54 **Dr Cameron:** Are there issues in terms of clinical treatment outcome research that you would like to see?

Professor Wolpert: That also could do with more evidence. I think again we need to get better about understanding the core components that help, rather than trying to compare things that have been artificially compared by ownership, in a sense. We are learning, and as a research community we are increasingly interested in trying to look at what are the core facts that make a difference, whether it is in a school, a clinic or a voluntary sector provider, trying to disentangle what those things are. That is what we should be focusing our energies on doing.

Sarah Brennan: To come back to simple things, as was mentioned earlier, for instance, for a young person receiving a text can change how they feel. Sometimes we can ignore them. It is one of the key components that is very important, because it can be just about how you are treated or how you are helped along the way through the system in very simple ways rather than a particular type of treatment model. It can be how things are done rather than the actual clinical intervention itself.

James Kenrick: Can I add on that that it is really important that the system incentivises prevention and early intervention? That means there is a lot of work, as has been alluded to, around tackling the causes of mental health problems and social determinants of young people's mental health. If we do not count any of that and we only count clinical outcomes and presenting issues, then there is not going to be an

incentive for commissioners to develop a system that puts prevention at its heart. If we only measure clinical outcomes, that will not be the case.

Q55 **Dr Cameron:** So you are looking for holistic data really.

James Kenrick: Yes.

Professor Wolpert: For example, South Derbyshire agreed a common outcomes framework across social care, health and education, so there are opportunities to do that and to look at those wider moderators as well.

Q56 **Dr Caroline Johnson:** I want to ask some questions about demand. Anecdotally, working in a children's ward, which is what I have done as a paediatrician—I am a consultant—when I first started practising it was common that about once a week we would see a young person, usually around 15, admitted to the ward having taken an overdose or had some episode of self-harm. Often, if they came in on a Friday, they would have to stay all weekend because there was no weekend provision for them. Nowadays, there is weekend provision, so children are able to go home more quickly, but we are seeing—or certainly I am seeing—much younger children and many more children, so it is common to have at least one child experiencing that sort of stress on a ward at any given time rather than once a week. What do you think is driving that increasing demand in young people?

James Kenrick: There are four things I would identify. The first is a positive driver, which is reduced stigma. That is a good reason for there being a high demand. The other three are not so positive. First, there is a rising level of housing and money problems that we are finding in young people.

Q57 **Dr Caroline Johnson:** Do you think that it is affecting the under-16 age group?

James Kenrick: Not so much the under-16s, no; that is more—

Q58 **Dr Caroline Johnson:** I am thinking of children admitted on to children's wards—under-16s.

James Kenrick: I have less experience of that. That would not affect them, although it might be affecting their families—

Sarah Brennan: There are the social determinants of mental health, absolutely, and family poverty.

James Kenrick: I would also point to cuts to other services. Children's social care, youth services and housing support all have an impact on their mental health needs; also, the rising thresholds in CAMHS, which are a result of rising demand, have certainly led to a huge increase in demand for voluntary sector services. We are increasingly finding that GPs, social workers, teachers and CAMHS themselves are referring far more cases directly to the voluntary sector—the types of cases that would

not have come to the voluntary sector in the past where there is sometimes quite severe and very complex mental health need that, ideally, probably would not be dealt with in the voluntary sector. Some GPs often find that it is simply not worth spending the time it would take to try to make a referral of a young person to CAMHS because they are not going to get in there, so they are increasingly referring directly to voluntary sector services.

Sarah Brennan: I would agree with those factors completely, but we also need to take into consideration the changing nature of childhood and the fact that the experience of childhood has changed. We are kind of catching up with that. In terms of risk taking and children learning about risk-taking behaviours, about self-management, in some ways they are in a very risk-averse society, where they are very closely managed or monitored. But then, in terms of the internet and social media, they are very open, with no risk management. Also, we know that clamping down does not actually help children build resilience. They need to learn how to manage themselves safely on the internet. That is another factor that we have to take into consideration when we consider what is happening.

Q59 **Dr Caroline Johnson:** That is the children you see at the more severe end—the children who are admitted to acute paediatric wards who have taken overdoses or hurt themselves in some way.

We looked at some of the figures in our briefing about children who had taken their own life. It demonstrated that 60% of those young people—we are talking about children—had been in contact with mental health services in the recent past. There are two questions that come from that, one of which is, what are we missing such that we are not able to identify those children before this happens? The second is, why are we identifying the other 40% at all before they go to the point of taking their own life?

Sarah Brennan: I do not feel completely qualified to answer this in detail, but in terms of the 60% who had been in contact with CAMHS who then go on to take their own life, is your question why?

Q60 **Dr Caroline Johnson:** If we know that, why are we not able to identify those children and put grades of intervention in?

Sarah Brennan: So the 40%, and why we are not identifying them.

Q61 **Dr Caroline Johnson:** There are two groups: children who have been to mental health services for support and, for whatever reason, have not managed to access support that was adequate to prevent that outcome; and then there is another group of children who are not accessing any support at all, in which it seems there are no obvious concerns and then there is that devastating outcome. What more can we do to predict which children might be vulnerable to this sort of thing, and what can we then put in to prevent it?

Sarah Brennan: I think there is also something about the numbers of young people who do take their own lives. In terms of young people, we

have been successful in reducing the suicide rate. I think there has been some success in that, although we have seen a change, certainly for young men in their 20s, and there has been experience of self-harming indeed beforehand.

In terms of the access of young people who then go on to take their own lives, this is also something about education and an awareness about spotting changes in young people's behaviour and mood, so identifying in general. This is not about, necessarily, people who have never been to services. It is about spotting young people in distress and spotting the signs. This is a public health education programme. We have a parent helpline, and certainly a lot of parents are saying, "Is this something to worry about? I don't know." That certainly is one factor for those 40%, and for the 60% I would not feel able to comment, not being a qualified clinician, about why that help was not then successful in terms of the outcomes for those children. I would not want to go there.

Q62 **Dr Caroline Johnson:** My final question is, how do you define "poor mental health"? We have talked about early intervention and different rates of prevalence. It was said in our briefing that poor mental health now affects one in 10 children. I guess what I am asking is, what defines poor mental health? What is defined as normal adolescence and part of adolescent growing up? We have all been adolescents at some point and it is a difficult time. How do we ensure that children recognise that some of what they are going through may be normal and then teach them how to deal with that, and how do we recognise which children have a medical problem that we need to deal with?

Sarah Brennan: The one in 10 is about diagnosable mental health problems as well, so it is not even poor mental health; it is quite severe to be diagnosable. What you are raising is a really important point, which again is about public health education, and, also, all the children's workforce should have some basics in their training on child development. We are talking about just child development. You are absolutely right that behaviours change in adolescence—everything changes in adolescence—and for parents and teachers it is very confusing as well as for the young people themselves. This should be something that is openly discussed and understood and those behaviours should be recognised. This is ourselves; this is our next generation.

One thing that we call for—I know a number of organisations do this—is that anybody working with young people should be expected to have the basics of understanding both of development and of the signs of difficulty, as well as what you do about it in terms of their mental health and wellbeing, because this is about normal experiences and normal growth. Even a happy, healthy adolescent needs help sometimes. This should be seen as ordinary and normal, not problematised immediately as being, "Oh, and this now needs a special service," because for many young people that is not the case.

James Kenrick: The only thing I would say about that is that, of course, some young people do not know what their problem is and they might not present to a mental health service because they have not necessarily categorised themselves as having a mental health issue. What is really important is that they have access to some kind of service that they can go to when they know they need to talk. They have an issue, but they do not know necessarily what it is. That is where early intervention services are absolutely key; if you have a service that allows a young person to explore whatever issues they have, an emerging mental health issue could pop up in one of many different ways. It is important that they have a place they can go where they can talk about a range of issues without necessarily having to have a diagnosis and it being clear that they need a mental health service.

Dr Caroline Johnson: I think you are right that it is important not to medicalise normal adolescence, but, equally, I did the mental health first-aid course. I have to say I found it very educational and would definitely recommend it—it is being rolled out nationally—just to give everybody a very brief overview of how to approach this sort of problem.

Chair: Thank you. I know there is a quick follow-up from Luciana and then we are coming on to Lisa's question.

Q63 **Luciana Berger:** This is an extension of the question you have just been asked about those young people who very sadly take their lives who were in contact with services. It is a question for Sarah. We heard from the Association of Educational Psychologists. It surveyed its members—and some of their members came back to say that CAMHS was only providing a diagnostic service rather than ongoing treatment. They said that children were assessed but then their case was closed; that there was no intervention other than diagnosis. Does that chime with anything you have heard from the young people that you engage with and/or their parents?

Sarah Brennan: Sometimes there can be the initial assessment and then sometimes with CAMHS there is "watch and see". Sometimes you do not want to intervene because intervening can make things worse rather than better. Also, it is again about the thresholds, about whether CAMHS feels that they can help this young person in terms of their own workload. Certainly, we hear in particular from parents about their problems of accessing CAMHS and that they can have an assessment but then no further service. Again, that can be very confusing and problematic. Even if it is for a good reason, for a parent, that can still be difficult to understand.

Again, I think how information is passed over is very patchy across services, and how parents are involved and engaged is also very patchy across services. Especially for children, they are a key player in this. They are generally the main advocate for their child. They are the person who is chivvying and knocking at doors, and they are the people who feel overwhelmed, worried, guilty and confused about what is going on. There

is a gap potentially in how the parent is involved in that and understands what the reason is for that gap.

Professor Wolpert: I completely agree. We had an earlier conversation about it being about trying to embed services across agencies. We need to find a way of communicating that so that people do not feel that CAMHS is the only way of getting help. I do not know in those particular instances whether or not it was appropriate, but certainly there would be some cases where it is better for that young person to get support outside of the health service, whether it is in the voluntary sector or their schools or communities, because, long term, with some of these difficulties that are relapsing and remitting, you want to try to help people within their communities rather than take them off to a particular specialist for whom they may have to wait a long time. I think it is about trying to communicate that and to give those services the equivalent status that they deserve.

Going back to the mental health first-aid kit, it is great to hear that you found it useful, but I would also remind people that there is this free resource called MindEd, which was developed by the Royal College of Paediatrics and Child Health and the Royal College of Psychiatrists. I think it is extremely useful, and teachers and others may find it very helpful, if they want to have a look at that.

Chair: Thank you for that.

Q64 **Dr Cameron:** This is about the structure of service provision. Can we address the mental health needs of children and young people within the current structure of service provision, or is there another approach or model that you think is required?

Chair: Who is going first?

Professor Wolpert: I could start on that one, since I have created a model. Colleagues and I have thought about something called the THRIVE model, which is an attempt to conceptualise—have a framework that would allow multi-agency support in using a coherent language of getting advice, getting help, getting more help, or getting risk support as a framework. It is not trying to say that you have to structure services using those categories, but it is trying to get a common language across agencies that people can pull around. It is a balance. No organisational structure is perfect, so trying to find the ideal organisational structure and restructuring to that is a huge burden and stress on everyone, but we all want to find a common language by which people can make imperfect services work, and in particular collaborate together and be less fragmented. Some of the examples we were seeing were at St Helens and Knowsley, and in Manchester, where they have No Wrong Door, which means that one door gets you access. That is what we want so that parents and young people do not have to navigate themselves—so that the system helps them navigate without having to understand its complexities.

James Kenrick: The absolutely key principle should be that services are built around the needs of children and young people, not the needs of the system. That is the seismic shift, which was mentioned before, that is needed. I still think that services are built around silos and bureaucracies. It kind of meets the system's needs. If you construct things so that the design of services is entirely built around young people's needs and they are involved in deciding where resources get spent as well, you end up with a very different structure of services with far greater emphasis on the easy access, integrated young person-centred services in the community that support young people all the way up to the age of 25. At the moment, the system does not allow that to happen, unfortunately.

Sarah Brennan: We also have to recognise the chronic underfunding of these services. We have had now nearly three years—two and a half years—of increased funding. Change does take a huge amount of time, but, as freedom of information requests have shown year on year, although the new funding is going through, the block contract of funding that goes to trusts for funding of mental health services has been shrunk at times. The investment is not even across the country. CCGs have not always continued the funding, so there has not been the net increase that there should have been. It is almost like we have not given this a chance to actually happen yet.

As much as we need it, exactly as Miranda is saying about THRIVE, and exactly as we need to improve how the structure operates, we need to follow the route map we set out, which is still not able to completely do its bit because of local leadership. We cannot just depend on local leadership, which is sort of how it seems to end up happening, and there has to be a much bigger thrust not just in words but in action about how the resources reach the services and do not get filtered off for other things that are seen as more important along the way.

Q65 **Dr Cameron:** Do we need more flexibility for more complex cases such as dual diagnosis or where someone has perhaps a learning disability and a mental health problem, or a mental health and an addiction problem developing? It seems as if the system tries to compartmentalise conditions.

James Kenrick: It is again where the need for joint commissioning comes in. One thing we have been trying to encourage over the last few years is a joint planning and commissioning approach across a number of different services to get out of the siloed approach. We have attempted to do that in some local areas, but, as I mentioned earlier, it is making it happen that is very difficult because people—the commissioners and the politicians—in the end find it very difficult to make it happen.

Sarah Brennan: With the changes in SEND, there was a window of hope again because mental health needs were included and young people were seen as whole people. On the "Future in Mind" report, I co-chaired the vulnerable young people's group. We realised very much that there would be any number of vulnerabilities and we would end up carving up young

people into issues rather than seeing them as people with different needs. We know also that learning difficulties and traumatic experiences have a direct impact on a young person's emerging mental health, maybe not immediately but down the line. It is about how we do that joined-up thinking and how we assess young people in terms of their whole needs. But I think that is also a training issue as well as a structural issue. We are very good at carving up according to particular issues. How do we bring those funds together to respond to the population in a local area, maybe through place funding?

Chair: I am very conscious of time because we have another panel, but thank you very much. We are going to come on to our last question from Luciana.

Q66 **Luciana Berger:** It is an extension of the points that have been made about funding and a question to all of you as to whether you believe there is adequate funding available to support all children and young people with their mental health needs. Do you believe that the money that we have been told has been made available is actually reaching the frontline, and, if it is not, what do you think should be done about it?

James Kenrick: The proportion of all mental health money spent on children and young people is clearly too low. There is a problem with getting the new moneys for children and young people's mental health to the frontline. We would all be far happier about the funding if it was all being used as intended. To that extent, the level of funding, I would say, is only part of the issue. It is just as much about how that funding is used. That is very much what young people say to us. Whatever funding there is, they want it used an awful lot better. The issue there is ensuring accountability and greater transparency about how moneys are used. That lack of transparency is fomenting fragmentation and creating division between providers at local level, and causing quite a lot of anger among young people as well.

Professor Wolpert: As people have said, we all acknowledge that child mental health services have been the Cinderella of a Cinderella service. There is evidence of initiatives coming through that are very exciting. There is evidence across the country of people trying different things and of money being used in creative ways. For me, it is about making sure that we learn from that in a systematic way so that we can then start developing an evidence base that is wider than the one we have now.

Sarah Brennan: In our FOI, we found last year that, of 50% of CCGs who responded, only 50% increased their current spend to reflect their additional Government funds. I think that says it all, and CAMHS has 0.7% of the NHS budget.

Q67 **Luciana Berger:** In your FOI, of those 50%, you said that some CCGs were using extra money intended for CAMHS for other priorities. Did your FOI flag up what other priorities money is being spent on?

Sarah Brennan: Yes. Often, what CCGs say is that they have to spend it on the emergencies, and that is A&E and hospital beds, so it is the perception of mental health as not being the utmost crisis and emergency to fund.

Q68 **Luciana Berger:** In the previous session we had with the Children's Commissioner, she said she believed that we should ring-fence the money available for children and young people's mental health. Do the panel share her view?

James Kenrick: I think that would probably improve things. I know there are arguments against it, but I think, on balance, we would probably support that.

Professor Wolpert: I would want the money to get to CAMHS. Whether or not ring-fencing is the best way of doing that, I would bow to others' expertise.

Sarah Brennan: There has to be accountability and transparency. There seem to be pros and cons to ring-fencing, but there still is not the transparent accountability about where the money goes—all the money, not just the additional money—and trying to track the money is a minefield.

Chair: Thank you all for coming this afternoon.

Examination of witnesses

Witnesses: Jackie Doyle-Price, Jonathan Marron, Claire Murdoch, Tim Kendall and Chris Roebuck.

Q69 **Chair:** Thanks very much to our final panel of the afternoon. I am sorry to have kept you waiting. For those following from outside, would you mind starting by introducing yourselves, starting with you, Chris Roebuck?

Chris Roebuck: Yes, certainly. I am Chris Roebuck. I am head of profession for statistics at NHS Digital.

Tim Kendall: I am Tim Kendall, the national clinical director for mental health, NHS England and NHS Improvement.

Jackie Doyle-Price: I am Jackie Doyle-Price. I am the Minister for care and mental health.

Jonathan Marron: I am Jonathan Marron. I am the director general for community care at the Department of Health.

Claire Murdoch: I am Claire Murdoch. I am the national director at NHS England for the five year forward view for mental health. I am also the chief executive of an NHS trust—Central and North West London NHS foundation trust.

Chair: Thank you very much. Andrew is going to open the questioning.

Q70 **Andrew Selous:** Good afternoon. I would like to start with the area of equivalence between child and adolescent mental health services and adult mental health services, particularly why we lack equality in both the monitoring of them and the targets set for children and young people, compared with adult mental health services. I have a brief quote from the report of the CQC—the regulator—from last month, which states that "it is…difficult to get a clear picture of what services are available in different parts of the country and whether these services adequately meet the demand for mental health care," and they go on to say that "there is no reliable data to tell us how many children and young people can be cared for across the mental health system."

Perhaps starting with you, Minister, that is not really good enough, is it?

Jackie Doyle-Price: It is not. I would agree with a lot of what has been said there, and that really is why we are where we are in terms of prioritising children and adolescent mental health as part of the Prime Minister's overriding priority for mental health. We know that the majority of people who suffer poor mental health in adulthood present with symptoms before they are 18 and certainly before they are 24. It is clearly evident that the more we can do to support children and young people, the more success we are going to have in looking after everyone's mental health. That is very much our starting point.

This is a transformational programme. We want to improve significantly support for young people with mental health issues. You are absolutely right that, when we started out on this journey, the data was extremely poor. Until we have a robust body of data, it is difficult for us to use data reliably to draw any clear conclusions and indications on where to go, but we are on it. We have started collecting much more meaningful data and we are starting to develop that body. I do not know if Chris wants to add anything on that.

Chris Roebuck: It is fair to say that adult mental health has had a big head start in terms of data, but over the last few years we have started to capture a lot more data around children's mental health, most notably by extending the mental health services dataset to include children from 1 January 2016. It takes a while to build up a set of data around it, but we are publishing, as an official experimental statistic on 30 November, the first annual report drawn from that dataset.

The other big area is the prevalence of mental health conditions among children and young people. The last published survey specifically on this was from 2004. However, a new survey was commissioned. Our contractors have completed the field work, and that is going to be published in November next year.

Q71 **Andrew Selous:** I would point out that the CQC report is from last month, so it is a very current report. Another thing it goes on to say is

that data on children and young people is reliant on voluntary self-reporting from providers and therefore may not be representative of all providers. Again, that is not really good enough. Are there other proposals to make sure that this data collection is mandatory and not voluntary?

Chris Roebuck: It is mandatory for all NHS-funded care. It is not mandatory for local authority-funded care, but some local authority-funded care providers submit that data.

Q72 **Andrew Selous:** These services are being provided with public money, so my question still stands, perhaps to the Minister as well: are there proposals to look again to make sure that we do have robust data? Given the long history of poor data collection, is this an area where you would go and have a look just to make sure that what is being provided by the voluntary sector, which we heard in the earlier sessions is quite significant in some areas, and paid for with public money is properly reported?

Jackie Doyle-Price: Absolutely. We have made significant changes in this area. If we go back two years, the data was extremely poor indeed. I am not satisfied with where we are, but the direction of travel is positive. Bearing in mind that we are using the mental health dashboard as our indicator and measure of where we need to direct attention to improving performance, it is essential that we improve data in this area, and we are on it.

Q73 **Andrew Selous:** That leads me on to my next question. When can we expect the data available for children's services to be equivalent to that for adult services?

Jackie Doyle-Price: As to "to be equivalent," again, we need to build up that data over a number of years. I do not know if Jonathan would like to comment.

Jonathan Marron: This is the first time we have collected this data. The mental health services dataset is the first national dataset that has included children's mental health services. We have just started recording that and we published it for the first time in April. We are trying to publish early. We know that the statistics are not quite right. We think it is much better to make this transparent and get the data out. We think that if we use it people will respond by filling it in. That is where we are. We expect the data to improve. We are working hard at NHS Digital, NHSE and the providers to improve the quality of the data each time it is submitted. We should see improvements rapidly.

Q74 **Andrew Selous:** Given that we have established the model with adult services, it should, I would have thought, therefore, be quicker and more straightforward to get to the same level with children's services, given that we have a template from the adult side to act on. Would you accept that?

Jonathan Marron: I think that is a reasonable assumption.

Q75 **Andrew Selous:** Just looking back at work that the predecessor Committee has done, a lot of these points were raised back in November 2014—concerns about data availability and funding getting through to the frontline—and yet here we are. This Committee is back here three years later to the month raising the same issues. We are really looking for some confidence that a future Committee will not be here in three years' time still going over the same ground.

Jackie Doyle-Price: That is an absolutely fair challenge, but when we look at datasets there are some aspects of data that are easier to collect than others, which are straightforward measures of waiting times, seeing people in and people out. But, if we are really measuring performance and the extent to which we are delivering, data collection is much more complex and does rely on us having a good survey and assessment of prevalence. Accepting everything you have said, coming back to what Chris said about doing that strong analytical survey, which again is a lot of field work and a lot of intelligence, that is done less frequently. Over time, that is going to give us a much more robust collection of data. Again, I cannot emphasise enough that we are on a journey here and I appreciate the Committee's impatience—and, actually, I am impatient too—but we are where we are because we are starting from such a poor base.

Q76 **Andrew Selous:** On the proportion of total mental health spend that goes on children, we heard from the Children's Commissioner for England earlier that—if I heard correctly—children are 20% of the population and yet they only get 6% of the mental health spend. Surely if they are 20% of the population, we should even that up to 20% of mental health spend.

Jackie Doyle-Price: Overall, we are spending 11.6—

Q77 **Andrew Selous:** I am talking about the proportion of the total spend that goes on children compared with adults. You have told us about the data journey you are on, and we welcome that and will watch carefully to see it happening. I am asking about the proportionate split of what we do spend—I am not talking about the size of the cake but about how we divide it up—between adults and children. Children are 20% of the population but get 6% of the spend. It seems seriously out of kilter; that is three times less, proportionately.

Jonathan Marron: On the general point of whether we spend enough on children—

Andrew Selous: Proportionately out of the total.

Jonathan Marron: The challenges are whether we spend the right amount on children and meet the needs that are out there? On the best data we have, we think we are reaching around one in four children with a diagnosable condition. Our plan is to improve that to one in three. One

in three still does not feel like we have finished the job and there is still much more to do to get mental health services for children that meet the needs in a way that we would like.

Q78 **Andrew Selous:** Let me put the question another way one last time, if I may. Why would it be unreasonable to spend a proportion of existing mental health spend that represents the proportion of children in the population as a whole?

Jackie Doyle-Price: Being crude about it, I guess it depends on the mental health condition, however many years people are going through treatment. It is very crude, but what is sitting behind your question I agree with wholeheartedly, which is that the balance is not quite right. Again, the more that we can do to improve treatment of children and young people, the more we can tackle people with poor mental health earlier and the better outcomes we will achieve all round. In a sense, the fact that we are spending a greater proportion on adult mental care is itself symptomatic of an earlier failure.

Chair: We do have some more detailed questions on funding specifically, so perhaps now would be a good point to come to those. We will come to Luciana and I know several colleagues have follow-up points to ask.

Q79 **Luciana Berger:** Where else in the health service is it our ambition to have a target of, essentially, ignoring 65% of children with a diagnosable mental health condition? Where else in the NHS do we say, "Our ambition is only to support 35% and we will ignore the rest of them"?

Jackie Doyle-Price: I do not accept the premise behind your question. We will always make sure that people can access treatment based on clinical need. Just looking at the data on this, a mental health condition can cover anything from behavioural issues right up to psychosis, and it is a matter of clinical judgment where appropriate interventions are needed. At the moment we are treating one in four. We think one in three will be more realistic and will be a better service, but I would not characterise that as ruling out treatment for 65% of people in clinical need because I do not accept that is true.

Q80 **Luciana Berger:** Yet the majority of the evidence that this Committee received was about the increasing thresholds; too many young people across our country have to have suicidal thoughts or have attempted to take their life in order to access treatment. Is that a situation we should find ourselves in?

Jackie Doyle-Price: I do not agree with that analysis either. I will come to Tim, because he can speak with far more authority than I can on this, but we have put in very clear targets for treatment for those at a stage of acute psychosis and for those with eating disorders, recognising that that is the biggest killer. Those are particular targets and we are more than meeting them. People can achieve treatment very promptly indeed. Beyond that, it is an issue of clinical assessment as to how promptly they receive treatment, but perhaps I could bring you in, Tim.

Tim Kendall: It is worth saying that across mental health we are starting at a lower level than a lot of other parts of health. For example, at the moment we only reach 15% of people who have depression or anxiety. The investment that is going into IAPT services is to increase that to 25%. It is not just children who are not getting services. I absolutely agree with you that one third is shocking, and whenever I stand up at conferences and say that we are going to improve this from one quarter to one third, my heart often sinks. It is true that dementia was a very similar story, if you go back 10 years. An awful lot of mental health is catching up.

Q81 **Luciana Berger:** But we have had enshrined in law since 2012 parity of esteem for mental health. We are supposed to be achieving equality for mental health, and yet I cannot think of any example in physical health where we endeavour, aim, achieve or have the aspiration of treating only a third of people affected with a condition.

Tim Kendall: We have to do it step-wise and there are some very good practical reasons for doing this step-wise. We cannot just suddenly expand the workforce from what we have now to a workforce that could cope with everybody and every child, whatever age, with a mental health problem. We do have limitations about how fast you can do this, but I am absolutely aware that, when Simon Stevens was at the Public Accounts Committee last year, he made it quite plain that where we are going to end up with the five year forward plan for both children and adults is not the end of the story.

Jonathan Marron: It is not really fair to characterise the five year forward view as our ambition. The five year forward view was about what we think we can achieve in five years given the very low starting point we have come from. It was a credible plan to invest. We should see an extra 70,000 children per year treated by 2025[4]. We are already seeing that 21,000 extra were treated last year. The increase in resources to children's mental health services last year was 20%—over £100 million. These are big increases—with large numbers of staff coming on. There is a limit to how quickly you can grow a service, so I think we are making real strides to make improvements here. It is very clear that the Government do not accept this is all that is intended, which is why the Prime Minister announced the Green Paper on mental health and we are working with DFE on the next stage of this particular policy story.

Jackie Doyle-Price: Essentially, parity of esteem is a massive cultural change given our starting point, and that will always take time to bed down. I say again that we are on a journey, that our direction of travel is positive, but there is some way to go.

Chair: Lots of colleagues want to come in—Caroline, Diana, Johnny and Paul, so let us start with Caroline.

[4] The witness has supplied a correction. He should have said "by 2020" rather than "by 2025"

Q82 **Dr Caroline Johnson:** I have a couple of questions. We have heard about the increased investment in mental health, which is brilliant. We have also heard about the need for better data and better evidence. I recognise, as a doctor myself, the need to have an evidence base so that we know when we are providing treatment or care that it is actually going to make someone feel better and not just be something that we provide so that we can say we are doing something. Also, collecting data, creating and measuring targets and creating a dashboard—all these things we have talked about today—cost money and take time. How will you ensure that when you have this money to spend it is directed at caring for children and young people and not on collecting data and measuring what you are doing?

Jackie Doyle-Price: That is a subject very close to my heart, it has to be said. We have to make it very easy. We have the mental health dashboard, which allows the collation of those figures. Again, the most important thing we are trying to do here is not measure inputs and outputs. We are trying to achieve better outcomes, and that is really what is sitting behind this. We are, obviously, telling CCGs what we expect of them by way of outcomes. We are making additional money available to them. We are also saying to them, given it is a priority, that we expect them to make more money available than that which we are giving them, and we will measure their performance on that. They are actually quite simple measures to capture but are a good indicator of how CCGs are responding to the challenge.

To be fair, in the main, they are. We know that we have given across the board an extra 3.7% to their baseline budgets to deliver extra services. In actual fact, overall, they are spending an extra 6.7%, and through our dashboard we can identify those CCGs that need to do better. Certainly, Claire is overseeing that and has been giving the appropriate challenge. I do not know if you want to say something about that.

Claire Murdoch: I am happy to. If I might say so, the five year forward view for mental health will see a 70,000 increase in children seen in specialist CAMHS. We will invest £1.4 billion in doing that. That money will support a really clear targeted set of interventions and service developments. It is vitally important that we flow the data, flow the money and understand the outcomes. You have heard that an enormous amount of work that really is post-2016 and supported by the new investment continues to 2021. The job will not be done then, and I think everybody who has supported the ambition of the five year forward view for mental health sees it as a step along the way.

The other thing that is really important, and we will no doubt return to, is that it is not all just about the NHS. I have been very gratified to hear the questioning of this Committee that recognises that. We know, or believe really, at the moment that some 73% of CCGs nationally have uplifted their spend on CYP mental health. As you say, we also know that the average uplift for the NHS last year was 3.7%, the uplift in spend on

mental health was 6.8%, and the uplift on spend for children and young people was 20%. What we are starting to see, I believe, is the slow turning of the oil tanker.

There is much more to be done. We use the dashboard, which is a CCG-by-CCG breakdown of spend, outcomes, activity and access waiting times to drive transparency. It is fair to say that in its first year of operation—I think we are on the fourth publication of that quarterly dashboard—it is driving as many questions as it answers. I both apologise for that, because the data is not yet perfect, and sit here unapologetic for it because we are putting experimental and new data into the public domain. People such as yourselves, MPs, service user groups, the local public, us through CCGs, STPs and the regions, the Royal College of Psychiatrists and the Royal College of Nursing, all the YoungMinds third sector organisations, are all scrutinising that data and trying to make sense of it. There is no doubt that in many instances that scrutiny and shining a light on it will help us perfect it.

Q83 **Dr Caroline Johnson:** You mentioned the CCGs. We heard earlier from the CQC on how they decide whether a service is good or requires improvement. They are examining the provider trusts to see whether they are providing the service well, but they provide what they are commissioned to provide. If the CCGs are commissioning a service that does not meet the needs of the population because the thresholds are so high but that service is provided well, is that a good service or a service that requires improvement because it is not meeting the needs of the population?

Jackie Doyle-Price: Coming back to where we are in this journey, the CQC have been very frank in their advice to us about that and we have commissioned them to do more work. There is a challenge to commissioners, and, as Claire has just outlined, we are on the fourth iteration of the dashboard, which is showing things. Some questions probably have sensible answers; some perhaps do bear more examination. It comes back to what I said earlier. We have started from a very low base and we need to have a good pattern of data before we can draw any robust conclusions from that.

It is very clear in my mind that there may be some more challenges we need to give to commissioners in terms of what makes good commissioning. Good commissioning does not necessarily mean, "This is my budget for my service. You provide what you can according to it." Good commissioning may be something else, but we need to do a lot more work. Again, the work that is happening via NHSE in terms of supervising what is going on locally will help feed that.

Q84 **Diana Johnson:** My question is for Chris. I think you said in your comments that the prevalence survey data would be available next November. Did you mean next November?

Chris Roebuck: Yes, this time next year.

Q85 **Diana Johnson:** It takes a year to work that out. You said that the work had already been done to—

Chris Roebuck: The field work, the collection, is done, and these are expert contractors dealing with it—the NatCen Social Research. Essentially, there are very lengthy interviews with all the subjects, and then trained psychologists go through and write up and clinically code the diagnoses. Then various statistical techniques are applied, so it is on a subset of the population, but to draw the inferences then across the whole population. These big surveys are done infrequently. They are really big academic exercises. It is important to get them right and they are used for years to come, so doing that is an intensive process.

Tim Kendall: It is these surveys that have told us that there are four times as many children out in the community with a mental health problem diagnosable by the clinicians than we are getting inside services. These seven-yearly cycles for both adults and children are absolutely essential for us to be able to know what we have out there.

Q86 **Diana Johnson:** The last one was done in 2004. So, when you say a seven-yearly cycle, how can that be right?

Jonathan Marron: The adult survey has been repeated every seven years. It has taken a bit longer to get round to children.

Chair: The follow-up was cancelled in the last year of the last Labour Government. It was one of those issues that, as I understand it, has now just been reintroduced.

Q87 **Johnny Mercer:** When it comes to spending public money in this way, clearly we have to account for it all and we have to get something for it. I do not understand why some of these schemes have gone ahead and you do not have some of this data already. If you just push off public money on to a project and then have no accountability for it, that is called tokenism. Where is the accountability for some of these schemes?

Jackie Doyle-Price: We have data on how money is being spent and performance at CCG level. What we are talking about now is how we measure what we are delivering against society's wider demands.

Q88 **Johnny Mercer:** I understand that, but in one of the previous panels we had a very long conversation about how underfunding and strategy for mental health was driven by data, statistics and analysis. What you are saying is that we are at such an immature stage in collection of children's mental health statistics that we are still trying to formulate that. I am asking where all that public money has gone previously into this stuff, and where are the tangible results that these guys can scheme and plot child mental health strategies on?

Claire Murdoch: There is an enormous amount of evidence out there about the onset of mental health problems in childhood, and interventions that work, and certainly my colleague Professor Kendall will

say more about that. I would also say that Future in Mind and the five year forward view taskforce spoke to some 21,000 service users, professionals, public and others to see which things have the strongest evidence base and would respond best to either new or a greater reach of investment. For example, this year we have set up 70 community eating disorder services across the country because we know from evidence that an increasing number of young people are suffering from eating disorders and so on and so forth. So, there is evidence there.

Q89 **Johnny Mercer:** Of course, yes. If the evidence is there, why are we not picking best practice in areas across the country, and why are you at an NHS level not pulling together best practice, taking command of the situation and saying, "This is what is working in some of our most vulnerable communities. Therefore, we are going to roll it out across the country."?

Claire Murdoch: We are doing that, and Professor Kendall may say more about that work.

Jackie Doyle-Price: I think we are doing that. Claire has just mentioned the 70 eating disorder teams. That is very much drawing from best practice. We are being very frank about the challenges there, but we have made considerable progress since we have made this a priority.

Johnny Mercer: I don't doubt that for a minute.

Jackie Doyle-Price: Twenty thousand more children were treated in the last year, so the direction of travel is positive.

Q90 **Johnny Mercer:** No one disputes that the service continues to improve absolutely, but the demand that we see in our constituencies is growing exponentially as well, so it is a race to close that delta, is it not? My question is, why does it take such a long time? You mentioned November there; you have explained it in terms of your academic studies and I get that. But we are not going to win a race if it takes 15 months, as Diana said, to analyse some of this data.

Jackie Doyle-Price: There are two issues here. There is the data we talked about just there in terms of prevalence, which I think is a long-term academic exercise, and then there is the data about performance relative to inputs, which is what we are looking at quarterly. That is where we are going to get that granular activity at the coalface where we see what really works. We are probably just entering the phase where we can spread so much more of that out across the country.

Claire Murdoch: For example, we are investing in perinatal services, which do affect the newborn, the infant and their lifelong chances and other children in a family. We have said that we will see an additional 30,000 women by the end of this period. We have set these teams up in 90 CCG areas this year, and we have a second wave about to go live. That is all underpinned by an evidence base about the interventions of specialist perinatal teams and the impacts they can have on the life

chances of the infant, the mental health of the mother, the economic status of the father and family, and so on and so forth. So, there is a very big economic human and clinical evidence base that underpins the things we are doing. Bringing children back from tier 4 beds closer to home is another aim, and so on and so forth.

I like to think that everything we are doing in the NHS programme between now and 2021 has a strong evidence base. We know how many people in each of those services we want to see, but we need to know that that nests within the third sector, local authority, education and wider societal schemes of primary care.

Johnny Mercer: Thank you very much.

Q91 **Dr Williams:** We heard from the Children's Commissioner earlier that we need a seismic change, but what I have heard from this panel is that we are on a journey—the slow turning of a tanker. Can I suggest to you that, despite there obviously being an increase from really not enough money to still not enough money, we have heard a story today of a child who is having suicidal thoughts who did not meet the threshold because they had not actually attempted suicide? Can I put it to you that we are rationing suicide prevention here because we do not have enough resource being put into this? Despite all of you obviously caring about what you are doing, you are having to defend underinvestment in children's mental health services?

Jackie Doyle-Price: I do not accept that at all. This is a step change in children's mental health services. I would be more than happy to look into the example you have just given me, because that is certainly not a situation that is in any way acceptable or should happen. I would be more than happy to look into that.

The reality is that, when you are trying to embed cultural change of the size that we are talking about here, it does take time. It is not something that can be done overnight, and, to be honest, the fact that we have seen such a step change already is, for me, something that we should be proud of. In truth, the NHS has stepped up to the plate to deliver this, and I think that is a matter for celebration. Ultimately, we should never be complacent about what we are trying to achieve here, and there will be room for improvement. We will always find extra places to go. I do not think there is any need for pessimism here. There is every need to hold our feet to the fire to make sure we deliver, but this is a significant change in the direction of provision that we are making for young people.

Chair: I can see that Tim wants to come in here.

Tim Kendall: I just want to make it completely clear. We are starting from a low base, I have no doubt, but we will now have community-based eating disorder services across the whole of England by the end of this year. That has radically changed the waiting time for getting access to those services. Before, it would not be uncommon that you would be

told you had to wait 18 months for your first appointment. We are now at the point where approximately 75% of all kids who are referred in to these services are seen within four weeks if it is not urgent and within one week if it is urgent.

The same applies to early intervention services. Early intervention in psychosis starts at 14. They cover the whole of the country and they are reaching about 75% of people, who start NICE-concordant treatment within two weeks of referral. That has had a massive impact and an unexpected one in psychosis, where we are discovering that there are a lot more people than all our original incidence data suggested. I have no doubt that we are having an impact.

If you look at what funding is going into CAMHS, it has gone up £100 million in the last year. I think these are reasons to think something very good is happening. It does not make us sit back, but it does make us think, "Let's be optimistic," particularly for people working in CAMHS, who I think have become very pessimistic about the future and are seeing something good happening now.

Q92 **Dr Williams:** I celebrate what has happened and thank you for your contributions to that, but families in Stockton South who have children with suspected autism are being told that they have to wait 44 months for their first assessment from CAMHS. What would you say to them?

Tim Kendall: I would say mea culpa. I absolutely accept that we do not have a major autism programme already under way. Having said that, in September this year the transforming care programme published a new document on what we should do about children with autism, with a learning disability, or both. I know that from our point of view—and from NHS England's point of view—we are looking at what more we should be getting going. But it is also fair to say that there was no specific resource allocated to this in the five year forward view, so we are going to have to look further afield. I absolutely accept what you are saying—that what we are doing now for autism is not good enough.

Jackie Doyle-Price: I would say that we are collecting data from April next year by CCG on the waiting time standards for autism. We do not think that it should be more than three months. The 44 months you tell me about raises a worry with me.

Q93 **Dr Williams:** It came from a freedom of information request. I was able to collect the data today from an FOI.

Jackie Doyle-Price: There is an issue, though, between first referral and diagnosis. A lot of the debate in this space is about the fact that it takes too long for people with autism to be diagnosed. Of course, there is a tension there: the earlier you can have a diagnosis, the better you can put in a programme of care. Equally, assessing for autism does take time in assessment, so it is a challenge. But you are absolutely right to raise this. From my perspective, the whole issue of learning disabilities has

received rather less prominence than I believe it should and it is something that, personally, I want to make a priority.

Claire Murdoch: It is not so much about autism. It is about all those children and young people who do not receive the speed or standard of service currently that they deserve and that we ought to be aspiring to in 2017 and beyond, and the fact that we have to look at the programmes that we are introducing, the successes we are having, the difference that we are making to people's lives today, next year and beyond in perinatal, the increase in tier 4 beds, the earlier intervention in psychosis and the eating disorder services. It is really important that we note it and encourage the workforce and the public to come forward.

I would just say to this Committee, please do not mistake that for any sense that we think anything other than that this money must flow; this programme must deliver. When we get to 2021 the next phase of this work must be up and running in earnest. This is work of a decade and more.

It is that difficult messaging between absolutely responsibly needing to know what works, doing more of it, demonstrating and being held accountable for the delivery of the plan that we have agreed in a very public way with Ministers and so on and so forth, and acknowledging that money, investment and the next phase of the plan is imperative.

The only other thing I would like to say at this point is that we do need other parts of the system as well as the money to flow into the NHS. It does need to flow into local government where we have seen some huge reductions in spend such as, we think, nearly a 40% reduction in the early intervention grant over the last five years.

Dr Williams: It is going back—

Claire Murdoch: Of course, we do worry that if other areas are not funded as they ought to be, or we see that scale of reduction, the 56% increase in referrals to specialist CAMHS that we have seen in the last four years will continue, with youngsters in A&E with self-harm who perhaps never needed to get there, and so on and so forth.

It is really important to us that we do celebrate and acknowledge the successes we are having. We simply cannot have an unremitting narrative of negativity around mental health because no one will use the services and no staff will work in them. Let us celebrate what we are doing, and deliver the five year forward plan. but let us acknowledge it is a journey of a decade and it is not just the NHS. I am not defending what—

Chair: Luciana and then Andrew also want to come in.

Q94 **Luciana Berger:** It is not just autism services in Stockton and the massive cuts to local authority budgets in public health that are making an impact. The panel talked about extra money going to frontline

services, yet in my area in this financial year my CCG is cutting—I have the whole schedule of cuts here—massively young people's mental health services. Our key service for young people, YPAS, has seen a cut of over £750,000, which is 43%; the support available to children in schools through the Seedlings service was cut by 50%; there are the child bereavement services; then the services to young carers. I have the whole schedule—it is as long as my arm—and this is the reality for young people in Liverpool today.

I had a letter from a teacher who said he believed the system is at breaking point. He is worried that a young person will be harmed as a result and a serious case review will follow, which will only tell us what we already know—that funding cuts are having a direct impact on our most vulnerable members of society. That is what is happening in my area, but it is not just in my area. I have a whole body of evidence here. I have a whole thing from Norfolk where they say the biggest issue is—and this is in response to a scrutiny committee—that the money that you say is available goes into the CCG's bottom line. It is not new recurrent money given to the CCG for CAMHS, and yet the money you say is available is not ultimately reaching the frontline. What do you say to that?

Jackie Doyle-Price: Again, I cannot agree with that because in most areas it is. Of the money we have made available, more of that is being spent at CCG level. We are aware that there are, I think, 39 CCGs where it is not, and Claire and Sir Bruce Keogh have written to them to challenge them on their performance and outcomes.

Q95 **Luciana Berger:** Can I pause you—I am sorry—because the 39 you referred to does not include my CCG. Liverpool is not on your list of areas that are not meeting the mental health investment standard and yet they are not even adding money. They are cutting services to young people's mental health in my area.

Claire Murdoch: There is the mental health investment standard overall. We measure whether the level of investment in mental health in total is greater than the increase given to any CCG area that year in terms of their allocation. Additionally, at NHS England, we do dig beneath that and look at CAMHS-specific spend and uplift, and I assure you that Liverpool is on that list, in our sights, and we are very well aware of that. We know that a quarter of CCGs have not uplifted CAMHS this year, so you will find many—50—across the country that have not. As you say, Sir Bruce and I wrote out earlier this year to the system. We do bespoke deep dives into individual CCGs to understand what is happening as well as at regional and national level. The point you make is well made—that not every area of the country has passed on the uplift.

Q96 **Luciana Berger:** That means in practice that almost a thousand fewer young people in my area cannot access services. There is this talk about everything being rosy, but, in reality, that is what it means just in my area, let alone for the however many areas across the country that are

not doing what you say they should be doing.

Jackie Doyle-Price: We know that across-the-board performance is better than that, but, ultimately, we have a system of local commissioning and decision making here. We can set out from the centre what we expect a level of service to be in terms of outcomes and we will work hand in hand with local partners to make sure that they are achieved, but ultimately those decisions need to be made locally.

Q97 **Luciana Berger:** Equally, you ring-fence budgets for other parts of the NHS. Why won't you ring-fence the young people's mental health budgets?

Jackie Doyle-Price: I can understand why you are attracted to the idea of a ring fence, but in my experience ring fences ultimately become ceilings. Again, we want to get to a policy-making system that is very much outcome focused, not input based. It should not be just about how much money goes in. It is very much about the outcomes we are delivering for that money.

Q98 **Luciana Berger:** On that point, none of the indicators in the dashboard is about outcomes for people's mental health services. They are just about numbers of people going into services. They do not actually measure the outcomes of young people's experience in the mental health services in our country.

Jackie Doyle-Price: Again, it comes back to where we are in terms of building that dataset. We have started from a very, very low base. We are building on that. We will be challenging that system. As I say, we know we have a long way to go with this, but we have reacted to all the intelligence we have received and we are driving things forward.

Q99 **Andrew Selous:** We know that provision is increasing nationally, but it seems that demand could be running even further ahead. What are the big things we need to do as a country across society to reduce demand in this area?

Jackie Doyle-Price: That is a big question. Obviously, we can all look at the NHS to deliver this, but prevention is always better than cure. A big part of this is tackling the stigma that affects mental health. It is about raising awareness among all of us, not just for our own mental good health but also to look out for and support other people. We have been looking very much at that kind of culture change to make society much more supportive of people with mental ill health.

Obviously, in the last couple of weeks we have had the report by Paul Farmer and Dennis Stevenson about how we can improve things in the workplace. Clearly, in terms of children and young people's mental health, what happens in schools is extremely important. People need to be aware of when someone might be suffering from mental ill health, what things to look for and what support networks can be involved in it. What has been really encouraging as we have embarked on this work is

that schools have grasped this need to have a mental health lead. We now have more than 50% of schools doing that. We have piloted single points of contact in schools, and we are using the out-turn of that to feed into our forthcoming Green Paper.

There is a lot to be said for things that Government cannot do that society can. We have also invested in the Time to Change programme of advertising and public education to make it much more user-friendly so that people can become much more aware of these issues.

Personally, I am a big fan of "EastEnders", and when they do a storyline it gets through to millions of people and raises awareness about these issues. In recent months, they have done fantastic pieces on post-partum psychosis, post-traumatic stress and bullying in schools. As a society, we need to be a lot more aware of what poor mental ill health looks like and what we can do to support people who are going through a rough patch, because it is when people are left alone that it gets worse and worse. We will do our bit and we will continue to invest and improve services, but this is a challenge for the whole of society.

Q100 **Chair:** I take the point entirely about not having an overwhelmingly negative narrative about this and recognising where things are moving on, but can I return to a point that came through loud and clear from the Children's Commissioner's report, which was about early intervention and prevention and something that our predecessor Committee heard about voluntary sector providers limping from one tiny budget to another, with very short-term pots of money? Can you assure this Committee that in the Green Paper you will be looking actively at the balance and how we are going to get funding through to these sectors?

Jackie Doyle-Price: I think you will not have very long to wait for the Green Paper.

Q101 **Chair:** Do we have the date?

Jackie Doyle-Price: Before Christmas is what I can tell you. I know you will be very forthcoming with your views on it. What is running through there is what we can put in place between the health service and schools to make sure that we can get that early intervention so that you have the infrastructure in place in schools to signpost children when they need help.

Coming back to the Children's Commissioner, as you say, she has been very, very critical, but, frankly, that is her job and I would expect her to be.

Q102 **Chair:** It is constructive criticism.

Jackie Doyle-Price: Indeed, and we need to take those points that she has made in the spirit of constructive dialogue and address them. I hope that we will engage with her and with young people as well on the

recommendations that we come up with in the Green Paper because we need to design a system that helps all parts of the system.

Q103 **Chair:** That brings us on to engagement, which Lisa is going to be talking about, but I can tell that Tim wants to come in on the point before we do that.

Tim Kendall: Very quickly, the Secretary of State asked me, Peter Fonagy and Steve Pilling from UCL to undertake a full systematic review of different strategies for helping kids that might work within schools. This has taken thousands and thousands of person hours to do, but we have come to a conclusion, and the Green Paper has listened very clearly to what we have said about whether it is best to go for prevention, early intervention secondary care, or whatever. The Green Paper will be informed by a serious evidence base.

Q104 **Chair:** Thank you. Looking at the issues around the fragmentation of commissioning and all those issues that have been raised, they are all going to be there in the Green Paper as well, are they?

Tim Kendall: I could not possibly tell you.

Chair: I hope so. Lisa is coming on to engagement with young people.

Q105 **Dr Cameron:** How are you planning to respond to the Select Committee's recommendations that you should hold a series of engagement events around the country with young people to test proposals? How are you going to make it services that are led by the people who use them and that you listen to young people's voices?

Jackie Doyle-Price: Obviously, we do have the Green Paper coming out soon and young people are a key audience in terms of their feedback. To be honest, I cannot give you a menu, but I will go away and think about that and write to the Committee about how to improve it. I am inclined to think that at an "interface with the service" level that is not something that I can do. Whether we need to encourage local practitioners to have youth involvement in their decision making is perhaps something we need to think about. Claire, do you want to add anything?

Claire Murdoch: I will add a bit. You heard from YoungMinds earlier, an organisation for which we have huge regard and work well with at NHS England, and we have a contract with them already for youth engagement. Certainly, if you attend any of our events they are inspiring, and parents are involved as well. They offer us invaluable insights into what young people are saying, what they want, what works for them and what does not. We work with other third sector organisations and experts, but I see no reason why the Green Paper cannot be road-tested. We have a good infrastructure in place already with organisations that are incredibly expert at mobilising youth opinion. We are really determined to shape services in light of what they tell us.

Q106 **Dr Cameron:** We have heard that what is needed is a formulation or

holistic-based approach rather than perhaps a medical or compartmentalised approach. That would require a massive culture shift surely.

Jackie Doyle-Price: That is the story of the NHS, is it not? We fix the issue that is in front of us but do not necessarily look at the person. We have to empower people with their own tools to do that, to make sure that people own their care and that the system works with them rather than does things to them, but we can all do much more about that in terms of education.

Q107 **Dr Cameron:** In terms of engagement and people being engaged in services, we have heard that young people who perhaps self-harm get to services but are not accepted. Is it possible that there could be a care pathway for young people who self-harm but who perhaps do not have a diagnosable condition?

Jackie Doyle-Price: I will come back to Tim on this one, but we have set very clear targets for very prompt treatment for people who are really in acute need, and that will include people with self-harm. Most of them will be seen within a week, but if there is any indication that we are not meeting that then I would quite like to hear about it. I do not know if you want to say anything.

Q108 **Dr Cameron:** I think it is the follow-up, because if you are diagnosed as not having a mental illness where does the follow-up come from, even though the person might have repetitive behaviours of self-harm? How is the care pathway set for that vulnerable group of children?

Tim Kendall: This is an area that is quite problematic. It is difficult for people to understand. We do not have any tests for a mental illness.

Q109 **Dr Cameron:** We have a diagnostic manual for mental illness, actually, and often CAMHS uses that.

Tim Kendall: Sure, we have the international classification of diseases, volume 10, with volume 11 coming out. We have the diagnostic and statistical manual from overseas—over in the States. You can measure things such as behaviour and attention deficit hyperactivity disorder and so on, but fundamentally what makes someone mentally ill rather than mentally healthy is that their behaviour and experience is associated with impairment and distress. If people are not being diagnosed when they are coming along with clear impairment and distress, it is a problem to me. When I hear of people saying, "Oh, they've got to be worse before they come into services," I do not think that is right, and we should be saying that is not right.

Q110 **Dr Cameron:** Is that something on which you are going to be giving us a clear message right across NHS England, such that it is not about perhaps having a diagnosis of depression or a major mental illness, but that if a young child comes along with distress and behavioural problems related to self-harm perhaps that is enough for admission to CAMHS—

that is sufficient?

Tim Kendall: Do you mean whether or not they are seen within CAMHS?

Q111 **Dr Cameron:** Yes—well, seen but then not just discharged as not having a mental health problem.

Tim Kendall: The message I would clearly give is that, if people are suffering and they are impaired by their mental health, to me that means they should be seen. If they are being turned away because they are not thin enough or whatever, that is not acceptable, in my view. That is a clinical issue. People should not be turning people away saying, "When you have lost more weight, we will treat your anorexia." That, to me, is not acceptable.

Claire Murdoch: I completely agree. Additionally, though, if a young person is acting out and in distress, and has self-harmed because of family problems or things going on at home or at school or bullying, which is what makes the CAMHS assessment when they are in A&E or a paediatric ward, say, post harm so vital, you really do need to assess whether what is next needed is a clinical intervention because that young person has self-harmed and there is a medicalisation of that problem. If that is what is needed, then, absolutely, what we are straining every sinew to do is to increase capacity, train people and develop the models of care that respond quicker. But I do think it is a really serious point.

You have already heard what I have said about the NHS offering. It is a journey of a decade and we are not close even if we deliver everything we want to by 2021. However, I think right here, right now, we need the input of teachers, the local authorities and support to vulnerable families, and the ability to respond to drugs and alcohol, which often lead to an attempt at self-harm, or to somebody splitting up from a boyfriend—that kind of level of distress, which is really serious but may not need an expert assessment from a doctor and a nurse but might need other intervention. It is vital that the support sits there as well.

Q112 **Dr Cameron:** But the care pathway for that is not clear.

Claire Murdoch: I see what you are saying.

Tim Kendall: The care pathway, if you look at NICE guidance on this, is absolutely clear. Everybody who self-harms and turns up in A&E, whether a child, an adult or whatever, has to be assessed and they should have a full psychosocial assessment. In doing that, the evidence is that you reduce our best proxy for later suicide, which is repetition of self-harm.

Q113 **Dr Cameron:** I am not going to labour the point, but the assessment may be given yet the follow-up might be lacking. That is the point I am making.

Tim Kendall: We are getting data in from two vanguard sites where we have introduced crisis services for kids. It is looking very much like it is reducing out-of-area placements for them; it is reducing admissions to

hospital. If this turns out to be true, this is the sort of thing that will in the long run save us money, so that might be a way in which we could generalise this.

There is no doubt that there is a will to try to get these better crisis services out across CAMHS. They are not there everywhere, and we absolutely accept that, but there is a serious will. We have wave two, I think—Claire might be more on top of this—sites, of which I think there are six or seven that are now being rolled out.

Chair: We have a quick follow-up from Caroline and then our final question from Luciana.

Q114 **Dr Caroline Johnson:** My colleague asked you about prevention—something that is very important. You spoke about how young people's ability to access services, their awareness of services and their awareness that they may have a mental health problem are being improved, which is great, but what about other areas, such as the role of parents, parental education, the importance of good sleep, issues around drugs, online activity, education, family breakdown and access to good social care? All of those are issues. I appreciate they are not all issues for the Department of Health, but what work are you doing with other Departments to ensure that we genuinely prevent young people, where possible, becoming unwell in the first place?

Jackie Doyle-Price: That is a very good point. The silo culture in Government is the enemy of good policy outcomes and it is where things fall between two stools that things go wrong. Obviously, in the whole area of children's mental health, the Department for Education is a key partner, and this Green Paper is probably bringing the two Departments together more closely on this than they have ever been.

Q115 **Dr Johnson:** It is not just schools, is it? It is families; it is lots of other things as well.

Jackie Doyle-Price: Indeed, and obviously, in terms of the context you are talking about, local authorities will also be involved in some of those cases. We also have a partnership going with the Department for Digital, Culture, Media and Sport about the whole issue of social media.

There is more than one aspect to that. You have mentioned sleep. One of the sources of sleep deprivation is the fact that we do not enjoy good guidelines about how long people use electronic games. We need to be much more on the front foot about getting those kinds of messages out. I think every parent has done the thing of sticking their child in front of the TV to keep them occupied, but when that starts to become self-regulating because kids now have TVs in their bedrooms—they didn't in my day, but now they do—obviously that can become quite a significant risk, particularly with gaming. We are working with DCMS there as part of the internet safety strategy. Equally, though, the whole issue of the internet and social media has a positive role to play here because children and

young people can access information and advice and find ways of getting self-help.

The point you make is a good one. It is why the Prime Minister has made this a challenge for society and made it a key priority, and we really do need a holistic vision to achieve societal change.

Chair: So we are going to see a cross-Government approach in the Green Paper. Finally, on to Luciana.

Q116 **Luciana Berger:** Minister, you acknowledged in your contribution that there are a number of CCGs across the country that are not meeting the mental health investment standard, ultimately not spending the money that you say is earmarked for mental health. Can you tell us what is going to happen to that money? Ultimately, is that money going to be permanently lost from the money that you say is available for mental health? Can you give us an assurance about the money that was promised to Future in Mind just over two years ago—the £1.4 billion? Will all that money that was promised a few years ago be dedicated to young people's mental health over the entire five-year period, because there has been some underspending in the last two years?

Jackie Doyle-Price: That £1.4 billion will be spent on children's mental health between now and 2021. I can give you that absolute assurance—no ifs, no buts. In terms of the money we are giving to CCGs, obviously it is going to hit their baselines. We do have localism in decision making and commissioning, but we will have that robust conversation with NHS England about the outcomes we expect to be delivered. Those conversations have already started and will continue through Claire and Sir Bruce Keogh.

Q117 **Luciana Berger:** If they don't spend that money, is it, therefore, permanently lost from the money that you said was available for them to help?

Jackie Doyle-Price: Do you want to say something on that, Claire?

Claire Murdoch: I would say a couple of things at this point, and, bearing in mind it is the last question, I will say what I wanted to say now as well about the money. We will move heaven and earth to get that money—that £1.4 billion—to the frontline. We track it, we know what the uplift this year has been, and we absolutely have a very granular plan to see that rolled out to 2021. In that sense, I am absolutely prepared to sit here as the SRO held accountable for this programme and give you an assurance that that will happen. I am not saying it is not complex and I am not saying it is easy to make CCGs right across the country—207 of them—do exactly what we want them to do when we want them to do it. If it were, you would only need one of us and we would just issue instructions, so it will be a very complex task.

My biggest concern about the threat to that is about the wider NHS funding. As the squeeze comes in on the NHS, I see the struggles, both in

my own trust but right across the NHS, that we are having to balance the NHS books and the thought of another several years of that. I should have said that I am a registered mental health nurse of 34 years as well, and mental health has been my lifelong working passion. My only doubt is what happens if the whole NHS at this stage goes into a decline or a crisis around the money. However, we are all programmed to make sure that that £1.4 billion gets through.

Chair: Thank you very much, and obviously it is a big day tomorrow. No doubt, Claire, you will be back in front of this Committee and we would be very grateful if you would keep us updated with your progress on getting this money to the frontline.

Claire Murdoch: I hesitate to say I look forward to it, but thank you.

Chair: Thank you all for coming this afternoon.