Health Select Committee inquiry: Child and Adolescent Mental Health Services

Written evidence submitted by the Royal College of Paediatrics and Child Health

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Introduction

The RCPCH welcomes the opportunity to respond to the Health Select Committee inquiry into child and adolescent mental health services. Mental disorders in children and young people are increasing and represent a hidden epidemic. This has significant implications for society as whole, both today and in the future.

Mental health is the foundation of healthy development and mental health problems in childhood and adolescence can have adverse and long-lasting effects.[1] Green (2005)[2] reported that 1 in 10 aged between 5 and 16 have a diagnosable mental health disorder. Early and appropriate intervention minimises the mental health challenges for children and young people and the potential lifelong impact. *Our Children deserve better: prevention pays* reported that 50% of mental illness in adult life (excluding dementia) starts before age 15 and 75% by age 18.

1. CAMHS: Service Provision

For young people using mental health services**,** lack of adequate information is a repeatedly highlighted problem. They say that the quality of information given to them about Child and Adolescent Mental Health Services (CAMHS), the illness and the treatment can be inadequate. Some young people report that they have been referred to specialist CAMHS without being given any information. Others have said that, although they were given all the information at the time, they could not take it all in as they were in too much turmoil and they needed further support to empower them to use the service.

Joint Service Needs Assessments (JSNA) often fail to adequately identify the number of children and young people in a locality that are likely to require mental health services. This has led to disinvestment in early help services and increased pressure on CAMHS. CAMHS services also face pressure and cuts as the part of their budget that is supported by local authorities comes under budgetary constraints. To ensure that provision meets demand it is therefore imperative that data are collected on the prevalence and incidence of mental health conditions and an annual audit of services and expenditure in the area undertaken.

Increasing caseloads and limited resources have led to a reduced number of specialist services. With this in mind it is concerning to hear that the only new referrals that CAMHS is accepting are young people who present with active life threatening conditions. Conditions commonly cited as excluded from a CAMHS service were Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), emotional problems, anxiety, children aged under 5, behavioural problems, post abuse and trauma intervention and learning disability. **Efforts need to be made to support the delivery of effective CAMHS by addressing workforce and training issues and shortfalls in resources as there is an increasing gap in parity between physical and mental health services.**

[1] Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays

[2] Green, H., McGinnity, A., Meltzer, H., et al. (2005). *Mental health of children and young people in Great Britain 2004*. London: Palgrave

Although there had been considerable investment in services since 2004, there is anecdotal evidence which suggests variation in access to services and in implementation of evidence-based interventions. More recently, however, there has been disinvestment in CAMHS, particularly in local authority expenditure.[3] There are also frequent anecdotal reports of services having long waiting lists and of thresholds being too high in terms of referrals of children and young people with less severe problems not being accepted. The multi-agency nature of services allow the potential for a lack of co-ordination or integration between agencies which, particularly at a time of shrinking budgets, may mean that children and young people fall through the net. There may also be reluctance for agencies to invest in interventions when they themselves may not benefit from any savings accrued, for example by providing early intervention.

2. Funding and commissioning

It is widely acknowledged that mental health services for children have been chronically underfunded relative to need[4],[5]. Strategic leadership is required to recognise the long term benefits and potential savings to the public sector of ensuring all children and young people are offered appropriate early intervention, and access to high quality evidence based treatments. ***This requires commitment from the Government to resource services at all levels through:***

- resourcing preventative services and prioritising these programmes within universal services as part of a commitment to 'invest to save'.
- ensuring that paediatric and specialist CAMHS services have sufficient capacity to meet the needs of children and young people.
- efforts need to be made to support the delivery of effective CAMHS by addressing workforce and training issues and shortfalls in resources.
- integrated commissioning between the different CAMHS tiers to ensure alignment between specialised services commissioned by NHS England and those services commissioned by Clinical Commissioning Groups.

Children and young people with mental health problems can become adults with mental health problems. Early intervention is crucial to ensure the best possible outcomes for a child or young person. Early intervention and commissioning of mental health provision in schools and clinics, which have been shown in some studies to improve outcomes and life chances for children and young people into adulthood, may be an opportunity for commissioners to prevent and reduce mental health disorders in adulthood.

A study quoted by the YoungMinds charity found that more than half of all adults with mental health problems were diagnosed in childhood but less than half were treated appropriately at the time.[6]

There are many costs to not intervening early:

- individual children and young people and their families continuing to suffer with no support or inappropriate support.
- resources in NHS acute services used to treat children and young people at crisis point who could have been helped earlier.

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[3] YoungMinds. Local authorities and CAMHS budgets 2012/2013. www.youngminds.org.uk/assets/0000/7313/CAMHS_2012.13_briefing_local_authorities.doc

[4] Department of Health (2010) *Getting it right for children and young people*: *A review by Professor Sir Ian Kennedy*. HM Stationery Office: London

[5] Medical Research Council (2010) *Review of Mental Health Research*. MRC: London

[6] Kim-Cohen, J., Caspi, A., Moffitt, TE., et al (2003): *Prior juvenile diagnoses in adults with mental disorder*. Archives of general psychiatry, Vol 60, pp.709-717

- financial costs in the criminal justice system, social care, welfare and voluntary sector support.

With recent disinvestment in CAMHS services it is of no surprise that this has had a significant impact on other services. Commissioners, lacking an understanding of broader issues, have failed to fill the gap left by shrinking specialist CAMHS provision.

Specialist community CAMHS teams have understandably responded to reductions in resources by focusing on core mental illnesses suffered by children and young people, at the expense of broader mental health concerns, or cases where there might be an overlap between CAMHS and other services, which are now held in other services.

3. Trends in children's and adolescent mental health

Among the 5 to 10 year olds, 10% of boys and 5% of girls had a mental disorder while among the 11 to 16 year olds the prevalence was 13% for boys and 10% for girls. The prevalence of anxiety disorders was 2–3%, depression 0.9%, conduct disorder 4.5–5%, hyperkinetic disorder (severe ADHD) 1.5% and autism spectrum disorders 0.9%[7].

Rarer disorders including selective mutism, eating disorders and tics disorders occurred in 0.4% of children. Conduct disorders, hyperkinetic disorder and autism spectrum disorders were more common in boys, and emotional disorders were more common in girls[8].

Significantly more children have mental health 'difficulties' which have a long-term impact on education, family function and life chances. There are strong links between mental health problems and adverse life circumstances (parental substance misuse, parental mental health, abuse and neglect and poverty). Early and appropriate intervention minimises the mental health challenges for children and young people and the potential lifelong impact.

There has been and increase in number and complexity of children presenting with emotional and or behavioural problems in paediatrics. Evidence from SEN consultations performed by the DfE suggest that a similar pattern is evident in schools, who feel they are holding increasingly complex cases themselves. Paediatricians as well as other professionals within child health feel that they lack adequate training, or the access to CAMHS backup and consultation, needed to manage these children and young people; impacting on care quality, morale and, crucially, family satisfaction. An increase in workload has an effect on capacity within services, with waiting time breaches commonplace.

The most recent British surveys carried out by the Office for National Statistics of children and young people aged 5–15 years in 1999 and 2004 (referred to as the British Child and Adolescent Mental Health Surveys or B-CAMHS). **The B-CAMHS surveys should be repeated to provide more up-to-date information in order to aid planning of healthcare services. In view of the recognition of the importance of the early years as a focus for intervention, the survey should be extended to the under-5s. The new survey should also address the need for better evidence on the mental health of children and young people from ethnic minorities.**

4. Transition to adult mental health services

[7] Green, H., McGinnity, A., Meltzer, H., et al. (2005). *Mental health of children and young people in Great Britain 2004*. London: Palgrave

[8] *Ibid*

Transition refers to the period were the care of adolescents with mental health problems is transferred from child and adolescent services to adult mental health services. Adolescence is considered a risk period for serious mental health disorders, substance misuse, and risk-taking behaviours as well as poor engagement with health services[9],[10]. **Therefore this should be a crucial time to ensure robust transition,** however mental health provision is often lacking during this period.

Many young people fall between the gap of children's and adult's mental health services, especially for those with neurodevelopmental, severe emotional or emerging personality disorders. Improved liaison, collaboration and joint working between children's and adult's mental health services and primary care are required to ensure genuine pathways of care that meet the needs of the young person and their family. Young Minds *Same Old...the experiences of young offenders with mental health needs* highlighted that only 4% of young people reported a good transition from CAMHS to AMHS.

Differing commissioning arrangements furthers the CAMHS–AMHS (adult mental health services) divide, where CAMHS are often commissioned by acute care or children's services, whereas AMHS is firmly within mental health commissioning[11]. **There should be joint commissioning between mental health services for children and adults and shared commissioning approaches at a regional level are the best ways to improve transitional care and a seamless pathway for young people with mental health problems.**

5. Mental Health: Views from RCPCH Youth Advisory Panel

The Youth Advisory Panel (YAP) believe children need more knowledge of how to access services and that it should be easy and timely access, with less gaps for people to fall through. All services provided should be confidential in nature; meetings should take place without parental knowledge and should not be conducted during school hours.

The YAP told us that better education of mental health and earlier diagnosis is required: this is key to empower children and young people, removes stigma and gives young people a better understanding and are therefore taken more seriously.

They also told us that a mental health worker cannot be a young person's family GP but someone who is easy to talk to and friendly and it should be apparent who this person is. Advice should be targeted at CYP and talk about mental health in CYP seriously. Support for families of ill children and young people with long term illness (relationship support) should be provided. Acknowledgement of mental health issues in young people by health professionals, parents and carers as well as having an awareness of lesbian, gay, bisexual, transgender and vulnerable groups (child carers). Counselling services in school need to be fixed with more consistency, more private sessions and better availability.

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[9] Patel V, Flisher AJ, Hetrick S, McGorry P. Mental health of young people: a global public-health challenge. Lancet 2007; 369: 1302–13.

[10] McGorry P. The specialist youth mental health model: strengthening the weakest link in the public mental health system. Med J Aust (suppl) 2007;187: s53–6

[11] Swaran P. Singh, Moli Paul, Tamsin Ford et al. Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study. *BJP* 2010, 197:305-312.

Supporting health and other professionals

RCPCH is involved in the creation of MindEd, a resource for the many adults who are in regular contact with children and young people but who have little or no idea how to recognise or respond to. The resource will be launched at the end of March 2014 and will offer free resources for all professionals who interact with children. We would welcome the opportunity to demonstrate this resource to members of the Committee.

About the RCPCH
The College is a UK organisation which comprises over 15,000 members who live in the UK, Ireland and abroad and plays a major role in postgraduate medical education, as well as professional standards.

The College's responsibilities include:

- setting syllabuses for postgraduate training in paediatrics
- overseeing postgraduate training in paediatrics
- running postgraduate examinations in paediatrics
- organising courses and conferences on paediatrics
- issuing guidance on paediatrics
- conducting research on paediatrics
- developing policy messages and recommendations to promote better child health outcomes
- service delivery models to ensure better treatment and care for children and young people

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