

Services for children and young people with emotional and mental health needs

24 November 2009





This report has been prepared jointly by the Wales Audit Office and the Healthcare Inspectorate Wales (HIW), supported by Estyn and the Care and Social Services Inspectorate Wales (CSSIW), and is presented to the National Assembly under the Government of Wales Acts 1998 and 2006.

Further information on the roles of the Wales Audit Office, Healthcare Inspectorate Wales (HIW), Estyn and the Care and Social Services Inspectorate Wales (CSSIW) is given in Appendix 4 of this report.

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The images used throughout this report have been selected from material produced by children and young people who took part in group work sessions as part of the consultation undertaken as part of this review.

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Foreword

In One Wales, A progressive agenda for the government of Wales, the Assembly Government placed a new priority on providing for mental health, including child and adolescent mental health services. This report, on services for children and young people with emotional and mental health problems, is intended to support the Assembly Government, NHS bodies and local authorities in delivering against this priority.

The review arose because of concerns raised during related audit and inspection work, and from issues raised by a wide range of stakeholders. Children and young people with emotional and mental health problems often have complex and wide ranging needs that require a co-ordinated response from different professionals and services in the fields of health, social care and education. As a result, it was appropriate for us, as the audit and inspection bodies covering these sectors in Wales, to work together in delivering this report. This is the first time that all four of our organisations have been involved in a major service review.

In undertaking the review we sought to answer the question 'Are services adequately meeting the mental health needs of children and young people?' We have concluded that despite some improvements in recent years, services are still failing many children and young people, reflecting a number of key barriers to improvement.

A key part of our review has been to gather the views and experiences of children, young people and their parents or carers. These feature throughout our report. Our thanks go to Barnardos Cymru for undertaking the consultation exercise on our behalf, and most importantly to all those who shared their experiences of services.

The challenges faced by the Assembly Government and those providing services in meeting the needs of children and young people with emotional and mental health problems are considerable. Given the scale of the task ahead, our organisations will over the coming years continue to monitor the progress made across Wales in developing comprehensive, effective and safe services.

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Summary and recommendations

- 1 Mental health is one of the Assembly Government's key health priorities. Most recently, the Assembly Government in the One Wales document placed a new priority on providing for mental health, including Children and Adolescent Mental Health Services (CAMHS)ⁱ.
- 2 Accurate figures on the number of children and young people at risk of or experiencing mental health problems are not available. However, the Assembly Government estimatesⁱⁱ that:
 - more than 40 per cent of young people have recognisable risk factors;
 - between 30 per cent and 40 per cent may at some time experience a mental health problem; and
 - up to 25 per cent may experience a more severe or persistent mental health disorder.
- 3 In September 2001, the Assembly Government published its CAMHS Strategy, *Everybody's Business*, which set out a 10-year programme to establish comprehensive, high quality services across Wales. This multiagency strategy has been further developed through various Welsh Health Circulars, and the 2005 National Service Framework (NSF) for children, young people and maternity services.
- 4 *Everybody's Business* identified a number of concerns about CAMHS provision at that time. These included:
 - the distribution of services owing more to historical patterns and local advocacy for service development than it did to assessed needs;
 - education and social services not playing their full parts in planning or delivering mental health services;
 - first-line staff groups working with children and young people having little capability to deal with mental health problems due to a widespread lack of training and uncertainties about roles;
 - children's services provided by a range of organisations, such as social services departments, educational psychology and special education services, community and hospital paediatricians, child and adolescent psychiatry services, and child clinical psychology services, being valued but under enormous pressure;

- specialist CAMHS being in danger of being swamped by rising levels of demand with many services having long waiting lists and waiting times;
- the distribution, role and volume of more specialised services needing to be rethought, with the capacity of specialised services such as day care and inpatient services being too small, and psychiatric inpatient services lacking the most appropriate focus; and
- good practice being disseminated, but slowly, incompletely and not systematically.

5 To address these shortfalls *Everybody's Business* set a series of high level objectives for services, including:

- improving the mental health of children and young people, and providing effective and timely interventions for those presenting with mental health problems;
- making services available across Wales on the basis of need;
- building child protection measures into all services, to provide safeguards for children and young people wherever and whenever they are cared for or treated;
- promoting a multiagency, multi-disciplinary approach and integrated service provision;
- involving parents and carers in a meaningful way in planning and commissioning services; and
- establishing child-centred services which take into account the views of the young people and families using them.

6 The 2001 strategy set broad priorities for action. These included the development of the range, scope and diversity of services; increasing the volume of local services; and improving the capacity of services, particularly within the fields of training and staff development, prevention, early intervention and the provision of services for people with the most serious problems. The priorities were supported by detailed actions to be taken by the Assembly Government, service

commissioners and providers. The NSF for Children, Young People and Maternity Services built upon the strategy and set out 22 targets relating to CAMHS.

About our review

7 The review set out to establish whether services are adequately meeting the mental health needs of children and young people in Wales. Healthcare Inspectorate Wales (HIW) and the Wales Audit Office jointly undertook the review, supported by Estyn and the Care and Social Services Inspectorate Wales (CSSIW). The review arose from concerns

Box 1 - Terminology used in the report

In this report, the term 'child and adolescent mental health services' refers to all services that impinge on the psychological well-being and mental health of children and young people. Some of these services are specialist in nature, but many of them do not specifically provide mental health services. We use the term CAMHS to refer to the full range of services provided by all sectors and professionals, and the term specialist CAMHS to refer to those services provided by specifically trained health and social care professionals such as psychiatrists, psychologists, and mental health nurses. Appendix 1 shows which NHS organisations in Wales provide specialist CAMHS.

The terms 'emotional health', 'emotional well-being' and 'mental health' are used interchangeably throughout this report to refer to a broad range of issues, ranging from relatively common emotional or behavioural difficulties through to more severe and persistent mental health disorders.

Use of the term 'parent' in this report includes all natural parents and any person who, although not a natural parent, has parental responsibility for a child or young person or has care of a child or young person.

We undertook our fieldwork prior to the creation in October 2009 of the new NHS bodies, and as a result, evidence was collected from the former Local Health Boards (LHBs) and NHS trusts. Throughout this report, we use the term 'LHBs' or 'NHS trusts' to refer to the former organisations and 'health boards' to refer to the new bodies.

raised about CAMHS during related work undertaken by these audit and inspection bodies, and from issues raised by a wide range of stakeholders.

- 8 We drew on evidence from a variety of sources over the period 2007 to 2009. We gathered the views of children, young people, and their parents through a consultation exercise undertaken on our behalf by Barnardos Cymru. We also gathered evidence from service commissioners, and statutory and voluntary sector providers. [Appendix 2](#) provides more details of how we undertook the review.

Main conclusions

- 9 Our overall conclusion is that **despite some improvements in recent years, services are still failing many children and young people, reflecting a number of key barriers to improvement.**

Service provision

[Services that focus on prevention, early intervention and those with less severe problems](#)

[Comprehensive services are still not in place despite some important developments in services that focus on prevention, early intervention and supporting those with less severe problems.](#)

- 10 Parenting and family intervention services have been developed through various funding streams, including those overseen by children and young people's partnerships. There is widespread support for these services from professionals and parents.
- 11 School-based counselling services have been expanded and the Assembly Government has committed to making these services available to all school pupils. However, developing these services for children on the fringes of, or excluded from, school, for those in transition from primary to secondary school, and outside of school hours will be challenging.
- 12 Services targeted on children and young people at risk of developing mental health problems and early intervention services for those who subsequently develop problems are underdeveloped in many parts of Wales.
- 13 The extent to which staff who work on a day-to-day basis with children provide active support to children and young people with emotional or mental health problems varies too much. We found this variation to be the case across a broad range of staff including school nurses, community and inpatient paediatricians, social services, schools staff and educational welfare services.
- 14 Progress has been made in introducing primary mental health workers in many areas. They provide support to a wide array of professionals who work with children and young people, such as GPs, school nurses, schools staff and social workers. Many non-specialist staff told us that they valued the support provided by primary mental health workers and reported that, as a result, they were more confident in identifying and managing emotional and mental health problems in their early stages. However, the role of these workers varies, and the provision of consultation and advice from specialist CAMHS to other professional staff can be inadequate. Also, meeting the target number of primary mental health workers will be challenging.
- 15 Educational psychology services provide support in educational settings with all aspects of children and young people's learning, behaviour, and social and emotional development. However, we found that the input from educational psychologists to meeting the needs of children and young people with a mental health problem varied, and that closer co-ordination with specialist CAMHS would be beneficial in many parts of Wales.

Specialist community services

Some specialist services in the community are not provided within Wales and there are unacceptable variations in the availability and quality of those services that are provided.

- 16** Unlike in other parts of the UK, there are no specialist mental health services in the community for children under five years of age. Further, although a lower age limit for specialist CAMHS teams is often set at five years, this can be as high as 11 years and, as a result, younger children can lack specialist CAMHS support.
- 17** There is too much variation across Wales in eligibility criteria and referral arrangements for specialist CAMHS teams, and the referral process is often unclear. There is evidence that waiting times for initial assessment and intervention by specialist CAMHS have reduced since 2008, in response to a waiting times target. However, we do have concerns about the interpretation of, and the measurement of performance against, this target, and there is a risk that the benefits implied by the reported improvements in waiting times are not fully delivered in practice. There is also a risk that the waiting time target could have some adverse consequences on other aspects of care and support.
- 18** Access to specialist CAMHS in the community for some children and young people depends on where in Wales they live. This includes access by children and young people with a learning disability; aged 16 to 18 years; placed from out of area; with unstable home and family circumstances; with a substance misuse problem; and with a diagnosis of conduct disorder. Overall, access is too variable across Wales and some children are not receiving the specialist CAMHS support they need.
- 19** Community intensive therapy and treatment services have been established in some parts of Wales, but in others, children and young people can only access intensive support from inpatient settings. As a result, children and young people in similar circumstances are supported in the community in some areas, but in others, they are being admitted to an inpatient unit.
- 20** There has been slow progress in establishing comprehensive services for children and young people with mental health problems who are at a high risk of offending. Despite funding being available, it has taken considerable time to put in place a Forensic Assessment and Consultation service. There are also shortfalls in the specialist mental health services provided in the two units housing young offenders in Wales, although action is in hand to address these.
- 21** The availability of day care and eating disorder services is particularly patchy and bears little relationship to the local need for such services. There is also inconsistency in the availability of advocacy services; although a pilot national advocacy and advice service is in place, significant local improvements are needed if the Assembly Government's aims for universal and integrated advocacy are to be met.
- 22** Specialist CAMHS teams in many parts of Wales are struggling to provide services in a way that meets the specific needs of children and young people. The location, environment, and opening times of services are frequently not child or family friendly.
- 23** Children and young people who miss appointments are, as a consequence, 'discharged' by specialist CAMHS teams in many areas, and a lack of routine follow-up of missed appointments can put children at risk. In some parts of Wales' professionals in different organisations are not appropriately sharing information on individual cases, putting children and young people at further risk and undermining child protection arrangements.

24 In many parts of Wales, children and young people are not receiving holistic care based on meeting their often wide-ranging needs. A multiagency and multi-professional response to meeting the individual needs of children and young people is rare. Many children and young people are inadequately involved in planning their care, and do not always feel that professionals listen to their views. Overall, there is a lack of information for children and young people on their rights and what they should expect from CAMHS.

25 There are inadequate arrangements to ensure a smooth and effective transition from CAMHS to adult mental health services in many parts of Wales, increasing the risk that young people disengage from services.

Specialist inpatient and residential services

There are important weaknesses with specialist inpatient and residential services.

26 A new inpatient unit opened in North Wales in July 2009. In South Wales, the unit was temporarily relocated in December 2007, with a new unit planned for 2011. However, there are a number of issues with inpatient services, the resolution of which will require more than investment in new facilities.

27 The development of a new unit in North Wales will address some of the existing limitations in inpatient services there. Unlike the former unit, the new facility is able to accept emergency admissions and those detained under the Mental Health Act, and to provide care for acutely disturbed children and young people.

28 Following the opening of the new inpatient units, the total number of inpatient beds routinely in use has increased in North Wales. However, bed numbers in South Wales are lower than originally planned and have fallen. Until December 2008, there were no dedicated emergency inpatient beds in Wales. Although eight emergency beds are now routinely available in the two inpatient units,

the number is lower than the 11 originally planned. There was a considerable delay in making these beds available following the opening of the new facilities; and in South Wales, the emergency beds have resulted in a corresponding reduction in the number of beds for general use.

29 There are a number of significant differences between the two inpatient units in Wales and, as a result, young people in North and South Wales have access to different types of care and support. Differences include different psychological therapies and varying access to education, dedicated social worker support, occupational therapy and physiotherapy.

30 Some children, young people and their parents were not satisfied with the inpatient services they received in the past, although their concerns over the quality of facilities should have now been addressed with the development of the two new units. Parents can also experience significant problems due to the significant distances they may have to travel to see their children for routine visits or for attending family therapy sessions.

31 Significant numbers of children and young people are being placed, or kept, inappropriately on paediatric or adult mental health wards, giving rise to concerns about the effectiveness and safety of the care provided. Reasons for inappropriate use of paediatric or adult mental health beds include insufficient CAMHS inpatient beds, especially emergency beds, and inadequate access to a CAMHS assessment, particularly out of hours. The improved availability of emergency beds may help to reduce the inappropriate use of adult mental health and paediatric wards.

32 Care for children and young people who are placed out of their local authority area is often poorly co-ordinated. There has been inadequate clinical input to decisions on health placements made by Health Commission Wales (HCW), although this has now been addressed.

Barriers to improvement

It is unclear how policy should be implemented

- 33** The Assembly Government's commitments to develop more detailed guidance to support the implementation of *Everybody's Business* have not been met in a number of key areas. These include specific guidance on the role of different sectors and professionals in delivering CAMHS, information sharing, workforce development, and the precise level of investment required.
- 34** Service development priorities over the medium term are unclear. National priorities for the NHS are set through the Annual Operating Targets. In addition, the children, young people and maternity services NSF flagged 5 of the 22 CAMHS targets to be achieved by March 2006. However, a timeline for the delivery of specific targets over the medium term is not in place.
- 35** Only limited routine support and guidance has been provided to local commissioners and providers. A common issue for all groups of staff who work with and support children and young people with emotional or mental health problems has been that the respective roles of different professionals and agencies is often unclear. The provision of coherent and consistent advice, guidance and leadership across CAMHS is a particular challenge given the range of services and service providers involved. The Assembly Government has a CAMHS adviser who has a health background, but there is no equivalent advisory input or leadership from the social care, education or voluntary sectors.
- 36** Planning and commissioning arrangements are complex and unclear. A significant number of LHBs, specialist CAMHS providers, social services departments and education departments stated that responsibilities for planning and commissioning all forms of CAMHS are unclear. This reflects the complexity of arrangements, the variable links between planning and commissioning groups, and a lack of clarity over roles and responsibilities.

- 37** Children and adolescent mental health services are not adequately covered in the key strategies and priorities of NHS bodies and local authorities. Children and young people partnership plans and health, social care and wellbeing strategies are not yet universally providing a clear strategic direction for CAMHS. There has also been only limited progress in developing joint comprehensive plans for CAMHS that support these strategies and cover all service providers.

There are fundamental weaknesses with the approach to service development

- 38** A child-centred approach to service planning and development is lacking in many parts of Wales, and the views of children and young people are not driving change within statutory organisations. Some NHS bodies and local authorities could not provide examples of how they had changed services in response to the views of children and young people. Others could only provide limited examples.
- 39** The extent and effectiveness of joint working between the health, local authority and voluntary sectors is very variable, resulting in some children and young people receiving services that are poorly co-ordinated. Difficulties have been experienced at both a strategic and operational level, and contribute to the lack of co-ordinated and integrated services. Despite directly funding and providing a substantial range of services, voluntary sector organisations are often excluded from strategic planning processes.
- 40** The Assembly Government has committed additional funding to CAMHS, but the ways in which services are funded do not always support sustainable improvements, because:
- the funding needed to address identified service gaps and inequalities has not been fully established;
 - full transitional funding to support the repatriation of children placed out of area has been lacking;
 - bids for non-recurrent funds were often rushed and the nature of the funding does not support sustainable services; and

- some statutory and voluntary sector organisations are concerned about being able to maintain the current level of funding for CAMHS.

- 41** Some specialist services, such as inpatient and forensic mental health services, have been poorly managed and controlled. The Assembly Government has made additional recurrent funding available to HCW for the development of emergency beds and a Forensic Adolescent Consultation Service within Wales. However, HCW has taken considerable time in establishing these services, and there are deficiencies in the way inpatient services have been planned. The Assembly Government has been slow to address these issues.
- 42** Good practice in service provision is not widely shared and service evaluation is often weak. Some shared learning is taking place through, for example, the all Wales CAMHS Nursing Forum and CAMHS commissioning networks (CCNs). However, a well-developed and comprehensive infrastructure for sharing good practice across professions, statutory organisations and voluntary sector agencies is lacking. We also found little evidence of processes to support the adoption of evidence-based best practice.

There are important challenges in developing an appropriate workforce for delivering CAMHS

- 43** There are key challenges in developing an appropriate workforce for delivering CAMHS, and a comprehensive workforce plan to address these challenges is lacking. There are substantial variations across Wales in staffing levels and the expertise of the CAMHS workforce, which are not explained by variations in the local need for services. The expertise and management capacity to plan, commission and monitor CAMHS is also lacking in many parts of Wales.
- 44** Some NHS bodies have experienced problems in recruiting staff in recent years. The planned expansion of some parts of the workforce, such as primary mental health workers, will provide a challenge, as there may only be a small pool of staff with the necessary skills and expertise to draw upon locally or within Wales.

- 45** Effective supervision and support is not in place for some staff groups, particularly for staff outposted to other teams. These include social workers within specialist CAMHS teams and nurses in youth offending teams. Although some staff groups have received relevant training, the approach to training and skills development is not consistent or comprehensive.

Although there is emerging evidence that performance management arrangements within the NHS are becoming more robust, further development is needed

- 46** There are a number of potential sources of information that could be used to assess CAMHS performance, but the available data is not yet sufficiently robust and reliable. Some potentially useful information, such as self-assessments of progress against NSF targets, is not used to manage performance.
- 47** Over recent years, NHS bodies and local authorities have frequently missed key NSF and Annual Operating Framework targets (and the former Service and Financial Framework targets) in relation to CAMHS. Some targets have been delivered, but significantly later than envisaged, and performance against the five NSF targets that had been flagged for delivery by the end of March 2006 has been very poor. There has, however, been some progress against a few important NHS targets in the last year.
- 48** Although performance management arrangements have been strengthened for AOF targets within the NHS, it is too early yet to judge their full effectiveness. Robust performance management arrangements for the broader range of NSF actions for CAMHS are not in place, and CAMHS targets are not an integral part of performance management arrangements within local authorities. There is no overarching body with responsibility for managing performance on CAMHS across NHS bodies and local authorities.

Recommendations

In support of its One Wales objectives for child and adolescent mental health services, the Assembly Government has allocated £6.9 million of recurring funding over three years from 2008-09.

The development of a school counselling service is also being supported by funding of £6.5 million, again over a three-year period. In addition, capital funding of £35.7 million has been made available for new inpatient units. Some service improvements have already been delivered through this additional funding, and in other service areas the impact of additional funding should become apparent in future years. Nevertheless, the scale of the task ahead in developing comprehensive and effective services is considerable. It is also clear that additional investment will not on its own deliver all the improvements needed; the way services are designed and delivered also needs addressing:

- a** It is clear from our review that the way services are currently planned and provided is not leading to the well co-ordinated and child-centred services envisaged by *Everybody's Business*. The overall approach is one of assessing whether a child or young person's needs meet a service's criteria, rather than building services around the specific needs of the individual. **We recommend that:**
 - i** **The Assembly Government reviews the way services are organised and delivered to ensure the outcomes envisaged by *Everybody's Business* can be achieved. This should not delay the implementation of our other recommendations.**
- b** Many of the service gaps and deficiencies identified in *Everybody's Business* in 2001 remain in place. The objectives set out in *Everybody's Business* are still appropriate, but there has been a lack of drive and coherence in its implementation. To ensure service's improvements are delivered as a matter of urgency **we recommend that:**

- i** **The Assembly Government develops a national plan within six months of the publication of this report to address the issues with the availability and quality of services we have identified. The plan should set clear priorities and target dates for all relevant bodies, including a deadline for specialist CAMHS to be available to all groups of children and young people, such as those aged 16 to 18, those with a learning disability, and those placed out of area.**
 - ii** **The Assembly Government strengthens CAMHS leadership at a national level by identifying senior champions for CAMHS within its departments that are responsible for education, health, social care and local government.**
 - iii** **The Assembly Government clarifies and simplifies planning arrangements for CAMHS at a national, regional and local level.**
 - iv** **Health boards and local authorities develop, for Assembly Government approval, local multiagency plans for implementing the national plan.**
- c** To address the weaknesses in monitoring performance at a national and local level and to strengthen performance management, **we recommend that:**
- i** **Health boards and local authorities monitor delivery of the local multiagency CAMHS plan and report progress, at least annually, to the relevant boards and scrutiny committees.**
 - ii** **The Assembly Government should commission the development of information for children, young people and their parents on their rights relating to CAMHS and what they should expect from these services.**

- iii **The Assembly Government, health boards and local authorities, put in place arrangements to involve children, young people and their parents in all parts of the development, implementation and review of services.**
- iv **The Assembly Government and other public bodies put in place effective arrangements for the management and scrutiny of performance, ensuring that results are widely available. This will require:**
 - clarification of the roles and responsibilities of local bodies in monitoring and managing performance;
 - covering the full range of issues outlined in the *Everybody's Business* and the NSF; and
 - performance measures for CAMHS to be integrated into local government arrangements.
- d Delivering improved services will require an appropriately skilled and experienced CAMHS workforce. **We recommend that:**
 - i **The Assembly Government identifies national priorities for developing the CAMHS workforce and a process by which these priorities will be addressed at a regional and local level. This should include a detailed action plan for achieving the staffing levels and expertise required to meet the needs of children and young people.**
 - ii **The national priorities for the CAMHS workforce include the development of leadership and management capacity and expertise in CAMHS.**
 - iii **Health boards and local authorities strengthen, where necessary, staff supervision and support, particularly for out-posted staff.**
- e We have identified a number of circumstances in which the practices of service providers are putting children and young people at risk. A number of steps need to be taken immediately and **we recommend that:**
 - i **The Assembly Government, in collaboration with health boards, take steps to ensure children and young people are not placed inappropriately on adult mental health wards. Until the issue is resolved, the Assembly Government and health boards should monitor the numbers of inappropriate placements.**
 - ii **Health boards and local authorities ensure that all staff working with children and young people understand their safeguarding responsibilities, as set out in Welsh Assembly guidance Safeguarding Children Working Together under the Children Act 2004.**
 - iii **Health boards and local authorities, in collaboration with the Assembly Government, ensure that all staff working with children understand their responsibilities for sharing information on individual children and young people.**
 - iv **Health boards and local authorities, in collaboration with the Assembly Government ensure that cases are not routinely closed due to non-attendance at appointments, and that safe and effective routine follow-up occurs when appointments are missed.**
 - v **Health boards and local authorities put in place effective monitoring to check, at least annually, on compliance by service provider staff with:**
 - safeguarding children and young people;
 - information sharing; and
 - action taken following missed appointments.

Service provision

Despite some improvements in recent years, services are still failing many children and young people

Comprehensive services are still not in place despite some important developments in services that focus on prevention, early intervention and supporting those with less severe problems

Some specialist services in the community are not provided within Wales and there are unacceptable variations in the availability and quality of those services that are provided

There are important weaknesses with specialist inpatient and residential services



Part 1 – Services that focus on prevention, early intervention and supporting those with less severe problems

- 1.1** A broad range of services can help prevent mental health problems, provide early intervention when problems do arise, and support children and young people with less severe problems. The expansion of these services and the gaps that remain are summarised in this section.

Availability of services

Parenting and family intervention services

- 1.2** The range of family intervention services, including parenting support and education programmes, has increased in recent years. There is widespread support for these services from professionals who see children and young people with suspected mental illness or behavioural problems. Many of these professionals believe that poor parenting is often the root cause of mental health problems in young people.
- 1.3** Promoting positive parenting was one aim of the Assembly Government's 2005 Parenting Action Plan. The plan sought to ensure that parents in Wales got the advice and support they need, by setting out what the Assembly Government intended to do for parents over the period up to March 2008. The plan includes 10 specific actions to achieve its aims. Although the Parenting Action Plan was modest in its ambitions and was not underpinned by a comprehensive analysis of need, the plan had raised the profile of parenting in Wales and, by October 2008, nearly all the actions in it had been fully or partly delivered. The Children and Young People Committee of the National Assembly have investigated parenting in Wales and the delivery of the Parenting Action Plan. Their report published in May 2009 calls for a refreshed Parenting Strategy and Action Plan.
- 1.4** Parenting support services have been developed through a number of funding streams, many of which are controlled by children and young people's partnerships. Services include those provided by:
- health staff, such as health visitors and primary mental health workers;
 - voluntary sector agencies;
 - specific programmes, such as Sure Start and Flying Start; and
 - specialist CAMHS teams, either directly or through advice and support to other professions.

1.5 Support can be delivered on a one-to-one or a group basis. Some programmes, are targeted at groups with specific needs. For example, Flying Start is targeted on the youngest children and their families.

Counselling services

1.6 Counselling services provide valuable support to young people, enabling them to articulate issues and address concerns before they develop into more serious problems. Voluntary and statutory agencies provide counselling services at a variety of locations, including schools and other community locations. They can be available to all or to specific groups of children and young people, such as looked after children. Formal services are based around referrals and fixed appointments. More informal services, such as drop-ins, are also available.

1.7 The Assembly Government estimated in December 2005 that around half of Welsh local authorities had a schools-based counselling service. In April 2008, the Assembly Government published a national strategy for school-based counselling services. Supported by funding of £6.5 million over three years, the strategy aims for a counselling service to be available to all pupils in Wales.

1.8 Initially the focus has been on expanding provision for secondary school pupils, but as a condition of the Assembly Government funding for the second year local authorities have to develop their out of school provision, and the Assembly Government told us that all authorities have plans to expand in this area. This is much needed as children and young people excluded from attending school, or who receive their education outside the schools system, are more likely to need support. We found a number of counselling services run by both statutory and voluntary agencies based outside school settings, however the availability of such services was patchy across Wales, and in some areas they were only available to particular vulnerable groups or to young people within certain age ranges.

1.9 In addition, in rolling-out the national strategy, children and young people partnerships are required to consider how counselling services can be made available for children on the point of transition from primary to secondary school.

1.10 We identified some schools that, through their day-to-day work, were seeking to equip children and young people to build resilience and address their problems. This could be as part of daily classroom activities, such as circle time discussions, school-wide schemes, like playtime buddies and mentoring, or targeted programmes, such as Pyramid Clubs. However, we identified a number of issues with children and young people's access to school-based counselling services where these were in place:

- many school-based services are only available during school opening hours and are not provided in school holidays;
- some school-based services allow self-referral by young people or offer a drop-in service, but others can only be accessed by referral or with parental consent; and
- some staff or head teachers monitor who was accessing services, which could deter some young people.

1.11 In its national counselling strategy, the Assembly Government has committed to work with children and young people's partnerships to consider how school-based services could be provided outside school hours or during school holidays. The Assembly Government and the British Association for Counselling and Psychotherapy intend to publish jointly a school-based counselling toolkit. This will provide guidance, standards and exemplar materials for help in developing school counselling services.

1.12 However, there is a risk that the development of school-based services may discourage local statutory organisations from investing in alternative and complementary counselling services provided in other settings, or targeted on particularly vulnerable groups of young people.

Supporting children and young people at risk of developing mental health problems and early intervention services

- 1.13** There are children and young people whose family and social circumstances mean they have a greater risk of experiencing emotional difficulties and mental health problems. These include:
- looked after children in foster or residential care;
 - asylum seekers and migrant children who have been victims of trauma or abandonment;
 - young carers;
 - victims of sexual abuse or domestic violence; and
 - children whose parents have mental health or substance misuse problems.
- 1.14** Specialist CAMHS teams, including primary mental health workers, provide training, advice and support to other professionals who have routine contact with children and young people. This helps these other professionals support children and young people at risk of developing mental health problems, or those who have developed a problem. Support can include, for example, consultation and advice to youth offending services and social services teams working with looked after children. The voluntary sector also provides a range of services targeted on at risk children and young people.
- 1.15** However, our discussions with, and surveys of, specialist CAMHS teams indicate that in many parts of Wales there is no comprehensive approach that targets all at risk groups of children and young people. For example, adult mental health services in fewer than half of the former NHS trusts that responded to our survey stated that they routinely referred to CAMHS children whose parents have mental health problems. Of these, only one referred all such children, the remainder only referring children they considered to have already developed mental health problems.

'There seems to be a lack of clarity about whether CAMHS should provide services only to children and young people with a diagnosed mental illness or deal with children and young people who have therapeutic needs, such as those who have been sexually abused, are misusing drugs or who have challenging behaviour'

Service professional

- 1.16** The availability of specialist mental health services to help children and young people in the early stages of developing a problem is very patchy. Our fieldwork visits identified that specialist CAMHS teams are not routinely intervening at an early stage, although some primary mental health workers are reported to do this. The CAMHS mapping data collected by the Assembly Government (see [Appendix 2](#)) showed that no specialist CAMHS team and only one of eight primary mental health worker teams were providing early intervention services.
- 1.17** The integrated family support teams, outlined in the proposed children's and families measureⁱⁱⁱ, are intended to strengthen support to vulnerable children and families. The teams would, in time, focus on families with a parent who is dependent on alcohol or drugs, is a victim of domestic violence or abuse, has a history of violent or abusive behaviour, or has a mental disorder. The Assembly Government proposes that the teams will initially be available to parents with substance misuse. These teams, if developed, have the potential to strengthen the support provided to children and young people at risk of developing mental health problems.

Nature and quality of services

Staff who work on a day-to-day basis with children

1.18 *Everybody's Business* identifies a key role for staff who work with and support children and young people on a day to day basis. These include GPs, health visitors, school nurses, school staff, and children's social workers. The strategy makes clear that such staff are not necessarily trained as specialists in mental health but, by the nature of their roles, they 'are well placed to recognise, assess and intervene with children's mental health problems.' *Everybody's Business* also states that such staff should also identify risk factors and promote resilience. We found that the extent to which these staff groups undertake the role as envisaged by *Everybody's Business* varies significantly between and within professions.

General practitioners

1.19 Our survey of LHBs indicates that few GPs have a special interest in CAMHS. Only 3 of the 16 LHBs that responded were aware of any GP with such a specialist interest within their area. Furthermore, these GPs did not appear to be accredited; rather they had a general interest in children and young people's mental health. No LHB was aware of any practice nurses with a specialist interest in CAMHS.

1.20 The LHB survey also identified a lack of clarity and guidance on the role of GPs in managing children and young people with mental health problems:

- just 7 of the 16 LHBs responding to the survey stated that they had agreed with general practices the role of Primary Care in providing CAMHS;
- few LHBs have agreed with general practices which type of children with emotional or mental health problems should be supported by general practices (four LHBs) or be supported on a joint or shared care basis with specialist CAMHS (five LHBs); and

- few LHBs have developed guidelines for general practices to help them identify children and young people with mental health problems (only one LHB had guidelines fully in place), and for the management of these children and young people (in place in five LHBs).

1.21 We met a small number of GPs as part of our fieldwork visits. Generally they accepted they have a role to play, but were not always confident they have the skills or training to provide the right help. They tended to have limited contact with their younger patients, particularly those who have reached their teenage years, and so have little opportunity to spot problems early on. Often, it is parents who come alone to talk to GPs about their concerns.

Health visitors

1.22 Health visitors can provide a range of services to support children with emotional and mental health problems and their parents. Services include behaviour modification and management, and can be provided either to individuals or to groups. Health visitors often work with very young children. Most former NHS trusts told us that health visitors are routinely seeking to undertake the range of tasks set out for them by *Everybody's Business*.

1.23 Five of the seven NHS trusts responding to our survey stated that since the publication of *Everybody's Business* in 2001 the health visiting service has been developed to better meet the needs of children with mental health problems. Developments reported by NHS trusts include training, better working with specialist CAMHS, increased awareness by health visitors of their role in mental health, and better assessment and intervention.

1.24 There are issues, however, with staff training. All seven NHS trusts responding to our survey stated that not all health visitors have received training in the risk factors for developing emotional and mental health problems, and in how to advise and support children with emotional and mental health problems.

School nurses

- 1.25** The Assembly Government has committed to providing a universal school nursing service, with a target of having at least one school nurse per secondary school by May 2011. The Assembly Government's framework for school nursing^{iv} acknowledges that the role of school nurses has remained open to local interpretation resulting in an inconsistent service with varied levels of training and professional supervision. The framework outlines a common school nursing service for the future, which includes a service for all 5 to 18 year olds, whether in school or not.
- 1.26** Having a universal service with the targeted number of school nurses will be a significant challenge. Not all schools currently have a school nursing service and, where there is one, the number of pupils and size of geographic area covered by each nurse can vary considerably. Across the six NHS trusts that provided us with the relevant data, the number of pupils per school nurse in 2008 ranged from 1,052 to 4,761. The variation in provision has been highlighted by the Royal College of Nursing in its survey of school nurses in 2009. In addition, some services only operate during term times.
- 1.27** We issued a school nursing survey to 13 NHS trusts. Of the eight NHS trusts that responded, six stated that since publication of *Everybody's Business* the school nursing service had developed to better meet the needs of children and young people with mental health problems. Developments included closer working with specialist CAMHS staff or primary mental health workers, and improvements in the training of school nurses. However, a number of factors are limiting the potential support available from school nurses and there is wide variation in the support provided.

- 1.28** We found that in some NHS trusts school nurses are not providing any direct support to children and young people with emotional and mental health problems, whilst others are providing drop-ins or one-to-one support to children and their parents. Other key differences across NHS trusts include:
- a minority of services report that prevention, early identification and early intervention is a key strength of their service;
 - three of the eight NHS trusts stated that the school nursing service is not delivering, or supporting schools in delivering, programmes which promote positive emotional and mental health well-being;
 - three of the eight NHS trusts stated that school nurses are not routinely identifying risk factors relating to mental health and taking opportunities to reduce their impact, or seeking to identify mental health problems early in their development;
 - in two of the eight NHS trusts school nurses do not provide advice and interventions for children and young people who have emotional or mental health problems; and
 - school nurses can encounter problems with finding suitable locations within schools to provide nursing services, with particular concern for ensuring pupils are not easily identified as having seen the nurse.
- 1.29** The training in emotional and mental health received by school nurses varies across Wales and could be strengthened. Our survey identified that some NHS trusts have not provided any training in specific problems or conditions, such as Attention Deficit Hyperactivity Disorder (ADHD), eating disorders or self-harm. We met with a small number of school nurses during our fieldwork visits. They told us that they needed more training, and that they are seeing increasing numbers of children and young people with serious issues, such as self-harm, and more unusual cases, with the age of onset becoming younger.

Schools staff

- 1.30** Schools staff have the potential to undertake an important role in identifying risk factors and emotional problems at an early stage, given their regular contact with children and young people. However, only 6 of the 18 local education departments responding to our survey stated that they have made schools staff aware of the role envisaged for them in *Everybody's Business*, and there is no consensus between local education departments on the role of school staff. Some do not expect school staff to promote resilience of families, to assess children who may have problems, or provide advice and interventions. Education departments also report that the willingness amongst school staff to play their part in supporting children with emotional and mental health problems varies.
- 1.31** Although many schools are part of the Healthy Schools Programme, the focus of activities is on physical, rather than emotional health, addressing such topics as healthy eating, substance misuse, smoking cessation and sexual health. Fifteen education departments stated that activities in relation to promoting positive behaviour and emotional health have been, or will be, undertaken as part of the Better Schools Fund.

- 1.32** Our survey of education departments identified that schools staff have had a range of relevant training. However, the topics covered differ, and training in such key areas as recognising emotional and mental health problems or advising and supporting children with emotional and mental health problems has not always been provided. Some local authorities refer to having systematic approaches to training in place, but in other areas, arrangements are less well developed. One local authority stated that training is 'at best patchy', whilst another stated that there has been no authority-wide initiative to promote such training with only ad hoc provision and little interest from schools.
- 1.33** The Assembly Government has decided to issue guidance on emotional health and well-being in schools and early years settings. This guidance will focus upon the role that education staff play in providing preventative services and improving the emotional well-being of children and young people and strengthening their resilience.

Education welfare services

- 1.34** Educational welfare services are often an early port of call when schools need to deal with an attendance problem, which can be an early symptom of a developing emotional or mental health issue. The majority of the 17 education welfare services that responded to our survey estimated that a significant proportion of their caseloads have an emotional or mental health problem. Of the 15 educational welfare services that provided an estimate, 12 stated that at least one in five of the children and young people on their caseloads have an emotional and mental health problem. However, few education welfare services (only 4 of the 17) stated that they have any staff with experience of, or training in, emotional and mental health issues.

'For some staff there is a challenge of adding what they perceive as an additional role to their jobs'

Education professional

1.35 We found that the capacity of services varies considerably, with the number of pupils per Educational Welfare Officer (EWOs) varying between 1,759 and 4,224 across the 17 local authorities. There is also variation across Wales in the role educational welfare services perform in relation to children and young people with emotional and mental health problems. Only five services responding to our survey stated that staff have been made aware of the role envisaged for them in *Everybody's Business*, and only one of these services reports that revised job descriptions have been issued.

1.36 Some services see their role as being limited to directing children and young people to other services, whilst others adopt a broader role, including providing input to developing resilience, early identification and ongoing support. Although some EWOs and other staff, particularly special educational needs co-ordinators, reported that they were keen to provide help and support to young people with mental health problems, a number had been told by their managers that this was not part of their role.

1.37 The training provided to EWOs also varied. A number of services stated that their staff have not received training in risk factors (5 of 17 services), how to recognise (5 of 17) and how to advise and support (7 of 17) children with emotional and mental health problems. However, some education welfare services had identified a range of steps to be taken to support continuing access to education for children with an emotional or mental health problem. These include negotiating revised timetables, reintegration packages and home tuition.

Social services

1.38 Thirteen of the 17 social services departments responding to our survey stated that there has been an expansion of emotional or mental health-related services for children, young people and their parents provided or commissioned by social services since the publication of *Everybody's Business* in 2001.

'Whilst the expectation is that all staff will undertake this role via the assessment, care planning and review of children's needs this will depend on experience and confidence of social care staff, and their knowledge of and links with specialist services'

Social service professional

Developments mostly related to increased staff resources, but developments were also reported in areas such as commissioning therapeutic and other services from the voluntary sector, and enhanced training and support for foster carers.

1.39 We issued a separate questionnaire for completion by a selection of social service teams working with children and young people, and received returns from 20 teams in 11 local authorities. These teams estimated that between 30 per cent and 100 per cent of the children and young people on their caseloads had an emotional or mental health problem. However, the extent to which social workers are undertaking the role envisaged by *Everybody's Business* varies. Some teams stated that all staff routinely carry out duties such as identifying risk factors and identifying and supporting children with mental health problems, but in others this is limited to only some team members.

'The services provided (by social services) are acknowledged to be inconsistent'

Social service professional

1.40 Across the social service teams that responded to our survey a common concern was the lack of staff training, knowledge and experience to deal with the emotional or mental health needs of children and young people. Only three of the 20 social service teams that responded have members who are specialists in children's mental health or provide therapeutic support. Training in the recognition of risk factors and problems and providing advice varied across teams, with one in five teams having had no training in these areas. One social services assessment team stated that no training had been received in any of these areas, increasing the risk of problems being missed or a child not being pointed to other services, especially if they were assessed as not requiring any further social services involvement.

Community paediatric teams

1.41 *Everybody's Business* has had a variable impact on community paediatric services. Only three of the seven NHS trusts responding to our survey stated that since the publication of *Everybody's Business* in 2001 the community paediatric services had been developed to better meet the needs of children with mental health problems. Some of the improvements had been limited to a greater awareness of mental health issues in children and young people, although one trust reported new pathways for ADHD and Autistic Spectrum Disorder (ASD).

1.42 Our survey showed that the extent of direct support provided by community paediatric services to children and young people with emotional or mental health problems varies across Wales:

- some community paediatric teams support children and young people with learning difficulties, ADHD, and ASD, who are often excluded from specialist CAMHS services;

- some provide direct support to children and young people with emotional or mental health problems only in collaboration with other services; and
- in some areas staff attend joint clinics with specialist CAMHS staff.

1.43 With just one exception, the community paediatric services responding to our survey stated that they seek to identify and take steps to reduce risk factors, promote resilience and identify problems early in their development. However, this appears to be on an opportunistic or reactive basis rather than a formalised and systematic approach. Fewer community paediatric services stated that they are involved in assessment (four of the seven responding services) and intervention (three services).

1.44 Our survey also identified that mental health training varies across Wales. In one community paediatric service, no staff have received training in identifying mental health problems or risk factors, or providing advice and support to children with mental health problems. Where training has been provided, there has been little focus on specific conditions and problems. For example:

- no community paediatric staff had been trained in psychotic problems, such as schizophrenia or manic depressive disorder, or in conduct problems;
- only one service has trained staff in emotional problems, including anxiety and depression;
- only two services have trained staff in self-harm; and
- staff have been trained in eating disorders in just half of the responding services.

1.45 All seven NHS trusts responding to our survey considered that if the role of community paediatricians was to be developed further then this would require more training, better support from and liaison with specialist CAMHS, and increased resources.

Inpatient paediatrics

1.46 Six out of 12 NHS trusts responded to our inpatient paediatric survey. The respondents estimated that between 20 per cent and 60 per cent of all the children and young people admitted to paediatric wards have some degree of an emotional or mental health problem. Four inpatient paediatric services stated that since the publication of *Everybody's Business* in 2001 the service had been developed to better meet the needs of children with mental health problems. Improvements included using appropriately qualified agency nurses when a child is admitted with a serious mental health problem; increased awareness; increasing the age limit of children admitted to wards; improved ward nurse training; and better links with specialist CAMHS.

1.47 Our survey identified the need for improved training in mental health in many inpatient paediatric services. One service stated that staff have not been trained in identifying risk factors and problems, or in providing support to children and young people with mental health problems. Training around specific conditions and problems is also very variable. For example, of the six inpatient paediatric services that responded to our survey:

- four have not trained staff in ADHD or emotional problems, such as anxiety and depression;
- three have not trained staff in conduct problems; and
- two have not trained staff in eating disorders, self-harm and psychotic disorders.

Accident and Emergency staff

1.48 Accident and Emergency (A&E) staff can be the first point of contact when a crisis, such as self-harm or attempted suicide, occurs. However, we found that A&E staff often believe they lack the relevant training and skills to deal with such issues, and are not always able to easily access support from specialist CAMHS (*Case study 1*).

'We are very good at doing trauma but this (dealing with children and adolescents with a mental health problem) is beyond us'

A&E staff member

1.49 Our survey of specialist CAMHS teams found that they all have protocols in place with A&E staff for dealing with children and young people who self-harm. However, 10 of the 24 CAMHS teams that responded stated that A&E staff do not have protocols for dealing with other potential mental health problems.

Case study 1

In one former NHS trust staff described a regular situation that occurs. When a young person arrives at A&E having taken an overdose, often with a large amount of alcohol, the protocol is to admit the person to a paediatric ward for assessment by the CAMHS team. There is no CAMHS liaison support available directly to A&E staff at any time.

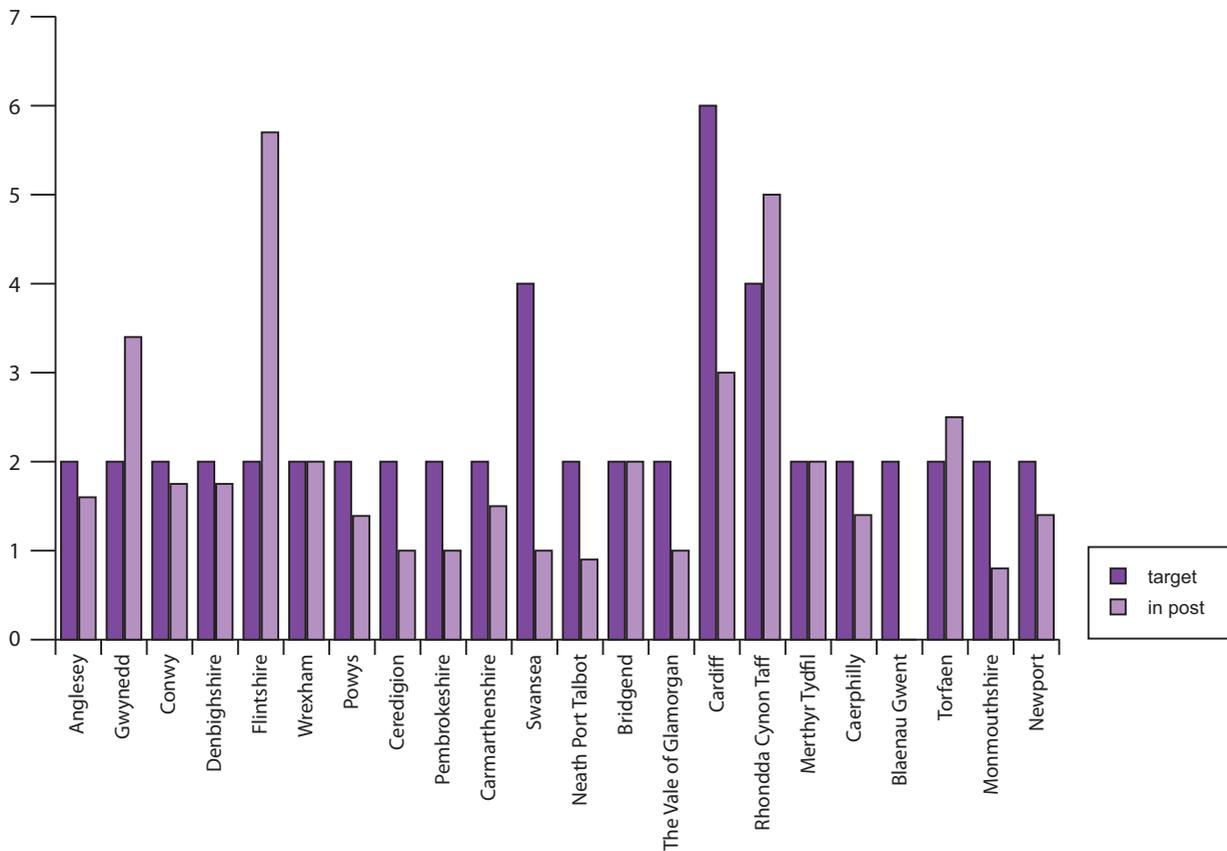
If the person is admitted on a Friday they would have to wait until the CAMHS team's visit to the paediatric ward on the Monday. However, when the young person is told they cannot be discharged, they can become frustrated, try to leave or cause a disturbance to the other patients.

Specialist CAMHS

Primary mental health workers

- 1.50** Primary mental health workers provide support to the wide array of professionals who work with children and young people, such as GPs, school staff, school nurses and social workers. The services they provide include consultation, training and advice in relation to children and young people's mental health. Most non-specialist staff told us that they valued the support provided by primary mental health workers. Many reported that, as a result, they were more confident in identifying and managing emotional and mental health problems in their early stages.
- 1.51** The numbers of primary mental health workers has increased in recent years, stimulated by service performance targets and additional recurrent funding from the Assembly Government. As part of the 2008-09 and 2009-10 Annual Operating Framework, NHS trusts were set a target of having two primary mental health workers per 100,000 LHB population, with a minimum of two primary mental health workers for those LHBs with a population of less than 100,000 people.
- 1.52** In calculating the individual targets for LHBs, the Assembly Government has adopted a simplistic approach that is less challenging than it could be. The target is based on broad population bands as follows:
- less than 100,000 population and between 100,000 and 199,999 would require two workers;
 - between 200,000 and 299,999 would require four workers; and
 - between 300,000 and 399,000 would require six workers.
- 1.53** So for a population of 150,000 an LHB would be targeted to have two workers rather than the three that would be required if a proportionate approach was taken. The number of workers required under the current approach is 52 whole-time equivalents, but this would rise to 63 if a proportional target was calculated.
- 1.54** Local health boards have made variable progress towards achieving their targets, with only seven LHBs reporting that they have met or exceeded the target as at June 2009 (Figure 1). Across the LHBs not achieving the target there are 19.5 whole-time equivalent primary mental health workers in place, and the numbers would need to increase by a further 16.5 whole-time equivalents if the target is to be achieved in all LHBs. Blaenau Gwent LHB reported having no primary mental health workers in post.
- 1.55** Nevertheless, since the mapping data reflecting staffing at 2007 the total number of primary mental health workers has increased, from 30 whole-time equivalent staff in 2007 to 42 by June 2009. The mapping data was based on NHS trust areas, and a more detailed analysis shows that:
- the majority of progress has been made across two NHS trusts which account for 10 of the 12 increased number of workers;
 - another NHS trust doubled the number of workers; and
 - four NHS trusts have either reduced the numbers of workers in post, stayed the same or have only improved marginally.
- 1.56** Primary mental health worker posts are funded in a variety of ways, including on a short-term basis through Cymorth or Wanless funds. The recurring funding being provided by the Assembly Government provides an opportunity to secure long-term funding for these workers.
- 1.57** All NHS trusts reported to us in 2008 that primary mental health workers were providing routine advice and support to primary care staff, school nurses, health visitors, schools staff, social services and the voluntary sector. There are, however, some key differences in the roles carried out by primary mental health workers:
- there is variation in the training provided by primary mental health workers to different staff groups – only five of seven specialist CAMHS services stated that they provide training to primary care staff,

Figure 1 – Numbers of primary mental health workers in post compared to Annual Operating Framework target – June 2009



only four provide training to community paediatric staff, and only one provides training to school staff, social services staff or the voluntary sector;

- in one trust, primary mental health workers provided no support to community paediatric staff;
- only four of seven trusts stated that primary mental health workers provide an initial assessment or gate keeping service for referrals into specialist CAMHS services; and
- primary mental health workers in only three trusts provide direct support, including therapeutic support, to children and young people who have less complex problems – the Annual Operating Framework target states that direct intervention should account for approximately 20 per cent of worker time.

Specialist advice and support

1.58 The provision of advice and support from specialist CAMHS and primary mental health workers is a key part of their roles. The importance of this function has been reflected in an Annual Operating Framework target for specialist CAMHS to offer consultation and advice to professionals such as GPs, school nurses, schools staff, and social workers within two weeks of a request being made. In June 2009, only two LHBs reported that they were not achieving this target (a further two did not provide data).

1.59 The Assembly Government acknowledges that gathering data against CAMHS targets is in its early stages, and that there may be problems with the quality of the data. Our analysis indicates that the data relating to the provision of consultation and advice may not be very robust. For example, in June 2009 the

Cardiff and Hywel Dda areas, which have similar size populations (321,000 and 375,000 respectively) and similar numbers of primary mental health workers (3.0 whole-time equivalents and 3.5 whole-time equivalents respectively), report very different numbers of requests for consultation and advice, with 71 reported by Cardiff and 225 reported by Hywel Dda. The average number of reported requests per month for a primary mental health worker can be as high as 88.

1.60 Our fieldwork and surveys found that some NHS and local authority service providers report good working relationships with specialist CAMHS, and support is provided in many forms, such as training sessions, weekly telephone consultation sessions, case note reviews, joint assessments, participation in ward rounds, and specialist support for staff dealing with looked after children.

1.61 However, overall we found very variable levels of satisfaction amongst agencies with the advice and support provided by Specialist CAMHS. Although the provision of advice and consultation by primary mental health workers has seen some recent improvement, many agencies told us about a range of local problems with specialist CAMHS advice and support, including:

- the unavailability of specialist staff to provide advice, particularly for out-of-hours emergencies;
- a lack of formal arrangements, with an over-reliance on ad hoc arrangements or informal networks built up over time;
- variability in attitudes towards providing support between specialist CAMHS teams from the same NHS trust and even between individuals within the same team;
- the lack of a clear local approach to developing the expertise of non-specialist staff;
- the exclusion of some services, such as educational welfare and voluntary sector services, from the support and advice provided by specialist CAMHS; and

- specialist CAMHS placing unrealistic expectations on a range of statutory and voluntary sector services to manage cases that the services believe they are not appropriately skilled or trained to deliver.

1.62 Finally, the Annual Operating Framework for 2009-10 has a target for mental health advisors, drawn from the experienced staff of specialist CAMHS, to be available to each youth offending team. As at June 2009, 11 of 20 LHBs reported non-compliance with this target.

Educational psychology services

1.63 Educational psychology services provide support in educational settings with all aspects of children and young people's learning, behaviour, and social and emotional development. In addition to statutory special needs assessment duties, these services can provide advice and training to school staff, as well as working directly with individual children and young people.

'(Lack of capacity) often results in a one-off hit and run type approach'

Educational psychologist

1.64 We issued a survey to education psychology services and received returns covering 20 of the 22 local authority areas. The survey identified that the capacity of services varies considerably, with some local authority areas having nearly twice the number of pupils per educational psychologist than others. The survey and our fieldwork visits identified that the exact role and focus of educational psychology services in relation to children and young people with emotional or mental health problems also varies, with, for example, differences in:

- the extent to which services focus on proactive prevention of emotional and mental health problems;
- the extent to which services support specialist areas of educational work, such as youth offending teams or pupil referral units; and
- opinion in some areas about the appropriate aims and role of the service with regard to children and young people with emotional and mental health problems.

1.65 Discussions with educational psychologists and survey responses showed that a common frustration amongst educational psychologists was that other demands upon their time limit the extent to which they can use their skills and expertise to support children and young people with emotional or mental health problems.

'School weren't very useful at all, education psychologist would take them out of class, schools need to be more aware'

Parent/carer

In conclusion

1.66 Comprehensive services are still not in place despite some important developments with services that focus on prevention, early intervention and supporting those with less severe problems.

1.67 Our conclusions on the availability of these services are that:

- parenting and family intervention services have been developed through various funding streams, including children and young people's partnerships;

- counselling services have been expanded and are to be universally provided for all school pupils, although developing services for children on the fringes of, or excluded from, school, and for those in transition from primary to secondary school, as well as the provision of services outside of school hours will be a challenge; and
- services targeted on children and young people at risk of developing mental health problems and early intervention services for those who subsequently develop problems are underdeveloped in many parts of Wales.

1.68 Our conclusions on the nature and quality of these services are that:

- some staff who work on a day-to-day basis with children do not acknowledge that they have a role to play in supporting children and young people with emotional or mental health problems, whilst others provide active support;
- progress has been made in introducing primary mental health workers but meeting the target number of primary mental health workers is a challenge in many areas, the role of these workers varies, and the provision of consultation and advice from specialist CAMHS to other professional staff needs to be strengthened; and
- the input from educational psychologists to meeting the needs of children and young people with a mental health problem has been variable.

Part 2 – Specialist community services

- 2.1** There have been some improvements to specialist community services in recent years, such as the development of an additional community intensive therapy and treatment team and some examples of local service developments. However, significant issues remain with the availability and quality of specialist community services.
- 2.2** Overall, our consultation with children, young people and their parents or carers found very diverse experiences of CAMHS. Some made very positive comments about the support they have received, but others were very critical of the services available and the way these are provided.

'The service has provided excellent support right across the board. The service is an invaluable resource and is key to my child's wellbeing at present'

Parent/carer

'CAMHS has made me feel angry, let down and seriously (hacked) off. They have let the whole family down by not addressing obvious issues'

Parent/carer

Availability of services

Specialist mental health services for children under five years of age

- 2.3** Specialist mental health intervention to support an infant's relationship with his or her parent or carer can help prevent the development of emotional and psychological difficulties later on in life. However, unlike in some other parts of the UK, Wales has no specialist mental health service support in the community for very young children. The CAMHS mapping exercise requested data on the lower age limit for CAMHS teams, which indicated

that a lower age limit of five years is normal practice, but that this can be as high as 11 years of age (Case study 2).

- 2.4** Whilst schemes such as Flying Start and some health visitors and early years support staff provide services to infants and their families, there is no provision in Wales for additional specialist parent-infant mental health work other than inpatient mother and baby psychiatric care. Other parts of the UK have models of working that could be used to deliver a CAMHS service to very young children. Examples include the Solihull approach, the Mellow Parenting Programme and the Mellow Babies Programme from Scotland, and the child psychotherapy-led under-fives clinics run by various CAMHS teams across England.

Case study 2

We heard Jack's story from his family. Jack lived in England until he was six, where he received CAMHS services to address his hyperactive behaviour. Jack and his family then moved to Wales, where the local CAMHS team did not take referrals for children under seven. He was referred when he reached seven, but did not receive his first appointment until he was aged nine. Jack's school, educational psychology service and behaviour support team provided support to Jack in the intervening years.

Note: To ensure confidentiality, names have been changed in all case studies

Eligibility criteria, referral arrangements and waiting times for specialist CAMHS teams

Eligibility criteria

- 2.5** From our discussions with specialist CAMHS managers and staff it is clear that some specialist CAMHS are using tight eligibility criteria in an attempt to restrict referrals to a level that their resources can manage, focusing on those with the most serious needs. It can be difficult to get onto specialist CAMHS caseloads in these areas.

'Feel I had to fight over a number of years to get support for my son and family'

Parent/carer

- 2.6** All specialist CAMHS teams stated that there are restrictions on who can refer to the team, but these vary:
- self-referrals and referrals from parents are commonly not accepted;
 - referrals from the education sector are limited in some areas to educational psychologists or school nurses, with school staff and education welfare staff having to route referrals via these staff;
 - voluntary sector bodies are often not able to refer direct to CAMHS teams; and
 - one team preferring referrals to have been screened by a GP.
- 2.7** A balance needs to be struck between screening processes designed to ensure referrals to specialist CAMHS are appropriate and enabling timely and effective access to these services. It is not clear, for example, why skilled voluntary sector staff working with children and young people with mental health problems could not be relied upon to refer appropriately to specialist CAMHS. Similarly, if the child or young person and their carer is known to specialist CAMHS, it is not clear why they should not be able to refer direct. Relying upon GPs to screen all referrals assumes that GPs have the necessary skills and local knowledge of services and this will not always be the case.
- 2.8** We also found problems in areas close to the English border caused by geographical eligibility criteria. For example, whilst health services use the location of a child's GP, education and social services use place of residence. Thus, a child can live in England but be registered with a Welsh GP and attend

school in Wales. In these circumstances, the child can access a Welsh CAMHS team but not educational psychology or social services that are linked to that team.

Referral arrangements

2.9 Our discussions with specialist CAMHS staff identified that many CAMHS teams have concerns about the quality of the referrals they receive. For example, some referrals are accompanied by little information, or the referrer might only have seen a concerned parent or other third party but not the child being referred. Despite these concerns, some teams prioritise referrals based on the information in the initial referral alone. Referring agencies in some parts of Wales also perceive that they need to couch referrals in medical terminology to help get referrals accepted even though they are not clinicians.

'The whole service is clouded in mystery'

Service Professional

2.10 With only two exceptions, CAMHS teams claimed that they confirm the reasons in writing when rejecting a referral. However, this policy does not always appear to be implemented, as referrers in many parts of Wales seen during our fieldwork visits reported poor communication about whether a referral has been accepted or, if not, the reason for rejection. They also report varying practice in this regard between clinicians within some specialist CAMHS teams.

2.11 Our surveys and discussions with a broad range of staff found that referring organisations are frequently unclear both about the referral process and about what services specialist CAMHS teams are able to provide. Nearly all (23 of 24) specialist CAMHS teams stated they have referral criteria, which are widely distributed to primary care,

school nursing, health visiting, community and hospital paediatrics, educational support services, schools, social services and the voluntary sector. However, we found that:

- many partner organisations (such as 11 out of 20 social services teams, seven out of eight community paediatric services, and four out of six inpatient paediatric services) claim to have not received any written referral criteria;
- a broad range of staff in these organisations were unclear about referral criteria and processes, with staff from partner agencies in the same area having very different perceptions of what services the local CAMHS team offered and to whom; and
- a common perception exists amongst referrers that getting a service for a young person can be dependent upon knowing the right people to contact and being persistent in chasing up referrals.

Waiting times

2.12 Once a specialist CAMHS team accepts a referral, there is usually a wait for assessment and intervention. The Annual Operating Framework for 2008-09 and 2009-10 include the following waiting times targets:

- all patients referred to specialist CAMHS should be assessed and have any required intervention plans initiated within 16 weeks of referral; and
- all patients referred to specialist CAMHS who have sustained low mood of six weeks or more duration and ideas of suicide should be assessed and have any required intervention plans initiated within four weeks of referral.

2.13 Reliable and comparable information on waiting times was not available at the time of our review. We therefore gathered data in 2008 directly from specialist CAMHS, which indicated that at that time waiting times were variable and could be very long. The reported average waiting times from referral to first intervention varied between 19 weeks and 41 weeks.

2.14 The data provided to us was for average waiting times and some individual cases would have involved longer waiting times. It was also clear from our discussions with specialist CAMHS staff and referring organisations that waiting times can vary significantly depending on the intervention required, with particularly long delays in accessing child and family psychology, family therapy and play therapy in some areas.

2.15 The data on performance against the Annual Operating Framework target indicates that waiting times have reduced since 2008: 12 LHB areas reported breaches of the 16-week target in February 2009, but no breaches were reported in June 2009. However, we do have concerns about the interpretation of, and the measurement of performance against, the waiting time target, and there is a risk that the benefits implied by the reported improvements in waiting times are not fully delivered in practice.

2.16 Children and adolescent mental health services teams can have different interpretations on what constitutes an intervention. In some areas an intervention is seen as a separate step following assessment, whereas in other areas the assessment process is seen as therapeutic and therefore counts as an intervention. Performance may be measured, therefore, to the time of the assessment rather than the first substantive intervention, such as a therapeutic session with a psychologist. The guidance issued with Annual Operating Framework targets for 2008-09 does not clarify the position, stating that an intervention is 'an action following on from the completion of an assessment, or if appropriate forms part of an assessment'.

2.17 There is also a risk that the target for an initial intervention to take place within 16 weeks of referral could have some unintended consequences. These may include CAMHS teams:

- adopting tight referral criteria to reduce the overall number of new cases;
- reducing the length and quality of the initial assessment to enable more assessments to be completed; or
- focusing resources on ensuring initial interventions are more timely, but at the expense of the frequency, timeliness or quality of subsequent interventions.

2.18 Our review of case files found a lack of support for young people waiting for assessment and an appropriate intervention. In some cases there seems to be little support provided, either by the specialist CAMHS team or through advice to other agencies involved with the young person, to prevent deterioration in the young person's condition.

Access to specialist CAMHS teams for specific groups

2.19 The ability of some children and young people to access specialist community-based CAMHS depends on where they live in Wales. These include children and young people:

- with a learning disability;
- aged 16 to 18 years;
- placed from out of area;
- with unstable home and family circumstances;
- with a substance misuse problem; and
- with a diagnosis of conduct disorder.

Children and young people with a learning disability

2.20 *Everybody's Business* states that 'no child should be excluded from receiving a mental health service on the grounds of having a learning disability.' The NSF for Children, Young People and Maternity Services contains a key action that 'Children with a learning disability should have access to a network of appropriately skilled professionals that can respond to both their mental health needs and learning disability, according to their assessed needs.'

'I don't fit into learning disability, don't fit mental health other than my depression, don't fit disabled- where do I fit?....I feel society needs to stop putting people in boxes, because people like me don't fit'

Child/young person

2.21 Despite this clear policy guidance, in many parts of Wales children and young people with a learning disability cannot access specialist support for their mental health problems (Case studies 3 and 4). As part of the 2008-09 self-assessments of progress with NSF targets, only two of the 22 children and young people's partnerships reported that children with learning disabilities have appropriate access to CAMHS. Specific issues include:

- just 10 of 27 specialist CAMHS teams in Wales stated that they provide support to children and young people with a learning disability;
- in Wales, people are often classified as having a learning disability if they have an IQ score of less than 70, but some specialist CAMHS teams also exclude young people who have an IQ above 70 on the grounds that they do not have sufficient communication skills or intellectual capability to fully engage with therapy;
- as a result of not being able to access specialist CAMHS, some children and young people are not prescribed the medication they require; and
- in the absence of specialist CAMHS, children with learning disabilities who have mental health problems may be supported by child psychology or paediatric services, but they are not receiving the specialist mental health help they need.

Case study 3

A social services team told us about Harry. He has autism and as a result can present some very challenging behaviour. He is not eligible for support from the local CAMHS team. Harry's behaviour deteriorated to the point that his family were living solely in their front room in order to contain Harry and prevent him from harming himself and others. Social services put in a support worker, but this proved unsuccessful and they then organised specialist nursing care, forwarding the bill to the LHB. At one point Harry was so disturbed the police were called in. Eventually Harry was sectioned under the Mental Health Act, and was found a specialist placement in South East England.

Case study 4

An LHB told us about Jim, a 16 year old with Down's Syndrome and ASD whose behaviour became increasingly violent. Neither the local CAMHS team, learning disability service nor community paediatrics team would take the responsibility for assessing and treating Jim. Eventually Jim ended up being arrested and taken out of his family home.

2.22 Autistic Spectrum Disorder, including Asperger Syndrome, and ADHD are conditions where the practice of specialist CAMHS teams varies across Wales. Some teams provide services; others only assess young people and/or monitor medication. In some parts of Wales, children and young people with ASD or ADHD are managed by clinical psychology or community paediatric services, sometimes in partnership with CAMHS. However, in other parts of Wales there is no CAMHS input to address the particular needs faced by these young people. The ASD strategic action plan published by the Assembly Government in April 2008, supported by £3.6 million of additional funding over the following two years, provides an opportunity to improve access to mental health services for this particular group.

2.23 A report on learning disability services by HIW^v also identified some of these issues. The Assembly Government is developing action plans to implement HIW's recommendations, which included:

- the need to develop care pathways to ensure equal access to CAMHS for those with a learning disability;
- ending the use of an IQ level of 70 as a standalone criteria for excluding young people from services; and
- the need for the Assembly Government to clarify who should be responsible for the care of people with Asperger Syndrome and ASD.

Young people aged 16 to 18 years

2.24 *Everybody's Business* and subsequent Assembly Government guidance^{vi} set out that local services should adopt the goal of moving in a planned and negotiated way towards the position whereby specialist CAMHS ordinarily cover young people up to their 18th birthday. No deadline was set for achieving this change and very little progress has been made. In the meantime:

- 16 to 18 years olds still at school (and within the responsibility of the education support services) should be the responsibility of specialist CAMHS; and
- 16 to 18 year olds attending college or no longer in education should be the responsibility of adult mental health services.

2.25 Our discussions with specialist CAMHS staff and referring organisations established that in some parts of Wales young people aged 16 to 18 do not have access to support from either specialist CAMHS or from adult mental health services. Only one in four specialist CAMHS teams have moved to taking responsibility for all young people up to 18 years of age. And, although seven out of the eight primary mental health worker teams support all young people up to age 18, direct support to individual young people

from these teams can be very limited or not provided at all. However, many teams into which specialist CAMHS workers are posted, such as those for looked after children or youth offending teams, accept all young people up to 18 years.

2.26 We found that a wide range of criteria is used to determine which services, if any, 16 to 18 year olds can access, and there is widespread concern amongst service professionals about the potential impact of inadequate access on vulnerable young people (*Case study 5*). Those young people between 16 to 18 whom CAMHS will not take on cannot always access adult mental health services instead, as some adult services do not take anyone under 18 years of age. The range of eligibility criteria for CAMHS includes:

- educational status – this is still regularly used as a way of defining eligibility for CAMHS, despite Welsh guidelines calling for a move away from this, and the definition of full-time education varies between teams, with some including sixth form or other colleges and some not;
- the medium of education can determine eligibility in some parts of Wales – a pupil in a Welsh-medium school studying A level Welsh will attend sixth form in the school and is therefore deemed to be in full-time education, whereas a pupil studying for A levels in English will have to attend a sixth form college and is not deemed to be in full-time education;
- living at home – some services exclude young people aged 16 to 18 from CAMHS if they do not live at home, including homeless people, people living in a hostel or supported accommodation, and those leaving care, many of who could have significant support needs; and
- type of illness and service history – some services only consider certain illnesses or those young people already known to them before they turned 16, and the level of support can vary with no access to consultant psychiatrists in some areas.

Case study 5

We heard Jordan's story from his family. Jordan has learning disabilities and received help from a learning disabilities nurse working in a Challenging Behaviour Team. When Jordan was 16 it became apparent he was also developing mental health problems. Because of Jordan's age, he did not receive a service from either CAMHS or adult mental health services.

Eventually, Jordan was admitted as an emergency to a paediatric ward, in a segregated bed. Jordan was discharged home, on medication, and with agency nurse support during the daytime. After two months, the agency nurses were withdrawn.

Shortly after, Jordan broke down again and this time was admitted to an adult psychiatric ward. He was distressed and traumatised by the experience, and remains extremely frightened of returning to the unit. On discharge, Jordan received medication and occasional appointments with an adult psychiatrist to monitor his medication.

The family were grateful for the continued involvement of the learning disabilities nurse, who negotiated with her manager to continue to visit and support Jordan and his family until he reached 18 and became eligible for full support from adult mental health services.

Children and young people placed from out of area

- 2.27** Welsh children and young people may be placed in residential care or with foster families outside their home area, either elsewhere in Wales or somewhere in England. This is usually due to the lack of availability of suitable placements within their home area. For similar reasons, children from elsewhere in the UK are placed in Wales.
- 2.28** Some parts of Wales, especially in isolated rural locations, have seen the establishment of a significant number of privately run residential care settings for children. Powys, for example, has four per cent of Wales' child population, but 20 per cent of children placed in a care setting in Wales. The majority of these placements are from outside the

county, and many are from England. These residential settings often specialise in supporting children with high levels of emotional and behavioural difficulties, which can place increased demands on local community CAMHS services.

- 2.29** Since the establishment of LHBs in 2003, there has been a range of guidance and regulations outlining the responsibilities for commissioning care for out of area placements within Wales and across the border. However, despite this guidance we found a number of cases where looked after children and young people had been refused a service because they were not from the local area. The three examples we came across ([Case studies 6, 7 and 8](#)) all happened to involve children from England placed into Wales. We do not have any evidence as to whether the same issue is faced by Welsh children and young people placed out of their home area within Wales.
- 2.30** A number of registered care settings describe themselves as therapeutic communities or have access to a degree of therapeutic support for their residents. Our discussions with specialist CAMHS staff found that a small number of CAMHS teams are reluctant to provide services for young people in these settings as they expect homes that provide some level of therapeutic support to manage all the mental health problems of their residents, however serious these may be.

Case study 6

Kathy and Cheryl are two sisters from London aged six and nine, in the care of their local social services. As part of the arrangements for a foster placement in rural Wales, contact was made with local CAMHS to see if they could assess the girls with a view to providing treatment. There was much discussion locally as to whether these children could be taken on by the team, given that they were not local children. Additional confusion was caused by different agencies from their home borough making contact with different parts of the health service in Wales.

Case study 7

Oliver is a looked after child from South East England, living in foster care in Wales. The abuse he suffered as a young child meant he needed support from specialist CAMHS. He was first referred when he was nine years old and his needs assessed. However, due to a lack of clarity about who was responsible for funding his treatment his case was closed by CAMHS. He was re-referred and the case closed again, before funding was finally agreed over three and a half years after the original referral. It was not until then that he received any psychotherapy.

Case study 8

Gary is 16 and has a history of schizophrenia. He comes from the Midlands, and is a looked after child. Following a crisis, he was detained under the Mental Health Act and was an inpatient in an independent hospital in the London area. On discharge, his local authority found him a place in a specialist residential care home in rural Wales. The hospital contacted the local CAMHS consultant in Wales to arrange support for Gary. The consultant would not take Gary on, given that he was over 16 and not in education, although when Gary did have a crisis the CAMHS consultant did go and see him. Adult mental health services took the view that they did not have the appropriate on-call services to help Gary. Internal discussions about funding took place and the case files contain a note that there are insufficient resources to support Gary's routine needs 'without jeopardising the care of our own young people.' Finally, the CAMHS consultant informed the London hospital that they were 'not responsible' for Gary's care. Gary's placement in his care home is not sustainable without appropriate CAMHS support, and two months after he arrived he moved to another area.

Children and young people who do not have stable home and family circumstances

2.31 During our discussions with service providers a number of staff, particularly in social services and the voluntary sector, expressed concern that specialist CAMHS requires children and young people to have stable home and family circumstances before their cases are taken on. This reflects a treatment model that assumes that mental illness issues can only be clearly identified and addressed once the environment around the child is stable. In addition, the child would be able to engage better in such circumstances. However, this has the effect of excluding children whose mental ill-health is caused by, or otherwise related to, domestic or family circumstances. In addition:

- the unstable circumstances may be due to aspects of a child's mental health or behaviour, which will not be addressed through treatment;
- the roots of some unstable circumstances, and indeed mental health problems in children, can lie in the problems of other family members; and
- efforts made by one agency to avoid family breakdown may maintain the unstable circumstances that prevent the child or young person involved accessing the specialist CAMHS help they need.

Children and young people with a substance misuse problem

2.32 Our discussions with specialist CAMHS staff indicate that most specialist CAMHS teams work directly with children with substance misuse problems, but that some CAMHS teams do not take on a young person until their substance misuse is addressed, even though the two issues can be inextricably linked. In addition, our survey identified that nearly 40 per cent of CAMHS teams do not have agreed protocols with other substance misuse services.

'Recommended course of action was to place in dual diagnosis residential facility. There are none in Wales. There was no funding forthcoming to place him somewhere else. There were no alternative local services that might serve him and support the family'

Parent/carer

Children with a conduct disorder

2.33 Our discussions with specialist CAMHS staff and referring organisations identified that a diagnosis of conduct disorder is often used to exclude children and young people from specialist CAMHS services. This can occur even where there is little other provision in place to help these young people address their problems or to support the parents and carers dealing with the impact on the wider family.

Emergency and out of hours consultation

2.34 The children, young people and maternity services NSF states that children and young people should have access to emergency and out-of-hours consultation 24 hours a day, seven days a week. In self-assessing progress against the NSF for 2008-09, NHS trusts, LHBs, and local authorities identified this as one of the weakest areas of performance. The self assessments demonstrate that there has been little progress with this key action since 2006-07. Problems identified included:

- emergency specialist consultation and advice is not always available to primary care and A&E via 24 hours a day, seven days a week on-call CAMHS consultant psychiatrists;
- some A&E departments rely upon adult psychiatric liaison staff, rather than CAMHS professionals, seeing young people; and

- young people being admitted to a ward to ensure they are seen by specialist CAMHS at a later date.

Community intensive therapy and treatment services

- 2.35** The HCW is responsible for commissioning community-based intensive therapy and treatment services. These provide intensive support to seriously ill children, young people and their parents, with the aim of preventing admission to, or supporting earlier discharge from, inpatient units.
- 2.36** There are just two community-based intensive therapy and treatment teams, which at the time of our review were both run by Cwm Taf NHS Trust. One team covers the Rhondda Cynon Taf, Bridgend and Merthyr Tydfil areas and has been in existence for some 10 years. This team is funded by LHBs as a legacy from Mid Glamorgan Health Authority. The other team covers Cardiff and the Vale of Glamorgan and was established in 2006 with funding from HCW. The teams provide a variety of therapeutic regimes and medication, and have links to other statutory and voluntary sector services. We examined a sample of case files from both intensive therapy teams, and found examples of team members identifying and supporting mental health issues in parents as well as children and young people, providing a holistic service to families in need.
- 2.37** Data provided by the service provider, indicates that the community intensive therapy teams have led to significantly reduced use of inpatient beds and out-of-county placements. However, a formal evaluation by the service provider of the full impact of these services, particularly on patient outcomes only commenced in Autumn 2009.
- 2.38** The managers of the community intensive therapy teams reported to us that they can have problems obtaining the necessary support from occupational therapy, dieticians, physiotherapy and speech and language therapists. They told us that some therapy

staff do not provide support to children and young people with a mental health problem as they do not feel that they have got the necessary skills to work with this group.

- 2.39** There are inequalities of access to community intensive therapy and treatment services in Wales. In addition to the areas covered by the two community intensive therapy and treatment teams, two NHS trusts report funding some degree of intensive home therapy or outreach service. In Torfaen, there is also a multidisciplinary intervention service that provides intensive support for looked after children who have had a number of placements collapse or who are returning from an out-of-county placement. This service is a partnership between social services, education, the NHS, and Action for Children. In other areas, community intensive support is not available.
- 2.40** In the past, NHS trusts have submitted business cases to HCW for the development of community intensive therapy and treatment teams in both Swansea and Gwent. The business cases have not been accepted, and any future expansion in community intensive therapy and treatment services will require increased funding. Expanding these community services could be achieved through either establishing new teams or through increasing the capacity and skills within specialist CAMHS teams to provide these services.
- 2.41** Developing community intensive therapy and treatment services may allow the number and costs of inpatient beds to be reduced. However, HCW told us that further developing these services would not lead to fewer out-of-area placements in the future.
- 2.42** Children and young people may have been put at risk during the establishment of the Cardiff and Vale of Glamorgan community intensive therapy and treatment team. This was due to a lack of full transitional funding to ensure comprehensive community intensive therapy and treatment services were in place to receive children and young people returning from out of area placements.

- 2.43** The HCW agreed a phased investment of the community intensive therapy and treatment team. Out-of-area placements were brought to an end, and the funding that was then released was used to further develop the therapy team. However, the young people returning home were initially supported by agency nurses and an embryonic team of local specialist CAMHS staff. This left very vulnerable children without the support of a fully established community intensive therapy and treatment team over a period of several months. We also found evidence that HCW gave short notice about the change in these arrangements (Case study 9).

Case study 9

Annie was 15 and had schizophrenia. She was detained under the Mental Health Act, and placed on a locked ward of an independent hospital in South East England. Health Commission Wales funded this placement. Annie was considered to be a suitable case to be supported by a new Community Intensive Therapy and Treatment (CITT) team that was to be established in Wales and funded by HCW. However, the funds HCW needed to pay for the CITT staff were tied up paying for Annie's bed and for other out-of-area placements. Her hospital understood that she was working towards a planned discharge in March, but HCW informed them in January that she had to return to the local inpatient unit in Wales immediately. However, the local hospital was not able to take her, so Annie had to return to her home, but without the CITT team being in place to support her. Agency staff supported Annie at home until the appointment of the CITT staff. Her sudden unplanned transfer from a locked ward to community care provided by an embryonic team placed Annie at risk.

- 2.44** The HCW and the service provider told us that they put in place appropriate arrangements to reduce this risk, with senior medical and nursing staff planning and monitoring care. However, these risks could have been avoided, rather than reduced, by the provision of full transitional funding.

Services for children and young people with mental health problems who are at a high risk of offending

2.45 In 2004, the Assembly Government made funding of £300,000 available to HCW to establish a new Forensic Assessment and Consultation Service in Wales. This service focuses on children and young people at high risk of offending. It was envisaged that the service would be based around two forensic assessment and consultation teams, in North and South Wales. Health Commission Wales commissioning policy of 2006 stated that these teams would provide:

- consultation, advice and training to specialist CAMHS staff;
- direct clinical services for young people in response to selected and negotiated referrals from specialist CAMHS teams; and
- consultation, advice and training to the staff of other agencies.

2.46 There have been significant delays in establishing a comprehensive service as originally envisaged. In the meantime, a more limited service has been provided. North Wales has received advice and support from a consultant based in Manchester, and South Wales had a part-time consultant in post for a short period, which was followed by a nurse-led service.

2.47 Attempts to establish two teams were not successful, until a single all Wales consultant led Forensic Assessment and Consultation Service was established in 2009. The service is led by a single consultant who covers all of Wales, with teams in North and South Wales comprising of a nurse, psychologist and admin support. Recruitment to this service was still underway in October 2009, with the recruitment of psychology staff. The service provides assessment and treatment for very serious cases, with advice and support being made available to local CAMHS teams.

2.48 Some young offenders who have a mental illness require placement and treatment in specialist secure forensic hospitals. There are no such units in Wales, and HCW funds placements outside Wales as required.

2.49 There are two institutions in Wales that house young offenders. Hillside Secure Unit in Neath has 18 beds for 13 to 17 year olds who need secure care because of their offending behaviour or because of the risk they present to themselves or to the community. Parc Prison and Young Offenders Institution in Bridgend houses 64 offenders aged between 15 and 17. Neath Port Talbot social services commission some CAMHS services for Hillside, but these do not include specialist forensic skills. Prisoners of all ages at Parc Prison have access to general medical services as well as support from prison staff. There is a specialist adult mental health in-reach service, but no access to specialist mental health services for young people. However, the Bridgend Prison Health Partnership Board has developed a business plan for a CAMHS service, due to be available from Autumn 2009. The recently established all Wales Forensic Assessment and Consultation Service now provides support, via referral from a consultant, to young people in both units housing young offenders.

Day care services

2.50 The availability of specialist day care for children and young people with mental health problems varies across Wales, and we found little evidence that the configuration of day care services was based on an analysis of the need for such services. Three of the seven NHS trusts providing specialist CAMHS report having a day care unit. However at these units:

- the availability of day care varied between one and five days a week;
- each unit had a different therapeutic focus; and
- two units provided intensive support or were a 'step-down' facility between inpatient and community treatment.

Eating disorder services

- 2.51** Whilst some trusts provided a well-developed eating disorder service, others identified this as a shortfall in local services. Where local eating disorder services have been developed, there is an increased chance that children and young people will have earlier treatment and support, and that this may lower the risk of their condition worsening to such an extent that an inpatient admission is required. However, in some trusts the development of eating disorder services appears to rest as much upon the interest of individual practitioners as upon a strategic service planning decision based on an assessment of competing needs.
- 2.52** In October 2008, the Assembly Government recognised that services for adults with an eating disorder were poor and needed to significantly improve. Guidance to the NHS on improving services is under development, and additional funding of £1.5 million has been announced to take forward the development of community-based services. However, this initiative excludes children and young people, even if they are approaching the age of transition to adult services.

Advocacy services

- 2.53** Advocacy services help young people to express their views and wishes to others. In November 2002, the Assembly Government committed to provide universal access to advocacy services for all children and young people. In April 2008, it outlined a new framework for the future provision of advocacy services for children, which was to be implemented over a two-year period. The advocacy service was to comprise:
- a new National Advocacy and Advice Service to provide universal access to first line advocacy and support and, where appropriate, make referrals to the local/regional specialist integrated advocacy services and school-based counselling services; and

- a locally/regionally commissioned Integrated Specialist Advocacy Service covering health services, social care services and education, with a particular focus on providing statutory advocacy and broader support to assist vulnerable children and young people.

2.54 Progress has been with implementing these new services, with a pilot National Advocacy and Advice Service in place from September 2009 for a 12-month period. This service provides a single point of contact via free telephone or text, seven days a week. There has been less progress in establishing local or regional specialist advocacy services. A guide to the model was issued to local agencies in advance of the statutory guidance, which has been delayed until after the NHS reorganisation. The Assembly Government told us that some children and young people's partnerships have also begun to consider the way forward.

2.55 Our review indicates that developing suitable advocacy services for children and young people with mental health problems will be a significant challenge, because:

- in one NHS trust area there are no advocacy services for children and young people;
- in some areas services are available only for specific groups, such as looked after children, or are promoted only to those with complex problems;
- we found very few examples where service users had accessed advocacy services; and
- there is often a lack of staff awareness about local advocacy provision.

Support to parents and carers

2.56 An issue raised by the parents and carers of children and young people with a mental health problem that we consulted with was the inadequacy of the support they themselves have received. Some parents and carers commented positively on the improved understanding that they have developed through working with CAMHS. Parenting classes were also seen positively, but these focus on managing the behaviour

of children and young people, rather than support for the parent or carer in dealing with the stress they face.

'As a parent I have not been offered any support to help me deal with the stress of having a child with behavioural/emotional problems'

Parent/carer

Support for people from ethnic minority groups

2.57 Some specialist CAMHS services report difficulties in accessing translators who have the skills not only to work with young people but to convey information to and from patients regarding mental health concerns, some of which could be heightened by cultural considerations.

2.58 Some services also report that the demographic make-up of cases referred to them is not representative of their local communities, with an under representation from ethnic minority groups.

Nature and quality of services

Child and young person friendly services

'They don't know what it's like in my world if they don't come and see'
Comment from young person on clinic based care

Child/young person

Location of services

2.59 As far as is possible children, young people and their carers should be seen in non-stigmatising and accessible locations. Children and adolescent mental health services teams in Wales vary as to where they will see children. Evidence from our fieldwork visits and surveys and the Assembly Government's mapping data identifies that many CAMHS teams operate mainly on a clinic basis, frequently provided from hospital settings. The hospital settings used include acute hospitals, psychiatric hospitals and community hospitals. All CAMHS teams stated that they offer appointments in other locations, such as at home or school, but this was often on an exception basis rather than routine practice (Case study 10).

Case study 10

Ieuan was suffering from an illness and this meant he did not feel able to leave his house. He was referred to his local CAMHS team. They were happy to take on his case, but required Ieuan to come to the clinic to demonstrate that he was prepared to engage with the therapeutic process. Ieuan found this impossible to do, and so received no treatment. When he reached 16, he was referred to adult mental health services, who undertook a home visit to assess Ieuan and then initiated a treatment plan.

2.60 The location of clinics can cause problems for families, especially when they have other family commitments or rely on public transport. Only half of children and young people spoken to as part of our review described the place where they access support or attend appointments as close to where they live. Just under a third of children and young people said that it takes a long time to get to the place where they access support. Those living in rural areas are particularly affected. We spoke to a consultant who had been requested by managers to stop running one clinic in his area because of the time they lost in travelling. He refused because he did not want families to face a 120 mile or more round trip to an alternative clinic.

2.61 Some specialist CAMHS teams have taken steps to make the location of services more accessible and child and family friendly by, for example, offering drop-in sessions in community facilities or by using partner facilities such as voluntary sector centres (Case study 11).

Case study 11

Kelsey lives in West Wales, and in the past her illness has led to her being admitted to the CAMHS inpatient unit, which at the time was based in Cardiff. Kelsey was very homesick during the stay at the unit. On discharge, her local CAMHS team, with support from the inpatient unit, treated her at home. When Kelsey's medication needs to be changed, this would usually involve a stay in hospital to monitor that this is working effectively. However, the CAMHS and inpatient teams have arranged for monitoring at home, to avoid Kelsey being homesick again.

Environment

2.62 The environments of many clinics require improvement. Our survey of specialist CAMHS teams showed that only 8 of the 24 teams considered that services are always provided from child-friendly facilities. Problems identified by CAMHS teams included:

- rundown or hazardous premises;
- a lack of space and privacy;
- sharing space with other services, such as continence clinics; and
- a lack of child-friendly facilities, such as infant-sized toilets.

2.63 Young people and their families also flagged up these issues. Just under one third of young people spoken to as part of our review said that the place they go for support does not look very nice or makes them feel uncomfortable, and around a fifth of parents we spoke to stated that the place where their child accesses support is not very pleasant. Children, young people, and their parents all identified the need for waiting areas to include magazines, games

and facilities suitable for older children and teenagers, as they frequently only contain toys or books for small children. Some also identified the need for more privacy in waiting areas.

'Comfortable for a hospital clinic'

Child/young person

'Waiting room was like a GPs – not very child-friendly'

Parent/carer

Opening times

2.64 Specialist CAMHS teams generally operate Monday to Friday 9.00am to 5.00pm, and in many areas routine out-of-hours consultations and interventions are not provided. Where out-of-hours services are provided, these vary from staff being available on a rota, to providing telephone advice only, through to a crisis response team.

'Many appointments are requested for after school times but, due to the hours of service, availability of these is limited'

Service professional

Missed appointments

2.65 Our fieldwork visits, surveys and case file reviews highlighted the common practice across Wales for specialist CAMHS teams to close cases when a service user fails to attend an appointment. In some areas, this can happen after only one missed appointment (Case study 12); in others, it can be after two or

three missed appointments. Some teams stated that they assess the level of risk before a case is closed. Some practitioners see missing appointments as an indication that the young person has not engaged with the therapeutic process and, therefore, there is no reason to continue providing support. In addition, if appointments are missed then assessment and intervention target times will be more difficult to achieve.

Case study 12

We heard Jack's story from his family. Jack waited two years for his first appointment with specialist CAMHS. However, circumstances meant that the family missed the second appointment, and when Jack's Mum contacted the clinic to find out when her son's next appointment was, she was told that he had been discharged. Jack then had to be re-referred and the family faced another long wait for another appointment.

- 2.66** Specialist CAMHS teams vary in their approach to maximising the likelihood of attendance. Some phone or e-mail in advance of an appointment to check attendance, whilst others take no action. Appointments to specialist CAMHS teams generally sit outside the main outpatient appointment booking systems, the use of which has had a significant impact in recent years in increasing outpatient attendance rates for general medical services.
- 2.67** There are also variations in the follow-up action that is taken when appointments are missed. Some teams routinely make contact with families, whilst others take no action unless they have specific concerns about a child. Although there is a specific standard for the action to be taken when an appointment is missed in the Children and Young People's NSF in England, there is no corresponding standard in Wales.

- 2.68** The report by the Confidential Enquiry into Maternal and Child Health, *Why Children Die*^{vii}, published in 2006, is highly critical of both the practice of closing cases due to non-attendance at appointments and the lack of routine follow-up. The report highlights non-attendance at CAMHS appointments as a particular area of concern and notes that a failure to attend can be an indicator of a family's vulnerability, potentially placing the child's welfare in jeopardy. Also, missed appointments may be due to the parents' or guardians' competing commitments, or other family problems. The report concludes that *'Whilst there may be policies in which adults are not sent repeat appointments, this will rarely be appropriate practice with children'* and that *'Child and Adolescent Mental Health Services should proactively follow up children who do not attend their appointments'*.

Information sharing

- 2.69** Our case file reviews identified examples where specialist CAMHS teams had identified issues of concern regarding the safety of a young person or others and taken appropriate action in informing other relevant organisations. For example, in one case staff identified that there was a potential risk to a patient's siblings and made a referral to social services; in another a girl disclosed to staff that she had been raped, and they then referred the case to the police for investigation.
- 2.70** However, we also found examples of cases where organisations have not properly shared information, even when there are identified child protection issues ([Case studies 13 and 14](#)). A number of high-profile reviews of deaths and other serious incidents in England and Wales have identified inadequate information sharing as a key issue. The Confidential Enquiry into Maternal and Child Health identified the lack of information sharing as an avoidable factor in child deaths. Our discussions with a range of professional staff, case file reviews and surveys identified that poor information sharing is underpinned by:

- confusion between agencies about what information can or cannot be shared – some specialist CAMHS professionals will not discuss any child with another service on the grounds of clinical confidentiality, some health and social care professionals believe that parental consent is always needed, and others believe that Caldicott rules prevent any information sharing;
- a lack of information sharing protocols with other agencies – only half of specialist CAMHS teams have these in place; and
- a lack of joint case files and information systems in multiagency teams.

Case study 13

Rhiannon is 13 and suffers from a depressive illness. In the course of her treatment, Rhiannon tells her therapist about the bullying and sexual abuse she has suffered from two other girls. In the case notes we examined, there was no evidence that this was raised with Rhiannon's school or that any action was taken regarding the other girls' behaviour and the risk they posed to others.

Case study 14

Karen is 15 and suffers from anxiety, combined with a substance misuse problem. Karen is receiving therapy from a CAMHS team member to address her risk-taking behaviours and drug problems. Karen disclosed to the team member that she was in a sexual relationship with her drug dealer, who is in his 30s. There was no evidence in the case notes that consideration was given to this young woman's vulnerability to exploitation, nor of any steps taken to consider the risk this man might pose to other under-aged girls.

'If the family consistently fail to attend appointments and do not respond to correspondence, we may have no option but to close the case regardless of risk, but would ensure that we inform all other agencies involved if we have permission to do so from the family/young person'

Service professional

2.71 We found a range of situations in which children and young people are being put at risk by the inadequate sharing of information between agencies, including:

- when specialist CAMHS teams close a case as a result of the child or young person not attending, other agencies involved with the child, including the referring agency, are not always informed;
- only 13 of 24 specialist CAMHS teams believe that social services routinely made them aware of any safeguarding concerns;
- some social services staff report being unaware of children and young people from their area who are admitted to inpatient settings, even though they would meet the definition of 'children in need' under the Children Act 1989; and
- during our fieldwork visits we were told about a variety of other examples where CAMHS staff have refused to confirm whether they were in contact with a child, have not felt able to discuss with a head teacher how they would like a service user to be supported when in school, or have not participated in case conferences.

'CAMHS will make some child protection referrals to us but we often receive child protection referrals from other agencies and then discover that CAMHS are working with the family. In one case they'd been involved for two years'

Service professional

Holistic and co-ordinated care

Co-ordination of care between agencies

2.72 Children and young people with mental health problems often have complex and wide-ranging needs. *Everybody's Business* stresses the importance of multiagency assessment and care planning, stating that co-ordinated multiagency treatment plans are required for individuals with multiple or complex needs. However, our case file reviews identified that such plans are not routinely being developed or delivered in many parts of Wales.

'Adults are desperate to refer on'

Child/young person

'CAMHS have produced a document defining the focus and limits of their service with no consultation with the other agencies who they now expect to provide services in their stead'

Service professional

2.73 Many specialist CAMHS teams that have developed eligibility criteria and referral protocols stated that these were not developed in association with other services. Although specialist services and their commissioners have the right to decide what services they provide and to whom, there are benefits in doing this as part of a holistic mapping of local services, to ensure clarity and that there are no serious gaps in meeting children and young people's needs.

2.74 However, there is no common multiagency care planning system for CAMHS within Wales, and only a few areas in Wales have developed local multiagency care planning arrangements. Even in these cases we found little evidence of routine multiagency management or discussion in reviewing individual case files ([Case studies 15 and 16](#)). In contrast, mental health services for adults in Wales are required by the Assembly Government to use the Care Programme Approach (CPA) to care planning, as are CAMHS teams in England.

Case study 15

Jane has a neurological disorder, which means she is likely to develop learning difficulties, physical issues, problems with speech and co-ordination as well as emotional and behavioural problems. In such a case, we would have expected to see paediatric, CAMHS, education and other therapy services working together throughout her childhood to develop a multi-professional approach to her support. However, Jane's case file showed that at times she was passed between paediatrics and psychiatry, and at no time could we find any evidence of a multi-professional discussion of Jane's needs and how best to address them. Children and adolescent mental health services identified that Jane needed support in school and an educational psychology assessment, but there was little input from education services – she was not considered for a statement of educational needs. Jane was not assessed for speech and language services until she was 15.

Case study 16

Callum had behaviour problems in school and at home, which were causing wide disruption to his family. A student social worker managed his case, and made a referral on to CAMHS. At this point, the student closed the social services file.

A number of agencies assessed Callum, each developed their own views of what action to take, and what risks he posed, for example, how much contact he should have with his mother. There was no evidence in the case files of a co-ordinated approach to planning Callum's care based on an agreed understanding of his problems and how best to address these. His case became increasingly complex with issues around housing, family relationships, self-harm and harm to others, but the case files did not provide evidence of a well co-ordinated approach. Regular changes of locum psychiatrists further complicated Callum's case, with each locum changing his diagnosis and treatment.

- 2.75** We found examples of some young people being passed between services with no one service taking responsibility for helping them. We also found examples of referrers relinquishing responsibility for a young person once the referral has been made or accepted. A child or young person with both health and social care needs may meet the criteria of only one of these services. As a result they will get input from one agency but not the other, despite the fact that their problems and needs may be interlinked.
- 2.76** Our discussions with specialist CAMHS teams established that some teams have only limited access to other therapeutic professionals such as dieticians, occupational therapists, physiotherapists and speech and language therapists. Whilst some services have access to these staff, for example dietetic support for eating disorders, this was the exception rather than the norm. Specialist CAMHS staff report that some of these services specifically exclude young people with a mental health and/or learning disability. Also, many CAMHS teams do not have protocols with the other relevant organisations in place for the

treatment of children and young people with a dual diagnosis of a mental health problem and a substance misuse problem, learning difficulty or other medical condition.

'The family did not receive a CAMHS service beyond a diagnosis and recommended course of action which was not funded'

Parent/carer

- 2.77** It is clear from the reports published following inspections of Welsh youth offending teams as part of HMI Probation's three-year rolling programme that there is a great deal of variation in the way youth offending teams are being supported by specialist CAMHS. These range from having protocols in place to ensure the provision of advice and support, through to dedicated input from specialist CAMHS professionals.

Care management within specialist CAMHS

- 2.78** The specialist CAMHS treatment options on offer to a child or young person with mental health problems can depend on where they live and, to some extent, the specialist interests of the staff involved in organising their care. For example, Dialectical Behaviour Therapy (DBT) is widely available in some parts of Wales, but not on offer at all in others.
- 2.79** A significant number of specialist CAMHS teams do not have protocols or policies in relation to key care management processes, such as:
- assessing, prioritising and allocating referrals (these are not in place in six teams in two of the seven NHS trusts providing specialist CAMHS);
 - care planning and review (not in place in 11 teams in five NHS trusts); and
 - discharge and onward referral (not in place in eight teams in three NHS trusts).

2.80 Many CAMHS teams told us that they use care plans. However, we found little evidence from our case file reviews of a common and systematic approach to care plans for patients in community settings. Nor did we find much evidence of cases being managed by multidisciplinary CAMHS teams. For example, we found that:

- a case may be allocated to a team member based on their availability or workload, or to the team member who undertook the initial assessment as they had already developed a relationship with the service user; and
- the team member allocated to a case would often provide the sole input to the child or young person, and there was little consideration about which team member or members could best support a young person as their treatment progressed.

2.81 Just under half of the children and young people consulted during our review received medication as part of their treatment. However, although some parents stated that the medication had had a positive impact on their child, children and young people and their parents had concerns about being given medication without any therapeutic support.

2.82 Some social workers develop additional skills in order to work with children and young people with mental health problems. These skills can vary from an increased understanding of mental health problems through to developing therapeutic skills. Eight of the 13 social services departments responding to our survey stated that they employed social workers with a mental health specialism. In most cases, they are based within specialist CAMHS teams.

2.83 The additional training that these social workers receive appears to vary significantly. Some authorities provide training in specific areas, such as dealing with sexual abuse, or in specific skills, such as family therapy. However, other authorities report that training has been limited to that provided by the specialist CAMHS team.

2.84 Our discussions with specialist CAMHS and social services staff highlighted that the roles undertaken by social workers who are based in specialist CAMHS teams vary widely. Some provide therapeutic care; others support specific groups, such as looked after children. Sometimes social workers are excluded from key team activities like considering referrals or prioritising cases. The extent to which their social work skills and knowledge are utilised also varies, depending on their role within the team, with some staff acting as generic team members, rather than providing social care expertise across the team's caseload. Overall, we found little evidence that social workers within specialist CAMHS teams are being used effectively as a link between specialist CAMHS and social services teams.

Informing and involving children and young people in planning their care

Involving children and young people in care planning and obtaining consent

'I regularly have appointments made for me, without anyone discussing the reasons or whether I want to go to appointments'

Child/young person

2.85 One of the key concerns arising from our consultation with children, young people and their parents or carers related to the extent to which children and young people are involved in planning their care. This was found to be variable, and particularly poor in respect of younger children. For example:

- just over half of children and young people said that they had been involved in decisions about their care, including being provided with information about the planning of their care and about different options available;

- younger children in particular were often not aware of the reason why they are involved with CAMHS;
- around 60 per cent of children and young people said that they are 'not always sure what is going to happen or why' or that they 'don't know what is going on most the time'; and
- some children and young people who attended day units or received support as inpatients felt that they were sometimes forced to attend group sessions.

2.86 Overall, the views of parents and carers were more positive, but they still have issues of concern. For example:

- two out of three parents or carers felt that they had not been given the opportunity to be involved in decisions about the care and treatment their child received; and
- just over half of parent or carers said that they have not received information about different options for the care and treatment of their child.

2.87 The variable extent of involvement in care planning was also evident from our case file reviews. Only half of the case files we examined clearly noted consent for any aspects of treatment, although in some cases consent could be considered to have been given by the involvement of the young person or their parent in assessment or care planning. Our survey of specialist CAMHS teams found that a standard process for recording the child or young person's consent to treatment is absent in 2 of the 24 teams, and five lacked a standard process for gaining parental consent. Only three teams stated that local arrangements for involving children, young people and their parents in discussing treatment, offering options, and gaining consent have been audited. As a result, most teams cannot demonstrate the extent to which local policy is put into practice, nor are they able to use audit results to improve performance.

2.88 In addition, there is also a lack of information available to children, young people and their parents on what rights they have and on what they should expect from CAMHS.

'It is important that my child be involved in his own decision making. This has empowered him and given him an element of control in his own wellbeing'

Parent/carer

Practitioner engagement with children and young people

2.89 Children and young people involved in our consultation exercise identified as important the ability for a practitioner to be a good listener, and to be honest, trusted, understanding and caring. They received support from a number of different practitioners and expressed mixed views about these staff. Some children and young people described very positive and important relationships with practitioners. However:

- some children and young people spoke about practitioners who were difficult to understand, rude and dismissive of their view;
- although just under half of children and young people said that practitioners listened to their views and delivered the support asked for, a quarter said that they did not think their views had been listened to and that the support they get 'doesn't really work' for them;
- although most practitioners were identified as good at explaining things, some children and young people made comments about being confused by, and not understanding, what practitioners say; and

- some children and young people had difficulties in understanding the 'language' of mental health professionals.

'The first person I saw listened more than asked questions. They just let me tell them how I felt'

Child/young person

'I didn't like how they spoke to me – like a little kid'

Child/young person

2.90 The views of parents and carers were a little more positive. Approximately two-thirds thought that practitioners had a good understanding of their child's needs, listened to the views of them and their child, and were good at explaining things, and that the information that practitioners provided was easy to understand. Where a diagnosis was provided, most parents said that the diagnosis had been explained to them.

Providing information to children, young people and their parents

2.91 The consultation with children, young people and their parents and carers identified a number of issues with the availability of information about their care:

- a third of children and young people said that someone talked to them about the help and support they could get, but only 16 per cent said that they were given a lot of information about the help that was available – some children and young people were confused about the reasons why support was sought and about mental health issues in general;

- just over half of parent and carers said that getting information about available support was 'not very easy' or 'quite difficult'; and
- a third of parents and carers said that no-one really told them what would happen next, once the need for support had been identified.

'Parents should be more informed about their child's treatment and care'

Parent/carer

2.92 Our surveys identified that the information about services provided by specialist CAMHS teams to both children and parents varied. It ranged from the ad-hoc provision of verbal information to a structured approach that includes written information on statutory and voluntary sector services and signposting to websites. Information on specific conditions or treatments, provided in leaflets and information sheets, appears to be of better quality than information on the services available. In some areas bibliotherapy services have been established whereby families can borrow books about issues ranging from parenting or bullying to serious mental health conditions.

2.93 The information provided is not always in the most suitable form. Some voluntary sector organisations told us that the materials made available by statutory services are not always in a style accessible to children and young people. And our survey identified that only 7 of 24 specialist CAMHS teams made available all their written information on services, conditions and treatments in both English and Welsh.

The transition from CAMHS to adult mental health services

- 2.94** A young person's move from children's to adult services should be planned and co-ordinated. However, we identified a number of problems with the transition, reflecting concerns expressed by some young people and their parents.
- 2.95** Agreed protocols between CAMHS and adult mental health services over transitional arrangements, for example covering who should be managing which cases and how a smooth handover is to be achieved, are lacking in many areas. Half of adult mental health services responding to our survey stated that they have not agreed such protocols. A similar proportion of specialist CAMHS teams told us that formal links with adult mental health services are not in place.
- 2.96** During our case file review we found little evidence of active forward planning and management of cases that were approaching the point of transition, even where guidelines or protocols were in place (Case studies 17 and 18 provide examples of how different the planning for transition can be). In some cases, the only documented action was a simple referral to adult mental health services.

Case study 17

Jenny is 17 and suffers from post-traumatic stress disorder following abuse earlier in her childhood. An assessment by the local CAMHS team identified that a course of therapy and support was needed that would not finish before her 18th birthday. Her local CAMHS team wanted the adult mental health team to take responsibility for her treatment from the outset, to avoid a change being necessary halfway through therapy. However, the adult mental health team would not take responsibility for Jenny until she reached 18 years of age.

Case study 18

Victoria was referred to her local CAMHS inpatient unit when she was 17 because of her depression and post-traumatic stress disorder. She was admitted six months later when a bed became available. Despite her turning 18 soon afterwards she was able to stay in the unit and work with the CAMHS team until well after her 19th birthday, during which time they worked with her adult team to facilitate a planned transfer.

- 2.97** There can be inconsistencies between agencies over the age at which transition can take place, making effective multiagency working more difficult to achieve. There may even be differences within a service. For example, a 17 year old young person not in education may not be eligible for direct support from a CAMHS team, but if they are involved with the local Youth Offending Team they could then have contact with the CAMHS input to that service.

'Personally I think there is too little help for disabled young people especially moving from children to adults. CAMHS team was excellent but needs extending to early 20's. It's too soon to move to adults. There are so few services for my age and I don't fit into adult services. They seem to think I'm old enough to take care of myself now'

Young person

- 2.98** Although there are key differences between children and young people's services and adult services, we found little evidence that the expectations of young people and their parents are being managed to reflect these differences. Key differences include:

- the two services can have different eligibility criteria;
- CAMHS and adult services have a different ethos, with CAMHS more focused on treating the young person within the context of their family; and
- there may be no local services for adults with particular conditions, such as ADHD, eating disorders, learning disabilities and challenging behaviour.

'Individual staff very good but getting into service difficult and once age 16 no further support available'

Parent/carer

In conclusion

2.99 Some specialist services in the community are not provided within Wales and there are unacceptable variations in the availability and quality of those services that are provided.

2.100 Our conclusions about the availability of services are that:

- there is no specialist mental health service in the community for children under five years of age;
- eligibility criteria and referral arrangements for specialist CAMHS teams vary too much across Wales, the referral process is often unclear, and although evidence indicates that waiting times for children and young people have improved in the last year it is not clear that this is delivering the intended benefits;
- access to specialist CAMHS in the community for some children and young people depends on where in Wales they live;
- community intensive therapy and treatment services have been established in some parts of Wales, but in others children and young people can only access intensive support from inpatient settings;
- there has been slow progress in establishing comprehensive services for children and young people with mental health problems who are at a high risk of offending;
- the availability of day care and eating disorder services is patchy and bears little relationship to the local need for such services; and
- there has been some progress in developing advocacy services but developing local specialist advocacy services in all parts of Wales will be a challenge.

2.101 Our conclusions about the quality and nature of services are that:

- specialist CAMHS teams in many parts of Wales are struggling to provide services in a way that reflects the specific needs of children and young people;
- children and young people who miss appointments are routinely 'discharged' by specialist CAMHS teams in many areas and a lack of routine follow-up can put children at risk;
- in some parts of Wales the inadequate sharing of information between organisations is putting children and young people at risk and is undermining child protection arrangements;
- in many parts of Wales children and young people are not receiving holistic care based on meeting their often wide-ranging needs;
- many children and young people are not well informed about, or involved in, planning their care, and do not always feel they are listened to; and
- there are inadequate arrangements in many parts of Wales to ensure a smooth and effective transition from CAMHS to adult mental health services, increasing the risk that young people disengage from the services they need.

Part 3 – Inpatient and residential services

- 3.1** There are two NHS units providing specialist inpatient mental health services to children and young people in Wales. The inpatient unit in North Wales was formerly based at Cedar Court in Colwyn Bay, but in July 2009 a new unit on the site of Abergele Hospital was opened with £13.7 million capital funding. Until December 2007, the Harvey Jones Adolescent Unit in Cardiff, run by Cwm Taf NHS Trust, provided inpatient services in South Wales. There had been long standing concerns over the structural safety and environment of this unit. As an interim measure, the service has moved to refurbished accommodation, known as Hafod Newydd, in Bridgend. The Assembly Government has approved £22 million capital funding to build a new unit in the grounds of the Princess of Wales Hospital in Bridgend, and this is planned to be operational in January 2011.
- 3.2** There are a number of issues with the availability, nature and quality of inpatient services used by children and young people with mental health problems. Although the case studies and views of young people and their parents in this report reflect experiences in the former inpatient units, not all of the issues raised will be resolved by the investment in new facilities.

Availability of services

Inpatient services in North Wales

- 3.3** The layout and condition of the former building at Cedar Court, together with planning constraints, meant that it could not support emergency admission or inpatient treatment of acutely disturbed or highly suicidal adolescents. Nor could it admit young people detained under the Mental Health Act. In addition, the building was not fully compliant with statutory obligations, such as the Disability Discrimination Act 1995. The unit was only opened during the week, further limiting the support that was available (*Case study 19*).
- 3.4** The new unit does not have these limitations providing a 24-hour inpatient service. It is designed to support planned, emergency and high dependency treatment, and provides therapy, recreation and education facilities for adolescents suffering from a range of problems, such as severe eating disabilities, anxiety, emotional disorders, psychotic disorders and severe obsessive compulsive disorder.

Case study 19

Rebecca is 17 and has an eating disorder. She was being treated at the Cedar Court Unit in North Wales during the week. However, at weekends her physical condition meant she could not return home when the unit was closed. So every weekend she was admitted to the paediatric ward of a local general hospital for care and treatment, supported by staff from the CAMHS unit.

Inpatient bed provision

- 3.5** Inpatient bed numbers have been increased as part of the development of the new unit in North Wales. The former unit had 12 general beds, and by November 2009, it is expected that 12 general and five emergency/high dependency beds will be available.
- 3.6** The actual number of beds routinely available in the south is below the number originally planned and consulted upon, and has actually fallen. The former inpatient unit had 16 beds in total (14 general and 2 high care beds), and this was planned to increase to 19 at the new unit (14 general beds and 5 emergency beds). As at October 2009, only 14 beds (11 general beds and 3 emergency beds) were routinely available in the new unit. The service provider has been informed by HCW that additional emergency and general beds will be made available on a case-by-case basis, up to the original planned numbers if demand arises.
- 3.7** In 2004-05, the Assembly Government made available £650,000 to fund adolescents requiring admission in an emergency, this was used to fund emergency placements in specialist CAMHS units in England. Up until December 2008 there were no beds in Wales dedicated to the emergency admission of young people with a mental health problem. If a suitable bed was not available within one of the CAMHS inpatient units, young people requiring emergency admissions were placed on paediatric wards, adult mental health wards or specialist CAMHS units in England.

- 3.8** There has been a considerable delay in providing the emergency beds in the south and the number of beds made available is lower than the numbers in the agreed plans in both North and South Wales.
- 3.9** The new unit in South Wales opened in December 2007, but it took until December 2008 for the emergency beds to be available. Only three of the five planned emergency beds are routinely available, and this has been achieved only by reducing the number of general beds.
- 3.10** The new inpatient unit in North Wales currently intends to open five of the six planned emergency/high dependency beds. They have been introduced incrementally with all five expected to be available in November 2009, four months after the unit opened.

Interventions and support

- 3.11** There are a number of significant differences between the two inpatient units in Wales and as a result, young people in North and South Wales have access to different types of care and support. For example, in North Wales a range of psychological therapies are offered, including DBT. This therapy is not available in the South Wales unit and some young people living in South Wales have been referred to the north to access this therapy ([Case study 20](#)).

Case study 20

Alice, 15, has a history of depression and self-harm. Following discharge from the Harvey Jones inpatient unit back to her home in West Wales, Alice visited her local hospital after a self-harming incident. She was admitted first to a paediatric ward, and then later transferred to an adult mental health ward, where she was nursed on a two-to-one basis due to her high risk. The South Wales inpatient unit was unable to readmit her, partly because they felt Alice required DBT, a kind of therapy they did not offer. This was however available at the North Wales unit. Alice was transferred there, but as the unit at that time was only open five days a week she had to undertake a long journey home every Friday and return on Monday morning.

3.12 In North Wales, Cedar Court did not have access to occupational therapy, physiotherapy or dietician support. There is now a full-time Dietician and Dietetic Support Worker in post in the new unit, but the other support services are not yet in place as originally intended. The unit in the south has occupational therapy and dietician support, and accesses physiotherapy support as needed from the local District General Hospital.

3.13 There are also differences with social services provision with no social work input to the former Harvey Jones Unit and no agreement yet for social work input to the new unit as was originally intended. However, in North Wales a full-time social worker is based with the inpatient team. Conwy Social Services host this post, and hold a Service Level Agreement with the six local authorities across North Wales, which, between them, are funding the post.

3.14 Educational provision is also significantly different between the two inpatient facilities. The former Cedar Court had a well-resourced educational unit which worked with local health services to create packages of care and activities. There were generally good links with patients' home education services to ensure continuity of education, including sitting exams, and also with local colleges and careers services. These arrangements have continued and expanded with the increased numbers of beds in the new unit. During term time, the unit has a full five-day education programme as part of its therapeutic programme.

3.15 In South Wales, the former Harvey Jones unit provided far more limited educational support, and there was no option for children to continue receiving their education through the medium of Welsh. The position has not improved with the move to the new unit.

3.16 The provision of education in inpatient units to those aged 16 and over is also an area of concern. There is little, if any, educational support for this group in South Wales. In the north, education is provided to this group, but the local education departments have expressed their concern that they do not receive any income for providing the education.

Nature and quality of services

3.17 There are some concerns about the service provided from the former inpatient unit in South Wales. In the past multidisciplinary involvement in case management was lacking. We experienced difficulties in gaining access to children and young people as part of our review and, although the numbers were small, the children and young people we spoke to who had stayed in the Harvey Jones unit were more negative about their experiences than those who had stayed at Cedar Court. The service provider acknowledges that there have been issues in the past, but reports that considerable change and improvement has taken place over recent years.

3.18 There are also issues with the location of the two units. Hafod Newydd is located in the grounds of a former Victorian institution, alongside buildings which accommodate a medium-secure forensic unit for mentally ill offenders and inpatient and community mental health services for adults and older people. We are not suggesting that the proximity to these other services is inappropriate or puts children at risk. But there is a possible stigmatising effect from being located next to such services. Unlike the former Cedar Court, the unit on the Abergele site is isolated from local facilities, such as shops and cafes, although there is a regular bus service into the nearest town, which is 1.5 miles away, and staff take out young people on frequent outings. There is also a potential risk associated with a bridge over a ravine on this site, although a full risk assessment has been undertaken and some alterations made.

User satisfaction with inpatient services

3.19 Nearly one in five children and young people who participated in our consultation exercise had accessed mental health inpatient services at a hospital or adolescent unit at some point. This included young people placed in England and those who attended the former inpatient units in Wales. This group were more critical of the support received than children and young people accessing other services. Amongst other things, they raised concerns about the lack of books, games and activities as well as the lack of private space. The provision of the new inpatient units in Wales should have addressed these concerns. However, children and young people also raised other issues, such as:

- most said that they had sometimes felt frightened in hospital;
- the majority did not feel being in hospital made them feel better, and a small number of young people had had extremely negative experiences of inpatient support;
- discharge arrangements were poor; and
- more flexibility was needed about the way in which days are structured.

'The things that have happened to me have scared me for life. When you are feeling low and you've given up on yourself and you have given up on fighting you need someone to fight for you, not against you'

Child/young person

Travel arrangements

3.20 If one inpatient unit is full, CAMHS teams are encouraged to first seek a placement in the other Welsh unit. During our case file review we came across examples of children from North Wales in the South Wales unit and vice versa. Given that the former Cedar Court was only open five days a week, a young person from South Wales resident at Cedar

Court would have been required to travel from North to South Wales and back every weekend.

3.21 If a place cannot be found in Wales, an individual is placed in an English Unit, and we found Welsh children being placed in Liverpool, Manchester, Birmingham, Bristol, London and Newcastle. This requires staff from local community teams to travel to inpatient units in Wales and England to participate in care planning for their patients. The improved inpatient provision within Wales should help reduce the need for placements into other inpatient units. However, placements will continue to be needed for very specialist support.

3.22 Children and young people who find themselves admitted to a unit some distance from home can have difficulties in maintaining contact with their families. In addition, many models of treating mental health problems in young people involve addressing these within a family context. Consequently, parents and carers are expected to participate in family therapy sessions, and their attendance is often seen as a measure of their engagement with therapy and their desire to help their child.

3.23 The previous inpatient units in Wales did not have any facilities where visiting families could stay. However, there is now a small flat for families to use at Hafod Newydd and an ensuite visitors' room at Abergele. We were also told by one NHS trust how they had been using their charitable funds to enable the parents of a pre-teenage daughter to visit her in a specialist unit in England. Nevertheless, the distances and time involved in visiting or attending therapy or care planning meetings can cause families many difficulties, such as:

- the financial costs of travel and accommodation, with financial support only available to parents on benefit (Case studies 21 and 22);
- being required to take considerable time off work, and loss of income (Case study 23); and
- caring for their other children whilst visiting inpatient units (Case study 24).

Case study 21

Annie was 15 and her schizophrenia resulted in her being detained under the Mental Health Act on a locked ward of an independent hospital in South East England. Her family wanted to visit her, and her doctors wanted them to come to participate in family therapy sessions. However, they found the cost of and time involved in travelling regularly from South Wales very difficult, and there was no financial support available. At one point, Annie's father had to sell his car due to help with travelling costs. Annie's doctors recorded their concerns in the case notes about the problems with maintaining contact with her family and the difficulties in completing the family therapy. Both were seen as having a detrimental impact on her recovery.

Case study 22

Connie is a 17 year old from North East Wales with an eating disorder. Connie received support from the local CAMHS teams, and had previously been admitted to hospital. Her physical condition deteriorated and Connie was admitted to an adult general medical ward at her local general hospital. The local CAMHS team identified that she needed another period of specialist inpatient care. The CAMHS inpatient unit in North Wales was not able to admit her, so her doctors recommended a placement in a specialist unit in England. After some discussion, HCW found her a place in the CAMHS inpatient unit in South Wales. Doctors at the South Wales unit were concerned that admitting a child from out of their catchment area would mean a local child failing to be admitted or having to be sent further afield. Connie's own doctor was also not satisfied, and wrote to HCW saying that 'on the grounds of humanity and equity it would have been much more reasonable, and equitable for other patients, for Connie to be offered an out of area placement in Stafford or Manchester'. Despite these concerns the placement in South Wales proceeded. Connie's parents were expected to make an eight-hour round trip to South Wales three times a week to participate in family therapy. Connie was in hospital in South Wales during the winter months, and on one occasion a heavy snowfall meant her parents felt it was unsafe to drive home. They asked permission to sleep in their car in the hospital's car park.

Case study 23

Danny and Sue's child was in hospital and they needed to participate in care planning and therapy sessions. Sue worked in a local authority so was able to take paid time off. However, Danny was self-employed and so lost a day's work and pay every time he had to attend the hospital.

Case study 24

Carol's daughter was in a hospital in England. She had three other young children and had great difficulty in visiting her daughter. Her CAMHS team helped her negotiate with social services and eventually Carol was able to access some childcare for her other children which allowed her to make hospital visits.

Use of adult mental health and paediatric wards

3.24 It can be appropriate for a young person with mental health problems to be admitted to an adult or paediatric ward due to maturity or co-existing physical needs. But evidence from our surveys and discussions with service providers clearly indicates that inappropriate placements are taking place. Reasons for inappropriate admissions to such wards include a lack of access to CAMHS inpatient units, especially emergency beds, and a lack of access to a CAMHS assessment, particularly out of hours. The development of emergency beds in Wales may reduce the incidence of inappropriate admissions to other wards, but there impact will need to be monitored over time.

Placements on adult mental health wards

3.25 Our survey of adult mental health services identified that the practice of placing children and young people on adult mental health wards is widespread across Wales. The youngest case reported to us was 11 years old; length of stay varied from between two days and seven months;

and the numbers admitted to an adult mental health unit can be as high as one a month. Although protocols are commonly in place for managing adult mental health wards when children and young people are admitted to them, our surveys and discussions with service providers identified a number of concerns, including:

- many adult wards being unsuitable for young people because they are mixed sex, lack privacy, lack stimulation and educational opportunities, and lack child appropriate restraining techniques;
- inadequate specialist CAMHS support and advice, with:
 - regular support and liaison not always being available; and
 - support from CAMHS staff being limited to those young people who are already on CAMHS caseloads, with young people unknown to CAMHS being supported by adult staff.
- adult mental health ward staff are not always trained in supporting young people with mental health problems, even where there are regular admittances, and it is not clear whether child protection training is at the correct level for those who work with children;
- many staff who were in post prior to the introduction of the Criminal Records Bureau (CRB) system have not been subject to enhanced CRB checks; and
- the placement of young people on adult mental health wards reduces bed availability and services for adults.

Placements on paediatric wards

3.26 Our surveys suggested that more young people are being admitted onto paediatric wards solely due to mental health problems than to adult mental health wards. Some NHS trusts estimate that as many as 50 or 60 children and young people per year are admitted, and that up to 20 children and young people a year cannot be discharged solely because of their mental health problem.

3.27 Paediatric wards can be unsuitable for accommodating children and young people with mental health problems, and our surveys and discussions with service providers identified that:

- staff on paediatric wards can lack specialist training in common mental health problems, such as eating disorders and self-harm, and in managing challenging behaviour, including practice in restraining children;
- most inpatient paediatric services report inadequate support and liaison from specialist CAMHS staff, and two of the six inpatient paediatric services responding to our survey stated that they do not have formal arrangements with specialist CAMHS staff to provide support and advice to their ward staff;
- some inpatient paediatric services are concerned about whether staffing levels allow competent observation, and some wards report that there are problems in finding bank or agency nurses with the appropriate skills and experience;
- there can be a lack of active therapeutic support or treatment during the person's stay on the paediatric ward; and
- paediatric ward environments may not be appropriate with, for example, ward areas not minimising the risk to children at risk of self-harm.

'The boy was extremely traumatised by his experience of being on an adult psychiatric ward – he remains terrified of returning'

Parent/carer

3.28 There are also implications for other children and young people admitted to paediatric wards, who do not have a mental health problem. These include the disruption and distress that can be caused to other children, some of whom can be very young.

Children and young people placed out of their local authority area

3.29 Children with mental health problems can be placed out of their local authority area by HCW and LHBs for specialist inpatient care or a local authority because there is a lack of suitable accommodation or specialist foster carers. Our surveys and discussions with a range of professional staff identified a number of risks associated with children who are placed out of their home area, including:

- a child's local Educational Welfare Service may not always take steps to support continuing access to education when a child is an inpatient out of area – one service stated that 'this is not our role';
- children being placed without the receiving local authorities being informed, and arriving with no health, social services or court records;
- a lack of specialist CAMHS team involvement when social services need to identify suitable placements for young people known to CAMHS;
- local authorities not being aware of independent foster carers in their area who are employed by an agency registered and based in England;
- finding appropriate placements, particularly for younger patients, can be difficult as many units will only take those aged 13 or above; and
- a lack of support available in England to children whose first language is Welsh.

3.30 At the time of our fieldwork we identified a number of concerns about the way HCW was making out-of-area placements. There appeared to be a lack of clinical input to decisions on placements, and there was a

widespread perception that decisions were based solely on financial criteria (Case studies 25 and 26). Health Commission Wales told us that decision-making arrangements have now changed. A nurse with a mental health qualification has replaced the Director of Finance as chair of the panel responsible for making decisions on out of area placements.

Case study 25

Bethan has bipolar disorder, and at 13 was admitted to an independent hospital, funded by HCW, as no bed was available in the local Welsh inpatient unit. Health Commission Wales were keen to transfer her to the local unit as soon as possible, despite clinical advice that transfer would be very destabilising and possibly detrimental to her condition. Health Commission Wales informed the independent hospital that funding was to cease with immediate effect and Bethan was moved to the local inpatient unit the following day.

Case study 26

Aziz, from North Wales, was 17 when he was admitted to an adult mental health unit following a psychotic episode. He also had a history of substance misuse. He was nursed on a one-to-one basis in accordance with child protection procedures. As the local CAMHS inpatient unit was not able to admit such high-risk patients at that time, CAMHS sought a placement in an adolescent unit in England funded by HCW. However, HCW were keen to admit Aziz to the other CAMHS inpatient unit in South Wales, but his clinicians felt this would be detrimental to his condition. Health Commission Wales initially agreed to fund an independent sector placement for one week, but the provider required a minimum contract of four weeks. Health Commission Wales agreed to this, with a number of conditions, including that Aziz comply fully with his treatment plan. His home clinical team were very concerned by this stipulation, as this would be impossible to guarantee given the nature of Aziz's illness.

In conclusion

3.31 There are important weaknesses with specialist inpatient and residential services. Our conclusions on the availability of services are that:

- the new inpatient units in North and South Wales should improve the availability of services;
- the total number of inpatient beds routinely in use has increased in North Wales but has fallen in the south;
- new emergency inpatient beds are now available in Wales although the number of emergency beds is lower than planned; and
- the two inpatient units provide very different types of interventions and support, and neither unit has a comprehensive range of services.

3.31 Our conclusions on the nature and quality of inpatient services are that:

- the environment of the inpatient unit in South Wales has been improved, although its location, is still not ideal;
- some children, young people and their parents are not satisfied with the standard of inpatient services and facilities that they received in the past, and more support is needed to help overcome the problems associated with significant travelling distances;
- significant numbers of children and young people are being placed or kept inappropriately on paediatric or adult mental health wards, raising concerns over the effectiveness and safety of the care provided in these environments; and
- care for children and young people who are placed out of their local authority area can be poorly co-ordinated, and clinical input to decisions on health placements has been lacking.

Barriers to improvement

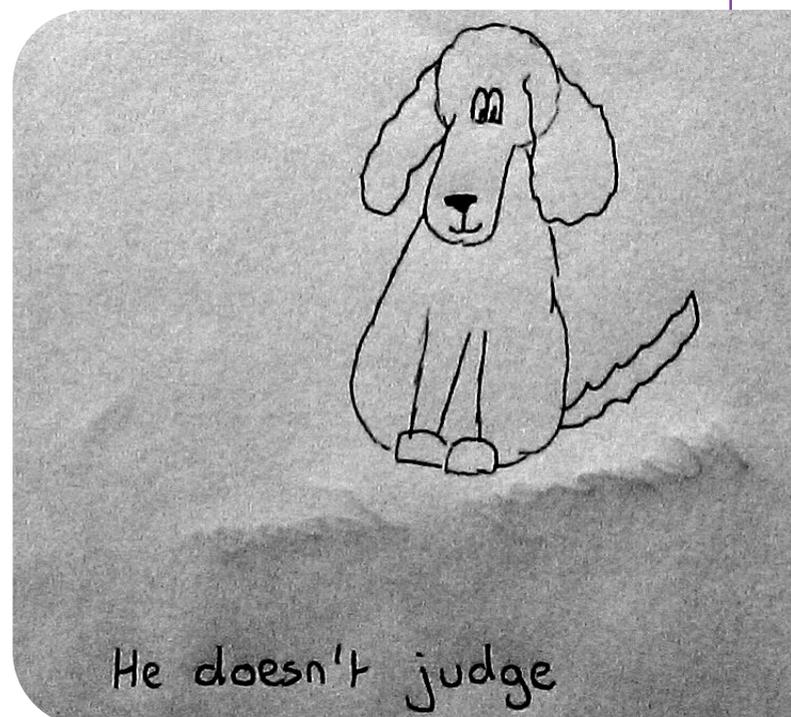
There are barriers to improvement that need to be overcome

It is unclear how policy should be implemented

There are fundamental weaknesses with the approach to service development

There are important challenges in developing an appropriate workforce for delivering CAMHS

Although there is emerging evidence that performance management arrangements within the NHS are becoming more robust, further development is needed



Part 4 – Implementing policy

Policy guidance

- 4.1** CAMHS policy is based around a four-tier strategic concept. The Assembly Government has, over the years, issued reformulations and clarifications of the four-tier concept. The most recent description of the tiers was issued in 2008 (Figure 2). The tiered framework is primarily intended to be a strategic and planning tool. However, a number of stakeholders told us that the tier system was difficult to understand and that there is a lack of clarity about the responsibilities of different professionals in each tier. The Assembly Government issued its 2008 guidance on the four tiers only to NHS bodies and not to other commissioners and service providers. This may have compounded the lack of clarity amongst stakeholders.

'The tier system employed by CAMHS is difficult to understand. Explaining the various levels of service in terms of Tiers 1 to 4 is convenient, from a theoretical point of view. However, it is difficult to get a picture on a local level of what is available in each of the tiers in terms of service, and for professionals to understand what the tiers mean'

Service professional

- 4.2** The four-tier concept is based on service structures, rather than on the range of needs of children and young people. Our discussions with service professionals and survey responses indicate that the tier system does not provide a clear and commonly understood 'language' between professionals. We came across many examples of professional staff focusing on what the tiers mean, rather than on how to meet the needs of children and young people.

Figure 2 – The four tier strategic concept for CAMHS

Tier 1	Children and adolescent mental health services is provided by professionals whose main role and training is not in mental health, such as GPs, health visitors, paediatricians, social workers, teachers, youth workers and juvenile justice workers.
Tier 2	Tier 2 CAMHS is provided by specialist trained mental health professionals, working primarily on their own, rather than in a team. They see young people with a variety of mental health problems that have not responded to Tier 1 interventions. They usually provide consultation and training to Tier 1 professionals. They may provide specialist mental health input to multiagency teams, for example for children looked after by the local authority. Tier 2 also consists of those practitioners and services from specialist CAMHS that provide initial contacts and assessments of children and young people and their families.
Tier 3	Tier 3 is reserved for those more specialised services provided by Multidisciplinary Teams (MDTs) or by teams assembled for a specific purpose on the basis of the complexity and severity of children’s and young people’s needs or the particular combinations of co-morbidity found on specialist assessment.
Tier 4	Tier 4 services are very specialised services in residential, day patient or outpatient settings for children and adolescents with severe and/or complex problems requiring a combination or intensity of interventions that cannot be provided by Tier 3 CAMHS. Tier 4 services are usually commissioned on a sub-regional, regional or supra-regional basis. They also include day care and residential facilities provided by sectors other than the NHS such as residential schools, and very specialised residential social care settings including specialised therapeutic foster care.

Source: Annual Operating Framework 2008-09

4.3 *Everybody’s Business* provides the strategic policy context for CAMHS, and the high-level principles contained in the strategy are widely accepted. The NSF for Children, Young People and Maternity Services in Wales includes 22 key actions relating to CAMHS. Children and adolescent mental health services targets have also been set for the NHS as part of the former Service and Financial Framework and its replacement, the Annual Operating Framework. However, there are key areas in which there is a lack of clarity about how policy should be implemented.

Implementing the commitments from *Everybody’s Business*

4.4 *Everybody’s Business* identified a long and detailed list of issues that required the Assembly Government to provide more detailed policy guidance, including guidance on:

- the role of different sectors and professions in delivering CAMHS;
- developing information sharing protocols;
- workforce development across local government and the NHS; and
- the level of investment needed to deliver the strategy.

4.5 However, since publication of *Everybody’s Business* in 2001, only very limited progress has been made in providing detailed policy guidance in many key areas (Figure 3).

4.6 The Assembly Government formed a multidisciplinary implementation advisory group to provide it with advice on the implementation of *Everybody’s Business*. Although some progress was made, the subsequent development of the CAMHS section of the children, young people and maternity services NSF became the priority for members of the advisory group.

Figure 3 – Delivery against policy guidance commitments

Commitment for more detailed advice and guidance, as set out in <i>Everybody's Business</i>	Progress to 2008
The composition of local specialist CAMHS in providing a minimum level of service.	No detailed policy guidance, although national targets include some waiting times.
Monitoring and advising on development of information sharing protocols between organisations.	Little evidence of monitoring and no additional guidance issued.
Advice and guidance on the role of different sectors and professions in delivering CAMHS.	Some further clarification on service tiers, but detailed guidance on each profession has not been issued and some service providers still unclear about roles.
Taking a lead role in resolving issues with the transition from CAMHS to adult mental health services.	Policy clarified on age of transition but no target date set for moving to 18 as the point of transition. Reviews undertaken into wider issues around transition such as differences in service culture and provision. However, no additional guidance has been issued.
Advice and guidance on emergency and out-of-hours services.	Targets have covered response times for emergency assessments. National Action Plan to reduce suicide and self-harm developed. However, no general policy on emergency and crisis services has been developed as originally intended.
Providing a mechanism to share learning, in particular disseminating the results of research and pilot projects across the country.	No formal mechanism has been put in place.
Assessing needs and providing guidance on workforce development across local government and the NHS.	A number of specific areas relating to training and workforce planning were identified for further advice and guidance. There have been some initiatives such as creation of consultant nurses and expansion of primary mental health workers. But no comprehensive advice, guidance or workforce plan has been developed.
Developing a common language across sectors.	No substantive action has been taken to develop a common language, and this remains a key barrier to joint working.
Reviewing investment and assessing the precise level of investment needed to deliver the strategy.	This has not been established.

Source: Documentation review, fieldwork and discussions with Assembly officials

- 4.7** The Assembly Government now regards the NSF as the mechanism for driving the implementation of CAMHS policy. However, the NSF does not provide any greater clarity on policy implementation in many of the areas covered by *Everybody's Business*. In addition, in places the NSF shifts responsibility for providing clarity on policy implementation from an all Wales to a local level. For example, *Everybody's Business* recommended that a broad range of professionals should have a role to play in providing CAMHS, but it did not specify the detail of what, for example, should be expected from a school teacher or a social worker. However, the NSF allocates responsibility for clarifying roles to individual children and young people's partnerships, the LHBs and local authorities. This puts at risk the consistent implementation of policy across Wales.
- 4.8** Following publication of the NSF in September 2005, a NSF implementation advisory group took over responsibility for CAMHS, alongside the other service areas covered by the framework, and the implementation advisory group for *Everybody's Business* stood down. The NSF implementation advisory group is responsible for monitoring performance against targets that cover the full range of services for children and young people, including maternity services, acute and chronic illness, disabled children, those in special circumstances, and CAMHS. With this broad remit, the group is not well placed to provide advice on the development of policy implementation guidance for CAMHS in line with the original commitments set out in *Everybody's Business*.
- 4.9** National level priorities for action and the associated timescales for delivery are unclear. *Everybody's Business* contained a broad range of high-level priorities but these were not developed into specific priorities with deadlines for achievement. The NSF contains five 'core key actions' for CAMHS, which were to be delivered by the end of March 2006. However, the remaining 17 key actions for

CAMHS are to be agreed and delivered locally by the end of the 10-year lifespan of the framework. For NHS bodies, national targets under the Annual Operating Framework also provide a focus for activity. However, a more explicit statement of national priorities and associated timescales over a three or five-year period is required, to provide a more robust basis for local service development across all relevant agencies.

- 4.10** We also identified some additional service areas where more detailed policy guidance would be beneficial. These included the role of different agencies and services in supporting children and young people with conduct disorders and challenging behaviours; and NHS continuing care funding for children.
- 4.11** In contrast to CAMHS, in recent years the Assembly Government has issued explicit guidance on adult mental health services in primary healthcare settings, and on the development of crisis resolution and home treatment services. In addition to supporting implementation, the guidance provides a solid foundation against which to review progress.

Routine support and guidance to local commissioners and providers

- 4.12** Where the Assembly Government had issued guidance, service commissioners and providers considered that:
- the guidance reflected a medical/psychiatric focus;
 - some communications, such as on what should be covered by costed plans and around bidding requirements for additional funding, are unclear and inconsistent; and
 - there were difficulties in getting Assembly Government staff and advisors to attend local meetings and respond to queries.
- 4.13** Given the breadth of services that are covered, providing advice, guidance and leadership across CAMHS is a particular challenge. The Assembly Government has a CAMHS adviser who has a health background, but there is no equivalent advisory input or leadership from social care, education or the voluntary sector.

Clarifying the roles of different service providers

4.14 A common issue for all groups of staff who work with and support children and young people is that the respective roles of different professionals and agencies in supporting children and young people with mental health problems is often unclear. For example:

- we found little evidence that the role of GPs in CAMHS had been agreed locally between the LHBs, GPs and other agencies;
- over half of the social service departments responding to our survey have not agreed their role with other agencies;
- around half of health visiting and school nursing services stated that they have agreed their role with specialist CAMHS, but only a few have agreed their role with other partners such as education or social services;
- there was little evidence that the role of community paediatrics had been discussed on a multiagency basis, although some paediatric services do have good relationships with their local CAMHS team; and
- few education welfare services have agreed their role with specialist CAMHS and, whilst most education welfare services report having guidelines for referral that have been distributed to all schools, these are not always issued to specialist CAMHS, social services or educational psychologists.

4.15 Despite the complementary nature of educational psychology services and specialist CAMHS, we found that co-ordination between the two services was often weak:

- in the majority of local authority areas (14 of the 20 that responded to our survey) the educational psychology service and specialist CAMHS have not jointly clarified which children and young people should be supported by educational psychologists, by specialist CAMHS teams, or on a joint or shared care basis;

- around half of local authorities that have guidelines for referral to the educational psychology service (these were in place in 18 of 20 services that responded to our survey) have not shared the guidelines with specialist CAMHS teams or social services; and
- only 11 of 20 educational psychology services stated they had been provided with written guidelines from specialist CAMHS on who should be referred to specialist CAMHS.

Planning and commissioning services

4.16 The planning and commissioning arrangements for CAMHS are complex, inconsistent and lack transparency. The NHS reorganisation will provide both opportunities and new risks in addressing these shortfalls. Developing more effective planning processes, in what is a complex service area, will be a challenge. In particular, the new NHS organisations each cover up to six local authority areas, and establishing planning and joint working arrangements that support a partnership approach will need careful consideration.

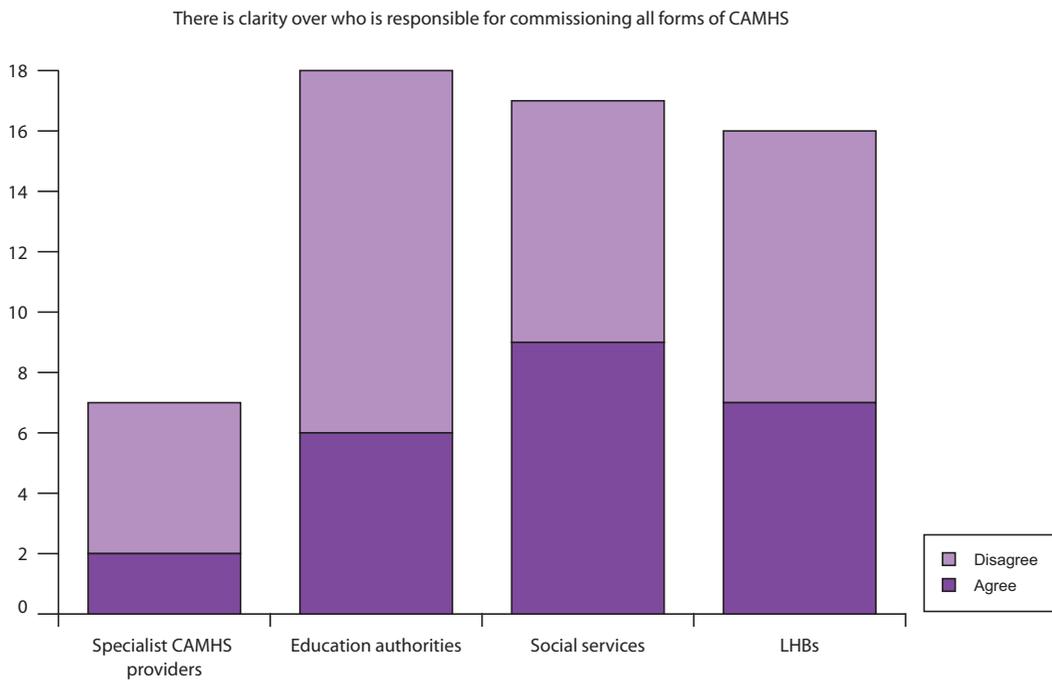
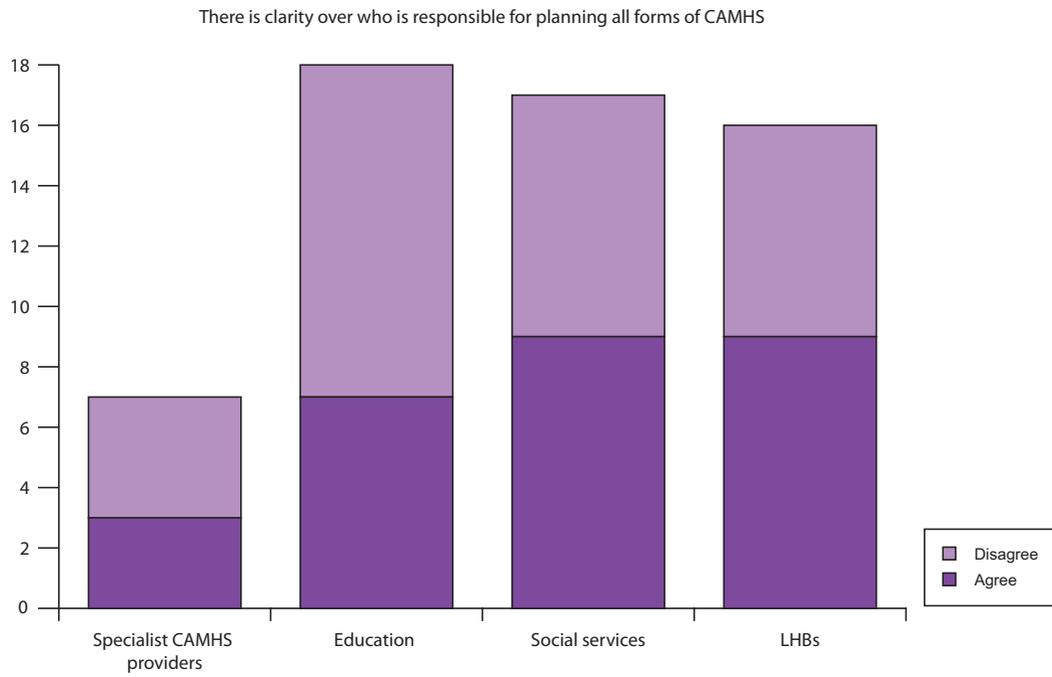
‘Commissioning responsibilities of LHBs and HCW are blurred and problematic’

Service professional

4.17 Around half of the agencies we surveyed reported that greater clarity is needed over who is responsible for planning and commissioning all forms of CAMHS (Figure 4). At the time of the survey the first children and young people’s plans were being produced. This may have contributed to the uncertainty about responsibilities, but we have identified a number of other contributory factors, including:

- the complexity of arrangements; and
- unclear roles and responsibilities.

Figure 4 – Agencies’ views on clarity of planning and commissioning responsibilities



Source: Wales Audit Office/HIW surveys 2008

4.18 Complex and unclear planning and commissioning arrangements make it more difficult to develop comprehensive multiagency plans covering all aspects of CAMHS, and for these to be supported by clear commissioning commitments. There are also risks that service development is disjointed and responsibility is not taken for addressing service gaps and deficiencies.

Complexity of arrangements

4.19 There have been a range of organisations and groups involved in planning and commissioning the different elements of CAMHS (Figure 5) and the relationships and links between them are complex. In 2003 the Assembly Government required the LHBs to come together to create three CCNs. The primary responsibility of each network was to provide commissioning advice to LHBs for the NHS-funded element of specialist CAMHS, with the exception of some Tier 3 services and all Tier 4 services, which are commissioned by HCW.

Figure 5 – Planning and commissioning responsibilities

Organisation	Main responsibilities
Children and young people's partnerships	Commissioning some Tier 1 services through control of funding streams, such as Cymorth. Providing a strategic oversight for Tiers 1 to 3 of CAMHS, through the Children and Young People's Plan. Monitoring implementation of the NSF across all agencies.
CAMHS commissioning networks (CCNs)	In conjunction with the LHBs, commissioning NHS services covering Tier 2 and part of Tier 3. Co-ordination of bids for additional funding made available by Assembly Government covering Tiers 2 and 3.
Former LHBs	Commissioning NHS Tier 1 services. In conjunction with CCNs, commissioning NHS elements of Tier 2 and part of Tier 3. Development of health, social care and well-being strategies, jointly with the local authority.
Local authorities	Commissioning of social care and education elements of CAMHS covering Tiers 1 to 4. Planning of children's services, primarily through children and young people's partnerships. Development of health, social care and well-being strategies, jointly with the LHBs.
HCW	Planning and commissioning part of NHS elements of Tier 3 and all of Tier 4.
NHS trusts	Involved in planning specialist services with other partners, networks and groups, and for planning children's services such as school nursing and paediatrics.

4.20 The different geographical areas covered by planning and commissioning bodies further complicated arrangements, making co-ordination between local, regional and national bodies difficult. In particular:

- NHS providers covered different geographical areas to some planning and commissioning groups;
- some NHS trusts covered more than one regional CAMHS commissioning network;
- in some areas, different services such as school nursing and specialist CAMHS, could be provided by different NHS trusts;
- some LHBs have developed collaborative commissioning with neighbouring LHBs, creating another geographic basis for planning and commissioning; and
- the three NHS regions and the four local authorities regional boards have different boundaries.

4.21 To illustrate the complex arrangements, Cardiff County Council needed to co-ordinate with the Cardiff LHB, two NHS trusts (one for specialist CAMHS and one for other services), the Children and Young People's Partnership, the CAMHS Commissioning Network and HCW. The Gwent NHS Trust needed to co-ordinate with five LHBs, five local authorities, five children and young people's partnerships, the Regional CAMHS Commissioning network, and HCW.

4.22 Our surveys and discussions with service commissioners and providers have identified that the links between the different planning groups and the people engaged by each group are inconsistent across Wales and add to the overall complexity of the arrangements. In particular:

- There is weak co-ordination and joint working between HCW and the various planning groups across Wales. Capacity at HCW is clearly an issue, but better joint working between local and regional planning structures and HCW is required.
- The involvement of specialist CAMHS in the development of children and young people's plans has varied across Wales.

One Specialist CAMHS provider reported that it had not yet been involved in the development of plans. Another reported being invited at short notice to a single meeting on the Children and Young People's Plan. In other areas, specialist CAMHS providers reported far better engagement.

- The engagement of local authorities in CCNs is variable, with social services more involved than education in some areas. However, the usefulness of local government engagement was questioned by some social care and education professionals, given that the focus of commissioning networks is on NHS provision of specialist CAMHS.
- Links between children and young people's partnerships and regional CAMHS commissioning groups are not always effective, and getting them to work in a joined up way is seen by some agencies as a significant challenge.

Roles and responsibilities for planning and commissioning

4.23 There are a number of issues with the way the three CCNs have developed and operate:

- at the time of our fieldwork visits commissioning networks were at different stages of development using different models, from multiagency to commissioner-led;
- they vary in the extent to which they focus on NHS specialist CAMHS or CAMHS from all service providers;
- there is little evidence of joint working or co-ordination with HCW;
- communication links between all three networks and Assembly Government policy leads could be more robust;
- the commissioning networks do not have a sound financial footing – usually they operate on annual non-recurrent funding, unlike other clinical and commissioning networks; and

- staffing arrangements in the commissioning networks vary, with two network managers being full time and another having a split role, and they have different levels of support.

‘Planning and commissioning can be undertaken through three bodies, the local Children and Young People’s Partnership, a regional commissioning body and nationally by Health Commission Wales, and there is little evidence of a ‘joined up’ approach’

Service professional

4.24 Some commissioners and providers told us that the role of the commissioning networks in relation to the main commissioning bodies – the LHBs and HCW – needed clarification as it was unclear who had lead responsibility. The LHBs and HCW controlled the main budgets, but commissioning networks managed bids for the additional funding from the Assembly Government.

4.25 Our surveys and discussions with a range of professional staff indicate that commissioning networks are seen by many as stimulating change and providing good support to NHS service providers and commissioners. Most LHBs responding to our survey (12 of 16) stated that improvements to services have resulted from the work of the networks. However, the examples given by these LHBs often related to training provision (funded from Assembly Government money channelled through the commissioning networks), or reflected optimism that the work programmes that have been developed or agreed will deliver improvements in the future. Many survey responses referred to it being ‘early days’ for the commissioning

networks. The Assembly Government told us that the commissioning networks are beginning to play an important part in helping delivery against the Annual Operating Framework targets.

4.26 There was also a lack of clarity over the division of commissioning responsibilities between HCW and the LHBs for some services, such as community intensive therapy and treatment services and day services. Some NHS trusts provide these services from LHB funding, although they are formally part of HCW responsibilities.

4.27 This lack of clarity has led to some disagreements between the LHBs and HCW over individual packages of care. We found cases where LHBs have directly funded placements in inpatient CAMHS units in England, which is a HCW responsibility. Although the reasons for LHBs funding these placements were unclear, LHBs informed us of other instances where this has occurred. For example, in one case there was a dispute between HCW and the LHB as to whether a young person was ready for discharge to local services, with the LHB continuing funding once HCW pulled out.

4.28 Some children and young people require complex packages of care to meet their health, social care and educational needs. There are frameworks in place which allow for bi or tripartite agreements between agencies to arrange and finance individual placements. Whilst these are reported to work well in some areas, we identified a number of issues that are undermining the effective provision of complex packages of care, including:

- the lack of involvement of all relevant agencies in funding panels;
- a reluctance to accept responsibility for funding a young person; and
- disagreement over the appropriate diagnosis or treatment regime between CAMHS services in the child’s home area and the area of placement.

4.29 The NSF details the organisations responsible for each key action but, where more than one organisation is involved, it is often unclear which should have lead responsibility. Similarly, local plans, such as children and young people plans, do not always identify lead responsibility for achieving outcomes and targets. Whilst all agencies have a part to play in implementing CAMHS, and effective partnership working is important, progress in implementing actions may be at risk where lead responsibility has not been clearly allocated.

CAMHS coverage in key local strategies and plans

4.30 Only 8 of 16 LHBs, one of seven Specialist CAMHS providers, and 5 of 17 social service departments responding to our surveys stated that there is a clear vision for CAMHS that is shared across partners.

Children and young people's partnerships and plans

4.31 Children and young people's plans are intended to be the defining statement of the strategic planning aims and priorities for all children and young people's services within an area, and should act as the reference point for all other plans. The plans cover a three-year period from 2008-2011. The plans appear to have senior level buy-in, and are giving a structure and focus to partnership working and planning for children's services.

4.32 Guidance on the development of children and young people's plans highlighted the need to cover CAMHS, and some stakeholders told us that the development of the plans has provided an opportunity to get CAMHS onto the agenda more easily than in the past. However, in some areas health professionals considered that the membership and leadership of children and young people's partnerships have not ensured a sufficiently high profile for health issues and, in particular, mental health issues for children and young people. Our analysis of a sample of seven plans shows that:

- there is variable coverage of CAMHS;
- only some plans contain detailed actions, including those relating to CAMHS;
- coverage of both NHS and local authority Tier 4 services is generally weak, and coverage of the other tiers is variable, with some focusing only on Tiers 1 and 2;
- plans do not cover or refer to performance against NSF targets;
- plans are required to identify local outcome measures and targets and these can be poorly developed for CAMHS; and
- when outcome measures and targets for CAMHS are set, these can focus on the local authority contributions rather than that of all partners.

'Anything that has been a priority for 10 years is not a priority'

Service professional

4.33 In addition, some interviews undertaken as part of our fieldwork indicated that ensuring that children and young people plans feed down to operational staff may be an issue in some areas, with GPs in particular not feeling engaged in developing the plan. Also, some partnerships have struggled more than others in developing the plan, in particular in undertaking needs assessments and in mapping existing services.

Health, social care and well-being strategies

4.34 Health, social care and well-being strategies provide a suitable vehicle for establishing a clear strategic direction for CAMHS, but the extent of CAMHS coverage in the strategies varies widely and is often limited to high-level aims. Analysis of the 22 strategies in force up to 2008 showed that:

- CAMHS was highlighted as a priority or key action area in 15 strategies;
- CAMHS had no mention at all in five strategies; and

- CAMHS did not feature prominently in the needs assessments that underpinned the strategies.

4.35 During the course of our review revised strategies were being produced covering the period 2008 to 2011. An analysis of a sample of these indicates that:

- most now refer specifically to CAMHS services, usually in the context of improving access to CAMHS or reviewing services;
- coverage of CAMHS is still mostly limited to high-level aims with few specific targets;
- around half specifically mention promotion of positive mental health and well-being; and
- half mentioned working on transition arrangements between CAMHS and adult mental health services.

Joint local plans for CAMHS

4.36 Children and young people's plans and health, social care and well-being strategies cover a broad range of services, including CAMHS. The extent to which these strategic documents are supported by more detailed and comprehensive joint planning for CAMHS varies widely. Our surveys and discussions with service commissioners and providers identified that:

- although most LHBs and social services stated that gaps in provision have been mapped, this was not always undertaken on a joint basis or across all service areas and providers;
- only 5 of 16 LHBs stated that there was a clear local vision and plan for CAMHS that covered and had been agreed by all partners – in some areas single agency plans have been developed, and in others plans have been developed but not agreed by key partners such as the NHS trust; and
- progress in developing care pathways through community, intensive and inpatient services across all agencies and for specific conditions has been slow.

4.37 There are some local plans, such as local delivery plans in the NHS that cover a broad range of services, including CAMHS. However, these plans are short term in nature, and do not provide a clear and comprehensive multiagency plan for CAMHS.

In conclusion

4.38 It is unclear how policy should be implemented, as:

- the Assembly Government's commitments to develop more detailed guidance to support the implementation of *Everybody's Business* have not been met in a number of key areas;
- there is limited routine support and guidance to local commissioners and providers, and service development priorities over the medium term are unclear;
- planning and commissioning arrangements are complex and unclear;
- CAMHS is not covered adequately in key local strategies or reflected as a priority by all relevant agencies; and
- there has been limited progress in developing comprehensive local plans for CAMHS that cover all service providers.

Part 5 – Weaknesses with the approach to service development

Taking account of the views of children and young people

- 5.1** Our consultation with children and young people and their parents suggested that there is a lack of a child-centred approach to service planning and development. We found some positive examples of statutory services gathering the views of children and young people, often involving the voluntary sector undertaking consultation on behalf of the NHS trusts and LHBs, or local authorities. However, in many areas we found little evidence that the views of children, young people and their parents are influencing change.
- 5.2** Only just over half of all LHBs responding to our survey could provide examples of how the views of children and young people with mental health problems or their parents have informed the planning and commissioning of CAMHS. Some of these could only provide one-off examples relating to specific service elements, such as training to address negative attitudes towards self-harm of staff working in A&E. Other LHBs provided examples of what children said they wanted changed, but gave no indication of how these views had been taken into account in delivering services. However, a few LHBs did refer to consultation exercises that informed the development of strategies and plans.
- 5.3** Five of the seven specialist CAMHS providers stated that services have been changed as a result of the views of children and their parents. In some, changes were limited to staff training or advising staff to work less formally and engage more with young people. However, others reported that local CAMHS plans had reflected the consultation with young people, and specific services such as ADHD have changed in response to the views of those using the service.
- 5.4** We found only limited evidence that services provided by local authorities were being shaped by the views of children, young people and their parents. Just 3 of 18 education departments and 6 of 17 social service departments were able to provide examples of how CAMHS have been changed in response to the views of children and their parents.

Joint working between the health, local authority and voluntary sectors

Joint working between statutory agencies

- 5.5** The effectiveness of joint working at a strategic and operational level varies widely across Wales, resulting in some children and young people receiving services that are poorly co-ordinated.
- 5.6** At a strategic level most of the LHBs (14 of 16) told us they had seen local improvements to services as a result of joint planning with CAMHS partners. Although many provided specific examples of such service improvements, some could not, and others pointed towards the development of primary mental health workers which is a centrally driven initiative. The impact of joint planning perceived by social services is not as significant. Social services in just 9 of 17 areas report that joint planning has resulted in local improvements to services. Improvements reported include new and expanded service provision.
- 5.7** At an operational level the effectiveness of joint working between services is often very dependent on relationships between key individuals. As a result, the effectiveness of joint working can be affected by changes in personnel. Other examples of difficulties in effective joint working that we found included:
- taking a number of years for a service level agreement between CAMHS and the social services department to be signed off;
 - in another area, we found evidence of a lack of communication and consultation with all partners around changes to key processes, such as referral;
 - we found few formal joint funding agreements or other arrangements; and
 - in some areas specialist CAMHS are not engaging routinely in partnership and multiagency working.

- 5.8** The NSF has a key action relating to co-ordination and joint working between partners. Self-assessments of progress against the NSF for 2008-09 identifies this key action as one of the weakest areas of performance. Furthermore, self-assessments indicate that there has been little progress with this key action over the last three years.

Partnership working between statutory agencies and the voluntary sector

'Despite working with some of the most vulnerable groups of families, children and young people, offering a variety of levels of practical, emotional and psychological support that would complement and increase the effectiveness of more specialised CAMHS input, we have no partnership working arrangements with CAMHS and no mutually developed pathways of referral between our services and statutory CAMHS in Wales'

Voluntary sector professional

- 5.9** The voluntary sector in Wales is a significant provider of services to children, young people and their parents, including:
- services to promote emotional health and well-being;
 - services focused on specific groups of young people who have a higher risk of developing emotional problems, such as young carers, those who have suffered physical or sexual abuse, or victims of bullying;

- services to address specific problems, such as bereavement counselling; and
- specialised services working with young people who have a mental health problem.

5.10 Many voluntary sector service providers told us that families often consider their services to be less stigmatising than those provided by the statutory sector. They believe that it is easier to explain or accept going to a 'project' based in a house or community centre, as opposed to visiting a clinic or hospital-based service that often includes 'mental health' in its service name.

5.11 Some services provided by the voluntary sector are funded by statutory agencies, but voluntary sector agencies also fund services from their own resources. However, funding for voluntary sector initiatives is often short term, and many voluntary sector organisations stated that services were at risk due to unsecure funding.

5.12 Our discussions with voluntary sector organisations identified that, despite directly funding and providing significant services, they are often excluded from strategic planning processes. We found that:

- children and young people's plans only briefly cover voluntary sector services – this can be no more than an acknowledgement that the voluntary sector provides services;
- voluntary sector providers had little input to the development of children and young people plans and are rarely represented on local planning groups or commissioning networks; and
- many voluntary sector organisations were not aware of whether local plans and strategies had been developed and, if developed, where they could be accessed.

5.13 At an operational level we have evidence of some effective co-ordination and joint working between statutory and voluntary sector providers. This is particularly the case where individual staff work for both statutory and voluntary organisations, and where

secondments are in place. Where close co-operation at an operational level is in place, both the statutory and voluntary sector providers report considerable benefits as a result. These include more appropriate use of one another's services and better support for children and young people. However, our fieldwork showed that close operational links are frequently not in place, with specialist CAMHS often working in isolation from the voluntary sector.

Funding arrangements

5.14 The Assembly Government has provided additional funding for CAMHS in recent years. An additional £1.2 million of recurrent funding was provided from 2004-05, a total of £2.5 million of non-recurrent funds was provided between 2005-06 and 2007-08, and £6.9 million of recurring funding has been allocated between 2008-09 and 2010-11. In addition, service developments in related areas, such as school counselling, have been supported by funding from other sources, and access to funding streams such as Cymorth has further supported service development. At a local level, some of the LHBs and NHS trusts reported making significant investment in CAMHS.

Costing key service gaps and inequalities

5.15 Many, if not all, of the key service gaps and inequalities identified in this report are widely acknowledged by those involved in planning, commissioning and providing services. However, the funding required to address key gaps and inequalities has not been fully established.

5.16 Each of the LHBs produced costed plans for CAMHS in 2005-06. We have not reviewed these plans, but the Assembly Government told us that they were extremely variable, with some based around the costs of meeting specific targets and others around the total cost of developing a comprehensive set of services.

5.17 It would be a complex task to identify the total costs of implementing in full *Everybody's Business*, and to do so would require clearer guidance from the Assembly Government on the type of services needed. However, a more robust and consistent approach to identifying, prioritising and costing service developments is required, to assess what is needed and what is affordable, and to inform future financial planning at both a local and national level.

Non-recurrent funding

'Whilst funding is always welcomed, the short-term annual funding has had minimal or no impact on addressing the underlying issues; in fact I would stress that these short term funding opportunities have hindered any real development work on the ground'

Service professional

5.18 Because non-recurrent funding is often made available at fairly short notice, bids for such funds are often rushed. In addition, the nature of the funding does not support long-term sustainable services. Non-recurrent funding was used to help develop the CCNs, which, once established, collated and managed bids for other non-recurrent funds on behalf of the organisations within their areas. Some LHBs, NHS trusts and commissioning networks, either responding to our surveys or during discussions, reported a number of issues with non-recurrent funding and the way it was allocated, indicating that better use could have been made of the additional monies. Commissioning networks and local NHS organisations were particularly critical of the bidding process, and referred to:

- a lack of detailed guidance on what funds were to be used for;
- the short timescales in which bids had to be submitted, or in which funds had to be spent;

- the considerable time and effort taken up by the bidding process, which diverts attention from other priorities; and
- the failure to allocate all available non-recurrent funding.

5.19 The LHBs and NHS trusts have mixed views on the impact of the non-recurrent funding. Some welcome the funds which, together with other central and local investments, they believe has helped develop services. However, others did not believe that the funds have helped secure long-term improvements in services. The main reasons for this are that:

- it is difficult to use non-recurrent funds to appoint additional staff, which is seen by the LHBs and trusts as the main challenge facing services; and
- the release of funds on an annual basis impedes effective planning over a longer period.

Maintaining funding levels

5.20 Some agencies are concerned about being able to maintain the current level of funding for CAMHS. In our survey of LHBs, we asked for comments on the sustainability of CAMHS funding, and the temporary nature of some funding was a common issue. There is also concern about those funding streams, such as Cymorth, that are to be transferred to local authority control and become part of the Revenue Support Grant. Many practitioners consider that the continued funding of CAMHS initiatives from these funding streams is at risk.

5.21 Children and Adolescent Mental Health Services providers across Wales also expressed concern that current services are at risk because of uncertainty about future funding levels. Areas at risk included:

- social services posts in some specialist CAMHS teams that are at risk due to financial pressure on social services budgets (one area already reports that funding has been withdrawn);
- some CAMHS team staff, primary mental health workers and CAMHS nurses in a youth offending team;

- some specific initiatives, such as a bereavement project; and
- one NHS trust being unable to recruit four primary mental health workers as the posts only have temporary funding.

The management and control of specialist services, such as forensic mental health and inpatient services

5.22 The Assembly Government made additional recurrent funding available to HCW for the development of emergency beds and a forensic adolescent consultation service within Wales. However, there were considerable delays in establishing these services, and they were not developed as originally intended.

5.23 These delays and changes reflect a variety of issues. These include differences between HCW and the NHS trust that formerly provided the inpatient unit in South Wales over the costs to be transferred to the new provider trust; differences of opinion between HCW and service providers over the focus of the service and the level of the funding required; the limited availability of funding by HCW; and recruitment problems, particularly at the new inpatient units. In the meantime, much of the additional funding made available by the Assembly Government was used to purchase services from outside Wales.

5.24 Health Commission Wales did not resolve these issues in a timely way. Nor did the Assembly Government take appropriate direct action to ensure the funds it made available were used effectively.

5.25 We also identified a number of broader issues with the planning and management of inpatient services by the Assembly Government and HCW. *Everybody's Business* clearly states that there is a need for the Assembly Government to adopt a central role in planning for improved inpatient service provision in Wales. Health Commission Wales has the responsibility for commissioning inpatient services.

5.26 *Everybody's Business* did not provide a detailed service model for inpatient services. As part of the consultation on the two new inpatient facilities, HCW outlined some common features, such as the range of patients likely to use the units, and the need for links to other health services and education and social services. However, a common core service model for the two inpatient units has still not been developed. As a result, many of the fundamental differences in the services available in North and South Wales are likely to persist.

5.27 Our discussions with commissioners and service providers highlighted a range of views on the extent to which the planning of the new inpatient facilities has been based on a comprehensive assessment of need. We were told by staff involved in the planning, commissioning and provision of the inpatient facilities that the final provision reflected the funds available rather than what was needed, with services 'built to a price'. The outline business case for the reprovision of inpatient services in North Wales identified, as a key constraint, the need for any change to be revenue neutral. In addition, some stakeholders told us that the number of beds in the South Wales unit had been determined by the space available in the new interim location.

5.28 Our fieldwork also indicates that a whole system approach has not been taken that considers the future number and type of inpatient beds and services alongside the development of community services, particularly intensive community-based support. There remains an opportunity in South Wales to plan the long-term inpatient unit alongside the planning of specialist community services, particularly intensive therapy and treatment services given the impact these can have on the demand for inpatient beds.

5.29 There was a lack of joint working around the move to the interim unit in South Wales. The adequacy of educational support in the previous inpatient unit has still not been addressed. The previous unit also had input from social services, but this has not been secured following the transfer to the interim unit, which is located in a different local authority area.

5.30 The move to the interim unit in South Wales occurred over the Christmas period and involved closure of inpatient services for a short period. There were contingency plans in place to deal with emergencies and urgent cases during this period. The provider trust informed the senior managers in the trusts using the inpatient facilities of the relocation arrangements. However, it is clear that this information was not effectively cascaded as specialist community CAMHS staff told us that they had not been made aware of the timing of the changeover, or of the contingency arrangements to handle urgent cases during the period of closure.

Sharing good practice and service evaluation

5.31 Shared learning is taking place through, for example, the all Wales CAMHS Nursing Forum and CCNs. However, a well-developed and comprehensive infrastructure for sharing good practice across professions, statutory organisations and voluntary sector agencies is lacking. There is also little evidence of processes being in place to ensure evidence-based best practice is adopted.

5.32 Our surveys and fieldwork visits indicated that some service evaluation and monitoring is taking place, often by the voluntary sector as part of service level agreements for services they provide that are funded by statutory services. There is also evidence that some discrete services or initiatives are being assessed by service providers.

However, many projects or new services, such as the community intensive therapy and treatment teams, have been set up with no plans to evaluate their effectiveness. There is little evidence of routine benchmarking of service provision and performance, although the recent mapping exercise is a step towards this.

5.33 Our discussions with HCW established that they have not gathered much information on the quality and performance of commissioned NHS services in Wales. Professor Mansel Aylward's review of HCW^{viii} identified this as an issue across services areas. The report highlights the lack of routinely available data from service providers, but stresses that it is within the contractual power of HCW to request data from commissioned services. Health Commission Wales does, however, use reports from the peer review of the Quality Network for Inpatient CAMHS standards and from Mental Health Act and Healthcare Commission visits to evaluate independent providers from whom they commission services.

5.34 Five of the seven NHS trusts providing specialist CAMHS reported that clinical audit has been undertaken within CAMHS. However, our fieldwork visits indicated that clinical audit is rarely undertaken on a multidisciplinary basis, and tends to focus on waiting lists and waiting times. Health staff pointed to workload pressures as a barrier to multidisciplinary clinical audit, along with the lack of routine collection of data and information systems that do not easily support the gathering and analysis of data.

5.35 Some specialist CAMHS measure outcomes for individuals, for example by using tools such as the Health of the Nation Outcome Scales for Children and Adolescents (commonly known as HONOSCA) and follow-up surveys of patients. Data from the mapping exercise indicates that 58 per cent of specialist CAMHS teams use some form of outcome measures.

In conclusion

5.36 There are fundamental weaknesses with the approach to service development:

- the views of children and young people are not driving change within statutory organisations;
- joint working between the health, local authority and voluntary sectors is often ineffective;
- the Assembly Government has committed additional funding to CAMHS, although some funding arrangements do not support sustainable improvements to services;
- there has been poor management and control of some specialist services, such as inpatient and forensic mental health services; and
- opportunities to improve services are being missed because good practice in service provision is not widely shared and service evaluation can be weak.

Part 6 – The CAMHS workforce

Staffing levels and expertise

6.1 We found wide variations in the staffing levels and skills of the specialist CAMHS workforce and in the services and support different teams offer. There are also notable differences across Wales in the roles undertaken within different sections of the CAMHS workforce. For example, there are wide variations in the therapeutic options available in different locations. There are also variations in the make-up of specialist CAMHS teams. And the input to specialist CAMHS teams from other professionals, such as child psychologists, family therapists and social workers, and from other statutory agencies, independent providers and the voluntary sector, is also highly variable. In addition, models of care varied, with some services being nurse-led with little medical input and other models being medically focused. To illustrate some of these variations data from the CAMHS mapping identified that:

- less than half of specialist CAMHS teams have a social worker or clinical psychologist as a member;
- just four teams report having occupational therapists as team members, with three having family therapists;
- around half of CAMHS teams stated that they provide structured parenting programmes;
- 16 teams stated that they offer Cognitive Behaviour Therapy (CBT), and three that they offer DBT, with 11 teams indicating that they provide neither of these therapies; and
- a few teams offer Play Therapy (five teams), Art Therapy (three teams) and Drama Therapy (two teams).

6.2 Our discussions with specialist CAMHS managers and staff indicated that these differences do not reflect a planned approach to aligning staff resources to meet the identified local need for services. Rather, these reflected a wide range of factors, such as ad hoc developments or local professional preferences.

Capacity and skills to support services and service improvement

6.3 The expertise and management capacity to plan, commission and monitor CAMHS is lacking in many parts of Wales. Our discussions with NHS staff identified that service managers for specialist CAMHS are not always in place, and, as a result, clinicians are required to develop policies and plans and attend meetings, to the detriment of front-line clinical services. This is sometimes compounded by a lack of administrative support in carrying out these duties. Where service managers are in place, they do not necessarily have a background in CAMHS. Our survey established that five of the seven NHS trusts providing specialist CAMHS believe that there is not appropriate capacity and skills to support service improvement.

6.4 The complex planning and commissioning arrangements for CAMHS place demands on the capacity and expertise of service managers. Our discussions with staff involved in planning and commissioning services indicate that there can be problems in ensuring people with the appropriate expertise and authority attend planning groups and meetings. This often relates to specialist CAMHS staff.

6.5 Our case file reviews also indicated problems with the knowledge and skills of staff in some of the LHBs and HCW to deal with CAMHS commissioning issues, particularly when managing requests relating to individual packages of care. Examples of this include:

- requesting explanations as to why a child with an eating disorder required tube feeding; and
- querying the need for bank or agency staff to provide high levels of patient observation when a child was admitted to an adult ward.

Recruitment

6.6 At the time of the CAMHS mapping exercise in November 2007, three of the seven NHS trusts providing specialist CAMHS reported difficulties in recruiting staff. Although the Assembly Government told us that the recruitment position has improved since then. The recruitment of clinical psychologists was an issue in all three NHS trusts, with the recruitment of psychiatrists also being an issue in one trust, and the recruitment of an educational psychologist also being an issue in another. The reasons given by service providers for the recruitment difficulties include:

- the rural nature and/or the large geographic size of some service catchment areas requiring extensive travelling;
- professional isolation associated with some posts;
- a traditional service model that is seen as inappropriate; and
- short-term funding of some posts.

6.7 The planned expansion of some parts of the workforce will provide a challenge, as there might only be a small pool of staff with the necessary skills and expertise to draw upon within the locality, or even within Wales. In addition to concerns about the ability to recruit the targeted number of primary mental health workers, a planned expansion in school counselling services will require the recruitment of significant numbers of new counsellors. Comprehensive information is not available on the supply of counsellors, and it is unclear whether there are sufficient counsellors available who are trained specifically to work with children and young people, and whether enough are Welsh speakers.

6.8 There is a risk that, faced with too small a pool of suitable personnel to fill posts, agencies will appoint staff into new posts who are already working within the service. This may have an adverse impact on other service elements and would not increase overall capacity within CAMHS.

Supervision and support

6.9 The extent to which specialist CAMHS staff are supervised effectively varies. Staff who are out posted to other teams, such as nurses in looked after children or youth offending teams, are more likely to lack adequate supervision. We found some creative approaches, such as establishing peer support groups across a number of teams. However, staff in some areas reported that there is a lack of senior staff to provide supervision, and as a result they have to turn to other colleagues or professionals for help and advice.

6.10 Some other health workers, such as school nurses, use supervision sessions to seek advice on cases in the absence of liaison and consultation from specialist CAMHS teams. They also turn to informal networks for advice and support. However, less experienced staff often do not belong to such networks.

6.11 Social workers should receive professional case supervision from social services management, but the processes for this vary when social workers are posted into CAMHS teams. We found one social services department buying in supervision services to support their staff with specialist mental health skills. Some common concerns we identified included:

- social work managers not feeling equipped to supervise staff with specialist skills;
- social workers being given professional supervision by CAMHS staff; and
- social work therapists paying for their own specialist supervision or consultation, in order to deal with the stresses of handling difficult cases.

Training and skills development

6.12 Many staff across different professions report the need for more training to help them to effectively support children and young people with mental health problems. We referred earlier in the report to the variations in training in mental health problems for education and schools staff, paediatricians,

school nurses, health visitors, GPs and social workers. In addition, non-specialist nursing and social work staff commented on the insufficient coverage of children's emotional development or mental health issues in their basic professional training.

6.13 The Assembly Government has provided funding for a post registration training module on working with children and young people with mental health needs. The modules are offered at the University of Glamorgan and Bangor University and are open to all professionals working within CAMHS, although most of the take up has been from nurses. An evaluation of this module by the University of Glamorgan^{ix} identified a range of benefits arising to those undertaking the module, but also recommended:

- the development of short courses lasting one or two days for those undertaking different roles within CAMHS eg, for Tier 1 staff;
- delivering one day courses and updates on specific conditions, such as eating disorders, self-harm and substance misuse; and
- further research into what levels of competence are appropriate for different staff working with children and young people with mental health needs.

6.14 Our surveys of and discussions with specialist CAMHS staff identified a mixed picture of training within specialist CAMHS teams. Five of the seven teams stated that there is a training budget for their specialist CAMHS staff. Whilst some staff had difficulty accessing training, due to time, distance or financial constraints, others did not experience any problems. We found examples of good quality training being given, such as to senior house officers in training placements. Staff at inpatient units also receive mandatory training, for example in cardiopulmonary resuscitation or restraint techniques. However, we also came across some poor practice, including:

- primary mental health workers not having access to CAMHS specific training;

- staff paying for their own training or accessing charitable funding for it; and
- a consultant with no protected time for training and development.

6.15 The extent of joint training is variable, with five of the seven specialist CAMHS providers stating that joint training with social services takes place, and three of these stating they also do joint training with education. However, two specialist CAMHS providers do not undertake joint training with either social services or education.

6.16 The NSF includes a key target that staff delivering services at Tiers 2, 3 and 4 receive regular multiagency training programmes that include the principles of *Everybody's Business*; information about mental health problems and disorders; use of cognitive and behavioural therapies; psychiatric interventions, including use of medication; and knowledge of the Mental Health Act. Self-assessments of the NSF by children and young people's partnerships in 2008-09 identified poor performance in meeting this target with:

- no areas stating that they fully achieved the target; and
- just three areas stating they have robust multiagency training in place that includes all of the essential components and is subject to regular review.

Workforce planning

6.17 Despite workforce-related issues being a significant constraint on the effective delivery of CAMHS, comprehensive workforce plans, either on a single or multiagency basis, have not been developed at either a national or local level. There is a lack of robust planning for current and future requirements in respect of staffing levels, skills development and supervision arrangements across all staff groups.

6.18 Where agencies do have workforce plans, they are not comprehensive. For example, four of the seven specialist CAMHS providers report having a workforce plan for CAMHS

staff, but these do not always cover all the main staff groups or map out the skills or resource shortages.

6.19 The children and young people's plans for 2008 to 2011 include a section on children's workforce planning. The Assembly Government's guidance^x on preparing the plans was for partnerships to focus on a small number of priorities. In the sample of seven plans that we reviewed, no partnership selected CAMHS as one of their priorities.

6.20 The Assembly Government envisages that a Children and Young People's Workforce Development Strategy, will provide the basis for the workforce section in future children and young people's plans. The Assembly Government has tasked the Care Council for Wales to develop the workforce development strategy on its behalf. More comprehensive workforce planning as part of future children and young people's plans would help address some of the current shortfalls in planning the CAMHS workforce.

In conclusion

6.21 There are important challenges in developing an appropriate workforce for delivering CAMHS:

- there are substantial variations across Wales in staffing levels and the expertise of the CAMHS workforce that cannot be explained solely by variations in the local need for services;
- the capacity and skills to support services and service improvement are lacking in some parts of Wales;
- some parts of Wales have experienced recruitment problems;
- effective supervision and support is not in place for some staff groups;
- although some staff groups have received relevant training, the approach to training and skills development is not comprehensive; and
- there is a lack of comprehensive workforce planning.

Part 7 – Performance management

Performance management information

- 7.1** There are four main potential sources of information on which to assess the performance of agencies in delivering CAMHS:
- a self-assessment monitoring tool for use by local agencies in reviewing progress against NSF key actions;
 - the LHB and NHS trust information on the achievement of annual operating framework targets;
 - the CAMHS mapping exercise funded by the Assembly Government provides some comparative information on specialist CAMHS; and
 - local government performance indicators.
- 7.2** The only source of information for assessing performance across the NHS and local authorities is the NSF self-assessment monitoring tool, which provides an annual self-assessment of progress against each NSF key action covering six service areas, one of which is CAMHS. The self-assessments are undertaken by local authorities and NHS bodies and are co-ordinated by the children and young people's partnerships. A scale of one to six is used to assess performance against each NSF action, with descriptors for each level to guide assessments. Annual reports are produced on behalf of the Assembly Government on the progress against all NSF actions.
- 7.3** Some of the key NSF actions reflect response and waiting time targets that the Assembly Government has subsequently reduced through the Annual Operating Framework targets. It is unclear whether partnerships are assessing themselves against the more recent Annual Operating Framework targets or are continuing to report against the original ones.
- 7.4** Although local authorities and NHS bodies have conducted self-assessments for four consecutive years, the Assembly Government has not sought to validate the self-assessments or to moderate the self-assessment scores to ensure consistent and reliable interpretation. The scores in respect of some NSF key actions appear to be consistent with the findings from our review, but the scores in respect of some others seem to overstate the progress made. For example, many areas have assessed themselves over the years as having 'case management as defined in *Everybody's Business*' in place. *Everybody's Business* states that

case management should be based on co-ordinated multiagency care plans, but we found that these are not routinely in place across Wales.

- 7.5** The NSF self-assessment monitoring tool is potentially a key source of information to manage performance. However, it was not intended that the tool should be used as part of a performance management process. Rather, it was designed as an aid for individual NHS organisations and local authorities to target action at a local level. There is reluctance, therefore, at a national and local level for it to be used to assess performance, as this could undermine both the accuracy of self-assessments and the local priority-setting responsibility of children and young people's partnerships.
- 7.6** The NSF self-assessment monitoring information is available to local partners and Assembly Government officials, but not to the staff in NHS regional offices who have had a performance management remit for the NHS.
- 7.7** NHS organisations are responsible for achieving their individual Annual Operating Framework targets (and the former Service and Financial Framework targets). However, in recent years there has been a lack of robust and comparable data on which to assess whether the targets relating to CAMHS have been achieved. No central data has been collected; nor has there been any robust and systematic data reporting at a local level.
- 7.8** This shortcoming has now been addressed and NHS bodies have been required to set up information systems to provide performance information against Annual Operating Framework targets. This performance data is reported to the Assembly Government as part of the National Performance Report process. Quarterly reports commenced in July 2009, and cover performance against Annual Operating Framework national targets and local delivery plans. However, the Assembly Government acknowledge that the data collection relating to CAMHS is 'still in its early stages and thus data quality cannot be

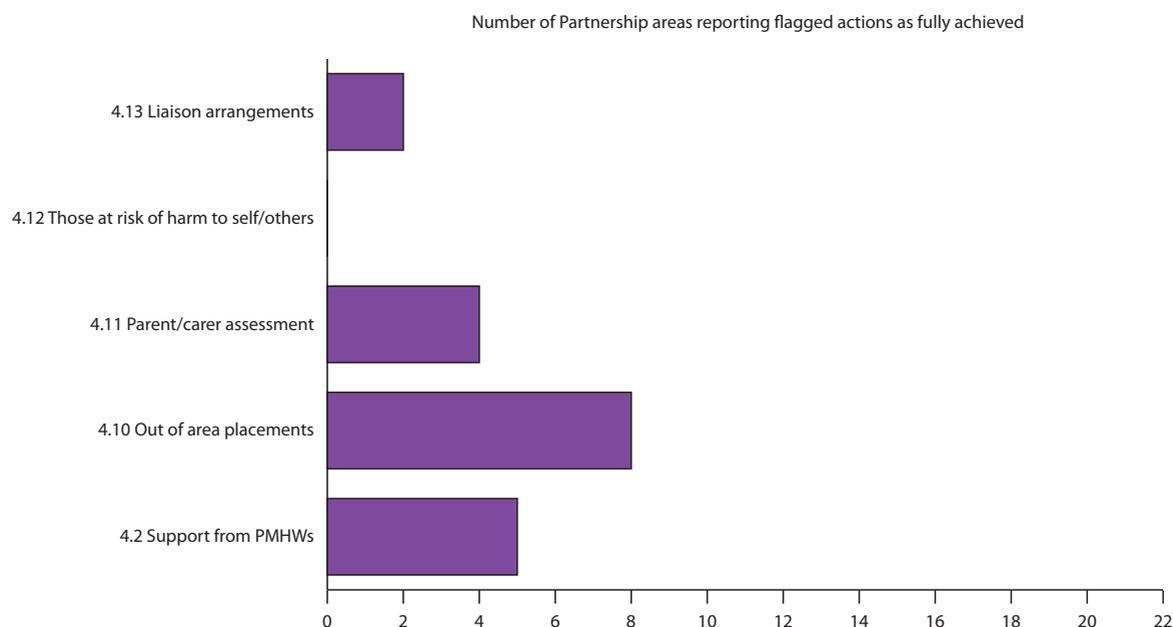
guaranteed'. Our analysis of the data reported for February, March and June 2009 confirms that it is not yet fully robust.

- 7.9** The Assembly Government has provided funding for Durham University to undertake an annual CAMHS mapping exercise. This captured information on specialist CAMHS covering, for example, the types of service provided, staffing, training provision and caseloads. Data was submitted by each NHS trust and LHB in November 2007 with the results reported in 2008. However, there were a number of problems with the robustness of the data. Although some of the mapping information could be used to assess performance, this would have required further analysis and manipulation of the data at a national and local level.
- 7.10** The Wales Programme for Improvement (WPI) provides the framework for continuous improvement within local authorities, and contains a number of performance indicators to assess a local authority's performance. However, there are no performance indicators relating to CAMHS.

Performance against targets

- 7.11** Key NSF, Annual Operating Framework and former Service and Financial Framework targets have been missed in recent years, although there is evidence of some progress against Annual Operating Framework targets in the last year.
- 7.12** The NSF included 22 key actions for CAMHS, of which five were 'flagged' to be achieved by the end of March 2006. However, the self-assessment returns completed by the children and young people partnerships for 2008-09 identified that few areas had fully achieved the flagged actions (Figure 6). Only one flagged action has seen any significant improvement since 2006-07. Better progress has been made across the other service areas covered by the NSF, with 55 of 79 flagged actions fully achieved by 2008-09.

Figure 6 – Performance against NSF flagged actions for CAMHS



Note: A full description of the flagged NSF actions can be found in Appendix 3.

7.13 The annual reports of self-assessments against NSF key actions highlight that performance against the 22 CAMHS key actions was initially very poor, but has since shown some improvement. However, as at March 2009:

- none of the 22 key actions has been fully achieved in all partnership areas, which compares poorly to other NSF service areas where one in three key actions have been fully achieved;
- no more than 10 partnership areas are fully achieving any one key action for CAMHS; and
- only five of 22 key actions show significant change across Wales, with the other key actions showing no substantive or only minor improvement across Wales.

7.14 Annual Operating Framework and the former Service and Financial Framework targets relate only to the NHS and cover important, but a limited number of, service elements. Assessing progress against these targets is complicated by the lack of robust data on performance in previous years. The available evidence indicates that CAMHS related targets have often been missed in the past (Figure 7).

7.15 There is evidence of progress against Annual Operating Framework targets in the last year. For example, there has been progress against Primary Mental Health Worker targets and the assessment and intervention targets for specialist CAMHS. This progress reflects the recurrent funding of £6.9 million over three years provided by the Assembly Government. Although we have some reservations about these targets, the progress is nevertheless encouraging.

Managing Performance

7.16 The Service Delivery and Performance Management Unit within the Assembly Government's Department for Health and Social Services is responsible for performance management of the NHS. Historically, performance management has focused narrowly on monitoring performance against Annual Operating Framework targets. The Service Delivery and Performance Management Unit intends to develop more outcome-based measures. Assembly Government officials also told us that some NHS trusts and LHBs have put less focus on delivering targets in some service areas,

Figure 7 – Performance against Annual Operating Framework and the former Service and Financial Framework targets

AOF/SaFF national target	Performance
From April 2005 CAMHS teams should aim to provide consultation and advice to professionals in Tier 1 within four weeks of the request [Target date for full implementation: 31 March 2006].	No central monitoring data, but very unlikely to have been achieved. Target date precedes growth in primary mental health workers and only 3 of 22 areas self-assessed as fully achieving a related NSF key action in 2006-07.
By 31 March 2008 the CCNs will commission Specialist CAMHS so that primary mental health workers offer consultation and advice to professionals in Tier 1 within two weeks.	This target built upon the earlier target by specifying the need for primary mental health workers, and reducing the target time for advice. No central monitoring, but only five areas self-assessed as fully achieving a related NSF key action in 2007-08. The delivery date for the target was extended to 31 March 2009 as part of following year's Annual Operating Framework.
All patients to be seen by specialist services within six months of referral for routine assessment and intervention (Target date: 31 March 2007).	No central monitoring data, but few areas are likely to have achieved the target. Information provided by NHS trusts as part of our review indicates that four of seven providers were still not meeting this target nearly 12 months after the target date.
Local health boards should come together to create the CCNs that were outlined in WHC (2003) 063. It is expected that the CCNs will be effective as from 1 January 2006, or earlier where possible.	Non-recurring funding made available in 2005-06 but target not achieved. Networks developed at different stages and all were established some considerable time after the target date. In one region, the network manager was being recruited during the course of our review.

including CAMHS, and that Assembly Government regional offices have been tasked with addressing this as part of their performance management responsibilities.

7.17 There has been little performance management by the Assembly Government of HCW contribution to CAMHS. The role of Assembly Government regional offices in performance managing CAMHS is also underdeveloped. Our fieldwork indicates that regional offices have not actively sought to performance manage either the NHS trusts or LHBs in respect of CAMHS.

7.18 The 22 children and young people's partnerships are responsible for monitoring and evaluating progress against the NSF. However, these partnerships do not have responsibility for managing performance and holding services to account, and have only a limited influence over the organisations delivering CAMHS, such as the commissioning networks, HCW, and local NHS bodies.

7.19 The WPI drives performance management within local authorities, with improvement plans and performance indicators subject to review by scrutiny committees. However, performance against NSF targets does not fall within the remit of local authority scrutiny committees, and as there are no

performance indicators relating to CAMHS, this service area is not embedded in local authority performance management arrangements.

In conclusion

7.20 Although there is emerging evidence that performance arrangements within the NHS are becoming more robust further development is needed because:

- the information available to assess performance is not yet robust and reliable and not all information that is available is being used;
- over recent years key targets have been missed, although there has been recent progress with a few important NHS targets; and
- although performance management arrangements have been strengthened for annual operating targets within the NHS, it is too early yet to judge their full effectiveness, and robust performance management arrangements for the broader range of NSF priorities for CAMHS are not in place across health and local government.

Appendix 1 – Who provides specialist CAMHS

At the time of our fieldwork, a number of NHS trusts provided specialist child and adolescent mental health services. Some specialist services worked in areas outside the normal boundaries of their home trust. A number of NHS trusts were reorganised during the review. The tables below summarise the position before and after NHS trust reorganisation. Each table details the areas in which each trust provided services and identifies which organisations provided general children’s services (eg, health visiting) and adult mental health services within the same area.

Table 1 – Pre-NHS trust reorganisation arrangements – specialist community CAMHS pre-2008

Specialist community CAMHS provider	LHB/unitary authority area covered	Providers of child and family services within catchment	Providers of adult mental health services within catchment
North West Wales NHS Trust	Anglesey Gwynedd	North West Wales NHS Trust	North West Wales NHS Trust
Conwy and Denbighshire NHS Trust	Conwy Denbighshire	Conwy and Denbighshire NHS Trust	Conwy and Denbighshire NHS Trust
North East Wales NHS Trust	Flintshire Wrexham	North East Wales NHS Trust	North East Wales NHS Trust
Powys Teaching LHB	Powys	Powys Teaching LHB	Powys Teaching LHB
Pembrokeshire and Derwen NHS Trust	Carmarthenshire Ceredigion Pembrokeshire	Carmarthenshire NHS Trust Ceredigion and Mid Wales NHS Trust Pembrokeshire and Derwen NHS Trust	Pembrokeshire and Derwen NHS Trust
Pontypridd and Rhondda NHS Trust	Bridgend Cardiff Merthyr Neath Port Talbot Rhondda Cynon Taf Swansea Vale of Glamorgan	Bro Morgannwg NHS Trust Cardiff and Vale NHS Trust North Glamorgan NHS Trust Pontypridd and Rhondda NHS Trust Swansea NHS Trust	Bro Morgannwg NHS Trust Cardiff and Vale NHS Trust North Glamorgan NHS Trust Pontypridd and Rhondda NHS Trust Swansea NHS Trust
Gwent Healthcare NHS Trust	Blaenau Gwent Torfaen Caerphilly Newport Monmouthshire	Gwent Healthcare NHS Trust	Gwent Healthcare NHS Trust

Table 2 – Post-NHS Trust reorganisation arrangements – specialist community CAMHS post-2008

Specialist community CAMHS provider	LHB/unitary authority area covered	Providers of child and family services within catchment	Providers of adult mental health services within catchment
North West Wales NHS Trust	Anglesey Gwynedd	North West Wales NHS Trust	North West Wales NHS Trust
North Wales NHS Trust	Conwy Denbighshire Flintshire Wrexham	North Wales NHS Trust	North Wales NHS Trust
Powys Teaching LHB	Powys	Powys Teaching LHB	Powys Teaching LHB
Hywel Dda NHS Trust	Carmarthenshire Ceredigion Pembrokeshire	Hywel Dda NHS Trust	Hywel Dda NHS Trust
Cwm Taf NHS Trust	Bridgend Cardiff Merthyr Neath Port Talbot Rhondda Cynon Taf Swansea Vale of Glamorgan	Abertawe Bro Morgannwg University NHS Trust Cardiff and Vale NHS Trust Cwm Taf NHS Trust	Abertawe Bro Morgannwg University NHS Trust Cardiff and Vale NHS Trust Cwm Taf NHS Trust
Gwent Healthcare NHS Trust	Blaenau Gwent Torfaen Caerphilly Newport Monmouthshire	Gwent Healthcare NHS Trust	Gwent Healthcare NHS Trust

Table 3 – Current NHS arrangements – specialist community CAMHS post 1 October 2009

Specialist community CAMHS provider	Unitary authority area covered	Providers of child and family services within catchment	Providers of adult mental health services within catchment
Betsi Cadwaladr University Health Board	Anglesey Gwynedd Conwy Denbighshire Flintshire Wrexham	Betsi Cadwaladr University Health Board	Betsi Cadwaladr University Health Board
Powys Teaching Health Board	Powys	Powys Teaching Health Board	Powys Teaching Health Board
Hywel Dda Health Board	Carmarthenshire Ceredigion Pembrokeshire	Hywel Dda Health Board	Hywel Dda Health Board
Cwm Taf Health Board	Bridgend Cardiff Merthyr Neath Port Talbot Rhondda Cynon Taf Swansea Vale of Glamorgan	Abertawe Bro Morgannwg University Health Board Cardiff and Vale University Health Board Cwm Taf Health Board	Abertawe Bro Morgannwg University Health Board Cardiff and Vale University Health Board Cwm Taf Health Board
Aneurin Bevan Health Board	Blaenau Gwent Torfaen Caerphilly Newport Monmouthshire	Aneurin Bevan Health Board	Aneurin Bevan Health Board

Table 4 – Inpatient services

Inpatient unit	Provider organisation	Catchment area by unitary authority
<p>Cedar Court (to July 2009)</p> <p>Abergele Unit</p>	<p>Formerly provided by Conwy and Denbighshire NHS Trust Then provided by North Wales NHS Trust</p> <p>North Wales NHS Trust and from October 2009 Betsi Cadwaladr University Health Board</p>	<p>Anglesey Conwy Denbighshire Flintshire Gwynedd Powys (part) Wrexham</p>
<p>Harvey Jones Adolescent Unit (to December 2007) Hafod Newydd (from January 2008)</p>	<p>Formerly provided by Pontypridd and Rhondda NHS Trust Then provided by Cwm Taf NHS Trust and from October 2009 Cwm Taf Health Board</p>	<p>Bridgend Blaenau Gwent Caerphilly Cardiff Carmarthenshire Ceredigion Merthyr Neath Port Talbot Newport Pembrokeshire Powys (part) Rhondda Cynon Taf Swansea Torfaen Vale of Glamorgan</p>

Appendix 2 – How the review was undertaken

Objectives and scope

Healthcare Inspectorate Wales and Wales Audit Office consulted with a wide range of statutory and voluntary sector stakeholders over the scope and aims of the review. There was a consensus that the review should cover a broad range of services and processes. The overall objective of the review was to assess whether services are adequately meeting the mental health needs of young people in Wales.

The review sought to establish whether:

- services are comprehensive, accessible, safe and effective; and whether
- effective arrangements are in place for managing service delivery and improvement.

At the time of the review, a number of other reviews of CAMHS or adult mental health services were underway, including the Burrows-Greenwell review and a review of Secure Services. The review team decided not to focus work specifically on areas that would form part of these other reviews, for example, mental health services for young people in secure locations.

Healthcare Inspectorate Wales and Wales Audit Office led the review supported by Estyn and CSSIW. This enabled:

- more robust and comprehensive assurance about CAMHS;
- a wider input of experience and expertise; and
- proportionate and integrated audit and inspection of a high-priority service area, following Concordat principles.

Methods

The review gathered evidence using the following main methods:

- gathering the views of children, young people and their parents;
- case file reviews;
- service questionnaires;
- reviewing existing information, reports and documents; and
- interviews and focus groups during fieldwork visits to selected areas within each of the three NHS regions within Wales.

Gathering the views of children, young people and their parents

Following a tendering exercise, we awarded Barnardo's Cymru a contract to gather the views of children, young people, and their parents who have experienced CAMHS. They spoke to 68 children and young people aged between 8 and 20 years old, and 60 parents/carers across Wales between October and December 2007. This included meeting children and young people in both inpatient units in Wales.

The consultation gathered views on the:

- availability of information, support and services;
- ease of access to support and services;
- satisfaction with support and services received;
- gaps in services or unmet need;

- involvement in care planning and in decision making including issues of choice and consent; and
- extent to which services are child friendly and non-stigmatising.

Barnardo's Cymru used a mix of methods such as individual and group meetings, telephone interviews and questionnaires for parents.

In addition, we invited comments on CAMHS via a press release and direct contact with user support groups, voluntary organisations, NHS services, social services, and education services.

Views could be submitted via letter, e-mail or a specific online response form. We received over 30 responses from a range of people including parents and professionals.

Table 5 – Case file review numbers

Specialist service provider	Number of case files reviewed	Services covered
Community services		
North West Wales NHS Trust	15	Anglesey and Gwynedd CAMHS
Conwy and Denbighshire NHS Trust	12	Conwy and Denbighshire CAMHS
North East Wales NHS Trust	14	Wrexham and Flintshire CAMHS and ADHD
Powys Teaching LHB	15	Powys CAMHS
Pembrokeshire and Derwen NHS Trust	25	Carmarthenshire, Ceredigion, and Pembrokeshire CAMHS
Pontypridd and Rhondda NHS Trust	37	Six CAMHS teams covering service area and two CITT teams
Gwent Healthcare NHS Trust	13	Gwent CAMHS
Inpatient and out of area placements		
Cedar Court	15	
Harvey Jones Adolescent Unit	12	
Health Commission Wales	6	

Case file reviews

A review of case files from all child and adolescent mental health specialist community and inpatient services was undertaken in the last six months of 2007. A review team of HIW and Wales Audit Office staff and peer and lay reviewers undertook in total 131 community and 27 inpatient case file reviews.

Each specialist services was asked to provide files for up to 20 cases that had been seen in the previous 12 months, ensuring a representative cross-section of:

- age groups;
- conditions and diagnoses;
- emergency, urgent and non-urgent referrals;
- social backgrounds – eg, living at home, looked after children, at risk children; and
- geographical spread.

The team then selected a random sample of these files and examined:

- referral routes;
- waiting times;
- care planning and case management;
- inter-agency working and information sharing;
- unmet needs; and
- involvement of children, parents and carers in care planning.

A number of the cases included an out-of-area placement funded by HCW. For a selection of these cases, we also examined the HCW paperwork to provide an understanding of the organisation's decision-making processes.

Service questionnaires

We sent out questionnaires to a broad range of specialist and non-specialist services in 2008, as summarised in [Table 6](#). These gathered data and information across a common range of topics.

Documentation review

We reviewed a range of information sources including inspection reports and other external reviews; and documents collated during fieldwork visits covering local policies and procedures. We also gained access to information collated across Wales as part of the:

- reporting of progress against Annual Framework Operating targets as at June 2009;
- monitoring of progress against children, young people and maternity services NSF actions for the years up to and including 2008-09; and
- mapping of specialist CAMHS in November 2007 funded by the Assembly Government.

NHS bodies are required to report progress against Annual Operating Framework targets to the Assembly Government on a quarterly basis, commencing from July 2009. We have accessed the data relating to the CAMHS targets.

The children, young people and maternity services NSF contains 21 standards and 203 actions setting out the quality of services that children, young people and their families have a right to expect and receive. To monitor progress in implementing NSF actions a web-based self-assessment audit tool is in place. The 22 children and young people's partnerships are responsible for the co-ordination of the self-assessment audit tool, which is completed on an annual basis. We accessed self-assessment data, as well as to the annual reports summarising progress across the NSF generated by the NSF Implementation Support Manager, based at the Welsh Local Government Association.

A specialist CAMHS mapping exercise funded by the Assembly Government gathered data in November 2007, with the results being reported in 2008. We have accessed this information, which includes specialist CAMHS team data on:

- staff numbers;
- services and therapeutic inputs offered;
- caseloads;
- service costs; and
- age ranges accepted.

This was the first attempt at collating this information and there are some issues with its robustness. As a result, we have used the data with caution.

Fieldwork visits - interviews and focus groups

We undertook fieldwork in each NHS region during late 2007 and early 2008. We selected a cross-section of organisations to provide a mix of different types of area, as summarised in [Table 7](#). Teams comprising staff from HIW, Wales Audit Office, Estyn and CSSIW

along with HIW peer and reviewers undertook the fieldwork.

The local fieldwork in each NHS region involved:

- semi-structured interviews with staff in a range of service providers and commissioners at both operational and strategic level; and

- group discussions with a range of staff working with children and young people.

In addition, we undertook a number of interviews at a national and regional level during 2008. [Table 8](#) summarises the range of professionals that attended interviews and focus groups.

Table 6 – Questionnaire response rates

Questionnaire	Details and response rate
Specialist CAMHS	All seven of the NHS trusts providing specialist CAMHS at the time of the review responded.
Specialist CAMHS teams	We issued questionnaires to each NHS trust for completion by individual CAMHS teams. In total, we received 24 returns covering all specialist teams in Wales.
Social service departments	Seventeen of the 22 social services responded.
Social service teams	We issued questionnaires to each social services department for completion by a selection of up to three individual social services teams working with children and young people. We received 20 returns from individual teams in 11 local authority areas.
Education services	Eighteen of 22 education departments responded.
Educational psychology services	Twenty of the 22 educational psychology services responded.
Education welfare services	Seventeen of 22 education welfare services responded.
School nursing services	Eight of 13 NHS trusts responded.
Health visiting services	Seven of 13 NHS trusts responded.
Community paediatric services	Seven of 13 NHS trusts responded.
Inpatient paediatrics	Six of 13 NHS trusts responded.
Adult mental health services	Six of 11 NHS trusts providing adult mental health services responded.
Local health boards	Sixteen of 22 LHBs responded.
Voluntary sector	We received submissions from 23 voluntary sector organisations providing information on the services they provide and on their views of CAMHS provision.

Table 7 – Organisations selected for fieldwork

Region	Organisations selected
North Wales	North West Wales NHS Trust Anglesey LHB, education and social services at Anglesey Council Wrexham LHB, education and social services at Wrexham Council
Mid and South West	Powys LHB (commissioning and CAMHS provision functions) Education and social services at Powys council Pembrokeshire LHB, education and social services at Pembrokeshire Council
South East	Pontypridd and Rhondda NHS Trust (to review CAMHS provision covering Cardiff and Vale area) Cardiff and Vale NHS Trust (to review working arrangements with specialist CAMHS provision eg, A&E, Paediatrics) Vale of Glamorgan LHB, and education at Vale of Glamorgan Council Cardiff social services Torfaen LHB, education and social services at Torfaen Council

Table 8 – Range of professionals involved in fieldwork visits

Local fieldwork interviews and group discussions	Organisational leads for CAMHS in LHBs, NHS trusts, Social Services and Education Local Health Board chief executives, medical directors and public health directors Children and young peoples partnerships chairs and co-ordinators Health social care and wellbeing co-ordinators Chair and manager of CCNs GPs and practice nurses Educational psychologists Special educational needs co-ordinators Education welfare officers Social services staff, both general children's workers and those with CAMHS experience and specialist skills School nurses and health visitors Community paediatric and ward staff A&E Services Adult mental health ward staff CAMHS team staff, including social workers Primary mental health workers Child psychologists Voluntary sector service providers
National and regional level interviews and meetings	Assembly Government policy leads relating to children Assembly Government regional office staff Health Commission Wales staff Welsh Local Government Association Office of the Children's Commissioner Major voluntary sector organisations

Appendix 3 – National Service Framework – flagged actions for CAMHS

The five 'flagged' targets for CAMHS which were to be achieved by March 2006 are summarised below.

- Key action 4.2** Professionals delivering services at Tier 1 level have direct access to professionals (primary mental health workers) at Tier 2 for consultation, training and joint work. In accordance with Service and Financial Framework Target WHC 2004 (083). To be delivered by March 2006.
- Key action 4.10** If it becomes necessary to place a child or young person in residential or inpatient services out of the home area, the case co-ordinator ensures that:
- placement arrangements are agreed between organisations with responsibility for the child or young person and the relevant body in the area where the placement is made;
 - necessary services are available;
 - funding arrangements are agreed; and
 - there is a nominated lead practitioner in the receiving/referring area who is responsible for monitoring each child's progress, evolving needs and return to their home area.
- Key action 4.11** Parents/carers of children with mental health problems or disorders are offered an assessment under the powers given by the Carers and Disabled Children Act 2000. The assessment should be carried out using the Framework for Assessment of Children in Need and their Families 2001 where appropriate.
- Key action 4.12** When making decisions about service provision, risk assessments are undertaken and appropriate services commissioned, in respect of all children whose behaviours may place others at risk of harm, or whose vulnerability may place them at risk of harm from others and themselves.
- Key action 4.13** All services and settings, which provide services for children, have agreed robust liaison arrangements with other professionals and organisations to deal with the management of overdoses and deliberate self-harm, as well as possible mental disorders and seriously challenging behaviour.

Appendix 4 – Audit and Inspection bodies involved in the review

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales is the independent inspectorate and regulator of all healthcare in Wales. Healthcare Inspectorate Wales' primary focus is on:

- making a significant contribution to improving the safety and quality of healthcare services in Wales;
- improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee;
- strengthening the voice of patients and the public in the way health services are reviewed; and
- ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

Healthcare Inspectorate Wales' core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Assembly Government and healthcare providers that services are safe and of good quality. Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systemic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales, the Local Supervising Authority for the Statutory Supervision of Midwives and is responsible for monitoring approved nurse education programmes provided by higher education institutions in Wales.

Healthcare Inspectorate Wales carries out its functions on behalf of Welsh Ministers and, although part of the Assembly Government, protocols have been established to safeguard its operational autonomy. Healthcare Inspectorate Wales' main functions and responsibilities are drawn from the following legislation:

- Health and Social Care (Community Health and Standards) Act 2003;
- Care Standards Act 2000 and associated regulations;
- Mental Health Act 1983 and the Mental Health Act 2007;
- Statutory Supervision of Midwives as set out in Articles 42 and 43 of the Nursing and Midwifery Order 2001; and
- Ionising Radiation (Medical Exposure) Regulations 2000 and Amendment Regulations 2006.

Healthcare Inspectorate Wales works closely with other inspectorates and regulators in carrying out cross-sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

Wales Audit Office

The Auditor General is totally independent of the National Assembly and the Assembly Government. He examines and certifies the accounts of the Assembly Government and its sponsored and related public bodies, including NHS bodies in Wales. He also has the statutory power to report to the National Assembly on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also appoints auditors to local government bodies in Wales, conducts and promotes value for money studies in the local government sector and inspects for compliance with best value requirements under the WPI. However, in order to protect the constitutional position of local government, he does not report to the National Assembly specifically on such local government work, except where required to do so by statute.

Estyn

Estyn is the office of Her Majesty's Inspectorate for Education and Training in Wales. We are independent of, but funded by, the National Assembly. The purpose of Estyn is to inspect quality and standards in education and training in Wales.

Estyn is responsible for inspecting:

- nursery schools and settings that are maintained by, or receive funding from, local authorities;
- primary schools;
- secondary schools;
- special schools;
- pupil referral units;
- independent schools;
- further education;
- adult community-based learning;

- youth support services;
- youth and community work training;
- local authorities;
- teacher education and training;
- work-based learning;
- careers companies;
- offender learning; and
- the education, guidance and training elements of The Department for Work and Pensions funded training programmes.

Care and Social Services Inspectorate Wales

Care and Social Services Inspectorate Wales encourages the improvement of social care, early years and social services by regulating, inspecting and reviewing, and by providing professional advice to Ministers and policymakers. Through our work, we aim to raise standards, improve quality, promote best practice and inform people about social care.

Four regions (North Wales, South East Wales, Mid and South West Wales and South West Wales) are the focus for professional assessment and judgement about services and organisations. They inspect and review local authority social services and regulate and inspect care settings and agencies.

Our national teams lead on managing and analysing information to deliver all-Wales reviews and provide professional advice to improve services.

Appendix 5 – Glossary

Accident and Emergency (A&E) – A hospital department which provides emergency treatment and initial treatment for both injuries and illnesses.

Advocacy – The process of supporting and enabling people to express their views and concerns; access information and services; defend and promote their rights; and, explore choices and options. Advocates support and argue the case for service users and help them put across their point of view.

Annual Operating Framework – A document issued by the Assembly Government which sets out the expectations of the NHS within any one financial year. It included the national targets, Efficiency and Productivity Measures as well as additional service requirements.

Better Schools Fund – Provides pump priming support to help schools and local authorities implement new initiatives and develop innovative approaches to raising standards of attainment in schools.

Caldicott Guardian – A senior clinician in each NHS organisation who is responsible for implementation of aspects of the Caldicott report, which reviewed the protection and use of patient information.

Care package – Following an assessment, a care package is agreed to enable a patient to receive care appropriate to their needs. Where necessary this covers both NHS and social care.

Care pathway – A defined set of treatment and care steps designed to meet the particular needs of each patient.

Care plans – Written agreements setting out how care will be provided within the resources available for people with complex needs.

Care Programme Approach (CPA) – The CPA provides a framework for care co-ordination for service users in specialist mental health services. The main elements are the allocation of a care co-ordinator, a written care plan that is reviewed regularly with the service user (and sometimes the carer) and the professionals and agencies involved.

Carers – People who look after their relatives and friends for no pay, often in place of a nurse.

Case conference – A formal meeting attended by all those involved in the provision of care or services to a child or family, often but not necessarily involving the individual or family members, in order to reach a shared agreement on how best to move forward. In children's services, the term is perhaps most often used as shorthand to refer to a child protection case conference (or child protection conference).

Caseload – The group of patients managed by an individual health care professional.

Case mix – The mixture of clinical conditions – and severity of condition – found in a particular healthcare setting or in the caseload of a health care professional.

Child and adolescent psychiatrist – Specialise in working with children and young people who have mental health problems. Psychiatrists are medically trained doctors who have gone on to train and specialise in psychiatry and so can prescribe medication. However, psychiatrists work with a wide range of therapeutic techniques, including individual psychotherapy, behavioural therapy and family therapy. Where medication is prescribed for children, it will usually be as part of a much broader range of treatment.

Children and young peoples partnerships – Each local authority area has a children and young people's partnership, made up of organisations that work with children and young people, from voluntary, community and statutory public service sectors. The partnerships are responsible for producing a children and young people's single plan, which is the strategic plan for children and young people covering a wide range of needs. The partnerships also manage the Assembly Government's Cymorth Funding, which aims to improve services and outcomes for children and young people. Children and young people partnerships have no responsibility for the direct provision of services

Children in need – The Children Act 1989 places a statutory duty on local authorities to 'safeguard and promote the welfare of children within their area who are in need'. Under Section 17 of the Act, a child is said to be in need if:

- 'he [or she] is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority';
- 'his [or her] health or development is likely to be significantly impaired, or further impaired, without the provision of such services'; and
- 'he [or she] is disabled'.

Clinical audit – Evaluation and measurement by health professionals of how far they are meeting standards that have been set for their service.

Clinical psychologist – Work with people with any one of a wide range of psychological or mental health problems, including mental illness. They may work directly with individuals, families or groups, assessing their needs and providing appropriate interventions; or they may work indirectly, for example by providing support to parents, carers or other professionals. Assessment often involves the use of psychometric tests and direct observation of behaviour.

Clinical risk management – Understanding the various levels of risk attached to each form of treatment and systematically taking steps to ensure that risks are minimised.

Clinical supervision – A formal process of professional support and learning which enables individual practitioners to develop practice and enhance patient protection and safety of care in complex clinical situations.

Cognitive Behaviour Therapy – A number of therapies that all have a similar approach to solving problems, which can range from sleeping difficulties or relationship problems, to drug and alcohol abuse or anxiety and depression. Cognitive Behaviour Therapy works by changing people's attitudes and their behaviour. The therapies focus on the thoughts, images, beliefs and attitudes that we hold (our cognitive processes) and how this relates to the way we behave, as a way of dealing with emotional problems. Cognitive behaviour therapy is a combination of psychotherapy and behavioural therapy. Psychotherapy emphasises the importance

of the personal meaning we place on things and how thinking patterns begin in childhood. Behavioural therapy pays close attention to the relationship between our problems, our behaviour and our thoughts.

Commissioning – The processes local authorities and LHBs undertake to make sure that services funded by them meet the needs of the patient.

Common Assessment Framework – Development of a national, common process for assessing, and co-ordinating the needs of children and young people at risk of not meeting their potential. Aims to be a more preventative, effective and multiagency coordinated process.

Community health services – Local services provided outside a hospital. Many community staff are attached to GP practices and to health centres.

Conduct disorder – A diagnosis that psychiatrists use to describe a pattern of persistent and serious misbehaviour in children and young people. For a diagnosis to be made, the misbehaviour must be much worse than would normally be expected from other children of a similar age, and be clearly distinguishable from the sort of routine naughtiness or adolescent rebellion which is characteristic of most children's and young people's development.

Confidentiality – The legal and ethical obligations that prevent the disclosure of patient information to third parties.

Consent – Permission, granted by a patient (or, in the case of minors, a parent or guardian) to allow a health treatment, examination or investigation to be undertaken.

Continuing Professional Development – A continuing learning process that complements formal undergraduate and postgraduate education and training.

Counselling – Aims to help young people by allowing them a space and context in which to discuss and explore (with a counsellor) any problems that may be causing them to be upset, distressed or confused.

Criminal Records Bureau (CRB) – An executive agency set up to help organisations make safer recruitment decisions by providing wider access to criminal record information. The CRB helps employers in the public, private and voluntary sectors identify candidates who may be unsuitable for certain work, especially that involving contact with children or other vulnerable members of society.

Cymorth – An Assembly Government scheme which is administered through local children and young people's partnerships within each local authority. It has replaced the former programmes Sure Start, Children and Youth Partnership Fund, National Childcare Strategy, Youth Access Initiative and Play Grant.

Data protection – A requirement upon public bodies and others to act responsibly in managing personal data. Such responsibilities are covered by the Data Protection Act 1984 and the Computer Misuse Act 1990, designed to safeguard data held on individuals.

Dialectical Behaviour Therapy – Is a psychotherapy used for adolescents who have difficulty managing their emotions. It is aimed at changing the typical behaviour patterns of emotionally challenged adolescents such as self-injury and other self-destructive behaviours. Dialectical behaviour therapy teaches clients alternative ways of managing their emotions and tolerating distress.

Early intervention – The process or act of intervening when a child or young person, of whatever age, first shows signs of having difficulties. Early intervention aims to ensure that individuals receive the help they need as soon as possible, thereby preventing a problem escalating and becoming more difficult to deal with.

Early years – A term used within education, generally to refer to children (or provision for children) within the age range 0-7. However, it is also sometimes used more narrowly to refer to the pre-reception years, or under-fives, or to those settings, such as nurseries, where pre-school children are cared for and educated.

Educational psychologist – Work within the education system to help children who are experiencing problems at school. These may be children who have learning difficulties, a learning disability, or emotional or behavioural problems. Educational psychologists work directly with children (and their parents) to support educational and psychological development, as well as in an advisory and training capacity with schools and teachers.

Education Welfare Officer – Employed by local authorities to resolve problems of children and young people regularly missing school. They work closely with families to investigate the reasons behind school absence. As well as addressing the problems of individual pupils, they provide advice and support to schools on promoting whole school attendance. They work closely with a wide range of agencies.

Family therapy – A way of working with families when one or more family members are experiencing problems. It is based on the idea that the behaviour of people is influenced and maintained by the way in which they interact with others, particularly within strong social systems such as a family. By addressing the 'system' – ie, the family as a functioning unit – family therapy works to address and overcome the problems being experienced by the individual(s) within it.

Flying Start – An Assembly Government initiative which funds services for children aged 0-3 years in the most disadvantaged communities in Wales including extra health visiting, free childcare for two year olds, basic skills programmes and parenting courses.

General Practitioner – A family doctor.

Health Commission Wales – An executive agency of the Assembly Government, responsible for commissioning specialist health services for the people of Wales.

Health visitor – A health professional working in the community, often responsible for prevention, health advice and promotion and community health development.

Healthy Schools programme – A programme that encourages schools to contribute to the improvement of children's health and wellbeing.

The Incredible Years Parenting Programme – Is designed to help families with children up to the age of eight who are highly aggressive, disobedient, hyperactive and inattentive and to promote social competence and prevent, reduce, and treat aggression and related conduct problems in babies, toddlers and young children. The Incredible Years Wales Centre was established in 2003 and is located with Bangor University.

Local health boards – Statutory bodies responsible for implementing strategies to improve the health of the local population, securing and providing primary and community health care services and securing secondary care services.

Looked after – A term used to describe any child who is in the care of the local authority or who is provided with accommodation by the local authority social services department for a continuous period of more than 24 hours. The term is not restricted to children in respect of whom a compulsory care order or other court order has been made; for example, it covers also children subject to accommodation under a voluntarily agreed series of short-term placements like short breaks, family link placements or respite care.

Mapping exercise – The Assembly Government has provided funding for Durham University to undertake an annual CAMHS mapping exercise. This captures information on specialist CAMHS covering, for example, the types of service provided, staffing, training provision and caseloads.

Mellow Parenting – Is designed to support families with relationship problems with their infants and young children; and in addition the Mellow Babies Programme incorporates such issues as child care skills, child protection and activities suitable for parents and babies.

Multidisciplinary Team – A team consisting of health and social service professions and non-professionals, including doctors, nurses and therapists, working together to provide care and treatment for patients.

NHS Trust – A self-governing body within the NHS, which provides health care services. Trusts employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc. Acute trusts provide medical and surgical services usually in hospital(s). Community trusts provide local health services, usually in the community, eg, district nurses, chiropodists etc. Combined trusts provide both community and acute trust services under one management.

National Service Framework – National standards of care published for a variety of conditions which are designed to improve the quality of care and reduce variations in standards of care.

Occupational Therapist – A professionally trained person who uses purposeful activity and meaningful occupation to help people with health problems. In mental health they play a key role in helping people overcome problems and gain confidence in themselves.

Out of area – There are instances when local services do not meet the needs of people and as a result services outside of the local area, often outside of Wales will be commissioned to meet that need. When this happens the service user concerned will have to physically move to where that service is provided.

Primary Care – The first point of contact with health services. In the UK this is family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

Psychotherapies – Psychological methods for treating mental disorders and psychological problems.

Pupil referral unit – A type of school that is established and maintained by a local authority and is specially organised to provide education for children who are excluded, sick or otherwise unable to attend mainstream school (eg, school phobics).

Pyramid clubs – Activity clubs usually run after school for small groups of primary school children who may be quiet, shy, anxious, isolated, withdrawn or finding it difficult to make friends. At the club, children do lots of activities to help them improve their confidence and develop new friendships. In some areas, Pyramid clubs are run by organisations other than schools, but the format is much the same.

Safeguarding – The term used to describe the process of identifying children and young people who have suffered or who are likely to suffer significant harm, and taking the appropriate action to keep them safe.

Social Services – A term generally used to refer to local authority, social services departments. These are responsible for non-medical welfare care of adults and families in need. Among other services it provides needs assessments for people and provide services under community care for adults, children and families.

Social Worker – A person professionally qualified and registered to deliver social work to individuals and their families in a variety of settings. Many social workers work for social services within local unitary authorities. Social workers promote social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

The Solihull Approach – Is designed to be used as a brief intervention for professionals working with children and families who are affected by behavioural and emotional difficulties, and is available for 0-5 year olds as well as for children of school age.

Substance misuse – The use of illegal drugs and the inappropriate use of legal drugs, including alcohol, prescription medicines and substances such as solvents. Misuse is a broad term encompassing harmful use and dependence.

Sure Start – Cross government programme that helps children and parents, through increased availability to childcare, and improved health and emotional development for young people.

Youth Offending Team – Multiagency teams who draw their members from probation, social services, local education authorities, health services and the police. Youth offending teams oversee the outcomes of the criminal justice process in each young offender's case. This includes: deciding on appropriate rehabilitation programmes and accommodation, overseeing reparation orders and community sentences, writing court reports, supervising bail and supporting the young person during and after custodial sentences, as well as setting up youth offender panels.

Appendix 6 – References

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Appendix 7 – Acknowledgements

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