Written evidence from Rowan Munson

Please could the committee note that until young people’s mental health services receive funding proportionate to that of physical health we cannot believe parity of esteem can be achieved. With only around 6p in each pound of the NHS spends on mental health being spent on children and young people, we cannot consider young people to have equality with adults. This is also damaging to the preventative life-course approach recommended by myself and recent studies on the topic. I recommend that the government increase levels and proportion of funding for young people’s mental health services and encourage Local Authorities to ring-fence mental health budgets for young people to protect from cuts. I have made specific recommendation below as to where additional resource is required.

1. Culture of Education
   1.1. An education system centred around league tables, terminal exams and grades, has led to an exam season where it is not uncommon for students to have breakdowns in toilets or to sleep under desks during break time. “Education is the cause of my anxiety; exams, fear of failure” said one witness to the Youth Select Committee. Another said she felt that there was “no hope for the future” whilst sitting exams at school. The Committee concluded that exam culture causes significant significant stress to pupils and that schools need to offer specific additional support during these periods. The DfE needs to lead on piloting, evaluating and sharing good practice projects to promote this, and it should be reviewed by Ofsted.
   1.2. One member of staff will not be able to change this situation. A step-change in the whole culture of education is needed. The issue of mental health cannot be considered to have been effectively dealt with by expecting one person in each school, who may be an already overwhelmed member of staff, to lead a change in the culture of behaviour, policies, curriculum, pastoral care, staff support and support for pupils and parents.
   1.3. It should be noted in particular that current guidance from the Department for Education focuses on authoritarian approaches to discipline and disruptive behaviour. In contrast, evidence-based programmes for conduct disorder emphasise the effectiveness of clear rules and instructions combined with promotion of positive behaviour through praise and encouragement.

2. School Exclusion
   2.1. A University of Exeter study found that children with depression, anxiety, ADHD and autism spectrum conditions, are more likely to be excluded from the classroom, and that exclusion is a predictor of future mental health issues. This suggests we need to be providing more support to deal
with challenging behaviour, to prevent exclusion, and also to combat mental health issues arising from exclusion (see paragraph 1.3 above).

2.2. The green paper is unclear what support will be available for young people not established in education. This is even more important given that over the last five years the number if home-educated children has grown by 64% across England, and almost a thousand young people with a statement of special educational needs await a place. Neither does the green paper explain how it will ensure that all kinds of schools; state, voluntary-aided, free schools, academies, private, pupil referral units, and special schools will be included in the rollout.

3. **Mandatory Training for Teachers in Mental Health**

3.1. The Youth Select Committee recognised that teachers are the key professionals working with young people day-in, day-out, and as such, they are well placed to advise students who look to them for guidance. In particular to be able to spot warning signs and to signpost them where to refer for help. We recommended to Government that although teachers do not need to be mental health experts, that there should be mandatory minimum training for all teachers in mental health.

3.2. A non-mandatory framework of content for initial teacher training was published in July 2016, including the need for emphasis on the importance of emotional development, such as attachment issues and mental health, for pupils’ performance. We have already seen a number of providers start to include training on mental health and well-being, however there is more to be done with standardising and monitoring training quality.

3.3. In 2017/18 the Youth Mental Health First Aid programme trained around 1,000 teachers how to spot common signs and triggers of mental health issues, providing them with the knowledge and confidence to help. With over 450 times this number of full-time teachers in state funded schools alone, this is simply a drop in the ocean. Unless we increase training dramatically for current teachers, it will be a long time before we see any tangible change in the culture of schooling in our education system.

3.4. To highlight an example of good practice, the presence in every school in Camden of an experienced clinician who is part of the wider CAMHS team makes for a seamless response when there is a need to escalate. The clinician can support both students and staff as part of a whole school approach. This pays dividends in staff resilience and young people finding it easier to seek – who otherwise might go unseen by mental health services.

4. **PSHE Education**

4.1. Without a statutory provision these lessons remain optional, and do not attract the rigour equal to that of a statutory subject, as the experiences of young people who gave evidence to the committee are testament.

4.2. The Youth Select Committee recommended that if physical education (PE) requires statutory attainment levels, then mental education should not be any
different. These levels should be in place from the age of 5, demonstrable and assessed by Ofsted. These should lead to a BTEC or GCSE in Mental Health with a practical (self-help, peer support 1 to 1 and group delivery) element, just like PE. This would give mental and physical health parity of esteem and increase mental health literacy. Mastery of techniques, learning by observation and social persuasion, and contributing as a peer supporter can contribute to self-efficacy, increased resilience, and behaviour and stigma shift.

5. Prevention

5.1. As the Chief Nursing Officer said in her 2012 report “Prevention Pays” and the evidence for this is clear. 50% of adult mental illness starts before age 15 and 75% has started before the age of 18. It is clear that universal provision including that delivered by youth services, good education, and good peer support is great for prevention, and this needs a funding increase, and best practice sharing so quality services can reach every child and young person.

5.2. However the best prevention mechanism I see is refocussing the approach of public services including health, education, justice and others around a healthy lifestyle. That is to say, they should focus on providing young people with the tools to be resilient, healthy and happy. Doing this rather than looking at academic achievement, health, and offending in isolation is the only way to positively tackle the greatest problems facing my generation, and help us fulfil our needs and achieve our goals.

6. Early Intervention

6.1. For many young people experiencing mild to moderate mental health issues, GPs are the first person they go to for help, but the green paper makes no mention of their role. The Youth Select Committee report highlighted how GP mental health provision often resulted in poor experiences of care, and concluded that there should be compulsory training in young people’s mental health for GPs.

6.2. Instead the green paper proposes to provide new capacity through non-clinical staff offering evidence based mental health intervention with clinical supervision. Linked to groups of schools and colleges, these staff will train other professionals in local authorities, offer self-help and signposting and link with school nurses where appropriate. However with drastic cuts to local authorities and school nurse provision inconsistent – this element of the delivery plan appears flawed.

a) Local Authorities: There has been a £1.6bln real terms decrease in spending on Children and Young People’s services and a 40% real terms cut in spending in early intervention according to a recent report from the NCB (https://www.ncb.org.uk/sites/default/files/field/attachment/Turning%20the%20tide%20report_final.pdf). The most deprived local authorities have seen a fall in spending on children and young people’s services more than six times as large as the least deprived councils. However the 7% increase in spend on late intervention can be seen as a knock-on effect of the on-going reductions
to early intervention. As these services become less able to support children, demand for late intervention increases.

b) School Nursing: There are currently around 2,600 school nurses in the NHS, and approximately 24,300 schools, that is around one school nurse to nine schools. I met my school nurse once in seven years at my secondary school and sixth form. There are some amazing school nurses, but with numbers this low, they cannot be relied upon to deliver a comprehensive and universal service.

6.3. What we saw from the Mental Health Service and Schools Link Pilot, was that although referrals became more appropriate, there was not an overall reduction. It is important that we recognise that although earlier intervention will prevent problems escalating in the long-term, in the short-term post implementation we may actually identify many more mental health problems, with a resultant need to fund specialist and targeted services appropriately.

7.1. It’s great to see the decisive action on waiting times as part of increasing the availability of treatment and sign-posting to it. However it is unclear as to where the waiting time can be counted from – there are many “implicit” waiting times within the process. In my own case recently, there was a wait to get an initial assessment (24hrs as urgent 7 days as non-urgent), a wait for care transfer from the assessment to treatment team (in my case around three weeks, during which time the assessment team, A&E doctors and emergency department psychiatric team were hesitant to take me off drugs I was having seizures as a reaction to) and a further wait of three to four weeks for the Clinical Psychologist to make a recommendation for psychological therapies. All in all that is approximately two months from first referral before I am even on a waiting list for psychological therapy. Without a named point of contact for over a month this further compounded the feelings of hopelessness that had caused me to ask for a referral from my GP to the service, combined with the severe reactions I was experiencing to the drug that I was put on. This is unacceptable. “implicit” waiting lists need to be accounted for in the new standards.

8. Shame and Stigma
8.1. If one thing stands out for me from my whole experience in the mental health sphere it is “shame”. One of the key aspects of mental health problems that prevented people from seeking support was shame; shame of yourself, shame about what has happened to you, shame that you were different from other young people. Increasing mental health literacy and peer support is a great move to counteract this, but it has been generally lacking one vital element, the youth voice.
8.2. The Youth Select Committee believe that anti-stigma campaigns will only be successful if they make use of the expertise of young people. A steering group of young people should co-produce the campaign, and it is important that this comproses of people both with and without a history of mental health issues.
8.3. The green paper proposes to build on the success of Time To Change with £15m in training a million members of the public in basic mental health awareness and first aid. I think this will be a great way to increase mental health literacy and peer support, but to be successful would need to be co-produced with young people.

9. Peer Support

9.1. The impact of mental health information is increased if delivered by similar, credible, facilitators to young people themselves; their lived experience provides a more immediate comparison and can help to reduce stigma, increase mental health literacy and raise well-being. How peers are selected, their status and trustworthiness and the degree of “contact” rather than just “education” will help determine their effectiveness. A “prefect” or “wellbeing monitor” approach would not be effective and identifying people within the school who have lived experience is obviously problematic in a stigmatising environment. Peer contact may initially be better facilitated by mental health providers external to the school.

9.2. Volunteering has a positive effect on wellbeing. It is proven to lead to achievements, mastery, stress reduction, increased resilience, self esteem, self efficacy and employability.

9.3. Peer-support remains outside of the given educational mandate and exists unevenly across the country. The government launched a call for evidence regarding approaches to peer support but has not yet implemented its findings. (https://www.gov.uk/government/consultations/children-and-young-peoples-mental-health-peer-support)

10. Young Carers

10.1. There are many young people caring for parents or other relatives with mental health problems and my question is simply “Who cares about the carers?” The 2017 GP Patient Survey found that 45% of young adult carers reported suffering from depression or anxiety compared to 31% of young people not in a caring role.

   a) Young carers may find it hard to understand the illness and may not have someone to explain it to them in an age-appropriate way. Others may be embarrassed about their parent’s illness, bullied because of it, or scared by its unpredictable nature.

   b) Providing emotional support to a parent at risk of harming themselves or committing suicide, or dealing with the aftermath of these actions and the intermittent and unpredictable needs of individuals with mental health difficulties can be extremely distressing.

10.2. The caring role of young carers, and many of their families’ circumstances serve as a barrier to accessing support. The committee must note that this means young carers struggle to access the right services at the right time, which would address their mental health, their caring role and any relationship between them.

10.3. Carer Passport schemes and Carers Trust and The Children’s Society’s joint Young Carers in Schools programme could be introduced by Designated Senior Leads for Mental Health as part of a whole school approach to mental health.
11. Social Justice

11.1. A recent report from Youth Access (http://www.youthaccess.org.uk/downloads/socialdeterminantsofypshealth.pdf) noted three key connections; the experience of legal problems is a key predictor of mental health problems, mental health problems are even more common where multiple legal problems are reported, mental health deteriorates as new legal problems emerge. Investment should focus on services, such as Youth Information, Advice and Counselling Services, that can provide social welfare legal advice alongside mental health interventions in accessible young person-friendly settings. See paragraph 5.2 and note application of a life-course approach.

11.2. Social welfare advice addressing young people’s housing and money problems, delivered as part of an integrated young person-focussed service alongside counselling, has been found to be a cost-effective mental health intervention in its own right, resulting in significant improvements in levels of stress and general health among 16-24 year olds.

11.3. Young people who are NEET (not in education, employment or training) and socially isolated are twice as likely as non-NEET young people living with older adults to experience mental health problems even when they have no social welfare legal problems; and are five times more likely when they do.

11.4. Anyone who has been subjected to neglect, abuse or bullying; LGBTQI+ young people; those in the criminal justice system; those who have been looked after by local authorities; and young adults experiencing housing, money and employment problems are all at higher risk of mental health problems.

12. Transition

12.1. I am surprised that after NHS England themselves described transition from child to adult mental health services to the Youth Select Committee, as “poorly planned, poorly executed and poorly experienced” and Future In Mind reported that “the issue of transition for young people is longstanding” the green paper has not addressed Children and Young People’s Mental Health as a seamless pathway covering the whole period to age 25.

12.2. The adolescent brain continues to develop until that age, which marks the peak period for first presentation of mental health problems and all those who are aged 18-25 should be covered by proposals meant for “young people”. We go through many life changes and transitions in our childhood and teenage years. It’s why the age of 18 is the wrong time for CAMHS to “hand over” to adult services.

12.3. While acknowledging that some geographical areas have adopted a 0-25 approach, the green paper delays assessment of whether further action is required to improve the experience and outcomes of transition until next year. Frequently described as a ‘cliff-edge’, the Department of Health acknowledged that the nature of current transition leads to young people relapsing or stopping using services. So why do we need more data before we take action on this issue? To look at one section of the pathway independently of the rest is unconscionable, and suggests an
unwillingness to tackle the legal issues around adulthood, including children’s rights, and the age of majority and medical treatment.

13. Young Adults (16-25)
13.1. A recent policy briefing from Youth Access (http://www.youthaccess.org.uk/downloads/young-adult-and-ignored-briefing.pdf) noted how new funding to date has been focussed on under 18 services, and the “treatment gap” for young adults may be increasing despite many examples of good practice such as “Service User Passports” or “Ready, Steady, Go” at Southampton Children’s Hospital. I would like to reiterate calls for the Government to make additional targeted funding available to improve transition.

13.2. There are also issues regarding the treatment of mental and physical health conditions between home and university. My term at university is 24 weeks of the year – recently I was told that I could not access an IAPT service in my home NHS Trust as I was not registered with a GP practice in the area. I was not aware that registering at university had de-registered me at my home practice. I was told that I could only be taken on as a temporary patient at home and I would be unable to be referred or to self-refer for IAPT treatment. This delayed my referral to mental health services, and by the time I was referred my condition had worsened to the extent that I was a suicide risk and required secondary care.

13.3. I would support the extension to age 25 on all services. Contrary to concerns that such a model would merely delay transition, evidence actually suggests it could prevent premature disengagement and more serious problems developing later on. Adult mental health commissioners must assume greater responsibility for ensuring the needs of young adults are met. Neither CAMHS nor AMHS are currently tasked with specifically addressing this issue.

13.4. Guidance currently suggests creating local CQUINs (Commissioning for Quality and Innovation payment framework enabling commissioners to reward excellence by linking a proportion of providers’ income to achievement of local quality improvement goals) however there is little evidence current guidance is impacting practice.

13.5. The Committee must note that the biggest killer of men under 45 in the UK is suicide, Young men are less likely to seek or receive help than young women, some targeted support for young men is required.

14. Social Media Leading to Poor Mental Health
14.1. Increased social media use is linked to poorer mental health. Cyberbullying and sites that promote self harm have a significant impact on the mental health of young people; that is certain. The policy trend seems to be towards “keeping children and young people safe” by restricting the content that they have access to, which will be required to a certain extent. The Government published the Internet Safety Strategy Green Paper in October 2017. However, the internet is human built,
and technology reflects our own world back at us. Instead, we really need to be looking in the long-term for what is best for our young people, which is to make them more resilient; educate them, listen to them, and innovate with them.

14.2. The Youth Select Committee suggested that the Government should facilitate a roundtable for charities, technology companies, young people and the government to work together to find creative solutions to help young people to stay safe online. The green paper proposes a similar working group with the Chief Medical Officer producing a report on the impact of technology on children and young people’s mental health. One creative educational tool the committee heard about was a social-media plug-in that scans messages for negative content and then asks, “This comment could be seen as abusive. Are you sure you want to post it?” with an eight second lag. In trials. This empowering approach yielded very positive results with 80% of young people counteracting their comment, which has a potentially massive implication for rates of cyber-bullying.

15. Social Media as a Resource to Improve Mental Health

15.1. Despite, it seems, having been side-lined by the Green Paper, the internet can also be a rich resource for provision of information, advice and guidance to young people. As well as NHS Choices, there are a range of videos, resources and social media accounts that provide concise and quality information. The problem is how to sort the wheat from the chaff, as this information is often buried under unreliable, and potentially harmful advice.

15.2. The Government’s Mental Health Taskforce Report Future In Mind recommended consideration of a “kitemarking scheme” to identify officially endorsed websites and resources. This was seconded by the Youth Select Committee who added that the system should be developed in consultation with young people who can advise on what they, and their peers would find useful. The Committee also recommended that the Department of Health work with young people to develop a trusted mental health first aid kit app with clear signposts to mental health services, and links to other online resources. They stipulated that it should have NHS branding and a bright, simple design. In the interim, NHS Go has been developed by the Healthy London Partnership, and is well used. Despite being a general health app, one of the most frequently accessed areas on the app is mental health.

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