Unite the union response to:
Transforming Children and Young People’s Mental Health Provision: A Green Paper

This response is submitted by Unite in Health. Unite is the UK’s largest trade union with 1.5 million members across the private and public sectors. The union’s members work in a range of industries including manufacturing, financial services, print, media, construction, transport, local government, education, health and not for profit sectors.

Unite represents in excess of 100,000 health sector workers. This includes eight professional associations - British Veterinary Union (BVU), College of Health Care Chaplains (CHCC), Community Practitioners’ and Health Visitors’ Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Hospital Physicists Association (HPA), Doctors in Unite (formerly MPU), Mental Health Nurses Association (MNHA), Society of Sexual Health Advisors (SSHA).

Unite also represents members in occupations such as nursing, allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.
1. **Some key points contained in our response**

1.1. The Green Paper is nowhere near bold enough to address the burning injustice of children and young people’s mental ill health (2.3)

1.2. The Green Paper consultation process is totally inadequate (2.4)

1.3. A revised Green Paper should commit to initiating a School Nurse Implementation Plan, similar to the previous ‘Health Visitor Implementation Plan’ (4.3)

1.4. A revised Green Paper should commit to reintroducing the Health Visitor Implementation Plan to address the crisis currently unfolding (6.4)

1.5. A revised Green Paper should ensure it addresses the total absence of focus on the first 1,001 critical days (7)

1.6. A revised Green Paper should address the significant problems in specialist Child and Adolescent Mental Health Services (8)

1.7. The government must reverse its austerity agenda that is causing untold damage to citizens and communities across England (9)

2. **Introduction**

2.1. Unite welcomes the opportunity to respond to ‘Transforming children and young people’s mental health provision: A Green Paper’. As part of this response, Unite has used its ongoing routes throughout the organisation to hear back the views of its members. These have been used to formulate this response.

2.2. Transforming children and young people’s mental health should be a priority for any government. It is welcome that the Prime Minister has recognised this, including in previous statements where she identified mental ill health as a ‘burning injustice’ that needs to be appropriately tackled.

2.3. Whilst it is welcome that the Department of Health and Social Care (DHSC) and the Department for Education (DfE) have laid out three core principles in this green paper, that Unite is sure will make some improvements to the care and support that children who are suffering from mental ill health will receive in future, this green paper is nowhere near bold enough to address this ‘burning injustice’.

2.4. It is concerning that the consultation process, alongside this green paper, is not sufficient to properly allow feedback on the significant omissions of the paper, with the questions asked showing evidence of implicit bias in favour of your preferred options. Unite asks that in future both departments make considerable more efforts to ensure that green paper consultations are much more meaningful. Unite have also included a copy of the response we have submitted online in appendix A.

This full response must be read in conjunction with our online submission.

2.5. Unite strongly supports; guaranteeing access to NHS treatment and reducing waiting times, firm commitments to properly resourcing the NHS, including £30bn in extra funding, scrapping the NHS pay
cap, legislation to ensure safe staffing levels, re-introducing bursaries and funding for health-related degrees, boosts for capital funding, ring fencing and investing in mental health services particularly for children and young people. We believe all of these will have a positive impact of children and young people’s mental health.

3. Core principle 1: Designated Senior Lead for Mental Health

3.1. Unite believe it is right to ensure that every school in England has a ‘designated senior lead for mental health’. We are unsure however how the government can claim this principle is a ‘bold ambition’. As the green paper itself recognises, a majority (highlighted to be between one half to two thirds) of schools, already have an individual in place that performs this role (66). Further, with the green paper talking about incentivising rather than mandating for this role to be in place, we are unsure how this will improve the situation, and would argue that the schools least likely to be won over by an incentive may be the schools that would benefit most from having this role in place. We therefore recommend that this role is not just incentivised but becomes a requirement, and this is monitored via Ofsted alongside its regular school inspections.

3.2. It is unclear why, when the government requires schools to have a ‘designated safeguarding lead (DSL)’, which includes the need to have the role specified in the individuals job description\(^1\), it is not laying out the same expectation in the Green Paper for the designated senior lead for mental health. It seems sensible to give this new role the same statutory footing and we ask that this be done. Further, we note that the DSL role has not been evaluated for its effectiveness\(^2\), we recommend that this is done.

3.3. As well as ensuring that this role is in place, we believe a set of standards should be adopted to ensure that this role is sufficient enough to deliver improved outcomes for children at each school. A good starting point for this would be to mirror those laid out for the DSL role\(^3\); “This person should have the appropriate status and authority within the school to carry out the duties of the post. They should be given the time, funding, training, resources and support to provide advice and support to other staff on [children and young people’s mental health], to take part in strategy discussions and inter-agency meetings – and/or to support other staff to do so – and to contribute to the assessment of children”. We believe these are critical to ensure that the person holding the role maintains competence and the confidence of others, including pupils, parents and fellow staff.

\(^1\)https://www.nspcc.org.uk/globalassets/documents/information-service/schools-factsheet-role-designated-safeguarding-lead-dsl.pdf

\(^2\)http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2018-02-08/127756/

3.4. Although the Prime Minister has stated that ‘record amounts of funding are going into education’⁴, independent assessments paint a different story. One analysis⁵, by Prof. Sandra McNally, highlight that ‘per pupil’ funding between 2010/11 and 2015/16 was ‘largely frozen’. Looking in to the future, with the government’s current plans of freezing, in cash terms, real terms school spending, this translates into a reduction of around 6.5% of per pupil spending between 2010/11 and 2019/20. This would be the biggest real-terms fall in school spending per pupil in 30 years. McNally also points out that the outlook for spending in further education (age 16-18) is even worse, with the likely fall to be around 13% between 2010/11 and 2019/20.

3.5. We are concerned that, with these significant cuts to schools funding, this designated senior role could become something in name only. This will do nothing to improve outcomes for children. We therefore recommend that the green paper ensures focused funding, that is ring-fenced to this role, and this funding must include appropriate backfill to ensure the lead has appropriate time to discharge their duties effectively. The government must also address it’s cuts to schools funding as a matter of urgency.

3.6. Our members in the NHS also highlight that the approach may mirror one often taken in their [health] services, whereby rather than appropriately funding someone to lead on an issue, a champion is appointed who is unable to properly develop the role because of a myriad of other demands on their time. If a school has already cut its teaching staff, something has ‘to give’.

3.7. Whilst this proposed new role is focused on children and adolescents in school, we also recommend that similar roles are mandated for;

3.7.1. **Pre-school (Designated Senior Leads for supporting Infant Mental Health):** We have provided more information about concerns regarding the absence of support to under-5’s in the Green Paper later in our response.

3.7.2. **Universities:** This would help to address the ‘mental health crisis’⁶ in our Universities. Surveys have shown that “almost nine in 10 (87%) of first year students find it difficult to cope with social or academic aspects of university life”, and in the Institute for Public Policy Research report, ‘Not by Degrees: Improving student mental health in the UK’s universities’⁷ they highlight that “Our survey reveals that HEIs have – over the past five years – experienced significant increases in demand for (overall) student services... 94 per cent report an increase in demand for counselling services, while 61 per cent report an increase of over 25 per cent”

3.8. As one member responded: “The trouble is that the Govt policies have created problems and they are trying to patch this up with individualised solutions, rather than proper systems support. There

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⁴http://www.bbc.co.uk/news/education-39302746
⁵https://inews.co.uk/news/fact-check-education-spending-highest-level-record/
⁶https://www.theguardian.com/education/series/mental-health-a-university-crisis
⁷https://ippr.org/research/publications/not-by-degrees
should not be an ‘either/or’ provision but a ‘both and’. Many psychologists and mental health professionals are worried that specialisms are being diminished at a time when the structures need reinforcing, in readiness for the cohort of young people who may reach specialist CAMHS and adult services later”.

3.9. A member also highlighted: “The creation of Academy schools has reduced the amount of regulation that Local Authorities now have over those schools, and they have become increasingly autonomous units, with decision-making over which services they buy in. This has led to a reduction in the contracting in of ‘external’ services from the Local Authority (such as educational psychology). In the current funding situation, Local Authorities and schools appear to be struggling to fulfil duties around providing Statements of Special Educational Needs (SEN) and the follow on Education, Health and Care Plans (EHC Plan or EHCP), which outline what reasonable adjustments schools or colleges need to make and what extra support or therapy a child is entitled to. Given this current situation, Unite members are concerned about how the proposals in the Green Paper will address the scale of young people facing mental health problems.”

4. Core Principle 2: Mental Health Support Teams

4.1. From the Green Paper, it appears that the Mental Health Support Team will not include, but will work closely with a number of professionals (79) including; educational psychologists, school nurses and counsellors, local authority troubled families’ teams, social services, peer networks, service user forums, and voluntary and community sector organisations. It is unclear why these professionals will not be included as part of these teams. Further we have concerns that some of these groups of professionals have faced significant cuts, therefore making this core principle more likely to fail in improving services to children and young people.

4.2. Educational psychologists

4.2.1. From a response to a Parliamentary Question, we understand that between 2010 and 2016, the number of educational psychologists has been cut by 350, or 20.3%. We recognise that this data may be incomplete, therefore we recommend that this information is improved so the government can correctly assess the level of educational psychologists available to schools in England.

4.3. School nurses

10http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/(Commons/2017-12-12/119091)
4.3.1. Since 2010, there has been a cut of 20.1% in the number of school nurses employed in the NHS, with 2,987 employed in May 2010 and 2,371 employed in October 2017\(^\text{11}\). The number of qualified (specialist community public health nurse) school nurses have decreased from 1,121 to 1,060, a 5.4% cut. This is at a time where the population of children aged 5-19 has increased by 3.1% or over 291,000\(^\text{12}\)\(^\text{13}\). This means that every 5-19 child in England, only gets, on average, just over 11 minutes of a school nurses time per year and each school nurse, has on average 9,130 5-19 year old children each. This amount of time that school nurses can spend supporting children and young people continues to decrease as we see the cuts to school nurses and increases in child population.

![NHS school nurse numbers (May 2010 - Oct 2017)](image)

4.3.2. We believe that the green paper is making a major omission by not including a ‘Implementation Plan’ for school nurses, to mirror the plan that ran between 2011 and 2015 which saw a near 4,200 increase in the number of health visitors in England.

4.3.3. If the green paper set out such a target, we believe that the mental health outcomes, alongside many other outcomes for school age children, would markedly improve. We therefore recommend that an enforceable target on school nurses is included in a revised paper going forward. A good starting point for this target would be the Unite/CPHVA recommendation of: one (specialist community public health) school nurse in each (averaged sized) secondary school, and; one in each cluster of primary schools.

4.3.4. This would significantly increase the amount of time children would receive support from a school nurse each year. It would also ease the pressure on school staff, so they can dedicate more time to teaching children.


4.4. Mental health nurses

4.4.1. Since 2010, there has been a cut in the number of mental health nurses working in the NHS of 4,639 or 11.4%, from 40,630 to 35,991 in October 2017. Unite recommends that the government set a much higher priority on ensuring that these cuts are reversed and the mental health nurse profession is increased, at scale and pace. Our members in the Mental Health Nurses Association (MHNA) are willing to support any positive developments on this issue. We are also keen for government departments and agencies sign up to support #MHNursingFuture campaign14.

4.4.2. Members in MHNA highlight that there should be increased investment in mental health nurse speciality role in CAMHS and children and young people’s mental health services, drawn from increased funding in the recent Mental Health Taskforce report. As one member commented; “Inreach expert MHNs with a special ‘interest’ and experience can, if properly resourced, add huge value, both in front line criteria based assessments, finite sessional casework and support. supervision and training of in-situ staff, for example teachers”.

5. Core Principle 3: Reduce waiting times for NHS services for those children and young people who need specialist help

5.1. The Green Papers aim to reduce waiting times for children and young people who need specialist help is certainly welcome, but as the Green Paper recognises in some areas there is a far way to go with some waits from referral to treatment of over 100 weeks (17).

5.2. However, as the Children’s Commissioner in England highlighted in her ‘CAMHS Lightening Review’15, the number of children being turned away is variable across the country:

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14 https://adaywithdave.wordpress.com/2018/02/08/mhnursingfuture/
5.2.1. “On average, 28% of children and young people referred to CAMHS were not allocated a service. However, this varied across England. Whereas, one CAMHS providing services in two regions in England stated that 75% of children and young people referred were not allocated a service only 18% of children and young people referred to CAMHS in the South East and West Midlands were turned away.

5.2.2. 79% of CAMHS stated that they imposed restrictions and thresholds on children and young people accessing their services – meaning that unless their cases were sufficiently severe they were not able to access services.”

5.3. What causes even greater concern is when the Children’s Commissioner in England reported:

“Of particular concern were some of the 3,000 children and young people we heard about who were referred to CAMHS with a life-threatening condition (such as suicide, self-harm, psychosis and anorexia nervosa), of whom:

- 14% were not allocated any provision;
- 51% went on a waiting list;
- Some waited over 112 days to receive services.

5.4. Unite believes that the current proposals on waiting time standards are nowhere near bold enough and would argue that the green paper fails the government’s own parity of esteem test in that a similarly limited solution would not be proposed if there were such significant problems identified in core NHS services for cancer, heart disease or diabetes.

5.5. In making this recommendation, we acknowledge that the solution is not just to set a more stringent target, as a target alone is likely to make matters worse. A properly resourced plan is needed that increases the number of staff, including specialist, at significant scale and pace.

6. A ‘greater ambition’ for children versus ‘the under-fives do not belong in this Green Paper’

6.1. We (through Unite/Community Practitioners’ & Health Visitors’ Association) are a member of the Maternal Mental Health Alliance16, a coalition of over 80 national charities and Royal Colleges that work together to ensure that all women get consistent, accessible and quality care and support for their mental health during pregnancy and in the year after birth.

6.2. In the response submitted by its chair, Dr Alain Gregoire, he lays out in detail, concerns regarding the lack of ambition in the green paper. We support and echo his concerns, and those of fellow Alliance members. Our response should be read alongside the Alliance response, contained in a letter sent to Rt. Hon. Jeremy Hunt MP17.

16 https://maternalmentalhealthalliance.org
6.3. Although we do not wish to repeat the concerns raised in our response, we do want to highlight an area of significant concern, the ‘collapsing’ number of health visitors in England since 2015.

6.4. **Health visiting**

6.4.1. Between May 2010 and October 2017, the number of health visitors who work in the NHS has increased by 5.9%. Although welcome, this increase is from a near ‘historical’ low point which needed significant correction, by the coalition governments ‘Health Visitor Implementation Plan’\(^{18}\). It is also at a time when the total population in England has increased by 5%, and the population of under-5’s has increased by 4.5%.

6.4.2. What is most concerning is that since the responsibility for commissioning health visiting services has transferred to local authorities’, the number of health visitors working in the NHS has been cut by 19.0% (down from 10,309 in October 2015 to 8,346 in October 2017). From feedback from our members working on the front line, these cuts are continuing, showing no signs of slowing down. It is our belief that at some point during 2018, the gains made through the years of the Health Visitor Implementation Plan will have been ‘wiped out’.

6.4.3. As one member expressed: “Again the career structure has been diminished with clinical nurse specialist posts disappearing – we lose experienced staff…”

6.4.4. Considering the above statistics, it is maybe unsurprising, but shocking, that the minister, Jackie Doyle-Price (MP) stated that ‘the under-fives do not belong in this Green Paper’ (Q190)\(^ {19}\).

6.4.5. It also causes us concern that in responding to MPs questions about health visitor numbers and on the question of what efforts that the DHSC is making to increase them\(^ {20}\), the responsible minister reports that in 2016/17 Health Education England (HEE) made ‘over 800’ new training places

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available but ignores that fact that over one third of these places were left vacant. Our members in universities report this to be primarily due to lack of confidence from provider organisations, that once these individuals have qualified, there will be a lack of jobs available to employ them.

6.4.6. The impact of this lack of health visitors is already apparent in the services offered to families with Public Health England reporting in its ‘Universal health visiting service: mandation review’ that: “In some specific areas the [5 mandated reviews] service was delivered to less than 10% of the eligible child population.” It should be stressed that the mandated service is the minimum that any family in England should expect.

6.4.7. We believe that, unless the government acts now to reintroduce the Health Visitor Implementation Plan targets numbers, which we are recommending, untold damage will be done to your desire to address mental ill health in children and young people. It is not sufficient to discharge responsibility to local authorities by stating “it is an issue for local authorities to decide how they allocate their resource” (Q190) as the impact of this laissez faire approach is having the impact that we have described above.

7. Early intervention in the Green Paper versus Early Intervention – The first 1,001 Critical Days

7.1.1. The Green Paper mentions ‘early intervention’ nine times. However, it is clear that early intervention is not properly understood in terms of children and young people’s mental health.

7.1.2. It is well recognised, including being backed up by increasing research, that early intervention should consider the period between a baby’s conception and its second birthday, commonly referred to as the ‘first 1,001 critical days’.

7.1.3. It is of vital importance that this period is properly included in a revised paper, as if it continues to be ignored, the ability to actually prevent mental ill health will be squandered. A revised paper must reflect the three stages of childhood: infancy, childhood and young person/adolescence.

7.1.4. What the Green Paper fails to recognise is that by investing in the early years, many of these problems facing school age children would be significantly reduced and avoided with investment in earlier intervention. As well as providing support and services for those children experiencing poor mental health, there needs to be a strategy and investment in its prevention.

7.1.5. The evidence is clear, including international research from Professor Heckman’s, that such investment provides the biggest returns when focused in the first 1,001 days of a child’s life. There must be more emphasis on supporting children from the very beginning of life and seeing an investment in their wellbeing as a core value of our nation and society at large.

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21. https://www.nursingtimes.net/news/education/third-of-health-visitor-course-places-were-empty-last-year/7021668.article
23. https://heckmanequation.org/topic/health-research/
7.1.6. What makes the absence of policy initiatives on the first 1,001 Critical Days all the more frustrating is the reports that have been submitted to the UK government over recent years that have argued about its significant benefit both to child and family outcomes but also in finance terms, including Graham Allen’s ‘Early Intervention: the next step’ and the Conception to Age 2: First 1001 Days All Party Parliamentary Group inquiry report ‘Building Great Britons’.

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24 https://twitter.com/heckmanequation/status/956186120366247939
7.1.7. The 3 other UK member nations (Scotland, Wales and North Ireland) have all made commitments to greater funding in this area, we urge England to follow suit.

7.2. Research on the first 1,001 critical days

7.2.1. The Green Paper commits to commissioning more research (117 & 118), but there is already a wealth of compelling existing research on the importance of the first 1,001 days in supporting the social and emotional development of children. We would however recommend more research is needed in the following areas:

- The interventions that could improve outcomes for children with a high number of ACEs.
- The mechanisms that underpin interventions and their outcomes.

7.3. Adverse Childhood Experiences (ACE’s)

7.3.1. It is welcome that the Green Paper mentions ACE’s, however we agree with the Conception to Age 2: The first 1,001 Critical Days APPG (of which Unite is an active participant), when it states the following:

7.3.1.1. “It is good to see the recognition of increased mental health problems of those children who have experienced or witnessed domestic violence, abuse, parental mental illness and other forms of Adverse Childhood Experiences.

7.3.1.2. When children are exposed to chronic stressful events, their neurodevelopment can be disrupted. As a result, the child’s cognitive functioning or ability to cope with negative or disruptive emotions may be impaired. Over time, and often during adolescence, the child may adopt negative coping mechanisms, such as substance use or self-harm. These unhealthy coping mechanisms contribute to mental illness, physical illness, social problems and premature death.

7.3.1.3. It is therefore not right to see mental health problems as the start of the pathway, they in fact sit in the middle of the pathway, prompted by ACEs.

7.3.1.4. Causes can begin from pregnancy and infancy as this stage sets up the child’s internal biology and emotional regulation and attachment. Without a holistic approach for families to support the infant-parent relationship this early, trauma experienced becomes an underpinning cause of later social, emotional and behavioural issues.

7.3.1.5. Evidence shows that the educational, employment and engagement with the criminal justice system disadvantages experienced by children and young people (11) can all be attributable to experiences in the first 1,001 days”.

7.3.2. It is because of this that we agree that a greater recognition of the critical role of ACEs in the development of mental illness must be included in a revised paper.
8. Child and Adolescent Mental Health Services

8.1. It is welcome that Green Paper has considered some of the issues related to Child and Adolescent Mental Health Services (CAMHS) in schools. Our members are concerned however that there is nothing substantive in the Green Paper to address ‘Specialist CAMHS services’.

8.2. Referring to the proposal to have a Designated Senior Lead for Mental Health, members in CAHMS services highlight their significant concerns that this core principle does not address the issue of what happens when a child or young person is identified as having mental health needs which are beyond their competence to respond to; i.e. the child or young person should receive a referral to a ‘tier 3 CAMHS service’ however these services are not receiving sufficient funding or resources to deal with these referrals.

8.3. Members responses include concerns that in areas where children and young people practitioners are already operating in schools, they are unable to ‘manage risk’ and so refer to tier 3 CAMHS which are unable to respond. They also questioned who is providing supervision, what is the competence of these individuals, what training is offered and what is the quality of supervision.

8.4. Our members highlight their concerns as to the ethics of how cuts to funding and higher thresholds are driving the response that children and young people need to become ‘more ill’ before they are considered for treatment.

8.5. The focus on reducing waiting times is welcome, and important, however, our members report this can have a consequence of services focusing on ‘throughput’, encouraging professionals to deal with cases as quickly as possible, rather than quality of care, which members report is neither realistic or ethical.

8.6. Our members expressed concerns that as the core proposals in the Green Paper will increase the demands on their services, this must be met with significant commitments to improve funding. A revised Green Paper must make this commitment clear. We believe the ministers ‘assurance’ (Q18027) is totally insufficient to address the “years of underinvestment highlighted by NHS England28.

8.7. Our members also expressed concerns that whilst funding was now increasing in some parts of the NHS, this compares with large cuts to local authority budgets and this will have the effect, whilst NHS services may be improved/increased, services in local authorities will be cut. It is then for local campaigners to defend services against these cuts29. Some areas may save services, others may not.

8.8. Our members also expressed the importance of CAMHS multi-disciplinary teams have senior clinicians (applied psychologists) in place, to ensure that care is properly coordinated and any risks effectively managed. Members also commented on the importance of senior professionals having the

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capacity to ensure effective clinical supervision is available to members of the team. Benefits of reflective practice include; reducing risks (highlighted by the ‘Francis report’\(^{30}\)), improvements in staff stress levels, preventing staff burnout, improved retention of staff, etc.

8.9. As the Association of Child Psychotherapists state in their response to the Green Paper; Research\(^{31}\) supports previous findings that workforce difficulties are a key barrier to the implementation of the vision set out in Future in Mind. 83% of trusts which responded to the Time to Deliver report said they had experienced recruitment difficulties. Many NHS trusts have been restructuring their CAMHS to take out senior and experienced clinicians (at Band 8a and above) and replacing them with lower banded and less skilled practitioners. This has impacted psychiatrists, clinical psychologists, family therapists and child psychotherapists who are essential to good multi-disciplinary work with children with severe and complex needs. The impact of the above is evidenced this week by the ‘mortifying inadequate rating’ given by the Care Quality Commission to Birmingham Women’s and Children’s Foundation Trust\(^{32}\).

8.10. Members commented that there are a number of parenting programmes\(^{33}\) focused on promoting parenting and attachment, but that these don’t have a focus on the mental health of children, young people and their parents, which they have skills to provide.

8.11. On the age ranges covered by CAMHS services, members highlighted how currently the focus of services is between the ages of 5 and 18. We recommend that ring-fences are used to improve care to under-5s and 18 to 25-year olds. We believe this supports recommendations made in ‘Future in mind: Promoting, protecting and improving our children and young people’s mental health and wellbeing’\(^{34}\).

8.12. Members highlighted how young adults are vulnerable (citing research by Jean Twenge which demonstrates currently teens are 3 years behind their ‘chronological age’\(^{35}\)). This further backs up our recommendation to have a designated lead for mental health in universities (3.7.2).

9. The impact of childhood adversity and social deprivation

9.1. Over 14 million people now live in poverty in the United Kingdom, over one in five of the population. This figure is made up of eight million working-age adults and four million children. Eight million people in poverty live in families where at least one person is in work\(^{36}\). Rising income

\(^{31}\)http://epi.org.uk/report/time_to_deliver/
\(^{32}\)https://www.hsj.co.uk/mental-health/top-trust-receives-mortifying-inadequate-rating-for-new-service/7021789.article
\(^{33}\)https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence
\(^{35}\)https://books.google.co.uk/books/about/iGen.html?id=HIKaDQAAQBAJ&redir_esc=y
\(^{36}\)https://www.jrf.org.uk/report/uk-poverty-2017
inequality, poverty, reducing social mobility and growing numbers of people living in insecure, overcrowded and unsafe housing are all issues associated with poorer mental health37.

9.2. Evidence is increasingly showing that these experiences lead to lifelong mental and physical health problems and inter-generational cycles of distress. This distress is directly contributed to by the governments current ‘austerity policies’. The Green Paper ignores this reality and therefore improvements to children and young people’s mental health is significantly impeded.

9.3. If the government is truly interested in tackling the burning injustice of mental ill health, it must reverse its damaging austerity cuts that are having such a major impact to the countries citizens and the communities they live in.

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Appendix A – Response to the online consultation, submitted on Friday 2\textsuperscript{nd} March 2018

Consultation Questions

About you: Not applicable to this organisation response.

Question 1:

The core proposals in the green paper are:

- All schools and colleges will be incentivised and supported to identify and train a Designated Senior Lead for Mental Health who will oversee the approach to mental health and wellbeing.
- Mental Health Support Teams will be set up to locally address the needs of children and young people with mild to moderate mental health issues, they will work with schools and colleges [and] link with more specialist NHS services
- Piloting reduced waiting times for NHS services for those children and young people who need specialist help.

Do you think these core proposals have the right balance of emphasis across;

a. schools and colleges and

b. NHS specialist children and young people’s mental health services?

Please give your answer below (max 250 words)

On the first and second core proposals, the balance seems appropriate. On the third core proposal, it is not clear how schools and colleagues will be responsible for waiting times. What this question ignores however is how little the Green Paper has to say on any of the significant issues outside of these extremely limited core proposals. We have addressed this issue later and in our full response.

Question 2:

To support every school and college to train a Designated Senior Lead for Mental Health, we will provide a training fund. What do you think is the best way to distribute the training fund to schools and colleges?

Please rank the following in order of preference:

- Set amount of funding made available to each school, for them to buy relevant training with
- Funded training places made available locally for schools to book onto
- Funding allocated to local authorities and multi-academy trusts to administer to schools
- Funding distributed through teaching school alliances

If you wish, please provide any further information on why you have ranked in this order of preference (max 250 words)

It is imagined that different allocation methods may be required in different areas of the country. A main focus of any/all distribution methods must be that the training budget and/or training places are properly ring fenced to ensure that the allocated money is not used to make up for any other cuts to school’s
budgets. We have given more detail in our full response regarding the need to ensure this is properly funded including back-fill money.

**Question 3:**

Do you have any other ideas for how the training fund could be distributed to schools and colleges? *(max 250 words)*

As above, the training fund must be appropriately protected, and audited, to ensure it is used for its intended purpose.

**Mental Health Support Teams**

**Question 4:**

Trailblazer phase: A trailblazer phase is when we try out different approaches. Do you know of any examples of areas we can learn from, where they already work in a similar way to the proposal for Mental Health Support Teams?

**Please give your answer below (max 250 words)**

No

**Question 5:**

Different organisations could take the lead and receive funding to set up the Mental Health Support Teams.

We would like to test different approaches.

Which organisations do you think we should test as leads on this? Please rank the following organisations in order of preference:

- Clinical Commissioning Groups (CCGs)
- Groups of schools
- Local authorities
- Charity or non-government organisation
- Other:

It would seem sensible to test each organisational approach. As it is recognised that one of the current problems is ‘silhouette working’ it seems unfortunate that the Green Paper does not make more efforts to consider how this element, of organisation leadership could be developed and ensure that mental health support teams are delivered in a partnership approach, rather than looking at providing funding to one of the agencies to lead.

**Question 6:**
Mental Health Support Teams will work and link with a range of other professionals and we would like to test different approaches. From the list below, please identify the three most important 'links' to test in the way they would work with Mental Health Support Teams:

- Educational psychologists (2)
- Local authority troubled families’ teams
- Local authority children and young people’s services
- Local authority special educational and disability (SEND) teams
- School nurses (1)
- School-based counsellors (3)
- Charity or non-government organisation
- Youth offending teams
- Other:

An area where the Green Paper is silent is how the current cuts to services will impact on the areas that are receiving investment in the Green Paper. For example, we believe it is critical that a well-resourced school nursing service is available to all schools in England. Previously we have argued that each secondary school and each cluster of primary schools must have a full time, year-round (specialist community public health nurse) school nurse. However, since 2010, the number of school nurses in the NHS have been cut by 20.1%. Therefore, in testing different approaches, it must be done with cognisance of how these groups have been cut recently. The Green Paper is a missed opportunity to mandate services to ensure that there are sufficient staff in the mental health support teams for schools to link with.

**Question 7:**

Mental Health Support Teams and Designated Senior Leads for Mental Health in schools and colleges will work closely together, and we will test this working through the trailblazer phase. Out of the following options how do you think we should measure the success of the trailblazer phase?

**Please pick your top three:**

- Impact on children and young people’s mental health (1)
- Impact on quality of referrals to NHS Children and Young People Mental Health Services
- Impact on number of referrals to NHS Children and Young People Mental Health Services
- Quality of mental health support delivered in schools and colleges
- Amount of mental health support delivered in schools and colleges
- Effectiveness of interventions delivered by Mental Health Support Teams
- Children and young people’s educational outcomes
- Mental health knowledge and understanding among staff in school and colleges
- Young people’s knowledge and understanding of mental health issues, support and self-care (3)
- Numbers of children and young people getting the support they need
- Other: The number/percentage of children receiving effective support relative to the number of children that require that support. (2)

**Question 8:**
Trailblazer phase: A trailblazer phase is when we try out different approaches. When we select areas to be trailblazers for the Mental Health Support Teams, we want to make sure we cover a range of different local factors. What factors should we take into account when choosing trailblazer areas?

Please rank the following in order of importance:
- Deprived areas (1)
- Levels of health inequality (2)
- Urban areas (5)
- Rural areas (4)
- Areas where children and young people in the same school/college come under different Clinical Commissioning Groups (CCGs) (3)
- Other:

**Question 9:**
How can we include the views of children and young people in the development of Mental Health Support Teams? **Please provide your answer below (max 250 words)**

By asking children and young people’s opinion in a way that ensures they are able to contribute in a meaningful way. This contribution must also be used to influence the development of the service.

**Piloting a waiting time standard**

**Question 10:**
Waiting time standards are currently in place for early intervention for psychosis and for eating disorder services. Outside of this, are you aware of any examples of local areas that are reducing the amount of time to receive specialist NHS help for children and young people’s mental health services? Can we learn from these to inform the waiting times pilots? **Please give your example(s) below (max 250 words)**

No

**Schools and colleges**
**Question 11:**
Schools publish policies on behaviour, safeguarding and special educational needs and disability. To what extent do you think this gives parents enough information on the mental health support that schools offer to children and young people?

- All of the information they need
- Most of the information they need
- Some of the information they need (X)
- None of the information they need
- Don’t know

**Please tell us more about why you think this (max 250 words)**
Without seeing a range of the above policies for random schools, it is impossible to provide an accurate answer to this question. A best guess however would be that they will provide ‘some’ of the information. To better answer this question, we would encourage that a random sample of policies are reviewed.

**Question 12:**
How can schools and colleges measure the impact of what they do to support children and young people’s mental wellbeing? **Please give your answer below (max 250 words)**
A range of measures could be taken to measuring the impact. This consultation survey has already suggested 10 different approaches in question 7. These seem a sensible place to start.

**Vulnerable groups**

**Question 13:**
In the development of the Mental Health Support Teams, we will be considering how teams could work with children and young people who experience different vulnerabilities. How could the Support Teams provide better support to vulnerable groups of children and young people?

**Please give your answer below (max 250 words)**
We would hope that each team would be properly resourced to ensure that all children and young people that require support will receive it, and this support will be tailored to their specific needs. However, if the professionals in the teams continue to be cut, it should be expected that this tailored approach would not be possible.

**Support for children looked after or previously looked after**

**Question 14:**
As we are rolling out the proposals, how can we test whether looked after children and previously looked after children can easily access the right support? **Please give your answer below (max 250 words)**
It would be expected that this will be apparent from the data and feedback from service users collected via the trailblazers, as to how children that are/were looked after are represented in the service.

**Support for children in need**

**Question 15:**

As we are rolling the proposals out, how can we test whether children in need who are not in the care system can access support? **Please give your answer below (max 250 words)**

It would be expected that this will be apparent from the data and feedback from service users collected via the trailblazers, as to how children in the care system are represented in the service.

**Support for children and young people with special educational needs or disability**

**Question 16:**

As we are rolling the proposals out, how can we test whether children and young people with special educational needs or disability are able to access support? **Please give your answer below (max 250 words)**

It would be expected that this will be apparent from the data and feedback from service users collected via the trailblazers, as to how children with special educational needs or disability are represented in the service.

**Providing evidence for an Impact Assessment**

A consultation stage Impact Assessment was published alongside the green paper. The following questions seek to gather further evidence to inform future versions of the Impact Assessment. We welcome references to any evidence, published or in development, or expert opinion on the topics set out above to help refine our final Impact Assessment. If you have not read the Impact Assessment or do not wish to respond to these questions then please skip to the next section.

**Question 17:**

Please provide any evidence you have on the proportion of children with diagnosable mental health disorders, who would benefit from support from the Mental Health Support Teams

**Please give your answer below**

**Question 18:**

Please provide any evidence you have on the proportion of children with pre-diagnosable mild to low-level mental health problems who would benefit from support from the Mental Health Support Teams.

**Please give your answer below.**
**Question 19:**
Please provide any evidence you have of the impact of interventions for children with mild to moderate mental health needs, as could be delivered by the Mental Health Support Teams. We are interested both in evidence of impact on mental health and also on wider outcomes such as education, employment, physical health etc. Please give your answer below.

**Question 20:**
Please provide any evidence you have on the impact of Children and Young People Mental Health Services therapeutic treatments. Please give your answer below

The STTP (Short Term Psychoanalytic Psychotherapy) for adolescents with depression is an intervention delivered by Unite members (Child & Adolescent Psychotherapists, members of the Applied Psychologists OPC) that, following a Randomised Controlled Trial, has been seen as effective and is recommended by NICE for depression in adolescents. It is also an "Early Intervention" in that it can prevent chronicity in older adolescents and adults- further research studies are planned.

**Question 21:**
Is there any other evidence that we should consider for future versions of the Impact Assessment? Please give your answer below.

**Demographics:** Not applicable to this organisation response.