



## **Somebody Else's Business?**

**Report of a scoping exercise of child and adolescent  
mental health services in Wales in 2007**

**Children's Commissioner for Wales  
November 2007**

## Foreword

Whilst Everybody's Business was widely applauded as a comprehensive strategy when it was launched in 2001, we have repeatedly listened to the negative experiences of children and young people with mental health problems which prompted the Commissioner to repeat, in successive Annual Reports, that Child and Adolescent Mental Health Services (CAMHS) as a whole are "*in crisis*" in Wales.

To try and understand the issues facing children and young people who need to access mental health services, we conducted face-to-face structured interviews with key personnel about the implementation of Everybody's Business at a local level. We were fortunate in having previously forged good working relationships with many of the attendees in their role of Designated Liaison Officers with this Office from Local Health Boards (LHBs) and National Health Service (NHS) Trusts– as recommended in the Carlile report *Too Serious a Thing*.

We were aware from the outset that much of the implementation of Specialist CAMHS (Some Tier 3 and all Tier 4 Services) at a local level is heavily dependent on the published national commissioning policy and guidelines contained within Welsh Health Circulars and we took these into account in evaluating services and preparing this report.

The aim of the interviews was to take a snapshot of chosen areas of mental health services at the time of the scoping exercise in early 2007. We are aware that since that time there have been developments in the recommissioning of inpatient units in both North and South Wales and changes in the functioning of FACTS teams. Nevertheless, most of the findings of this scoping exercise remain valid.

We are also aware that the Wales Audit Office and Health Inspectorate Wales have embarked upon a joint review of CAMHS and we have regularly met with them and have shared our findings. The NSPCC and other organisations have also published reports into the experiences of service users.

Following the writing of the report, the findings were shared with Designated Liaison Officers at three regional seminars held across Wales in late September 2007. During these seminars, the following points were highlighted as areas of further concern:

- Access to CAMHS, described in the report as being problematic for 16-18 year olds, is also an issue for younger children, this was highlighted by the case of a young girl who is just 10 and has a severe eating disorder. It was described as "a battle" for her to access provision.
- "Non-recurrent" funding has been provided for CAMHS for each of the last three years. Despite being intended to promote the development of new services and projects, this funding is often used to shore up existing core services. A similar concern was expressed about the lottery funded Inspire project which aims to support children and young people who have self-harmed. The initial evaluations shows that the project is actually plugging gaps in core services and so is not able to offer additional services.

- Disputes around commissioning, funding and access to services are common to all areas of Wales. However, it appears lessons are not learnt and solutions not shared. Procedures and guidance are not revised. This leads to the inefficient use of professionals' time and delays in treatment for children and young people.
- Liaison officers reported that Health Commission Wales' (HCW) stance on funding treatment retrospectively has hardened during 2007 and HCW are more reluctant to engage with LHBs and others in discussion. When they do it can take up to 10 days to get a decision and this places children at risk.
- HCW are only funding eating disorder services for 6 weeks but this is not considered to be sufficient time to carry out assessments and treatment of the child. Many of the centres that offer these services will not accept children and young people unless they are provided with 12 week funding.
- Children's nurses are very concerned about the placing of CAMHS patients on paediatric wards where staff may not have the necessary skills to deal with children who have mental health problems. There were concerns that CAMHS patients may be in side wards but still very close to very young children.

Finally, we hope that this report will be of use to all those who commission and provide mental health services to children and young people in Wales. We are very grateful for the help we have received from our designated liaison officers within LHBs and NHS Trusts across Wales and we will continue, with their help and the feedback we get from children and young people, to scrutinize the development of CAMHS over the coming years.



Maria Battle  
Deputy/Acting Commissioner  
Children's Commissioner for Wales

## Contents

Glossary of abbreviations used in report

### **1. Background**

- 1.1 UNCRC and the Children's Commissioner for Wales
- 1.2 Children's Commissioner for Wales Annual Reports about CAMHS
- 1.3 Children's Commissioner for Wales' Designated Liaison Officers in Health Services

### **2. Scoping exercise aims and methodology**

- 2.1 Scoping exercise aims
- 2.2 Scoping exercise methodology
- 2.3 Structure of the report

### **3 Child and Adolescent Mental Health Policy in Wales**

- 3.1 Child and Adolescent Mental Health Services (CAMHS) in Wales
- 3.2 Everybody's Business: child and adolescent mental health strategy for Wales
- 3.3 The Carlile Report – Too Serious a Thing
- 3.4 Children and Young People Rights to Action
- 3.5 The National Service Framework for Children, Young People and Maternity Services in Wales
- 3.6 Additional funding for CAMHS
- 3.7 Overview of the situation in Wales
- 3.8 Welsh Assembly Government's Submission to the UK Government's report to the United Nations Committee on the Rights of the Child
- 3.9 Commentary on WELSH ASSEMBLY GOVERNMENT submission

### **4 Issues identified in scoping exercise with designated liaison officers**

- 4.1 Commissioning responsibilities
- 4.2 Commissioning issues for 16-18 year olds not in full-time education
- 4.3 Funding available for CAMHS
- 4.4 Exclusion of children and young people with learning disabilities and a mental illness from CAMHS
- 4.5 Self-harm and CAMHS
- 4.6 Children and young people whose parents misuse substances
- 4.7 Children and young people who exhibit sexually harmful behaviour

### **5. Key findings and conclusions**

### **6. Conclusions**

References

## **Appendices**

Appendix A	LHB Designated Liaison Officers
Appendix B	NHS Trust Designated Liaison Officers
Appendix C	Participants in the scoping exercise
Appendix D	Implementation of Everybody's Business questions
Appendix E	Children's Commissioner for Wales Annual Report comments focussing on CAMHS
Appendix F	Welsh Assembly Government statement on CAMHS in <i>Rights in Action</i>

## Glossary of main terms used

A & E	Accident and Emergency
ACPC	Area Child Protection Committee
CAMHS	Child and Adolescent Mental Health Services
Care Pathway	A Care Pathway is an outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes
CITT	Community Intensive Therapy Team
CYPFP	Children and Young People's Framework Partnership
DELLS	Department for Education and Lifelong Learning and Skills of the Welsh Assembly Government
ELWa	Education and Learning Wales – former Assembly Sponsored Public Body with responsibility for post 16 learning in Wales. This body merged with the Welsh Assembly Government in April 2006 and its functions are now part of the Department for Education and Lifelong Learning and Skills (DELLS)
Everybody's Business	The Welsh Assembly Government's CAMHS strategy launched in 2001
FACTS	Forensic Adolescent Consultation and Treatment Service
HCW	Health Commission Wales (Specialist Services) - HCW (SS) - an executive agency of the Welsh Assembly Government.
LHB	Local Health Board
LSCB	Local Safeguarding Children's Board
MAPPA	Multi-Agency Public Protection Arrangements
NHS Trust	National Health Service Trust
NPHS	National Public Health Service
NSF	National Service Framework for Children, Young People and Maternity Services in Wales
QAF	Quality Assessment Framework
SaFF	Service and Financial Framework
UNCRC	United Nations Convention on the Rights of the Child
WAG	Welsh Assembly Government
WIISMAT	Wales Integrated In-depth Substance Misuse Assessment Tool

# 1. Background

## 1.1 UNCRC and Children's Commissioner for Wales

We are fortunate in Wales to have had a great many of the UK's firsts in relation to children's rights. One of these was the establishment of the Children's Commissioner for Wales in 2001. The post of Children's Commissioner for Wales, the first of its kind in the UK, was established by the Care Standards Act 2000 and the Children's Commissioner for Wales Act 2001 broadened the remit and set out the Commissioner's principal aim, which is to safeguard and promote the rights and welfare of children in Wales.

The Children's Commissioner for Wales' team is committed to making the United Nations Convention on the Rights of the Child (UNCRC) a reality in Wales. Listening to children and young people, empowering them, learning from and acting on what we have heard are foundation stones of our approach. The broad remit of the Children's Commissioner's role is reflected in the breadth and variety of what we do.

The Children's Commissioner and the team are there to help make sure that children and young people in Wales:

- are safe from harm and abuse
- get the opportunities and services they need and deserve
- are respected and valued
- have a voice in their communities and are able to play as full a part as possible in decisions that affect them
- know about their rights and the UN Convention on the Rights of the Child.

All the work of the Office is underpinned by the United Nations Convention on the Rights of the Child (UNCRC) but the focus has been sharpened because the UK government must report to the UN Committee on the Rights of the Child on progress in 2007. The UK Children's Commissioners will have the opportunity to report independently to the UN Committee on the Rights of the Child.

When the UK government ratified the United Nations Convention on the Rights of the Child it made a commitment to bring its guidance and legislation in line with the Convention. It also agreed to report to the Committee on the Rights of the child every 5 years on progress made. The last UK Government report was in 2002 and the next is due in July 2007. The Welsh Assembly Government published *Rights in Action*, its contribution to the UK Government's report.

## 1.2 CCFW Annual Reports about CAMHS

The Children's Commissioner for Wales publishes an annual report in which the Commissioner reviews issues that affect children and young people in Wales. In four of his previous annual reports the Commissioner has made comment regarding the development and provision of CAMHS in Wales. These are reproduced in Appendix (E) at the end of the report.

### Commentary

The concerns that Peter Clarke expressed in his 2002-2003 annual report were instrumental in the Welsh Assembly Government announcement of additional funding of £700,000 for CAMHS in 2003. This was welcomed, however the continuing concerns that Peter Clarke voiced were that genuine commitment to the improvement of CAMHS does not exist in the Welsh Assembly Government. In the various Welsh Assembly Government responses to the Commissioner's annual reports there have been continued references to the ten year duration of the strategy for improvement. Whilst a long-term plan is essential, it is difficult for children and young people, parents and professionals engaged in CAMHS to see real progress being made in the improvement of the service.

In the response that was made to the 2002-2003 report the Welsh Assembly Government stated that during the next financial year a start would be made on investing in forensic CAMHS service within Wales. The results of this *scoping exercise* have shown that in 2006-2007 an all Wales service has yet to be established with patients from North Wales being treated by specialists from Manchester. In March 2006 in her statement on the Welsh Assembly Government's response to the Annual Report of the Children's Commissioner for Wales, Jane Davidson stated '*our commitment to CAMHS has been backed up by significant funding.*' However when compared to the investments made in England this significant funding is poor.

## 1.3 Children's Commissioner for Wales's Designated Liaison Officers

*Too Serious A Thing - The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales* otherwise known as the *Carlile Report* was published on 5 March 2002. Amongst other issues the report raised the issues of the provision of children's advocacy and arrangements for complaints and whistleblowing in the NHS in Wales. With reference to the Children's Commissioner for Wales the report stated that:

*7.12 It is important that there should be some clarity about the Commissioner's role in relation to NHS matters. He and the NHS are partners in the sense of having the shared objective of ensuring that healthcare is in itself a non-abusive experience, and one that has the best chance of dealing with abuse arising elsewhere.*

*7.13 It is our view that this would best be achieved by the designation as Children's Commissioner Liaison Officer of a person functioning within each health organisation. The role would be part-time, and would require routinely a small amount of protected time each week to keep abreast of the Commissioner's activities and to maintain whatever contacts*



*and correspondence were necessary. This role could usefully be given to a manager responsible for children's services, or to one of the named clinicians.*

#### **Carlile Report - P.78**

Following the establishment of LHBs on the 1<sup>st</sup> April 2003, the Children's Commissioner for Wales hosted three seminars on a regional basis in October 2003 with LHBs. Similar seminars were held with NHS Trust representatives in July 2004.

In the autumn of 2006, a further series of seminars was held. On this occasion designated liaison officers from LHBs and NHS Trusts were invited to the same seminars.

A report was published as a result of the seminars and circulated to Chief Executives and Designated Liaison Officers. An overview of the seminars is shown below and the full report can be downloaded from the website [www.childcomwales.org.uk](http://www.childcomwales.org.uk).

#### **Session One – *United Nations Convention on the Rights of the Child (UNCRC) and the reporting process- links to health***

The first presentation described the reporting mechanisms to the United Nations Committee on the Rights of the Child about the implementation of the United Nations Convention on the Rights of the Child (UNCRC) in Wales. The UK Government are required to submit a report to the UN Committee by the summer of 2007. The UK report will contain information provided by the Welsh Assembly Government. A separate report compiled by Welsh Assembly Government will be published in Wales. The four Children's Commissioners in the UK will provide written and oral evidence, about the government report, and their own comments, to the UN Committee in 2008.

The presentation focussed on the main articles contained within the UNCRC related to health and also asked delegates to consider responsibilities to children and young people in NHS settings arising from the other articles.

Article 3	acting in the best interest of the child
Article 6	the right to life
Article 12	respecting the views of the child
Article 13	child's right to information and freedom of expression
Article 14	child's right to freedom of thought, conscience and religion
Article 18	parents' joint responsibilities, assisted by the State
Article 19	child's right to protection from all forms of violence
Article 20	children deprived of their family environment
Article 23	rights of disabled children
Article 24	child's right to health and health services
Article 28	child's right to education
Article 30	children of minorities or of indigenous people
Article 31	child's right to leisure, play and culture
Article 34	sexual exploitation of children
Article 39	rehabilitation of child victims

The presentation questioned the extent to which both primary and secondary health providers ensure that these articles are implemented within their settings, for example what educational provision is made for children who are long-term inpatients in hospital settings and are the views and wishes of the child sought as to either their treatment or planning for delivery of services?

The group were invited to discuss how Article 3 of the UNCRC is implemented in health settings. Groups made brief oral presentations of their discussions and notes were taken on the emerging issues. Feedback from this group task at the three seminars is shown later in this report.

### ***Session Two - The role and work of the Advice and Support service of the Office of the Children's Commissioner for Wales***

The purpose of this presentation was to explain the advice and support service of the Children's Commissioner for Wales. A multi-agency team is available to give advice to any person in Wales and to assist and support individual children. The service is child-centred and non-bureaucratic. It is solution-focussed and through negotiation, mediation and information tries to resolve children's problems quickly. Most cases are referred by adults, including health professionals. Examples were given of health cases. In 2005/2006, 566 children were assisted, 90% of cases were resolved and 7% partially resolved. Intervention in individual health cases has resulted in improvements in policy and practice. The Commissioner is also a designated body under the Public Interest Disclosure Act. There was an opportunity for designated liaison officers to discuss the presentation and ask questions.

### ***Session Three – Key Health Issues in relation to CAMHS***

The purpose of this presentation was to discuss a number of key health policy and practice issues about which the Children's Commissioner for Wales has concerns. In particular,

- *Tier 3 and 4 CAMHS commissioning*
- *Self Harm*
- *Sexually Harmful Behaviour*
- *Hidden Harm*

The commissioning of Tier 3 and 4 CAMHS has been a continuing area of concern for the Children's Commissioner for Wales. There are concerns about the complexity of the commissioning process and which body has lead responsibility for coordinating the assessment and diagnosis process for a child or young person requiring Tier 3 or 4 CAMHS.

Self-harm is a manifestation of many issues within the life of an individual child or young person. Our presentation highlighted the findings of the recent national inquiry into self-harm entitled *Truth Hurts* which called self-harm a '*major public health issue in the UK today.*' This hidden phenomenon has to be better understood by all professionals who work with children and young people.

Our own research with local Area Child Protection Committees has shown that not all local authorities have services in place for children who present sexually harmful behaviour. This is despite the fact that strategy documents such as *Working Together to Safeguard Children* have identified the link between treatment and reduction in offending behaviour for these children and young people.

Hidden Harm is the term used to describe the harm suffered by children of parents who misuse substances, for example classified drugs or alcohol. At present the Welsh Assembly Government's Substance Misuse strategy has a very low emphasis on this issue. We are concerned that children who may suffer hidden harm do not have the opportunity to express their views on this harm to professionals who are working with them.

The presentation and discussion acted as a starting point for a scoping exercise between the designated liaison officers and the Children's Commissioner for Wales on these four areas.

### **Background to the Scoping Exercise**

At the seminars, as part of the scoping exercise, a series of questions (Appendix D) relating to the implementation of Welsh Assembly Government's Child and Adolescent Mental Health Strategy '*Everybody's Business*' were discussed, with and distributed to designated liaison officers. Although it was recognised that the officers may not work exclusively in the field of child and adolescent mental health services, we felt that they needed to know the answers to the questions posed, in order to liaise with the Children's Commissioner for Wales' staff at both an individual case level and an overall policy level.

The designated liaison officer within the LHBs were (generally) of a seniority to carry responsibility for Children's Services within the LHB. Consequently, it seemed sensible that as the commissioning agents for CAMHS from the NHS Trusts, they would have an understanding of the service that they commissioned. Similarly, the designated liaison officers within the NHS Trusts were (generally) at a senior level within the organisation with direct responsibility for Children's Services. It seemed obvious therefore that they would have an awareness of the CAMHS provided by the Trust.

A series of follow up scoping meetings was then arranged with the designated liaison officers to discuss the questions that we posed, gather their answers, and capture the key points from the debate.

Appendices A and B show the Children's Commissioner for Wales' designated liaison officers in each LHB and NHS Trust in Wales.

## **2. Scoping Exercise aims and methodology**

### **2.1 Scoping Exercise aims**

The aim of the scoping exercise was to establish the progress made in implementing some aspects of *Everybody's Business*, to be achieved through asking questions of designated liaison officers. Within this overall aim there were a number of smaller objectives, which included:

- gathering evidence to support the submission of the Children's Commissioner for Wales to the United Nations Committee on the Rights of the Child in 2007 about CAMHS provision
- extending our knowledge about the range and geographical location and spread of CAMHS and the arrangements for service delivery
- gathering evidence to present to Welsh Assembly Government

A copy of the questions is included at Appendix D.

### **2.2 Scoping Exercise methodology**

#### **Fieldwork**

During January and February 2007, we met with the designated liaison officers. The questions were structured in such a way so as to promote discussion and debate. Designated liaison officers had complete discretion and flexibility to arrange these meetings in their local areas and to invite other colleagues. In some cases, meetings were held with one or more LHB and NHS Trust attending. Some meetings were attended by colleagues from other agencies. Notes were taken by the Children's Commissioner's team and liaison officers were invited to forward/ send further details of issues discussed. We received excellent cooperation from the LHBs and NHS Trusts with only 2 of the 35 being unable to either meet or to return any comments (see Appendix C for full list).

#### **Analysis**

The notes and supporting information were analysed to produce a series of overarching key themes that had emerged as a result of the scoping exercise.

These were analysed along with key documentation from THE WELSH ASSEMBLY GOVERNMENT and HCW.

A narrative description has been produced to enable the reader to engage with the issues and the underpinning policy framework. Where policy and practice differ this has been highlighted in the text.

A series of key findings were then produced. These were based on recognition of the need to further develop CAMHS in the future so that they provide the most effective service to all children and young people in Wales up to the age of 18.

## **2.3 Structure of the report**

The report presents:

- 1 An overview of the importance of CAMHS to the Children's Commissioner for Wales
- 2 The aims and methodology of the scoping exercise
- 3 An overview of CAMHS policy in Wales
- 4 The findings of the scoping exercise with Designated Liaison Officers
- 5 Key findings and conclusions

### **3 Child and Adolescent Mental Health Policy in Wales**

#### **3.1 Child and adolescent mental health services (CAMHS) in Wales**

The United Nations Convention on the Rights of the Child was ratified by the UK government in 1991. The last report submitted by the UK, to the United Nations Committee on the Rights of the Child about progress in implementing the articles of the UNCRC, was in 1999. In their *Concluding Observations* report, the UN Committee said that they remained '*concerned that many children suffer from mental health problems and that rates of suicide among young people are still high*' (Paragraph 41). They recommended that the UK Government:

*(c) take all necessary measures to strengthen its mental health and counselling services, ensuring that these are accessible and sensitive to adolescents, and undertake studies on the causes and backgrounds of suicides;*

The very fact that children and young people are still admitted to adult psychiatric wards, without being offered a choice in the matter is evidence that there has been little progress since 1999, to ensure that services are sensitive and accessible to the needs of adolescents.

#### **3.2 Everybody's Business: child and adolescent mental health strategy for Wales**

The child and adolescent mental health strategy in Wales was published under the title *Everybody's Business* in 2001. It was welcomed as a comprehensive strategy that would, if properly resourced, make Wales a leader in this area of services.

As one would expect of a strategy, *Everybody's Business*, considers the whole range of CAMHS, provided by both statutory and voluntary agencies, and, as is often the case, the whole is more than the sum of its parts. Successful implementation also depended on co-operative planning and commissioning and service delivery by both the local authority and the NHS in Wales.

The CAMHS implementation group, set up by the Welsh Assembly Government, estimated that an additional £10m per year would be needed for the first three years of delivering on the strategy outlined in *Everybody's Business* and, in the Foreword, a financial commitment was made by Jane Hutt AM then Minister for Health and Social Services (and Minister for Children):

*Many of the reforms we want to see will be achievable through better planning and organisation. However, full implementation will require additional funding. The National Assembly has made mental health a priority and has supplied extra funding to support this. I want to see results from this injection of hard won cash and I expect to see CAMHS receive its fair share of it.*

However, despite this commitment, made in 2001, CAMHS provision is in crisis across Wales largely due to lack of investment.

This state of affairs is disappointing, and difficult to understand, particularly as the *Carlile Report – Too Serious a Thing*, published in 2002 made over twenty recommendations about CAMHS several of which are about children and adolescents requiring in-patient treatment at Tier 4 level.

### **3.3 The Carlile Report – Too Serious a Thing**

The Carlile Review panel was convened by the Minister of Health and Social Services, (and Minister for Children,) in September 2000 in the aftermath of the publication of the *Waterhouse Report – Lost in Care*. The review was asked to make recommendations so that proper safeguards could be in place wherever a child had contact with the NHS. Lord Carlile comments as follows about the admission of young people to wards for adult patients with a mental illness:

*14.40 As we recognise in Chapter 4, a matter of ever-active concern in CAMHS provision is the use of adult wards for children and young people who present as emergency admissions, or are in an area of Wales where separate facilities are not available. This is not a problem peculiar to CAMHS services, but can be particularly serious in the mental health field.*

*14.41 As a general principle, whenever possible children and adolescents should not be placed in adult wards save when it cannot be avoided, and even then in a side room with appropriately qualified and experienced nurses. Staff who are not police checked or trained in child protection procedures should not have any involvement with this group of patients when they are in adult wards. Our findings and the principles derived from them resonate with the recurrent concerns and recommendations of the Mental Health Act Commission.*

Later Lord Carlile commented on the practice of admitting young people to adult mental health wards at para 13.7:

*Children admitted to adult wards can find the experience upsetting and intimidating, especially if the ward contains very sick and often elderly patients displaying distressing symptoms. Nursing and other staff on adult wards may have no expertise in the care of children, and will not have gone through the appropriate employment checks or training in child protection.*

### **3.4 Children and Young People Rights to Action**

*Children and Young People Rights to Action* – was published by Welsh Assembly Government in January 2004, and follows on from a previous publication in July 2002, *Framework for Partnership*. These publications set out the strategic direction and policy framework for children's services provision in Wales. The latter publication sets out the commitment from the Assembly Government to adopting and implementing the United Nations Convention on the Rights of the Child. To that end, seven core aims were established. The Assembly Government promised to ensure that all children and young people have:

- A flying start in life
- A comprehensive range of education, training and learning opportunities
- The best possible health free from abuse, victimisation and exploitation
- Access to play, leisure, sporting and cultural activities
- Children and young people are treated with respect and have their race and cultural identity recognised
- A safe home and community that supports physical and emotional wellbeing
- Children and young people not disadvantaged by poverty

Several of the core aims support children and young people's emotional wellbeing, however the commitment to promoting their emotional wellbeing is explicit at core aim 6. The publication also contains the admission, on page 40, that:

*When the Assembly Government came into office we recognised that mental health services for children and young people had been neglected for a very long time. Mental health services remain largely hidden from public view, coming to political and media attention only at a time of crisis.*

This suggests a commitment from the National Assembly for Wales to ensuring that there would be adequate and appropriate level of funding to implement the much applauded CAMHS strategy.

### **3.5 The National Service Framework for Children, Young People and Maternity Services in Wales**

The National Service Framework for Children, Young People and Maternity Services in Wales (Children's NSF) was published in 2004. It is a ten-year programme setting out eleven standards for health and social care that authorities must achieve by 2014. The Welsh children's NSF contains 203 key actions of which 82 were flagged as core key actions for delivery by the end of March 2006. The remainder are to be delivered over the 10 years of the NSF programme.

Chapter 4 deals with children and young people with mental health problems and disorders but disappointingly, of the twenty key actions listed in this chapter, only five were flagged for early delivery. Chapter 2 deals with universal actions, and following key action is flagged:

*2.57 NHS trusts Chief Executives, Local Authority Chief Executives and Directors of Social Services are aware of the outcome of the audit of their services following the publication of the Assembly's response to the recommendations of the Laming Report, and Carlile Review, and ensure that they have implemented their action plan.*

It is difficult to understand how exactly the LHBs and the Trusts as well as the local authorities are supposed to implement the recommendations in the *Carlile Report* without dedicated and specific funding streams and the direction for this contained within the Service and Financial Framework (SaFF) Document. Key action 2.18 of the Children's



NSF refers specifically to the placement of children on adult wards, and is disappointing in its content, in that it does not clearly recommend that children and young people are not admitted to adult settings. However, the standard requires that there be systems in place to protect children and young people from harm when placed in adult settings – which bears out the comments made by Lord Carlile.

Not all the targets that were flagged in the Children's NSF have been achieved. Instead of reinforcing a commitment to achieve the targets set by the Welsh Assembly Government in their Service and Financial Framework (SaFF) Document, those targets have now been dropped for the next financial year. Indeed the SaFF contains no targets for achieving the standards laid down within the Children's NSF. It is unclear how exactly, if there is no financial commitment, implementation will be achieved.

### **3.6 Additional funding for CAMHS**

In March 2004, the Health and Children's Minister's announced an additional £700,000 for CAMHS but this is proving totally inadequate in the face of the continuing crisis in provision. We are continually being told how the absence of proper mental health support is undermining real progress in all areas of service for children. Timely intervention is crucial for these children, and its absence will mean some of them will struggle far into their adult lives unnecessarily. The piecemeal allocation of relatively small amounts of money towards aspects of the strategy is not as effective or efficient a remedy as careful consideration of the funding and budgetary implications of *Everybody's Business* as a whole.

The Welsh Assembly Government has now required that LHBs and Trusts develop costed plans, but children in Wales are still left as the poor relations to their peers in England where, starting in 2002, almost £300 million was to be invested over a three year period for the development of a comprehensive CAMHS by 2006.

### **3.7 Overview of the situation in Wales**

The current situation is that Wales has fewer adolescent mental health beds per head of population than anywhere else in the UK. The placements that do exist in Wales are not always able to provide 24 hour care every day of the year and they are often not able to accept emergency admissions.

*There are currently 28 NHS CAMHS in-patient beds commissioned in Wales*

- *2 High Dependency & 14 in-patient beds in the Harvey Jones Unit in Cardiff (South Wales)*
- *12 in-patient beds in Cedar Court in Colwyn Bay (North Wales)*

*Every effort is made in an emergency to admit a patient to one of these units. If a patient requires an emergency admission and there is not a NHS bed available, a bed will be commissioned in an in-patient unit from the Independent Sector in England.*

**Mental Health Services for Children and Young People  
Health and Social Services Committee HSS(2)- 06-06(p30)**

It remains the case that children and young people with a mental illness have to be placed far from home, out of Wales, and usually detained under the Mental Health Act 1983 in order to receive treatment, therapy and services. Many children who normally receive education through the medium of the Welsh language are unable to do so in most placements. Children with mental health problems and placed so far from their normal sources of support are probably the most vulnerable in Wales and yet are likely to be the least safeguarded.

The commissioning of Tier 4 placements in Wales is the responsibility of the Welsh Assembly Government body Health Commission Wales. This is because, in the view of Welsh Assembly Government, services at Tier 3 and 4 must be considered on an all-Wales basis because they are very specialised and low volume. However, progress in commissioning a sufficient number of emergency placements in Wales has been slow, and we have advocated for children and young people who were receiving treatment on adult wards. The commissioning of services for children and young people with a prior diagnosis of learning disability is practically non-existent, and there is a poor and uncoordinated uniformity of practice not least due to an absence of WAG guidance about the development of forensic services and eating disorder services.

We are also aware that some children are admitted to paediatric wards because of a physical medical need but who are also assessed as having a mental health problem. These children often spend several weeks in the paediatric ward when their physical medical needs have been resolved before an appropriate CAMHS bed can be found for them. This was identified as a major issue in the joint Children's Commissioner for Wales and Office of the Children's Commissioner report *Pushed in to the Shadows*. This report focussed on the experiences of children and young people who had been placed on adult wards and their experiences of awaiting admission to appropriate CAMHS facilities.

At present there are specific concerns around access to appropriate services for 16-18 year olds as CAMHS is commissioned for children and young people up to 16 years of age unless they are still in full time education. It is discriminatory not to provide a service to a child solely on the basis they are not in full-time education. Adult Mental Health Services are commissioned for 18 years and over, resulting in a gap in mental health services for many 16-18 year olds and patchy and problematic provision. CAMHS should be commissioned and resourced to provide services to all young people up to their eighteenth birthday.

We have intervened in some cases in which Health Commission Wales has refused to fund placements that local CAMHS professionals and children considered to be appropriate for children's needs. Young people in dire need of specialist treatment are experiencing weeks of delay before they are admitted. Adolescents are also being treated on adult mental health wards, which are not attuned to providing services for this age group and where the experience can be a frightening and damaging one for young people.

There have also been some very positive developments in Wales and there is some innovative and good practice. Many health settings now recognise children's rights and welfare to a greater extent. Examples of such positive developments are as follows:

- Early identification work is being developed through Primary Mental Health Workers undertaking preventative work. Professionals have told us that three primary health workers per 100,000 children would ensure that children's mental wellbeing is safeguarded.
- There is development of a forensic adolescent consultation and treatment service (FACTS) for young people in North Wales. We were contacted by professionals in April 2007 with concerns that Health Commission Wales would not release the funding ring-fenced for the FACTS in South Wales. This highlights concerns that HCW are in fact putting children's health and well-being at risk with their decisions. At the time of writing it is unclear as to the status of the FACT team in South Wales.
- Projects that aim to tackle the issue of self-harm and 'hidden harm' are being developed. These are short-term projects which may only last for a few years and in some cases are being funded by Lottery money. The National Assembly for Wales must end this situation whereby important services are being run with short-term funding.

Healthcare Inspection Wales and the Wales Audit Office have announced a review of CAMHS in Wales. We welcome this review, are having regular meetings to assess progress and are hopeful that the outcome will reopen the debate about the funding and provision of CAMHS service for the children of Wales.

### **3.8 Welsh Assembly Government's Submission to the UK Government's report to the United Nations Committee on the Rights of the Child**

In March 2007, the Welsh Assembly Government published *Rights in Action, Implementing Children and Young People's Rights in Wales*. This report was published formally in Wales and was submitted to the Department for Education and Skills (DfES) in London. DfES are coordinating the UK Government's report to the United Nations Committee on the Rights of the Child. The section relating to CAMHS is of particular relevance to this report and is reproduced in full in Appendix F.

### **3.9 Commentary on WAG submission**

Many of the statements made by the Welsh Assembly Government relating to CAMHS are positive, however the findings of our scoping exercise demonstrate some of the challenges faced by LHBs and other partners in implementing *Everybody's Business*. These include the use of short-term funding streams for CAMHS which prevents the development of the service on a long-term sustainable basis. One LHB noted that Primary Mental Health Workers (PMHWs) were piloted in their area but the team of workers transferred to another local authority because the contracts on offer were permanent and so the original host LHB lost that expertise.

There was considerable discussion and debate around the emergency admission to hospital of young people with several areas stating that they would be unable to provide a placement for young people. In some cases, children and young people are either cared

for on a paediatric ward or on an adult ward with additional safeguards being put in place. How does this situation reflect the additional funding that THE WELSH ASSEMBLY GOVERNMENT has made available to resolve this issue?

The discussion around the targeting of CAMHS at the most vulnerable children is an interesting one as it raises concerns about a common perception that ran throughout this scoping exercise. In all too many cases, when we mentioned CAMHS people began to discuss Tier 3 and Tier 4 services as if Tier 1 and Tier 2 were not part of the strategy. Many of the professionals suggested that this also meant that partner agencies also regarded CAMHS as something to be dealt with by the health services and this meant that opportunity for potentially valuable contributions from teachers and educational psychologists was lost. In some areas, though, this misperception has been successfully addressed through, for example, joint training between CAMHS teams and Educational Psychologists and the establishment of protocols.

The title of the strategy is *Everybody's Business*, and it provides clear direction about the universality of services designed to promote and enhance emotional wellbeing, and provide intervention at the earliest and most appropriate level to avert crisis. The title also suggests that the strategy is less about a tiered approach that leads inexorably to a medical diagnosis but rather about a strategy that seeks to meet children's needs as they arise.

If there truly is a continuous spectrum of services, why is there a need to target the most vulnerable? Additionally, who decides which children are more vulnerable than others and therefore more 'deserving' of services? This may vary from area to area.

## 4 Findings from scoping exercise with designated liaison officers

### 4.1 Commissioning responsibilities

The discussions with the designated liaison officers demonstrated varying levels of understanding of the specific commissioning responsibilities of LHBs. The Welsh Health Circular 63 (2003) states that:

*Local Health Boards (LHBs), in partnership with local authorities and others, are responsible for commissioning health promotion, primary care, community health services, secondary care, mental health and public health services for their resident populations. NHS Trusts respond to commissioning plans prepared by LHBs and Health Commission Wales (Specialist Services) and working within their partnership relationships will deliver services in line with those commissioning plans. Other bodies may also be required by LHBs to provide services.*

*The four tier strategic concept for planning, commissioning and delivering CAMHS identifies:*

*Tier 1 Primary or direct contact services.*

*Tier 2 First-line specialist services provided by professionals from specialist CAMHS whose primary role is mental health-care.*

*Tier 3 Second-line specialist services provided by teams of staff from within specialist CAMHS.*

*Tier 4 Very specialised interventions and care (this includes inpatient psychiatric services for children and adolescents).*

The commissioning mechanisms for the NHS components of comprehensive CAMHS can be summarised as follows:

*Tier 1 services are provided by staff who are not trained as specialists in mental health and many have a wide range of other commitments. LHBs will be responsible for commissioning the NHS-funded health components of Tier 1 CAMHS in close conjunction with partner local authority departments and in awareness of plans for commissioning Tiers 2 and 3.*

*All LHBs should ensure that they commission a balanced programme of services that includes the functions listed in the annex. This is likely to require them to commission services from both the statutory and non-statutory sectors. The latter could make an enhanced contribution to mental health promotion and early intervention programmes. In particular, the voluntary sector should be enabled to play an expanded role in providing services for children in their early years and pre-school.*

*Tiers 2, together with Tier 3 Services other than those commissioned by Health Commission Wales (Specialist Services) will be commissioned by a number of LHBs grouped with Trusts to form CAMHS Commissioning Networks (CCN). Three such networks will be created, based on the NHS Regional Office areas. Such an approach*

*will create sufficiently wide geographical areas and critical mass to allow expertise in CAMHS commissioning and performance management to develop. Meetings will be organised by the Assembly before July 2003 to begin setting up these networks. Tier 4 and some Tier 3 services must be considered on an all-Wales basis, because of their very specialised nature and low volume. These services will be commissioned by Health Commission Wales (Specialist Services).*

**WHC (63) 2003 pages 12-13**  
**Part A - Commissioning Services**  
**Subsection e. Commissioning child and adolescent mental health services (CAMHS)**

In relation to CAMHS, this Welsh Health Circular states that:

*The strategy for CAMHS requires that services are not just the responsibility of, or only provided by the NHS; but are a multi-agency responsibility. Comprehensive CAMHS should be provided jointly by the health, education and social services in the statutory sector working together with non-statutory and voluntary sector services. As well as the Local Health, Social Care and Well-being Strategy, for CAMHS the Children and Young People's Framework will be a key determinant of which services are commissioned and how. Planning for CAMHS must be fully integrated into this Framework. Full guidance on this planning framework is set out in Framework for Partnership, available from the Children and Families Division of the Welsh Assembly Government.*

In late December 2006, Health Commission Wales published an updated commissioning policy for Child and Adolescent Mental Health Services. It became clear in the course of meetings (January and February 2007) that some LHBs had yet to receive a copy of this policy. One designated liaison officer stated that they would not have received a copy of the policy ...

*'had I not been part of the working group.'*

Designated liaison officers and other professionals were surprised that there had been little or no consultation about the policy prior to its publication. The lack of information flow between HCW and local commissioners is an area of considerable concern because it leads to delays in decision-making about treatment and placements for ill children, whose health deteriorates while they wait.

Article 24 of the United Nations Convention on the Rights of the Child states:

*1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.*

Even where there may be a lack of resources to make adequate provision, there can be no justification for the delays caused simply by the lack of clear commissioning guidelines.

The stated purpose of the HCW's commissioning policy is to:

- *clearly set out the circumstances under which patients will be able to access the services specified*
- *clarify the referral process*
- *indicate which organisations are able to provide a service for Welsh patients*
- *and define the criteria that patients must meet in order to be referred.*

**HCW Commissioning Policy  
Section 1 Introduction Page 3**

The commissioning policy makes reference to the need for HCW to make choices in order to avoid overspend and that:

*'the growth in demand, and the pace of development of services, means that there will always be limits on the services which HCW can commission at any given time.'*

**HCW Commissioning Policy  
Section 1.2 HCW Approach to Prioritisation - Page 3**

The policy also states that:

*'...promoting and supporting the mental health and well-being of children and young people is an important issue. This policy recognises this and aims to ensure that there is a reliable, efficient and expert service for children, young people and their families when requiring assistance for mental health issues in line with the Welsh Assembly Government's strategy Everybody's Business.'*

**HCW Commissioning Policy  
Section 1.3 Priority Given to this service - Page 3**

The Children's Commissioner has very real concerns that children and young people's mental health and well-being have been put at risk due to problems in commissioning the services they need. These concerns have been raised in successive Annual Reports which have been presented to the National Assembly for Wales. It is time that the way in which CAMHS services are commissioned is reviewed.

There were several specific areas where misunderstanding of commissioning guidelines became apparent. The first of these was the responsibility of LHBs in relation to Tier 3 CAMHS. According to the Health Commission Wales commissioning policy (2006):

*Health Commission Wales works with local Health Boards and the CAMHS Commissioning Networks in carrying out it's (sic) commissioning responsibilities. HCW is directly responsible for commissioning the services defined in Welsh Health Circular (2003) 62:*

### 3.1 Tier 3 Services Day Patient services

*Community and other intensive therapy programmes (e.g. Community Intensive Therapy teams)  
Community Forensic CAMHS*

### 3.2 Tier 4 Services

*NHS funded CAMHS placements outside Wales  
Inpatient psychiatric services within and outside Wales  
Forensic CAMHS*

## HCW Commissioning Policy Section 3 Commissioning Responsibility - Page 3

In relation to this guidance and the specific responsibilities of HCW, one liaison officer at a LHB stated that:

*'...we have had concerns about the perception of the Welsh Health Circular which came out in 2003 (63) that makes it clear in our view, that Tier 4 services are the responsibility of HCW and not the LHB and this included joint funded packages of care for Tier 4 but we have not had any luck with getting any engagement with HCW on these. We feel that the criteria have therefore changed on this matter but we have not been able to access any document that sets out the changes to this commissioning and when we have asked for such a document then we still cannot get that.'*

The corollary of this commissioning issue meant that the designated liaison officer felt that:

*'...as a statutory organisation HCW are asking us to go outside of our statutory role in terms of Tier 4 placements at present.'*

Other designated liaison officers concurred with this view and felt that the way in which Health Commission Wales are applying their commissioning policy means that they are not *'commissioning what they were set up to commission.'* Designated liaison officers were concerned that there was an inconsistency in commissioning across Wales and therefore there was a lack of clarity around who funds which elements of CAMHS. The implementation and structure of the commissioning policy undoubtedly impacts on the budgets (and frustration levels) of Health Commission Wales and LHBs **but**, more importantly, it infringes children and young people's rights to health care provision as it impacts negatively on the health and treatment of children and young people in Wales.

A number of designated liaison officers stated that **all** Tier 3 CAMH services are to be commissioned by LHBs whilst others stated that the responsibility for some elements of Tier 3 CAMHS lies with Health Commission Wales. This situation was viewed as *'fairly blurred'* and *'unclear'* with one designated liaison officer stating:

*'The current system for individual placements is currently operating inconsistently and funding can either be from the LHB via continuing healthcare funding or from HCW. This is a peculiar arrangement and can lead to inequity in service provision for children in the different areas.'*



Although there was recognition of the need for the tiered approach to CAMHS and the increase in specialist treatment that a child can access as they progress through the Tiers to Specialist CAMHS, a member of specialist CAMHS stated that:

*'young people do not fit nicely into black and white boxes. HCW has its own financial pressures and these have led to quite stringent gatekeeping procedures and these are not always helpful to health and well being of young people.'*

One designated liaison officer described the situation regarding commissioning as not providing:

*'clarity about some of the issues and sometimes it is down to personal arguments as to who picks up the funding and it is a very subjective rather than objective way of providing the funding.'*

This is clearly not what was envisaged by a commissioning policy which seeks to maximise a limited resource. The frustration evidenced by the designated liaison officers reinforces the picture of a service in crisis that should serve some of the most vulnerable children and young people in Wales.

One representative queried the clinical basis for the statement in the new commissioning policy that a child receiving an inpatient service will only be funded for 3 months because:

*'none of us would agree that that has a clinical basis it is done on an arbitrary resource based decision'*

and another said:

*'The policy is making things more and more rigid.'*

At worst, these mixed responses could be leading to a situation where legal responsibilities of various commissioners are not clearly understood or carried out effectively and consistently on a day-to-day basis and therefore children's health care could be adversely affected.

Several designated liaison officers outlined their use of disputes procedures with HCW, where there may be disagreement between the LHB and HCW as to who is responsible for commissioning a service for a child or young person. All participants assured us that in such cases, no child's health or treatment had been affected and that the LHBs had commissioned *'without prejudice.'* One designated liaison officer recalled a case of a young person with self-harming behavior and a learning disability and the issue around who was responsible for funding the treatment took 4 days to resolve. We are also aware of a young person with a prior diagnosis of learning disability, and a mental illness where the treatment and funding issues for him took nearly three years to resolve; it was three years before he received the appropriate treatment.

There was a consensus among designated liaison officers that it was important for children to receive the right care or treatment at the right time and that responsibility for funding be resolved separately to decisions about the child's treatment. In the absence of clearly

understood and agreed commissioning arrangements, there is clearly a need to develop dispute procedures between LHBs and NHS Trusts and with Health Commission Wales and for them to be put in place as soon as possible.

A further issue for designated liaison officers was the situation where a child may be placed within a Tier 4 setting, without having previously accessed any CAMHS provision funded by the LHB, and who subsequently is discharged from the Tier 4 provision into the community. At this point, the funding for the child becomes the responsibility of the LHB. However as the LHB has no prior knowledge of the child or the treatment then this can lead to interruptions to a child's care. One LHB felt that they needed to be involved in the decision making process rather than simply being told by HCW:

*'these children are now your responsibility and we have asked the provider to invoice you'.*

### **Referrals into Tier 3 or 4 CAMHS**

There was considerable discussion amongst participants about the need for specialist CAMHS staff to undertake assessments of children requiring Tier 3 or 4 inpatient treatment. In some cases, the diagnosis of the local clinicians has been disputed by the regional Specialist CAMHS teams. This led to frustration and in the words of a CAMHS professional:

*'I cannot think of any other system where a consultant who may want an inpatient service may not be listened to by the staff at that inpatient unit but that is the reality in children's services but that does not happen with adult services.'*

A mental health commissioner stated that in some situations there are concerns about the situation of:

*'a child who the local staff believe needs an inpatient setting but is not allowed, what local services are there for that child? We are ending up with children wrongly placed for a long time and that is a clinical governance risk that lies with local commissioners and local service providers. In some instances, the child will block a bed in a paediatric ward alongside children with physical medical needs and those are not a good mix. The issue is the interface between tiers 3 & 4 and that commissioning policy will not help.'*

An issue for many of the designated liaison officers was the referral criteria into local specialist CAMHS. These were felt by many of the officers to be *'tight'* and *'inflexible'*. There were concerns about the impact on children and young people if they are unable to access higher tier CAMHS. The tight referral criteria were felt to be driven by the need to ensure SaFF targets are met in terms of waiting times and performance targets. The SaFF targets for children and young people's health services were felt by liaison officers to receive less priority than adult targets. In some cases SaFF targets for implementing the Children's NSF have been dropped when they have not been achieved. It is clear that the lack of a designated children's budget within the LHBs and NHS Trusts means that less priority is placed on children's health issues than those of adults. Instead of reinforcing a commitment to achieve the targets set by the Welsh Assembly Government in their Service and Financial Framework (SaFF) Document, those targets are now dropped for the next financial year. Indeed the SaFF contains no targets for achieving the standards laid down

within the Children's NSF. It is unclear how exactly, if there is no financial commitment, implementation will be achieved.

It is, in our view, questionable whether this approach is in the best interests of the health and well-being of children and young people with mental health issues. One designated liaison officer summarised the issue:

*'I would question what happens to the child or young person who does not meet the criteria for specialist CAMHS?'*

In another area the following comment was made:

*'If a differential diagnosis is given by CAMHS and thus treatment is refused, not a lot else happens. There is the conflict between the assessments of local teams who have considerable knowledge of the child and the one off assessment of HCW. I have a fear that for some young people who are refused higher Tier services then we may end up with severe self-harm or even a death.'*

In some areas where a differential diagnosis is provided by Specialist CAMHS a further opinion is sought, however during this time the health and well-being of the child or young person is being adversely affected. In some cases parents seek out treatment programmes which the LHB may not agree to fund because the programme is not, in their view, the most appropriate and they are reviewing and challenging this.

#### **4.2 Commissioning issues for 16-18 year olds not in full-time education**

The commissioning of CAMHS for 16-18 year olds not in full-time education was found to be inconsistent across Wales despite the explicit statement in *Everybody's Business* which states:

*We now require specialist CAMHS in the NHS, which have not already gone beyond this stage, to adopt the practice of taking all children up to school leaving age but also to include responsibility for 16 to 18 years olds who are still at school (and within the responsibility of the education support services). Reciprocally, we wish to see the mental health services for adults accept responsibility for young people from 16 years of age who are attending college or no longer in education. Once this is achieved, we wish local services to adopt the goal of moving their interfaces in a planned and negotiated way so that the CAMHS ordinarily cover young people up to their 18th birthday (i.e. 0-17 years inclusive).*

In some areas these young people are unable to access CAMHS in line with the strategy and Wales Health Circular guidance whilst elsewhere a young person already known to CAMHS but not in full-time education would have access to CAMHS because practitioners in that area choose to ignore the guidance when they identify a medical need. This means that in some parts of Wales, young people with similar needs in neighbouring local authorities are treated differently. Staff working in CAMHS said the specific exclusion of 16-18 year olds not in full-time education was of concern because *'there are major resource implications from this as the incidence of mental illness increases in adolescence and so potentially we are maybe not taking the cases that are most in need of our services.'*

One NHS Trust stated that for 16-18 year olds not in full-time education it adheres:

*‘to the guidance set out in the Welsh Health Circular 2002 (125) “Age range of specialist child and adolescent mental health services”. This Welsh Health Circular states that the Welsh Assembly Government requires specialist NHS CAMHS to provide services to children and young people up to their 18<sup>th</sup> birthday if they are still in school. New referrals for mental health services aged over 16 years may be in further or higher education and still not fall within the remit of specialist CAMHS. New referrals for adolescents aged between 16 and 18 years who are not still at school will be passed onto adult mental health services for consideration. If they need inpatient services, they will be admitted to an adult mental health ward. Current patients who reach their 16<sup>th</sup> birthday and leave school may be transferred to adult mental health services as part of a negotiated and agreed transition plan with the patient, family and adult mental health.’*

In one NHS trust area, one LHB operates a policy under which all 18 year old young people can be referred to CAMHS, however in the neighbouring LHB only those 16-18 year olds in full-time education can be referred to CAMHS. If young people are not in full-time education then a referral is made to adult mental health services.

However it was found that the use of referrals to adult mental health services is problematic because they do not cover exactly the same spectrum of mental health issues as CAMHS, for example severe self-harm and therefore *‘their (young people’s) needs may not be met.’* There were also concerns about the ability of adult mental health services to safeguard and protect the welfare of children and young people as highlighted in the report of the Office of the Children’s Commissioner *Pushed into the Shadows*. CAMHS Commissioning Networks have identified this as an issue to be addressed, however without clear changes in national policy little effective change for children will be achieved through local changes in procedure.

Practitioners had concerns about the transition between CAMHS and adult mental health services. It was noted that for some young people adult mental health services may be more appropriate, however, this would seem to indicate a system based on individual need rather than clear commissioning procedures and policy for the whole population. It is recognised that this is an area that is being addressed through the on-going review of adult mental health services.

In other areas a clear decision has been taken to ensure that all children and young people aged between 16 and 18 can access CAMHS regardless of their educational status due to their *‘vulnerability.’* This decision had been met with resistance from some specialists, for example psychiatrists; however, this resistance has been overcome. In one area the extension of CAMHS to all 16-18 year olds has had considerable resource implications because those young people *‘represent a high percentage of our referrals and open cases.’* In other cases there were concerns that the extension of CAMHS beyond the commissioning guidelines to all 16-18 year olds is currently:

*‘being driven by professional’s interests and it is not commissioned and it is not a SAFF target’.*

In one case this led to a situation where:

*' a 17 year old boy who had left education was retained by CAMHS even though they said that policy should not have allowed for this.'*

It was felt by many designated liaison officers that adult mental health services will face new challenges in the future in addressing the needs of people with ADHD although this is not yet seen as a mental illness that would be covered by adult mental health services. One designated liaison officer stated that in response to a number of these issues that:

*'CAMHS should be extended up to 21 or even 25 because these children have such emotional difficulties.'*

One of the areas is considering further developing their CAMHS to provide a young adult service in response to the needs of 16-18 year olds and a key member of staff there asked:

*'Do we bite the bullet and design the service for all children and young people up to 18 or do we hold out for a young adult service for 16-19 year olds?'*

Staff had already visited other locations, in England, which provide a young adult service for 16-19 year olds to review how such a service could be provided in the future.

#### **4.3 Funding available for CAMHS**

Designated liaison officers compared the funding that has been provided to CAMHS with that provided for adult mental health services. Adult mental health services receive high levels of recurrent funding, whilst for CAMHS there is a varied approach with both recurrent and non-recurrent funding being made available.

The announcement of the additional £700,000 for CAMHS in Wales raised expectations for partner agencies that LHBs will have more resources. This was summed up by one LHB officer:

*'you find out that 500 thousand pounds was money already given to HCW to fund specialised placements and that can provide confusion for colleagues.'*

In fact the majority of the increased funding was allocated towards the development of a forensic adolescent service for Wales and CAMHS emergency admissions with a relatively small amount going to LHBs for funding primary mental health workers. This again is only likely to reinforce the perception that Tier 3 and Tier 4 CAMHS are the most important.

The use of non-recurrent funding to fund core elements of CAMHS demonstrates clearly to designated liaison officers that CAMHS are not as well funded as adult mental health services and:

*'it is acknowledged that there needs to be much greater investment in children's services but there is a difficult balance between providing sufficient resources for both old and young.'*

The use of non-recurrent funding was highlighted as a particular issue for service commissioners. It was viewed as producing instability in the system because it does not allow for services to be planned on a long-term basis and also raises expectations from service users, their families and also fellow professionals. When these raised expectations are not then realised on a local basis, trust and engagement with the service are reduced. One designated liaison officer stated:

*'I am unsure though whether the service users or others involved now have any expectations when it comes to CAMHS.'*

The thrust of the strategy *Everybody's Business* was to move mental health issues away from being seen solely as the responsibility of health professionals yet to date a multi-agency approach does not seem to have become a reality across Wales. One liaison officer stated that the provision of non-recurrent funding for CAMHS to LHBs causes challenges because that *'sends a mixed message to other partners.'*

Designated liaison officers were strongly of the opinion that the use of non recurrent funding has not benefited the development of the service because:

*'we are competing against each other for that funding and it tends to be that you adopt a sticking plaster mentality to this funding and go for what is added value and do not address your core service provision although you know that your core provision is not as you would wish it to be.'*

Bids for non-recurrent funding were seen as being very labour intensive and costly to prepare for a small return. In some cases LHBs receive notification of the availability of non-recurrent funding in November of one year which has to be spent by the end of March in the following year. One LHB spelled out both the benefits and potential difficulties of using non-recurrent funding for essential parts of CAMHS:

*'non recurrent funding is not helping in developing the service, for example, the CAMHS network manager in this area is starting to pull together the work across the region and to provide an overview but her post is funded with non-recurrent money and so that post may be under threat.'*

There were also concerns that the use of non-recurrent funding demonstrates a lack of commitment to improving the core CAMHS provision, because the funding provides small projects in local areas which then close before effective practice can be shared on an all-Wales basis. These projects, although valuable, are short term and therefore *'their effect is dissipated because they are not sustained.'* This project approach to service provision can raise expectations whilst neglecting the development of core services. In some cases participants felt that there is an expectation that what is funded on a non-recurrent basis is then expected to become core without any additional increase in funding. A further issue with the project-based funding has been the establishment of pilot projects which are successful but then the funding for posts within such a scheme is transferred to another area but on a permanent footing. Therefore the staff in the pilot area move with the funding and leave their previous health area with a staff and skills shortage. This is a situation that *'clearly impacts on the health and well being of the children in the area.'* One LHB has

therefore taken the step of introducing training posts so that they develop a greater number of CAMHS staff within their own organisation.

In some areas, additional funding streams have been used to provide project based services, for example lottery funding.

### **Community Intensive Therapy Teams**

The establishment of and funding for Community Intensive Therapy Teams (CITT) was an issue where there is lack of consistency. One designated liaison officer said:

*'there is a need for further discussion to remove the ambiguity as to who is responsible for Tier 3 community intensive treatment teams.'*

The designated liaison officers' responses provided a picture of an uncoordinated approach to the provision of such services. In one geographical area close to the South Wales inpatient CAMH unit, there are CITTs in each of the LHB areas. However some LHBs stated that they have to fund this provision themselves, whilst others have their CITT commissioned by HCW. This anomaly is clearly at odds with the commissioning policy that states:

*HCW is directly responsible for commissioning the services defined in Welsh Health Circular (2003) 62:*

#### **3.3 Tier 3 Services**

*Day Patient services*

*Community and other intensive therapy programmes (e.g. Community Intensive Therapy teams)*

*Community Forensic CAMHS*

#### **3.4 Tier 4 Services**

*NHS funded CAMHS placements outside Wales*

*Inpatient psychiatric services within and outside Wales*

*Forensic CAMHS*

### **HCW Commissioning Policy Section 3 Commissioning Responsibility Page 3**

Other designated liaison officers stated that business cases had been submitted to HCW for CITTs and that they were awaiting responses to these proposals. Some officers were hopeful of funding and had been told that HCW were supportive of the proposals but could not at present fund the team, whilst others were not hopeful and asked *'who will pay, will it be HCW or the LHB? Is the service a Tier 3.5 service?'* Some of these officers have therefore planned to use their own funding streams to ensure that a CITT is provided. In other areas a considerable distance from either of the current inpatient units, no CITT is provided and this was seen as a deficit within the current service provision. It is inequitable that areas close to the inpatient units are provided with a resource that allows children and young people to be treated as close as possible to their homes and that areas furthest from the units have no such provision. Some designated liaison officers

questioned the evidence base for the CITTs as outlined within the commissioning guidelines because *'I would say that our Tier 3 specialist CAMHS provide that anyway.'* In some areas, local CAMHS teams were seen as providing the same type of service as a CITT but on a case by case basis according to clinical need.

### **Priority for CAMHS – *Everybody's Business***

It became clear that the importance of child and adolescent mental health services differs across different localities in Wales. In some areas, designated liaison officers reported that children's issues and CAMHS specifically were discussed at high levels and there was senior executive level support for the implementation of *Everybody's Business*. However in other areas the emphasis on CAMHS was felt to have been lost because of the focus of children and young people's partnerships on universal services for all children and young people. Where the emphasis has been retained on CAMHS and ensuring the full implementation of *Everybody's Business* then there have been developments such as ensuring that CAMHS has been identified as a priority for the Framework Partnerships. However even in these areas, it is yet to be seen what priority will be placed on this issue when all of the other competing issues are considered.

In some areas health professionals stated that the membership and leadership of children and young people's framework partnerships have not to date ensured a sufficiently high profile for health issues and in particular mental health issues for children and young people. One designated liaison officer summarised the issue:

*'In joint planning groups the rhetoric is that CAMHS is for everyone but it is not realised because it is not part of their policy agenda. CAMHS should be for everyone but the CAMHS provider network is a very small number of providers.'*

#### **4.4 The exclusion of children and young people with learning disabilities and a mental illness from CAMHS**

It became clear that those children and young people who have a diagnosis of learning disability and a mental illness are excluded from CAMHS. This was viewed in a negative light by liaison officers who could not understand the reasoning for this decision.

In one area there had been an increase in the requests made for funding from the LHBs for children and young people with a learning disability. The liaison officer at one LHB felt that this was due to the merger of ELWa and the Welsh Assembly Government. Previously it was felt that ELWa would have funded the placements for such children and young people but:

*'that is now not happening to the same level as it is DELLS and they do not fund 100% and so they are requiring us and social services to pick up the funding for children who we have had no prior contact with. There are significant number of these and we have not been involved in the planning for these children but they are predicable in terms of cases and so in this local authority a working group has been set up to discuss this issue and to manage the expectations that the family and children may have.'*



Other designated liaison officers felt that the exclusion of children and young people with learning disabilities could lead to considerable clinical governance issues. This was described as a:

*'really significant issue. There is a real need to be able to have provision to assess those children as the service is so poor for them in Wales and at present because of that things are so unsafe and they are the ones that we struggle with. Those children have nowhere to go but are also very vulnerable.'*

One LHB exemplified the impact that this exclusion could have on the life of a child who had a:

*'primary diagnosis of a learning disability but also had a psychotic disorder and was in a school placement and was being visited by doctors who were constantly adding medication and those were short term interventions. In the end he became chronically unwell and we had to bring him into a CAMHS situation despite his learning disability diagnosis and we took him off some of the medication and the situation improved. Now I do not believe that the diagnosis that he had of a learning disability should have prevented him accessing the help that he needed.'*

The issue for the local CAMHS providers was that there was no appropriate location where the child could be treated and the conditions at the private placement where the child was treated initially were described as *'terrible'*. In another area a care pathway has been developed between adult services and learning disability services and the view was that a similar pathway needed to be developed between children's mental health services and learning disability services. Some of the workers in this area have been told that *'CAMHS cannot deal with a child because their IQ is too low.'* The decision should centre around the child's health needs and their rights to provision rather than an arbitrary discussion about IQ levels.

## **4.5 Self-harm and CAMHS**

### **Background**

The Report of the National Inquiry into Self-harm among Young People, entitled *Truth Hurts*, was published in 2006 and is essential reading for anyone working with children and young people. The report suggested that as many as 1 in 15 young people self-harm. Also of particular relevance to health professionals are the *NICE Guidelines on the Management and Prevention of Self-harm*.

Young people self-harm as a way of coping with emotional stress or problems in their lives. Some of the agencies we spoke to during our scoping exercise extended the concept of self-harm to include drug and alcohol misuse which may also be a coping mechanism.

When children and young people present to professionals - either because the self-harm has resulted in serious injury requiring medical intervention, or because they have themselves decided to seek help - the initial reaction is an important one. If their impression of the support they receive is negative, they may retreat to self-harm in secrecy for a long time, rather than continue to access support.

Self-harm is a symptom of the distress they are experiencing and therefore any support must attempt to address these underlying causes rather than simply attempt to stop the self-harm. The road to recovery is therefore a long one.

Although therapeutic intervention stays mainly in the domain of health services, prevention of self-harm is genuinely “Everybody’s Business” and interventions in school have been shown to be effective in offering young people opportunities to speak about the issues that are affecting them and which may lead to self-harm. The young people who spoke to the National Inquiry stressed that it was important to have someone to “listen” to them and “respect” their views. Many young people said they prefer to turn to other young people for support.

The Welsh Assembly Government’s recent commitment to providing school-based counselling services could be an additional preventative factor.

## **Findings**

There was overall agreement that children and young people who self-harm should be considered “children in need” (as defined by the Children Act 1989, section 17). However, it was clear that the very definition of a “child in need” varied from agency to agency.

Some agencies reported that, when they were sufficiently concerned about a child to make a referral to social services, their concerns were not shared and an assessment was not always conducted. This, they said, did little to encourage them to make further referrals. Sensibly, in those cases, a referral was made to a school nurse to monitor the child on a monthly basis.

There were reservations with some agencies reporting that only some children with more complex needs would be considered as children in need. Others reported that only where admission to hospital was necessary would the child be considered “in need” whereas those who were able to return home from A&E would not. Others, although they included alcohol and drug abuse within their definition of self-harm, suggested that isolated instances of excessive alcohol consumption would not normally be considered as potential children in need.

In general, the phrase “it depends” was used a lot referring to both the family circumstances of the child as well as the nature of the incident of self-harm. There is clearly a need for more guidance for medical professionals on how to deal with cases of self-harm with detailed criteria on which they can base their decisions.

Despite the problems reported above, all agreed that there should be a multi-agency process for coordinating services to children and young people who self-harm. There was less general agreement as to which agency should take the lead and there appeared to be considerable variation across Wales. Several agencies suggested that Health should take the lead and others that the LSCB should be the lead agency. One suggested that the lead should be within specialist CAMHS services, another suggested that social services would be the likely lead and one agency suggested that education would have a role to play. It

became clear that, although everyone was keen to demonstrate a commitment to multi-agency working, the actual practice in many areas did not always live up to the rhetoric.

Several respondents referred to work on self harm that had been done by Area Child Protection Committees (ACPCs). These are now being superseded by Local Safeguarding Children Boards (LSCBs) which, at the time of the scoping exercise, had had only a few meetings and some respondents suggested that it was too early to evaluate their impact. It was suggested that the statutory footing of LSCBs had encouraged input from local authority departments who had previously had little input into ACPCs and that the scrutiny role of LSCBs would be likely to provide greater direction to Children and Young People's Framework Partnerships (CYPFPs). There was, however, some concern that since, in some cases at least, the membership of the LSCB and the CYPFP were the same individuals and therefore it was difficult to see how they would effectively scrutinise themselves.

Health was normally represented on the LSCBs in the form of executive named nurses or doctors for child protection. However, local authorities were required by legislation to be represented by their chief executives as well as a wide range of other staff so that some health representatives said they felt underrepresented and that they had a lower status in the group. Additionally, since there is a great deal of specialisation in health, they often found it difficult to get emotional and mental health needs onto the agenda.

*Truth Hurts* carefully makes the distinction between self-harm and suicide:

*Self-harm is usually intended to harm: not to kill, or even to inflict serious and/or permanent damage. It is a strategy which (however maladaptive and damaging) makes it possible for the young person to continue with life, not to end it. Some people who self-harm do also try to kill themselves at some point but these are a very small minority. Fox and Hawton (2004) estimate that between 40 to 100 times as many young people have engaged in self-harm than those who have actually ended their own lives.*

**Truth Hurts - Page 28**

Nevertheless, we were keen to explore how LHBs and Trusts were able to analyse the circumstances of suicides by children and young people in their area. Many respondents quoted the requirement in Part 8 of *Safeguarding Children - Working Together under the Children Act 2004* which states:

*3.1 LSCB will always undertake a serious case review when a child dies (including death by suicide), and abuse or neglect is known or suspected to be a factor in the child's death. This is irrespective of whether children's social care is or has been involved with the child or family.*

This suggests that, even where there is a suicide, there need only be a serious case review where abuse or neglect is considered to be a factor.

The lack of clarity in this area was demonstrated by the fact that some respondents reported that there was currently no breakdown for the under 25s age group, and that

LHBs were not normally notified of suicides. Others suggested that they were seeking lottery funding for projects to undertake this type of work. Others suggested that work of this type was being undertaken by the National Public Health Service.

There was mention of a few specific projects that were intended to address self-harm by raising the underlying self-esteem of children and young people. These included the Amber Project Cardiff, Pyramid (used in schools) and the Catspaw theatre project. "Inspire" is an initiative which involved the youth service in long-term follow up support for children and young people who had presented at A&E with self-harm was reported to be very effective. Again, though, there was concern about how long the project could be continued as it was dependent on non-recurrent funding from the Big Lottery. Other agencies have expressed a wish to emulate this project in their own areas but have been unsuccessful in obtaining funding to do so.

Another use of non-recurrent funding was a multi-agency training initiative in Mid and West Wales. This offered training about self-harm to A&E staff, and school nurses as well as to schools. Some schools accepted the offer of training and others exercised their autonomy by rejecting it. The training was also offered to GPs – who reportedly, exercising their autonomy as independent contractors, rejected the offer. Fortunately, additional funding has been made available by the CAHMS network for the training to continue. Pembrokeshire and Derwen NHS Trust have produced a support, resource and training pack for those working with children and young people who self-harm entitled *Scratching the Surface*.

Several respondents mentioned the important role of GPs in identifying and responding to a child who self-harms. Although GPs have regular child protection training it is unclear as to whether self-harm forms part of that training. A specific concern was expressed strongly by one respondent in a LHB:

*'We need to get GPs to take responsibility. When I spoke to some GPs about this question, they told me to speak to the health visitor as they would have the expertise'.*

It is not entirely surprising that some GPs reject an offer of specific training in self-harm as, in common with many other issues relating to children's health, self-harm does not figure in the GPs' Quality Assessment Framework (QAF). That a LHB is unable to insist that those that they pay meet certain criteria in delivering services to children is worrying.

Some areas, but by no means all, had developed care pathways for use by both GPs and hospital staff. In general, under 16s who had self-harmed and presented to A&E would be admitted to a paediatric ward and, once their physical condition had been stabilised, they would be assessed by the CAMHS team prior to their being discharged. There were however several variations on this. Some areas reported that due to resource limitations the assessment by CAMHS would only be available 3 days a week and therefore some children and young people may not be assessed prior to discharge. Others suggested that in some cases, especially for over 16s, children and young people may be placed on adult wards and therefore may not be assessed by the CAMHS team before their discharge.

Others were less clear - suggesting that only where cuts or injuries were "significant" or the child was judged to be "at risk" would an assessment by the CAMHS team be considered

necessary before discharge. They were unable to provide the criteria whereby these judgements would be made. This is surprising considering the the National Institute for Clinical Excellence (NICE) and the National Collaborating Centre for Mental Health (NCCMH) have published a guideline (CG16 Self harm) for the NHS in England and Wales on the care of people who self-harm. The guideline makes recommendations for the physical, psychological and social assessment and treatment by primary and secondary care of people in the first 48 hours after having self-harmed.

One of the guidelines is:

*1.7.3.1 All people who have self-harmed should be assessed for risk; this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.*

**The National Institute for Clinical Excellence (NICE) and the National Collaborating Centre for Mental Health (NCCMH) have published a guideline (CG16 Self Harm) for the NHS in England and Wales on the care of people who self-harm - Page 27**

The concluding observation of the Committee on the Rights of the Child criticised the UK government when it commented that it:

*remains concerned that many children suffer from mental health problems and that the rate of suicide among young people is still high.*

**2002 Concluding Observations pages 10-11  
Paragraph 43 Adolescent health**

All children and young people who have self harmed have a right to an assessment before their discharge regardless of whether they have been placed on an adult or paediatric ward.

## **4.6 Children and young people whose parents misuse substances**

### **Background**

*Tackling Substance Misuse in Wales* was published by the Welsh Assembly Government in 2000 and was to be an 8 year plan. Therefore, in 2007 at the time of this scoping exercise, it is particularly relevant to see what services are available for this group of children and young people.

Published in 2003, the report of an Inquiry by the Advisory Council on the Misuse of Drugs *Hidden Harm* outlined how parental problem drug use can and does cause serious harm to children at every age - from conception, when the problem drug use can cause the medical harm to the child, throughout all developmental stages to adulthood.

Responses to the report were made by the Welsh Assembly Government and the National Service Framework for Children, Young People and Maternity Services in Wales makes a number of specific references to meeting the needs of children born to and living with

parental substance misuse, as well as requiring effective links to be in place with Local Substance Misuse Action Plans. These include:

2.61 Agencies are to adopt and implement protocols which ensure that children and young people who are cared for by adults that misuse substances are safeguarded.

Page 23

3.12 Pregnant women who:

- smoke have access to information and advice to assist them with smoking cessation;
- misuse other substances have access to information and advice on a range of appropriate treatment or interventions.

Page 28

3.21 There is a multi-agency strategy to provide pre-pregnancy advice including nutrition and exercise, benefits of breastfeeding, sexual health and avoidance of substance misuse, starting with school-aged young people.

Page 30

## Findings

The first recommendation of *Hidden Harm* (Page 10) was that '*all drug treatment agencies should record an agreed minimum consistent set of data about the children of clients presenting to them*'. We asked respondents how this happened in practice.

It was clear that respondents wanted to be able to reassure us that these children would be identified and, in some cases, we heard that the names and dates of birth of children of problem drug users are in fact recorded. In other cases, the fact that there were children in the family was only recorded in the files of the parents and the information did not reach children's services staff. Some other respondents reported that information about children is not collected.

There was little evidence, however, that the data, even where it was recorded, was used to identify their potential needs except where a child protection issue was also identified and referred as such. The thresholds for reporting concerns seemed to be lower where the parents abused drugs but where the parents abused alcohol it was less likely that a referral would be made.

One respondent suggested that, if the children and young people were formally identified as "young carers", more support for them would be forthcoming. This may well be true but, where parents misuse drugs, few young people would consider approaching the local authority for support unless they were prepared for legal action to be taken against their parents.

The new Welsh Assembly Government initiative, the Wales In depth Integrated Substance Misuse Assessment Tool (WIISMAT), is currently being piloted and has sections which look specifically at identifying the needs of children whose parents misuse substances and hence safeguarding them.

2.14 WIISMAT is described as *the first “specialist” assessment tool to be developed in Wales for health and social care workers to undertake specialist assessments of the needs of substance misusers. Its production involved a lengthy process to ensure the tool fits with existing health and social care processes and procedures. We commenced an extended consultation in June which involves the tool being tested in an operational environment through pilots in Monmouthshire, Ceredigion, Neath Port Talbot/Bridgend, Gwynedd and Ynys Mon. The pilots will inform refinements to the final version of the module which we are aiming to publish April 2007.*

<http://www.assemblywales.org/5bd8deed31935e20363803497890b083.pdf>

Social Justice and Regeneration Committee

SJR(2) –12-06(p2) Annex 1

Title: Substance Misuse – 4th Annual Progress Report

Page 6

One area reported that their child protection nurse provided training for the local drug and alcohol team. North Wales child protection policies are reported to include protocols about families in which parents misuse substances.

In other areas though, there was little confidence that adult services and children’s services had sufficiently robust procedures for communicating with each other in order to ensure that children were safeguarded. Indeed, except in one or two areas, there was little confidence that GPs had protocols to ensure the safeguarding of children whose parents misuse substances.

Many of the respondents raised concerns that this group of children are difficult to identify and are therefore difficult to involve in planning of services for them. Few agencies were able to report that the issues affecting children whose parents misuse substances were given sufficient prominence within their CYFPs and local drug action teams were not given the opportunity on these partnerships to report on the problem.

#### **4.7 Children and young people who exhibit sexually harmful behaviour**

##### **Background**

Home office statistics for England and Wales tell us that of all sexual offence convictions, 33% are perpetrated by young people under the age of 17years. This is a very significant figure. However this figure only relates to those cases that have been successfully prosecuted by the Crown Prosecution Service. By far the bigger proportion of sexual offences perpetrated by young people goes unreported to the Police, un-investigated by either the Police or Social Services and therefore remains untreated and unresolved. This is a major national public health issue.

We may locate the need to provide forensic assessments, therapeutic interventions and treatment options for sexually harmful behaviour within the framework of the UNCRC. Part 1 of Article 19 says that:

1. *The State shall protect the child from all forms of maltreatment by parents or others responsible for the care of the child and establish appropriate social programmes for the prevention of abuse and the treatment of victims.*

However, perhaps less widely known is Part 2 of the Article which says that:

2. *Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment...*

There is a broad consensus that the treatment of sexually harmful behaviours in young people requires a specialist component addressing this aspect of behaviour. It is also crucial that such interventions consider the young person's social and cultural factors, their cognitive and developmental level, and their experiences of victimisation.

The provision of specific and specialist services for the assessment and treatment of children and young people with sexually harmful behaviours is a right.

Sir William Utting in his report *People Like Us* published in 1997 identified the lack of service provision that was available for children and young people with sexually harmful behaviours. He called for an inter-departmental review of treatment options available for, as he then termed it, adolescent abusers. At the time the government response stated that the Home Office and the Department of Health would take forward the recommendation by Her Majesty's Inspector of Probation that youth justice services should include treatment to ensure sexual offending behaviour by adolescents is properly addressed through assessment, intervention and relapse-prevention services.

The Joseph Rowntree Foundation reviewed the recommendations made by Utting, and the progress made in implementation. The report was published in 2004 and commented that:

*Significant increases in treatment programmes are needed for this group of young people.*

Children and young people should not be judged by adult standards regarding their sexual behaviours. Some of the confusion experienced by professionals working with children with sexual behavioural problems has occurred when there is an over reliance on standards for adult sexual offending.

There is an inconsistent response to children and young people at the local level, with different systems and policies operating in different areas. There has been little development of the specialist resources required to meet the specific needs of this small but significant group of young people.

A coherent, strategic, response is needed to meet the needs of children and young people with a sexually harmful behaviour that will lower the level of child sexual abuse and help these children from developing their behaviour into adulthood.



Chapter 9 of *Safeguarding Children: Working Together Under the Children Act 2004*, published by Welsh Assembly Government in 2007, at paragraphs 9.37 to 9.45 provides unequivocal advice about the services which should be provided, saying at paragraph 9.39 that:

*...Early intervention with children and young people, who abuse others, may therefore play an important part in protecting the public by preventing the continuation or escalation of abusive behaviour...*

The guidance goes on to describe 3 key principles that should guide this kind of work with children and young people who abuse others, including a multi-agency coordinated approach and a specific assessment process.

## **Findings**

Many, though by no means all, agencies reported that they were able to offer a specialist risk assessment service for children and young people who exhibit sexually harmful behaviour. Some in South Wales reported that, depending on the severity of the behaviour, they may make a referral to the forensic service at Caswell Clinic in Bridgend. This was surprising and interesting feedback because the seven local authority areas comprising the South Wales Police Authority area, commission specific and specialist services for assessment and treatment programmes from a Barnardos project – Taith. We were not aware that specialist services for the assessment of children and young people sexually harmful behaviour such as those provided by the Taith project would be available from the Caswell clinic.

Agencies in North Wales reported that they currently obtain forensic assessments from the FACTS team based in Manchester and some of their CAMHS practitioners are undertaking training with FACTS.

We were given to understand that the commissioning, by HCW, of an All Wales forensic service was in progress but very much in its infancy. There were some concerns that the proposed service delivery model of having the nurse and psychologist based in the North with the remainder of the team based in the South would prove problematic. There were further concerns that the continuation of funding for the existing arrangements was already uncertain even though establishment of the All Wales forensic service was still some way off.

One area reported that there is a clinical nurse specialist in each YOT but there was uncertainty whether referral through either this route or through a consultant would meet the referral criteria for specialist CAMH services. This statement however was almost immediately contradicted by a statement that sexually “concerning” behaviour would be referred to CAMHS. They were unable to offer further explanation.

In some areas there were no local services for either risk assessment or treatment programmes. When services were required they were individually commissioned from other agencies, although there was no information either about that commissioning process, or about the agencies or organisations able to provide that service.

In one area we were informed that the LHB and local authority had jointly funded a counselling service for sexual abuse. This comment, however, illustrates the lack of understanding of the differences between post sexual abuse treatment services and sexually harmful behaviour.

Some concerns were expressed regarding the constitution of Multi-Agency Public Protection Arrangements panels (MAPPA). In some areas there is no CAMHS representation and therefore it is questionable how young people's rights are represented when they are considered for inclusion on the sex offenders register.

Sexually harmful behaviour is often seen as a youth justice or welfare issue rather than a behaviour that signifies a more complex set of needs that require full multi-agency involvement. One respondent described the failure of social services to recognise the level of need for a service of this type, without acknowledging that health agencies have equal responsibility for the commissioning of services in this area. Further evidence of the weaknesses of multi-agency working was evidenced by the inability, in some cases, to provide suitable alternative accommodation for some young people who exhibited sexually harmful behaviour. In other cases it was the availability of accommodation that dictated therapeutic services rather than medical need.

Few LHBs or NHS Trusts in Wales were aware that in their *Commissioning Policy – CAMHS*, HCW list sexual offending in their *Access Criteria* (Chapter 5) for *Forensic Adolescent Consultation and Treatment Services*. There is a dearth of FACT services in areas of Wales and therefore a major health inequality for very vulnerable children and young people with very concerning behaviour. By not providing timely and effective assessments and treatment programmes for these children, LHBs, Local Safeguarding Children's Boards and the NHS in Wales are storing up future health problems and difficulties not only for the young people with a sexually harmful behaviour but also, quite possibly, for future generations of children.

Children and young people with sexually harmful behaviours are without doubt 'children in need' as defined by Section 17 of the Children Act 1989, whether they are caught up in the Youth Justice System or not. Consequently, it will be imperative that guidance relating to the collation and production of local authority children's services plans and Local Safeguarding Children Boards Business Plans is required to specify and describe the services that are provided for these children and young people.

## 5 Key Findings and conclusions

In this section we present the key findings from the scoping exercise. Whilst it is recognised that the scoping exercise was carried out with designated liaison officers and not specialist CAMHS workers, it is important to recognise that the liaison officers are frequently the key local personnel in terms of commissioning CAMHS.

We recognise also that there is an ongoing Health Inspection Wales and Wales Audit Office review of CAMHS and a review of adult mental health services which is addressing issues of transition between adult and CAMHS.

It is expected that Welsh Assembly Government and HCW will respond directly to the concerns outlined in the key findings and conclusions below.

HCW is an executive agency of the Welsh Assembly Government, and is therefore only delivering and adhering to the policies and directives of Welsh Assembly Government. It is not therefore solely HCW that decides upon the commissioning policy it promotes.

**There is a need to review the policy and rationale for CAMHS in Wales coupled with reconsideration and appraisal of the level of funding required.**

The variable practice in terms of access to CAMHS for 16-18 year olds not in full time education demonstrates an inequity of service provision to some young people in Wales. Those areas where this group of young people can access CAMHS, have made this change in practice despite clear policy guidance from HCW to the contrary. All young people between the ages of 16 and 18 should be able to access CAMHS in their area.

**CAMHS should be commissioned and resourced to provide services to all children and young people up to their 18<sup>th</sup> birthday.**

**All 16-18 year olds should have access to CAMHS regardless of their educational status and the Welsh Assembly Government should change policy to make this clear.**

When a child requires inpatient treatment in a Tier 3 or Tier 4 facility, the additional need for specialist CAMHS staff to re-assess the child often results in delays in the child or young person's care. Health professionals were unable to exemplify any areas where a second opinion for specialist treatment would be required within adult services. Some LHBs felt that the denial of specialist CAMHS could mean that young people's health may suffer.

**Current referral criteria and practice, whereby an additional assessment by Specialist CAMHS staff is required before children and young people can receive Tier 3 or 4 inpatient treatment, should be reviewed**

The use of non-recurrent funding means that the core CAMHS is being given less priority whilst LHBs concentrate on bidding for project money. This project based approach leads to small isolated pockets of effective practice which LHBs and other providers find

challenging to sustain. This in turn leads to a loss of confidence in services from service users, their families and professionals.

**Welsh Assembly Government must end the practice of funding important CAMH services with short term non-recurrent funding. There must be stability in the funding of CAMHS in Wales as in adult mental health services.**

It would appear that resources and their scarcity are driving the provision of CAMHS rather than the needs of individual children and young people. The number of gatekeeping procedures and arbitrary decisions appears to place the mental health of young people at risk. Children often spend several weeks in the paediatric ward when their physical medical needs have been resolved before an appropriate CAMHS bed can be found for them. Adolescents are often being treated on adult mental health wards, which are not attuned to providing services for this age group and where the experience can be a frightening and damaging one for young people.

**There should be a review of the funding arrangements and commissioning to ensure there are:**

- **sufficient adolescent beds to avoid the need for the current practice of placing children and young people on adult wards**
- **sufficient child and adolescent mental health emergency placements**
- **forensic and eating disorder services in Wales.**

There is a broad consensus that the treatment of sexually harmful behaviours in young people requires a specialist component addressing this aspect of behaviour. It is also crucial that such interventions consider the young person's social and cultural factors, their cognitive and developmental level and their experiences of victimisation.

The provision of specific and specialist services for the assessment and treatment of children and young people with sexually harmful behaviours is a right. We have seen substantial progress in English local authorities following the mapping of current services initiatives commissioned by the Home Office and conducted solely in England. It is hard to understand why this initiative did not stretch beyond Offa's dyke.

**A coherent, strategic response is needed to meet the needs of children and young people with a sexually harmful behaviour that will lower the level of child sexual abuse and help these children from developing their behaviour into adulthood.**

**Funding that is ring fenced for the South Wales FACTS should be released.**

Most LHBs were unaware that the HCW responsibilities for commissioning Tier 3 and 4 services did not apply where there was a prior diagnosis of learning disability. The exclusion of young people with a learning disability from CAMHS, which was described as '*dangerous*' by one liaison officer, could have a massive impact on the development of those young people. All young people, regardless of their additional needs, have a right to receive the CAMHS they require.

**There is a definite need to develop Care Pathways for children and young people with a learning disability who may also need CAMHS.**

The varying levels of understanding are a major cause for concern given that LHBs are the primary commissioners of CAMHS in their local areas. LHBs clearly find it challenging to work with HCW in situations where a child or young person's care may be interrupted because of funding disputes. The new commissioning policy produced by HCW with little or no consultation with participants in the research is unhelpful and it was astonishing to find that many of these colleagues reported that they had not received this new policy from HCW. Some LHBs are unclear as to their specific commissioning responsibilities and this impacts on children and young people's treatment. The wishes of the child or young person should also be taken into account.

**The commissioning policy should be reviewed to ensure:**

- **it unambiguously clarifies the responsibilities of all partner organisations**
- **all LHBs and NHS Trusts understand and are able to follow the commissioning policy**
- **that the views of children and young people who use the service are taken into account in the review of the policy.**

**There is an urgent need for clear, effective dispute procedures for a quick resolution when there is disagreement between LHBs, NHS Trusts and HCW.**

Liaison officers reported that the use of the tight referral criteria into Specialist CAMHS means that some children and young people are not receiving services which could be of benefit to them. The inadequacy of funding means that LHBs and health providers may be required to provide health care for children and young people without the necessary expertise or funding. There were genuine concerns that this situation could place the emotional health and well-being of some young people at considerable risk.

**There is a need to review the statement in the current commissioning policy that a child receiving an inpatient service will only be funded for 3 months.**

According to designated liaison officers the funding of CITTs is a mixed picture with no clear reasoning as to why neighbouring LHBs have completely different funding arrangements for the CITTs. The lack of funding for CITTs in areas distant from inpatient units is incomprehensible.

**Community Intensive Therapy Team provision should be equally funded across all LHBs.**

Designated liaison officers reported that, to date, CAMHS has yet to become Everybody's Business and it has to gain importance within the local structures. However concerns were expressed that these bodies are configured in such a way that CAMHS staff and health professionals generally do not feel that they can positively influence the agenda.

**Children and Young People's Framework Partnerships need to include statements about local CAMHS in their Children and Young People's Plans and CAMHS should be identified as a priority service area.**

The tight referral criteria into specialist CAMHS are seen as a cause for frustration for designated liaison officers and other professionals. Whilst recognising the need for criteria to ensure that resources are used most effectively there is a need for criteria to be clearly explained to front line health professionals. A concern is what happens to a child who is unable to meet the referral criteria. The difference between the medical and social models of assessment is shown starkly here. The medical model completely denies services to those who don't meet the referral criteria. A social model, on the other hand, would assess need on a spectrum and provide services to meet the needs. It is to be hoped that with an increase in multi-agency working these different approaches can be reconciled.

Some areas, but by no means all, had developed care pathways for use by both GPs and hospital staff. In general, under 16s who had self harmed and presented to A&E would be admitted to a paediatric ward and, once their physical condition had been stabilised, they would be assessed by the CAMHS team prior to their being discharged. There were however several variations on this. Some areas reported that due to resource limitations the assessment by CAMHS would only be available 3 days a week and therefore some children and young people may not be assessed prior to discharge. Others suggested that in some cases, especially for over 16s, children and young people may be placed on adult wards and therefore may not be assessed by the CAMHS team before their discharge.

**All children and young people who have self harmed have a right to a specialist assessment before their discharge regardless of whether they have been placed on an adult or paediatric ward.**

## **6. Conclusions**

### **Conclusion 1**

There is a need to review the policy and rationale for CAMHS in Wales coupled with reconsideration and appraisal of the level of funding required.

### **Conclusion 2**

CAMHS should be commissioned and resourced to provide services to all children and young people up to their 18<sup>th</sup> birthday.

### **Conclusion 3**

All 16-18 year olds should have access to CAMHS regardless of their educational status and the Welsh Assembly Government should change policy to make this clear.

### **Conclusion 4**

Current referral criteria and practice, whereby an additional assessment by Specialist CAMHS staff is required before children and young people can receive Tier 3 or 4 inpatient treatment, should be reviewed.

### **Conclusion 5**

Welsh Assembly Government must end the practice of funding important CAMH services with short term non-recurrent funding. There must be stability in the funding of CAMHS in Wales as in adult mental health services.

### **Conclusion 6**

There should be a review of the funding arrangements and commissioning to ensure there are:

- sufficient adolescent beds to avoid the need for the current practice of placing children and young people on adult wards
- sufficient child and adolescent mental health emergency placements
- forensic and eating disorder services in Wales.

### **Conclusion 7**

A coherent, strategic response is needed to meet the needs of children and young people with a sexually harmful behaviour that will lower the level of child sexual abuse and help these children from developing their behaviour into adulthood.

### **Conclusion 8**

There is a definite need to develop Care Pathways for children and young people with a learning disability who may also need CAMHS.

### **Conclusion 9**

The commissioning policy should be reviewed to ensure:

- it unambiguously clarifies the responsibilities of all partner organisations
- all LHBs and NHS Trusts understand and are able to follow the commissioning policy
- that the views of children and young people who use the service are taken into account in the review of the policy.

**Conclusion 10**

There is a need to review the statement in the current commissioning policy that a child receiving an inpatient service will only be funded for 3 months.

**Conclusion 11**

There is an urgent need for clear, effective dispute procedures for a quick resolution when there is disagreement between LHBs, NHS Trusts and HCW.

**Conclusion 12**

Community Intensive Therapy Team provision should be equally funded across all LHBs.

**Conclusion 13**

Children and Young People's Framework Partnerships need to include statements about local CAMHS in their Children and Young People's Plans and CAMHS should be identified as a priority service area.

**Conclusion 14**

All children and young people who have self harmed have a right to a specialist assessment before their discharge regardless of whether they have been placed on an adult or paediatric ward.

**Conclusion 15**

Funding that is ring fenced for the South Wales FACTS should be released.



## References

Children's Commissioner for Wales (2003) *Annual Report & Accounts 2002-2003*  
<http://www.childcomwales.org.uk/publications/annual%20report%2003%20-%20english.pdf>

Children's Commissioner for Wales (200) *Telling Concerns*  
<http://www.childcomwales.org.uk/publications/telling%20concerns.pdf>

Children's Commissioner for Wales (200) *Children don't Complain*  
<http://www.childcomwales.org.uk/publications/Children%20dont%20complain.pdf>

Children's Commissioner for Wales (200) *Lifting the Lid*  
<http://www.childcomwales.org.uk/publications/School%20Toilets%20Report.pdf>

Children's Commissioner for Wales (200) *As Long as I get there safe*  
<http://www.childcomwales.org.uk/publications/As%20long%20as%20I%20get%20there%20safe.pdf>

Children's Commissioner for Wales (2004) *Annual Report & Accounts 2003-2004*  
<http://www.childcomwales.org.uk/publications/Annual%20Report%2004%20-%20English.pdf>

Children's Commissioner for Wales (2005) *Annual Report & Accounts 2004-2005*  
<http://www.childcomwales.org.uk/publications/Annual%20Report%2005%20-%20English.pdf>

Children's Commissioner for Wales (2006) *Annual Review 2005-2006*  
[http://www.childcomwales.org.uk/publications/CCFW\\_ann\\_review\\_eng.pdf](http://www.childcomwales.org.uk/publications/CCFW_ann_review_eng.pdf)

Children's Commissioner for Wales (2007) *Report of Liaison Seminar Meetings held between the Children's Commissioner for Wales and LHBs, NHS Trusts, NPHS Wales Designated Doctors and Nurses September 2006*

Office of the Children's Commissioner (2007) *Pushed into the Shadows - Young People's experiences of adult mental health wards*  
<https://www.childrenscommissioner.org/documents/Pushed%20into%20the%20shadows%20report%20final.pdf>

Welsh Assembly Government (2002) *Too Serious A Thing - The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales*  
[http://new.wales.gov.uk/docrepos/40382/40382313/childrenyoungpeople/403821/safeguards\\_text-e.pdf?lang=en](http://new.wales.gov.uk/docrepos/40382/40382313/childrenyoungpeople/403821/safeguards_text-e.pdf?lang=en)

National Assembly for Wales (2001) *Child and Adolescent Mental Health Services Everybody's Business- Strategy Document*  
<http://www.wales.nhs.uk/publications/men-health-e.pdf>

Welsh Assembly Government (2007) *Safeguarding Children - Working Together under the Children Act 2004*

<http://new.wales.gov.uk/docrepos/40382/dhss/4038226/1338309?lang=en>

Welsh Assembly Government's (2000) *Tackling Substance Misuse in Wales: a partnership approach*

United Nations Committee on the Rights of the Child (2002) *Concluding Observations on UK*

<http://www.crae.org.uk/cms/dmdocuments/uncrc%20concluding%20obs%202002.pdf>

Department of Health (2000) *Lost in care, report of the tribunal of inquiry into the abuse of children in care in the former county council areas of Gwynedd and Clwyd since 1974*

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4003097](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003097)

Welsh Assembly Government *2004 Children and Young People Rights to Action*

<http://www.assemblywales.org/N0016990.pdf>

Welsh Assembly Government *2002 Framework for Partnership*

Welsh Assembly Government (2004) *The National Service Framework for Children, Young People and Maternity Services in Wales*

<http://www.wales.nhs.uk/sites3/Documents/441/EnglishNSF%5Famended%5Ffinal%2Epdf>

Welsh Assembly Government (2007) *Rights in Action, Implementing Children and Young People's rights in Wales.*

<http://new.wales.gov.uk/docrepos/40382/4038232/403829/4038291/1104233/rightsinaction-e.pdf?lang=en>

Welsh Assembly Government (2003) *Welsh Health Circular 63 NHS Planning and Commissioning Guidance*

Health Commission Wales (SS) (2006) *Commissioning policy for Child and Adolescent Mental Health Services*

Camelot Foundation and Mental Health Foundation (2006) *Truth Hurts The Report of the National Inquiry into Self-harm among Young People*

<http://www.selfharmuk.org/docs/self%20harm%20report%20lowres.pdf>

National Institute for health and Clinical Excellence (2004) NICE Guidelines on the Management and Prevention of Self-harm

<http://www.nice.org.uk/page.aspx?o=cg016niceguideline>

## Appendices

### Appendix A – List of Local Health Board Designated Liaison Officers

<b>Local Health Board</b>	<b>LHB Designated Liaison Officer</b>
Anglesey	Elizabeth Powell <i>Nurse Director</i>
Blaenau Gwent	Bobby Bolt <i>Nurse Director</i>
Bridgend	Ms Sue Morgan <i>Nurse Director</i> <i>Director of Modernisation</i>
Caerphilly	Chrissie Hayes <i>Nurse Director</i>
Cardiff	Mrs Jenny Theed <i>Nurse Director</i>
Carmarthen	Jill Paterson <i>Executive Officer</i>
Ceredigion	Helen Williams <i>Nurse Director</i>
Conwy	Mrs Sue Owen <i>Executive Nurse</i>
Denbighshire	Jane Trowman <i>Executive Nurse Director</i>
Flintshire	Ms Nesta Rees <i>Director of Nursing</i>
Gwynedd	Mr Peter Liptrot <i>Executive Nurse Director</i>
Merthyr Tydfil	Maria Thomas <i>Nurse Director</i>
Monmouthshire	Ms Julie Thomas <i>Nurse Director</i> <i>Deputy Chief Executive</i>
Neath and Port Talbot	Mrs Judith Hill <i>Nurse Director</i>
Newport	Beverly Thomas <i>Executive Nurse Director</i>
Pembrokeshire	Dr June Picton <i>Medical Director</i>
Powys	Claire Lines <i>Head of Clinical Strategy</i>
Rhondda Cynon Taff	Lynda Williams <i>Director of Nursing</i>
Swansea	Jan Worthing <i>Nurse Director</i>
Torfaen	Vicki Warner <i>Nurse Director</i>
Vale of Glamorgan	Kath Bergmanski

Wrexham	Sue Willis <i>Nurse Director</i>

## Appendix B – List of NHS Trust Designated Liaison Officers

<b>NHS Trust</b>	<b>NHS Trust Designated Liaison Officer</b>
Bro Morgannwg	Karen Healey <i>Head Of Children's Nursing Services</i>
Cardiff & the Vale	Mrs Sue Gregory <i>Chief Nurse</i>
Carmarthenshire	Kevin Tribble <i>General Manager – Family &amp; Child Health Services</i>
Ceredigion & Mid Wales	Ruth Harrison <i>Nurse Child Protection</i>
Conwy & Denbighshire	Rachel Shaw <i>Director of Nursing Services</i>
Gwent	Ms. Sam Crane <i>General Manager, Child &amp; Family Division</i>
North East Wales	Val Doyle <i>Executive Nurse</i>
North Glamorgan	Ruth Walker <i>Director of Nursing</i>
North West Wales	Angela Hopkins <i>Executive Nurse</i>
Pembrokeshire & Derwen	David Morrissey <i>Clinical Services Manager</i>
Pontypridd & Rhondda	Mrs. Kath McGrath <i>Directorate Manager Women, Child &amp; Family (Acute)</i>
Swansea	Liz Rix <i>Director Of Nursing</i>
Velindre	Mrs. Diane Smith <i>Executive Director of Nursing/Quality</i>

## Appendix C Participants in the scoping exercise

Participated	NHS Trust or Local Health Board
N	Bro Morgannwg
N	Neath and Port Talbot Local Health Board
Y	Carmarthenshire
Y	Carmarthenshire Local Health Board
Y	Ceredigion & Mid Wales
Y	Ceredigion Local Health Board
Y	Pembrokeshire & Derwen
Y	Pembrokeshire Local Health Board
Y	Conwy Local Health Board
Y	Conwy & Denbighshire
Y	Denbighshire Local Health Board
Y	North East Wales
Y	Wrexham Local Health Board
Y	Flintshire Local Health Board
Y	Cardiff & the Vale
Y	North Glamorgan
Y	Pontypridd & Rhondda
Y	Cardiff Local Health Board
Y	Merthyr Tydfil Local Health Board
Y	Vale of Glamorgan Local Health Board
Y	Gwent
Y	Blaenau Gwent Local Health Board
Y	Caerphilly Local Health Board
Y	Monmouthshire Local Health Board
Y	Newport Local Health Board
Y	Torfaen Local Health Board
Y	Powys Local Health Board
Y	Swansea
Y	Swansea Local Health Board
Y	North West Wales
Y	Anglesey Local Health Board
Y	Rhondda Cynon Taff Local Health Board
Y	Velindre
Y	Gwynedd Local Health Board
Y	Bridgend Local Health Board



## Appendix D

### The Implementation of “Everybody’s Business”

The following questions are to elicit information about the range and availability of services in your area in order to gain a complete picture of services across Wales.

Name

Role

Organisation

#### 1 *Everybody’s Business*

1.1 Who, in your organisation, has overall responsibility for the implementation of *Everybody’s Business*?

1.2 What is the mechanism for the local education authority’s educational psychologist to liaise with health professionals over concerns about children?

1.3 Can children who are between 16 and 18 years, but are not in full time education, access CAMH services? If not, what services can they access? If they need inpatient services, will they be placed in a children’s ward or an adult ward?

1.4 What procedures would be followed when a parent refuses to allow therapeutic or medical intervention or medication for their child?

#### 2 Tier 3 and Tier 4 CAMHS

2.1 Does your organisation have a procedure for discharging its responsibility under sections 85 & 86 of the Children Act 1989?

2.2 Who is responsible for identifying that a child has needs that can only be met by a CAMH tier 3 or 4 service?



2.3 Who is responsible for commissioning and funding this service?



2.4 How many children in your area are currently placed in a Tier 3 or Tier 4 service in Wales?



2.5 How many children in your area are currently placed in a Tier 3 or Tier 4 service outside of Wales?



2.6 What resources are available in your area for Tier 3 inpatient assessment and treatment?



2.7 What Tier 3 community intensive intervention services are available in your area?



### 3 Children and young people who self harm

3.1 Are children and young people who self harm “children in need” - as defined by the Children Act 1989, section 17?



3.2 Should there be a multi-agency process for coordinating services to children who self harm? Which agency should take the lead?



3.3 Should self harm be identified and dealt with through child protection procedures or through medical intervention or both?



3.4 What process should a GP follow if there is suspected self harm? Are there protocols?





3.5 What is the referral process following emergency intervention either by primary care or A&E?



3.6 Should there be a multi-agency process for analysing the circumstances of suicides by children and young people on a local basis?



3.7 What are the arrangements for liaising with Local Safeguarding Children Boards?



## 4 Children and young people who exhibit sexually harmful behaviour

4.1 Does CAMHS in your area provide a specialist and forensic risk assessment service for children and young people with sexually harmful behaviour?



4.2 Is CAMHS in your area able to provide a therapeutic treatment and intervention service for children and young people with sexually harmful behaviour?



4.3 Standard 2.25 in Children's NSF is:

*There is a lead officer and lead member in each LHB; a lead executive and non-executive in each NHS trust and a Lead director and lead member for each LA for children and young people. They are responsible for co-ordinating and monitoring the implementation of the child protection procedures in line with Working Together to Safeguard Children and local **ACPC** procedures.*

Please identify how this responsibility has been discharged in relation to children who exhibit sexually harmful behaviour.



## 5 Children and young people whose parents abuse substances (Hidden Harm)

5.1 Does your organisation record data on the children of problem drug users?



5.2 Do your policies and practices relating to problem drug use of adults highlight the need, in the first instance, to safeguard children?



5.3 Does your organisation facilitate a process by which the children of problem drug users are able to have their voices heard and so influence the planning of delivery of services for them?



5.4 Is your local Drug Action Team represented on the Children and Young Peoples' Framework Partnership and the Young Peoples' Partnership?



5.5 Is there a protocol for GPs and primary care teams for reporting their concerns about the children of problem drug users?



5.6 Are any Tier 1 and/or 2 CAMH services, available to the children of problem drug users?



## Appendix E

### CHILDREN'S COMMISSIONER FOR WALES' ANNUAL REPORT COMMENTS FOCUSSING ON CAMHS

#### ANNUAL REPORT 2002-2003

#### Priority issues 2002-03

##### *Child and Adolescent Mental Health Services (CAMHS)*

*The publication of Everybody's Business – the all-Wales strategy for child and adolescent mental health services - was welcomed by many practitioners and commentators. It set out a clear strategic direction designed to ensure that adequate and appropriate emotional and mental health services were available for young people in Wales. It made prominent mention of a child centred approach which was welcome, although other elements of the strategy did not display as explicit a commitment to participation as they should. Nonetheless, the strategy was a bold and imaginative attempt to put mental health services for young people on the right track.*

*It is therefore all the more surprising that no funding has been identified and ringfenced to implement the strategy by the Welsh Assembly Government (WAG), who commissioned the report in the first place and action must be taken in order to address this.*

*The consequences are all too clear. I have been approached directly by professionals and their associations, and by individuals acting on behalf of young people. Their message is the same: They speak of a service in crisis, with poor and patchy provision, and a worrying drain of skilled and professional workers. Those remaining talk of low morale. Some of the particular service deficiencies include:*

- *a lower number of adolescent inpatient beds per head of population in Wales than anywhere else in the UK*
- *no children's inpatient beds in Wales*
- *no adolescent forensic service in Wales*
- *no eating disorder beds in Wales*
- *virtually no service for children with a learning disability*
- *no emergency adolescent beds in Wales*

*This last point means that some young people have to be admitted to adult psychiatric wards or children being placed hundreds of miles from home away from their families and their country, and that is wholly unacceptable. We have also been made aware of consultants with waiting lists of well over 12 months, and of significant staff vacancies in psychiatric and psychological services.*

*The lack of appropriate and timely help to young people with mental health problems can blight their entire lives. WAG is now working on National Service Frameworks including mental health. There seems little point in this further refinement of intention without a commencement of realisation. I am aware that in England £80 million was allocated to CAMHS with a further £140 million promised over the next 3 years.*

*It is about time the WAG either directly funded its much applauded strategy or gave up the pretence that it was committed to it. Without a clear, immediate and funded way forward for*

*CAMHS many of its other statements of commitment to children's wellbeing ring a little hollow.*

## **Annual Report 2003-4**

Quote: *'Children and young people can become lost within the CAMHS tier system, which puts people into boxes.'*

### **Child and adolescent mental health services (CAMHS)**

I regret to say that I am far less impressed with progress in the area of Child and Adolescent Mental Health Services. While the Health and Children's Minister's announcement of an additional £700,000 for these services after my last year's report was welcome, it is totally inadequate in the face of the continuing crisis in provision. In all areas of service for children I am hearing how the absence of proper mental health support is undermining real progress.

As I write this report there are many children and young people in Wales experiencing high levels of distress that could be lessened if the right resources were in place. Timely intervention is crucial for these children, and its absence will mean some of them will struggle far into their adult lives when they need not do so. Welsh Assembly Government is now requiring that Local Health Boards and Trusts develop costed plans, but our children in Wales are still left as the poor relations to their peers in England where almost £300 million is being invested over a three year period, the development of a comprehensive CAMHS by 2006 has been identified as an aim and a team of nine CAMHS Regional Development Workers has been recruited to provide guidance and assistance to local staff. While I welcome the emphasis placed on CAMHS with the National Service Framework, I find the difference with England especially hard to accept as Wales has a well respected and comprehensive strategy that should have made us a leader in this area of services. As one would expect of a strategy, *Everybody's Business*, considers the whole range of services, provided by both statutory and voluntary agencies, and as is often the case, the whole is more than the sum of its parts. Consequently the piecemeal allocation of relatively small amounts of money towards aspects of the strategy is not likely to be as effective or efficient a remedy as careful consideration of the funding and budgetary implications of *Everybody's Business* as a whole. I therefore repeat my plea of last year that the Assembly commit the necessary resources or publicly accept that it has abandoned its strategy.

## **Annual Report 2004-2005**

### **Child and Adolescent Mental Health Services (CAMHS)**

My anxiety regarding a strategic approach to eradicating child poverty in Wales – and also around the implementation of the NSF – is of course rooted in the experience of observing the slow progress made in implementing the CAMHS strategy, *Everybody's Business*, about which I have written in previous reports. While there is no doubt that the additional funding announced has been of benefit, concerns about the continuing failure in Wales to provide an adequate CAMHS response are still being brought to me by professionals working in the field.

Individual cases dealt with by my Advice and Assistance service confirm that there is still a long way to go. Professionals working with children and young people often express their frustration to me, as do parents and their children who suffer as a result. Among the positive developments during the past year are that early identification work is being developed through Primary Mental Health Workers undertaking preventative work. Experienced professionals tell me that we need to strengthen these teams across Wales to prevent unnecessary referrals and enhance the life chances of children. They also believe that to have three primary health workers per 100,000 children would ensure that children's mental wellbeing is safeguarded.

I am also pleased with the development of a forensic consultation and treatment service (FACT) for young people. Although limited at present, it is a good start. It is essential nevertheless that professionals trained specifically to work with children and young people are employed within these services. At present there are specific concerns around access to appropriate services for 16-18 year olds since CAMHS is commissioned for children and young people up to 16 years of age unless they are still in full time education. Adult Mental Health Services are commissioned for 18 years and over, resulting in a gap in mental health services for many 16-18 year olds and patchy and problematic provision. I recommend that CAMHS be commissioned and resourced to see all young people up to their eighteenth birthday.

I also await with considerable interest Health Commission Wales' costed plans regarding Tier 3 and Tier 4 CAMHS. It is a disgrace that sick children and young people have to be placed so far from home, out of Wales, and usually detained under the Mental Health Act in order to receive treatment, therapy and services. These children are probably the most vulnerable in Wales and yet are probably the least safeguarded.

## **Annual Review 2005-2006**

### **Child and Adolescent Mental Health Services (CAMHS) and other health services for children and young people**

I have made comments previously about the funding of CAMHS and it has become clear that provision of many services across Wales are unequal and so not all children may be able to access the services that they need. As mentioned earlier in this report, my office is continuing to deal with issues around the provision of mental health services for children and young people. It is clear that my concern over the lack of financial backing for the WAG strategy was legitimate. Indeed, it would seem that very little has changed since I last highlighted this issue. To date the funding made available has been insufficient to take forward the strategic and service delivery proposals outlined in Everybody's Business and the National Service Framework for Children, Young People and Maternity Services (Children's NSF). The relatively small increase in funding has only addressed a tiny proportion of the need. I would remind WAG that the CAMHS implementation group estimated that an additional £10m per year would be needed for the first three years of delivering on the strategy outlined in Everybody's Business. Despite the commitment made in that document and in the Children's NSF, CAMHS provision is in crisis across Wales. My advice and support service has been involved in a range of cases that have substantiated that Wales has insufficient adolescent inpatient beds. Within a two-week period the service

dealt with three cases – two of young people with eating disorders and one where there was self-harm – where Health Commission Wales refused to fund the placements CAMHS professionals considered to be appropriate for their needs. Young people in dire need of specialist treatment are experiencing weeks of delay before they are admitted. Adolescents are also being treated on adult mental health wards, which are not attuned to providing services for this age group and where the experience can be a frightening and damaging one for young people. Through the advice and support service I have also become aware that the one inpatient bed for CAHMS in West Wales was closed by the trust without consultation.

During the year my team has had considerable contact with health professionals. I am aware that there is some innovative and good practice and we were pleased that many health settings now recognise children's rights and welfare to a greater extent. Nevertheless, professionals have expressed considerable concern about the lack of funding for many of the new developments within the health service for children and young people.

For example, we are aware of projects that aim to tackle the issue of self-harm and 'hidden harm'. These are short-term projects which may only last for a few years and in some cases are being funded by Lottery money. The National Assembly for Wales must end this situation whereby important services are being run with short term funding. The Children's NSF has raised expectations but has not received sufficient resources to enable it to deliver all of its targets.

There are considerable differences in terms of guidance and funding for children's health when compared to adult health. Professionals tell us that guidance materials from Welsh Assembly Government are incomplete and that funding to make changes for adult services is not replicated for children's services. A further concern for professionals is that many needs are identified for children, but the means to meet these needs are not available and current funding formulas increase the inequalities of service provision.

Not all the targets that were flagged in the Children's NSF and due to be put in place by March this year have been achieved. However, instead of reinforcing a commitment to achieve the targets set by WAG in their Service and Financial Framework Document (the SAFF), those targets are now dropped for the next financial year. Indeed the SAFF contains no targets for achieving the standards laid down within the Children's NSF. I am unclear how exactly, if there is no financial commitment, implementation will be achieved.

### **2005-2006 Annual Review Case example involving CAMHS**

A foster carer called us about a boy with behavioural problems who had been placed with her out of his home county for 4 years. He had problems dealing with anger, was hearing voices, having morbid thoughts, had self harmed and had started a fire deliberately. While he had been assessed as needing specialist CAMHS support a dispute between two local health boards over who should foot the bill meant that he had been waiting two years for treatment. The foster carer was at the end of her tether and the lad had become involved in criminal activities and was excluded from school. We intervened and brought the situation to the attention of the Minister for Health and Social Services. The LHB in the county where

he was placed agreed to pay for his treatment. Clearer guidance will be issued from Welsh Assembly Government to ensure that it is clear that the placing LHB is responsible

## Appendix F

### Welsh Assembly Government Section about CAMHS in *Rights in Action*

#### Child and adolescent mental health services

In 2001, the Assembly Government published Everybody's Business, its 10 year strategy for the improvement of child and adolescent mental health services (CAMHS) in Wales

Mental health and psychological well being of children and young people is being addressed as one section of the National Service Framework for Children, Young People and Maternity Services. The NSF contains specific and measurable key actions for the delivery of multi-agency services across Tiers 1 to 4 that are closely linked to Everybody's Business.

Current policy is that the most vulnerable children and young people, including those who are looked after and young offenders, have access to high quality equitable and responsive services on the basis of their needs. Already, this policy has resulted in young offenders and children who are looked after receiving substantially higher levels of access to CAMHS than are available to the general population (evidence from Youth Justice Board, and from the ONS survey The Mental Health of Children Looked After by Local Authorities in Wales, 2002-03).

Funding of £1.2 million per annum has been made available for CAMHS services from 2004-05 for:

- providing beds for adolescents who require admission in emergencies;
- developing a new Forensic Adolescent Consultation Service (a new service in Wales has been initiated, developed with 2 teams commissioned by Health Commission Wales - one for South, Mid and West Wales and a second for North Wales);
- developing posts for Primary Mental Health Workers
- assisting local specialist CAMHS to implement New Ways of Working in Mental Health. This allows them to improve services for children and young people in ways that they think are best for their area, to make the best use of resources, and relieve some of the pressures on senior staff in all disciplines.

£1.4 million of one-off waiting times funding was made available in 2005-06 to help develop Regional NHS CAMHS Commissioning Networks, and achieve the Assembly Government's Service and Financial Framework targets set for 2005-06 and 2006-07. £600,000 of non-recurrent funding has been allocated to the CAMHS Commissioning Networks in 2006-07, based on measurable outcomes.

The application of the Service and Financial Framework (SaFF) access monies is linked to:

- refining Local Health Boards' costed plans;
- developing the Regional CAMHS Commissioning Networks;
- achieving the first part of the SaFF by the end of March 2006, and
- achieving the second part of the SaFF in 2007.



Funding has also been provided to the University of Glamorgan and the University of Bangor (2003-04 to 2005-06) to develop a diploma level multi-disciplinary module to meet the needs of nurses and other disciplines working in the CAMHS field.

There are now at least 27 Primary Mental Health Workers (PMHW) in Wales working mainly with children and adolescents. This level is broadly comparable with the numbers of posts for PMHWs in England reported by the PMHW professional association. It is also above the ratio of posts to population proposed by the Children's Commissioner for Wales in his 2004-05 Annual Report.

The Assembly Government will be consulting in 2007 on a national strategy for school-based counselling services. This will aim to put in place a comprehensive service across Wales which pupils will be able to access. This will help fulfil many of the actions set-out in the National Service Framework as well as responding to a specific recommendation of the Clywch inquiry. It is also planned to provide schools, local authorities and their partners with good practice guidance on promoting emotional health in education settings.

A review of the implementation of *Everybody's Business* will take place during 2007. This will review progress and outcomes to date, and set the direction for the remaining years of the Strategy. The review will also enable the success of current policy relating to vulnerable children to be evaluated and adjusted as appropriate.

### **Child suicides**

The Assembly Government takes the death of a child or young person very seriously, and has been looking at the suicide rates among young people in Wales to see if there are any common factors and what further investigations may be helpful.

The Assembly Government has supported, developed or funded a number of services which can offer support to children, young people and their families/ carers including:

- a Community Advice and Listening Line (CALL) - a mental health help-line (and is currently considering whether this can be extended to parents worried about their children);
- guidance for schools, local authorities and other partners to promote the mental health and social well-being of pupils. Guidance is currently being developed to cover nursery settings;
- strengthening Child and Adolescent Mental Health (CAMHS) services in Wales by building a balanced range of services across health, education and social care provision.