

Mind over matter

A report on the step change needed in emotional and mental health support for children and young people in Wales

April 2018



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About the Committee

The Committee was established on 28 June 2016 to examine legislation and hold the Welsh Government to account by scrutinising its expenditure, administration and policy matters, encompassing (but not restricted to): the education, health and well-being of the children and young people of Wales, including their social care.

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Torfaen

Current Committee membership:



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North Wales



Hefin David AM
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Caerphilly



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Chair's foreword

Support for the emotional and mental health of children and young people in Wales has been too limited for too long. We believe that the time has come to put mind over matter and deliver appropriate, timely and effective emotional and mental health support for our children and young people, once and for all.

We recognise the improvement made in specialist children and adolescent mental health services (CAMHS) in the last two years.

But it is not enough.

It is estimated that three children in every average size classroom will have a mental health issue. By the age of 14, half of all mental health problems will have begun. To stem the flow, we need a step change. We need to equip our children with the skills, confidence and tools to be emotionally resilient. We need to intervene much earlier, addressing the seeds of distress before they take root.

This will not be achieved through piecemeal change. Differences in the processes, structures, funding, cultures, knowledge and training of the various players – including health, education, local authorities, the third sector and the criminal justice system – mean a joined-up approach is crucial if the vision of child-centred support is to be delivered. Building a resilient, emotionally and mentally healthy population of children and young people has to be a stated national priority. But words alone will not do – they need to be underpinned by the planning, resource and commitment required to deliver real change.

For that reason we make one key recommendation. We state that the urgent challenge now lies at the “front end” of the care pathway – emotional well-being, resilience and early intervention – and that addressing this should be a stated national priority for the Welsh Government. Failure to deliver at this end of the pathway will lead to demand for specialist services outstripping supply, threatening their sustainability and effectiveness.

In line with the status of national priority, we think ring-fenced resource is needed to make schools community hubs of cross-sector and cross-professional support for emotional and mental well-being. We also think everyone who works with children and young people should be trained in emotional and mental health awareness, to tackle issues of stigma, promote good mental health and enable signposting to support services where necessary. We think that this, more than anything, will enable us to deliver the step change that is urgently needed if we

are to help prevent and manage the emotional, behavioural and mental distress experienced by an increasing number of our children and young people.

We recognise, however, that we cannot prevent all illness. To that end, we make a series of recommendations for improvements to the community and specialist services that are so important for the treatment of some of our most vulnerable and unwell children and young people. We recognise the enormous amount of work staff across public and voluntary services do on a daily basis to support children and young people in emotional or mental distress. We believe that they need further assistance to achieve the outcomes our children and young people deserve.

Our predecessor Committee was told in 2014 that too many children and young people entering specialist CAMHS were being referred there incorrectly and ought to be helped in other parts of the system. By 2018, not enough has changed. The pieces of the jigsaw that need to be in place to enable children and young people to be supported outside the most specialist settings are simply not there. Four years since the last inquiry, this is unacceptable and must be addressed urgently by the Welsh Government.

This is a subject that touches us all, and an area in which we all have a responsibility – and an ability – to make change happen. We are unwilling to allow this significant issue to be passed on yet again to a successor Committee with repeated conclusions of “more work left to be done”. The time has come to put mind over matter and make the step change that is so urgently needed.

Lynne Neagle AM
Chair, Children, Young People and Education Committee







Chapter 1:

Background

We launched our inquiry in July 2017. Our aim was twofold: to build on our predecessor Committee's work in 2014 on specialist child and adolescent mental health services, and to look in more detail at the support available for children and young people's emotional well-being, including prevention and early intervention services.

Our report makes one key recommendation, and 27 others. Taken together, we believe these will deliver the step change that is needed to build a population of emotionally resilient and mentally healthy children and young people in Wales.

1.1. Children and young people's mental health and well-being

1. Across the UK, it is estimated that one in four children will show some evidence of mental ill health, and three children in an average size classroom will have a mental health problem.¹ Half of all mental health problems begin by the age of 14, and three-quarters by an individual's mid-20s.²
2. Wales is no exception. Time to Change Wales – an alliance of leading Welsh mental health charities – reports that one in ten young people will experience a mental health problem, and nearly three in four young people fear the reaction of friends when they talk about it.³ Mental health is the issue most commonly raised with the Children's Commissioner for Wales by children, young people, their parents and carers, and was highlighted as a key priority when this Committee consulted on our work programme shortly after the Assembly elections in May 2016.⁴
3. Without support, mental distress can have a severe impact on children's happiness, well-being and development, their educational attainment and their potential to live fulfilling and productive lives. Children and young people with mental health problems also face stigma, isolation and discrimination, as well as challenges in accessing health care and education. But these are not inevitable consequences of mental distress. Evidence shows that with appropriate and timely intervention and support, children and young people can live well and happy lives.

¹ Young Minds, [Impact Report 2016-17](#) and [Wise up to Wellbeing in Schools](#)

² World Health Organization, [Child and adolescent mental health](#), accessed March 2018

³ Time to Change Wales, [Myths and Facts](#), accessed March 2018

⁴ Children, Young People and Education Committee, [Consultation: Priorities for the CYPE Committee](#), July – September 2016

1. 2. Our inquiry

4. In light of concerns about the increase in the prevalence of mental health problems among children and young people, and in response to our predecessor Committee's and stakeholders' calls for further work to be undertaken in this area, we announced our inquiry into the emotional and mental health of children and young people in Wales in July 2017.
5. We had two main aims for this work:
 - to assess whether the "root and branch" review to modernise and redesign services announced by the Welsh Government in October 2014 - which led to the establishment of the Together for Children and Young People Programme in February 2015 - is on track to deliver the step change in child and adolescent mental health services (CAMHS) provision identified as necessary by our predecessor Committee's [report](#); and
 - to establish whether early intervention, prevention and resilience services were in place to support the emotional well-being of children and young people in Wales.
6. We also wanted to ensure that we did not focus on diagnosable mental disorders alone - we recognise that mental illness spans a wide range of emotional, behavioural and psychological problems. We further recognise that mental health should not only be seen through a negative prism - positive dimensions such as life satisfaction, happiness and resilience also need to be considered, especially when identifying the steps that need to be taken to support the emotional well-being of our children and young people.
7. Our [terms of reference](#) identified specialist CAMHS, funding, transition to adult services and links with education as headline areas of interest. We also wanted to re-visit areas of concern highlighted by our predecessor Committee, including referral arrangements, waiting times, out-of-hours and crisis care, in-patient capacity, psychological therapy, and support in the community.
8. However, we did not want to concentrate on the most specialist services only. We were also keen to consider what support could be provided to avoid escalation to specialist services where possible. Provision in schools to help encourage emotional resilience and healthy coping mechanisms, particularly opportunities afforded by the development of the new curriculum, were of strong interest to us. We also wanted to measure the extent to which joint working

between health, education, social services, youth work, and the third sector was helping to create an environment in which people could discuss emotional well-being and mental health without fear or stigma.

Our evidence gathering






- 9.** In light of the breadth and importance of this subject, we undertook a substantial evidence gathering exercise to inform our conclusions and recommendations. Annexes B and C of this report provide full details of the written and oral evidence we received, all of which is available publicly.
- 10.** Given the reported prominence of emotional and mental health in the minds of children and young people, and the direct impact it can have on them and those around them, we were also keen to ensure that we reached out beyond the Senedd to hear from those with first-hand experience.
- 11.** To explore the extent to which emotional and mental health support is provided in schools, we held a roundtable meeting with over 40 frontline professionals providing a range of services in the school setting. We also conducted two surveys – one for children and young people in secondary school/college and one for education professionals.
- 12.** During the course of our inquiry we also visited a number of settings providing a range of emotional and mental health support. These included specialist in-patient units, a primary school, a third sector youth project and a secure children’s home.
- 13.** We are grateful to all those who took the time to contribute to our inquiry, but particularly those children and young people who shared their views and experiences so willingly and openly with us.

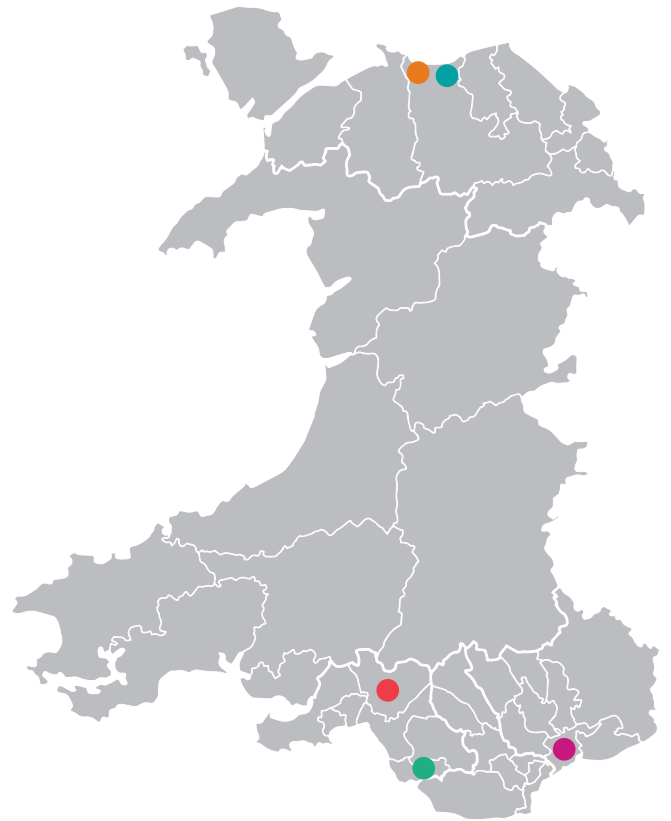
HOW WE GATHERED EVIDENCE

We wanted our report and recommendations to be informed by the direct experiences of children and young people, and those providing support to them. To do this, we conducted visits, hosted a roundtable discussion and ran a survey which received over 2000 responses.

OUR VISITS

We visited services across Wales to hear from those receiving and delivering a range of emotional and mental health support.

-  **Ysgol Pen y Bryn**
Colwyn Bay
-  **North Wales Adolescent Service**
Abergele
-  **Hillside Secure Children's Home**
Neath
-  **Tŷ Llidiard Inpatient Unit**
Bridgend
-  **Changing Minds Project**
Newport



SURVEY RESPONSES

1611 children and young people in secondary schools and colleges;
425 education professionals.



ORAL EVIDENCE SESSIONS

21 (and **75** witnesses)



ROUNDTABLE PARTICIPANTS

40 from frontline health and education services.



WRITTEN SUBMISSIONS

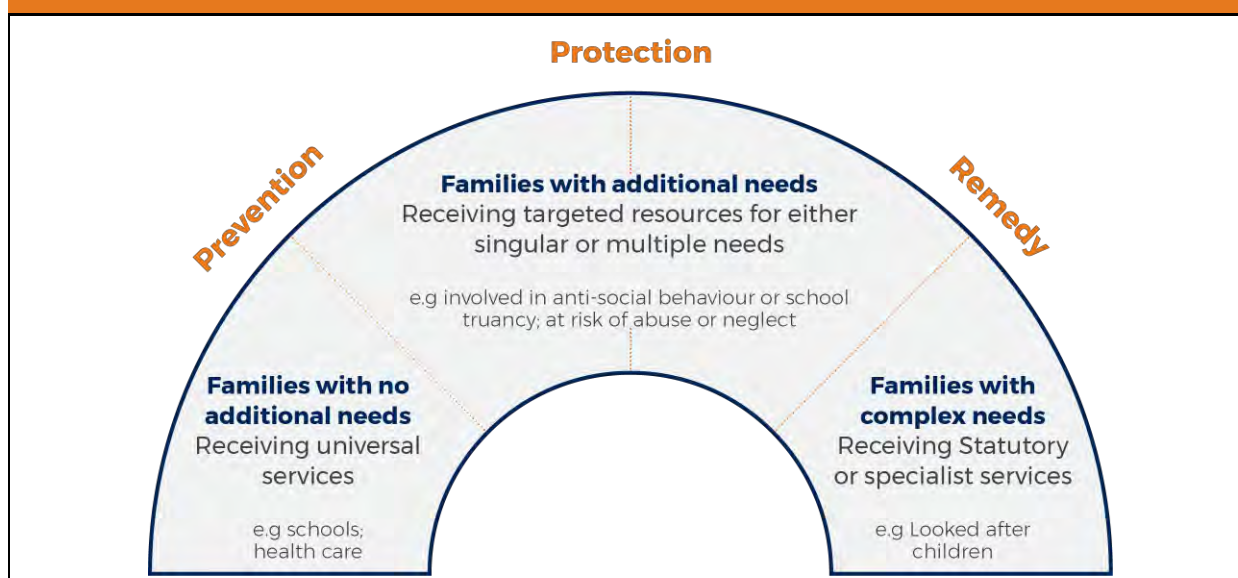
67 + **23** additional papers

1.3. Context

Together for Children and Young People (T4CYP) Programme

14. The T4CYP Programme is a multi-agency service improvement programme, led by the NHS. Its stated aim is to reshape, remodel and refocus the emotional and mental health services provided for children and young people in Wales. The Programme has adopted a “windscreen” model to develop the resilience of all children and young people in Wales, to intervene early for those at risk, and to ensure that those with mental illness get access to specialist CAMHS as quickly as possible.

Figure 1: T4CYP windscreen model



Source: T4CYP Programme – Framework for Action

15. The T4CYP Programme operates based on work streams that focus on: universal resilience, well-being, early years and early intervention; neurodevelopmental (ND) needs; and specialist CAMHS. Other cross-cutting streams include: workforce, education and training; care transitions; and Health Needs Assessment.

16. The Welsh Government established the T4CYP Programme initially for a three-year period, ending in March 2018. During the course of our current inquiry, the Welsh Government announced the extension of the Programme until October 2019.⁵

⁵ Written evidence, EMH 68 – Welsh Government

Funding

17. In May 2015, the Welsh Government announced an additional £7.65 million investment (recurrent on an annual basis) towards improving mental health services for children and young people.⁶ This was to be used alongside funding for children and young people services in the “general mental illness” and “other mental health problems” expenditure lines within the Health, Well-being and Sport Main Expenditure Group.

New service teams and targets

18. As part of the T4CYP Programme’s work and as a result of the additional funding allocated in 2015, steps have been taken by all health boards (with some ahead of others) to establish a number of new service teams to work alongside specialist CAMHS and local primary mental health teams. A number of performance targets have also been set with a view to driving service improvement. The teams involved are:

- **Neurodevelopmental (ND) Service teams** – to provide multidisciplinary assessment, diagnosis and treatment, information and advice for children and young people with a ND disorder (including autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD) and Tourette’s Syndrome), and their families. All children and young people should be **assessed within 26 weeks of referral**;
- **Community Intensive Treatment / Crisis teams** – to support children and young people who present in crisis (with availability out-of-hours and at weekends). All children and young people with **urgent needs should be seen within 48 hours**, reduced from the previous target of 4 weeks;
- **Early Intervention in Psychosis teams** – to support young people aged 15 to 24 with first episode and early psychosis; and
- **Existing specialist CAMHS teams** have been set a **waiting time target of 28 days from referral to assessment**, replacing the previous target of 16 weeks referral to treatment.

⁶ Welsh Government, [£7.6m funding boost for children and young people’s mental health services in Wales](#), 22 May 2015

Curriculum reform

19. Professor Graham Donaldson published his independent review of curriculum and assessment arrangements in Wales, [Successful Futures](#), in February 2015. This review has informed the process of developing a new curriculum for settings and schools in Wales. The new curriculum will be phased in from September 2022 onwards (starting with primary schools and year 7 in 2022, moving upwards through year groups on an annual basis thereafter).

20. The Welsh Government states:

“The whole approach to developing young people aged 3 to 16 will change. The new curriculum will have more emphasis on equipping young people for life. It will build their ability to learn new skills and apply their subject knowledge more positively and creatively. As the world changes, they will be more able to adapt positively.”⁷

21. The new curriculum will have six “Areas of Learning and Experience” (AoLE). One of these will focus on health and well-being.

⁷ Welsh Government, [New school curriculum](#), 31 January 2018 update





| | | | |
|----|----|----|----|
| 1 | 2 | 3 | 4 |
| 11 | 12 | 13 | 14 |
| 21 | 22 | 23 | 24 |
| 31 | 32 | 33 | 34 |
| 41 | 42 | 43 | 44 |
| 51 | 52 | 53 | 54 |
| 64 | 65 | 66 | 67 |



Chapter 2:

Emotional well-being, resilience and early intervention

With three children in an average size classroom having a mental health issue, more resilience and early intervention work is needed as a matter of urgency.

The costs of emotional and mental ill health – both personally to the individuals and families involved, and to the public purse – are too high for us not to try to stem the flow earlier.

Reform of the curriculum in Wales offers a once-in-a-generation opportunity to embed well-being into our children's lives. Furthermore, schools are ideally placed to make a significant contribution to building an emotionally resilient population of young people, reducing stigma and promoting good mental health.

But they cannot do it alone. Support from other statutory and third sector bodies, most notably health, is essential. The whole-school approach needs to be a cross-sector responsibility and a step change is needed to deliver it.

Support is also needed outside the school environment. Services available in the community, via primary care, need urgent attention.

2. 1. The role of education

22. There was a strong consensus in the evidence submitted to our inquiry that:

- education settings, including primary schools, secondary schools, colleges and universities, are **key to promoting emotional well-being and good mental health**;
- **levels of stress and anxiety among pupils are rising**, highlighting how important it is that schools and colleges help promote well-being and support children and young people to develop the resilience and skills needed to deal with stress and anxiety;
- it is crucial to develop a **whole-school approach**, embedding well-being into the entire school ethos, the curriculum, and staff training and professional development. A **substantial step change is needed to realise this ambition**. Furthermore, a whole-school approach does not mean schools meeting pupils' needs on their own – the **involvement of a range of professionals from other agencies is needed**;
- the **current reform of the curriculum** presents a once-in-a-generation opportunity to mainstream emotional well-being and mental health in education; and
- school-based staff, including teachers, often **lack the confidence and capacity** to help pupils with their emotional and mental health. There can be a particular fear of making things worse and therefore a tendency to refer to health professionals, adding to the pressures on already in-demand services.

23. The Samaritans summed up the general views articulated by stakeholders:

“Emotional health programmes in schools should be viewed as a form of promotion, prevention and early intervention which could reduce pressure on CAMHS, reduce specific mental health problems and increase academic achievement.”⁸

⁸ Written evidence, EMH 33 - Samaritans



What children and young people told us about the role of education

During our inquiry we conducted visits and ran a survey with secondary school pupils across Wales so that we could hear directly from children and young people. Here are some of the things they told us:

“I feel like there should be more access to support in schools and a lot more notice that the support is available.”

50% of the young people surveyed told us that their school or college gives information to them – or that they know where to get information – about emotional well-being and mental health.

“More emphasis must be put on reducing stigma around mental health issues. Often people worry they will be judged for admitting to having a problem.”

19% of young people who responded to our survey had used school or college based counselling. They told us that there were “nowhere near enough” counselling services available and that “it’s not a fun experience having to go and knock on the door...and not wanting others to know about your anxiety.”

“If teachers had a little bit more training to catch bad mental health, it doesn’t matter if you’ve got depression or anxiety, bad mental health is bad mental health, from not having enough sleep to worrying about exams, it all affects us.”

52% of young people who responded to our survey said their school or college was good or very good at helping them cope with exam pressure, bullying and peer pressure.

“Mental health is not given the amount of lesson time it deserves considering the devastating effects it has.”

65.9% of young people who responded to our survey said they would like their school or college to teach them more about how to look after their emotional well-being and mental health.

Primary school children at Ysgol Pen y Bryn told us how mindfulness helped them:

“It helps me when I’m worried...It calms me down – I use it outside school.”



Prevalence of emotional and mental health issues in school-age children

24. Action for Children highlighted that:

- the proportion of 15-16 year olds self-reporting anxiety or depression has doubled in recent years;
- one in ten 5-16 year olds suffers a diagnosable mental health disorder; and
- between 10-15 per cent of teenagers have some symptoms of depression at any one time.⁹

25. In addition to the increase in prevalence of emotional, behavioural and mental health issues, head teachers' representatives told us that those difficulties are more profound now than in the past and emerging among those of a much younger age than previously was the case:

“...the mental health issues we have around children and young people now are quite serious, and far more serious than they were [...] If I think back to the start of my career, which is probably about 20-odd years ago, in primary, I don't recall seeing anything like the sorts of things we are seeing now amongst young people.”¹⁰

26. Contributing factors to the increase in prevalence of these issues that were cited included:

- pressure to achieve academically (and associated restrictions on the scope for children and young people to do subjects other than English, maths and sciences, restricting their ability to do subjects they enjoy¹¹); and
- the influence of – and pressure from – social media, exacerbated by its accessibility 24 hours a day.

27. The Royal College of Psychiatrists noted that while there had been higher levels of self-harm and distress among children and young people in recent years, levels of understanding of the reasons why are poor.¹² The Royal College of Paediatrics and Child Health highlighted that a lack of data hampers

⁹ Written evidence, EMH 49 – Action for Children

¹⁰ Oral evidence, RoP [para 91], 30 November 2017

¹¹ Oral evidence, RoP [para 182-183], 30 November 2017

¹² Oral evidence, RoP [para 98], 14 December 2017

understanding of prevalence and the nature of the need, and limits services' ability to plan provision in an informed way. College representatives recommended the more regular updating of the [CAMHS survey results for Great Britain](#), which has not released new data since 2004. They warned, however, that the method used to measure prevalence is key. Counting medical diagnosis alone, without taking account of other distress or non-diagnosed conditions, would yield an analysis that only covered the "tip of the iceberg".¹³

Social media

28. Current World Health Organization (WHO) guidelines state that less than two hours per day of recreational screen time should be consumed by children and young people. In May 2017, the WHO published a study of 42 European Region countries that showed the guideline is met only by a minority of adolescents. In terms of the percentage of children using a computer two or more hours on weekdays, the study listed Wales as second highest of the 42 countries for boys and fourth highest for girls:

| Table 1: Children using a computer for two or more hours on weekdays (%) (Sample: 5000+ 11, 13 and 15 year olds in each WHO European Region country in 2014) | | |
|---|-------|------|
| Country | Girls | Boys |
| Wales | 76.4 | 84.6 |
| England | 74.6 | 76.5 |
| Scotland | 79.9 | 83.6 |
| Switzerland (the lowest for both genders) | 49.9 | 55.4 |

Source - World Health Organization, [Adolescent obesity and related behaviours: trends and inequalities in the WHO European Region, 2002-2014](#), published May 2017

29. The lead author of the report stated that the rise in social media was having an impact on young people:

"We know that a positive impact of social media is social connectedness and the sense of interaction. But we also know there are risks, such as cyberbullying and impact on mental health."¹⁴

30. Commenting on the advent of social media, head teachers' representatives said:

¹³ Oral evidence, RoP [para 302], 18 January 2018

¹⁴ The Independent, [Dramatic rise in screen time putting children's health at risk, WHO warns](#), May 2017

“We're always putting on an act in whatever role we have, children the same as adults, but when they got home [before social media existed] they could switch off. Now, children don't switch off. They've got a device with them virtually all of the time. They're always on show, and we're starting to see that. Problems with social media and bullying through texting are becoming a real issue.”¹⁵

Demographics

31. Several stakeholders highlighted that while associations exist between levels of deprivation and mental well-being, emotional and mental health issues affect those from all backgrounds. The British Psychological Society noted:

“Even in children who are high achieving with the best backgrounds, sometimes, the mental health needs come across just as much.”¹⁶

32. Head teachers' representatives highlighted that the pressure on young people to reach high attainment levels, which is often high in affluent areas, means that support is needed across the board. They said:

“the pressures for academic performance on our pupils is great, and therefore we do have a significant number of self-harm, eating disorders, with them striving for perfection [...]

I think the basic message is that the pressures may be different, but they're no less extensive in any particular school [...]

in terms of the scale of issues in different schools, I don't believe that's different between the different socioeconomic areas particularly, it's just that their specific needs might be different.”¹⁷

The Welsh Government's view on prevalence and contributing factors

33. The Cabinet Secretary for Education acknowledged the challenges caused by social media, repeating comments made to her by teachers that it was “the scourge” that regularly re-opened issues that had otherwise appeared to be resolved in the school environment. She highlighted the development of practical support in the form of online safety modules and resources for teachers, and the emphasis the Welsh Government had placed on the digital competency framework within the curriculum. She further highlighted the need to reach

¹⁵ Oral evidence, RoP [para 180], 30 November 2017

¹⁶ Oral evidence, RoP [para 250], 14 December 2017

¹⁷ Oral evidence, RoP [paras 227-228], 30 November 2017

beyond schools, noting that positive parenting support was also necessary to reduce instances of parents becoming involved in negative exchanges on social media.¹⁸

34. In relation to demographics and mental health, the Cabinet Secretary for Education said:

“there is a direct correlation between a child experiencing ACEs [adverse childhood experiences], or the likelihood to experience ACEs, and issues around deprivation. We know that deprivation can have a massive impact on a child’s mental health and well-being [...] but nobody [including the more affluent] is immune from mental distress and mental ill-health.”¹⁹

Emotional well-being and mental health in the curriculum

35. There was a clear consensus in the evidence we received that reforms resulting from Professor Graham Donaldson’s review of curriculum and assessment, *Successful Futures*, offered a once-in-a-generation opportunity to integrate emotional intelligence and healthy coping mechanisms into the new national curriculum in Wales. Furthermore, several respondents called for well-being to be embedded into all aspects of school life, not simply “bolted on”, or covered in Personal and Social Education (PSE) lessons. Some respondents, including the Samaritans, called for emotional health programmes to be a compulsory part of the curriculum. They argued that a preventative approach of this kind would reduce pressure on specialist and primary CAMHS services in Wales.²⁰

Areas of Learning Experience (AoLE) and pioneer schools

36. The Donaldson review of curriculum and assessment did not focus on content, concentrating instead on a higher-level conceptual approach to designing and structuring the curriculum. However, he recommended that one of the four purposes of the curriculum should be that young people become healthy, confident individuals and that one of the six Areas of Learning Experience (AoLE) within the new curriculum should be “health and well-being”.

37. The Welsh Government has allocated the task of developing content and populating AoLEs to “pioneer schools” primarily. They have selected pioneer

¹⁸ Oral evidence, RoP [paras 70-72], 15 February 2018

¹⁹ Oral evidence, RoP [paras 51 and 54], 15 February 2018

²⁰ Oral evidence, RoP [para 17], 10 January 2018

schools from urban and rural communities, and they are a mix of English-medium, Welsh-medium, primary, secondary, special and faith schools.

38. The Health and Well-being AoLE Working Group's Executive Summary, published by the Welsh Government in July 2017, advocated a cross-curricular, whole-school approach to health and well-being. It adopted the following six indicative thematic areas within the Health and Well-being AoLE: personal care and development; healthy choices; learning to learn; relationships and emotions; keeping safe; and physical activity. A further update was published in December 2017 and included initial drafts of "what matters" statements²¹ within the AoLE.

39. The group also reported the following:

"The H&Wb AoLE group recognises that good health and well-being begins with a strong sense of self which can be divided into three overarching domains: mind, body and emotions. Teaching and understanding the interconnection between the three lies at the heart of the H&Wb AoLE. When a person has a strong sense of self they are able to connect and build positive, healthy relationships with others."²²

40. The Samaritans praised the current PSE framework's focus on increasing children and young people's understanding of mental health, but noted that the key problem is:

"...it's the responsibility of schools in Wales to implement the framework and include the broad remit that it covers, and because of that reason, and because of mounting pressure on numerous topics, such as first aid, sex education or mindfulness, actual core emotional mental health lessons are excluded."²³

41. Evidence from head teachers' representatives acknowledged the variations in how schools incorporate well-being as part of their delivery of the current curriculum, particularly the variations in PSE provision. They told us:

"...there's potential within the new area of learning and experience [...] to have it [well-being] more widespread across the practice within the school than maybe PSHE ever was. It was always, in my experience as a

²¹ The "what matters" approach is the identification of the key elements that all learners should experience during their journey along the continuum of learning. Each AoLE will contain a series of "what matters" statements.

²² Welsh Government, A new Curriculum for Wales: The story so far..., p8

²³ Oral evidence, RoP [para 15], 10 January 2018

head, an extra. You recognised the importance of it, but, again, it was how you deliver it and where you deliver it in terms of time and space in the curriculum.”²⁴

42. Nevertheless, in its written evidence, the National Association of Head Teachers said:

“It is unclear, as yet, whether key work to focus on mental health, well-being and emotional resilience will be dealt with effectively within this AoLE.”²⁵

Alignment between the new curriculum and the T4CYP Programme

43. The Children’s Commissioner for Wales expressed significant concerns about what she described as a lack of alignment between the T4CYP Programme and the development of the new curriculum. She highlighted:

- the need to “urgently” align these initiatives so that joint working can develop and a collective vision for schools’ roles in preventing mental ill health and intervening early can be agreed; and
- that she found it “baffling” and “frustrating” that the T4CYP Programme and curriculum groups are “not sitting together and planning together, bringing the best of that health expertise and the best of that education expertise [together]”.²⁶

44. Head teachers’ representatives expressed a similar view:

“the key principles in it [the T4CYP Programme] are really positive, but it’s unclear to me, looking at it, how heavily involved education were in that. Sometimes, the aspirational part in those is disconnected, I think, to what’s actually happening on the ground in schools [...] there was an opportunity earlier on to get the partnerships in that involved.”²⁷

45. Health board representatives told us that opportunities to engage with the new curriculum in Wales had not yet been taken by health services:

²⁴ Oral evidence, RoP [para 200], 30 November 2017

²⁵ Written evidence, EMH 27 – National Association of Head Teachers (NAHT)

²⁶ Written evidence, EMH 29 – Children’s Commissioner for Wales and oral evidence, RoP [para 346], 22 November 2017

²⁷ Oral evidence, RoP [para 105], 30 November 2017

“...there's an offer there to embed mental health and well-being in the everyday teaching across the curriculum. I don't think we've yet found the right way of doing that. I think there are conversations going on, but I don't think there's an active work stream that says, 'How do we grab this opportunity right now with the curriculum'.”²⁸

46. The T4CYP Programme noted that there was more work to do with colleagues in education. They explained that well-being, resilience and early intervention work streams within the Programme had been merged and, over the next 12 months, a “much clearer route-map” would be needed with education about the expectations of schools (pioneer or not) and where other services, for example, health, could and should provide help and support.²⁹

The Welsh Government's view on curriculum reform and well-being

47. The Welsh Government stated that:

- the mental and emotional well-being of learners is being considered across all the Areas of Learning and Experience (AoLEs);
- the Health and Well-being AoLE working group has considered in depth the role of mental and emotional well-being within the AoLE, working with a range of stakeholders and experts to ensure learners are supported to develop understanding and positive behaviours in this area; and
- while the new curriculum will be instrumental, developing positive health and well-being in learners is a wider issue, which is highly dependent on a whole-school approach.³⁰

48. Responding in oral evidence to the Children's Commissioner's concerns about the lack of alignment between the T4CYP Programme and the AoLE work, the Cabinet Secretary for Education:

- acknowledged there had been a “slight hiatus” in the T4CYP Programme's work on early years resilience and well-being and early intervention and enhanced support, but said that the streams had been merged and more pace injected;³¹

²⁸ Oral evidence, RoP [para 264], 7 February 2018

²⁹ Oral evidence, RoP [para 204], 22 November 2017

³⁰ Written evidence, EMH 68 – Welsh Government

³¹ Oral evidence, RoP [para 11], 15 February 2018

- emphasised that the T4CYP Programme is an NHS-led programme. She noted that while it was important for education officials to be involved in its work,³² it needed to be recognised that “designing a curriculum is very, very different from Together for Children [and Young People Programme] and although we absolutely want to ensure that there is cross-learning, and where there is complementarity, that that is recognised and utilised, we also have to recognise that they are different things too”³³; and
- noted that she would act on evidenced examples of a lack of joint working between the T4CYP Programme and the groups working on curriculum reform, but that no specific examples had been given.³⁴

49. Further to this, we received copies of correspondence between the Children’s Commissioner and the Cabinet Secretary for Education in which the Children’s Commissioner noted her disappointment at the Cabinet Secretary’s comments. In that correspondence, the Commissioner repeated issues raised in her meeting with the Welsh Government in January 2018, including a recent T4CYP Early Resilience Group Meeting in which members had been unable to identify where the cross-governmental work on a whole-school approach to promoting and supporting children’s well-being was being taken forward.³⁵

OUR VIEW ON WELL-BEING AND THE CURRICULUM

50. Embedding well-being, emotional resilience, and healthy coping mechanisms in the new curriculum is vital. We agree with all those who gave evidence to us that the post-Donaldson reforms are a once-in-a-generation opportunity that cannot be missed.

51. We welcome the work pioneer schools and those leading the Health and Well-being Area of Learning Experience are doing to develop the new curriculum in Wales. However, we share the Children’s Commissioner for Wales’s concerns that much more needs to be done to make this work as robust and multi-agency as it needs to be. We are particularly concerned to ensure that the practical reality of how we promote and support emotional and mental health on the ground is not lost in the large scale, high-level curriculum discussions currently underway.

³² Oral evidence, RoP [paras 12 and 14], 15 February 2018

³³ Oral evidence, RoP [para 33], 15 February 2018

³⁴ Oral evidence, RoP [para 137], 15 February 2018

³⁵ [Letter from the Children's Commissioner for Wales to the Cabinet Secretaries for Health and Education](#), 22 February 2018 (published 28 February 2018)

Recommendation 1. That the Welsh Government publish, within three months of this report’s publication, a route map of how health (led by the Together for Children and Young People Programme) and education (led by the Health and Well-being Area of Learning Experience) will work together to inform the new curriculum. This route map should contain clear milestones and specify the agencies or individuals responsible for delivery.

Well-being as an educational priority

52. The need to give well-being equal weighting in terms of prioritisation in schools was a key theme in the evidence we received. The majority of witnesses noted that academic attainment was not possible without well-being. As the British Psychological Society put it:

“...emotional health is the root to the development of the leaves [...] the attainment levels.”³⁶

53. Head teachers’ representatives said:

“...literacy, numeracy and those sorts of things are fundamentally important [...] But if we make those the only measure of success, that pitches a field in a school that immediately, you could argue, will disenfranchise a certain section of those. And I think there's a risk in that. I think you've got to think a little bit more about what we see as success and how we measure in a way that doesn't minimise it, doesn't do it over such a short term that, for certain pupils, it can affect their sense of well-being.”³⁷

Education action plan

54. The Welsh Government has sought to increase the level of priority of pupil well-being in the education improvement agenda. This was one of the main differences between its new education action plan, Education in Wales: Our national mission, published in September 2017, and its predecessor, Qualified for Life. One of the three enabling objectives of the action plan is “strong and inclusive schools committed to excellence, equity and well-being”. The plan states:

“Children and young people who have strong relationships and a positive sense of self - and who can understand and manage their own

³⁶ Oral evidence, RoP [para 178], 14 December 2017

³⁷ Oral evidence, RoP [para 188], 30 November 2017

health and emotions – are in a better position to reach their full potential in the future.”³⁸

55. The Cabinet Secretary for Education told an Association of Directors of Education in Wales (ADEW) conference on 10 January 2017 that Wales was “at a turning point” in how schools deal with the well-being of children and young people. She said it must be part of the school ethos and implemented across the board as schools have a big role to play and teachers are well placed to notice changes in pupils’ behaviour.

Inspection framework

56. Well-being features more prominently than previously in Estyn’s new Common Inspection Framework, introduced in September 2017. Estyn told us it had “strengthened [its] focus on emotional well-being in [its] new inspection arrangements”.³⁹ ADEW’s representatives noted that including well-being in the inspection framework was very important for driving school performance in this area.⁴⁰

57. Head teachers’ representatives reported that well-being was an integral part of Estyn’s inspection framework but that qualitative measures of impact were not very good.⁴¹ ADEW’s representatives agreed:

“...it’s really important that the inspectorate look in the very broadest sense at well-being, and they are constrained to some of the traditional indicators we’ve used in the past around well-being, around things like attendance or behaviour and so on.”⁴²

The Welsh Government’s view on well-being as an educational priority

58. The Cabinet Secretary for Education emphasised the:

“...very, very strong and very clear emphasis [in the education action plan] on my expectation, the Government’s expectation, about well-being in our schools. If you look at previous plans, there was little if any

³⁸ Welsh Government, Education in Wales: Our national mission, September 2017, p31

³⁹ Written evidence, EMH 22 - Estyn

⁴⁰ Oral evidence, RoP [para 428], 30 November 2017

⁴¹ Oral evidence, RoP [paras 96 and 206], 30 November 2017

⁴² Oral evidence, RoP [para 428], 30 November 2017

mention of well-being in what the education system should be about.”⁴³

59. She went on to say:

“I recognise, and there is lots and lots of academic evidence, that children with higher levels of well-being generally achieve better educational outcomes and qualifications than those who have lower levels of well-being. So if we're interested—and I am definitely interested—in raising standards in our schools, I cannot afford to ignore issues of well-being in our classrooms, and making those linkages between high levels of well-being and what that translates to in terms of educational achievement. [...] We can't reduce the attainment gap and we can't improve standards for our children if we ignore well-being.”⁴⁴

60. In relation to the inspection framework, the Cabinet Secretary for Education acknowledged the difficulty of measuring well-being. She noted that the Welsh Government is looking at international examples of best practice to “create a set of data so we can better capture and measure in our schools issues of well-being”.⁴⁵

OUR VIEW ON WELL-BEING AS AN EDUCATIONAL PRORITY

61. We welcome the more prominent place given to well-being in the Welsh Government's education action plan and the inspection framework. We believe this is key to driving and supporting schools' activity in this area and is long overdue.

62. We agree wholeheartedly with stakeholders that attainment in school cannot be achieved without well-being. Furthermore, we agree that achievement should not be seen through the prism of academic attainment alone – the success, progress and development of children and young people must be viewed holistically and include consideration of how emotionally healthy and confident they are as individuals.

63. We are concerned that measures of well-being remain rudimentary. We welcome the work the Welsh Government has underway to make improvements.

⁴³ Oral evidence, RoP [para 36], 15 February 2018

⁴⁴ Oral evidence, RoP [para 37], 15 February 2018

⁴⁵ Oral evidence, RoP [para 39], 15 February

We urge it to complete this work urgently given the influence of inspection frameworks on performance and activity in schools.

Recommendation 2. That the Welsh Government prioritise the work of improving measurement of well-being in schools within the inspection framework in order to drive activity and performance. The development of these measures should involve all relevant stakeholders to ensure that they are fit for purpose and do not lead to unintended consequences. Most importantly, children and young people should be involved in the process of preparing these measurements to ensure that they capture correctly the factors that influence their well-being. These measures should be available within six months of this report's publication, or form part of the report of the independent review of the implications of the educational reform programme in Wales for the future role of Estyn, whichever is the earliest.

2. 2. A whole-school approach, a cross-sector responsibility

64. There was broad consensus in the evidence we received that:

- school settings (primary and secondary) are key to promoting emotional well-being and good mental health;
- the preventative approach needs to be embedded within the ethos of a school, not just in the lessons taught;
- teachers are not solely responsible – joint working between professionals from across sectors (health, education, social care, third sector, youth work and others) is key to delivering a whole-school approach; and
- while there may be commitment to the principle of a whole-school approach, implementation is challenging due to resource and funding constraints, joint working arrangements, and the continued pressure to deliver high attainment levels.

65. Professor Dame Sue Bailey, External Adviser to the T4CYP Programme, told us that a whole-school approach that delivered emotional literacy was key because children and young people regularly reported that they wanted:

- to have more knowledge and feel more in control of their own mental health and well-being;
- to be able to do self-guided help with support; and
- teachers to have more mental health awareness.⁴⁶

Schools

66. ADEW's representatives told us:

“No matter how excellent the teaching and learning you put in front of them [pupils] and wrap around them, they have to have the very best well-being to enable them to make the most benefit of that. So, I think, absolutely, schools recognise that as being a fundamental part of their role.”⁴⁷

⁴⁶ Oral evidence, RoP [para 199], 22 November 2017

⁴⁷ Oral evidence, RoP [para 327], 30 November 2017

67. The T4CYP Programme noted that a “real change” was emerging in the education sector around being more emotionally and mentally aware and being “healthy schools”.⁴⁸

68. Action for Children noted that there was some “very good” work on prevention and early intervention happening across schools in Wales, but it was “very sporadic”.⁴⁹ The Chair of the Applied Psychologists in Health National Specialist Advisory Group told us early intervention was happening but only “very little and in pockets”.⁵⁰ The Children’s Commissioner for Wales went further, saying:

“...we haven't really properly touched the surface of reforming prevention and early intervention aspects of children's emotional and mental health. I think there's an awful long way to go.”⁵¹

69. On 12 March 2018 the Welsh Government announced that a training package will be offered later this year to all primary and secondary schools in Wales to help children who face early childhood trauma such as family breakdown, bereavement or physical, sexual or substance abuse.⁵²

Early years and primary school

70. Many stakeholders suggested that work on emotional well-being, resilience and early intervention needed to start earlier, in primary or even pre-school.

71. Action for Children’s evidence encapsulated the views expressed by many:

“...conversations need to start with primary school aged children because if they are to develop good emotional literacy and emotional health, they’re going to have to learn these words very early on in life.”⁵³

72. The British Psychological Society’s representatives expressed their view that more emphasis on emotional well-being is needed antenatally “because some of these problems often stem from context and families that also have mental health conditions and need support themselves”.⁵⁴ They referred to the

⁴⁸ Oral evidence, RoP [para 180], 22 November 2017

⁴⁹ Oral evidence, RoP [para 328], 14 December 2017

⁵⁰ Oral evidence, RoP [para 213], 14 December 2017

⁵¹ Oral evidence, RoP [para 337], 22 November 2017

⁵² BBC News, [Schools trained to help children facing trauma at home](#), 12 March 2018

⁵³ Oral evidence, RoP [para 328], 14 December 2017

⁵⁴ Oral evidence, RoP [para 215], 14 December 2017

importance of work on attachment and bonding, by programmes such as Flying Start, for ensuring that these issues are addressed earlier, echoing themes arising in our 2016 consultation on the **First 1,000 Days** of a child's life.

Stigma

73. With three out of four children reported as fearing their friends' reaction if they talk about their mental health problems,⁵⁵ several stakeholders highlighted the important role schools can play in reducing the stigma associated with emotional and mental health. YMCA Cymru explained:

"Given the early onset of symptoms and the prevalence of stigma received at young ages, it is clear that interventions must start young and begin in the places young people most often frequent, namely schools and colleges.

Despite this, [in the YMCA's UK wide IAMWHOLE review, conducted jointly with the NHS] schools were named as the main arena in which young people experience this stigma, with 57% of young people who experienced stigma as a result of their mental health reporting to have experienced it here."⁵⁶

74. The Samaritans noted:

"...it is this reluctance to seek help, teamed with a lack of knowledge surrounding emotional health and healthy coping mechanisms, that can worsen a child's mental health and eventually lead to an unnecessary CAMHS' referral for the pupil and an over-referral to CAMHS' nationally."⁵⁷

The Welsh Government's view on the role of schools

75. The Cabinet Secretary for Education emphasised that the whole-school approach is not an intervention approach, but a promotion approach:

"The whole issue around having a whole-school approach is, actually, that that whole school promotes well-being and promotes positive mental health. Yes, it intervenes if somebody develops a problem, but it's how we can use the school to promote, and stop those problems arising in the first place. So, this is not just about an intervention, this is

⁵⁵ Time to Change Wales, **Myths and Facts**, accessed March 2018

⁵⁶ Written evidence, EMH 25 - YMCA

⁵⁷ Written evidence, EMH 33 - Samaritans

about positive promotion of health and well-being for the child in the round.”⁵⁸

76. She also noted the key role schools have to play in addressing issues as early as possible:

“We want to be able to support children at the lowest possible level and not to medicalise them and not to escalate those issues where we don't need to. And what we do know is that they will escalate if we don't intervene early.”⁵⁹

77. Finally, the Welsh Government highlighted:

“While the new curriculum will be instrumental, developing positive health and well-being in learners is a wider issue, which is highly dependent on a whole-school approach. Through our investment in the School Health Research Network (SHRN) and accompanying data infrastructure, data are being collected to assess well-being in schools and assess the importance of school environment.”⁶⁰

Box 1: Examples of best practice in schools

Delivering Emotional Awareness and Listening (DEAL) Programme (Samaritans)

The Samaritans have worked with five schools in Cardiff in 2016/17 to help them implement emotional health lesson plans into their school curriculum. These lessons cover common areas such as exam stress, building resilience, coping strategies, and dealing with social media. An evaluation of the programme is underway, but early indications show:

- the resources were very easy to use;
- the children and young people were much more confident in talking about their mental health as a consequence of the lessons; and
- the teachers, who had received a half day training course to accompany the delivery of the DEAL lesson plans, were much more confident in discussing difficult issues that they had feared previously.⁶¹

⁵⁸ Oral evidence, RoP [para 65], 15 February 2018

⁵⁹ Oral evidence, RoP [para 141], 15 February 2018

⁶⁰ Written evidence, EMH 68 – Welsh Government

⁶¹ Oral evidence, RoP [paras 4 and 8], 10 January 2018

Anti-Stigma School Pilot (Time to Change Wales)

This pilot is running for three years in nine pilot schools across Wales. According to Time to Change Wales, it was developed due to the “sheer demand” for anti-stigma interventions in schools. The programme:

- adopts a whole-school approach, given the importance not only of providing education and awareness raising to pupils, but to parents, the wider school community and teachers;
- aims to reduce stigma by informing and improving the emotional response of people who may be “stigmatisers” in future, and by providing a level of support for those who are currently experiencing difficulties; and
- by raising awareness, aims to improve mental health literacy among young people in Wales, many of whom have little knowledge of what mental illness is or how to seek help.⁶²

School mindfulness curriculum (Ysgol Pen y Bryn, Colwyn Bay)

Ysgol Pen y Bryn became involved in mindfulness in 2010. Mindfulness is used to develop an ability to pay deliberate attention to experiences from moment to moment. A growing body of evidence has found that when people intentionally practise mindfulness on a regular basis they feel less stressed, anxious and depressed,⁶³ and live with greater well-being, mental clarity and care for themselves and others.⁶⁴

In 2011, two of the teachers along with an experienced mindfulness teacher and a neuroscientist started to develop, in collaboration with the Mindfulness in Schools Project, a mindfulness curriculum for key stage 2 (ages 7 – 11) called “Paws B”. The curriculum introduces children to daily practices and shows children how mindfulness can be useful in their lives. It also explains what different parts of the brain do and how mindfulness can be beneficial to the development of the brain. Research undertaken on the “Paws B” curriculum shows children have improved concentration, self-regulation and appropriate choices.

⁶² Oral evidence, RoP [paras 313, 315 and 317], 14 December 2017

⁶³ Mental Health Foundation, [Be Mindful](#), accessed March 2018

⁶⁴ UK All Party Parliamentary Group on Mindfulness (October 2015), [Mindful Nation UK](#), accessed March 2018

OUR VIEW ON THE ROLE OF SCHOOLS

- 78.** Schools and their staff are key to ensuring that our children and young people are – and grow up to be – emotionally resilient individuals. Alongside a child’s parents or carers, we believe schools are one of (if not) the strongest influence on a child’s ability to talk about, and manage, the challenges that life will throw at them. However, schools should not be left to undertake this role alone – support from health professionals and others is needed. Teachers and other educational professionals must also be given the right training and the space within their working days to undertake this role.
- 79.** We welcome the work that is underway on the whole-school approach, and agree wholeheartedly that emotional and mental well-being should not be confined to lessons alone. The wider atmosphere and ethos of a school is crucial, especially if the significant problem of stigma is to be genuinely addressed.
- 80.** By the time a child enters secondary school, there is a risk that opportunities to build healthy coping mechanisms and emotional resilience have been missed. Our visit to a year 2 class in Ysgol Pen y Bryn illustrated clearly to us the benefits of speaking – responsibly and appropriately – with children as young as six and under about the way they feel and how their minds work. This is also a crucial time to remove the seeds of stigma before they take root.
- 81.** We commend the Samaritans’ Delivering Emotional Awareness and Listening (DEAL) Programme. The reported benefits to both teachers’ confidence in leading such discussions due to the training provided, and young people’s confidence in talking about common issues such as exam stress, coping strategies, and dealing with social media, are very promising. We believe this programme has the potential to be developed as a blueprint all schools could follow.
- 82.** There are numerous examples of successful emotional and mental health initiatives underway in Wales’s schools. We believe the Welsh Government needs to lead work to assess their impact and recommend best approach(es) for schools to adopt. We also believe that concerns about school funding need to be addressed to ensure that financial constraints do not act as a barrier to schools’ provision of emotional and mental health support (see paragraphs 114 to 116 for more detail on school funding arrangements).

Recommendation 3. That the Welsh Government undertake a review of the numerous emotional and mental well-being initiatives underway in Wales's schools, with a view to recommending a national approach for schools to adopt, based on best practice. The Welsh Government should work with exemplar schools such as Ysgol Pen y Bryn in Colwyn Bay to develop elements of this national approach, including but not limited to mindfulness.

Recommendation 4. That the Welsh Government, while undertaking the review we call for in recommendation 3, work in the meantime with the Samaritans to develop its Delivering Emotional Awareness and Listening (DEAL) Programme for wider use in schools in Wales. Subject to the results of the DEAL evaluation that is underway, the Welsh Government should fund the extension of the programme to the primary school sector.

Roles of other professionals

School nurses

83. The Welsh Government's School Nursing Framework states that the role of the school nurse is pivotal in supporting the emotional well-being of children and young people of school age, taking a public health approach to building resilience.

84. The Royal College of Nursing explained that the Framework sets a minimum expectation of the level of knowledge for school nursing services in Wales. The College said:

“...in order to meet these standards, the degree programme curriculum leading to the school nursing qualification should be revised and enhanced in the areas of emotional and mental health, and that existing staff in post would benefit from being upskilled in these areas.”⁶⁵

85. There was wide agreement that the role of the school nurse is very important in supporting the emotional well-being of school-aged children. Nevertheless, several stakeholders expressed concerns about a perceived decline in the numbers of school nurses and a narrowing of their roles. The National Association of Head Teachers and the Association of School and College Leaders told us that

⁶⁵ Written evidence, EMH 19 – Royal College of Nursing

school nurses tend only to deal with physical issues such as hygiene, vaccinations, injuries or emergencies.⁶⁶

86. The Royal College of Nursing stated that school nurses are “very stretched”, with 233 school nurses covering over 1600 secondary schools in Wales.⁶⁷ They observed that school nurses would need more time and capacity to prioritise work on emotional well-being and health.⁶⁸ The Royal College of Paediatrics and Child Health agreed:

“...[school nurses] don’t have the time to do their own job as they would like to, let alone now teach resilience.”⁶⁹

School counsellors

87. Local authorities have a statutory duty to make “reasonable provision” for a service providing independent counselling in respect of health, emotional and social needs for secondary school pupils.

88. Stakeholders noted that school counselling services were well-regarded but raised concerns that growing demand was leaving some services overwhelmed.⁷⁰ Relate Cymru raised concerns about variation in provision between schools, and called for school counselling to be more consistently available, including online.⁷¹ Action for Children called for school-based counselling funding to be ring-fenced, and services to be monitored, assessed and quality assured.⁷²

89. The Royal College of Nursing and Royal College of Paediatric and Child Health noted that statutory provision of school counselling services has been of significant benefit to children and young people. However, they highlighted that school counselling services need to be available to younger school-aged children at primary school if effective early intervention and prevention is to be fully realised.⁷³ Teaching unions agreed.⁷⁴

⁶⁶ Oral evidence, RoP [para 292], 30 November 2017

⁶⁷ Oral evidence, RoP [para 417], 18 January 2018

⁶⁸ Written evidence, EMH 19 – Royal College of Nursing

⁶⁹ Written evidence, EMH 23 – Royal College of Paediatrics and Child Health

⁷⁰ Written evidence, EMH 33 – Samaritans, EMH 51 – British Association for Counselling and Psychotherapy and EMH 56 – Betsi Cadwaladr University Health Board

⁷¹ Written evidence, EMH 15 – Relate Cymru

⁷² Written evidence, EMH 49 – Action for Children

⁷³ Written evidence, EMH 19 – Royal College of Nursing and oral evidence, RoP [para 330], 18 January 2018

⁷⁴ Oral evidence, RoP [paras 300 and 301], 30 November 2017

90. The British Psychological Society warned against school counselling becoming a default option:

“...if someone is presenting with a mental health need [...], they're just referred to the student counsellor, without any real assessment or formulation of what is going on in a lot of circumstances.”⁷⁵

91. ADEW said school counselling is being squeezed at both ends:

“People escalate to counselling, sometimes, more quickly than they perhaps should, and there are other people who could help, but, at the same time, counselling services are having to keep children and young people with them to provide them some support that they're not accessing through the CAMHS service.”⁷⁶

92. Several stakeholders highlighted the stigma that can be associated with accessing school counselling, particularly where this is visible to other pupils. They also highlighted the difficulties of managing access within the school day:

“They're missing lessons [...] But also in school, you're asking them to go and open their souls, their hearts, and then five minutes later they're going to French [...] And also in front of everyone—the perception of going and being seen to be going. If you've got an issue, then that's a problem.”⁷⁷

Educational psychologists

93. The positive role educational psychologists (EPs) can play in supporting well-being and training others to do so was emphasised in evidence. However, the Association of Educational Psychologists confirmed stakeholders' concerns that there is a shortage of EPs in Wales:

“There is a large shortage of EPs in Wales across all local authorities. There have been a number of posts cut from staffing so there appear to be fewer vacancies. However, this is because of the number of positions eliminated.”⁷⁸

94. The British Psychological Society highlighted that EPs are often well placed to work with pupils in schools on their emotional and mental health. However,

⁷⁵ Oral evidence, RoP [para 225], 14 December 2017

⁷⁶ Oral evidence, RoP [para 405], 30 November 2017

⁷⁷ Oral evidence, RoP [paras 310 and 311], 30 November 2017

⁷⁸ Written evidence, EMH 59 – Association of Educational Psychologists

they noted that they are regularly “tied up” undertaking statutory assessments in respect of Special Educational Needs (SEN) / Additional Learning Needs (ALN), leaving little time to look at mental health in an educational setting.⁷⁹

95. ADEW representatives highlighted that using the limited EP capacity available to develop Emotional Literacy Support Assistants (ELSAs) and upskilling staff in schools to manage low-level cases themselves can play a significant part in easing the reported problems accessing educational psychologists.⁸⁰

Others

96. Several stakeholders highlighted the important role youth workers have to play in emotional well-being in school settings. The contribution of the third sector was also emphasised, not least in relation to some of the programmes they have driven on emotional literacy and stigma (see Box 1 – examples of best practice in schools, and Box 2 – examples of best practice outside schools).

97. The importance of good links between schools and social care were also emphasised, especially where looked after children were involved.

The Welsh Government’s view on the roles of other professionals

98. The Cabinet Secretaries for Health and Education emphasised that the school nursing service was available in all schools in Wales, and counselling services were available in all secondary schools and for year six pupils in primary school.⁸¹

99. When challenged on why online counselling is not available on a national basis, so that all children and young people can self-refer without concerns about stigma or missing lessons, the Cabinet Secretary for Education said:

“It is the professionals on the ground in those local authorities that are best placed to make a decision about what service meets the needs of their children locally [...] There is no service that universally meets the needs of every child, and therefore you often need a mixture of approaches. Because, for some children, online might not be best. The ability to go and sit in a room and talk to someone might be what’s appropriate for that particular child. [...] Whilst we set the expectation to

⁷⁹ Oral evidence, RoP [para 256], 14 December 2017

⁸⁰ Oral evidence, RoP [para 352], 30 November 2017

⁸¹ Oral evidence, RoP [paras 51 and 52], 15 February 2018

local authorities that this service will be available, then, it is up to them.”⁸²

100. In relation to the availability of educational psychologists (EPs), the Welsh Government explained that local authorities are responsible for the provision of educational psychology services. It stated that:

- EPs have a key role to play in the Additional Learning Needs (ALN) Transformation Programme, and that workforce development is an important part of that;
- a £20m package of funding to support the implementation of the Additional Learning Needs and Education Tribunal (Wales) Act 2018 and delivery of the wider Transformation Programme has been allocated, with “much” of that funding targeted at workforce development; and
- officials have worked closely with the Association of Educational Psychologists to develop guidance on the role and responsibilities of EPs in Wales. This is aimed at parents and education professionals working with children and young people to create a better understanding of what to expect from the role of the EP.⁸³

OUR VIEW ON THE ROLE OF OTHER PROFESSIONALS

101. Teachers must not have to carry the weight of the whole-school approach alone. They are trained and appointed to teach. While they may be perfectly positioned to recognise and identify the early signs of distress or worry, other professionals are crucial to ensuring that appropriate cross-professional support is available.

102. We are concerned about the evidence that demand is too high, and staff numbers too low, within school nursing, school counselling and educational psychology to provide early emotional support to children and young people in the school setting. We acknowledge that this is partly attributable to the need to address the lack of services further along the care pathway, particularly in local primary mental health support services (see section 2.3 – support outside school). However, we believe that a comprehensive piece of work is needed to map the current coverage of services provided by non-teaching professionals in school and

⁸² Oral evidence, RoP [paras 94 and 96], 15 February 2018

⁸³ Written evidence, EMH FI 21 – Welsh Government

establish the anticipated level of future need (based on emerging lessons from the in-reach pilot discussed in the next section).

103. We were particularly concerned to learn about statutory school counselling services being overwhelmed. We were further concerned to learn from our oral evidence gathering, our roundtable discussion with frontline staff, and our survey that young people felt there was stigma associated with leaving lessons to visit the school counsellor. In light of this reported stigma, we believe that consideration should be given to providing counselling outside lessons and/or school, including via online services.

Recommendation 5. That the Welsh Government commission a mapping exercise of the availability of non-teaching staff in schools to support emotional and mental health and well-being, and the anticipated level of future need. This exercise should provide an outline of how any shortcomings will be addressed.

Recommendation 6. That the Welsh Government assess the quality of the statutory school counselling available, not least how the service copes with increasing demand, tackles stigma and meets the needs of children and young people. This should include consideration of providing counselling support online and outside lessons/school, and for those younger than 11 years old.

Implementation of the whole-school approach

104. Head teachers noted that while they were fully subscribed to the principle of a whole-school approach to embed emotional and mental health, implementation was more challenging:

“I don't think anyone would disagree with you in terms of that link between the emotional well-being of pupils and their ability to learn and progress and develop. I'd absolutely agree with it, but I just think that we need to be honest about the ability of schools to deliver that. And I don't believe there's an unwillingness from school leadership to address it. I just think there needs to be a recognition about what is currently maybe a barrier to that happening and some honest conversations around that.”⁸⁴

105. Pembrokeshire County Council highlighted conclusions about the whole-school approach that had emerged from work undertaken by the Public Policy

⁸⁴ Oral evidence, RoP [para 97], 30 November 2017

Institute for Wales on the promotion of emotional health, well-being and resilience.⁸⁵ These included:

- a warning that, while whole-school approaches to supporting mental health are encouraged, evidence suggests the implementation of such approaches is challenging;
- the need for school-based work on emotional health, well-being and resilience to be connected – rather than in competition – with other school priorities;
- the need for emotional health, well-being and resilience to extend beyond the delivery of a set of lessons in a classroom, if the perception of it being “something else” that schools need to do is to be avoided; and
- a warning that a whole-school approach is difficult to get right and good “off the shelf” models do not exist.

Joint working and expertise

106. It was clear from the evidence we took that the whole-school approach cannot – and should not – be shouldered by teachers alone. Work undertaken by the Public Policy Institute for Wales in 2015 on [Effective Pupil Support in Secondary Schools](#) found that an emphasis on well-being throughout a whole-school approach needed to involve all the relevant groups of professionals. It also highlighted the importance of a good supply of, and access to, these professionals.

107. ADEW emphasised the importance of remembering that the role of teachers is to help with children and young people’s understanding of well-being, not to fill the shoes of other services:

“...they are teachers, they're there to provide an education to our children, they're not there to be social workers and those things. That's where we need to work really effectively with our system to bring those skills in, but recognise the contribution [of teachers] ... On a day-to-day basis, they are the person you see, the person you form a very strong bond with. [...] but it is recognising the contribution that our other partners, such as the NHS, have to make in terms of the provision of

⁸⁵ Written evidence, EMH FI 06 – Pembrokeshire County Council

very specialist services to make sure that we maintain children's well-being throughout their lives."⁸⁶

108. There was a strong feeling among both education and health professionals that the whole-school approach should not be misconstrued as an opportunity to expect teachers to become mental health practitioners. Several stakeholders, including the Association of School and College Leaders Cymru, argued this was particularly important given:

- the difficulties schools face accessing specialist CAMHS (which was attributed to a shortage of staff within CAMHS and a "huge (and increasing) workload"; and
- the length of time CAMHS referrals take to initiate and the lack of effective and timely communication between them and schools (which means the young person does not have access to timely professional support).⁸⁷

109. Several witnesses emphasised that, due to a lack of services sitting beneath the support provided by specialist CAMHS (discussed in more detail in section 3.1 – the "missing middle"), schools were left "plugging the gap":

"If we're talking about the partnership working with agencies, and particularly with health, I think that the pressures that health are under mean that the whole provision [is] being salami-sliced down, a little bit every year, a little bit every year, until you get to the point where you turn around and realise actually that, if I extend the analogy, most of the salami's missing; there's not much left. But it happens quite insidiously and quite gradually, and I don't think that's intent from anywhere [...] there's great aspiration to work together, but actually what we're seeing is a reduction in provision[...] we are struggling and we're now funding ourselves health provision—therapy provisions—from our own budgets now to support the children in our care."⁸⁸

110. Head teachers' representatives voiced concerns about the availability of professionals from other agencies to come to schools to give the necessary support to teachers. They emphasised that teachers are only part of the picture and cannot replace the more specialist services pupils with more severe issues need:

⁸⁶ Oral evidence, RoP [para 419], 30 November 2017

⁸⁷ Written evidence, EMH 21 – Association of School and College Leaders (Cymru)

⁸⁸ Oral evidence, RoP [para 100], 30 November 2017

“Headteachers, senior leaders and ordinary teachers are really, really concerned about this and are going over and beyond maybe what they should be doing in an attempt to put their finger in the dyke that is leaking, and knowing that they can't do enough, but they do what they can. [...] There aren't enough qualified professionals out there coming into schools to give the support that is needed.”⁸⁹

111. The training and expertise of teachers was also cited as a potential barrier to the implementation of the whole-school approach. Head teachers' representatives highlighted concern about what is expected of teachers:

“We wouldn't expect GPs to do the work of consultants, but I feel that we are expecting teachers, as general practitioners, to do the work of experts. It's very dangerous, once we get untrained people doing their best in those kinds of world where, really we need the provision that's outside schools.”⁹⁰

112. The British Psychological Society noted that teachers needed help to feel more confident with children “rather than thinking, ‘This is mental health, who can I ring?’”. They said:

“...for lots of children, school is a sanctuary [...] but a lot of teachers I will speak to just are afraid of saying the wrong thing, doing the wrong thing. But, actually, with support and with training, they're much better placed to be able to do it than we [clinical psychologists] are because they're with the children for so much longer than coming to see someone like us once a fortnight. So, it's about that culture. People are now happy to talk about it, but they're still afraid of what to say next.”⁹¹

113. In relation to joint working on emotional well-being, resilience and early intervention in schools, the T4CYP Programme told us that there was much more to do, but:

“There is certainly a much greater awareness and much greater appreciation of the need for agencies to work together on [...] general resilience and well-being, often in school settings and preschool

⁸⁹ Oral evidence, RoP [paras 98], 30 November 2017

⁹⁰ Oral evidence, RoP [para 87], 30 November 2017

⁹¹ Oral evidence, RoP [para 218], 30 November 2017

settings, from the very early stages of life right the way through to some of that early help and support.”⁹²

Funding

114. Head teachers’ representatives told us that funding was a barrier to the implementation of a whole-school approach. They reported that resource was “so squeezed” their ability to adopt the approach was limited regardless of their level of willingness.⁹³

115. They also warned against relying on school budgets to fund health services:

“...there is a limited resource that sits with schools [...] if it’s some kind of health provision that should be given to support that [service], that cannot fall back on schools to do because we simply don’t have the resources, or you have to ring-fence funding that comes into the school to do it. You can’t do it on the basis of a school budget finding that.”⁹⁴

116. Finally, they suggested that the Education Improvement Grant (EIG) and/or the Pupil Development Grant (PDG) were “probably” being used to fund gaps in provision, including emotional and mental health support. One example given was the use of PDG to fund Emotional Literacy Support Assistant (ELSA) learning coaches and a family liaison officer to ensure hard-to-reach families access school.⁹⁵ Head teachers’ representatives highlighted concerns that use of grant funding in this way meant:

- “fundamental” issues around school funding (including sustaining staff levels) were being hidden; and
- contracts were only temporary which had an impact on the calibre of applicants and consistency of staff (with consistency being a particular challenge when trying to build the necessary relationships with children and young people to be able to discuss emotional and mental health).⁹⁶

Importance of leadership

117. There was broad consensus across the evidence we received that leadership is key to the delivery of the whole-school approach.

⁹² Oral evidence, RoP [para 178], 22 November 2017

⁹³ Oral evidence, RoP [para 95], 30 November 2017

⁹⁴ Oral evidence, RoP [para 262], 30 November 2017

⁹⁵ Oral evidence, RoP [paras 264 and 267], 30 November 2017

⁹⁶ Oral evidence, RoP [paras 269 and 270], 30 November 2017

118. Professor Dame Sue Bailey, Expert Adviser to the T4CYP Programme emphasised the importance of head teachers driving the approach and having a clear understanding of what emotional well-being is.⁹⁷ Head teachers' representatives emphasised the importance of enabling children to take a lead on the approach to well-being within a school.⁹⁸

119. Participants in our roundtable event with frontline educational staff agreed that embedding a focus on well-being in schools and making it a priority "from the top" is crucial to the delivery of the whole-school approach. Some suggested that including approaches to well-being within the National Professional Qualification for Headship (NPQH) would be a good starting point.

120. Roundtable participants also highlighted the need for every school to have a key worker(s), trained and enabled to coordinate and communicate across the relevant multi-disciplinary team (which could involve health, education and local authority staff). It was not envisaged that this would necessarily be a teacher, although some referred to the role of a "guidance teacher"⁹⁹ as a possibility (which chimed with suggestions made in evidence from the Samaritans).

CAMHS in-reach pilot

121. During the course of our inquiry the Welsh Government announced £1.4 million – jointly funded by health and education budgets – for an "in-reach" pilot in schools from 2018 to 2020. The focus of the pilots is early identification and intervention and they are intended to:

- provide support for teachers to better understand emotional and mental health problems, "upskilling" them to recognise and deal with low level problems within their competence;
- ensure that, in instances beyond teachers' competence, schools can direct pupils to more appropriate services, such as specialist CAMHS or Local Primary Mental Health Support Services (LPMHSS); and
- ensure that there is appropriate information sharing between schools and CAMHS, shared care arrangements where more intensive support is needed, and mechanisms to escalate or de-escalate support according to pupils' needs.

⁹⁷ Oral evidence, RoP [para 190], 22 November 2017

⁹⁸ Oral evidence, RoP [para 351], 30 November 2017

⁹⁹ This is a special category of teacher to provide emotional support, and is a model in place in Scotland.

122. There was broad welcome for the in-reach pilot, especially the opportunities provided for training teachers and improving links with specialist services. There was some caution expressed, however, particularly in relation to:

- maintaining support for non-pilot schools that will continue to need to provide for their pupils while the pilot runs;
- needing to continue progressing work on curriculum reform and wider emotional resilience and prevention in tandem; and
- managing expectations and planning an “exit strategy” in case the additional resource injected into schools through the pilot ends up withdrawn in two years’ time.

The Welsh Government’s view on implementation of the whole-school approach

123. The Cabinet Secretary emphasised the importance of ensuring that a suitable system is in place to underpin the implementation of the whole-school approach:

“...we have to recognise that teachers are not mental health professionals—they’re teaching professionals, so we have to ensure that there is a system around them that allows those people with the professional skills that are appropriate to be able to intervene and support them in a timely manner.”¹⁰⁰

124. When challenged on issues relating to funding, particularly whether schools in affluent areas were struggling to resource support for emotional and mental health issues due to funding formulae or grant allocations, the Cabinet Secretary for Education stated:

“...what is important to recognise is that all schools, regardless of where they are or the communities they serve—in a secondary school setting, all schools have access to counselling as a low-level intervention, and those counsellors have the ability to refer into more specialist services if that is felt appropriate. In our CAMHS in-reach service, the pilots have been specifically chosen to represent a wide range of settings, because we want to understand what works best where.”¹⁰¹

¹⁰⁰ Oral evidence, RoP [para 62], 15 February 2018

¹⁰¹ Oral evidence, RoP [para 55], 15 February 2018

125. On training and joint working, the Cabinet Secretary for Education said that training resources have been made available and new directories of services put together for schools.¹⁰² However, she also said:

“Are we providing enough professional learning for the teaching staff in the school to feel confident about these issues? Does the school as a whole feel that they are able to interact with social services and healthcare services in a way that is really timely and meets the needs of their students? [...] I think we'd all acknowledge there's more work to do in getting that right.”¹⁰³

126. In terms of leadership of the whole-school approach and communication and coordination between professionals, the Welsh Government stated:

“There is certainly a role for certain members of the school staff to be the link with specialist services, for example our Counselling toolkit sets out the importance of having a link person the school. However, ultimately any teacher could be that trusted adult a child turns to when they need help, and that trusted adult needs to be able to respond appropriately.

When it comes to leading a whole-school approach towards well-being, we expect head teachers to decide how a whole-school approach should be embedded, and to put the necessary arrangements in place to make this happen.”¹⁰⁴

127. Both Cabinet Secretaries highlighted the importance of the in-reach pilots, and explained they were developed in recognition of the need for health and education to work together:

“...this is an area where we need to work together, and we need to support the school to better support our education professionals, the whole school team, children, and actually where that support could and should be provided.”¹⁰⁵

128. When asked whether the in-reach pilots were being implemented with a view to upskilling teaching staff or embedding mental professionals in schools in future on a more permanent basis, the Cabinet Secretary for Education told us:

¹⁰² Oral evidence, RoP [para 13], 15 February 2018

¹⁰³ Oral evidence, RoP [para 43], 15 February 2018

¹⁰⁴ Written evidence, EMH FI 21 – Welsh Government

¹⁰⁵ Oral evidence, RoP [para 102], 15 February 2018

“There's going to be an evaluation at the end of [the in-reach pilot]. If that evaluation demonstrates that having those professionals in those roles has been advantageous, subject to budget discussions and finding resources, it would be my expectation that those roles, if it's demonstrated that they've made a difference, would, in some cases, carry on, yes.”¹⁰⁶

129. They both asserted that the in-reach pilots were an opportunity to explore the best ways of:

- raising school staff's confidence, upskilling them to feel better equipped to deal with emotional and mental health issues;
- improving liaison between CAMHS and schools, to make the links as seamless as possible; and
- approaching a mix of settings and environments, by selecting urban and rural, affluent and deprived, and Welsh- and English-medium settings “so that we can understand what works where”.¹⁰⁷

130. The Cabinet Secretary for Health and Social Services warned, however, that schools alone are not the answer:

“...you can't say that there is a simple answer and you just equip schools and then it'll all be fine. It's about recognising how children live their lives and have different attachments and different people who they trust. Lots of that trust will be invested in people around the school. But, actually, for a number of those children, that'll be the last place that they would want to go to discuss these issues. [...] the priority in all of this [is] how you get people to act at the top of their game and recognise their professional responsibilities for that child, and how they work with other professionals, whether they're from health, education or somewhere else, but ultimately, how we make it easier for that child and that family to get the right support.”¹⁰⁸

¹⁰⁶ Oral evidence, RoP [para 115], 15 February 2018

¹⁰⁷ Oral evidence, RoP [paras 55, 106 and 107], 15 February 2018

¹⁰⁸ Oral evidence, RoP [para 64], 15 February 2018

OUR VIEW ON IMPLEMENTING THE WHOLE-SCHOOL APPROACH

131. We recognise the challenges associated with the implementation of the whole-school approach, not least matters relating to cross-agency working and funding. Nevertheless, we simply cannot afford to allow these challenges to prevent a whole-school approach being in place across Wales's primary and secondary schools. The costs of emotional and mental ill health – both personally to the individuals and families involved, and to the public purse – are too high for us not to try to stem the flow earlier.

132. We believe that schools are perfectly placed to make a significant contribution to building an emotionally resilient population of young people. But they cannot do it alone. Support from other statutory and third sector agencies, most notably health, is essential. We are concerned to hear evidence of the “salami slicing” of health services raising expectations of teachers' and other professionals' ability to manage more severe emotional and mental health issues in the school setting. We are also concerned about the suggested impact this is having on school budgets.

133. Our recommendations in the next sections of this report outline where we think changes are needed to ensure that schools are able to concentrate on their areas of expertise: equipping children with the healthy coping mechanisms they need to be emotionally resilient and well individuals, and liaising with wider services if further, more specialist support is needed.

134. We welcome the in-reach pilots and the role they will play in raising teachers' confidence to handle early signs of emotional and mental issues, and facilitating the bridge between schools, primary care and specialist services. Nevertheless, we emphasise that while these pilots are underway, non-pilot schools will still require support to ensure that they are able to cater for their pupils' needs, often in the face of significant gaps in support services elsewhere. We also believe that it is important to clarify whether the main purpose of the in-reach pilots is to train school staff or for health professionals to have an ongoing presence in schools.

135. Pending the outcome of the in-reach pilots, we believe it is essential for education and health services that are not participating in the pilots to be given interim guidance and adequate resources to deliver emotional and mental health support for pupils.

136. The importance of leadership to the delivery of the whole-school approach was clear in the evidence we received. We believe further work is needed to

establish who is best placed in a school to lead on work to support the emotional health and well-being of pupils, including consideration of whether the role of a “guidance teacher” is one which should be piloted in Wales.

Recommendation 7. That the Welsh Government issue interim guidance to health and education services (and other relevant statutory bodies) about the support they should deliver for emotional and mental health in schools. This should specify the support that they should expect from each other as statutory services. This guidance should remain in place, and should be resourced adequately, until the findings of the in-reach pilots are reported to us and others. The guidance should be issued within three months of our report’s publication and reviewed after the in-reach pilots conclude.

Recommendation 8. That the Welsh Government pilot the role of “guidance teacher” in Wales, or adopt another model that allocates responsibility for the emotional and mental health of pupils to a lead member of teaching or non-teaching staff.

2. 3. Support outside school

137. As indicated by the Cabinet Secretary for Health and Social Services, school is not the only place where children and young people can access emotional and mental health support. References were made in evidence to primary care, including general practice and local primary mental health support services (LPMHSS), and support in the community, most notably via youth services.

138. Our predecessor Committee's 2014 report highlighted primary care provision as an area requiring further work and prioritisation. Evidence submitted to its inquiry raised concerns that:

- the creation under the Mental Health (Wales) Measure 2010 of all-age LPMHSS services (to replace the previously separate adult and child services) risked leaving “an inferior CAMHS service for children and young people”, focused on adult models of care;
- the Measure's focus on linking LPMHSS with general practice failed to take account of the fact that GPs are often not the first point of contact for young people;
- the creation of LPMHSS led to a workforce that did not always have the necessary expertise or experience of the specific issues relating to children and young people's mental health; and
- there was a risk that the valuable services provided by existing primary mental health workers for children would be lost due to pressure to meet all-age targets under the Measure.

Box 2: Example of best practice outside school

The Changing Minds Project was established in 2013 as a Gwent wide, five year lottery-funded project that delivers interventions to young people who are struggling with their mental health. Newport Mind provides a substantial suite of self-management courses, one-to-one transition support and peer support programmes in the community and in educational settings. The young people involved in the project report that the peer support (in which young people undertake group work together) has led to long-lasting arrangements for participants. They stressed the preventative nature of the project and the greater strain on GPs, A&E and Local Primary Mental Health Support Services if it did not exist.

Primary care

139. Under Part 1 of the Mental Health (Wales) Measure 2010:

- health boards and local authorities have a duty to develop Local Primary Mental Health Support Services (LMPHSS). The aim is to secure earlier and easier access to mental health services for people with mild to moderate mental health problems and those with more serious but stable conditions; and
- people who visit their GP surgery with mental health problems should be offered an assessment, within 28 days, to determine whether local primary mental health treatment or other local services might help. If so, access to help – which could include counselling or other therapeutic interventions (either one-to-one or on a group basis) – should be achieved within 28 days of assessment.

General practice

140. Several respondents to our inquiry highlighted a significant variation in individual experiences of seeking mental health support from GPs for children and young people. Factors influencing the quality of provision included the approach and training of the individual GP involved, and the availability of “lower tier” or local primary mental health support services to work with to support the child or young person.

141. Frontline education practitioners who participated in our roundtable discussion raised concerns that GPs “bounce” children and young people back to school for support, often via the school counsellor. This, they argued, led to demand for school counselling outstripping supply. Witnesses from the Royal College of General Practitioners (RCGP) confirmed that “bounce back” occurred, noting that services provided in schools are often the best available for children who do not meet the specialist CAMHS threshold or are deemed to need a therapeutic rather than medical intervention.¹⁰⁹ This leads to delays in support and frustrations for children and families.

142. The RCGP noted that the general lack of talking and psychological therapies was particularly acute for children and young people due to insufficient numbers of practitioners trained to help them.¹¹⁰ They also confirmed that there is no GP

¹⁰⁹ Oral evidence, RoP [para 42], 7 February 2018

¹¹⁰ Oral evidence, RoP [para 85], 7 February 2018

counselling service for under 18s in Wales.¹¹¹ They argued that this lack of “intermediate” services prevented young people progressing to suitable support, leaving them attending a GP surgery while waiting for a primary or secondary mental health care intervention. The RCGP explained that during this period, conditions can escalate to a level that ends up meeting the specialist CAMHS threshold or leaves the GP with little option but to refer them to specialist CAMHS because there is no other alternative at the primary level.¹¹²

Local Primary Mental Health Support Services (LPMHSS)

143. Part 1 of the Mental Health (Wales) Measure 2010 aims to deliver more local provision for children and young people with mental health problems, with a view to reducing the need for them to be referred to secondary care services. Under Part 2 of the Measure all children and young people in secondary care should have a care and treatment plan.

144. Stakeholders who submitted written evidence agreed that LPMHSS care pathways should be reducing referrals to specialist CAMHS by enabling access to services for children and young people with lower level mental health issues or possible onset. However, concerns raised about LPMHSS included:

- variations in the provision of LPMHSS across Wales (recognised by the health boards);
- a perceived dominance of an adult-, rather than child-centred, service provision model;
- recruitment of suitably trained staff with a background in child and family work;
- primary mental health services being overstretched by requirements of the Mental Health (Wales) Measure 2010;
- the need to expand the pool of people who can refer to LPMHSS, to ensure that people who best know the child are able to make referrals for further local support. GPs themselves noted that general practice can be a barrier to children and young people accessing services as they may not go to see them – this, they argued, made multiple referral routes, particularly via school-based professionals, essential; and
- the lack of Welsh language support services.

¹¹¹ Oral evidence, RoP [para 68], 7 February 2018

¹¹² Oral evidence, RoP [para 87], 7 February 2018

145. The Royal College of Psychiatrists reported that where LPMHSS were under developed, over-referrals were being made to specialist CAMHS.¹¹³ They also remarked that it used to be easier to signpost from specialist CAMHS to primary care CAMHS.¹¹⁴ They suggested that more could be done to train GPs, for example by allocating a CAMHS-commissioned post to work alongside GPs to develop skills and straightforward assessment in primary care.¹¹⁵ A recent survey undertaken by the College identified that GPs wanted more support especially for common issues like anxiety, depression and self-harm.¹¹⁶

146. In oral evidence health board representatives denied that LPMHSS lacked a focus on children. They noted that most primary mental health teams were located within their children's services (although Aneurin Bevan UHB noted it had invested in their local service in recognition of it being too adult oriented). However, they accepted that primary care services required further work and investment re-prioritised given the rapidly growing numbers requiring therapeutic, talking or behavioural support rather than a specialist medical intervention.¹¹⁷

147. The T4CYP Programme told us there is a review underway of the role and capacity of the LPMHSS for children. They explained that identifying gaps in services at this level would be one of the Programme's priorities if extended beyond April 2018. The Programme has since been extended to October 2019.

148. When asked about primary care provision the Cabinet Secretary for Health and Social Services said:

“...local primary mental health services are an all-age model, and the key points apply to children and adults, but we did specifically in 2015-16 invest an additional £800,000 a year, that's been recurrent since then, to improve primary care children's provision, and also will be using some of our additional provision going into CAMHS as well. So, we recognise that there's been some variation in how services have been implemented, and so we want to understand that variation itself and look for further improvement. But I wouldn't accept that the challenge is that there needs to be a different child-centred provision; we need to

¹¹³ Oral evidence, RoP [paras 11-15], 14 December 2017

¹¹⁴ Oral evidence, RoP [para 18], 14 December 2017

¹¹⁵ Oral evidence, RoP [para 39], 14 December 2017

¹¹⁶ Oral evidence, RoP [para 40], 14 December 2017

¹¹⁷ Oral evidence, RoP [paras 137 and 221], 7 February 2018

meet the needs of children appropriately in their setting, whether that's a family or a community or an individualised circumstance."¹¹⁸

149. He also noted that the NHS Delivery Unit would be undertaking work during 2018 to establish:

- why variation exists within primary care services for children and young people in terms of access and delivery; and
- what health boards and their partners need to do to ensure it is as easy as possible for children and their families to get the care they need.¹¹⁹

150. When asked to comment in further detail on access to primary mental health services for young people, in particular if all health boards are complying with the Mental Health Measure, the Welsh Government wrote:

“We have management data from Health Boards to enable us to track progress and to ensure that there is equal access for young people. For under 18s there is variation across Health Boards and in the consistency of improvement in waiting times for assessment and interventions in Local Primary Mental Health Support Services (LPMHSS).

As part of the work through 2018-19, the NHS Delivery Unit will work with health boards to consider how further improvements can be made including opportunities for sharing good practice and/or models. Later in the summer, the NHS Delivery Unit will also undertake a review of primary mental health services for children and young people.”¹²⁰

151. The Welsh Government’s written evidence stated that:

- expanding primary care mental health services will mean that many young people with low level conditions will not require referral to specialist CAMHS; and
- the T4CYP Programme has recommended the enhancement of LPMHSS, making them available to education and social care services, and not just primary care services under the Mental Health Measure 2010.¹²¹

¹¹⁸ Oral evidence, RoP [para 156], 15 February 2018

¹¹⁹ Oral evidence, RoP [para 159], 15 February 2018

¹²⁰ Written evidence, EMH FI 21 – Welsh Government

¹²¹ Written evidence, EMH 68 – Welsh Government

Youth work services in the community

152. Youth work in Wales is intended to be a universal entitlement, open to all young people aged 11 to 25 years. The principle is that young people access these services on a voluntary basis. However, as our [2016 report on youth work](#) highlighted, there has been an alarming decline in provision in recent years.

153. Youth work sector representatives told us:

- they are ideally placed to support children and young people with low-level mental health issues by listening to them and helping to support them manage their distress;
- the voluntary nature of the relationship means young people often present issues and concerns to a youth worker before school, parents or health services identify them;
- they could promote good mental health through their regular contact with young people;
- given more training on how to deal with mental health difficulties, and stronger links with primary and secondary specialist services, the youth service could be better used to help manage children and young people's mental health needs; and
- it is often youth work that acts as the “wrap around” support for a young person before, during and after counselling interventions “as the provision complements clinical input”.¹²²

154. The Children's Commissioner for Wales also highlighted the role the youth work service can play in emotional and mental health both in school and in the community.¹²³

OUR VIEW ON EARLY SUPPORT AVAILABLE OUTSIDE SCHOOL

155. The support available in primary care is in urgent need of attention. A significant gap in services and support was highlighted in the evidence we received, with reports of primary care provision for children and young people regressing rather than progressing since our predecessor Committee's 2014 report.

¹²² Written evidence, EMH 13 – Council for Wales of Voluntary Youth Services and EMH 16 - Wales Principal Youth Officers' Group

¹²³ Oral evidence, RoP [paras 340 and 354], 22 November 2017

156. The lack of focus on primary care is of significant concern to us. In light of the Welsh Government's response to our predecessor Committee's report, which emphasised that many of the problems facing specialist CAMHS were attributable to young people accessing them inappropriately, the Welsh Government and the T4CYP Programme should have done more by now to develop alternative low- to intermediate-support services.

157. The unintended consequences of the all-age model of local primary mental health support services introduced by the Mental Health (Wales) Measure 2010 have posed significant challenges for the provision of services for children and young people. While we note the Welsh Government's and the T4CYP Programme's assurances that investment has been made to begin to address these unintended consequences, the significant gap that exists at the primary care level still needs to be plugged. Without this, early intervention services at the front end of the pathway, and specialist services at the other, are in danger of being overwhelmed by children and young people who cannot access support from either.

158. We welcome the Welsh Government's confirmation that the NHS Delivery Unit will undertake a review of primary mental health services for children and young people this year. However, we are disappointed that the Welsh Government did not provide the health boards' management data tracking progress in relation to LPMHSS waiting times for assessment and interventions for children and young people.

Recommendation 9. That the Welsh Government make available the management data tracking progress in relation to local primary mental health support services (LPMHSS) waiting times for assessment and interventions for children and young people since the commencement of the provisions of the Mental Health (Wales) Measure 2010.

Recommendation 10. That the Welsh Government set out an improvement plan for local primary mental health support services (LPMHSS) for children and young people in Wales. This should provide an assessment of current levels of provision, the anticipated demand for services over the next 5-10 years, and the estimated level of resource needed to join the two. It should also outline how LPMHSS will engage with other statutory and third sector services, and provide the most accessible, appropriate and timely "intermediate" support services to bridge the gap between emotional resilience support on the one hand, and specialist CAMHS on the other. The improvement plan should outline clearly the pathways available for children and young people so that signposting to and

between each level of services is clearer and simpler. It should make explicit reference to how LPMHSS should liaise with schools in particular.

Our key recommendation

Our predecessor Committee's 2014 report focused on specialist services. It resulted in a wide-ranging review of CAMHS and significant additional investment in services.

Since its establishment in 2015, the T4CYP Programme has concentrated its initial efforts on these most specialist services given the urgent challenges they were facing.

Four years on, we believe the urgent challenge now lies at the preventative end of the care pathway – emotional well-being, resilience and early intervention.

Failure to deliver at this end of the pathway will lead to children and young people suffering unnecessary distress. For many, this distress could be reduced or even avoided by being able to draw on the right support at the right time, or by drawing on healthy coping mechanisms and their own emotional resilience. Prevention is better than cure.

Failure to deliver at this end of the pathway will also threaten the sustainability of more specialist services for those with more severe illness. The recent Care Quality Commission's review of children and young people's mental health in England summarises this perfectly as the "vicious cycle that drives demand and undermines the quality and sustainability of care"¹²⁴. A major step change

¹²⁴ Care Quality Commission, **Are we listening? A review of children and young people's mental health services**, March 2018



is needed in the priority given to emotional resilience and well-being of children and young people and the awareness and skills of all staff who work with them.

Key recommendation: That the Welsh Government make the emotional and mental well-being and resilience of our children and young people a stated national priority. This status should bring with it a commitment to:

- provide adequate and ring-fenced resource for our schools to become community hubs of cross-sector and cross-professional support for emotional resilience and mental well-being. Schools cannot shoulder this responsibility alone - the support of other statutory and third sector agencies, most notably health, is essential;
- ensure that emotional and mental health is fully embedded in the new curriculum;
- ensure that everyone who cares, volunteers or works with children and young people is trained in emotional and mental health awareness, to tackle issues of stigma, promote good mental health, and enable signposting to support services where necessary. This should include working with professional bodies to embed training in initial qualifications and continuous professional development; and
- publish every two years an independent review of progress in this area. This process should involve children and young people throughout.





Chapter 3:

Specialist services

Efforts to maintain emotional well-being and prevent the onset or escalation of mental illness are key. Nevertheless, for those with the most acute need, the support of specialist services will be crucial.

Significant work has been underway to deliver change since our predecessor committee's report in 2014. However, we should not underestimate the work that remains to be done to ensure that children and young people in most need of specialist support receive it in a timely way and in an appropriate setting.

A child's or young person's level of distress – emotional, behavioural or mental – should be the basis of the assessment of need. Specialist support should not be viewed as medical only in nature – being without a diagnosed disorder does not diminish the severity of distress and harm experienced, and should not act as a barrier to accessing support.

3. 1. Access to specialist services

159. Access to specialist CAMHS services was a key priority highlighted by our predecessor Committee's report on CAMHS in 2014. Concerns were raised about:

- the criteria for accessing the specialist services, most notably their dependence on the “medical model” of diagnosis;
- referrals not being accepted; and
- long waiting times between referrals and treatment for those children and young people who were deemed to be eligible for support.

160. Evidence submitted to our inquiry suggested:

- there has been marked progress in the last two years in relation to referral to assessment **waiting times** for specialist CAMHS, although a significant part of this is attributable to the creation of new neurodevelopmental (ND) services, which provide a separate pathway for those with ND issues and have therefore led to reporting changes; and
- the development of national **referral criteria** for access to services is to be welcomed, although several stakeholders raised concerns about the bar for access being set too high and being too focused on medical diagnosis.

161. The majority of those who gave evidence also:

- highlighted **variation in practice** across Wales, leading to possible inequity in access to specialist CAMHS;
- highlighted the difficulties facing children and young people who find themselves ineligible for CAMHS services but unable to find suitable therapeutic or “lower level” support – the so-called “**missing middle**”;
- questioned the **sustainability of waiting times improvements** for specialist CAMHS and the level of assurance current data provides about the **quality of outcomes** for those eligible for CAMHS or ND support; and
- highlighted the **much longer waits for ND assessment and treatment** faced by the children and young people who require them.



What children and young people told us about access to specialist services

During our visits we asked children and young people what they thought about the availability of specialist services. Here are some of the things they told us:

“It’s too hard to access services.”

Young people from the Changing Minds project in **Newport** told us that the bar to access services was too high. They also explained that they had experienced long waiting times only to be told they did not meet the criteria for access to support.

“You have to have a crisis first.”

When we visited north Wales’s in-patient unit in **Abergele**, one of the young people told us they had not met the threshold for CAMHS initially. They explained that they only received the specialist treatment they needed after finding themselves in a number of crises. Another young person explained that after eventually visiting the GP, they were referred to specialist CAMHS but had to wait a number of months before being seen. They felt they had waited too long to receive support.

“It takes too long.”

Young people in the south Wales in-patient unit in **Bridgend** told us that they had been suffering with mental health problems for a long time before they had access to specialist services. They told us that once a referral was made, it was very important for children and young people to be able to be given specialist support quickly.

In written evidence one former service user told us she was left wondering “why hasn’t anything been done yet?” and recalled her mother having to telephone services regularly to make sure she received the crisis care they felt was needed.

“You have to prove how unwell you are to the GP.”

The young people at Hillside Secure Children’s Home in **Neath** told us that finding specialist support in the community was extremely difficult. One young person recalled needing to gather as much information as possible to “prove” to the GP how unwell they were.



Variation in practice

162. A large number of those who gave evidence to our inquiry acknowledged that variations in practice are reducing under the guidance of the T4CYP Programme and because of the injection of additional CAMHS funding. Nevertheless, the vast majority emphasised that further work is required if children and young people are to get equal service regardless of where in Wales they live.

163. Barnardo's Cymru highlighted inequity of access across Wales in terms of both the availability and variety to services to support children and young people, not least in rural areas where access to services remains a challenge:

“There seem to be pockets of good practice, with strong service offers for certain conditions, whereas other services are chronically underfunded and overwhelmed.”¹²⁵

164. The Royal College of Psychiatrists told us that variations in practice across Wales had diminished, but that “significant work” was still required. They noted that “vast improvements” had been made with “probably less variation in the management of severe mental illness than before”, but that larger variation continued to exist in the delivery of primary mental health services.¹²⁶ The Royal College of Speech and Language Therapists highlighted significant variation in terms of the amount of provision funded in each ND service.¹²⁷

165. Our predecessor Committee's inquiry highlighted the difficulties monitoring and benchmarking service provision caused by poor information collection. The T4CYP Programme told us that, in acknowledgement of the need to improve the quality of data and use it as a driver for service development, all health boards had completed the “**Baseline Variations and Opportunities Audit**” which provided an assessment of specialist CAMHS across Wales in 2016. This Audit highlighted variation in service provision across Wales and provided lead clinicians and managers with feedback for improvement. Examples included

- increasing the use of single points of access for services;
- providing alternative ways of accessing consultation and advice; and

¹²⁵ Written evidence, EMH 24 – Barnardo's Cymru

¹²⁶ Written evidence, EMH 37 – Royal College of Psychiatrists

¹²⁷ Written evidence, EMH 06 – Royal College of Speech and Language Therapists

- reviewing the role and contribution of primary mental health workers.¹²⁸

166. In his written evidence, the Cabinet Secretary for Health and Social Services told us that the Audit had been prioritised to enable health boards to identify areas for local improvement, to target additional resources at “high impact areas” and to implement good practice already in place elsewhere. He also pointed to the specialist CAMHS Framework for Improvement, developed to:

- help health boards achieve consistent standards and outcomes across Wales;
- define (without being exhaustive) the role of specialist CAMHS; and
- define (without being exhaustive) the agencies able to access specialist CAMHS.

167. In relation to variation in ND services, the Cabinet Secretary for Health and Social Services wrote that a single, Wales-wide assessment pathway has been developed to ensure consistency and make the system much clearer for families.¹²⁹

Referral criteria and thresholds

168. The 2016 Baseline Variations and Opportunities Audit showed that the average acceptance rate for referrals into specialist CAMHS services was 59 per cent. Evidence submitted by health boards suggested some variation, with Aneurin Bevan reporting approximately 50 per cent,¹³⁰ Hywel Dda 64 per cent,¹³¹ and Cwm Taf 79 per cent,¹³² in 2017.

169. The majority of those who gave evidence to us cited thresholds for specialist CAMHS support as being an ongoing problem. Several respondents highlighted their concerns that referral criteria had tightened across all health boards, with CAMHS only accepting a referral where a young person’s needs constituted a diagnosable mental health condition or disorder, regardless of the symptoms or distress they were experiencing.

170. Head teachers’ representatives described the thresholds as too high, stating that teachers’ experiences suggested that unless children and young people were

¹²⁸ Written evidence, EMH 47 – T4CYP Programme

¹²⁹ Written evidence, EMH 68 – Welsh Government

¹³⁰ Oral evidence, RoP [para 180], 7 February 2018

¹³¹ Oral evidence, RoP [para 282], 7 February 2018

¹³² Oral evidence, RoP [para 173], 7 February 2018

deemed to be at risk to themselves or others, specialist CAMHS could not be accessed.¹³³

171. Several respondents questioned the medical model on which referral criteria for specialist support are based. The Children’s Commissioner noted that referral criteria were a barrier for those needing to access support,¹³⁴ arguing that social and emotional as well as medical needs need to be considered and addressed in a “holistic” way.¹³⁵ Aneurin Bevan University Health Board’s Child and Family Psychology and Psychological Therapies Services stated that the current model is dominated by medically defined, diagnosis-based referral criteria and that there is a risk of overlooking the distress caused by wider contextual influences, inadvertently “setting families and front line staff on a perpetual search for diagnosis and labels”.¹³⁶

172. Dr Liz Gregory, representing the Applied Psychologists in Health National Specialist Advisory Group told us:

“...there needs to be a culture shift in how we understand children’s mental health [...] When the Holy Grail is a diagnosis that very much locates the problem within the child it’s really hard then to work with the system [...]

These children [with behavioural or psychological needs] are incredibly distressed. This is very severe and it’s very complex, and it is mental health, but the model doesn’t allow it to be considered in that way.”¹³⁷

173. Dr Gregory went on to highlight the need to replace the traditional “pyramid” model of tiered care with what she described as the “iceberg” model. She explained that:

“...the pyramid, if you like—the tiered approach—misses a huge underbelly [...] many of the children that lots of people are very, very concerned about in terms of their behaviour don’t meet the criteria for a diagnostic disorder but are displaying very, very severe signals of

¹³³ Oral evidence, RoP [paras 125-127], 30 November 2017

¹³⁴ Oral evidence, RoP [para 384], 22 November 2017

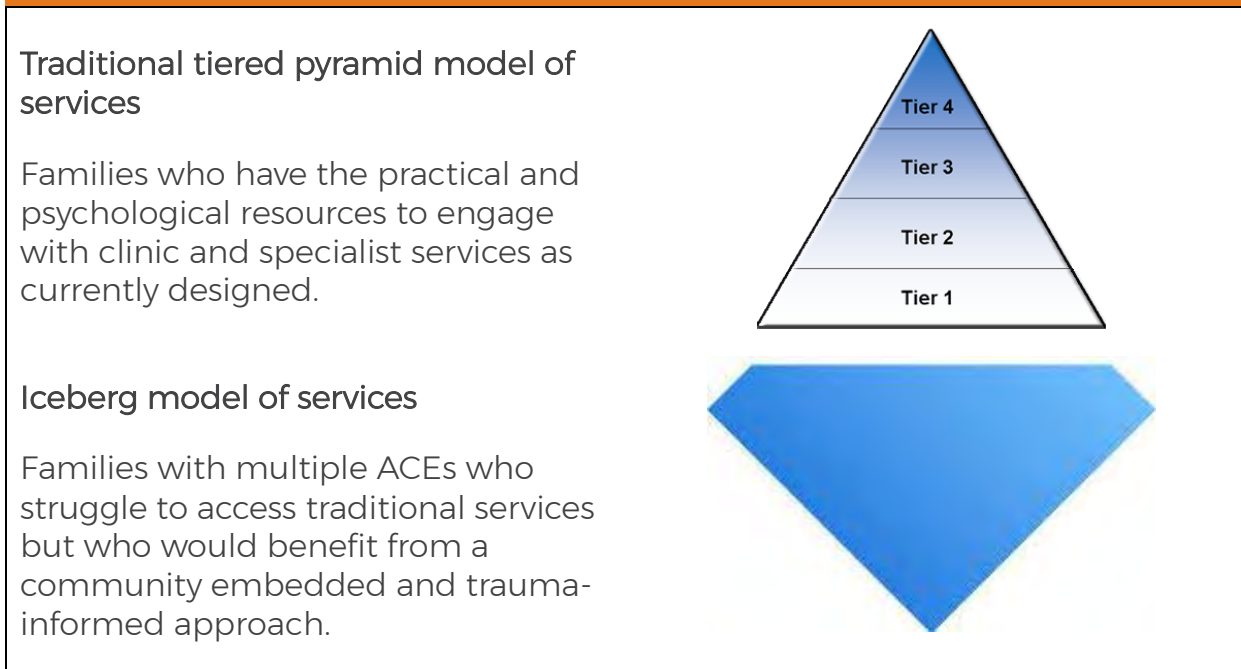
¹³⁵ Oral evidence, RoP [para 435], 22 November 2017

¹³⁶ Written evidence, EMH 05 – ABUHB’s Child and Family Psychology and Psychological Therapies Services

¹³⁷ Oral evidence, RoP [paras 161 and 176], 14 December 2017

distress, and the children at the bottom of this iceberg, if you like, rather than pyramid, are the ones who are costing society a huge amount.”¹³⁸

Figure 2: Proposed service model for emotional and mental health services



Source – Written evidence, EMH FI 02 and 03 – Dr Liz Gregory, Applied Psychologists in Health National Specialist Advisory Group

174. T4CYP Programme and health board representatives acknowledged the difficulties encountered by many children and young people when seeking to access specialist CAMHS, and recognised that more work needed to be done both on specialist CAMHS¹³⁹ and ND¹⁴⁰ referrals. They both highlighted that while the number of referrals was not growing at a comparable rate to earlier years, the complexity and acuity of cases were increasing.¹⁴¹

175. Examples of the steps being taken to seek to address these challenges included:

- the development of national referral criteria;
- the roll out of a “single point of access” approach to specialist CAMHS, to remove some of the variation in interpretation of information, and to ensure that clear responsibility is allocated for ensuring that some form

¹³⁸ Oral evidence, RoP [para 159], 14 December 2017

¹³⁹ Oral evidence, RoP [para 216], 22 November 2017

¹⁴⁰ Oral evidence, RoP [para 246], 22 November 2017

¹⁴¹ Oral evidence, RoP [para 179], 7 February 2018

of action is taken and children and young people do not end up lost in the system;

- the use of the choice and partnership approach (CAPA) model of referral into the specialist CAMHS system, which enables a more flexible approach to access for patients and a wider range of interventions from practitioners; and
- an increase in the availability of “phone first” consultations, to enable relevant professionals to discuss with specialists the most appropriate course of action for children and young people in need of support.

Attachment

176. Several stakeholders highlighted the need to include issues relating to attachment and bonding, loss, and trauma within the scope of services provided to children and young people. The British Psychological Society noted that attachment issues have a “huge impact in later life”.¹⁴² Barnardo’s noted that for looked after children in particular, support with attachment is key to the delivery of positive outcomes (see more about looked after children in section 3.2).¹⁴³

177. The Royal College of Speech and Language Therapists stated:

“There are a significant number of children and young people with attachment difficulties who do not access appropriate support to help them and without support these young people often develop mental health difficulties.”¹⁴⁴

178. The T4CYP Programme cited Aneurin Bevan University Health Board’s work on family therapy as a response to attachment issues. Programme representatives noted that learning from that work will help shape future services. Health board representatives told us:

“Some of the things we see referred into specialist CAMHS on an increasing basis now are around self-harm and attachment, and they’re really not things that we can deal with very well in a specialist CAMHS system. What those presentations do require—and indeed this is what young people tell them themselves—they want peer-group activities, they want locally supported activities, where they’re engaging with

¹⁴² Oral evidence, RoP [para 214], 14 December 2017

¹⁴³ Oral evidence, RoP [para 381], 14 December 2017

¹⁴⁴ Written evidence, EMH 06 – Royal College of Speech and Language Therapists

community nurses and school nurses who they trust and have a relationship with. So, for us, I think it's about building those kinds of services into schools and into communities.”¹⁴⁵

The Welsh Government's view on referral criteria

179. Responding to concerns about referral criteria and thresholds, the Cabinet Secretary for Health and Social Services acknowledged that it remained “a work in progress” but that latest figures showed 68 per cent of referrals had been accepted by specialist CAMHS. As specialist CAMHS does not have an “open referral” approach, we are concerned that this means 32 per cent of children and young people were turned away even though the referrals were made by qualified professionals. The Cabinet Secretary for Health and Social Services further noted that the challenge was to ensure that the third of children and young people not accepted by specialist services were signposted consistently and quickly across Wales to an appropriate form of intervention and support that meets the needs identified (see the next section for more detail).

180. The Welsh Government’s written evidence also noted that:

- the creation of the new ND pathway should lead to improvements in overall referral rates (as they have accounted for a significant number of referrals in recent years); and
- the overall key to addressing over-referrals in the longer term is workforce development, building capacity among staff who work on a day-to-day basis with children and young people.¹⁴⁶

181. In relation to attachment issues, the Cabinet Secretary for Education stated:

“What we're seeing increasingly in our schools, and what schools are having to respond to in some of our youngest children, are issues around attachment disorder, and, actually, what do you do then if you've got a child with issues around attachment [...] increasingly, I think issues around attachment are going to really, really come to the fore for our youngest children going into schools, and that's why we need the cross-sectoral approach between social services and family support, good parenting support, and then that's reinforced then by an environment in the school and the deployment of resources in the

¹⁴⁵ Oral evidence, RoP [para 155], 7 February 2018

¹⁴⁶ Written evidence, EMH 68 – Welsh Government

school, such as a nurture group for instance, that can best support that child.”¹⁴⁷

The “missing middle”

182. The vast majority of witnesses commented that urgent work was needed to address the lack (and in some cases absence) of services for children and young people who need support but do not meet the threshold for specialist CAMHS or ND support. Many witnesses referred to these children as the so-called “missing middle”, referring to the almost complete absence of services for them.

183. Action for Children told us:

“There’s a large gap that sits below the specialist CAMHS tier [...] we’ve got a lot of young children and young people who don’t meet the CAMHS criteria who then fall just short of that, and there are very little services out there to refer on to.”¹⁴⁸

184. The Royal College of Paediatrics and Child Health commented:

“...if you’ve got clear clinical depression as a young person, it’s easily identified where you are helped, but for that big group below that level, where they have got some emotional health problems, which may be temporary, may become long term—it’s that group of kids that we struggle with, to be able to help, and to stop them going on to have more severe mental health problems.”¹⁴⁹

185. Health board representatives acknowledged the gap in services and noted it as a key priority for the next phase of service development:

“...going forward, the challenge we’ve got to tackle is where do we refer some of the younger people who are a lower level [...] Numbers there are growing rapidly, and it’s where do we then link them into a more therapeutic and behavioural analysis and counselling, rather than a high-level intervention [...] That’s a big challenge now, how we start to scale up some of those services so that we meet the needs in a much more rapid way.”¹⁵⁰

¹⁴⁷ Oral evidence, RoP [para 143], 15 February 2018

¹⁴⁸ Oral evidence, RoP [para 306], 14 December 2017

¹⁴⁹ Oral evidence, RoP [para 326], 18 January 2018

¹⁵⁰ Oral evidence, RoP [para 137], 7 February 2018

186. A range of possible solutions, some of which were cited as being underway in some areas but not consistently across Wales, were suggested by stakeholders:

- basing access to services on the level of distress a young person is experiencing, as opposed to whether a young person is displaying the symptoms of a diagnosable disorder;
- moving towards a less tiered approach to services, enabling children and young people to access a range of services more flexibly and staff to work more collaboratively;
- re-distributing resources to enable therapeutic and psychological approaches to behavioural, social and emotional needs to be provided, as well as medical interventions for diagnosed conditions;
- adopting a more multi-disciplinary approach to service provision and embedding such services in the community rather than in clinic-based settings which many children and young people fail to access due to their lack of diagnosis or social/familial barriers; and
- expanding as a matter of urgency local primary mental health support services to support the delivery of this broader range of services, as well as supporting preventative and early intervention work to avoid the onset and escalation of mental and emotional distress and ill health.

187. The Cabinet Secretary for Health and Social Services recognised the need to address this group of children and young people in the “missing middle”, but warned:

“...there will be a variation in how that’s done, because otherwise you’re not going to be able to deliver the right sort of intervention for that child.”¹⁵¹

Waiting times

Specialist CAMHS

188. The current target for specialist CAMHS is that 80 per cent of patients should wait no longer than 28 days from the date the referral is received by the clinic to a first outpatient appointment. This brings specialist CAMHS in line with the target for adult mental health services.

¹⁵¹ Oral evidence, RoP [para 173], 15 February 2018

189. The 80 per cent target was met nationally in March 2017, but has been missed every month since:

| Table 2: % waiting less than 4 weeks from referral to assessment (Mar 2017 – Jan 18) | | | | | | | | | | |
|--|------|------|------|------|------|------|------|------|------|------|
| Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan |
| 87.1 | 57.8 | 66.3 | 57.6 | 46.7 | 39.3 | 44.7 | 52.5 | 44.7 | 47.8 | 52.2 |

Source - StatsWales, [Waiting times by specialty and patient type – outpatient waiting times](#).

190. Current waiting time measurements do not extend beyond an initial assessment and there is no data published routinely on commencement of treatment.

191. A significant amount of the evidence to our inquiry acknowledged reductions in waiting times for children and young people from referral to assessment for specialist CAMHS. Nevertheless, several respondents raised concerns about:

- the continued failure to meet the operational target of 80 per cent referral to assessment with 28 days, and therefore questioned the viability and sustainability of maintaining full compliance within current resources and given the reported increase in demand and acuity of cases;
- the focus on measuring referral to assessment waits, as opposed to waiting times for treatment or the quality of outcomes achieved as a result of the support provided;
- the accuracy of waiting time data; and
- the apparent increase in waiting times for community paediatrics and ND assessments, which some argued illustrated children and young people were simply being moved from one waiting list to another.

192. While welcoming the 28-day waiting time target for specialist CAMHS, the Samaritans warned:

“There can be a lot of people waiting six months to year for the actual eventual support they need [...] It completely worsens mental health [...] we hear all the time people who are on waiting lists who call the

service, who are experiencing distress because they're on that waiting list, and it just increases distress."¹⁵²

193. Health board representatives highlighted the need to manage what they saw as misperceptions of specialist CAMHS being inaccessible and subject to long waiting lists. They acknowledged, however, that the current variation across health boards in their performance against waiting time targets could fuel these perceptions.¹⁵³

194. Responding to questions about how meaningful it is to measure referral to assessment (as opposed to waiting times for treatment), health board representatives argued that where the CAPA model is in operation, it is a “false dichotomy” to measure between assessment and treatment because:

“...therapy starts the moment you come in the door. It isn't just a triage assessment and then you have to wait, because there are therapeutic elements built into that choice appointment.”¹⁵⁴

195. Representatives of the T4CYP Programme and the Royal College of Psychiatrists emphasised a “step change” had occurred in relation to waiting times for specialist CAMHS, but noted that rising demand for services and recruitment issues challenged health boards' ability to sustain full compliance with the target.¹⁵⁵ Nevertheless, children and young people, and organisations working directly with them, continued to highlight their experiences of long delays for access to specialist CAMHS.¹⁵⁶

Neurodevelopmental (ND) services

196. Standalone ND services are a new development in Wales, established using the additional funding provided to CAMHS by the Welsh Government in 2015. Previously, children with ND issues were referred to specialist CAMHS or community paediatric teams for assessment and treatment. The Welsh Government target is that no child or young person should be waiting more than 26 weeks for a ND assessment from April 2018 onwards. This will bring these services in line with the target for paediatric services.

¹⁵² Oral evidence, RoP [para 107], 10 January 2018

¹⁵³ Oral evidence, RoP [paras 226 and 228], 10 January 2018

¹⁵⁴ Oral evidence, RoP [para 236], 10 January 2018

¹⁵⁵ Oral evidence, RoP [para 235], 22 November 2017 and [para 73], 14 December 2017

¹⁵⁶ See written evidence, for example, from CWVYS (EMH 13), Welsh Women's Aid (EMH 14) and from three service users, submitted with the assistance of Barnardo's (EMH 40)

197. Until April 2018 the target was operating on a pilot basis and routine data was not published. According to the T4CYP Programme, approximately half of all health boards were meeting the 26-week pilot target,¹⁵⁷ however health boards provided the following data:

| Table 3: Number waiting over 26 weeks for ND assessment (Feb 18) | | |
|--|--|--------------------------|
| Health board | No. waiting more than 26 weeks | % seen within 26 weeks |
| Cwm Taf | 60 | 81% |
| Cardiff and Vale | 102 | 74% |
| Aneurin Bevan | 73 | 70% |
| Betsi Cadwaladr | 1000+ | All waiting 12-18 months |
| Hywel Dda | 248 from the historical waiting list; all new referrals are seen within 26 week target. | |
| Powys | Due to recruitment problems, the ND team was only operational from February 2018. The team is aiming to clear referrals on the historical waiting list (65 children) within 3 months and all new referrals (of which there were 28 as at 12 March 2018) within 4 months. | |
| Abertawe Bro Morgannwg | No response was received to our request for information. | |

Source – Oral evidence, RoP [paras 338, 339 and 347], 7 February 2018 and EMH FI 14-19 – additional written evidence requested by the Committee from health boards, received February 2018

198. Both the Royal College of Psychiatrists and health board representatives recognised that waits are “significantly longer” for those awaiting ND interventions.¹⁵⁸ They attributed the delays to inheriting long historical waiting lists (shifted across from specialist CAMHS when the new NS services were created), capacity constraints (including sickness absence and recruitment issues) and increased demand.¹⁵⁹

Eating disorders (ED)

199. During the course of our inquiry, in January 2018, the Cabinet Secretary for Health and Social Services wrote to the Cross-Party Group on Eating Disorders to inform its members that a review of the 2009 ED Framework for Wales would begin shortly. He noted that the reviews would be led by Dr Jacinta Tan and

¹⁵⁷ Oral evidence, RoP [para 241], 22 November 2017

¹⁵⁸ Oral evidence, RoP [para 154], 14 December 2017 and [paras 338 and 345], 7 February 2018

¹⁵⁹ Oral evidence, RoP [para 365], 7 February 2018

would consider, among other things, whether waiting times for ED services akin to those adopted in England should be considered for Wales.¹⁶⁰

The Welsh Government's view on waiting times

200. The Welsh Government's written evidence attributed much of the improvement in waiting times for specialist CAMHS to the creation of the new ND service. It also acknowledged that more work is needed to meet the specialist CAMHS target in a sustainable way – it reported the allocation of an additional £300,000 in 2017-18 to ensure performance meets expectations by March 2018.¹⁶¹

201. In oral evidence, the Cabinet Secretary for Health and Social Services and his officials clarified:

- for specialist CAMHS, their expectation that the 28-day target will be met more consistently at a national level and maintained from April 2018 onwards, but that variation in performance at a local health board level was expected due to the length of existing waiting lists;
- for ND services, their expectation that there will be an improvement from April 2018 as waiting lists will be reported formally according to strict criteria (they explained that, to date, there has been variation in the way health boards interpreted how to report their ND waiting lists);
- for both services, their acknowledgement of the need to establish performance measures that go beyond waiting times to a qualitative assessment of outcomes. They indicated that further announcements about core data sets will be made over the next 12 months, but that there must first be confidence that any new data sets will drive appropriate behaviour within the system; and
- their commitment to the decision to remove ND waiting times from the overall data for specialist CAMHS because it provides a better level of accuracy, not because it presents a better outcome.¹⁶²

¹⁶⁰ Letter from the Cabinet Secretary for Health and Social Services to the chair of the Cross-Party Group on Eating Disorders, Bethan Jenkins AM, 17 January 2018

¹⁶¹ Written evidence, EMH 68 – Welsh Government

¹⁶² Oral evidence, RoP [paras 179 and 181], 15 February 2018

OUR VIEW ON ACCESS TO SPECIALIST SERVICES

202. We recognise and welcome the progress made to address concerns about specialist services since our predecessor Committee's report in 2014. It is clear from the evidence we received that there have been improvements in the time children and young people are waiting between referral to specialist services and assessment, the benchmarking of services across Wales to enable identification of variation and sharing of best practice, and the development of more consistent criteria for acceptance into services. We also welcome the creation of the ND service, which we believe is a significant step forward. We would like to put on record our thanks to all those committed staff who have worked so hard in recent years to implement the changes identified four years ago as being needed urgently.

203. Nevertheless, a significant amount of work remains to be done if access to specialist CAMHS and ND services is to be as good as it should be. We believe that the changes made to date will only be truly effective when they deliver a positive and direct impact on children, young people and their families. We want specialist CAMHS and ND services to have a reputation for excellence.

204. We believe the key recommendation we make earlier in this report about the step change needed in schools, communities and primary/community care to build emotional resilience and early intervention services are crucial if specialist services are to be sustainable and effective in treating those children and young people in most emotional and mental distress. Without that fundamental step change, we believe that at best, specialist services will continue to be over-stretched and children and young people will wait too long for the support they need. At worst, if we fail to stem the increasing tide of emotional and mental health issues among children and young people, specialist services will be overwhelmed entirely.

205. Alongside our key recommendation about building emotional resilience and early intervention services, we believe there are a series of specific improvements that should be implemented to enhance specialist services.

Variation in practice

206. We believe that equity of access to specialist CAMHS and ND services across Wales is fundamental – a child or young person's postcode should not dictate the quality or duration of support he or she receives, nor the speed at which he or she can access it. We welcome the multi-agency work undertaken to deliver both the

CAMHS Framework for Improvement (to enable the sharing of best practice, the defining of the role of specialist CAMHS and those agencies able to access it), and the work to develop sufficient data collection tools (to be able to benchmark services across Wales).

207. However, we remain concerned that, while the planning is being done and the processes are being put in place, in practice, it is taking time to translate into concrete changes on the ground. Given the distress caused by emotional and mental health problems, the pace of change must be increased.

Recommendation 11. That the Welsh Government ensure:

- consistent pathways for all specialist CAMHS services, based on the national referral criteria once agreed, are implemented by all health boards (and related agencies where relevant) in Wales within six months of this report's publication;
- each pathway is accompanied by defined standards against which all health boards can be measured and benchmarked consistently; and
- information is made publicly available so that health boards and the Welsh Government can be held to account for performance in a transparent and well-informed way.

Referrals, thresholds and the “missing middle”

208. We welcome the steps taken to develop national referral criteria for specialist services, and the introduction of the Choice and Partnership Approach (CAPA) model, which enables more collaborative practice and shared decision-making between patients, their families and practitioners when accessing services.

209. Nevertheless, we have significant concerns about the evidence we received that new referral criteria remain heavily influenced by a medical model that:

- fails to give adequate attention to emotional, social and behavioural issues alongside diagnosable medical disorders; and
- leaves too many children and young people without the specialist support they need if a medical diagnosis cannot be made or a medically defined threshold met.

210. This so-called “missing middle” needs to be addressed as a matter of urgency. Being without a diagnosed disorder does not diminish the severity of distress experienced, and should not act as a barrier to children and young people

who need support. From the evidence received, we believe progress can be achieved in two main ways:

- first, by implementing the changes we have suggested in our earlier key recommendation on emotional resilience, early intervention, education and primary/community services, all of which are aimed at ensuring that only children with the most acute levels of distress (medical or otherwise) reach specialist services; and
- secondly, by re-thinking specialist CAMHS referral criteria so that they are based on levels of distress experienced by children and young people (the source of which can be behavioural, social and/or medical in nature), rather than the historical medically defined, diagnosis basis. Consideration should be given to replacing the traditional “pyramid” model of care with the “iceberg” model presented to us in evidence.

Recommendation 12. That the Welsh Government outline as a matter of urgency, and within three months of this report’s publication, how it intends to address the challenges faced by the group of children and young people who do not meet the threshold for specialist CAMHS but for whom alternative services are not available – the so-called “missing middle”. This should include:

- the detailed steps it will take over the next six months to ensure that their needs are met and that relevant agencies are held to account for delivery; and
- an account of the consideration given to focusing referral criteria on levels of distress experienced by children and young people (the source of which can be behavioural, social (including attachment-related disorders) and/or medical in nature), rather than on a medically defined, diagnosis basis alone. This should include consideration of replacing the current “pyramid” model of care with the “iceberg” model presented to us in evidence.

Waiting times for specialist services

211. We acknowledge and welcome the progress made in relation to waiting times for children and young people accessing specialist services. We recognise the significant impact the injection of additional funding for the reduction of specialist CAMHS waiting times and the creation of ND services has had since 2015.

212. We remain cautious, however, about underestimating the work that remains to be done. It is clear from the evidence we received that there are significant concerns about how sustainable compliance with the new specialist CAMHS target (28 days from referral to assessment) will be for health boards. We note the Cabinet Secretary for Health and Social Service’s optimism that we will see more consistent and sustained compliance with the target from April 2018 onwards, but we remain to be convinced – waiting time figures for the last 9 months show that, with the exception of March 2017, the target has not been met once on a national basis. Our concerns are heightened by the fact that, even with the significant amount of pressure lifted off specialist CAMHS’ waiting lists by the movement of ND assessment and treatment to the ND service, difficulties remain with meeting the target.

213. We are deeply concerned by the ND waiting times reported by Betsi Cadwaladr University Health Board. The disparity between north Wales and other areas is unacceptable. This is especially concerning given the fact that Betsi Cadwaladr University Health Board is already in special measures, an arrangement that was applied in part to ensure “tangible improvements” in mental health service provision.¹⁶³

214. Given the historical position of ND waiting lists and the challenge ND services face in certain areas to overcome the legacy they have inherited, we also question how achievable the ND target (26 weeks from referral to assessment) will be once formally introduced in April 2018.

215. More broadly, we recognise that the length of wait from referral to assessment was a sensible and relatively straightforward starting point for measuring service performance. However, we believe it is a relatively blunt tool, and one that fails to measure either the length of time a child or young person has to wait for treatment or the eventual quality of outcome(s). We were pleased to hear the Cabinet Secretary for Health and Social Services agree, and welcome the work that is underway to establish data sets that aim to provide a qualitative assessment of outcomes. We believe that this will go further towards delivering transparent data, which will enable greater accountability for service delivery and performance.

Recommendation 13. That the Welsh Government develop an immediate recovery plan for neurodevelopmental services in Betsi Cadwaladr University

¹⁶³ Welsh Government, [Health Minister sets out detail of Betsi Cadwaladr University Health Board special measures](#), 9 June 2015

Health Board to address the unacceptably long waiting times faced by over 1000 children and young people.

Recommendation 14. That the Welsh Government prioritise work to ensure qualitative measures of performance are developed to sit alongside existing referral to assessment waiting time data within six months of this report's publication. This information should be made publicly available so that those responsible can be held to account for service delivery and performance.

3. 2. Structure and delivery of specialist services

216. The structure and delivery of specialist services was highlighted as a key concern in our predecessor Committee's 2014 report. Issues raised included:

- arrangements for the provision of CAMHS on an emergency basis;
- the adequacy of in-patient provision and the frequency of out-of-area placements;
- the transition from child to adult services;
- access to psychological therapies; and
- levels of prescribing of medication for children and young people with mental health problems.

217. Evidence submitted to our inquiry suggested that:

- the additional investment in **crisis and out-of-hours** care has made a noticeable difference but more work remains to be done;
- **in-patient provision** in south Wales meets demand for those with general admission needs however recruitment challenges have left an unacceptable gap in north Wales. Most of those requiring highly specialist in-patient care still need to travel to England on out-of-area placements, regardless of where they live in Wales;
- despite the creation of guidance on the **transition from child to adult services**, significant challenges remain with its implementation;
- the investment in **psychological therapy** has led to the development of services in all health boards but provision varies and a follow-up review of the use of **medication** to treat children and young people with mental health problems is needed;
- given the move towards treating more children and young people with mental health issues in the community, an active offer of **advocacy** needs to be extended beyond in-patient settings; and
- emotional and mental health **support for vulnerable children**, including those who are looked after and adopted, needs to be improved significantly.



What children and young people told us about service structure and delivery

During our visits we asked children and young people what they thought about the way services are delivered. Here are some of the things they told us:

“We’re still young people.”

The young people at Tŷ Llidiard, **Bridgend** told us in-patient units needed to be focused on young people with a greater range of activities on offer. Overall, they felt that staff at the unit did their best to support them, but described a facility that was very focused on their level of risk and their medical needs, rather than wider social issues or their behaviour.

“Support is needed earlier, before you end up in hospital.”

In **Abergele**, the young people at the in-patient unit called for earlier intervention to avoid children being admitted to hospital. They also felt that they had seen too many different professionals before eventually speaking with a specialist. One young person referred to their difficulties as a cross-border patient, that accessing services in England and Wales had been difficult.

“We shouldn’t be relying on tablets.”

At Hillside Secure Children’s Home in **Neath**, young people felt that GPs turned too many people away or put them on tablets. They felt tablets should only be used as a last resort.

“We were expected to become adults overnight.”

Three young people wrote to us about their experiences as former service users. They described moving from children to adult services as “scary”. They did not know what to expect and felt CAMHS was not proactive in preparing them. They pointed out that when they turned 18, they were “expected to have become adults overnight”, while in reality they felt they were “jumping off a cliff edge”. They encouraged children and adult services to communicate more effectively in order to bridge the gap between them both.

“Having services in the community helps.”

Young people at the Changing Minds project in **Newport** told us that community mental health services had helped them, but that moving from children to adult services was not always timely or smooth.



Crisis and out-of-hours care

218. Several respondents and witnesses welcomed the investment made in creating crisis intervention teams (also referred to as emergency liaison, crisis outreach, and community intensive treatment teams in certain areas), and noted the improvements achieved through their cooperation with specialist CAMHS, accident and emergency (A&E) and paediatric services. The Royal College of Psychiatrists stated that their creation had improved access to urgent care, enabled better coordination of care on admission, increased the proactive management of discharge, and reduced lengths of stay for children and young people.¹⁶⁴

219. Nevertheless, a number of ongoing concerns about inadequate crisis care were raised, including:

- variable provision across Wales when crises occur, often exacerbated at weekends or in the evenings where out-of-hours services are insufficient;
- a lack of appropriate in-patient beds for children and young people experiencing a crisis, leading to inappropriate admissions to paediatric or adult wards;
- A&E becoming a “default” option, especially for cases of overdose and/or self-harm, because of historical/continued difficulties accessing support from specialist CAMHS and/or primary care;
- children and young people being discharged without suitable follow-up support, even after suicide attempts or self-harm;
- the level of police resource being used while mental health assessments are undertaken and needs are established; and
- inadequate arrangements with English providers when those in border areas are admitted to A&E outside Wales.

220. The Royal College of Paediatrics and Child Health stated that despite the creation of the new crisis teams, there was increased demand on A&E and an increase in self-harm admissions.¹⁶⁵ The NSPCC reported that the number of young people admitted to A&E departments for self-harm had increased by 41 per

¹⁶⁴ Oral evidence, RoP [para 78], 14 December 2017

¹⁶⁵ Oral evidence, RoP [para 362], 18 January 2018

cent in the past three years.¹⁶⁶ The increase in self-harm was corroborated by frontline crisis staff.¹⁶⁷

221. The Samaritans told us that this increase in admissions to A&E among children and young people had occurred:

“...because they don’t have a crisis care plan because they haven’t had the right support or interactions with secondary services in the first place. They have had anxiety or depression that’s gone untreated, and back to maybe impulsivity, they end up self-harming or trying to take their own life, and there’s no other place for them.”¹⁶⁸

222. Frontline crisis mental health practitioners stated that where assertive outreach teams exist and where there has been enhanced crisis response, more people have been cared for at home.¹⁶⁹ Nevertheless, they noted that for those who did need admission, “different progress” was being made across Wales in relation to the requirement to hold designated beds that could be staffed adequately for unders-18s.¹⁷⁰ They also argued that referral and assessments were more of a challenge than the availability of beds in crises, explaining that children and young people are often subjected to too many assessments at a highly stressful and difficult time for them.¹⁷¹ Barriers they identified to working more effectively included difficulties recruiting mental health specialists, and a lack of capacity within their own and specialist CAMHS teams to work together on crisis care and wider liaison with earlier intervention services.¹⁷²

223. Police representatives told us that in recent years an increasing amount of their resource had been used on managing mental health crises involving children and young people and that reducing the demand was a “challenging area”.¹⁷³ However, they reported that they expected some improvement in the amount of resource required in light of:

- recent investment in mental health training for officers;

¹⁶⁶ Written evidence, EMH 50 - NSPCC

¹⁶⁷ Oral evidence, RoP [para 260], 10 January 2018

¹⁶⁸ Oral evidence, RoP [para 119], 10 January 2018

¹⁶⁹ Oral evidence, RoP [paras 154], 10 January 2018

¹⁷⁰ Oral evidence, RoP [paras 147], 10 January 2018

¹⁷¹ Oral evidence, RoP [paras 140-142], 10 January 2018

¹⁷² Oral evidence, RoP [paras 166 and 224], 10 January 2018

¹⁷³ Oral evidence, RoP [para 368], 10 January 2018

- the application of the Mental Health Crisis Care Concordat (a national agreement setting out how services and agencies involved in the care and support of people in a mental health crisis will work together to provide the necessary support); and
- improved triage arrangements, for example mental health practitioners sitting in control rooms to advise officers on the best course of action when faced with a child or young person in crisis.¹⁷⁴

224. Challenges highlighted by the police included difficulties sharing information across public services, limitations in the availability of out-of-hours crisis services and reduced staffing after core hours in designated health based places of safety.¹⁷⁵ They also highlighted that police budgets currently funded training and triage arrangements, putting pressure on other areas of service. Wales lead for the National Police Chiefs' Council, Assistant Chief Constable Jonathan Drake of South Wales Police, noted that consistent provision of police triage across Wales' four forces – which he estimated would cost approximately £1 million – would be “a very small investment” when compared to a multi-billion pound budget for health and public service generally. He argued that this could have a potentially significant impact on the well-being of patients by mitigating some of the challenges presented by limited out-of-hours services and information sharing across agencies.¹⁷⁶

225. The Samaritans and Barnardo's raised concerns about the level of follow-up care after discharge following a crisis. The Samaritans said:

“If someone's attended A&E due to self-harm or a suicide attempt, the following seven days is the period where there's the highest risk of suicide. So, if they're not given follow-up support, within those seven days, suicide attempts or ideation is increased. It's crucial that support is given to them as soon as possible.”¹⁷⁷

226. The Samaritans referenced work by Mind Cymru which stated that only Aneurin Bevan University Health Board records how many people get follow-up support after discharge, explaining “that's a real concern because we have no idea how many children and young people have just been discharged and that's it,

¹⁷⁴ Oral evidence, RoP [para 321], 10 January 2018

¹⁷⁵ Oral evidence, RoP [paras 308, 344 and 398], 10 January 2018

¹⁷⁶ Oral evidence, RoP [paras 382-384], 10 January 2018

¹⁷⁷ Oral evidence, RoP [para 113], 10 January 2018

that's the end of it".¹⁷⁸ Crisis care teams who attended Committee (from Cwm Taf, Powys, Aneurin Bevan and Abertawe Bro Morgannwg Health Boards) all noted that they felt their follow-up care was sufficient.¹⁷⁹

227. Health board representatives acknowledged that 24/7 services do not exist in all health board areas and inappropriate placements still occur in crisis situations.¹⁸⁰ However, they told us:

- a range of arrangements were in place between crisis teams and adult mental health, primary mental health and paediatric teams to seek to provide 24 hour response;¹⁸¹
- it was important to avoid wasting resources in periods where demand was not high (for example in Aneurin Bevan University Health Board, where full weekend crisis cover was withdrawn following an analysis of demand which demonstrated that resources could be deployed more cost effectively elsewhere);¹⁸² and
- more work was needed "up stream" to avoid crises later on:

"To concentrate only on the crisis end doesn't solve the problem [...] early intervention is critical, and having sound, well-functioning, well-resourced community teams that can respond quickly to crisis is going to reduce demand on crisis beds."¹⁸³

228. The T4CYP Programme's additional written evidence stated:

- a review of all crisis teams in Wales and their impact is underway (report due March 2018) – this will review the impact of the various models in place to identify best practice approaches;
- a reduction of 45 per cent in the number of young people being placed on an adult mental health wards between 2015-17; and

¹⁷⁸ Oral evidence, RoP [para 115], 10 January 2018

¹⁷⁹ Oral evidence, RoP [paras 264-268], 10 January 2018

¹⁸⁰ Oral evidence, RoP [para 204], 7 February 2018

¹⁸¹ Oral evidence, RoP [para 394], 7 February 2018

¹⁸² Oral evidence, RoP [para 181], 10 January 2018

¹⁸³ Oral evidence, RoP [para 398], 7 February 2018

- the success of a range of initiatives introduced in Aneurin Bevan to improve emergency responses, halving overnight bed occupancy and delivering a net release of 350 paediatrics bed days per year.¹⁸⁴

229. The Welsh Government highlighted the impact of crisis teams in decreasing lengths of stay and bed occupancy but acknowledged the need to provide a more consistent service across Wales.¹⁸⁵ In response to concerns that children and young people were being placed inappropriately on adult wards, officials explained that the majority involved 16-17 year olds and were for short, temporary periods where admissions late at night made it inappropriate to seek a transfer to a specialist in-patient bed.¹⁸⁶ When asked the age of the youngest patient admitted to an adult ward, the Welsh Government responded:

“Between December 2016 and November 2017, not including over cautious reporting by BCU, the youngest to have been admitted temporarily to an adult ward was 15.”¹⁸⁷

230. The Welsh Government acknowledged that a “conversation was needed” about how to care for the 15-25 year old transition age group, what the best service would be for those young people in crisis, and “maybe the lack of options” that had existed to date.¹⁸⁸ In relation to the concerns raised about insufficient follow-up on discharge after a crisis, the Cabinet Secretary for Health and Social Services stated that a young person should have follow up support and that he would be interested to know more detail about examples where this was not the case.¹⁸⁹

Suicide

231. In 2016, Childline Cymru recorded a 20 per cent increase in calls relating to suicide.¹⁹⁰ The Samaritans reported there were 16 suicides among 15-19 year olds in Wales in the same year, which was the highest number in five years, and the second highest in 12 years. They told us:

“Young people are a high-risk group for mental illness and suicide, and in Wales, we are witnessing a significant rise in precursory factors such

¹⁸⁴ Written evidence, EMH FI 04 – T4CYP Programme

¹⁸⁵ Written evidence, EMH 68 – Welsh Government

¹⁸⁶ Oral evidence, RoP [para 203], 15 February 2018

¹⁸⁷ Written evidence. EMH FI 21 – Welsh Government

¹⁸⁸ Oral evidence, RoP [para 205], 15 February 2018

¹⁸⁹ Oral evidence, RoP [para 208], 15 February 2018

¹⁹⁰ Oral evidence, RoP [para 96], 10 January 2018

as self-harm, admissions for eating disorders and referrals to the specialist Child and Adolescent Mental Health Service (CAMHS) which can contribute to suicidal ideation or intent in adolescents.”¹⁹¹

232. Dr Mark Griffiths, Clinical Director of CAMHS at Aneurin Bevan University Health Board, observed that while there had not been a discernible increase in suicides among children and young people under 18 years old (remaining consistently at around 12 suicides a year), recent increases in reported suicides were among 18 and 19-year-olds.¹⁹² He went on to say that, where children and young people were known to services, it was very rare for suicide to be completed (only once every seven years, approximately):

“The tragedy is, [the vast majority of those who commit suicide] are not known to us. That seems to be because once we are involved, we know we're a huge protective factor.”¹⁹³

233. The Samaritans emphasised the importance of enabling people to talk about suicide:

“We hear that a lot, not just with schools, but that idea that talking about suicide increases the likelihood of suicide, when it's actually the opposite; it reduces the likelihood of suicide [...] Evidence shows that embedding lessons around suicide and self-harm actually reduces attempts and increases help-seeking behaviour. So, that's what we want to see: help-seeking behaviour on the increase, and I think the only way we can do that is by talking about suicide and self-harm more openly.”¹⁹⁴

234. They went on to call for:

- the Welsh Government to provide more guidance to schools on talking about suicide;¹⁹⁵
- basic mental health training, including how to talk about suicide, to be part of initial teacher training, so that all new teachers are equipped to talk about it;¹⁹⁶ and

¹⁹¹ Written evidence, EMH 33 – Samaritans

¹⁹² Oral evidence, RoP [para 259], 10 January 2018

¹⁹³ Oral evidence, RoP [para 260], 10 January 2018

¹⁹⁴ Oral evidence, RoP [para 56], 10 January 2018

¹⁹⁵ Oral evidence, RoP [para 61], 10 January 2018

- the Samaritans' guidelines for the media on suicide to be implemented, to encourage sensitive and appropriate reporting of suicide rather than sensationalist coverage which has the potential to contribute to a "contagion effect".¹⁹⁷

235. The Assembly's Health, Social Care and Sport Committee is currently undertaking a detailed inquiry into suicide prevention, focusing on people aged 15 and over in Wales.

OUR VIEW ON CRISIS AND OUT-OF-HOURS CARE

236. We recognise the significant progress made as a consequence of establishing crisis teams (known by various names) in each health board, and the initial indications that they are resulting in a reduction in both length of hospital stay and inappropriate placements on adult or paediatric wards. We are alarmed, however, at the evidence presented of a significant increase in self-harm admissions to A&E among children and young people in the last three years, and the increased rate of suicide among 18-19 year olds during 2016.

237. We believe that implementing the changes we have suggested in our earlier key recommendation on emotional resilience, early intervention, education and primary/community services is essential to reducing the number of mental health crises experienced by children and young people. In addition, we think that practical improvements could be made, not least in relation to:

- supporting the police to improve the triage arrangements they are implementing to introduce mental health practitioners to their management of crisis situations;
- resourcing crisis teams to be able to provide training for A&E staff (and other relevant frontline services) to ensure that they are fully aware of the appropriate pathways for children and young people presenting in crisis, particularly those who may be suicidal or self-harming;
- ensuring that comprehensive follow-up care is provided after discharge, in light of the heightened risk of further crises following first admission;

¹⁹⁶ Oral evidence, RoP [para 66], 10 January 2018

¹⁹⁷ Oral evidence, RoP [para 71], 10 January 2018

- ensuring that arrangements for the holding of designated beds for children and young people admitted in crises are in place and sustainable;
- ensuring that the “single point of access” approach to specialist services is in place and working in all health boards; and
- supporting health boards to manage safely, and as cost-effectively as possible, out-of-hours care, reflecting on the results of the review of crisis care best practice once available.

Recommendation 15. That the Welsh Government, within six months of this report’s publication, in relation to crisis and out-of-hours care:

- work with Welsh police forces to scope an all-Wales triage model which would see mental health practitioners situated in police control rooms to provide advice when children and young people (and other age groups, if appropriate) present in crisis;
- outline how resources could be directed towards enabling crisis teams in all health boards to provide training and cascade expertise to other frontline services, particularly colleagues in A&E, in border areas (to improve cross-border relations with those centres most often accessed by Welsh domiciled patients), and in schools (to normalise conversations about suicide and self-harm in particular);
- ensure that follow-up support is being provided by health boards after discharge, provide information on how health boards monitor this provision, and commit to making this information publicly available to ensure transparency and accountability;
- ensure that all health boards are adhering to the requirement to hold designated beds that could be staffed adequately for unders-18s in crises, indicating how this will be monitored and reported in future, and what steps will be taken if such beds are not available;
- implement with pace and in a uniform way across health boards the single point of access approach to specialist services, to ensure timely and appropriate access to support, urgent or otherwise; and
- reflecting on the results of the review of crisis care, outline what more needs to be done to deliver a safe and cost-effective 24/7 crisis care service in all areas of Wales, how that will be done, and by when.

Recommendation 16. That the Welsh Government, in relation to suicide specifically, work with expert organisations to:

- provide, within three months of this report’s publication, guidance to schools on talking about suicide and self-harm, to dispel the myth that any discussion will lead to “contagion”;
- work with expert organisations to prioritise the issuing of guidance to schools where there has been a suicide or suspected suicide; and
- ensure that basic mental health training, including how to talk about suicide, becomes part of initial teacher training and continuous professional development, so that all teachers are equipped to talk about it.

In-patient care and out-of-area placements

238. Wales has two in-patient units: one in the North Wales Adolescent Centre, Abergele with 12 beds commissioned by the Welsh Health Specialised Services Committee (WHSSC) on behalf of all health boards, and one in Tŷ Llidiard, Bridgend, with 15 similarly commissioned beds. During our inquiry, we visited both units.

239. We received mixed evidence about in-patient capacity in Wales. Hafal told us:

“We have evidence from young people and their carers that there is insufficient in-patient capacity across Wales, with young people reporting travelling long distances both within and outside Wales to access appropriate in-patient services and support.”¹⁹⁸

240. Several respondents reported that demand was being met for general in-patient services in south Wales, but problems continued to exist in meeting:

- general in-patient demand in north Wales; and
- demand across Wales for specialist forensic and learning disabilities in-patient services, and in-patient services for children under 11 years of age.

¹⁹⁸ Written evidence, EMH 36 – Hafal

South Wales

241. Evidence from the south Wales unit in Tŷ Llidiard confirmed that they did not have capacity issues and there was no waiting list for its beds. This was corroborated by WHSSC, who noted that in the last three years, only one young person who would otherwise have been admitted to Tŷ Llidiard had been placed out-of-area due to the unit being full.¹⁹⁹

242. WHSSC told us that, at the time of giving evidence, three children/young people from south Wales were in out-of-area placements due to the need for highly specialist support currently unavailable in Wales. They reported that a total of six out-of-area placements had been made for south Wales based patients since April 2017, and said:

“Going back three years, probably that was bordering on 25 per year. So there have been dramatic improvements, I would say, in south Wales.”²⁰⁰

243. While a [2017 Healthcare Inspectorate Wales](#) reported “dignified and compassionate care for patients”, it also highlighted “significant and numerous shortfalls” at the unit in Tŷ Llidiard.

North Wales

244. In contrast to the situation in south Wales, significant concerns were raised in relation to the capacity of the north Wales unit to meet demand. While the North Wales Adolescent Service (NWAS) unit was built initially to house 18 beds, in recent years, WHSSC has only commissioned 12 for use. When we visited the unit, some staff attributed this to the successful management of a higher number of young people in the community via the specialist community team, referred to as the “KITE” team. However, other staff noted that the “mothballing” of the unit’s second ward was due to difficulties recruiting and retaining the number of staff necessary to maintain safely the full complement of beds.²⁰¹

245. WHSSC and Betsi Cadwaladr University Health Board acknowledged that north Wales services have been running at under capacity in the last year due to significant workforce issues, including:

- recruiting and retaining nursing staff, many of whom had moved to the newly established community services (largely due to higher pay

¹⁹⁹ Oral evidence, RoP [para 476], 7 February 2018

²⁰⁰ Oral evidence, RoP [para 519], 7 February 2018

²⁰¹ Summary note of visits, published November 2017

bandings in the new community services relative to the in-patient unit); and

- recruiting a consultant psychiatrist to lead the service (due to a UK-wide shortage of consultant psychiatrists).²⁰²

246. WHSSC stated:

“The reason that they’ve gone [the NWAS unit] to a clinical-psychologist- and then a consultant-nurse-led service, support in terms of Mental Health Act functions by the other senior consultants in the community teams, is because they have to. There is not another alternative. You can’t find adequately trained and competent staff. Several services are in that position, nationally.”²⁰³

247. WHSSC also highlighted that because of the unit’s capacity issues, since April 2017, 10 children and young people who would otherwise have been admitted to NWAS had been placed in out-of-area settings. They said that they had placed only one of the 10 out-of-area in the last three months so “the situation has stabilised and is improving”. They indicated that, at the time of giving evidence (February 2018) the unit was able to take between eight and 10 patients (depending on acuity) but that they would hope to reach 12-bed capacity “by the summer”.²⁰⁴

248. With regard to overcoming workforce issues, WHSCC observed that Betsi Cadwaladr University Health Board was taking “mitigating actions” to over-recruit qualified nurses given issues around retention.²⁰⁵ They also said:

“The medical workforce [...] is a slightly different issue. We are confident that the interim model they’ve put in is safe and sustainable at the moment. Longer term, they [the health board] need to develop a sustainable plan about what they’re going to do about recruiting consultants into that service.”²⁰⁶

²⁰² Oral evidence, RoP [para 420 and 447], 7 February 2018

²⁰³ Oral evidence, RoP [paras 443-444], 7 February 2018

²⁰⁴ Oral evidence, RoP [paras 449, 455 and 457]], 7 February 2018

²⁰⁵ Oral evidence, RoP [para 450], 7 February 2018

²⁰⁶ Oral evidence, RoP [para 451], 7 February 2018

Specialist forensic, learning disabilities and under 11s beds

249. Several respondents raised concerns that there are no beds available for specialist forensic or learning disabilities support, or under 11s requiring in-patient services. They reported that children and young people requiring such support are placed out-of-area, in England, which can prove difficult in terms of maintaining contact with family and getting support, and can prove costly for the NHS.

250. Health board and WHSSC representatives acknowledged that such specialist services did not exist in Wales at the moment, largely because it was suggested that the low level of demand for them meant delivery within Wales was neither sustainable nor cost effective. The T4CYP Programme explained:

“Due to the small numbers of young people requiring very specialised services there will always be a need to place a small number of young people out of area, as it would be neither clinically appropriate or cost effective to provide these in Wales. These include young people who are deaf and those requiring forensic inpatient services.”²⁰⁷

251. Nevertheless, the T4CYP Programme emphasised that there had been a reduction of over 50 per cent in the number of young people placed out-of-area over the last three years, from 23 in 2015 to 11 in 2017. Health board and WHSSC representatives highlighted that a review of in-patient capacity in Wales was underway and that it would consider whether beds not currently commissioned for general in-patient care in the units in north and south Wales could be suitable for use in a more specialist context. They indicated that the review’s report was due in “late summer”.²⁰⁸

“Step-down” services

252. When we visited Hillside Secure Children’s Home staff emphasised the value of having a “step-down” facility, especially for young people placed on lengthy orders. We were told that a step-down facility of around four beds would provide the opportunity for semi-independent living in a secure setting.²⁰⁹ The Royal College of Psychiatrists stated that the availability of step-down care varied from one kind of admission to another and from health board area to area. They went

²⁰⁷ Written evidence, EMH FI 04 – T4CYP Programme

²⁰⁸ Oral evidence, RoP [para 462], 7 February 2018

²⁰⁹ Summary note of visits, published November 2017

on to emphasise the need for provision for step-down support to be mapped before facilities were set up.²¹⁰

The Welsh Government's view on in-patient capacity and out-of-area placements

253. The Welsh Government's written evidence states:

- its expectation that, wherever possible, a young person should be catered for in Wales rather than sent out-of-area;
- the number of young people placed outside Wales in 2017 was below the national target of 14, but that there would always be cases where, for a variety of reasons, a young person will need to be placed in England at a specialist unit which often provides for the whole of the UK; and
- improving models of care between in-patient and local CAMHS services had decreased lengths of stay.²¹¹

254. Responding to the criticism about insufficient capacity in north Wales, particularly the fact that six beds in the NWS unit had not been commissioned since its creation despite several north Wales patients being placed in England for treatment, the Cabinet Secretary for Health and Social Services and his officials told us:

- the north Wales unit was built before the Community Intensive Treatment Teams had been established. They argued that CITTs had led to a drop in demand for in-patient beds which meant a fully staffed range of additional wards that were hardly used would be an expensive waste of resources; and
- if staffing and recruitment challenges could be overcome, the 12 beds available would be sufficient to meet demand.²¹²

255. The Cabinet Secretary for Health and Social Services explained:

“We’re reviewing the capacity that we want to be able to have, both for the current levels of need that we service within Wales, and also in seeing if we can have a more specialist end of service that would deal with some of the current out-of-area placements [...] that’s the right

²¹⁰ Oral evidence, RoP [para 118], 14 December 2017

²¹¹ Written evidence, EMH 68 – Welsh Government

²¹² Oral evidence, RoP [para 242], 15 February 2018

thing and the right way to try and manage our resources in a prudent way.”²¹³

OUR VIEW ON IN-PATIENT CARE AND OUT-OF-AREA PLACEMENTS

256. The improvements in capacity for in-patient care in south Wales are to be welcomed, particularly the fact that only one patient has been placed out-of-area in the last three years due to Tŷ Llidiard being full.

257. In contrast, the situation in north Wales is unacceptable. It is alarming that 10 young people, all of whom must have been suffering severe mental health issues to have warranted in-patient care, have been placed out-of-area since April 2017. Given that a specialist building is in place, too many children and young people are finding themselves faced with the heightened distress of being placed further away from their homes because of a lack of adequately trained staff. Aside from the personal cost to the children, young people and families involved, the financial cost to the Welsh NHS of these otherwise unnecessary out-of-area placements is also significant.

258. We recognise that much of the challenge lies in the recruitment and retention of the specialist workforce required to run an in-patient unit. Lessons need to be learned from the loss of nurses from the in-patient unit to the community team. If, as suggested, this was at least in part attributable to the opportunities to access higher pay bandings in newly established community services, there has been a significant failure in workforce and service planning. The knock-on effects of creating a new service within the same area of specialism should have been at the forefront of the minds of those planning services. Staffing issues have been a long-term challenge for the north Wales unit, and we are deeply concerned to learn that many of the issues identified in our predecessor Committee’s report continue four years later, despite investment in services.

259. We recognise that the low level of demand for very specialist services such as forensic and learning disabilities beds, and beds for the under 11s, mean that the sustainability and cost-effectiveness of provision within Wales would be challenging. Furthermore, we welcome the review of in-patient capacity that is underway and the consideration it is giving to whether very specialist beds currently only available in England could be developed in Wales. As highlighted in our [2017 report on perinatal mental health in Wales](#), traffic need not flow in one direction only – if demand is insufficient in Wales to sustain a service, the Welsh

²¹³ Oral evidence, RoP [para 255], 15 February 2018

Government and NHS should explore the option of providing services for English patients in Wales and engage in dialogue with counterparts in England to scope viability. Thought should also be given to the viability of using any spare in-patient capacity on the NHS estate to develop step-down services.

Recommendation 17. That the Welsh Government:

- engage as a matter of urgency in addressing the reduced capacity in the north Wales in-patient unit; and
- provide in its response to this report an action plan detailing the practical support it is going to give to Betsi Cadwaladr University Health Board to return the unit to its commissioned capacity of 12 beds by summer 2018.

Recommendation 18. That the Welsh Government use the results of the review of in-patient capacity in Wales as a basis to:

- provide as many services as close to home as possible for Welsh domiciled children and young people;
- engage in dialogue with NHS England about options for the creation of very specialist in-patient beds that could serve populations both sides of the border; and
- explore the viability of using spare in-patient capacity on the NHS estate to provide step-down services for those leaving placements.

Transition from child to adult services

260. The T4CYP Programme stated that policies are in place to support successful transition between children and adult services, and that the Programme’s focus was not only on care transitions between children and adult services but between different components of children’s services. The T4CYP Programme acknowledged that more work was needed in this area to embed the “Good Transition” guidance and “young person’s transition passport” it had produced in conjunction with Barnardo’s.²¹⁴

261. While welcoming the guidance, Hafal noted:

“Whilst we recognise that both Welsh Government and NICE guidance regarding transitions recognises the importance of services being

²¹⁴ Oral evidence, RoP [para 314], 22 November 2017

delivered based on need rather than age, in practice, the majority of young people are still being transitioned at the arbitrary point of their 18th birthday.”²¹⁵

262. Written evidence from service users illustrated that poor service transition can lead to disengagement, despite continued need. Three service users told us the transition from CAMHS to adult mental health services is “scary”. They explained that when they turned 18, they were expected to have become adults overnight, while actually they felt “like they were jumping off a cliff edge”.²¹⁶ This echoed clearly the evidence that young people gave to our predecessor Committee in 2014. The Royal College of GPs noted that the process is not seamless and that many young people transitioning from children to adult services “disappear into a black hole”.²¹⁷ Youth work representatives warned:

“...there's a recurring theme that young people transitioning from being on the youth side, the youth services of mental health, into the adult services find it incredibly difficult, and sometimes can get lost within the system. They find it difficult to get because the support is decreased from what they were getting at the youth level, and they're often expected to do even the most basic things—making their own appointments, taking over all responsibility for themselves, and they find that even that is impossible; it's out of their realm.”²¹⁸

263. Evidence from frontline staff and the Children’s Commissioner recognised that the guidance produced is sensible and good, but that implementation – and moving away from adult and children “silos” – remains a challenge.²¹⁹ Dr Mark Griffiths, Clinical Director of CAMHS at Aneurin Bevan University Health Board said:

“Each time there’s a new document, it’s saying the same things—all sensible stuff—to make it really smooth for the young person going into adult services. It’s not that we need a brand new idea; we need to deliver on it.”²²⁰

²¹⁵ Written evidence, EMH 36 - Hafal

²¹⁶ Written evidence, EMH 40 – Three service users, submitted with the assistance of Barnardo’s

²¹⁷ Oral evidence, RoP [para 125], 7 February 2018

²¹⁸ Oral evidence, RoP [para 247], 18 January 2018

²¹⁹ Oral evidence, RoP [para 439], 22 November 2017 and [para 277], 10 January 2018

²²⁰ Oral evidence, RoP [para 279], 10 January 2018

264. Dr Griffiths also emphasised that the transition point is a particularly dangerous time, with an increase in suicide rates in younger adults of 18-19 years of age, suggesting there are often times when transition fails.²²¹

265. The Welsh Government's written evidence states:

- guidance has been published by the T4CYP Programme to address the view held by young people that transition has been poorly planned and managed in the past;
- the guidance seeks to shift the emphasis from an arbitrary age related transition point and instead focus on the young person's best interest; and
- it is still too early to assess the guidance's impact, which will be reviewed by December 2020.²²²

266. The Cabinet Secretary for Health and Social Services repeated in oral evidence that guidance was in place but recognised three key challenges existed:

- ensuring that the guidance is implemented;
- ensuring different staff groups work together; and
- recognising how children and young people see themselves and at what point they think the transition is appropriate for them to manage.²²³

OUR VIEW ON TRANSITIONS

267. Moving from childhood to adulthood is challenging enough without contending with a transition from one set of mental health services to another. We welcome the transition guidance and its aim of shifting the emphasis from an arbitrary age related transition point, instead focusing on the young person's best interest. Nevertheless, guidance is only as good as its implementation, and it is clear from the evidence we received that implementation remains poor in many areas of Wales. Given the particular vulnerabilities highlighted for this age group – with higher rates of suicide being the most worrying of all – this needs to be addressed as a matter of priority.

²²¹ Oral evidence, RoP [para 259], 10 January 2018

²²² Written evidence, EMH 68 – Welsh Government

²²³ Oral evidence, RoP [para 321], 15 February 2018

Recommendation 19. That the Welsh Government, in light of the importance of the transition period in retaining engagement with support services and the heightened vulnerabilities of young people as they enter adulthood, require health boards and local authorities to report to them on a six monthly basis:

- the steps they have taken to ensure implementation of the transition guidance;
- their assessment of their level of adherence to the guidance; and
- details of the challenges they encounter when seeking to deliver smooth transitions and how they are mitigating those risks.

Psychological therapies and the use of medication

268. In May 2015, the Welsh Government set out its expectation that some of the additional funding being provided for specialist CAMHS should be allocated to the provision of psychological therapies. However, a significant number of stakeholders highlighted that the lack of therapeutic provision locally remains an issue.

269. The Children’s Commissioner for Wales drew attention to the fact that the Welsh Government’s policy implementation guidance on psychological therapies makes no reference to children and young people²²⁴ and said that planning for psychological therapies was “very adult oriented”.²²⁵ She called on the T4CYP Programme to prioritise psychological therapies in the next phase of its work.²²⁶

270. The T4CYP Programme stated that there had been an increase in the availability of psychological therapies in Wales, and that all health boards had services. Nevertheless, they recognised not all were up to the “full menu” of therapies provision and more work is needed to make coverage fully comprehensive across Wales.²²⁷ The T4CYP Programme also reported that work was underway on “Matrics Cymru”²²⁸ to provide a definitive list of psychological therapies for children.²²⁹

²²⁴ Written evidence, EMH 29 – Children’s Commissioner for Wales

²²⁵ Oral evidence, RoP [para 393], 22 November 2017

²²⁶ Written evidence, EMH 29 – Children’s Commissioner for Wales

²²⁷ Oral evidence, RoP [para 260], 22 November 2017

²²⁸ Matrics Cymru is a structured guide to assist the planning and delivery of evidence-based psychological therapies within local authorities and health boards in Wales, including commissioned third sector and independent sector services. It provides guidance to support greater quality and consistency in the delivery of psychological therapy across Wales. To date

271. Powys, Hywel Dda and Besti Cadwaladr Health Boards said in oral evidence that they did not have significant waiting lists for psychological therapies.²³⁰ Aneurin Bevan, Cwm Taf, Cardiff and Vale and Abertawe Bro Morgannwg Health Boards confirmed there is no specific waiting list for psychological therapies as it is part of the specialist CAMHS waiting list, with referral into specific psychological therapies an intervention which would follow the initial assessment stage.²³¹

272. The National Youth Advocacy Service (NYAS) argued that the commissioning of psychological therapies for children and young people should be considered within a national framework approach to ensure consistency of provision across Wales.²³² Cwm Taf University Health Board made a similar point about a variation in provision existing in Wales and the need for more “joined up” commissioning.²³³

273. Several stakeholders noted the importance of ensuring that therapists had sufficient training, particularly in relation to children’s therapy, to practice. NYAS emphasised the importance of ensuring that professionals providing psychological therapies are registered with a regulatory body.²³⁴

274. The Children’s Commissioner highlighted concerns that limited availability of psychological therapies may prevent health boards complying with NICE guidance, which states that antidepressant medication should not be offered without “a concurrent psychological therapy”.²³⁵ The Royal College of GPs agreed, stating that medication should only be deployed as part of a wider package of support,²³⁶ but that problems providing sufficient talking therapy were particularly difficult for children and young because of the lack of people who are child-trained.²³⁷

275. The T4CYP Programme told us that the impact of psychological therapies on the levels of prescribing medication is yet to be determined. Its representatives said that there was potential for a further commissioned study to understand this in due course, building on the work undertaken by Professor Ann John in previous

Matrics Cymru has focused on adult services as service structure and settings for children and young people were deemed sufficiently different to require the development of specific guidance.

²²⁹ Oral evidence, RoP [para 261], 22 November 2017

²³⁰ Oral evidence, RoP [para 384], 7 February 2018

²³¹ Written evidence, EMH FI 14 – FI 19, health boards

²³² Written evidence, EMH 35 – National Youth Advocacy Service

²³³ Written evidence, EMH 34 – Cwm Taf University Health Board

²³⁴ Written evidence, EMH 35 – National Youth Advocacy Service

²³⁵ Written evidence, EMH 29 – Children’s Commissioner for Wales

²³⁶ Oral evidence, RoP [paras 107], 7 February 2018

²³⁷ Oral evidence, RoP [paras 85], 7 February 2018

years on prescribing trends for children and young people with emotional, behavioural and mental health needs. In written evidence, Professor John said:

“There is a strong case for monitoring diagnostic and prescribing trends for mental health issues in young people regularly to both assess and review current trends and practice informing future guidance. Identifying those most likely to receive a diagnosis or medication allows for targeted interventions and support to individuals, families, carers and professionals.”²³⁸

276. Several stakeholders raised concerns that, for children and young people who do not reach the specialist CAMHS threshold, or are seen but are not deemed to have a mental health diagnosis, it appears to be difficult to access any psychological therapies which they said are reserved largely for patients in specialist CAMHS. This so-called “missing middle” is discussed in more detail in section 3.1.

277. The Welsh Government’s evidence states:

- health boards have used £1.9 million of new CAMHS investment to recruit an additional 41 “whole time equivalent staff” to provide and support psychological interventions in both primary and secondary services;²³⁹
- data on prescribing medication for young people is not held within CAMHS services, but there will always be a need for it (in line with clinical best practice) along with a wider “whole treatment” based approach involving talking therapies;²⁴⁰ and
- work is ongoing to ensure that primary and secondary mental health care and specialist CAMHS work together seamlessly and effectively to deliver psychological therapies.²⁴¹

278. The Cabinet Secretary for Health and Social Services and his officials emphasised the need to provide medication for a child or young person where that is the right thing to do, but to guard against defaulting to medication where it is not.²⁴² They also highlighted the importance of recognising that evidence for

²³⁸ Written evidence, EMH 64 – Professor Ann John

²³⁹ Oral evidence, RoP [para 161], 15 February 2018

²⁴⁰ Written evidence, EMH 68 – Welsh Government

²⁴¹ Written evidence, EMH 68 – Welsh Government

²⁴² Oral evidence, RoP [para 161], 15 February 2018

some psychological therapies has come from adult models, which does not always fit as well for children. They noted that this is why CAMHS professionals have spent time recently considering the psychological models that need to be incorporated for children within the Matrics Cymru framework.²⁴³

OUR VIEW ON PSYCHOLOGICAL THERAPIES AND MEDICATION

279. Evidence submitted to this inquiry highlights the crucial importance of therapeutic support for many children and young people with emotional and mental health issues that range in severity. It is clear that while investment has been made to establish a psychological therapies service in each health board area, significant work remains to be done to ensure that a full complement of child-appropriate therapies is available for all those who need it. Without these, there remains a risk that:

- children and young people for whom therapeutic support would be the most suitable form of support will not receive it, leading to likely deterioration in their emotional and mental health; and
- children and young people will be inappropriately prescribed medication without the package of other support that should always accompany it.

280. We welcome the work undertaken to consider the models of psychological therapies most suitable for children and young people, and recognise that it is not possible to adopt a “one size fits all” approach to different – or even within – age groups. Nevertheless we are not convinced that we will have sufficient resource and workforce capacity to deliver the menu of suitable therapies that children and young people with a range of emotional and mental health issues need.

Recommendation 20. That the Welsh Government, in light of the current variation in provision and the crucial role therapeutic interventions have to play, set out a national action plan for the delivery of psychological therapies for children and young people. As a minimum this should include:

- an outline of how primary, secondary and specialist services will work together to ensure a range of therapeutic services across the spectrum of need are delivered effectively;

²⁴³ Oral evidence, RoP [para 164 and 166], 15 February 2018

- specific plans for developing and maintaining a stream of sufficiently trained (and regulated/registered) therapeutic practitioners;
- details of the proposed review of prescribing trends for children and young people with emotional, behavioural and mental health problems, building on previous work undertaken by Professor Ann John and including an assessment of whether other interventions have impacted on these trends, to begin in the next 12-18 months; and
- an assessment of the plan's financial implications and affordability, and how its outcomes will be measured.

Advocacy

281. Children and young people in Wales have a right to independent mental health advocacy (IMHA) if they are:

- treated under compulsory powers of the Mental Health Act 1983;
- detained in hospital under a certain “short term” sections of the 1983 Act; and
- receiving assessment or treatment for mental ill health in an in-patient setting on a voluntary or informal basis.

282. Health boards in Wales are responsible for commissioning IMHA services for their areas. Under the [Social Services and Well-being \(Wales\) Act \(2014\)](#) local authorities in Wales also have a statutory duty to provide other advocacy services to some groups of children, specifically looked after children, children in need and care leavers.

283. The Children's Commissioner raised concerns about inconsistency in general advocacy provision across Wales and called for better provision for children and young people across all health settings:

“...we have a new national approach to advocacy provision in children's social care services. I think it will be relatively straightforward for commissioning to go on that would extend that provision to health as well. [...] it's completely inconsistent around Wales, which is obviously unacceptable.”²⁴⁴

284. In its evidence the National Youth Advocacy Service told us:

²⁴⁴ Oral evidence, RoP [paras 363], 22 November 2017

- not all health boards are commissioning IMHA for all age groups which means not all children and young people are getting an active offer of IMHA service;
- having advocacy and specialist youth workers as part of a crisis team could help save police time, enable crises to be managed at home, work restoratively, and uphold rights and liberty;
- young people waiting too long for primary care services should have access to specialist mental health advocates so their experiences of care and treatment, their views, wishes and feelings are taken into account and are part of decision-making processes;
- children and young people receiving any tier of mental health support services should have access to a generic independent advocacy services;
- consideration should be given to merging the IMHA and generic advocacy roles to increase resource and quality of training;
- the integrity of the offer of advocacy needs to be improved by offering more than once, especially when the first offer may be made at a time of confusion and distress; and
- frontline healthcare staff need training on patients' rights to advocacy and what it can offer.²⁴⁵

285. In oral evidence the Chair of the T4CYP Programme agreed that children and young people sitting just below in-patients should be supported:

“...there is a need for us to reflect on advocacy for children not just in the general sense of things, but as they enter into mental health services, not necessarily in-patient, but whether that be an out-patient consultation liaison, and particularly those children who we are supporting in the community [...] My view is that every child should have access to advocacy.”²⁴⁶

286. When asked in February 2018 if they were currently commissioning advocacy provision for children and young people (including IMHA), all health boards bar Aneurin Bevan confirmed that they were commissioning advocacy services for those in in-patient settings. Aneurin Bevan stated: “We do not currently

²⁴⁵ Written evidence, EMH 35 – National Youth Advocacy Service, and oral evidence, RoP [paras 16, 49 and 56], 24 January 2018

²⁴⁶ Oral evidence, RoP [para 207], 22 November 2017

commission this service, however we have advanced plans to commission these services in the new financial year”.²⁴⁷

287. The Welsh Government told us:

- rather than an “active offer” there is a statutory duty to provide information about the right and availability of advocacy services to all qualifying children and young people and health boards are required to discharge this duty appropriately;
- all health boards report they are meeting the requirements of Part 4 of the Mental Health Measure, and that “every person has contact with an IMHA within 5 working days of their request”;
- the right to IMHA under the Measure also extends to people who are discharged from hospital subject to Community Treatment Orders and (in the case for a young person who is aged 16 or over and not a ward of the court) Guardianship Orders; and
- the Welsh Government’s funded national information, advice and advocacy helpline for children and young people aged up to 25, MEIC, provides support and listening services to children and young people and acts as a signpost for those needing information and advice. The service can be accessed by phone, SMS text message, web-based instant messenger or e-mail 24 hours a day, seven days a week.²⁴⁸

OUR VIEW ON ADVOCACY

288. Our [2017 report on statutory advocacy provision](#) sets out our views on the importance of ensuring an active offer of advocacy for some our most vulnerable children and young people. We believe that, in the case of all children and young people accessing mental health services – not just those in in-patient settings – advocacy should be available. Given the age and vulnerabilities of the children and young people involved, we believe that consideration of a more active offer is needed. Furthermore, we agree with the National Youth Advocacy Service that the integrity of any such offer relies on it being made more than once, especially when the first offer may be made at a time of confusion and distress.

²⁴⁷ Written evidence, EMH FI 14 – Aneurin Bevan University Health Board

²⁴⁸ Written evidence, EMH FI 21 – Welsh Government

Recommendation 21. That the Welsh Government, within six months of this report's publication, commission a review of the current provision of – and need for – advocacy services for children and young people accessing all mental health services, not just those in in-patient settings. This review should be undertaken in consultation with key stakeholders such as the Children's Commissioner, the National Youth Advocacy Service, commissioned providers of services, and children and young people. Based on the review the Welsh Government should assess the viability of providing an active offer of advocacy to all children and young people accessing mental health services and should publish a full account of its conclusions.

Support for vulnerable groups

289. Looked after and adopted children,²⁴⁹ young carers,²⁵⁰ youth offenders, those who are homeless, black and minority ethnic children and young people,²⁵¹ care leavers, and those with substance abuse problems²⁵² were all cited by stakeholders as potentially vulnerable and in need of specific support for emotional and mental health issues.

Looked after and adopted children

290. Looked after and adopted children have a much higher prevalence of mental health issues, often as a result of neglect or trauma. Many have lived in families where they have been exposed to mental illness, alcohol/drug misuse or domestic violence. A significant percentage will have experienced abuse and/or neglect. These early negative experiences or trauma can lead to significant emotional, behavioural, educational or developmental difficulties.

291. A Social Care Institute for Excellence report published in November 2017, [Improving Mental Health Support for Children in Care](#), found that “almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs”. According to The Fostering Network, for those in residential care homes the figure is nearer 70 per cent, and young people leaving care in the UK are five times more likely than their peers to attempt suicide.²⁵³ In written evidence, Social Care Wales said:

²⁴⁹ Written evidence, EMH 63 – All Wales Heads of Children's Services, WLGA and the National Adoption Service

²⁵⁰ Written evidence, EMH 2 – Carers Trust Wales

²⁵¹ Written evidence, EMH 13 – Council for Wales of Voluntary Youth Services (CWVYS)

²⁵² Written evidence, EMH 24 – Barnardo's Cymru

²⁵³ Written evidence, EMH 52 – The Fostering Network

“Children who are looked after are more likely to experience emotional and mental health issues, including those in the secure estate. In particular, there is a need for specialist support for trauma and attachment issues for children who are looked after by local authorities.”²⁵⁴

292. Looked after children are a priority group identified by the T4CYP Programme. However, evidence from the All Wales Heads of Children’s Services, the WLGA and the National Adoption Service stated:

- the investment made thus far to CAMHS services in Wales has had little impact on looked after children due to service issues and/or the complexity of their needs;
- in the face of increasing demand and complexity, services for the care and protection of vulnerable children are being pushed, in many areas, to “breaking point” both financially and practically;
- the “crisis” currently being experienced within the provisions for children who are looked after is exacerbated by “the disconnect across services areas”;
- referrals based on a medical model where diagnosis carries the weight of access to services is based on adult services – this fails to recognise that children, especially looked after children, do not have the same control over their life choices so need a different model of care;
- the provision of an appropriate range of support for looked after children’s psychological and emotional health, including during transition to adulthood, needs to be “urgently addressed on an all-Wales basis”;
- for the vast majority of looked after children, their emotional and mental health needs are not assessed formally on entry into care – routine assessments for looked after children should include emotional and mental, as well as physical, health;
- the correct balance has not been struck between local authorities and health boards in terms of funding mental and emotional support for looked after and adopted children, with local authorities resorting to funding their own specialist therapeutic support because children who

²⁵⁴ Written evidence, EMH 62 – Social Care Wales

are presenting with symptoms but do not have a diagnosis or do not meet the referral criteria and thresholds cannot access specialist CAMHS;

- Regional Partnership Boards have focused on adults and need to do more on delivering integration and cooperation between the NHS, local authorities and the third sector for children; and
- the current “fragmented” system and “stretched public services budget” are leaving many vulnerable children without access to early help services while children and families who are experiencing significant trauma are simultaneously “floundering without the services to meet their needs”.²⁵⁵

293. Other concerns highlighted about looked after and adopted children included:

- the Royal College of Speech and Language Therapists, who said there are significant gaps in CAMHS for looked after children, especially those in residential care;²⁵⁶
- the South East Wales Adoption Service (SEWAS), who stated that there is significant variation in the accessibility of mental health services for adopted children across Wales and that more early intervention is required;²⁵⁷
- the Fostering Network, who said the overall experience of foster carers and those children and young people in their care is one of piecemeal provision which fails to address their needs in a holistic way, and that more training is needed to recognise symptoms of attachment disorder;²⁵⁸
- the NSPCC, who argued that there is a need to further scrutinise how CAMHS are meeting the needs of vulnerable children and young people, especially with regard to therapeutic support;²⁵⁹ and

²⁵⁵ Written evidence, EMH 63 – All Wales Heads of Children’s Services, WLGA and the National Adoption Service and oral evidence, RoP [paras 23, 35, 40, 46 and 82], 18 January 2018

²⁵⁶ Written evidence, EMH 06 – Royal College of Speech and Language Therapists

²⁵⁷ Written evidence, EMH 09 – South East Wales Adoption Service

²⁵⁸ Written evidence, EMH 52 – The Fostering Network

²⁵⁹ Written evidence, EMH 50 – NSPCC

- the National Adoption Service, who told us that despite clear messages from parents to our predecessor Committee’s inquiry on adoption that there was insufficient support for the emotional health of their adopted children, there had been “no discernible improvement”, with parents still reporting “a battle” to access CAMHS unless a particular “label” had been applied to their child.²⁶⁰ They also noted that they had found it difficult to “break in” to the T4CYP Programme to begin the dialogue about what might need to change.²⁶¹

294. The Cabinet Secretary for Health and Social Services highlighted work underway by the Outcomes for Children Ministerial Advisory Group, established to consider ways in which looked after children can be supported to be more resilient and achieve better outcomes, chaired by David Melding AM. The Cabinet Secretary told us:

“We spend lots of money, and we need to think about: are we getting better outputs for those children for that significant amount of the public purse that we’re spending? I think we’d be honest and say we don’t think we were getting the sort of outcomes we want. That’s why we’ve got the specific programme and a board to look at those outcomes.”²⁶²

295. While the Cabinet Secretary recognised that looked after children have higher levels of need generally, he did not accept the assertion that investment in CAMHS services had made little difference to them and adopted children:

“The real improvements that have been made in CAMHS have been for all children, based on their need. So it isn’t that we’ve said that looked-after children must leapfrog anyone else [...] I appreciate there’ll be frustration, because you’ll be able to identify looked-after or adopted children who have real need, and they’re still waiting. That’s because we have children waiting, not because we’re deprioritising looked-after children.”²⁶³

296. Responding to concerns about an alleged lack of early intervention for adopted children, Albert Heaney, Director of Social Services and Integration at the Welsh Government, noted that the Cabinet Secretary had allocated £125,000 to

²⁶⁰ Oral evidence, RoP [para 50], 18 January 2018

²⁶¹ Oral evidence, RoP [para 9], 18 January 2018

²⁶² Oral evidence, RoP [para 283], 15 February 2018

²⁶³ Oral evidence, RoP [para 286], 15 February 2018

the Service to provide post-adoption therapeutic support to help children and young people write and understand their life journey and their life course.²⁶⁴

297. In relation to concerns about the National Adoption Service struggling to engage with the T4CYP Programme, the Cabinet Secretary for Health and Social Services stated that: he would not have thought that they were “a voice that would find it particularly difficult to be listened to”; they were involved in the Programme’s care transition work stream; and he would welcome any “specific suggestions for improvement”.²⁶⁵

298. Referring to the alleged imbalance between local authorities’ and health boards’ funding of mental and emotional support for looked after and adopted children, the Cabinet Secretary for Health and Social Services pointed to the need for Regional Partnership Boards to promote the pooling of budgets where services are developed jointly. He further highlighted the Welsh Ministers’ statutory powers to direct partners to establish pooled funds to make better use of resources and further improve well-being outcomes.²⁶⁶

299. Dr Dave Williams, the Chief Medical Officer’s Adviser on Child and Adolescent Psychiatry, told us that he and the Chair of the T4CYP Programme had sent a joint letter to the heads of the regional adoption services and the clinical directors. The purpose of the letter was to request they start meeting formally to discuss how adoption services could be supported by local CAMHS and what the appropriate model for that would be.²⁶⁷

Young offenders

300. The prevalence of common mental health disorders in adolescent young offenders is much higher than in the general adolescent population. As such, improved provision for those in the youth justice system was one of the areas in which the Welsh Government invested part of the additional funding for CAMHS allocated in 2015 on a recurring basis.

301. Cardiff and Vale University Health Board, the Youth Offending Team Managers Cymru, and South Wales Police commented that despite investment, mental health services for young offenders had not shown improvement yet.²⁶⁸

²⁶⁴ Oral evidence, RoP [para 289], 15 February 2018

²⁶⁵ Oral evidence, RoP [para 299], 15 February 2018

²⁶⁶ Written evidence, EMH FI 21 – Welsh Government

²⁶⁷ Oral evidence, RoP [para 300], 15 February 2018

²⁶⁸ Written Evidence, EMH 20 – Youth Offending Team Managers Cymru, EMH 28 – South Wales Police and EMH 55 – Cardiff and Vale University Health Board

CWVYS representatives told us there was geographical inequality in Wales in terms of access to mental health resources for young people who are in contact with the criminal justice system, and reported that they can wait considerably longer to access services, which can lead to a deterioration in their mental state and reoffending.

302. In respect of forensic CAMHS the Welsh Government said:

“For those at risk of entering the youth justice system we also made available £250,000 of our CAMHS investment to improve provision and support to Youth Offending Teams. The funding has enabled us to expand the existing all-Wales Forensic Adolescent Consultation and Treatment Service (FACTS) to recruit 4 wte staff. We are also working with the Youth Justice Board to develop an all-Wales referral pathway and supporting guidance for health boards and Youth Offending Teams to promote consistency and a shared understanding of what support should be available to young people in the criminal justice system.”²⁶⁹

OUR VIEW ON SUPPORT FOR VULNERABLE GROUPS

303. We are disappointed and concerned about the evidence we received on the alleged lack of emotional and mental health support available for vulnerable groups, particularly looked after and adopted children, and young offenders. We were particularly alarmed to receive joint evidence from children’s services, adoption services and local authorities describing services for looked after children being at “breaking point” and “in crisis”, with joint working arrangements between the NHS and local government on therapeutic services described as arguably falling “backwards”.²⁷⁰

304. The Welsh NHS is one of the public bodies responsible for being the corporate parent for looked after children. It is the NHS’s duty – along with partners in local government and other public bodies, including the Welsh Government – to ensure that looked after children get the emotional, behavioural and mental health support they need as one of the most vulnerable groups in our society.

²⁶⁹ Written Evidence, EMH 68 – Welsh Government

²⁷⁰ Oral evidence, RoP [para 74], 18 January 2018

305. It is clear from the evidence we received that our predecessor Committee's conclusion on the need for improved mental health services for adopted children has not come to fruition. That Committee recommended:

“...that the new Together for Children and Young People three year programme of change in CAMHS [must] deliver the changes needed for adopted children, and that consideration of their needs is a key consideration in the development of the new dedicated neuro-developmental services and the funding for psychological therapies.”²⁷¹

306. While we recognise that it is relatively early days for the additional investment to support those in the youth justice system, we were concerned that frontline stakeholders could not yet report improvements.

Recommendation 22. That the Welsh Government work across agencies to ensure that the emotional and mental health needs of children and young people are assessed on entry to care and on receipt of a referral order within the youth justice system, and routinely thereafter. This will help inform planning of adequate provision of multi-disciplinary support to meet their often-complex needs in a timely and appropriate way.

Recommendation 23. That the Welsh Government, within six months of this report's publication, undertake a piece of work on the provision of emotional, behavioural and mental health support for looked after and adopted children. This should:

- be informed by the activity of the Ministerial Advisory Group on looked after children and the T4CYP Programme's work; and
- consider, in the case of looked after children, the extent to which public bodies are adhering to their responsibilities as corporate parents to provide both the physical *and* emotional support they need.

²⁷¹ Fourth Assembly Children, Young People and Education Committee, [Report on the Follow-up Inquiry into Adoption Services in Wales](#), March 2016

3.3. Resourcing specialist services

307. Our predecessor Committee's 2014 report highlighted concerns about the level of resources available for mental health services for children and young people, specifically staffing and funding levels.

308. On staffing, our predecessor Committee highlighted concerns about:

- the impact of staff shortages on service provision, compounded by vacancies;
- skills mixes among staff; and
- the negative impact of high rates of staff turnover on continuity of care.

309. On funding, our predecessor Committee was worried about the overall level of funding for specialist CAMHS suggesting a further ring-fence for child mental health should be included in the mental health ring-fence. In particular, it was concerned about the allocation of resources to specialist CAMHS being proportionally less than adult mental health services.

Workforce

310. Several stakeholders raised concerns about workforce capacity in oral and written evidence to our inquiry.

311. "Substantial workforce challenges" in consultant psychiatry in particular were highlighted, with the vacancy in the north Wales in-patient unit in recent months contributing to its being unable to work to commissioned bed capacity (and subsequently 10 otherwise unnecessary out-of-area placements). Royal College of Psychiatrists' representatives explained that workforce issues meant recruitment and service sustainability were challenges, particularly (but not exclusively) in rural areas. They also highlighted that one vacant post or one extended period of absence would have an impact on services' responsiveness.²⁷²

312. Concerns about workforce capacity in both nursing and psychological therapies were also highlighted. The Royal College of Nursing (and others) explained that the school nursing workforce is overstretched and often unable to deliver the emotional and mental health support required. Comments received in our survey of pupils and education professionals supported the view that while school nurses were valued, they were overstretched. The Royal College of Nursing also told us that specific data on the number of school nurses trained and

²⁷² Oral evidence, RoP [para 80], 14 December 2017

available to provide emotional and mental health support across Wales was not available, but would be welcomed.²⁷³ The Royal College of Psychiatrists stated that there is variability in terms of the provision of psychological therapy due to workforce recruitment and the skill sets of available staff.²⁷⁴ The Royal College of GPs raised concerns about general practice's capacity given workload and increasing demand for services.²⁷⁵

313. The Royal College of Paediatric and Child Health pointed to concerns about the lack of data available about the community child health workforce. The College highlighted that it carries out a census of the paediatric medical workforce every two years, however by February 2018, only two of the seven health boards (Powys and Abertawe Bro Morgannwg) had provided complete data. The College went on to state:

“There is much discussion in Wales about designing services for the future, not least in response to the recent report from the Parliamentary Review. However, it is difficult to see how we can accurately design and support services without workforce information.”²⁷⁶

314. Data supplied from the T4CYP Programme on health boards' specialist CAMHS staffing numbers was as follows:

| Table 4: Specialist CAMHS staffing establishments | | |
|---|-----------------|-----------------|
| Health board | Total WTEs 2016 | Total WTEs 2017 |
| Aneurin Bevan | 67.7 | 103.7 |
| Abertawe Bro Morgannwg | 48.5 | 57.8 |
| Betsi Cadwaladr | 175.8 | 209.6 |
| Cardiff and Vale | 21.6 | 61.3 |
| Cwm Taf | 23.0 | 41.0 |
| Hywel Dda | 68.3 | 58.8 |
| Powys | 29.5 | 26.9 |
| Total | 434.5 | 559.0 |

Source: Written evidence, EMH FI 04 – The T4CYP Programme, p4

²⁷³ Oral evidence, RoP [para 415], 18 January 2018

²⁷⁴ Oral evidence, RoP [para 50], 14 December 2017

²⁷⁵ Oral evidence, RoP [para 13], 7 February 2018

²⁷⁶ Written evidence, EMH FI 2 – Royal College of Paediatrics and Child Health

315. In terms of vacancy rates, the T4CYP Programme confirmed that there is a 9 per cent all Wales vacancy rate reported in the health board CAMHS Benchmarking returns for 2017 (the same as the 9 per cent vacancy rate reported in 2016 for all NHS staff across England, Wales and Northern Ireland). It also said “there will always be a certain level of vacancies in staffing establishments, due to natural turnover and recruitment processes”.²⁷⁷

316. In evidence to us, Aneurin Bevan University Health Board reported vacancies of 6.85 per cent this year, which they noted was commensurate with staff vacancy rates in CAMHS for the last three years.²⁷⁸ Cwm Taf University Health Board reported a significant vacancy rate of 17 per cent in 2017-18 in the areas where it is operationally responsible for services (Cwm Taf, Abertawe Bro Morgannwg and Cardiff and Vale University Health Boards), compared to 5 per cent in 2015-16.²⁷⁹ Betsi Cadwaladr University Health Board described its vacancy rate as “significant” while Hywel Dda University Health Board told us it had “a number of vacancies”.²⁸⁰ Powys Teaching Health Board noted that its vacancies were more difficult to fill because of rurality.²⁸¹

317. There was a broad consensus across those who gave evidence that workforce issues made joint and more innovative ways of working essential. This was summarised by the Royal College of Paediatrics and Child Health representatives who stated that, to address gaps in the medical workforce:

“...it isn't necessarily that you have a doctor doing something, it's that you have an appropriately skilled person with the right training and expertise doing something. [...] you could have a pathway that has the same standards, that has the right quality outcomes for that child and that family, but it's delivered by a slightly different professional. That surely doesn't matter as long as you get the right outcome.”²⁸²

318. With regard to joint working, both the Royal College of Paediatrics and the National Youth Advocacy Service commented on the need for greater clarity on who is responsible for what, and overarching responsibility for coordination and cooperation:

²⁷⁷ Written evidence, EMH FI 04 – T4CYP Programme

²⁷⁸ Written evidence, EMH FI 14 – Aneurin Bevan University Health Board

²⁷⁹ Written evidence, EMH FI 17 – Cwm Taf University Health Board

²⁸⁰ Oral evidence, RoP [paras 314 and 315], 7 February 2018

²⁸¹ Oral evidence, RoP [para 318], 7 February 2018

²⁸² Quote from the Royal College of Paediatrics and Child Health, oral evidence, RoP [para 376], 18 January 2018; for National Youth Advocacy Service, see RoP [para 84], 24 January 2018

“...for children and young people's mental and emotional health problems, they [the Welsh Government] need to be fostering and facilitating a system that does encourage us to work together and look at the bigger picture together. And that's not easy, because we've all got different agendas; we've all got different requirements on us to provide the service we do provide. But some sort of overarching group to guide the way we manage these problems [...] that needs to have some teeth as well.”²⁸³

319. The Cabinet Secretary for Health and Social Services acknowledged concerns about workforce capacity but emphasised that “supply” is a UK and worldwide problem. He went on to argue that the “choice and partnership approach (CAPA)” model allows services to identify the capacity that is needed across the multi-disciplinary team and is reviewed regularly. He also confirmed that core psychiatry is a current priority for recruitment.²⁸⁴

Welsh language services

320. During our visit to the Changing Minds project in Newport, one of the young people told us he felt better able to express himself in Welsh and preferred to communicate with Welsh-speaking professionals. The Royal College of General Practitioners emphasised the importance of children and young people being able to seek emotional and mental health support in the language of their choice:

“...it makes sense that, if you're in a very vulnerable position, to be able to communicate in your own language, there's a great advantage to that, in allowing people to really understand what your problems are.”²⁸⁵

321. Youth work service representatives,²⁸⁶ and the Welsh Language Commissioner raised concerns about the availability of services in Welsh for children and young people. The Commissioner requested that further consideration be given to:

- the extent to which legislative requirements to assess linguistic needs and provision in the Welsh language in various aspects of the assessment and planning of health provision and care are being met;

²⁸³ Oral evidence, RoP [para 365], 18 January 2018

²⁸⁴ Oral evidence, RoP [paras 313, 315 and 318], 15 February 2018

²⁸⁵ Oral evidence, RoP [para 80], 7 February 2018

²⁸⁶ Oral evidence, RoP [para 285], 18 January 2018

- concerns about current capacity for providing specialist services through the medium of Welsh, and the extent to which health, education and social care services work together to respond to the demand;
- the extent to which additional funding for CAMHS has been invested to drive changes to allow fair access to services in a way that respects linguistic needs; and
- the progress made by the T4CYP's Framework for Action in reflecting linguistic as well as well-being legislative and policy requirements.²⁸⁷

322. The T4CYP Programme representatives acknowledged that Welsh language provision was very variable across Wales.²⁸⁸ They linked this to workforce challenges.²⁸⁹ They confirmed that there is no language stream in the T4CYP Programme's work, no specific work has been done on it to date, but that:

“There is probably some specific work that we need to pull out in terms of the profile on CAMHS at a national level—the health boards will know—just to see whether there is anything more that we can do to push that along.”²⁹⁰

323. The Cabinet Secretary for Health and Social Services emphasised the importance of recognising that Welsh language needs exist across the country, not just in traditional Welsh-speaking areas in the north or west. He also emphasised the importance of encouraging non-Welsh speaking staff to learn Welsh, as well as recruiting more Welsh-speaking staff.²⁹¹ He recognised the need to improve services for Welsh speakers, and said:

“...there's a real care need there, because it's a care need and not a preference [...] we recognise that there are needs that we need to deliver on, and that isn't easy and I wouldn't try and pretend that it is. We've got challenges about recruitment and getting people into those posts. We've got to be able to make sure that we equip that whole team to be able to deliver.”²⁹²

²⁸⁷ Written evidence – EMH 30, Welsh Language Commissioner.

²⁸⁸ Oral evidence, RoP [para 224], 22 November 2017

²⁸⁹ Oral evidence, RoP [para 228], 22 November 2017

²⁹⁰ Oral evidence, RoP [para 230], 22 November 2017

²⁹¹ Oral evidence, RoP [para 328], 15 February 2018

²⁹² Oral evidence, RoP [para 329], 15 February 2018

OUR VIEW ON WORKFORCE

324. We recognise that workforce recruitment and retention is a significant challenge to the effectiveness and capacity of specialist CAMHS services. We further recognise that recruitment to certain specialisms such as psychiatry are not unique to Wales. However, in order for our services to be sustainable in the future, the issues flagged four years ago by our predecessor Committee, and again by us now, must be addressed.

325. We agree with the Cabinet Secretary for Health and Social Services that there needs to be a focus on recruitment to psychiatry. We also agree with other stakeholders such as the Royal College of Paediatrics and Child Health (RCPCH) who argued that stronger leadership is needed to drive the innovation and joint working that is required if shortfalls in certain specialisms are to be overcome. Furthermore, we agree with the RCPCH that better data on workforce numbers is needed to design services that are fit for purpose.

326. We agree with the Welsh Language Commissioner that a focused and comprehensive piece of work on the availability of Welsh language emotional and mental health services needs to be established by the T4CYP Programme.

Recommendation 24. That the Welsh Government, within three months of this report, act on the evidence received from the Royal College of Paediatrics and Child Health that it needs to establish an overarching group “with teeth” to manage the joint working that is needed between statutory and third sector organisations in order to deliver effective and timely emotional and mental health support services.

Recommendation 25. That the Welsh Government ensure that all health boards respond promptly and comprehensively to surveys on workforce numbers conducted by the Royal Colleges in Wales. This will help enable the design of services that take into account staffing capacity and respond in an effective and innovative way to any shortages.

Recommendation 26. That the Welsh Government ensure the T4CYP Programme undertake a comprehensive piece of work on the current and future availability of Welsh language emotional and mental health support services.

Funding

327. In May 2015, the Welsh Government announced an additional £7.65 million investment (recurrent on an annual basis) towards improving mental health services for children and young people.²⁹³

328. Table 5 provides detail of the allocations by service area. Annex A to this report provides details by health board.

| Table 5 - Allocation of £7.65m additional CAMHS funding by service area | |
|---|--------------|
| Service area | Investment |
| Crisis intervention team development | £2.7 million |
| Neurodevelopmental service development | £2.0 million |
| Provision of expanded psychological therapies | £1.1 million |
| Improved children's local primary mental health support | £800,000 |
| Early intervention in psychosis team development | £800,000 |
| Third sector support workers | £318,000 |
| Improved provision for those in the youth justice system | £250,000 |

Source: Welsh Government response to the CYPE Committee's report on the draft budget 2018-19

329. From 2018-19, a further £1.1 million recurrent funding will be provided to CAMHS to "support further improvements". The Welsh Government has also invested £1.4 million in a pilot for CAMHS practitioners to operate in schools – the "in-reach" pilot – that will run until 2020.²⁹⁴

330. Latest figures for 2015-16 show expenditure on CAMHS of £45.8 million (up from £41.3 million in 2014-15), representing 6.7 per cent of total mental health expenditure of £683 million in 2015-16. The Welsh Government notes that services to children and young people are also delivered and captured financially in the "general mental illness" and "other mental health problems" expenditure lines within the Health, Well-being and Sport Main Expenditure Group which together accounted for £424 million in 2015-16.²⁹⁵

331. The Children's Commissioner for Wales expressed concern that support for emotional and mental health is underfunded in Wales:

²⁹³ Welsh Government, [£7.6m funding boost for children and young people's mental health services in Wales](#), 22 May 2015

²⁹⁴ Written evidence, EMH 68 – Welsh Government

²⁹⁵ Written evidence, EMH 68 – Welsh Government

“I do understand that children have less in-patient care than adults—obviously, in-patient care is an enormous expense—but it still seems to me, when we think that children are nearly 20 per cent of the population, that 7 per cent does feel to me to be on the low end. Whilst we've seen that additional and welcome funding of £7.5 million—and it is recurrent; I've had reassurance because I've asked if it is recurrent funding—it's certainly made some changes to the clinical end of NHS care. It's quite clear to me that that's not going to do the job that's needed for some of the preventative and primary mental health services. I would really welcome more of the spend to go on children's mental health than is currently going on it.”²⁹⁶

332. We asked health boards to provide details of their expenditure on children and adolescent mental health as a percentage of overall mental health spend. Figures provided ranged between 4.3 per cent in Hywel Dda University Health Board²⁹⁷ to 8.0 per cent in Cwm Taf University Health Board.²⁹⁸ Health board representatives indicated, however, that figures were counted differently across health boards and were not comparable. Health board representatives were asked to provide the national expenditure on children and adolescent mental health as a percentage of overall national mental health spend but this information had not been provided at the time of writing.

333. Responding to concerns about the comparative percentage spend on emotional and mental health services for children and young people, the Cabinet Secretary for Health and Social Services said:

“It's got to be about meeting need, not about setting a percentage in the budget. And if you just think about it, you're an adult, or you expect to be an adult, for a lot longer than you expect to be a child. You're thinking about when need arises. Whilst we're unfortunately seeing more challenges in children at an earlier age, you still expect the most acute end and the most specialist end of need in mental health to arrive later in childhood. So, actually, if you are spending 20 per cent of the budget on children's services, I'd be questioning whether that actually is the right proportion being spent on the adult end of the services. [...] So, it's got to be about the appropriateness rather than wanting to set a hard budget figure, because we all recognise that

²⁹⁶ Oral evidence, RoP [paras 374 and 375], 22 November 2017

²⁹⁷ Written evidence, EMH 10 – Hywel Dda University Health Board

²⁹⁸ Written evidence, EMH 34 – Cwm Taf University Health Board

need is relative; it doesn't neatly go in exactly the same pocket through an age range or through a geographic location."²⁹⁹

OUR VIEW ON FUNDING

334. We welcome the additional recurring funding allocated to CAMHS since 2015. Furthermore, we welcome the £20 million increase in the mental health ring-fenced allocation in the 2018-19 Welsh Government budget, bringing it to nearly £650 million for 2018-19 and 2019-20.

335. However, as highlighted in our 2017 report on the Welsh Government Draft Budget 2018-19, while we welcome the protection for mental health services in the Health, Well-being and Sport Main Expenditure Group, we are concerned that:

- there is no protection for CAMHS in and of itself; and
- it is unclear whether the mental health ring fence is resulting in the right level of service provision for children and young people.

336. We are further concerned by the range of ways in which health boards report their expenditure on mental health services for children and young people. It appears to lack uniformity, clarity or transparency, which makes it harder still to assess decisions on prioritisation, the affordability of services, and the extent to which value for money is being achieved.

Recommendation 27. That the Welsh Government require health boards to report expenditure on emotional and mental health services for children and young people in a uniform way to increase accountability and transparency. This data should include information on all services, not specialist secondary CAMHS services only, and should be broken down by area (e.g. primary, secondary, crisis, therapeutic, third sector etc.) This information should be made publicly available so that those responsible can be held to account in relation to the affordability, relative prioritisation and value for money of the services provided.

²⁹⁹ Oral evidence, RoP [paras 303 and 305], 15 February 2018

Annex A - Indicative allocations of the additional CAMHS funding by health board

| CAMHS service, based on population number of under 18s from the 2011 census | | | | | | |
|---|---------------------|---------|-------------------------|-------------|------------------------------|----------|
| | Neuro-developmental | LPMHSS | Psychological therapies | Crisis/s136 | Early intervention psychosis | Total |
| Abertawe Bro Morgannwg | £0.330m | £0.132m | £0.182m | £0.446m | £0.132m | £1.222m |
| Aneurin Bevan | £0.393m | £0.157m | £0.216m | £0.530m | £0.157m | £1.452m |
| Betsi Cadwaladr | £0.445m | £0.178m | £0.245m | £0.600m | £0.178m | £1.647m |
| Cardiff and Vale | £0.318m | £0.127m | £0.175m | £0.429m | £0.127m | £1.177m |
| Cwm Taf | £0.198m | £0.079m | £0.109m | £0.268m | £0.080m | £0.984m* |
| Hywel Dda | £0.236m | £0.094m | £0.130m | £0.319m | £0.094m | £0.873m |
| Powys | £0.080m | £0.032m | £0.044m | £0.108m | £0.032m | £0.296m |

* Cwm Taf was also allocated Health Board £0.250m for nursing posts within the CAMHS Young Offending Teams.

Source - Welsh Government response to the CYPE Committee's report on the WG Draft Budget 2018-19, January 2018

Transitional Support Workers (for the under 18s population) are funded a total of £318,550 from 2017-18 onwards, broken down as follows:

- Abertawe Bro-Morgannwg University Health Board - £52,755
- Aneurin Bevan University Health Board - £62,284
- Betsi Cadwaladr University Health Board - £70,790
- Cardiff and Vale University Health Board - £50,949
- Cwm Taf University Health Board - £31,556
- Hywel Dda University Health Board - £37,519
- Powys Teaching HealthBoard - £12,646

Annex B – Oral witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. **Transcripts of all oral evidence sessions** can be viewed on the Committee’s website.

| Date | Name and Organisation |
|------------------|--|
| 22 November 2017 | <p>Carol Shillabeer, Powys Teaching Health Board and Manager of the Together for Children and Young People Programme</p> <p>Professor Dame Sue Bailey, External Advisor to review of CAMHS in Wales</p> <p>Professor Sally Holland, Children’s Commissioner for Wales</p> <p>Nia Evans, the Office of the Children’s Commissioner for Wales</p> |
| 30 November 2017 | <p>Tim Pratt, Association of School and College Leaders</p> <p>Jane Sloggett, Porthcawl Comprehensive and representative of the Association of School and College Leaders</p> <p>Rob Williams, National Association of Head Teachers</p> <p>Steve Rees, Evenlode Primary School in the Vale of Glamorgan and representative of the National Association of Head Teachers</p> <p>Chris Britten, Ysgol Y Deri Special School, Vale of Glamorgan and representative of the National Association of Head Teachers</p> <p>Nichola Jones, Pembrokeshire County Council and representative of the Association of Directors of Education in Wales</p> <p>Kathryn Morgan, Bridgend County Borough Council and representative of the Association of Directors of Education in Wales</p> <p>Pippa Raggett, Ysgol Dewi Sant, Haverfordwest and representative of the Association of Directors of Education in Wales</p> <p>Will McLean, Monmouthshire County Council and representative of the Association of Directors of Education in Wales</p> <p>Tabitha Sawyer, Ysgol Pen y Bryn, Colwyn Bay</p> <p>Amber Stock, Ysgol Pen y Bryn, Colwyn Bay</p> |

Arun Ramesh, Ysgol Pen y Bryn, Colwyn Bay

Sarah Silverton, Freelance mindfulness teacher and trainer, working through the Centre for Mindfulness Research and Practice, Bangor University

14 December 2017

Professor Alka S Ahuja, Royal College of Psychiatrists in Wales

Dr Amani Hassan, Royal College of Psychiatrists in Wales

Dr Warren Lloyd, Royal College of Psychiatrists in Wales

Dr Peter Gore Rees, Royal College of Psychiatrists in Wales

Dr Bethan Phillips, British Psychological Society

Dr Rose Stewart, British Psychological Society

Dr Abigail Wright, British Psychological Society

Dr Liz Gregory, Applied Psychologists in Health National Specialist Advisory Group

Lowri Wyn Jones, Time to Change Wales

Ian Johnson, Time to Change Wales

Sara Payne, Barnardo's

Sandra White, Action for Children

10 January 2018

Emma Harris, Samaritans Cymru

Carol Fradd, Samaritans Cymru

Sharon Stirrup, Powys Teaching Health Board

Darren Rennie, Powys Teaching Health Board

Caren Weaver, Cwm Taf University Health Board

Dr Mark Griffiths, Aneurin Bevan University Health Board

Melanie Jones, Abertawe Bro Morgannwg University Health Board

Assistant Chief Constable Jonathan Drake, South Wales Police

Detective Chief Constable Alistair Mitchell, South Wales Police

Superintendent Nicholas McLain, Gwent Police

| | |
|-----------------|---|
| 18 January 2018 | <p>Sally Jenkins, Newport City Council and representative of the all Wales Heads of Children's Services</p> <p>Annabel Lloyd, Merthyr Tydfil County Borough Council and representative of the Welsh Local Government Association</p> <p>Suzanne Griffiths, National Adoption Service</p> <p>Geraint Hopkins, Rhondda Cynon Taf County Borough Council and representative of the Welsh Local Government Association</p> <p>Sianne Morgan, Volunteering Matters</p> <p>Alison Mawby, KPC Youth in Pyle</p> <p>Jo Sims, Wales Principal Youth Officers' Group</p> <p>Steve Davis, Wales Principal Youth Officers' Group</p> <p>Emily Arkell, Royal College of Paediatrics and Child Health</p> <p>Dr Simon Fountain-Polley, Royal College of Paediatrics and Child Health</p> <p>Dr Catherine Norton, Royal College of Paediatrics and Child Health</p> <p>Dr Shabeena Webster, Royal College of Paediatrics and Child Health</p> <p>Lisa Turnbull, Royal College of Nursing</p> <p>Angela Lodwick, Royal College of Nursing</p> |
| 24 January 2018 | <p>Gareth Jacobs, National Youth Advocacy Services Cymru</p> <p>Derith Rhisiart, National Youth Advocacy Services Cymru</p> |
| 7 February 2018 | <p>Dr Jane Fenton-May, Royal College of General Practitioners</p> <p>Dr Rob Morgan, Royal College of General Practitioners</p> <p>John Palmer, Cwm Taf University Health Board</p> <p>Melanie Wilkey, Cardiff and Vale University Health Board</p> <p>Rose Whittle, Cardiff and Vale University Health Board</p> <p>Angela Hopkins, Abertawe Bro Morgannwg University Health Board</p> <p>Nick Wood, Aneurin Bevan University Health Board</p> |

Dr Warren Lloyd, Hywel Dda University Health Board

Liz Carroll, Hywel Dda University Health Board

Dr Peter Gore-Rees, Betsi Cadwaladr University Health Board

Dr Alberto Salmoiraghi, Betsi Cadwaladr University Health Board

Rhiannon Jones, Powys Teaching Health Board

Carole Bell, Welsh Health Specialised Services Committee

Carl Shortland, Welsh Health Specialised Services Committee

Robert Colgate, Welsh Health Specialised Services Committee

15 February 2018

Kirsty Williams AM, Cabinet Secretary for Education

Vaughan Gething AM, Cabinet Secretary for Health and Social Services

Dr Dave Williams, Chief Medical Officer's Adviser on Child & Adolescent Psychiatry, Welsh Government

Albert Heaney, Director, Social Services and Integration, Welsh Government

Joanna Jordan, Director, Mental Health, Governance and Corporate Services, Welsh Government

Lowri Read, Senior Well-being Implementation Officer, Welsh Government

Annex C – Written evidence

The following people and organisations provided written evidence to the Committee. All **consultation responses and additional written information** can be viewed on the Committee’s website.

| Organisation | Reference |
|--|-----------|
| Individual | EMH 01 |
| Carers Trust Wales | EMH 02 |
| Play Wales | EMH 03 |
| Individual | EMH 04 |
| Child and Family Psychology and Psychological Therapies Service, Aneurin Bevan University Health Board | EMH 05 |
| Royal College of Speech and Language Therapists | EMH 06 |
| Mindful Schools Wales | EMH 07 |
| The British Dental Association | EMH 08 |
| South East Wales Adoption Service | EMH 09 |
| Hywel Dda University Health Board | EMH 10 |
| Powys Teaching Health Board | EMH 11 |
| Volunteering Matters | EMH 12 |
| Council for Wales of Voluntary Youth Services | EMH 13 |
| Welsh Women’s Aid | EMH 14 |
| Relate Cymru | EMH 15 |
| Wales Principal Youth Officers’ Group | EMH 16 |
| Diverse Cymru | EMH 17 |
| British Psychological Society | EMH 18 |
| Royal College of Nursing Wales | EMH 19 |
| Youth Offending Service Managers Cymru | EMH 20 |
| Association of School and College Leaders | EMH 21 |
| Estyn | EMH 22 |
| Royal College of Paediatrics and Child Health | EMH 23 |
| Barnardo’s | EMH 24 |
| YMCA Cymru | EMH 25 |
| Individual | EMH 26 |
| National Association of Head Teachers Cymru | EMH 27 |

| | |
|--|--------|
| South Wales Police | EMH 28 |
| Children's Commissioner for Wales | EMH 29 |
| Welsh Language Commissioner | EMH 30 |
| Family Intervention team – Partnership project between Aneurin Bevan University Health Board and Action for Children | EMH 31 |
| Aneurin Bevan Community Health Council | EMH 32 |
| Samaritans | EMH 33 |
| Cwm Taf University Health Board | EMH 34 |
| National Youth Advocacy Service | EMH 35 |
| Hafal | EMH 36 |
| Royal College of Psychiatrists | EMH 37 |
| Welsh Health Specialised Services Committee | EMH 38 |
| National Deaf Children's Society | EMH 39 |
| Three young people - Former CAMHS users; current AMHS users | EMH 40 |
| Public Health Wales | EMH 41 |
| National Adoption Service | EMH 42 |
| Newport Mind | EMH 43 |
| Welsh NHS Confederation | EMH 44 |
| Welsh NHS Confederation Policy Forum's Children's Mental Health Sub-Group | EMH 45 |
| Children in Wales | EMH 46 |
| Together for Children and Young People (T4CYP) programme | EMH 47 |
| Save the Children | EMH 48 |
| Action for Children | EMH 49 |
| National Society for the Prevention of Cruelty to Children | EMH 50 |
| British Association for Counselling and Psychotherapy | EMH 51 |
| The Fostering Network | EMH 52 |
| Time to Change Wales | EMH 53 |
| The Children's Society Cymru and the Church in Wales | EMH 54 |
| Cardiff and Vale University Health Board | EMH 55 |
| Betsi Cadwaladr University Health Board | EMH 56 |
| Youth Justice Board for England and Wales | EMH 57 |
| Professor Judy Hutchings and Suzy Clarkson, Centre of Evidence Based Early Intervention - Bangor University | EMH 58 |
| Association of Educational Psychologists | EMH 59 |

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| Board of Community Health Councils in Wales | EMH 60 |
| Healthcare Inspectorate Wales | EMH 61 |
| Social Care Wales | EMH 62 |
| All Wales Heads of Children’s Services, Welsh Local Government Association and the National Adoption Service | EMH 63 |
| Professor Ann John | EMH 64 |
| Care Inspectorate Wales | EMH 65 |
| Dyfodol Powys Futures | EMH 66 |
| Royal College of General Practitioners | EMH 67 |
| Welsh Government | EMH 68 |

Additional Information Received

| Organisation | Reference |
|--|-------------|
| Royal College of Psychiatrists | EMH FI 01 |
| Dr Liz Gregory, Applied Psychologists in Health National Specialist Advisory Group | EMH FI 02 A |
| Dr Liz Gregory, Applied Psychologists in Health National Specialist Advisory Group | EMH FI 02 B |
| Children's Commissioner for Wales | EMH FI 03 |
| Together for Children and Young People (T4CYP) Programme | EMH FI 04 |
| Action for Children | EMH FI 05 |
| Pembrokeshire County Council | EMH FI 06 |
| Samaritans | EMH FI 07 |
| Action for Children | EMH FI 08 |
| Aneurin Bevan University Health Board | EMH FI 09 |
| CAMHS Emergency Liaison Audit | EMH FI 10 |
| CAMHS Crisis Liaison Service – Swansea, Neath Port Talbot and Bridgend | EMH FI 11 |
| North Wales Police | EMH FI 12 |
| Cwm Taf Crisis Liaison Team | EMH FI 13 |
| Aneurin Bevan University Health Board | EMH FI 14 |
| Cardiff and Vale University Health Board | EMH FI 15 |
| Hywel Dda University Health Board | EMH FI 16 |
| Cwm Taf University Health Board | EMH FI 17 |

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| Betsi Cadwaladr University Health Board | EMH FI18 |
| Powys Teaching Health Board | EMH FI 19 |
| Royal College of Paediatrics and Child Health Wales (RCPCH) | EMH FI 20 |
| Cabinet Secretary for Education and Cabinet Secretary for Health and Social Services | EMH FI 21 |
| Cwm Taf Crisis Liaison Team | EMH FI 22 |
| Powys CAMHS Crisis Team | EMH FI 23 |

