Children and young people's mental health services

Targets, progress and barriers to improvement

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Content warning

The topics we discuss in this report – including suicide – can be distressing and emotionally challenging for some people. Help and support is available here for anyone who may need it.

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Glossary

Organisations

CQC. Care Quality Commission. The CQC is the regulator of all health and social care services in England.

DfE. Department for Education. DfE is a government department responsible for policies related to children's services and education in England.

DHSC. Department of Health and Social Care. Previously known as the Department of Health, DHSC is a government department responsible for policies related to health and social care in England.

HEE. Health Education England. HEE coordinates the education and training of the health and public health workforce within England. As of April 2023, HEE was merged and incorporated into NHS England.

HSCSC. Health and Social Care Select Committee. HSCSC examines the policies and spending of the Department of Health and Social Care.

NAO. National Audit Office. The NAO is responsible for auditing government departments.

NHS Benchmarking Network. The NHS Benchmarking Network provides its members with data on a variety of areas, e.g. workforce, finances and outcomes.

NHS Digital. NHS Digital provides information and data for the NHS and social care. As of February 2023, NHS Digital was incorporated into NHS England.

NHS. National Health Service. The NHS is a publicly funded healthcare system. Over recent years there have been changes to the way the NHS is structured. Currently, NHS England leads the service in England.

NHSE. NHS England. NHSE leads the NHS in England.

NHSI. NHS Improvement. NHSI was created to improve services. As of July 2022, it no longer exists, having merged with NHS England.

OCC/CCO. Office of the Children's Commissioner. The Office of the Children's Commissioner is an executive non-departmental public body which promotes the perspectives and interests of children in England.

PHE. Public Health England. PHE *was* an agency of the DHSC. It aimed to improve physical and mental health and reduce health inequalities. Public Health England has now been replaced by the UK Health Security Agency and Office for Health Improvement and Disparities.

Organisation structure and governance

CCG. Clinical Commissioning Group. CCGs were NHS organisations that organised the delivery of NHS services in local areas in England. Integrated Care Boards (ICBs) have taken on the planning functions previously held by CCGs.

ICB. Integrated Care Board. ICBs plan and commission services in a particular area.

ICP. Integrated Care Partnership. ICPs bring together local government, the voluntary, community and social enterprise sector, NHS organisations, and others to develop a health and care strategy in a particular area.

ICS. Integrated Care System. The NHS splits England into 42 Integrated Care Systems. Each system brings together health and care organisations to plan and commission health and care services in the area it covers. Each ICS is made up of an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP).

STP. Sustainability and transformation plans. STPs were plans covering NHS spending in England. England was split into 44 areas, each covered by a plan.

Services

CAMHS. Child and Adolescent Mental Health Services. A specialist NHS service that supports children, young people, and their families when a child or young person is experiencing mental health difficulties.

CYPMHS. Children and Young People's Mental Health Services. Encompasses all mental health provision for children and young people.

IAPT. Improving Access to Psychological Therapies. Now referred to as NHS Talking Therapies, IAPT was developed to improve the delivery of and access to psychological therapies within the NHS. CYP IAPT is a national training initiative to upskill the existing IAPT workforce to support children aged 16 and under.

MHST. Mental health support teams. MHSTs work with schools and colleges to provide support to pupils and develop a whole-school approach to mental health.

Policy papers

Green paper. Green papers are consultation documents in which the government seeks out input and feedback from a range of people.

White paper. White papers are documents produced by the government which set out their proposals for future legislation.

Miscellaneous

FOI requests. Freedom of Information requests. FOI requests are requests for information made to government departments and public bodies.

CYP. Children and Young People.

SEND. Special Educational Needs and Disabilities.

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Executive summary

Mental health is both integral to wellbeing and a powerful predictor of educational and occupational success. Evidence from the last three decades suggests that mental illness is becoming more common amongst children and young people in England and prevalence has risen sharply since the Covid-19 pandemic.

In response, successive governments, particularly since 2015, have introduced a series of policy proposals, accompanied by funding commitments, to 'transform' children and young people's mental health services. However, gaps in data published by the government and its arm length bodies make it difficult to gauge whether government targets have been met. To hold the government to account, this report serves as EPI's assessment of the progress made in improving children and young people's mental health services since 2015.

Some progress has been made to improve service provision, but the impact on the experiences and outcomes of young people with mental health needs is unclear

- There are four key policy documents taking the government's strategy forward including 'Future in Mind', 'The Five Year Forward View for Mental Health', 'Transforming children and young people's mental health provision: a green paper', and the 'NHS Long Term Plan'.
- We extracted 135 policies relating to children and young people's mental health from these documents and examined the progress that has been made against the government's ambitions to improve provision.
- We reviewed a range of data, including government mental health data; reports by the Office of the Children's Commissioner, the Care Quality Commission, the National Audit Office, and the Health and Social Care Select Committee; and transcripts of parliamentary questions and debates. We also consulted with our advisory group made up of researchers, charities, school leaders, frontline providers and young experts by experience, along with NHS England and the Department for Education.
- We published our findings in an online 'policy tracker' available here: https://epi.org.uk/cypmhs-policies-tracker/
- In sum, we found that 36 per cent of policies had been fully implemented. Some action had been taken for 58 per cent of policies and for 6 per cent of policies, it was unclear whether any progress had been made.
- Positive changes over the last eight years include more young people with mental illness accessing treatment, however it is unclear what proportion of young people with a diagnosable condition currently receive appropriate treatment, in part due to the significant rise in prevalence of mental illness since the pandemic.
- There has been a notable expansion of the mental health workforce and the introduction of crisis care helplines for young people across the country.
- Overall, most policy plans which have been implemented are related to improving processes rather than the experiences and outcomes of young people with mental health needs.

There remains significant geographic variation in mental health service provision and a lack of transparency around the local service offer

- We sought to understand how aspects of mental health service structure, organisation, and delivery varied across the country in six areas the government had not sufficiently addressed: these included early intervention; service fragmentation for young people with complex needs; extending services to age 25 in line with National Institute for Health and Care Excellence (NICE) guidelines; crisis follow-up care; support whilst on waiting lists; and the range of available therapeutic treatments.
- To do this, we sent Freedom of Information requests to the 42 Integrated Care Boards (ICBs) across England which plan and commission mental health services for children and young people.
- Many ICBs did not hold the information we requested, raising concerns about effective service planning and whether young people's mental health is currently a priority. They often directed us to the local authority or NHS trusts instead.
- Amongst ICBs which held the data, we found some proactive attempts to screen at-risk young people for mental ill-health, including refugee and asylum-seeking children and those in contact with social care, as well as some work to overcome the fragmentation of service providers in their area.
- The data also indicated significant geographic variation in service delivery, including following a mental health crisis and whilst on a waiting list for clinical treatment; the ages at which children and young people's mental health services are accessible; and the range of evidence-based therapeutic treatments on offer.
- Four ICBs (10 per cent) reported they did not know if a crisis care team existed in their area. Follow-up care after a mental health crisis ranged from signposting to referral to a home treatment team. Around a quarter of ICBs did not respond to the question about care following a crisis.
- Common approaches to supporting young people on waiting lists included signposting to other services and check-in calls to assess risk and offer support. Others included online platforms and apps, and information packs provided by Mental Health Support Teams; one ICB reported they assign a key worker to young people, another that they offer parent support groups, and another drop-in wellbeing cafes. It is unclear whether young people are taking up these waiting list interventions.
- The majority of ICBs offered at least one alternative evidence-based treatment for eating disorders, aside from cognitive behavioural therapy.
- Only two ICBs explicitly reported to us that the full suite of mental health services for young people in their area were available up to age 25. The NHS Implementation Plan set a target for all areas to extend their offer by 2023-24.
- The findings underscore the need for greater transparency around service availability across the country and better government data on service quality, how central government funding is spent locally, and outcomes for young people who access services.

EPI recommendations for a future government's children and young people's mental health services strategy

- **Any future taskforce or national ambition should produce policy plans with more clarity and internal consistency, accompanying implementation strategies, and accountability mechanisms.** Policy commitments should be accompanied by implementation and measurement strategies and should avoid setting targets and deadlines without clearly laying out how they will be met. The government should be transparent about the choice of policy commitments, for example, regarding why waiting time standards are introduced for treatment for one type of disorder but not for others. There should be clarity around the department directly responsible for the implementation of commitments, with a coordination mechanism for accountability, particularly in the case of cross-departmental strategies.
- **NHS England and the Department of Health and Social Care must improve mental health data and transparency.** This includes better data, and improved access to existing data, on the prevalence of mental health issues in different areas of the country. This is necessary to equip ICBs with the necessary information to effectively plan and commission services. Additionally, it is crucial that remaining data gaps in national and service level data – e.g. on coverage, uptake and outcomes – are addressed. A full picture of provision would require coordination with local partners where appropriate, including schools, colleges and the voluntary and independent sector.
- **The government should consider updates to their pre-pandemic children and young people's mental health workforce strategy and implementation plan, and explore introducing an annual statutory CYPMH workforce census.** Slow progress on workforce expansion is a major risk to delivering ambitions to improve access to services. Understanding progress is hindered by a lack of data on the mental healthcare workforce. There has not been a new specific mental health workforce strategy since 2017, before the Covid-19 pandemic. DHSC should consider developing a ten-year mental health workforce recruitment and retention strategy including clear plans for funding, delivery, and accountability. To support this, DHSC should explore introducing a statutory data collection to create a staff-level dataset.

- Given the rise in prevalence of mental health issues, **NHSE and DHSC must continue to focus on increasing access to services,** including implementing a 'no wrong door' policy which allows for multiple entry points into the mental healthcare system. This must also include ensuring that 'gatekeepers' of referrals to mental health services, including GPs, have the knowledge and skills to sensitively recognise and respond to children and young people with mental health needs; expediting the rollout of Mental Health Support Teams, as well as considering how to reach the most vulnerable children who are not in schools; and developing a plan to extend the service offer up to age 25 in all areas, per best practice laid out in NICE guidelines.

- As we have previously recommended**, all secondary schools should have access to a qualified and accredited mental health professional.**[1] Regarding counselling specifically, schools should pursue approaches to providing support that are high quality and evidence based, non-stigmatising, do not bring unwanted attention to any young person receiving individual support, ensure confidentiality between the young person and any relevant professionals, and allow time and space to decompress following counselling sessions.

- **The Department for Education should aim to ensure all teachers have the knowledge and skills to recognise and respond appropriately to mental health needs in their classroom, and continue to develop and expand age-appropriate programmes to help pupils and teachers discuss mental health from an early age.** Surveys indicate that half of teachers feel ill-prepared to respond to pupils with mental health issues, and that most children with a mental health disorder approach a teacher when dealing with a mental health issue.[2] DfE should consider how to embed improved understanding and practice through high quality training and resources, and ways of tracking the extent to which this training has been completed.

- **The government should design a policy programme which reflects the evidence on drivers of, and the importance of early intervention for, mental health issues.** Outside of the Prevention Concordat and guidance issued by Public Health England there is little attention paid to the social and environmental determinants of mental health, and the inequalities in mental health outcomes related to experiences of discrimination based on sex, ethnicity, (dis)ability, and gender identity. There is also limited focus on provision and monitoring of local preventative and early intervention services, outside of the Mental Health Support Teams which are only available in a minority of areas. **The government should gather data on early intervention services including availability of these services in local areas, access, and spend, to generate a clear picture of the landscape and to monitor progress made in developing and offering services of this kind.** Given the likely causal links between socio-economic factors, including poverty and adverse experiences in childhood and adolescence, and poor mental health, as well as the importance of relationships for positive mental health, an effective prevention programme will require action from across government. **The government should consider a strategy which includes concerted action to reduce child poverty; expanding access to high quality early support services for families in all areas; and ensuring a well-equipped workforce in all schools to support pupils with additional needs.**

[1] Crenna-Jennings, Perera, and Sibieta, 'Education Recovery and Resilience in England'.
[2] Casebourne, 'Half of UK Teachers Don't Feel Confident Helping Pupils with Their Mental Health'; NHS Digital, 'Mental Health of Children and Young People in England, 2017'.

Introduction

Mental health is integral to wellbeing and a powerful predictor of educational and occupational success.[3] Evidence from longitudinal studies over the last three decades suggests that mental health issues are becoming more common amongst children and young people.[4] In England, prevalence figures point towards a sharp rise in mental health issues, with an estimated 20 per cent of 8- to 16-year-olds having a 'probable mental disorder' in 2023 compared to 12 per cent in 2017.[5] Yet, according to best available estimates only a minority of young people with a probable mental health disorder are currently accessing treatment, despite research suggesting that a large proportion of lifelong mental health conditions develop in childhood and adolescence.[6] These figures underscore the urgent need for comprehensive mental health support for children and young people.

In response, governments – particularly since 2015 – have initiated a series of policies, accompanied by funding commitments, to *'transform'* children and young people's mental health services. These interventions have included expanding access to treatment, reducing waiting times, and providing mental health support through schools. Despite some movement in the policy sphere, including the development of various frameworks, little is known about the progress that has been made against these commitments. Gaps in available data published by the government and its arm's length bodies make it hard to gauge whether targets have been met. To hold the government to account, this report serves as EPI's comprehensive assessment of the progress made in improving children and young people's mental health since 2015.

Policy context

Understanding the mental health policy landscape

Since 2015, the government and its arm's length bodies have published various documents aimed at improving children and young people's mental health. Figure 1 provides a timeline setting out the main developments in the government's plans to improve children and young people's mental health services. The main programmes that have taken this forward include:

- **Future in Mind,** published by the Children and Young People's Mental Health and Wellbeing Taskforce, a group established jointly by the Department of Health and NHS England.[7]
- **Five Year Forward View for Mental Health (FYFVMH**) which built on "Future in Mind" and provided more detailed objectives to improve children and young people's mental health services.[8] NHS England supplemented this document with the '**Implementing the five year forward view for mental health'** which detailed how it intended to deliver the

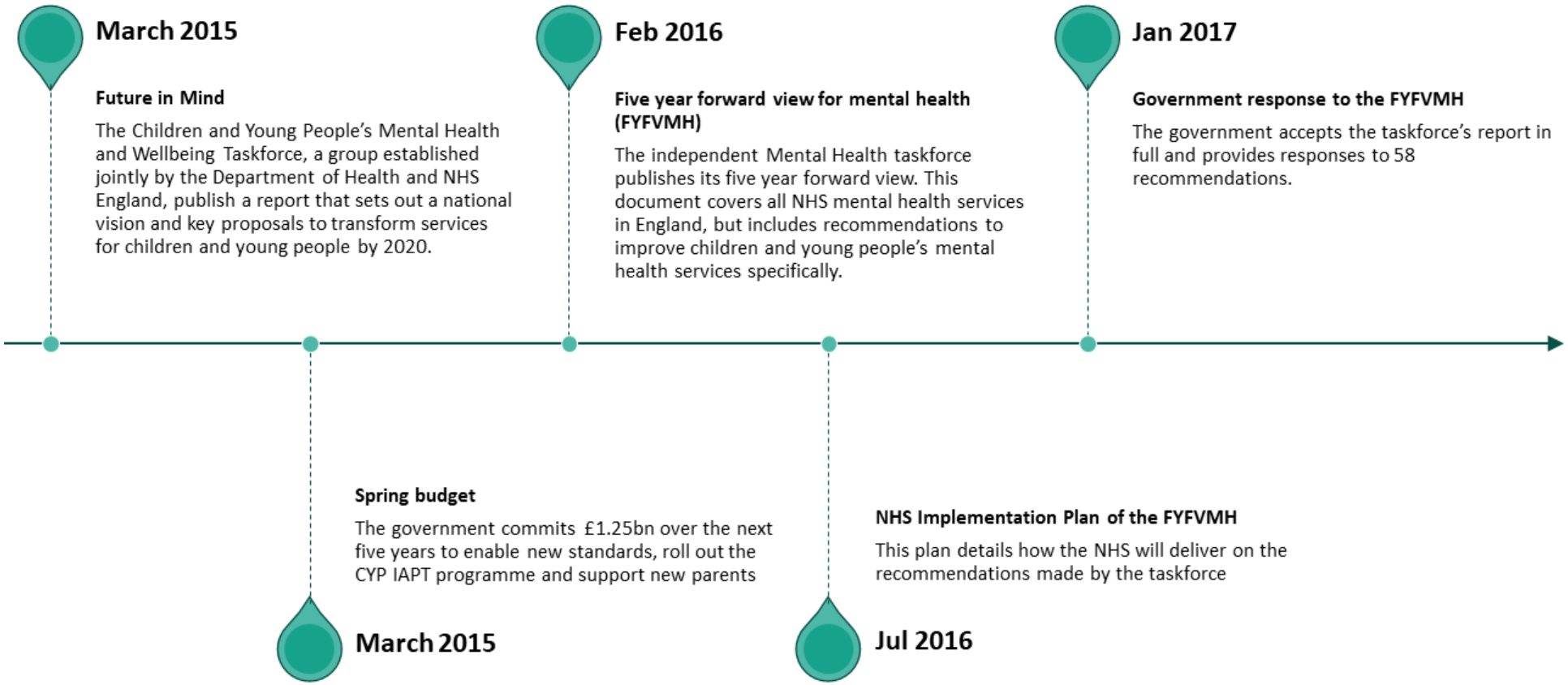
[3] Clayborne, Varin, and Colman, 'Systematic Review and Meta-Analysis'; Wickersham et al., 'Systematic Review and Meta-Analysis'.
[4] Holt-White et al., 'Briefing No. 4. COVID Social Mobility & Opportunities (COSMO) Study'.
[5] Newlove-Delgado et al., 'Mental Health of Children and Young People in England, 2023.'
[6] Grimm et al., 'Improving Children and Young People's Mental Health Services'.
[7] Department of Health and NHS England, 'Future in Mind - Promoting, Protecting and Improving Our Children and Young People's Mental Health and Wellbeing'.
[8] Mental Health Taskforce, 'The Five Year Forward View for Mental Health'.

recommendations made by the taskforce.[9] This plan presented more specific time frames for the delivery of the programme of work.

- **Transforming Children and Young People's Mental Health Provision: a green paper** was jointly published by the Department of Health and the Department for Education in December 2017.[10] It had three core aims:
    - Encourage schools and colleges to identify and train a designated senior lead for mental health.
    - Support new mental health support teams
    - Pilot a four-week waiting time for access to specialist NHS children and young people's mental health services across various areas in England.
- The **NHS Long Term Plan** which detailed priorities for the NHS.[11] This document was followed by the **NHS Mental Health Implementation Plan** with specific targets and time frames for children and young people's mental health services.[12]

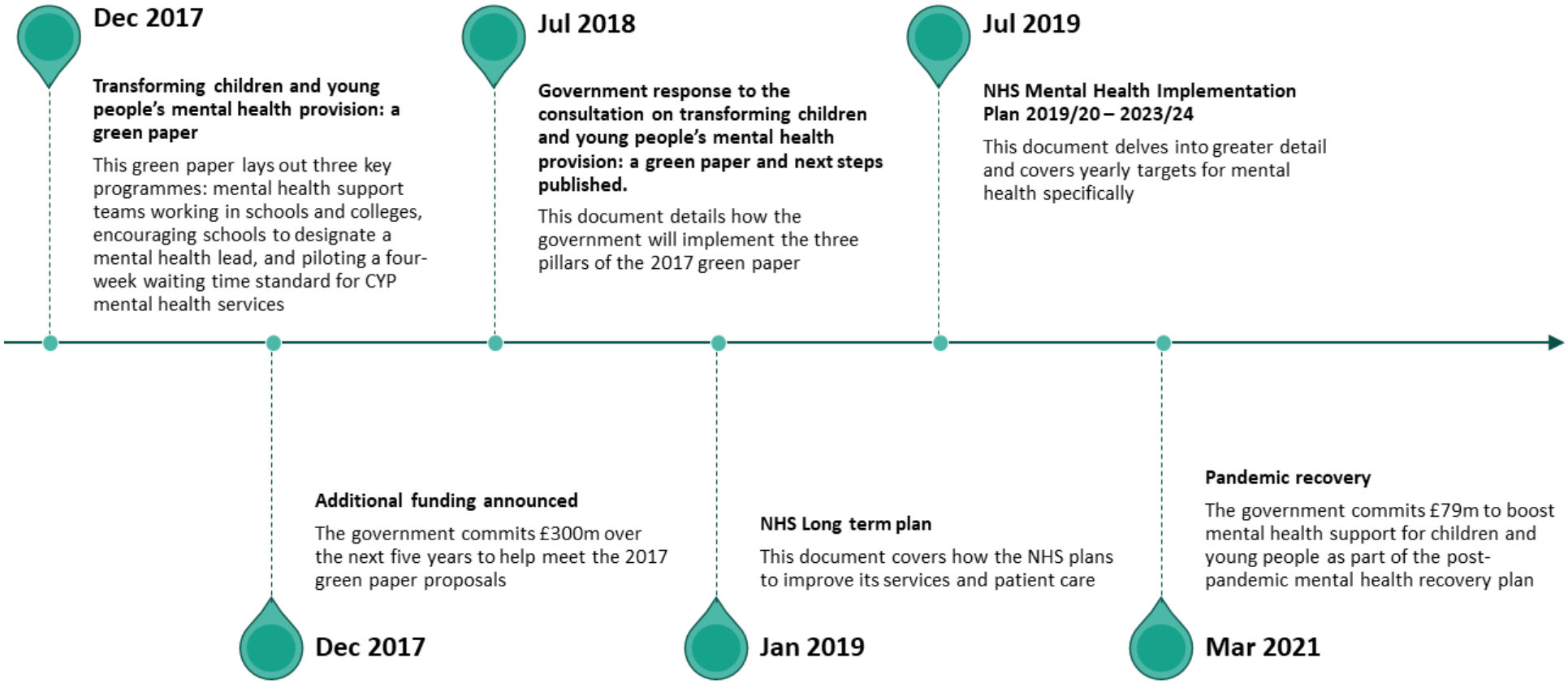
[9] NHS England, 'IMPLEMENTING THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH'.
[10] Department of Health and Department for Education, 'Transforming Children and Young People's Mental Health Provision: A Green Paper'.
[11] NHS England, 'The NHS Long Term Plan'.
[12] NHS England, 'NHS Mental Health Implementation Plan 2019/20 – 2023/24'.

Figure 1: Timeline of key developments in children and young people's mental health policy since 2015



[13]

[13] Department of Health and NHS England, 'Future in Mind - Promoting, Protecting and Improving Our Children and Young People's Mental Health and Wellbeing'; HM Treasury, 'Budget 2015'; Mental Health Taskforce, 'The Five Year Forward View for Mental Health'; NHS England, 'IMPLEMENTING THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH'; HM Government, 'The Government's Response to the Five Year Forward View for Mental Health'.



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[14] Department of Health and Department for Education, 'Transforming Children and Young People's Mental Health Provision: A Green Paper'; Department of Health and Social Care et al., 'Government Proposals on Children and Young People's Mental Health'; Department of Health and Social Care and Department for Education, 'Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: A Green Paper and Next Steps'; NHS England, 'The NHS Long Term Plan'; HM Government, 'COVID-19 Mental Health and Wellbeing Recovery Action Plan'.

What do we know about progress made to improve mental health services to date?

Government efforts to improve mental health services for children and young people have been subject to significant attention in recent years. Several organisations have sought to review the progress that has been made to improve service provision:

- The **National Audit Office** (NAO) conducted two reviews, one focusing on improvements in mental health services for children and young people in 2017 and for all ages in 2023. While the NAO's report on children and young people's mental health services recognised substantial strides made by the government, both reviews underscored concerns regarding the absence of a well-defined, cost-effective strategy to realise the government's ambitions. Additionally, the reviews highlighted data limitations and workforce shortages as significant risks in the successful implementation of key policy commitments.
- The **Health and Social Care Select Committee's Expert Panel** found that as of 2021 although there had been some progress in ensuring greater access to evidence-based treatments, a significant number of children and young people still could not access these vital services. While the commitment to reduce waiting times for eating disorder treatments appeared to be on track, the pandemic disrupted this progress. The panel did acknowledge the successful implementation of 24/7 crisis support lines but called for substantial improvements in crisis care services to better serve the needs of children and young people.
- The **Care Quality Commission** (CQC) has also published two reports on the quality and accessibility of mental health services for children and young people in 2017 and 2018. Their findings reveal a fragmented system, inconsistency in the quality of care and varying levels of accountability across the country. They also identified issues with the workforce as some staff in mental healthcare settings lacked the skills or capacity to identify mental health needs.[15]
- The **Office of the Children's Commissioner** has been tracking data relevant to children's mental health since 2017. They found significant geographic variation across the measures they explored: These include spending on children's mental health services, referral rates, and lastly, waiting times for children accepted into treatment.[16]
- The **NHS** and the **Department for Education (DfE)** have also published data relevant to the commitments outlined in the policy documents. For example, the NHS has published a data dashboard which collates data from across local areas (rather than individuals) to measure progress in delivering on *some,* though not all, of the targets from the FYFVMH and NHS long term plan. [17] For example, the latest data suggests that as of July 2023, 698, 851 individuals were accessing mental health services. The data is currently available across different levels of geography, including at a national and 'Integrated Care Boards' (ICB) level. [18] DfE has also published some data relevant to the 2017 green paper, namely the coverage of mental

[15] Care Quality Commission, 'Review of Children and Young People's Mental Health Services. Phase One Report.'; Care Quality Commission, 'Are We Listening? Review of Children and Young People's Mental Health Services'.
[16] Office of the Children's Commissioner, 'Children's Mental Health Services 2020/21'; Office of the Children's Commissioner, 'The State of Children's Mental Health Services 2019/20'.
[17] NHS England, 'NHS England » NHS Mental Health Dashboard'.
[18] The NHS splits England into 42 Integrated Care Boards and they are directly responsibly of commissioning services in their area.

health support teams. [19] The latest DfE data suggests that the coverage of mental health support teams has increased; as of 2023, Mental Health Support Teams cover 35 per cent of pupils in schools and learners in further education in England across 6,800 schools and colleges. Overall, however, reporting on progress is fragmented across departments and platforms, making it difficult to gain a full picture.

- The **Policy Innovation and Evaluation Research Unit** and the **BRACE Rapid Evaluation Centre** are currently leading a multi-part evaluation of Mental Health Support Teams operating in groups of schools and colleges in some parts of the country.[20] Findings from an early evaluation published in 2023 show that school staff felt more confident and had faster access to advice, yet sites reported they faced challenges retaining the new education mental health practitioners. Survey respondents also raised concerns about children falling through the gap between the teams' 'mild to moderate' remit and criteria for specialist support as well as certain groups being underserved by teams including those with SEND or neurodiversity, those from certain ethnic minority backgrounds and/or those living in challenging social circumstances.

Despite these insights, there remains a gap in understanding of progress made against the full set of commitments aimed at improving mental health services for children and young people. Prior evaluations and data in dashboards have focused on a select few, overlooking a holistic evaluation of the policies both directly and indirectly related to improving children and young people's mental health and wellbeing.

This report seeks to address the gaps in existing research by undertaking a review of policies that are directly and indirectly related to children and young people's mental health outcomes – including, for example, reducing stigma and promoting perinatal mental health support for new parents. It also extends existing research by examining progress made against largely overlooked objectives, including in relation to addressing self-harm and suicide, and commitments outlined in the NHS long-term plan which set ambiguous targets to be met by 2023/24.

[19] Department for Education, 'Transforming Children and Young People's Mental Health Implementation Programme: Data Release'.
[20] Ellins et al., 'Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report'.

Research aims and method

To comprehensively assess the progress made improving children and young people's mental health since 2015, our research questions included:

- To what extent has the government made progress in improving children and young people's mental health services?
- What are the gaps in the government's approach and data related to children and young people's mental health service provision?
- What features would an effective mental health strategy include following the significant rise in mental health issues in recent years?

To answer these questions, we employed a mixed methods approach:

- **Policy review**: We first reviewed all government policies related to children and young people's mental health, assigning them into three categories – "Implemented", "Some action has been taken according to available evidence" and "Unclear if any action has been taken". We used a combination of publicly available data, data accessed through Freedom of Information requests, responses to Parliamentary questions, existing reviews of the progress that has been made to improve mental health services and discussions with relevant government departments and sector experts.
- **Service provision analysis:** Based on gaps in available data, policy areas that the government has overlooked and input from our advisory group, we collected new data from local commissioners of mental health services through Freedom of Information requests. The requests covered questions assessing the availability and accessibility of mental health services and their alignment with national guidelines.
- **Consultation with young people**: Lastly, we consulted directly with young people with lived experience of mental health to seek feedback on our findings and inform our thinking around policy recommendations.

Is the government on track to deliver the key elements of its mental health strategy?

We extracted 161 policy commitments from the key policy documents outlined in Figure 1. As the Five Year Forward View for Mental Health and the NHS Long Term Plan include commitments related to adults as well, we excluded 26 policy commitments that were more closely related to older adults or NHS staff wellbeing outcomes – whilst acknowledging that adult and workforce mental health issues are related to children and young people's mental health outcomes – resulting in a total of 135 policy commitments. We then grouped the policy commitments into the following six policy areas, available in Table 1.

Table 1: The number of commitments in each policy area

Policy area	Number of commitments in each policy area
Addressing workforce weaknesses	11
Improving CYPMHS structure	56
Research & data for service improvement	31
Reviewing current policies	10
Suicide prevention	3
Wider support services for CYP wellbeing	24
Total	**135**

- The **'Addressing workforce weaknesses'** policy area involved commitments to enhance the capacity and training of the mental health workforce embedded within health, social care, and education systems. Examples of commitments included building capacity to deliver NHS talking therapies.
- The **'Improving CYPMHS structure'** policy area consisted of commitments that aimed to address the need for integrated and improved support across the entire child and young people mental health pathway. For example, it included the roll out of Mental Health Support Teams (MHSTs).
- The commitments in the '**Research & data for service improvement'** policy area focus on improving data collection and transparency in mental health services. They include plans to introduce metrics to benchmark services and conduct prevalence surveys.
- The policy area **'Reviewing current policies'** revolves around calls to either overhaul existing policies as well as introducing new policies including enhancing the legal rights of those with mental health needs and internet safety.
- The policy area of **'Suicide prevention'** underscores repeated commitments to reduce suicide rates by 10 per cent nationally. This involves the implementation of multi-agency suicide prevention plans in local areas, with a focus on evidence-based interventions.
- The policy area of '**Wider support services for CYP wellbeing'** covers policies that aim to enhance the provision of services that result in positive mental health. It includes commitments to combat stigma, mental health first aid training, and expanding support for parents.

We then assigned a rating to each policy commitment according to whether commitments had been delivered upon, as seen in Table 2. This assessment was based on a combination of publicly available data, Freedom of Information requests, responses to Parliamentary questions, existing reviews of the progress that has been made to improve mental health services, including reports from the National Audit Office and the Health and Social Care Select Committee, and consultation with relevant government departments and sector experts. Of note, the policy commitments outlined in the NHS Long term plan were set to be implemented by 2023/24. Unless these have been achieved ahead of schedule, if they were on track, we coded these as 'Some action taken'.

Table 2: The number and proportion of commitments in each category

Status tracker	Number of commitments that meet progress tracker definitions	% of commitments that meet progress tracker definitions
Implemented	48	36
Some action has been taken according to available evidence	79	58
Unclear if any action taken	8	6

Note: Per cent may not total 100 due to rounding using the largest remainder method

Figure 2 shows progress made within each thematic policy area.

Figure 2: The current status of progress for each of the policy areas

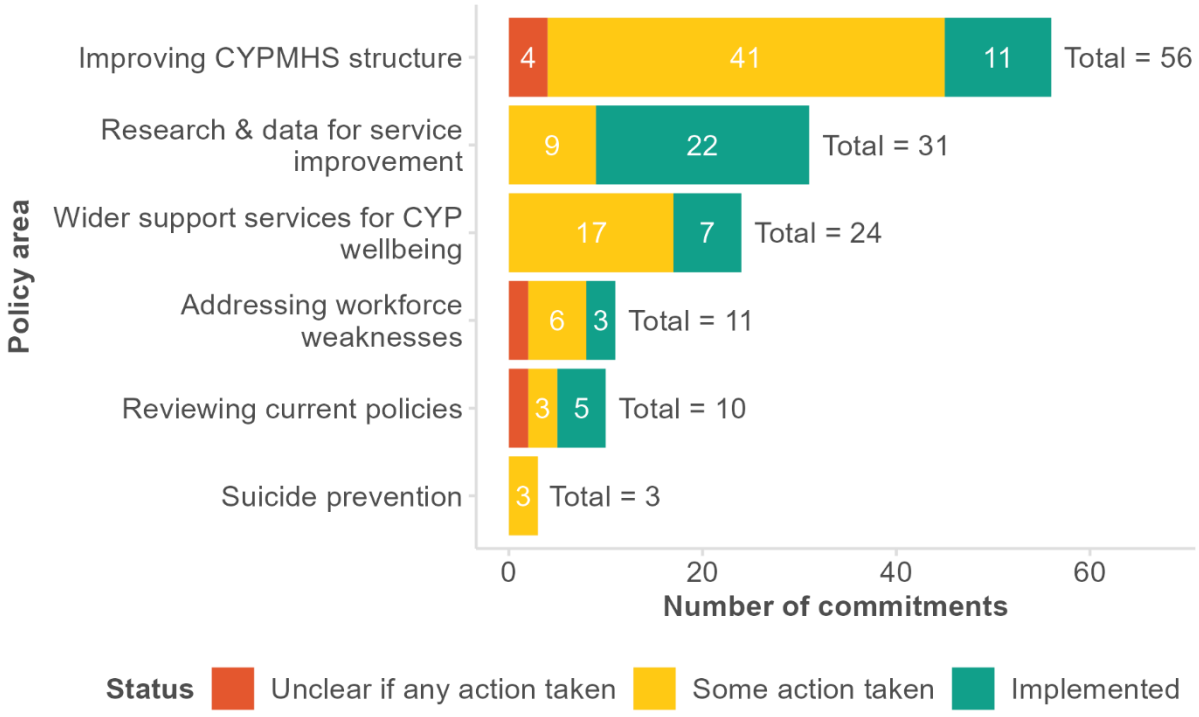
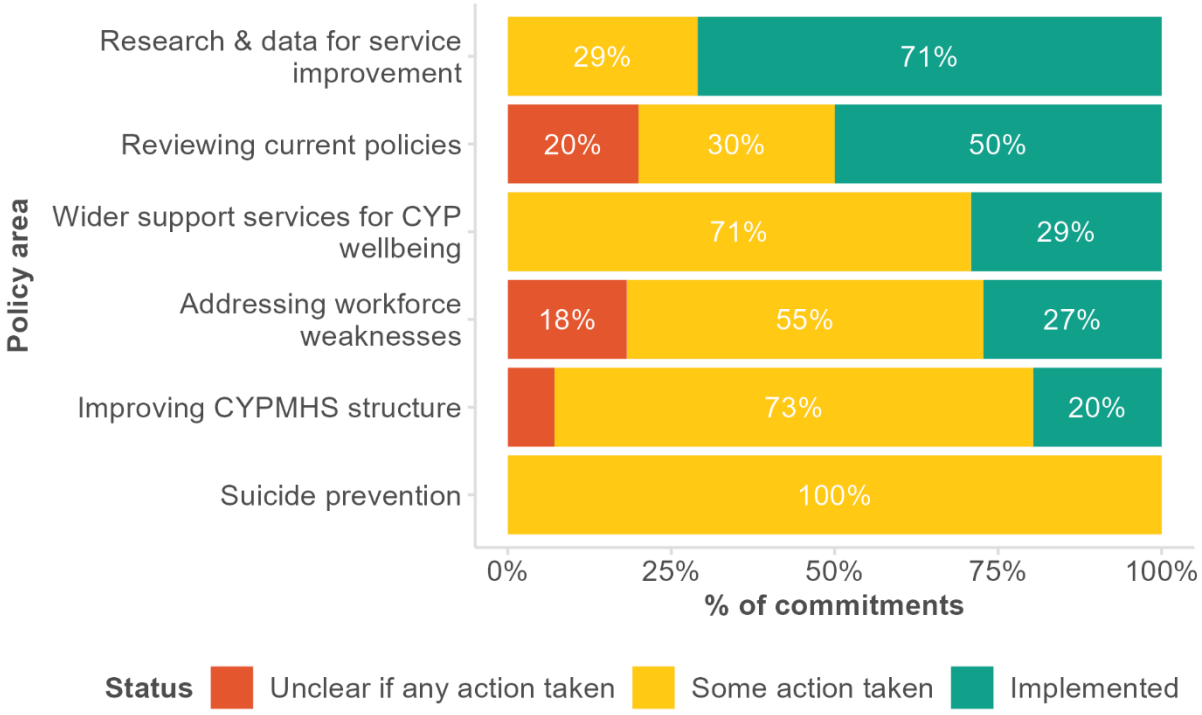


Figure 3 illustrates the progress made in each policy area as a proportion of the number of commitments. The majority of commitments in the 'Research and data for service improvement' policy area had been implemented. 'Addressing workforce weaknesses' was the policy area with the highest proportion of commitments for which it was unclear if any action had been taken.

Figure 3: The current status of progress for each of the policy areas as a per cent



Ratings of each the 135 policies can be found in the interactive tracker here: https://epi.org.uk/cypmhs-policies-tracker/

Our review of available data shows there have been a number of positive changes to provision for young people in recent years. A growing number of young people are now benefiting from community mental health treatments; in July 2023, according to NHSE data, 698,851 young people were accessing mental health services – up 22 per cent from 572,912 in March 2021.[21] This increase in the number of young people being seen by services is positive, yet these figures must be considered against a backdrop of rising prevalence rates of mental illness and higher levels of need amongst the population of children and young people. The health and education sectors are working together through the Mental Health Support Teams operating in many areas across the country; some findings from the evaluation of the 'trailblazer' areas suggest that schools and colleges have welcomed the additional support as staff felt more confident talking to pupils about mental health issues.[22] Additionally, there has been a notable expansion of the core CYPMHS workforce from 11,687 full time staff in 2016 to 20,526 in 2022.[23]According to NHS England, mental health crisis phone lines are operating nationwide.[24] Lastly, there has been some increased transparency through data releases to allow for measuring accountability.

However, many of these improvements have occurred from a very low starting point. There has been little focus on prevention and regard for the wider determinants of mental health, including

[21] NHS Digital, 'Mental Health Services Monthly Statistics'.
[22] Ellins et al., 'Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report'.
[23] NHS Benchmarking Network, 'CYPMHS Workforce Census 2022'.
[24] NHS England, '24/7 Urgent Mental Health Helplines Available across the Country'.

poverty and adverse experiences in early life. There still exists a fragmented mental health care system where young people are signposted to different agencies, and a lack of transparency and accountability in areas of the mental health care pathway (e.g., non-specialist and non-clinical mental health support and crisis care). Further, some school and college leaders felt that the remit of the Mental Health Support Teams, the government's flagship policy in this space, have been too narrowly focused on 'mild-to-moderate' mental health issues, whilst those with more severe complex needs still face long waiting times in core CYPMHS services.[25]

The pandemic has exacerbated existing challenges. Targets and projections have been based on historical data – meanwhile, the rates of probable mental health disorders have continued to rise, waiting times, particularly for eating disorders, continue to be affected by the pandemic, and retention rates in the mental health workforce have fallen.[26] Administrative data does not provide a complete picture of service availability and quality, and longstanding concerns around the quality of existing published data remain.

Additionally, our analysis shows that:

- Most policy plans which have been implemented are related to improving processes rather than the experiences and outcomes of young people with mental health needs (see Figure 3). The majority of policies related to wider support services for young people's wellbeing, addressing weaknesses in the mental health workforce, and improving service structure have not been fully realised, according to available information. Given that the majority of these commitments – aside from the three cornerstone green paper policies of designated mental health leads in all schools; a four-week waiting time standard; and mental health support teams in all areas of the country – were to be met by 2023/24, it is unlikely they will be fully realised within proposed timescales.
- Although not all targets necessarily have to be quantifiable, we found that some of the reviewed commitments, particularly in Future in Mind and the 2017 green paper, were exceptionally ambitious and overarching, and lacked a clear implementation or measurement strategy. Additionally, the origins of specific benchmarks, such as the 35 percent access rate for CYPMHS, remain unclear. Equally, it is unclear why certain operationalisations of targets were used – e.g., why waiting time standards were developed for eating disorders and not other disorders which are more prevalent.[51]
- Many commitments did not have metrics or specific targets with milestones associated with them which allow for an objective assessment. Even for quantifiable commitments, there were data quality issues for some of the metrics and we were not always able to track delivery using publicly available data released by NHS Digital (now part of NHSE), the DfE and DHSC. We turned to information obtained by the Children's Commissioner using her legal powers, parliamentary debates, parliamentary questions, and the work of other researchers to piece together a picture of progress.

[25] Ellins et al., 'Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report'.
[26] Office of the Children's Commissioner, 'Children's Mental Health Services 2020/21'; NHS Benchmarking Network, 'CYPMHS Workforce Census 2021'; NHS Benchmarking Network, 'CYPMHS Workforce Census 2022'; Department for Education, 'Transforming Children and Young People's Mental Health Implementation Programme: Data Release'.

- Furthermore, we found inconsistencies between policy and implementation documents. For instance, in the Five Year Forward View for Mental Health, there is a target to 'ensure that by 2020/21 at least 30,000 more women each year access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.' However, the accompanying implementation document focuses on increased access to perinatal mental health support without referring to quality but rather focuses on care closer to home. Meanwhile, the NHS dashboard tracks the 'number of women accessing specialist community perinatal mental health services.' This lack of internal consistency complicates measurement of progress and operationalisation of data.
- We also found inconsistencies between commitments specifically for children and young people, and those relevant to all-age mental health services. Some commitments relevant to children and young people were incorporated within broader ones for all-age mental health services, and yet performance has not been reported separately. For instance, the 'Five Year Forward View for Mental Health' includes an aim to eliminate inappropriate out-of-area placements by 2020/21. It is unclear from the policy document what age range this covers. In the accompanying implementation document, the policy apparently applies to children and young people, whilst in the NHS Long Term Plan, inappropriate out-of-area placements are explicitly referred to as relevant to adults. Adding to the confusion, data in the NHS dashboard only pertains to adults.
- Finally, it was often unclear which department should oversee a particular initiative. In some cases, when we consulted with the department apparently accountable for commitments, they referred us onto others. Additionally, despite the introduction of multiple cross-government policies, it remains unclear whether the Cabinet Office plays a direct role, or if the responsibility for fulfilling these commitments ultimately rests on the NHS.

In the next section, we focus in on one commitment from each of the six policy areas to showcase our approach to evaluating progress and some of the difficulties we encountered.

Addressing workforce weaknesses

Only three of 11 policies (or 27 per cent) in this area have been implemented. Below, we focus on one commitment related to increasing the number of therapists. Information available in the policy tracker is presented in the table below, with additional detail on our approach presented after.

Expanding the mental health workforce: Therapists

Source document: Implementing The Five Year Forward View for Mental Health

Commitment: Delivering the increase in access to mental health services will require a significant expansion in the workforce: Therapists.

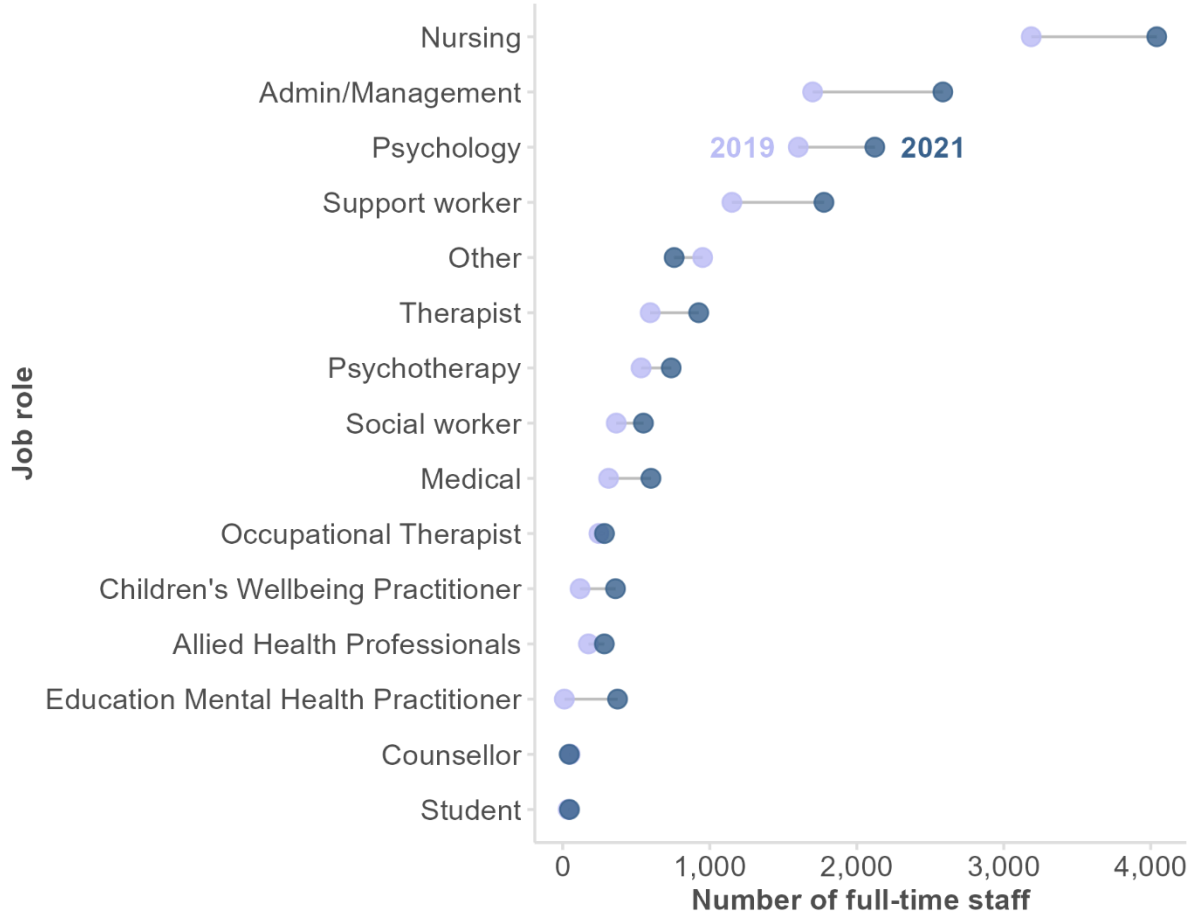
Year	2016/17	2017/18	2018/19	2019/20	2020/21
Number	200	428	428	228	52

Action to date: The NAO report from 2018 shared that "As at May 2018, NHS England and Health Education England considered there was a risk that the Forward View targets for 2020-21 would not be met." Mental health workforce statistics are not publicly available at a granular level and so it is unclear how NHSDigital was monitoring this target. More recently, evidence from the NHS Benchmarking survey of the CYPMH workforce suggested an increase in the number of therapists from 595 in 2019 to 925 in 2021, which is less ambitious than the original plans to recruit 1,336 new therapists. It should also be noted that it is unclear which professionals count as a "therapist" and whether definitions have stayed consistent between the target and the NHS Benchmarking survey. Lastly, although this target was set to be achieved in 2021, a census from March 2022 suggests a decrease in the number of therapists, down to 682 from 925 the previous year.

As we could not access relevant data from NHSDigital, we studied data from the NHS Benchmarking survey of the CYPMH workforce (see Figure 4). The March 2021 census (by which date the target was meant to be achieved) indicated that the increase in the size of the 'therapist' workforce fell short of the policy commitment by 775 therapists. Figure 4 also reveals that the profession with the highest percentage growth has been Education Mental Health Practitioners, reflecting the roll out of Mental Health Support Teams in schools and colleges. As some progress had been made, we coded this as 'Some action taken'. Importantly, child and adolescent psychiatrists are omitted from this data; according to census data from the Royal College of Psychiatrists, the overall number of child and adolescent psychiatric consultants has grown in recent, pre-pandemic years, and the vacancy rate has fallen very slightly from 12.0 per cent in 2017 (86 out of 717) to 11.2 per cent in 2019 (134 of 1193).[27] A third of all consultant vacancies reported in the census are found within child and adolescent and old age psychiatry.

[27] Royal College of Psychiatrists, 'Workforce Figures for Consultant Psychiatrists, Specialty Doctor Psychiatrists and Physician Associates in Mental Health, Census 2021'.

Figure 4: There has been an increase in the size of the NHS CYPMHS workforce since 2019



Source: EPI analysis of the NHS Benchmarking Network's census of the CYPMH workforce

Analysis of the NHS Benchmarking network census data suggests that the retention of staff remains a challenge. A subsequent 2022 census by the NHS Benchmarking Network suggested a decrease in the number of therapists, down to 682 from 925 the previous year.[28] The National Audit Office has also highlighted that the NHS does not have a clear, long-term plan for its workforce. This absence of a strategic vision makes it difficult for both national and local organisations to work together effectively in training and hiring staff. The challenge is compounded by the fact that funding for education and training is often short term and doesn't consistently match projected staffing needs.[29] The Benchmarking Network, whilst a step in the right direction, is not statutory and receives varying levels of response from the NHS, independent, local authority, and voluntary, community and social enterprises (VCSE) sectors.

Improving CYPMHS structure

Only 11 out of 56 policies (or 20 per cent) had been implemented in this policy area. One policy commitment was to ensure all children and young people are able to access NHS-funded services within four weeks. Although the specific commitment presented below was to trial a four-week waiting time in selected areas, children and young people starting care within four weeks from

[28] NHS Benchmarking Network, 'CYPMHS Workforce Census 2022'.
[29] National Audit Office, 'Progress in Improving Mental Health Services in England'.

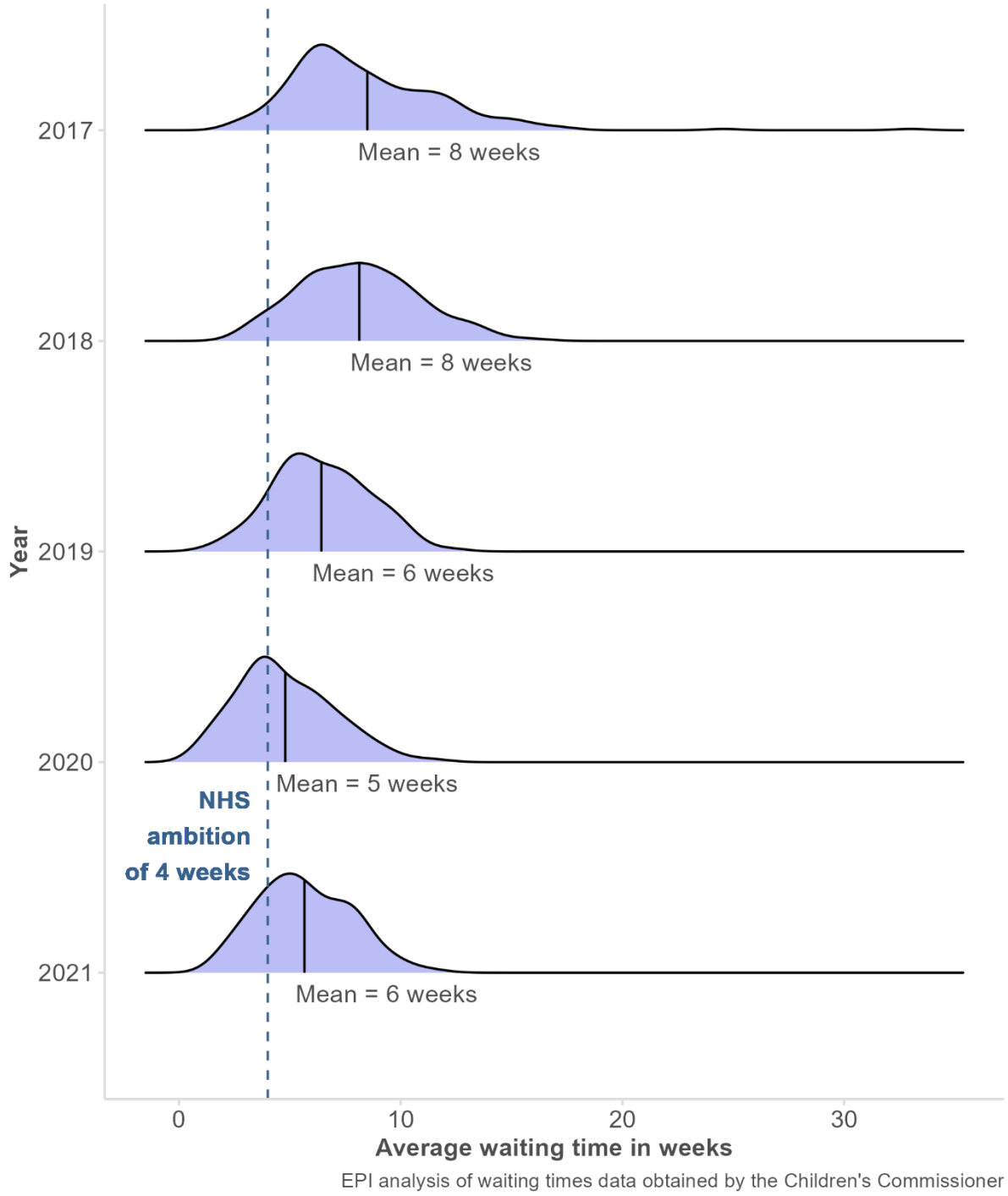
referral became a national ambition in 2021 when the NHS published the 'Mental health clinically-led reviews of standards' report.[30]

A new four week waiting time standard
Source document: 2017 green paper
Commitment: As we trial and roll out the new Mental Health Support Teams, the NHS will pilot implementing reduced waiting times for access to NHS-funded children and young people's mental health services in some of the trailblazer areas outlined above. This will aim for children and young people in those areas to be able to access NHS-funded services within four weeks. Evaluation of the trailblazers will look at the impact the new Mental Health Support Teams and the Designated Leads for Mental Health in schools and colleges have on referrals to NHS mental health services. The evaluation of the Mental Health Service and Schools Links Pilot suggested that better links between schools and the NHS mental health services resulted in more appropriate referrals to NHS mental health services, although not an overall reduction in referrals. At this stage, we anticipate that, in the long term, the creation of the new Mental Health Support Teams will lead to a reduction in referrals to NHS services, as earlier intervention prevents problems escalating. However, we will look carefully at this issue during the waiting times pilots and trailblazer phase.
Action to date: This is currently being evaluated. CCO research indicates wide variation in current waiting times for children and young people and a slight increase in average waiting times for the first time 2017

Figures obtained by the Children's Commissioner indicate that the NHS is long way off from ensuring a maximum waiting time of four weeks.[31] The latest data indicates that waiting times increased for the first time since records began in 2017, following four years of decreases (see Figure 5). A focus on average waiting time hides wide variation; in Figure 1Figure 5, we also see that the variation in average waiting times across Clinical Commissioning Groups is decreasing, indicating a narrowing of geographical disparities in waiting times – it is unclear, however, whether this reflects real improvements to waiting times in the areas with the longest waiting times, whether data collection processes have improved, or both. [32] Moreover, as of 2021, only 26 per cent of children and young people are seen within four weeks of referral, when the national ambition was a *maximum* waiting time of four weeks.

[30] NHS England, 'Mental Health Clinically-Led Review of Standards. Models of Care and Measurement'.
[31] Office of the Children's Commissioner, 'Children's Mental Health Services 2020/21'.
[32] The NHS used to split England into a number of Clinical Commissioning Groups which commissioned services. CCGs have now been superseded by Integrated Care Boards.

Figure 5: The average waiting time across Clinical Commissioning Groups between referral and treatment in weeks



Research & data for service improvement

Twenty two of 31 policies (or 71 per cent) had been successfully implemented in this policy area. Here, we look at the following commitment to develop measures that covered access, waiting times, and outcomes.

Development of a robust set of metrics covering access, waiting times and outcomes
Source document: Future in mind

Commitment: Development of a robust set of metrics covering access, waiting times and outcomes to allow benchmarking of local services at national level.
Action to date: The NHS launched a dashboard to track access and waiting times across select indicators. More recently, outcomes data was reported for the first time. Benchmarking of local services at the national level however requires caution as differences in indicators could indicate variations in levels of need, service provision or data quality.

The NHS dashboard captures measures related to children and young people's *access* to mental health services. The Children's Commissioner publishes data from NHSDigital on waiting times.[33] Two years past the 'Future in Mind' deadline, outcomes data are now being released, so we have marked this target as 'Implemented'.

Since the creation of the dashboard, there have been questions regarding its quality and completeness. The quality of the Mental Health Services Data Set lags behind that of other administrative health datasets including Emergency Care and Outpatient services. Given that better data is vital to measuring the impact and quality of services, the reporting of outcomes data is a step in the right direction. However currently the data only covers a minority of young people using NHS mental health services. Of the approximately 6,000 children with outcome data in July 2023, less than half reported a measurable improvement to their mental health during the course of treatment.[34]

Additionally, data covering adults vastly exceeds the information available for children and young people. Unlike data available from the Department of Education through Explore Education Statistics, data available from the Department of Health and Social Care and NHSDigital is not as easily accessible or comprehensive. For instance, there are significant gaps in the list of chosen indicators, including no data on access, waiting times, and/or outcomes (e.g., readmission, recovery rates) across:

- Socio-demographics;
- The type and severity of mental health condition and for those with more than one diagnosis (i.e., complexity);
- The types of treatment (e.g., Cognitive Behavioural Therapy);
- How treatments are delivered (digital support, school/community based, inpatient, etc.);
- Levels of engagement from the child or young person;
- The average number of sessions;
- The average length between first (assessment) and second appointment (start of intervention).

Whilst the collection and reporting of data is a step in the right direction, poor data quality at this level is a barrier to transparency across the whole system. The NHS warns that geographical disparities in these metrics may be due to variations in the prevalence of mental illness, service provision, or due to limitations in data quality; they state that the dataset is "known to be incomplete" and fluctuations in trends over time may be due to "the result of MHSDS data quality

[33] As of February 2023, NHS Digital was merged and incorporated into NHS England.
[34] NHS Digital, 'Mental Health Services Monthly Statistics'.

issues". [35] These factors limit our understanding and knowledge of whether some conditions or treatment offers are prioritised over others; in a context of limited capacity, it is possible that resources are diverted and young people requiring treatment for other conditions may receive poorer quality care as a result. Whilst the NHS prevalence surveys present a national picture of mental health issues, data on regional and area differences are imprecise and non-existent respectively. To address this limitation, the government must equip local authorities and Integrated Care Boards with data to effectively address treatment gaps in their areas. Given the resource-intensive nature of prevalence surveys, it may be worthwhile to explore the feasibility of using routinely collected data (e.g., the Social, Emotional, Mental Health Flag in the school census that occurs three times a year) or alternative data sources (e.g., GP notes in the Clinical Practice Research Datalink). In doing so, we could rule out that geographical disparities in service indicators are solely due to variations in levels of mental illness. This may also help the NHS more effectively 'horizon scan' through employing epidemiological modelling techniques that provide projections of mental health needs for the commissioners of mental health services.

We also observed that sometimes data was collected (e.g., by NHS England) but it was not always made publicly available. For example, in this presentation at the Association of Directors of Children's Services Annual Conference, it is clear that NHS England collect data relevant to the commitments. [36] However, we were unable to locate further information, which inclines us to believe that the data are not easily or readily available. The obtuse format – with little detail on methodology – makes it challenging to scrutinise progress through publicly available data solely.

There is also a broader question around data completeness, specifically whether the data can ever reflect *actual* need. Access, waiting time, and outcome figures capture those who sought and successfully gained access to services – and, even so, published data on outcomes following engagement with NHS services currently covers only a very small number of young people. These figures do not capture children and young people not accepted for treatment in the first place. Our previous research has indicated that the most common reason for referrals being rejected was that children's mental health conditions were not serious enough to meet the eligibility criteria for treatment.[37] There is currently no data on what happens to children and young people referred but not accepted for treatment, including whether they access other services or receive no support. Levels of unmet need are likely to be noteworthy given the gap between prevalence and mental health treatment rates.

In addition, we know very little about the care that is provided through local authorities, voluntary, and independent providers. To our best knowledge, this data is not routinely and systematically collected which means solely drawing conclusions based on NHS data cannot provide us with a full picture of provision or how metrics – such as access, waiting times, and outcomes – vary.

Lastly, NHSE has not established indicators that would allow understanding of the full impact of its plans, for example, regarding the quality of care. Most of the data that is publicly available is reported from routinely collected administrative data. This data cannot offer insights into how the cases has changed over time (e.g., in the severity of the mental health condition) except for crises

[35] NHS Digital.
[36] Chitsabesan and Brown, 'Children & Young People's Mental Health: Progress of Long Term Plan and Impact of COVID-19'.
[37] Crenna-Jennings and Hutchinson, 'Access to Children and Young People's Mental Health Services - 2018'.

and cannot shed light on the acceptability of services or satisfaction with care. Beyond qualitative studies of young people's (often poor) experiences, we know very little about how these vary across key factors (e.g., demographics or mental health condition).

Reviewing current policies

Five of ten policies (or 50 per cent) have been implemented in this area. Here, we looked at a commitment to regulate therapies. One survey of mental health support in schools found that of the schools offering counselling services, one in seven hosted counsellors with no professional qualifications or registrations.[38] Following powerful stories of unqualified counsellors treating patients and mental health conditions worsening, there have been repeated calls to regulate the profession. [39]

Regulation of psychological therapies
Source document: The Five Year Forward View for Mental Health
Commitment: The Department of Health should consider how to introduce the regulation of psychological therapy services, which are not currently inspected unless provided within secondary mental health services.
Action to date: The government currently has no plans to introduce regulation of counsellors and psychotherapists. Professions such as psychotherapist and counsellor are not registered professions. During a Parliamentary debate, Lord Bethell said "However, more rules are not always the answer to every problem. While statutory regulation is sometimes necessary where significant risks to users of services cannot be mitigated in other ways, it is not always the most proportionate or effective means of assuring the safe and effective care of service users."

Currently, anyone in the UK can call themselves a "counsellor" without standardised qualifications or training. Moreover, it is voluntary for therapists working outside the NHS to be accredited by the Professional Standards Authority. From the evidence we reviewed from a parliamentary debate, there has been resistance from the government to introduce legislation. [40] Therefore, we classify this target as 'Unclear if any action taken'.

Suicide prevention

We rated all three policies in this area related to suicide as 'some action taken'. Here we look at the commitment to reduce the number of suicides, with a national ambition to reduce the figure by 10 per cent. Although the policy does not explicitly refer to children and young people, we note that suicide rates amongst 15–19-year-olds have been increasing since 2010; the latest figures from the Office for National Statistics (ONS) suggest the suicide rate in this age group has reached its highest point since the turn of the century with a suicide rate of 6.2 per 100,000 people in 2021.[41] It is important to know that absolute numbers of suicides in this age group are low and care should be taken when drawing conclusions about how the rate has changed over time.

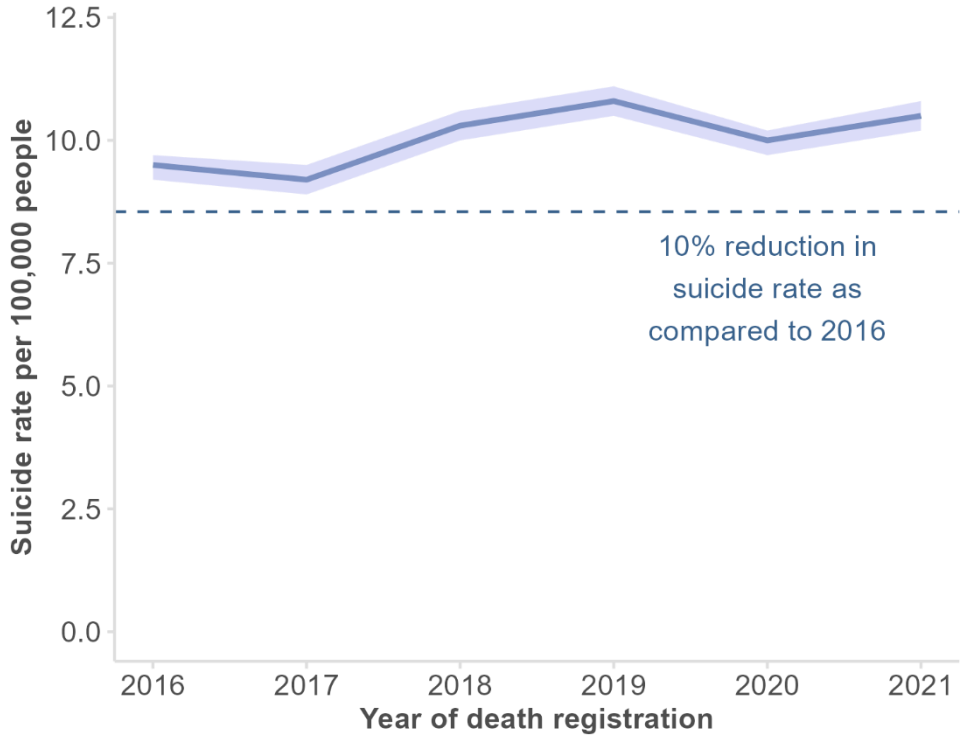
Reduce the number of suicides

[38] Marshall et al., 'Supporting Mental Health in Schools and Colleges: Quantitative Survey'.
[39] Dunbar and Subedar, 'Mental Health'.
[40] 'Mental Health'.
[41] Office for National Statistics, 'Suicides in England and Wales: 2021 Registrations'.

Source document: Implementing The Five Year Forward View for Mental Health
Commitment: By 2020/21, the Five Year Forward View for Mental Health set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. To support this, by 2017 all CCGs will fully contribute to the development and delivery of available local multi-agency suicide prevention plans, together with their local partners.
Action to date: PHE, now the UK Health Security Agency and Office for Health Improvement and Disparities, published guidance for local areas. This progress report suggests that all areas have a multi-agency suicide prevention plan in place. Research from Samaritans and the University of Exeter in 2019 which surveyed local authorities and analysed every area's local plan, found that while 'preventing and responding to self-harm' was included in 92% of plans, actions were being delivered in only 55% of them. The latest progress report also suggested that "following several years of decline, the number of suicides registered in England increased in 2018 and 2019". Of note, in 2018, the standard of proof used to determine whether a death is suicide was lowered to the balance of probabilities where previously it had been beyond reasonable doubt. The Suicide prevention in England: 5-year cross-sector strategy reaffirmed that a reduction in suicide rates was a priority.

Figure 6 shows the suicide rate per 100,000 people. In 2016, the rate was 9.5; a ten per cent reduction entails a target of 8.55 by 2021. Yet, the figure does not reach this target and instead fluctuates considerably. However, as the commitments also includes the implementation of local multi-agency suicide prevention plans and available evidence suggests that all local areas have these plans in place, we coded this target as 'Some action taken'.

Figure 6: The government failed to reach its commitment to reduce suicide rates by 10 per cent as compared to 2016



It is important to remember that suicides often take place outside of healthcare settings and are the result of a complex range of influences that are not always within the scope of mental health services. Effectively tackling suicide requires the coordination of an effective cross-government strategy that brings together a wide range of services including, at the least, mental health services, the VSCE sector, children's services, education and health services, justice including police and transport police, public health, employers, and government.

Wider support services for CYP wellbeing

Seven of 24 policies (29 per cent) were coded as 'Implemented' in this policy area. Here we look at the following commitment from the 2017 green paper to provide mental health awareness training for teachers.

Mental health awareness training for teachers
Source document: 2017 green paper
Commitment: We are committed to building on [the Youth Mental Health First Aid training] programme so that, as set out in our manifesto, a member of staff in every primary and secondary school in England receives mental health awareness training.
Action to date: In the government response to the 2017 green paper, it stated that "To reduce stigma and promote awareness, we have trained a member of staff in Mental Health First Aid in a third of state secondary schools; by this time next year we will have reached a further 1,000 schools…We remain committed to providing mental health awareness training to every secondary school by 2019 and every primary school by 2022. In the first year, we invested £200,000 in the training, and have achieved the first milestone of training a member of staff in a third of secondary schools (1,000). By this time next year we will have reached a further 1,000 schools. We are scoping delivery of our commitment to rolling out mental health awareness training to primary schools which we hope to begin soon." It is unclear what progress has been made since.

It is unclear what progress has been made in this area *since* the government response to the 2017 green paper published in 2018.[42] It is possible that this policy was later amalgamated into a policy related to 'Senior Mental Health Lead' training as one of the learning outcomes for this training is "signpost, increase and promote awareness of resources to support staff".[43] If we take this to be true, around six in ten state-funded schools and colleges (62 per cent) have completed their *application* for a grant which enables them to undertake senior mental health lead training. Given that training is provided by 61 providers, it is possible quality in training is variable.[44] The ambiguity around the target and what data exists to support any of the government's assertions inclined us to code this as 'Some action taken'.

[42] Department of Health and Social Care and Department for Education, 'Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: A Green Paper and Next Steps'.
[43] Department for Education, 'Learning Outcomes for Senior Mental Health Leads in Schools and Colleges'.
[44] Department for Education, 'DfE Assured Senior Mental Health Lead Training Courses'.

Gaps in our knowledge of service provision

Despite efforts from various organisations to shed light on progress the government has made in improving mental health services, there remain gaps in our knowledge of service structure, organisation and delivery and how these vary across the country. Nationally, the indicators published quarterly by the NHS do not comprehensively reflect what matters for service quality; for example, they do not capture the level of need across the country. In the absence of this information, we turned to the 42 newly formed Integrated Care Boards (ICBs). We selected six areas of service provision that had either been overlooked by existing policy commitments or where we could not ascertain what was being delivered from the available data without going directly to providers of services. We used Freedom of Information requests to better understand these 'blind spots' and geographical variation in service provision. Lastly, we identified and reflected upon examples of good practice from ICBs.

How proactive are services?

During our policy review, we noticed a strong interest in addressing the needs of individuals with mental health issues; however, there appears to be a notable gap in the attention given to proactively identifying young people with mental health needs. We therefore asked whether there were arrangements for screening groups of young people with known higher risk of mental ill-health:

- In the area you cover, are there services / pathways / arrangements for screening groups of young people with higher risk of mental ill-health (e.g., children in contact with social care; care leavers; children who require support from multiple services; asylum-seeking children).

It was evident from the responses that the provision of these screening arrangement and pathways varies by ICB, the responsibility for commissioning services varies, and some ICBs simply do not hold the information on what support is available for at-risk young people. Twenty-seven ICBs reported having specific arrangements. For example, children in care were often prioritised for assessment – though not always for treatment. ICBs shared case studies of the Initial Health Assessment though we note that there is a legal requirement to arrange a health assessment for looked after children. We were provided with evidence of good practice – for example, Leicester, Leicestershire and Rutland ICB told us that they administered the Strengths and Difficulties Questionnaire annually to children in care. Some ICBs told us that unaccompanied asylum-seeking children were covered under their process for screening children in care, though these services were sometimes commissioned by the local authority and sometimes by the ICB. Additionally, eight ICBs had no specific arrangements, relying on clinical need instead. The remaining seven ICBs did not hold this information and suggested to contact the local trust (provider) or local authority. No ICB explicitly mentioned its liaison and diversion service, which are supposed to exist in all areas and identify individuals with mental health concerns, learning disabilities, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system.[45]

[45] NHS England, 'Liaison and Diversion'.

How is fragmented service provision dealt with?

Previous research by EPI and others has highlighted fragmented provision of services across agencies.[46] The introduction of Integrated Care Systems (ICS) was designed to bring various stakeholders together and to commission services more effectively.[47] We sought to understand how the existing fragmented service structure was dealt with in relation to vulnerable young people with cross-cutting needs. We asked:

- In the area you cover, are there specific arrangements for young people with complex needs, which may cut across multiple services, e.g., NHS mental health services, social care, youth justice, etc.?

We again saw a wide variation in arrangements for young people whose needs cut across multiple services. Thirty-three ICBs responded they had implemented a range of strategies and arrangements, largely around multi-agency collaboration and multi-agency meetings. We heard from ICBs that local authorities, NHS trusts, and various voluntary, community and social enterprises worked closely together to address the needs of young people with complex issues. Specific approaches and services vary by region, with some areas having risk assessments, care plans, and regular multi-agency meetings to discuss complex cases, assess needs, contribute to the design of Education, Health and Care plan, and deliver interventions. We heard examples of good practice from ICBs. For example, in South Yorkshire these multi-agency meetings are attended by members of the CAMHS Crisis Team, Social Care, the Police, Youth Justice Service and other key agencies to ensure young people with cross-cutting needs receive appropriate mental health support. Further, CYPMHS services in Essex told us they collaborate with local substance misuse services to jointly manage young people on their caseload. We also received vague answers such as "Yes, [ICB] complies with all national policies and frameworks" in response to our FOI question. Lastly, six ICBs told us that they did not hold this information and referred us to trusts for further information.

The availability of crisis care and follow-up care

The number and proportion of 0–18-year-olds who attend Accident and Emergency Accidents for mental health crises has continued to rise and findings from the Care Quality Commission (CQC) suggest that some young people struggle to access services until they reach crisis point.[48] Meanwhile, EPI and others (including the Health and Social Care Select Committee) have noted a lack of transparency around crisis care and accompanying intensive home treatment for children and young people, beyond the NHS acknowledging the 100 per cent national coverage of 24/7 mental health crisis care and urgent mental health helplines. For example, it is unclear what quality of the care looks like and whether follow-up care is offered for those discharged from crisis care teams. Therefore, we asked the following two questions:

- Is there a mental health crisis care team for all young people in the area you cover?

[46] Crenna-Jennings and Hutchinson, 'Access to Child and Adolescent Mental Health Services in 2019'.
[47] Integrated Care Systems are composed of Integrated Care Boards which plan and commission services and Integrated Care Partnerships which bring together local government, the voluntary sector, NHS organisations, and others to develop a health and care strategy for the area.
[48] Care Quality Commission, 'Review of Children and Young People's Mental Health Services. Phase One Report.'; Care Quality Commission, 'Are We Listening? Review of Children and Young People's Mental Health Services'; National Audit Office, 'Improving Children and Young People's Mental Health Services'.

- Is follow-up care provided after contact with the mental health crisis team is terminated?

We received a range of responses to this question. We were surprised that four ICBs responded they did not hold this information, in spite of NHS England claiming that all areas had a mental health crisis team. In response to the second question regarding follow-up care, we again observed that follow up care varied. Follow up care was generally determined on a case-by-case basis. Some ICBs offered signposting to voluntary, community, social enterprise sector services; a phone call within a specific time frame (often 7 days); or a referral to community specialist CAMHS or Intensive Home Treatment Team. Of note, however, far fewer ICBs responded to the follow-up question, with 10 either not responding or not holding the information requested suggesting we contact NHS trusts for further information.

Extending services to age 25

There is widespread consensus that a good model of mental healthcare is one in which provision extends to age 25; in fact, the NHS Mental Health Implementation Plan states that there will be a comprehensive offer for 0–25-year-olds by 2023-24.[49] Given this, we asked:

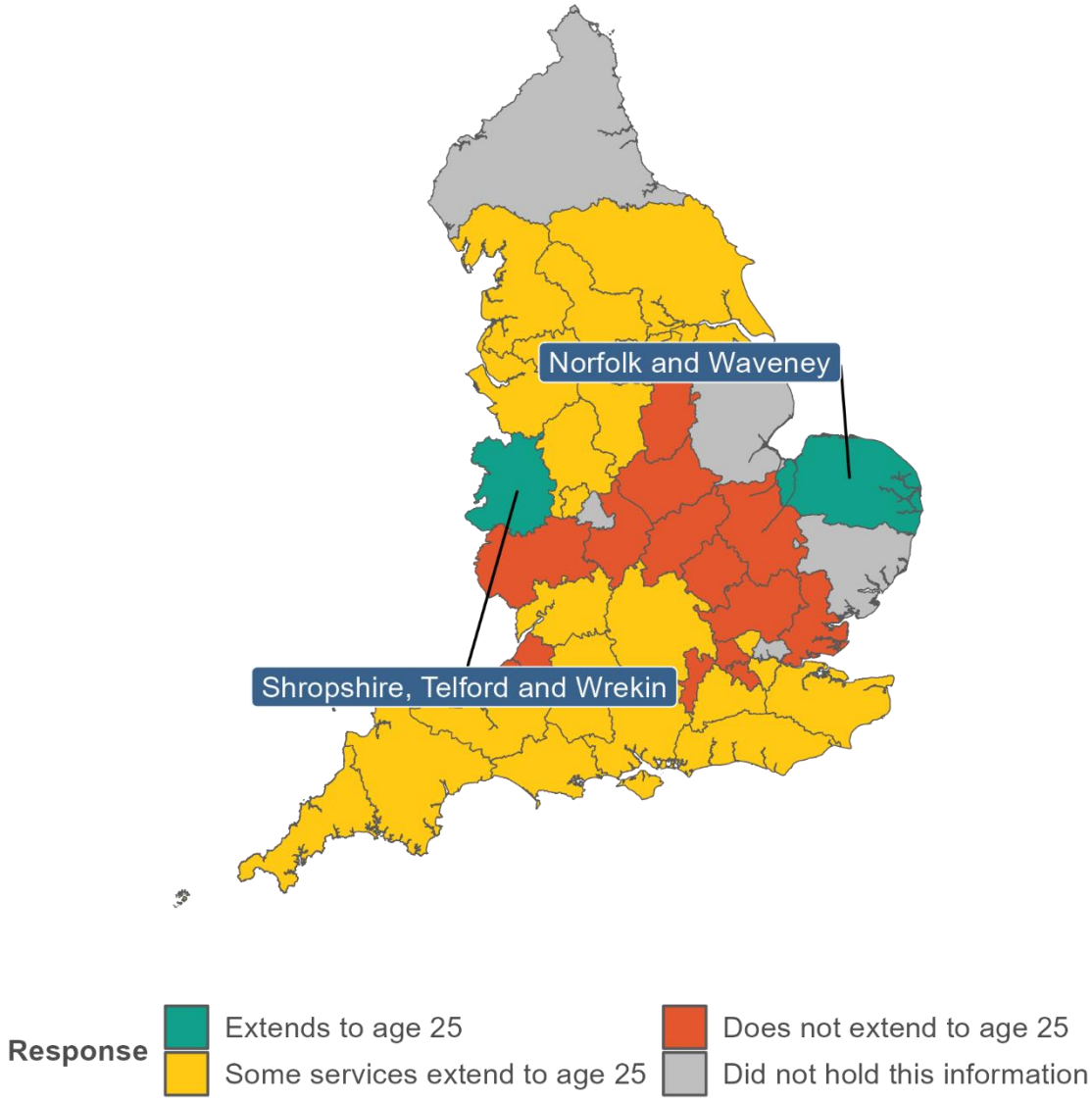
- Do children and young people's mental health services in your area extend to age 25 in accordance with National Institute for Health and Care Excellence (NICE) guidance?

We found wide variation in what was available across the country (see Figure 7). Only two ICBs explicitly reported to us that CYPMHS in their area were available for young people up to age 25. Twenty-two ICBs told us that some services (e.g., eating disorders, early intervention in psychosis) extended to age 25 or for those with specific conditions (e.g., those with special educational needs and disabilities). Some ICBs mentioned they had services to aid with transitions to adult services in their response. For example, Coventry and Warwickshire ICB told us they had a Peer Mentoring Support Service (PMSS) for young adults aged 16-25 transitioning between CYP MH services and Adult MH services. However, to our best knowledge, there has been no national quantitative evaluation on the success of local systems at managing transitions and how they have done it, limiting our understanding of how services can improve transitions. Qualitative work indicates that the transition to adult services can be challenging as young people are treated as autonomous adults and there is limited family involvement. [50] Lastly, five ICBs simply did not hold this information.

We also noted that some ICBs provided us with more information than others, reflecting a limitation of relying on FOI requests. We therefore urge caution on interpreting whether the two ICBs identified as having a comprehensive offer actually do so in practice across *all* services. For example, some ICBs also told us that they commissioned online mental health support services, e.g., Kooth, for young people up to age 25. It is therefore unclear whether *all* services extend to age 25 in those two ICBs.

[49] NHS England, 'NHS Mental Health Implementation Plan 2019/20 – 2023/24'.
[50] Broad et al., 'Youth Experiences of Transition from Child Mental Health Services to Adult Mental Health Services'.

Figure 7: A map of Integrated Care Boards with mental health services that extend to age 25



Waiting list interventions

As depicted in Figure 5, waiting times for treatment vary across the country. The consequences of long waiting lists can be severe; patients who wait longer have worse patient outcomes. [51] This can be further exacerbated by the rising number of CYPMHS appointments being cancelled by mental health providers. [52] We therefore sought to understand what support was available for children and young people waiting to begin treatment. To date, we know very little about a national picture of the services available. We asked ICBs:

- What support is in place for children accepted into NHS mental health services who are on a waiting list to begin treatment?

[51] Reichert and Jacobs, 'The Impact of Waiting Time on Patient Outcomes'.
[52] Mind, 'Thousands of Mental Health Appointments for Young People Cancelled'.

The support systems in place for children awaiting mental health services across ICBs varied. Common elements included signposting to available services and check-in calls to assess risk and offer support. In Hertfordshire and West Essex ICB, young people waiting for treatment are allocated a key worker who maintains contact with them. Online platforms, such as Kooth, along with mental health apps, were mentioned as a possible resource for more immediate support. Additionally, some ICBs referred to the Mental Health Support Teams in their area who provide information packs to help pupils in schools and colleges whilst waiting. Derby and Derbyshire ICB coordinated parent support groups and Northamptonshire ICB offered drop-in wellbeing cafes. Overall, we see various efforts to help those on waiting lists using online, telephone and face-to-face support. It is unclear whether these interventions have been selected based on their efficacy in reducing mental illness or cost effectiveness, or at a more basic level, whether young people are taking up these wait list interventions. It is vital that those commissioning services understand what happens to the children and young people waiting for specialist services. This includes whether they are able to access alternative services or other forms of support outside the NHS, or whether they deteriorate to the point of needing more intensive care.

Eating disorder treatments offered other than Cognitive Behavioural Therapy (CBT)

The Implementing the Five Year Forward View outlined a commitment to offer evidence-based community eating disorder services in all areas by 2020/21.[53] However, there is no national picture of what children and young people are offered besides Cognitive Behavioural Therapy (CBT), whether services follow NICE guidelines and in the absence of a recommendation from the NICE guidelines, if the treatments have an evidence base. We sought to understand whether the full suite of evidence-based treatments was available to all children and young people presenting with eating disorders and how this varied across England:

- Which of the following mental health services are offered in your area for children and young people with eating disorders?
    - Family therapy
    - Cognitive behavioural therapy
    - Guided self-help
    - Interpersonal psychotherapy
    - Focal psychodynamic therapy

Figure 8 presents geographic variation in the treatments available for children and young people with eating disorders. We see that CBT and family therapy for eating disorders are most commonly available for the treatment of eating disorders with 26 ICBs offering the pair, in line with NICE guidelines. Focal psychodynamic therapy was only offered in six ICBs; Black Country ICB informed us that training in Interpersonal psychotherapy (IPT) and Focal psychodynamic therapy (FPT) in these are limited nationally. Our figure highlights that some areas have the additional luxury of being able to provide alternative therapies including IPT and FPT.

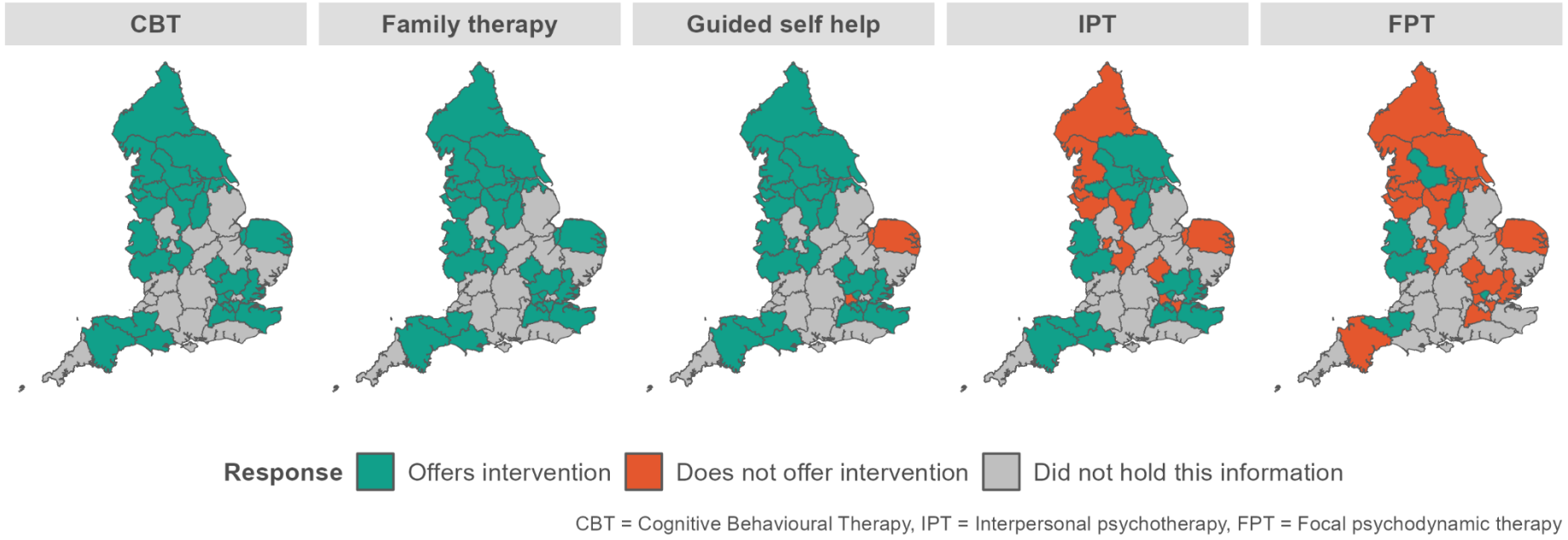
Whilst CBT and family therapy are the primary recommendations for treating eating disorders in children and young people, the approach shifts for adults. For adults, if CBT or other treatments prove ineffective, focal psychodynamic therapy is suggested. This discrepancy in treatment

[53] NHS England, 'IMPLEMENTING THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH'.

approaches for individuals who are just a few weeks apart in age—considering that what is suitable at 18 years and 1 month may not be considered appropriate at 17 years and 11 months—raises questions about the consistency of treatment recommendations. More research into effective interventions for young people in late adolescence is required in order to ensure appropriate interventions are accessible for young people transitioning into adult services. Furthermore, the ongoing expansion of mental health services for children and young people up to age 25 adds another layer of complexity. It is unclear whether the existing guidelines have been updated to accurately reflect this shift, given that current guidelines typically categorise young people as aged 13-17 and adults as 18 years and over.[54] Most concerningly, we also see that many ICBs, or commissioners of services, simply do not know which interventions are offered in their local area.

[54] National Institute for Health and Care Excellence, 'Eating Disorders: Recognition and Treatment'.

Figure 8: There are marked differences in the treatments available for eating disorders across England



Overall, whilst there have been notable efforts to enhance service integration and reduce geographical disparities in service structure, organisation and delivery, there are still considerable challenges that need to be addressed. Our findings highlight, as many researchers have before, significant geographical variation with regards to service delivery (including following a crisis and whilst on a waiting list), the age at which services are accessible to young people, and the range of treatments available. It is also clear that some commissioners of mental health services simply do not have the data and information at their disposal to commission services given many did not hold the information we requested. Our findings underscore the need for greater transparency in mental health services to ensure that children and young people can access and receive the best possible mental healthcare, regardless of their age or geographical location.

Gaps in administrative data collection and reporting mean that it is necessary for us to collect our data through Freedom of Information requests to each commissioner. The quality of the data provided to us make it very difficult to accurately assess service quality and whether provision indeed varies across the country or reflects variation in the information provided to the caseworker handling our FOI request.

What matters to young people?

We sought to understand progress made to improve mental health services according to young people with experience of mental health issues and services. We presented findings to, and participated in a discussion with, the Maudsley Biomedical Research Centre's Young Person's Mental Health Advisory Group. This group of young people aged 16 to 25 years have lived experience of mental health services or caring for someone who has used these services, and were convened by the National Institute for Health Research (NIHR) Clinical Research Network. They have supported previous research projects and have shaped research at the South London and Maudsley NHS Foundation Trust and King's College London. The feedback below does not represent a properly weighted focus group and cannot, therefore, be considered as representative of all young people. However, it is a useful insight into the views of young service users and much of the feedback we received echoes the wider evidence around weaknesses in service provision.

There is little focus on prevention and early intervention

- Young people told us that their needs were not being picked up early enough, and that they waited too long to get the help they need.
- Some individuals wished they had access to a range of services available to them whilst they waited for treatment.
- Some young people felt they had to reach crisis point to access services as they felt it was hard to access mental health services otherwise.
- Service users told us that safeguarding concerns expressed to social care and education professionals were not taken seriously to kickstart the process for getting help.

There was a lack of clarity and information around services

- Some young people told us that health and education professionals had shut them down and it was not obvious what services, interventions, or therapies they could ask for. In response, some users felt that it was important to educate young people about their rights and empower them to advocate for themselves (e.g., requesting a change of clinician/practitioner).
- The young people in our advisory group told us that our finding that many commissioners of mental health services did not readily know which services were available in their area was not surprising. This matched their experiences as they felt that many professionals lacked crucial information about the availability of mental health services in their local area.
- Some young people told us that signposting to websites was not enough – especially whilst they were waiting for treatment – and in their experience this felt like a 'litmus test' for suitability of treatment as they received web links that sent them around in circles and to various forms to fill in.
- Service users told us that whilst they waited for treatment, they were often left in the dark with few updates on whether their case had been passed onto the relevant team and how long they should expect to wait.

The quality of care varies

- Some young people felt that support available from professionals was “hit and miss” and that it was “easy to slip through the cracks”.
- Some young people shared negative experiences with GPs, who they felt pushed medication instead of therapy. They felt that some GPs were dismissive and unhelpful as they were not always taken seriously during appointments. Whilst this may not reflect everyone’s experience with GPs, it highlights the importance of training for GPs to respond to young people struggling with their mental health.
- Some services users felt that follow up after a mental health crisis was inadequate.
- Some service users felt they had been discharged from mental health services too early.
- One young person told us they waited for over two years for therapy and that the transition to adult services took a long time.
- On a positive note, service users found support workers and peer support valuable in navigating the mental health care system.

Schools, colleges and universities must play a role in addressing stigma

- The young people underscored the need for proactive efforts to encourage open conversations about mental health; they told us that some schools did not make all young people with mental health needs feel welcome.
- There were fears of stigmatisation around discussing mental health with certain teachers as some young people encountered dismissive attitudes (e.g., “everyone is depressed these days”) when they sought help.
- Some young people were concerned that discussing mental health issues with teachers may affect their long-term relationships with teachers.
- Some young people reported being bullied for their mental health needs or had rumours spread about them by their peers.
- Participants noted that universities often focused on low level issues – or “bad days” – rather than mental ill-health.
- Young people told us that further mental health first aid training for educators was needed.
- Some young people told us that they felt that adult professionals with whom they were in contact did not advocate for them.

Different perspectives exist on mental health support delivered in education settings

- There were mixed opinions regarding embedding mental health support in schools. Some felt that having services that were easily accessible and offered by a clinical professional or teacher they trusted was important.
- In contrast, others feared being ostracised if they were seen entering a specific room or taken out of lessons/break time for mental health reasons.
- There were also concerns expressed around confidentiality, with multiple young people reporting that private details discussed in counselling sessions were shared with school staff.
- There were also concerns that there was no ringfenced time to ‘decompress’ after counselling as pupils were expected to promptly attend their next lesson. Evidence of ‘good’ practice in the eyes of young people included sensory rooms or spaces to “chill out”.

Conclusion and policy recommendations

Our review shows that progress to improve mental health services for children and young people has been made in some areas – for instance, in the number of young people accessing services over recent years. All existing administrative data, which covers only certain parts of the system, indicates improvements since data began to be published in 2016, albeit often from a low starting point – and questions around data quality remain. Any improvements must also be understood against a backdrop of significantly increased numbers of children and young people who need support.

However, wider research consistently shows that many young people continue to experience long waiting times for treatment, and many are not making reliable recoveries.[55] Administrative data shows that performance against a narrow set of metrics that the government has chosen to benchmark a 'good' mental healthcare system differs around the country. Slow progress expanding the CYPMHS workforce, in addition to difficulty retaining staff, poses a significant threat to delivery. The pandemic has brought new challenges including further rises in of mental illness, which means that it will likely take longer, and require more ambitious plans, to close the treatment gap between demand for mental health services and provision.[56]

The Major Conditions Strategy is the government's next comprehensive plan aimed at improving the healthcare system and address the growing challenges posed by the rising prevalence of multiple health conditions. It focuses on six major health conditions, including mental health, and emphasises prevention and improving outcomes. Whilst we await publication of the Major Conditions Strategy, this review sets out the key challenges that any incoming government will need to tackle to improve outcomes and reduce inequalities.

Furthermore, our research shows that mental health provision for young people continues to vary considerably across the country, including access to support while on waiting lists, follow-up care following contact with the local mental health crisis team, the therapeutic interventions on offer and whether CYP mental health services can be accessed after age 18. Integrated Care Boards also vary in how proactive they are around identifying and support children with complex needs at increased risk of mental health issues. A significant minority of ICBs, which are responsible for planning and commissioning services, reported to us that they did not hold information on these areas of provision.

The government must now ensure a coordinated cross-departmental response to prevent derailment of the remaining commitments and deliver its national ambitions. It is essential that any updated strategy cover the whole spectrum of mental health support, from prevention to inpatient provision, including details on how a highly effective workforce is secured and is delivered across government. Whilst successive governments have committed to expand early intervention services through the Mental Health Support Teams, there are mixed findings around the acceptability of these teams, and they have yet to be rolled out to many areas of the country.

[55] Office of the Children's Commissioner, 'Children's Mental Health Services 2020/21'; NHS Digital, 'Mental Health Services Monthly Statistics'.
[56] Newlove-Delgado, 'Mental Health of Children and Young People in England 2022 - Wave 3 Follow up to the 2017 Survey'.

Based on our comprehensive review of policy commitments, the data we collected, and feedback from experts including experts by experience, there is more work to do if policymakers are to realise their stated objective of providing timely access to high quality mental health services to all children who need them.

The following set of policy recommendations are based on findings from our review and data collection, informed by consultation with our advisory groups, and shaped by the wider body of research around mental health provision for children and young people. Given that many lifelong mental health issues develop in childhood and adolescence, there is a strong case to be made for focusing resources on this period of life.

- **Any future taskforce or national ambition should produce policy plans with more clarity and internal consistency, accompanying implementation strategies, and accountability mechanisms.** Policy commitments should be accompanied by implementation and measurement strategies and should avoid setting targets and deadlines without clearly laying out how they will be met. The government should be transparent about the choice of policy commitments, for example, regarding why waiting time standards are introduced for treatment for one type of disorder but not for others. There should be clarity around the department directly responsible for the implementation of commitments, with a coordination mechanism for accountability, particularly in the case of cross-departmental strategies.
- **NHS England and the Department of Health and Social Care must improve mental health data and transparency.** This includes better data, and improved access to existing data, on the prevalence of mental health issues in different areas of the country. This is necessary to equip ICBs with the necessary information to effectively plan and commission services. Additionally, it is crucial that remaining data gaps in national and service level data – e.g. on coverage, uptake and outcomes – are addressed. A full picture of provision would require coordination with local partners where appropriate, including schools, colleges and the voluntary and independent sector.
- **The government should consider updates to their pre-pandemic CYPMH workforce strategy and implementation plan, and explore introducing an annual statutory CYPMH workforce census.** Slow progress on workforce expansion is a major risk to delivering ambitions to improve access to services. Understanding progress is hindered by a lack of data on the mental healthcare workforce. There has not been a new specific mental health workforce strategy since before the Covid-19 pandemic in 2017. DHSC should consider developing a ten-year mental health workforce recruitment and retention strategy including clear plans for funding, delivery, and accountability. To support this, DHSC could explore introducing a statutory data collection to create a per-staff level dataset.
- Given the rise in prevalence of mental health issues and psychological distress, **NHSE and DHSC must continue to focus on increasing access to – and eliminate barriers to accessing – services,** including implementing a 'no wrong door' policy which allows for multiple entry points into the mental healthcare system; ensuring that 'gatekeepers' of referrals to mental health services, including GPs, have the knowledge and skills to sensitively recognise and respond to children and young people with mental health needs; expediting the rollout of

Mental Health Support Teams, as well as considering how to reach the most vulnerable children who are not in schools; and developing a plan to extend the service offer up to age 25 in all areas, per best practice laid out in NICE guidelines.

- As we have previously recommended**, all secondary schools should have access to a qualified and accredited mental health professional.**[57] Regarding counselling specifically, schools should consider approaches to providing support that are high quality and evidence based, non-stigmatising, do not bring unwanted attention to any young person receiving individual support, ensure confidentiality between the young person and any relevant professionals aside from safeguarding concerns, and allow time and space to decompress following counselling sessions.
- **The Department for Education should aim to ensure all teachers have the knowledge and skills to recognise and respond appropriately to mental health needs in their classroom, and continue to develop and expand age-appropriate programmes to help pupils and teachers discuss mental health from an early age.** Surveys indicate that half of teachers feel ill-prepared to respond to pupils with mental health issues, and that most children with a mental health disorder approach a teacher when dealing with a mental health issue.[58] DfE should consider how to embed improved understanding and practice through high quality training and resources, and ways of tracking the extent to which this training has been completed.
- **The government should design a policy programme which reflects the evidence on drivers of, and the importance of early intervention for, mental health issues.** Outside of the Prevention Concordat and guidance issued by Public Health England there is little attention paid to the social and environmental determinants of mental health, and the inequalities in mental health outcomes related to experiences of discrimination based on sex, ethnicity, (dis)ability, and gender identity. There is also limited focus on provision or monitoring of local preventative and early intervention services, outside of the Mental Health Support Teams which are only available in a minority of areas. **The government should gather data on early intervention services including availability of these services in local areas, access, and spend, to have a clear picture of the landscape and to monitor progress made in developing and offering services of this kind.** Given the likely causal links between socio-economic factors, including poverty and adverse experiences in childhood and adolescence, and poor mental health, as well as the importance of relationships for positive mental health, an effective prevention programme will require action from across government. **The government should consider a strategy which includes concerted action to reduce child poverty; expanding access to high quality early support services for families in all areas; and ensuring a well-equipped workforce in all schools to support pupils with additional needs.**

[57] Crenna-Jennings, Perera, and Sibieta, 'Education Recovery and Resilience in England'.
[58] Casebourne, 'Half of UK Teachers Don't Feel Confident Helping Pupils with Their Mental Health'; NHS Digital, 'Mental Health of Children and Young People in England, 2017'.

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