Written evidence submitted by Professor Cathy Creswell, University of Oxford (MHS0014)

Background

I am a Professor of Clinical Developmental Psychology at the University of Oxford and an Honorary Consultant Clinical Psychologist in Oxford Health NHS Foundation Trust. I conduct research to improve outcomes and access to psychological therapies for children and young people with common mental health problems both in school and clinic settings. In recent years this has involved interview studies with young people, parents and carers, and with mental health practitioners, including those that work in schools.

Response to consultation
Policy Area: Children and Young People's Mental Health

At least 70,000 additional children and young people each year will receive evidence-based treatment.

Was the commitment met overall?

The Children's Wellbeing Practitioner (CWP) and Education Mental Health Practitioner (EMHP) training programmes have been a positive step forward to improve access to evidence based treatments however progress so far should only be considered a starting point towards meeting the need.

Our consultations with CWPs and EMHPs have highlighted that once they have completed their training they often take on cases that go beyond their training and their remit. They have reported that they often receive referrals for complex and severe cases, with presenting problems that are not covered within their training (e.g. obsessive compulsive disorder, eating problems, social anxiety disorder). They have reported that, despite not feeling qualified to treat these cases, they will take them on as they do not feel that there is an alternative treatment option for these children or are concerned that they will face long waits for specialist support. As such the children may receive support but are not receiving evidence-based care from suitably qualified clinicians. Furthermore the CWPs/EMHPs have told us that this causes high stress for them personally and risk of burn out. This situation highlights the need for more closely integrated links between first-line (e.g. CWP/ EMHP staffed) services and specialist services, with significantly reduced waits for specialist services so that first-line services can 'step-up' cases promptly as required.

In addition to the CWP/EMHP workforce it appears that significant sums of money are invested in services that do not offer evidence-based treatment and/or are staffed by practitioners that have not been trained in delivering evidence-based psychological treatments. For example, we have come across counselling services that are commissioned by CCGs/ICSs that are unable to specify what treatment they deliver or to whom. We know, for example, that lots of children presenting with anxiety problems end up in these services and offered unspecified treatments despite there being a substantial evidence base to inform treatment. We have also recently come across NHS services which are predominantly staffed by 'Mental Health Practitioners' where training in psychological therapies is only a 'desirable' and not a 'required' criteria in job descriptions. It is impossible to imagine a physical health service where this would be the case and highlights the continuing lack of parity of esteem and risk of poor quality practice in children and young people's mental health settings. There needs to be greater support for and scrutiny of CCGs/ICSs to ensure they don't continue commissioning services that are clearly not offering evidence-based care. This situation is likely compounded by a focus on targets based on numbers of children seen, rather than what happens when they are seen. Many of these services work with relatively high numbers of children

and young people relatively quickly, which looks good from an access and waiting time perspective. However this is likely to be a false economy in terms of longer term outcomes and service use. Going forwards it will be critical that there is a more appropriate balance between access targets/waiting times and getting people the right care and good outcomes.

Indeed, there often appears to be a conflict between hitting waiting time targets (e.g., 4 weeks for routine cases) and making sure young people receive evidence-based treatment. Most anxiety and depression treatments, for example, take significantly longer than 4 weeks to complete. Whenever treatment takes longer on average than the target waiting time to be seen, hidden waiting lists quickly build up within teams. Prioritising waiting times for initial contact also means there's often a big gap between assessment and starting treatment, during which time things can change a lot for children, young people and their families. As a result, young people either need to be reassessed at the point they start treatment (which is a poor use of resources and not a good experience for young people and their families), or they receive an intervention that is no longer the right one. To hit waiting time targets, teams often end up allocating a disproportionate amount of resource to completing initial contacts and managing problems that arise for young people on waiting lists, both of which take resource away from delivering effective treatment. It appears that in many cases the most effective way to sustainably hit waiting time targets without building up hidden waiting lists is for large numbers of people to be discharged after their first contact, which clearly isn't helpful. There needs to be a move away from a sole focus on waiting time targets towards sufficiently funded, realistic, and achievable delivery models that allow for evidence-based treatments to be delivered in ways that are both sustainable and acceptable to the public.

<u>Was the commitment effectively resourced?</u>
No, see above.
The CWP and EMHP training programmes have been a positive step forward but the resourcing is not sufficiently ambitious to meet the need. This also must be seen as just one part of the picture. If other parts of children and young people's mental health services are also not better resourced and able to build capacity we will continue to see overstretched CWPs/EMHPs (and practitioners in non-evidenced based services, see above) providing treatments for presenting problems that go beyond their training and remit.

<u>Did the commitment achieve a positive impact for people living with mental ill health?</u>
I am confident that there has been a positive impact for some children, young people and their families- particularly through the CWP and EMHP workforce development which has enabled the provision of relatively brief, evidence-based treatments for children and young people. In the services that I regular interact with we have seen the CWPs and EMHPs achieve excellent outcomes, which can be demonstrated because of high rates of completion of Routine Outcome Measures (ROMs). While ROMs completion is typically high during training, this is not always sustained in practice so the ability to draw conclusions about positive impacts is limited in many services. Going forwards it will be critical that services are not evaluated purely on the basis of numbers seen but on demonstrating the evidence-based treatments are delivered and that acceptable outcomes are achieved.

The limited scale of resourcing provided so far means that there continue to be marked inequities in access to evidence based treatments. The private practitioners that I am aware of have faced huge demand over the last year due to families' inability to access support through NHS/Local authority providers. The cost of a course of treatment (which may not necessarily be high quality/evidence based) through this route is typically well over £1000, which clearly makes this an impossible option for many families.

Was it an appropriate commitment?

It was appropriate to commit to increasing access to evidence-based treatments for child and adolescent mental health problems. However the scale of the commitment needs to be more ambitious to meet the need. As we have seen from survey data and service data, this need has only grown as a result of the pandemic.

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