‘Feeling heard’: partner agencies working together to make a difference for children with mental ill health

Findings from joint targeted area inspections (JTAIs), with a deep dive investigation into the experiences of children in need, including children in care and those on child protection plans, who live with mental ill health

This report summarises findings from our JTAIs of how multi-agency partnerships identify and respond to children with mental ill health. These inspections took place between September 2019 and February 2020. We reviewed the practices of individual agencies, as well as the effectiveness of multi-agency working arrangements, including children’s social care, health services, youth offending services, schools and the police. The findings in this report consider the extent to which agencies work collaboratively with partners to identify children experiencing mental ill health, as well as how they intervened early to support these children and get them the help that they need when problems arise.

The report shows that when partners work together effectively to understand children’s needs and identify and support children living with mental ill health, this improves children’s access to support with their mental health.

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Contents

Introduction

This report describes our findings from six JTAIs carried out between September 2019 and February 2020. Joint inspections are carried out by Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services (HMICFRS) and Her Majesty's Inspectorate of Probation (HMI Probation).

Together, we looked into how local partnerships and services were responding to children and their families when children were living with mental ill health.[1] We reviewed the practices of individual agencies, as well as the effectiveness of multi-agency working arrangements, including children's social care, health services, youth offending services, schools and the police. We focused on:

- how agencies work collaboratively with partners to identify children experiencing mental ill health
- how agencies intervene early to support these children and get them the help that they need when problems arise
- the leadership and management of this work.

We included an inspection of 'front door' services and how these responded to children with mental ill health. We also carried out a deep-dive investigation that evaluated the experiences of children aged 10 to 15 who were subject to child in need and child protection plans, and children in care who have mental ill health.

We commissioned the children and young people's mental health charity Young Minds to consult with young people with experience of mental ill health in order to gain their perspective on many of the issues that we addressed in the inspections. Young Minds carried out:

- a survey of 149 young people aged 10 to 18
- a workshop with eight young people aged 14 to 16.

This provided a valuable perspective from a wider group of children, and we have included the findings in this report. We are very grateful to all the young people who took part.

We also:

- carried out a literature review of current research

[1] Partners included children's social care, education, the police and health. Services included children's social care, schools, the police, youth offending services, emergency departments, school nurses, GPs, CAMHS, children looked-after health specialist teams, young persons' substance misuse services, and community and voluntary sector providers.

- analysed national and local data
- held focus groups with the multi-agency inspection teams that led the six inspections
- consulted stakeholders from a range of organisations that work in the field of children's mental health to help us develop the methodology.

The six local authorities we inspected were: Bexley, East Sussex, Milton Keynes, Plymouth, Portsmouth and Sefton. The JTAIs took place before the COVID-19 (coronavirus) pandemic affected England. This report shares the most significant learning from these areas, in order to help improve practice, knowledge and understanding. The report is not a summary of all of the inspection findings; we published letters containing that information following each inspection.[2]

Please note that children's names and personal information have been changed for all case studies included in the report to protect their identities.

Executive summary

We have seen that when partners work together effectively, prioritise children's mental health and build a skilled and knowledgeable workforce, this improves children's access to support with their mental health.

In many areas visited, local partners are changing their models of care and maximising opportunities for agencies to work together to improve the identification of children with mental ill health. This includes building capacity in the system through joint work between mental health specialists and professionals working with children. Having a single point of access that professionals can contact for advice and refer children for support was seen to make a positive difference.

Good knowledge of the local community, together with consultation with children and wide partnership engagement, is leading to a better understanding of children's need for support with mental ill health.

In those areas where there is wide engagement across the partnership, including the voluntary and community sector, and a comprehensive assessment of local needs involving children, we found that partners were better able to develop a shared approach to commissioning services. Some areas have more work to do to achieve this and all areas need to do more to consult with diverse groups of children and better understand their needs. This includes children from diverse ethnic backgrounds.

[2] You can find our inspection letters by searching for each one on our reports website: https://reports.ofsted.gov.uk.

Some children have to wait too long for their mental health needs to be identified and to access a specialist service.

Although the picture is improving, the availability of specialist child and adolescent mental health services (CAMHS) remains limited in some areas even when needs have been identified. Children with autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) often have to wait far too long to receive specialist help.

Professionals do not identify some children's needs early enough. This includes some children on child in need and child protection plans, as well as some children in care. We found that for some of these highly vulnerable children, there is a legacy of drift and delay in agencies identifying and responding to their mental health needs.

Individual professionals across a range of agencies can, and do, make a real difference to children with mental health needs.

When a child first speaks about their mental ill health, it is important for them to know that they have been heard. Children told us that the initial response from a professional makes a real difference and that they need to feel they can trust the professional who is there to help. It is essential that professionals build trusting relationships with children if they are to help them, and flexibility in approaches and taking the time to understand all the needs of the child are crucial.

We found that children experience a more joined-up approach to meeting their needs from agencies that have had appropriate training and a shared model of practice to help professionals understand children's mental health needs and the impact of trauma.

Some health professionals focus too much on presenting issues, problems and behaviours and do not ask the right questions in order to identify children's mental ill health.

When children attended hospital emergency departments with clear signs of mental ill health, we saw some effective multi-agency work that led to quick identification and ensured that children received the right help.

But when children attended for other reasons, we found that they did not always receive a holistic assessment of their emotional well-being or mental health. This is a missed opportunity to identify needs early.[3]

[3] 'All [children and young people] presenting to a children's [emergency department] have a developmentally appropriate assessment of their immediate emotional and mental health needs.' Standard 39 in 'Facing the future: standards for children in emergency care settings', Royal College of Paediatrics and Child Health, June 2018; www.rcpch.ac.uk/resources/facing-future-standards-children-young-people-emergency-care-setting.

GPs generally provided good support to children with obvious mental health needs. However, when children's risks of mental ill health were less evident, GPs did not always ask the right questions in order to explore any underlying mental health needs.

In only half of the areas visited did we feel confident that school nursing services had systems and capacity to identify children with mental ill health.

In our previous JTAI inspections, we found wide variation in the level of service that children receive from school nurses. We have also found gaps in school nursing provision in this JTAI. In half of the areas visited, school nurses' health assessments of children did not consistently or sufficiently address the emotional well-being and mental health needs of children. This is a lost opportunity to identify needs early.

Children value the role that schools play in supporting their mental health. In order to do this, schools need support from partner agencies and we found that children are benefiting from this joined-up approach.

We have seen many examples of schools working well with other agencies to support children's mental health needs. Some schools have a good understanding of children's mental health and take a flexible approach that enables them to work with the child to build a supportive environment. This is so that the child can remain in education and get the help they need from specialists when they need it.

However, when a child is not in full-time education, or not attending regularly, this can limit their access to help and support.

Children attending youth offending teams (YOTs) receive skilled and detailed assessments so that their needs, including the need for support with mental ill health, are understood.

We have seen many examples of children receiving help and support from professionals in the YOT, who strive to understand children holistically. Most of these professionals recognise that it is important to get the 'full picture' about a child who finds themselves in the youth offending system, including their history, their circumstances, any problems that they might be facing and the reasons why they might be behaving the way that they are.

Poor communication is a mental health risk factor: children with speech, language and communication needs are at increased risk of developing mental health problems.[4] Speech and language assessments take place in many YOTs, and this supports better multi-agency engagement with children by ensuring that their

[4] 'Improving mental health outcomes for school age children: evidence of links with speech, language and communication', Royal College of Speech and Language Therapists, January 2019; www.rcslt.org/-/media/Project/improving-mental-health-outcomes.pdf.

specific communication needs are recognised and understood. It is a concern that, for many children, these needs have not been identified earlier by schools, or early years or health providers. It is also a concern that not all YOT teams across England provide this service.

Police forces need to share good practice to drive improvements across areas so that all children get the response and care that they need.

Some police forces have developed training and support for their frontline officers so that they are better equipped to recognise and help children with mental ill health.

This progress has enabled professionals to identify risks to these children early. Effective joint working has meant that information is shared across agencies and that children are supported to get the help that they needed.

However, this response is not consistent across all areas. Some responses from police did not take account of the vulnerability of children with mental ill health. We saw too many examples of children who were kept in custody overnight and who were not helped to get the support that they needed.

Context

We recognise that there is much debate and controversy about definitions and formal diagnoses of mental ill health. For the purpose of these inspections, we included children for whom professionals have identified concerns about mental ill health, as well as those children who have a mental health diagnosis. Throughout this report, we also refer to emotional health and well-being. Emotional health and well-being needs are not the same as mental ill health, although these do exist on a continuum. Developing and maintaining good emotional health is crucial to help children increase their resilience and gain the skills needed to overcome life's challenges. When we use the wider term 'emotional well-being and mental health' in this report, it reflects services' approaches to responding to a spectrum of children's needs. This includes strategic and service responses to early identification and response to need to prevent deterioration and decline into mental ill health.

In 2018, NHS Digital published statistics about the mental health of children and young people.[5] It found that one in nine children aged five to 16 have a diagnosable mental health condition but only one in four children with mental ill health accessed specialist mental health services in the previous year. Children were much more likely to have accessed other support. For example, they were more likely to seek online support, help from family or friends and/or professional support from teachers or primary care professionals. In 2020, NHS Digital published its most recent report,

[5] 'Mental health of children and young people in England, 2017', NHS Digital, November 2018; https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017.

which covers the COVID-19 period. The report shows that one in six children aged five to 16 were identified as having probable mental ill health.[6]

Around half of all people who have a mental health problem at some point in their life will experience their first symptoms before they are 14 years old.[7] Seventy-five per cent will experience these by the age of 18.[8] Mental ill health can have a devastating impact on a child's life, including on their physical health, their relationships, their ability to lead a fulfilling life and engage in education, and their future.

There are some groups of children who are at increased risk of developing mental ill health.[9] These include: children with ADHD, attention deficit disorder and autism spectrum conditions/disorders; children who experience some form of adversity, such as living in a situation of crisis, or having parents with poor mental health or who misuse substances; children in care; children in the youth justice system;[10] and children and young people who identify as LGBT+. Nearly three quarters of children with mental ill health also have a physical or developmental condition.

There are pressing ethical and economic arguments for investing in children's mental health. Since 2015, successive governments have pledged to improve mental health support for children and young people through a range of policies and increased funding.[11]

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[6] 'Mental health of children and young people in England, 2020: wave 1 follow up to the 2017 survey', NHS Digital, October 2020; https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up.
[7] 'The mental health of children and young people in England', Public Health England, December 2016; www.gov.uk/government/publications/improving-the-mental-health-of-children-and-young-people.
[8] 'Chief Medical Officer annual report 2012: children and young people's health', Department of Health and Social Care, October 2013; www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays.
[9] 'CAMHS – facts and figures', Local Government Association; www.local.gov.uk/about/campaigns/bright-futures/bright-futures-camhs/child-and-adolescent-mental-health-and.
[10] Children in care are four times more likely to experience mental health problems than their peers; a third of children in the youth justice system are estimated to have a mental health problem.
[11] The government, Department of Health and Social Care, NHS England and partners across the NHS, education and local government have aimed to drive improvement through: 'Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing', Department of Health and Social Care, March 2015; www.gov.uk/government/publications/improving-mental-health-services-for-young-people; 'The five year forward view for mental health', NHS England, February 2016; www.england.nhs.uk/publication/the-five-year-forward-view-for-mental-health; 'Transforming children and young people's mental health provision: a green paper', Department of Health and Social Care and Department for Education, December 2017; www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper.

In the last few years, a number of reports have highlighted the continuing concern that many children still cannot access the help that they need. The National Audit Office reported in 2018 that, despite the government's intentions, there was likely to remain 'significant unmet need for mental health services' for children in need of help.[12] The Children's Commissioner's report published in the same year highlighted the variation in children's access to CAMHS across the country and called for more support for children in schools.[13]

Most recently, the NHS long-term plan (2019)[14] set out proposals to further increase the availability of mental health services and reduce waiting times in specific services. The plan aims to improve mental health support in schools and colleges and strengthen partnerships between schools and specialist NHS mental health services. This builds on the government's response to a 'green paper' on mental health provision for children and young people, which included the aim for all schools to have a designated mental health lead.[15] In addition, since 2015/16, NHS England has met its commitment to increase local funding for mental health; recent data shows progress against the NHS's set target.[16]

The government commissioned the CQC to carry out two reviews of children's mental health. The first review, in 2017, found that although there were some very positive examples of professionals working well together to support children, the system for providing services to children was often fragmented and complex. The second review, in 2018, found that many children experiencing mental health problems did not get the care that they needed. It also found that professionals on the frontline of services needed to be better trained and supported so that they could help children with their mental ill health.[17,18]

The CQC therefore recommended that this JTAI programme focuses on multi-agency work with children with mental ill health.

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[12] 'Improving children and young people's mental health services', National Audit Office, October 2018; www.nao.org.uk/report/improving-children-and-young-peoples-mental-health-services/.
[13] 'Children's mental health briefing', Children's Commissioner, November 2018; www.childrenscommissioner.gov.uk/report/childrens-mental-health-briefing.
[14] 'The NHS long term plan', NHS England, January 2019; www.longtermplan.nhs.uk/publication/nhs-long-term-plan/.
[15] 'Transforming children and young people's mental health provision: a green paper', Department of Health and Social Care and Department for Education, December 2017; www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper.
[16] 'NHS mental health dashboard', NHS England; www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/.
[17] 'Are we listening? A review of children and young people's mental health services', Care Quality Commission, March 2018; www.cqc.org.uk/publications/themed-work/are-we-listening-review-children-young-peoples-mental-health-services.
[18] 'Review of children and young people's mental health services: phase one report', Care Quality Commission, October 2017; www.cqc.org.uk/publications/major-report/review-children-young-peoples-mental-health-services-phase-one-report.

Limitations of the report

Mental ill health is an extremely wide topic. These inspections could not cover all aspects of it. Because we focused specifically on particular groups of children, we recognise that our findings are not necessarily representative of all children in need of mental health support.

For example, we did not include children transitioning to adult services, or those who needed specialist psychiatric care in hospital. This was so that we could ensure that the focus was on a particular group of children, and that we had a big enough sample size to identify some key findings.

Findings are based on inspections in six local authority areas and this sample was not nationally representative. Therefore, any generalisation should be made with care.

The JTAIs took place before the COVID-19 pandemic affected children. Although much is still unknown about the longer-term effects of the COVID-19 pandemic, evidence suggests that the pandemic, alongside the lockdown measures and ongoing restrictions, are having a negative impact on the mental health of some children and young people.[19] Evidence also shows that the pandemic is affecting children and young people's access to services to help with their mental ill health.[20] The issues that children and young people face include disruption to existing services, notably face-to-face appointments either being cancelled or replaced by remote consultations. For example, our recent visits to children's homes found that, in some areas, CAMHS had a policy of no face-to-face contact, which meant that psychologists and therapists were unable to visit children in children's homes.[21] Although our findings pre-date the pandemic, they contain valuable lessons to support the sector at this challenging time, particularly in terms of what agencies do well when working together to identify and support children with mental ill health.

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[19] 'The mental health emergency: how has the coronavirus pandemic impacted our mental health?', Mind, June 2020; www.mind.org.uk/media-a/5929/the-mental-health-emergency_a4_final.pdf; 'Coronavirus: impact on young people with mental health needs', Young Minds, March 2020; https://youngminds.org.uk/about-us/reports/coronavirus-impact-on-young-people-with-mental-health-needs/.

[20] 'Coronavirus: impact on young people with mental health needs', Young Minds, March 2020; https://youngminds.org.uk/about-us/reports/coronavirus-impact-on-young-people-with-mental-health-needs/; 'The mental health emergency: how has the coronavirus pandemic impacted our mental health?', Mind, June 2020; www.mind.org.uk/media-a/5929/the-mental-health-emergency_a4_final.pdf; 'Lack of mental health help: "I felt nobody cares"', BBC News article, 14 October 2020; www.bbc.co.uk/news/newsbeat-54529217.

[21] 'COVID-19 series: briefing on children's social care providers, September 2020', Ofsted, October 2020; www.gov.uk/government/publications/covid-19-series-briefing-on-childrens-social-care-providers-september-2020. The full set of our COVID-19 briefings is available here: www.gov.uk/government/collections/ofsted-covid-19-series.

Part 1: Early identification of children with mental ill health and barriers to identification

Early recognition of children's mental health needs

It is crucial for children that their mental health needs are recognised early. Providing support to children at the time that is right for them can prevent problems worsening and early intervention can reduce the risk of longer-term impact from mental ill health. We know from the Young Minds consultation that children and young people want professionals to understand and recognise their needs, and that an appropriate early response means that they are much more likely to ask for help in the future if they need it. As one child put it:

> 'Earlier intervention is needed to stop issues getting worse. [A lack of early intervention] ultimately leads to people using services for longer in the long run anyway because their issues get worse and worse.'

In this section, we will consider how well different agencies are identifying children who have mental ill health. Not all frontline professionals can be mental health experts, so we considered how partners are working together to achieve this.

We found that professionals across many agencies have opportunities to identify children with mental ill health and to ensure that they get the support that they need. In most of the areas we visited, many children were benefiting from agencies working well together to achieve this. However, there is still too much variation across local areas. Areas need to do more to drive improvements and consistency in practice so that professionals can identify children's needs early and enable them to access help promptly.

The role of schools

We saw plenty of evidence that schools play an important role in identifying children's mental health and well-being needs early, but in order for them to be able to do this well, they need support from partners.

In Portsmouth, multi-agency partners have developed the 'team around the school' and the 'team around the professional' model to build awareness, understanding and skills among professionals who work with children, including staff in schools. In this model, individual workers and schools receive advice and guidance from specialist services including educational psychologists, CAMHS, outreach services and safeguarding professionals. This means that children's mental health issues are quickly identified. Support is then provided either by the professional involved with the child, or a referral made to an appropriate service.

We saw that, when schools have dedicated support from someone who champions and takes a lead in developing awareness and understanding of children's mental health needs, this makes a real difference. In East Sussex, schools are supported

well by the local authority and health providers. A well-established local authority school adviser for mental health supports schools with a range of initiatives, including extensive training, newsletters, comprehensive guidance and a widely used mental health audit tool. This approach helps school staff to build skills and confidence in recognising and responding to emerging mental health issues. The schools' 'mental health network' has 194 schools and 85 link governors, and a mental health working group brings together schools, key health partners and the local authority to review and develop further this area of work in schools.

Identifying mental health needs in schools is dependent on the child attending school, or attending regularly enough for their needs to be recognised. The Portsmouth partnership has developed an assessment tool for schools to use to promote children's attendance at school. This includes a strong focus on the emotional health and well-being of children, including training staff, consulting with pupils, having a named lead for emotional well-being and making sure that staff and children are clear about who to contact if they have concerns about a pupil's emotional well-being. These standards align with what children in the Young Minds consultation told us is important to them.

School nurses can also play an important role in identifying children's mental health needs. In our previous JTAI inspections, we found wide variation in the level of service that children receive from school nurses.[22] We have also found gaps in school nursing provision in this JTAI. Often, the service is limited due to a lack of capacity. In only half of the areas visited did we feel confident that school nursing services had systems and capacity to identify children with mental ill health. In Sefton, however, the service includes a specialist emotional health and well-being nurse, who supports early identification of children's needs. School nurses use a questionnaire to allow children to rate their own emotional well-being, thereby helping them to feel fully involved in the assessment. It was also a real strength that both Sefton and Portsmouth were providing an outreach school nursing service to home-educated children to identify and respond to their mental health needs.

Assessment of children's needs in the YOTs

In most local areas, we found that children in receipt of a service from a YOT had their mental health needs identified. We found some very positive examples of detailed and comprehensive assessments that were informing plans to help children. This was helping professionals to have a thorough understanding of children's individual needs, including the interrelationship between needs such as speech and language difficulties, the child's behaviour and their mental health.

In the best examples, therefore, assessments were based on an informed understanding of the links between childhood experiences, such as abuse, neglect and/or exploitation, and mental ill health and offending behaviour. Any additional

[22] You can find a list of the themes we have looked at in our JTAIs at: www.gov.uk/government/collections/joint-inspections-of-local-area-services.

factors that contributed to the child's behaviour were also considered, such as speech and language difficulties. Poor communication is also a mental health risk factor: children with speech, language and communication needs are at increased risk of developing mental health problems.[23] A limited ability to communicate and understand will impact on all aspects of a child's life, including their ability to engage with the outside world, their education and their mental health. However, for many children, the first time they received an assessment of their speech and language was when they attended a YOT service. It is concerning that these children have to wait until they become known to the criminal justice system before their speech and language is assessed.

Comprehensive assessments in the YOT helped all professionals working with the child to better understand the child's life experiences and their impact on the child's mental health and emotional well-being. Very often, the assessments identified particular issues with speech and language.

Portsmouth

Jude was a 14-year-old girl who had experienced multiple adverse experiences in her life. She was now in care, living with mental ill health. She recently had a speech and language assessment from a YOT. The findings from this were informing all the professionals working with her as to how best to communicate with her. Importantly, this helped them to gain her views. There were specific subtleties in relation to her speech and language needs that had not previously been understood. Professionals said that had her communications needs been better understood at an earlier stage, then interventions to support and help her may have been more successful.

We saw that skilled staff in YOTs provided some very effective support for children, which had a real and positive impact on them. These staff had a holistic and comprehensive understanding of children's needs. This included knowledge and understanding of the child's life experiences, how abuse and neglect can impact on children and lead to trauma and mental ill health, and the importance of understanding children's communication needs.

However, this approach was not universal. In one area, we found that YOT assessments did not always address children's mental ill health or make the connection between children's experiences of abuse and neglect, their mental health and well-being and their offending behaviour.

[23] 'Improving mental health outcomes for school age children: evidence of links with speech, language and communication', Royal College of Speech and Language Therapists, January 2019; www.rcslt.org/-/media/Project/improving-mental-health-outcomes.pdf.

In addition, carrying out a speech and language assessment is not mandated in any statutory guidance. Therefore, not all YOTs, including some visited for these inspections, offer children a speech and language assessment.

Identification of children's needs in times of crisis: police and emergency departments

At a point of crisis in a child's life, it is important that professionals have the right support to identify when a child may be suffering mental ill health. Professionals then need prompt access to a specialist who can assess the child's needs and ensure that children get the help that they need. This worked well for children where there was effective joint working between agencies.

We found wide variation in how police respond to children with mental ill health. Good examples included joint work between the police and health services, and police and liaison and diversion services, to ensure that children who came to the attention of the police had their mental health needs identified, and support was provided. This shows that a good response can be achieved with partnership commitment, and children have the chance to be diverted away from the criminal justice system as a result of this positive work. However, in some cases, children's mental health needs were not recognised or understood, their information was not shared with other agencies and they were left without the support they needed.

Joint work between the police and health services in some areas meant that, when it was suspected that a child may have mental ill health, they received a prompt assessment of their needs when the police attended an incident.

> In Sefton, the police force has invested in a mental health triage system. A specialist mental health nurse attends incidents with the police that involve adults and children who may have mental ill health. This enables a prompt assessment of a child's mental health to be carried out. The specialist nurse can offer immediate advice and police officers are increasingly feeling confident about responding to children and young people with mental ill health. This has also reduced the occasions in which police have used section 136 of the Mental Health Act.[24]

However, arrangements like these are not available in all areas. For example, in one area, a 'triage car' with a mental health nurse and police officer is available to respond to children over the age of 16 and adults with mental health issues, but this service was not available for younger children.

For children, being placed in police custody can be an extremely stressful and anxious situation. This is particularly the case for those children who suffer from

[24] Mental Health Act 1983, section 136; www.legislation.gov.uk/ukpga/1983/20/section/136.

mental ill health.[25] In most areas that we inspected, we found that children who are detained in custody are supported through timely identification of their mental health needs by the liaison and diversion service.[26] In areas where this service worked effectively, we found that children's needs are assessed, and assessments are then promptly shared with relevant agencies, so that children get the right support.

> In Bexley, police complete background checks on all children coming into custody, including on whether children have a history of mental ill health. The form that professionals complete when a child comes into custody includes a section on mental health and requires officers to discuss this with the child. This screening process helps the police to understand the child's background and needs. It also informs the risk assessment and helps to determine how best to manage the child's welfare while in custody. It also means the child can be referred on for help or signposted to appropriate services.

In Portsmouth, the police have a clear escalation process to senior officers so that they can challenge other professionals when a child in custody requires a mental health assessment but has not received one. This increases the opportunity to remove children with mental health needs from custody and focus on getting them the help they need.

We found that, where there was good joined-up working between specialist CAMHS and emergency departments in hospitals, there was a speedy response to identify and meet the needs of children who presented with mental ill health.

> In Portsmouth, an increasing number of children have been going to the emergency department at the Queen Alexandra Hospital with mental ill health. In partnership with CAMHS, the trust has successfully piloted a children's psychiatric liaison service based within the department to promptly assess and respond to the mental health needs of children, so that children can quickly be referred on for support. This initiative has resulted in a 83% reduction in hospital admissions for children, and the clinical commissioning group was planning to implement this service for all ages.

Seeking and sharing information to support identification of children with mental ill health

We found that 'front door' safeguarding systems were not consistently effective in identifying the mental health needs of children referred to them. This means that

[25] Children who end up in police custody are three times more likely to have mental health problems than those who do not. They are very likely to have more than one mental health problem and a learning disability. 'Youth justice', Centre for Mental Health, August 2020; www.centreformentalhealth.org.uk/youth-justice.
[26] Funded by NHS England, this is an additional resource for YOTs to identify and support the most vulnerable children.

initial decisions may be based on partial information, without considering all the risks to and needs of the child. Only half of the areas visited routinely sought CAMHS information to inform decision-making in the multi-agency safeguarding hub (MASH). In Milton Keynes, we saw better practice. A CAMHS worker is based in the MASH one day a week. This direct access to a CAMHS worker made a significant difference to the level of consultation and led to improved understanding of, and focus on, children's mental health needs at the point when the child first comes into contact with children's services. This arrangement or similar was not in place in other areas.

We found that social workers' attention was more focused on children's emotional well-being and mental health needs when agencies included information about this in a referral to children's social care. When social workers' initial analysis at the front door took into account children's mental health, plans were more likely to take into consideration all of the child's needs. The quality of the referral information and the initial assessment by a social worker therefore has a significant impact on future practice with the child and their family.

In one area, we found that the content of the majority of referrals does not help staff to identify whether children have emotional well-being and mental health needs. This then restricts social workers' ability to consider the impact of children's circumstances on their mental health.

Barriers to children's needs being identified

Despite many examples of good practice, in all areas there were some children who did not have their mental health needs recognised early enough by professionals.

Professionals focusing only on presenting issues

In most areas, we found cases when professionals focused only on children's presenting issues and behaviours without recognising that these might be linked to a mental health need.

It was our expectation that children attending hospital emergency departments should routinely receive a holistic assessment, including of their emotional well-being and mental health.[27] It was disappointing to find this was not the case in all areas. This included examples of a child attending hospital as a result of having self-harmed, and a child who had punched a wall and damaged their hand. A child attending in these circumstances provides an opportunity for professionals to show curiosity, look beyond the presenting issues and ask questions about the child's

[27] 'All [children and young people] presenting to a children's [emergency department] have a developmentally appropriate assessment of their immediate emotional and mental health needs.' Standard 39 in 'Facing the future: standards for children in emergency care settings', Royal College of Paediatrics and Child Health, June 2018; www.rcpch.ac.uk/resources/facing-future-standards-children-young-people-emergency-care-setting.

emotional well-being and their mental health. This was not found to be routine across the emergency departments that we visited.

We identified similar concerns in primary care. We found that GPs generally did respond effectively to children who obviously had mental ill health. However, when children's mental ill health was less evident, GPs did not always ask the right questions in order to explore the potential risks of mental ill health. Given that the children in the Young Minds consultation highlighted GPs as one of the main professionals who they would seek help from, this is a significant finding. The young people in the consultation explained that 'a lot of [young] people do tell their GP about mental health concerns', but they said that 'a lot of GPs are quite dismissive of mental health concerns'. When GPs do take a child's mental health concerns seriously, they can make a significant difference, as we heard from one young person:

> 'The GP was the most helpful… it was the first time I was fully able to express what was happening and the other person understanding completely.'

In half the areas we visited, school nurses' health assessments did not consistently or sufficiently address the emotional well-being and mental health needs of children. This is another lost opportunity to identify a child's needs early. When school nurses had limited capacity to work with children, we found that they sometimes focused on the presenting issue rather than showing professional curiosity and delving deeper to understand the causes of the child's problems and identify any potential mental health needs.

In two areas visited, it was clear that police staff in the custody suite had not had sufficient training on the importance of identifying children's mental health needs when they are brought into or held in custody. Significantly, this means that, while, in other areas children coming into custody who have mental health needs may benefit from an assessment and referral for support, in these two areas that opportunity could be missed. It also means that information that could be used to inform multi-agency intervention and prevention is not shared and used to inform an analysis of risk and need.

> Elliot was a teenage boy who was arrested and brought into police custody. He was under the influence of drugs, violently self-harming and displaying very clear signs of mental ill health, including hearing voices. Elliot told the police that he was using drugs to 'numb the pain'. The police did consider whether they needed to share any information with other agencies, but as they had identified that the YOT team were working with Elliot, they decided that it was not necessary to share information about the incident. Elliot was kept in custody overnight and did not see an appropriate adult for a long time. Clearly this was a child with mental health needs that should have been considered as soon as the police came into contact with him. The lack of recognition by the

police of Elliot's mental health vulnerability meant that he was inappropriately treated as a criminal rather than as a child in need of help.

These inspections have identified some of the effective work by agencies to identify children who are highly vulnerable and have mental health needs; however, all children deserve and need this careful, considered and informed response and it is a real concern that this is not in place for all children.

A legacy of drift and delay in identifying children's mental health needs

For some children who had had professionals working with them and their families for many years, including children on child in need and child protection plans and children in care, there is sometimes a legacy of drift and delay in identifying and responding to their mental health needs.

Although all the children whose cases we reviewed received support services to help them with their mental ill health at the point of the inspection, too many had experienced a delay in their mental health needs being recognised. In addition, for some children, the type of support that they were receiving was not appropriate to meet their need. We were very concerned about the delays that we saw for some of the most vulnerable children with mental health needs. Sometimes, this was due to a lack of recognition by professionals of the emotional impact that abuse, neglect, exploitation, trauma or loss might have on a child's mental health.

We also found that when multiple professionals are working with a child, they are not always challenging each other appropriately when the child is not receiving the services that they need. We saw some cases where children were clearly distressed and experiencing mental health issues, yet professionals had not identified this early enough and they had not escalated concerns when the child was not receiving a service that they needed. Lack of escalation of concerns about a child and lack of challenge in the multi-professional group led to delays for some children. It is concerning that this has been identified in many JTAIs.

Sarah was a child with mental ill health and a disability who was on a child in need plan. Children's social care, school and health services, including CAMHS, had worked together with her for a number of years. However, there was a failure across these agencies to fully recognise her and her family's vulnerabilities, risks and needs. The ineffectiveness of the child in need plan to bring about sustained improvement in Sarah's physical and mental health had not been challenged by professionals. The case was only escalated to a child protection plan after five years of Sarah's mental and physical conditions deteriorating. There had been a widespread lack of professional curiosity and accountability across agencies, which had meant that no one had taken responsibility for challenging the lack of positive outcomes for Sarah.

Lack of understanding of children's diverse needs as a barrier to identification

We saw some evidence that a lack of attention to, and understanding of, a child's needs and identity could at times prove to be a barrier to professionals recognising their mental health needs.

At times we noted what appears to be a lack of attention to and understanding of children's identity, in terms of their background and their specific needs. For instance, we saw evidence of a child with mental ill health who only had very limited English whose voice, views and feelings were not clearly understood by professionals due to what they termed 'the language barrier'. By chance, an outreach worker happened to speak the same language as the child and was used as an interpreter, which was leading to better communication between professionals and the child. Planning had failed to properly address the child's need for a trained interpreter, however, which had meant that those working with her had limited understanding of her wishes and feelings. In another case in which a child with ASD was non-verbal, we found very limited attempts by professionals to work with him to understand his behaviour and support his mental health needs.

Professionals sometimes showed a lack of understanding of the links between children's life experiences and their current circumstances. For example, in one area, professionals did not recognise the specific vulnerabilities of unaccompanied asylum-seeking children and did not consider the likelihood that these children had experienced trauma. Therefore, the full potential impact of what these children had experienced was not assessed or considered in the context of their mental health needs. Conversely, this was done well in Portsmouth, an area that has a significant number of unaccompanied asylum-seeking children.

> Professionals in Portsmouth had a well-developed understanding that unaccompanied asylum-seeking children would be vulnerable and likely to have experienced some level of trauma. For example, the police had taken action to ensure that, if these children came to their attention, they would be able to understand their vulnerabilities and convene complex strategy meetings where appropriate. Social work teams had an appropriate focus on these issues when they first came into contact with a child and commenced an assessment. Unaccompanied asylum-seeking children were also given additional time for initial health assessments to be completed, and were provided with interpreters. This recognition of the specific needs of this cohort was well embedded, and this enabled the children's needs to be met more effectively.

Part 2: Engaging and supporting children

Establishing a trusting relationship

Children who participated in the Young Minds consultation identified some of the qualities and approaches that they need professionals to demonstrate in order for them to feel comfortable to talk about their mental health needs.

Children spoke about the need for a non-judgemental response from professionals, such as 'being accepting' of what children are saying and not being 'patronising' or 'condescending'. Being taken seriously was important. Some children spoke of difficult experiences that they had had when discussing their mental health. One said: 'As soon as my problems were put down to being a teenager I felt unable to talk about them.'

Children told us that professionals being 'available' and giving them a safe space to open up was vital for them to feel comfortable to talk about their mental health. They spoke about the significance of a trusted professional 'be[ing] there no matter what…' and giving them 'time, space and attention'. They stressed that they 'need time… to build up confidence.'

This combination of being approachable, taking the child seriously and listening with compassion and empathy is summarised well in the case of one young person:

> 'My chemistry teacher was the one who reached out to me when he saw me struggling… All we need is time and an ear… him being there for me when no one else was saved my life. Him being there… when I had panic attacks made me feel safe. We kept speaking every week and I would just vent and he'd listen and help me as much as possible.'

Children with mental ill health who have experienced abuse and trauma may find it particularly difficult to build trusting relationships with professionals. Their experience of adults may be that they have too frequently let them down.[28] For this group of children, it is particularly important that they are helped to build trusting relationships with professionals. The qualities outlined above are all crucial, but establishing trust also means that all the usual professional boundaries are in place and that the child is clear about the role of the professional, what support the professional can provide and when they might need to ask for specialist help for the child. The behaviour and approach of the professional who the child encounters then can be highly significant in whether the child will feel safe to open up and to able to accept help.

[28] While there is variation in the way that children respond to abuse and some do show incredible resilience, for others the impact includes the destruction of basic trust.

A 'trusted adult' in school

Throughout our inspections, we found that school staff often played a central role in engaging with children with mental ill health. When children attend school regularly we found that, in many cases, schools knew their circumstances and their families well. This enabled them to be a powerful advocate for the child. Children who had experienced mental ill health told us that relationships in school with individual members of staff who had taken the time to get to know them well and understand their needs were important. This was also highlighted in the Young Minds consultation with young people.

In one local area we inspected, a child was not regularly attending school despite extensive efforts by a member of staff to work closely with him and support him in school. At a time of extreme crisis for this young person, the only person he would agree to speak with was this member of staff at school. Having developed a trusting relationship with the child, this member of staff was able to support him when he most needed it, and defuse what was a critical incident.

In Sefton, we saw that when children attended school, they had a strong support system because schools were very aware of the needs of individual children. This made a positive difference for a particular child:

> The strongest advocate for Sophie was her school. School staff knew her, her family and her background, and she trusted them. Sophie experienced a traumatic event that led to changes to her life circumstances, and this was a time when she was in desperate need of an advocate. The school's designated safeguarding lead took that role and developed a strong working relationship with both CAMHS and social care. This ensured that there was a coordinated package of care around Sophie that addressed all her needs. The impact of her childhood experiences was well considered, her wishes and feelings were recorded clearly and her needs were considered holistically. As a result, she was able to maintain her attendance at school and make appropriate progress while accessing support with her mental health.

The wider role of schools in meeting the child's needs

More generally, when schools showed flexibility and understanding towards children with mental ill health, this was seen to be effective in building a supportive environment for children where they could establish good relationships with staff, remain in education and work towards reaching their full potential. For example, in Portsmouth, professionals were committed to flexible and adaptable arrangements in response to children's mental health needs. This included outreach work provided by schools and recognition that some children are very anxious about school attendance or particular aspects of the curriculum. We saw real flexibility in some schools to enable children with mental health issues to remain in school. One school recognised the need for a broadly consistent approach to behaviour, but also that an

individualised, graduated response might be required for a child with mental ill health, as recommended in government guidance.[29] In another school, leaders had amended the curriculum in the short term for some children who were struggling with mental ill health to engage in all aspects of the curriculum.

> Lee had experienced difficulty in attending school as he struggled with his mental health. However, he had a good relationship with the school staff, who supported him and understood his needs. They adapted their approach to the management of behaviour to support him, recognising that, due to his mental ill health, it was difficult for him to fully comply with the standard behaviour policy. In recognition of his specific needs, they worked with him to develop a personalised curriculum that enabled him to feel more comfortable in school and build his confidence in his ability to achieve in lessons. Staff supported his interest in music as a way for Lee to express himself. Lee's attendance at school improved significantly as a result of these arrangements, and staff were confident they could work with him towards engaging with all aspects of school.

We heard from children who participated in the Young Minds consultation that their school showing flexibility was important to them. For instance, a child highlighted that 'being able to sit out of lessons and calm down when I needed it' made a positive difference to their mental health.

However, during these inspections we found that around a quarter of children who we reviewed in depth were either not attending school regularly or not in full-time education. Children who do not attend school regularly are evidently missing out on their education but are also not as well known by school staff, who might have limited awareness of their circumstances. Understanding the needs of these children and building relationships with them so that they can access the appropriate services can be difficult.

Engaging with social workers

In East Sussex, children with mental ill health and their families told us that they valued the trusting relationships that they had with their social workers. This was a consequence of the low turnover of staff in children's social care, which meant that there was continuity in these relationships. Professionals in this area worked well together to ensure that the mental health needs of children were prioritised at the child's pace. Children were involved in the planning of specific therapeutic interventions. This gave them a sense of control, which was particularly beneficial to those children who were anxious. By working in this flexible way, the multi-agency partners were helping to keep children engaged.

[29] 'Mental health and behaviour in schools', Department for Education, November 2018; www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2.

In another area, by contrast, we saw variability in how well social workers engaged with children, with workload mentioned as the main reason for this issue. The impact for one child was that no professional had built any sort of relationship with her and she felt like she had no one that she could trust:

> Vicky was a child receiving support from a YOT. Her mental health needs, her links with local gangs and the risk of her being exploited were not well recognised, so they were not given appropriate priority. Vicky's attendance at school was reducing, meaning that school staff had little oversight of her well-being. As Vicky's violent outbursts in the family home escalated, professionals were concerned about their own safety and stopped visiting her at home. Only her youth offending worker was left to engage with her. None of the professionals who worked with Vicky had built any sort of relationship with her, and she was left with no allies who she trusted. Vicky, her mum and her younger brothers were left at risk, and her family members, who had their own mental health needs, were not well supported.

In Milton Keynes, we saw professionals who were diligent in working to build trusting relationships with children with mental ill health who in many cases have experienced abuse, neglect, disruption in placements and significant loss in their lives. Manageable caseloads mean that professionals have time to get to know the children they work with well, and social workers could demonstrate how children's views have influenced care planning in most cases.

Engaging with the YOT

In Milton Keynes, thoughtful responses from staff within the YOT meant that children who were reluctant to engage, because of a history of trauma or because of their complex needs, were able to build sound and trusting relationships with staff.

> Ali, a child who had complex mental health needs and a history of abuse and neglect, did not want to work with mainstream mental health services. Ali's social worker therefore helped them to better understand their life circumstances and family history. Ali's YOT worker focused on helping them to think about, and explore, their strong emotions, including feelings of anger. The YOT worker learned what Ali liked and tailored the work appropriately. Because Ali found it difficult to articulate their feelings, the worker used magic tricks and gaming to begin to build a relationship and explore the challenges that they faced. This was a creative, patient way to engage and support Ali and work together to develop ways of addressing and overcoming their problems.

Showing flexibility and creativity in involving the child

Professionals adapting arrangements for meeting children's specific needs and showing flexibility in approaches were seen to make a positive difference to engagement.

In the best examples, professionals recognised that children's circumstances and/or mental health issues made it difficult to engage with professionals. Flexibility in systems and services is important. For example, not all children feel comfortable attending a specialist service, for a range of reasons, such as lack of trust in unknown professionals, not knowing what to expect or because they are suffering from anxiety. Professionals being flexible about where to meet with the child and taking account of their wishes and feelings was seen to make a difference in the ability of professionals to engage with children.

We found examples of areas recognising this and seeking to engage with children in a way that was comfortable to them. For instance, in Portsmouth, we saw professionals responding to some children's wishes about where they preferred to meet, with CAMHS supporting a child in school rather than at the clinic. Another child had medical professionals offering home visits when it was difficult for them to attend appointments outside of the home:

> Due to an eating disorder, Max needed regular appointments with her paediatrician and dietician. Both professionals recognised that it was often difficult for Max to attend appointments due to her mental ill health, so they visited Max at home as this suited her better. Max also had a good relationship with staff at her school. Staff regularly visited Max at home to support her to attend school.

A range of agencies in East Sussex provided support and interventions in a flexible way based on the needs of the individual child, offering to see children in venues of their own choosing where possible.

> Sean had primary health care and specialist health services working with him in a focused and flexible way in response to his identified needs. There was a very high level of concern across health services about Sean's physical and mental health. Practitioners recognised that his mental ill health was preventing him from engaging with professionals and that an assertive outreach approach was required. Frequent home visits were carried out by the GP, specialist health worker and CAMHS to support Sean in getting to know staff in a safe and secure environment. This helped build his confidence to accept help and support for both his physical and mental health needs.

Children who participated in the Young Minds consultation also said that, in order to maintain the relationship with a professional who they trust, and to remain engaged, it is important for them to continue to feel supported even if meetings are not

possible. They mentioned emails or phone calls to 'check in' so that they are 'still hearing updates'. They explained that sustained contact is valuable as 'something to feel less alone'. The importance of checking in regularly and maintaining an ongoing relationship may be particularly relevant during the COVID-19 pandemic.

We found some innovative ways in which agencies were seeking to re-engage children in services. In Portsmouth, for example, when a child disengages from CAMHS treatment, practitioners identify a trusted adult who the child has a good rapport with. This person, referred to as the 'agent for change', is either a professional or significant adult who will carry out joint visits with CAMHS practitioners and attempt to re-engage the child with treatment. In Bexley, the CAMHS team works flexibly and creatively with multi-agency partners to ensure that the needs and vulnerabilities of children who are finding it difficult to engage with the service are met. This includes multi-agency meetings to discuss risks and ways forward to help the child, and joint visits with a professional who the child may know well. This assertive and joined-up response to reach out to children was helping them to engage with treatment.

Most of the children that we spoke to during these inspections reported to inspectors that they valued the importance of these relationships.

Hearing and capturing the child's voice

Capturing the voices of children in documents is a means of supporting a shared understanding of the needs of children with mental ill health. In East Sussex, the police are trained in the importance of listening to and understanding the child's voice when they are found in situations where they are vulnerable and at risk. Awareness is maintained by 60-second briefing notes, a 'think child' campaign and supporting material on the force's intranet. We saw evidence of officers capturing children's experiences and providing detailed accounts in referrals, which means that their mental health needs are clearly recognised and shared with professionals who can support the child.

Bexley

When Debbie, a child with mental health needs, went missing, the police officers who found her took the necessary time and approach to really understand her vulnerability. This provided Debbie with an opportunity to speak out about her experiences, her perspective and her needs. Understanding and recording Debbie's voice meant that the police could then communicate this to agencies that could support her. The language used in police documents reflected this approach, which was informed by an understanding of trauma and meant that police staff were compassionate and empathic towards this highly vulnerable child.

However, children's voices, their wishes and feelings, and their perspectives and experiences were not captured in all records seen during these inspections. For

example, children's voices were not consistently captured well across all health services, such as hospitals' emergency departments. It was also noted that there was a disparity in how children were managed in emergency departments, with children aged 16 to 17 often treated as adults; this resulted in their views not being captured well.

We found a small number of cases where children had directly expressed high levels of distress and anxiety but these clear messages about their mental ill health were not recognised or heard quickly enough by professionals. All of these children had highly complex needs and had experienced multiple adverse events in their lives. It sometimes seemed that the complexity of the children's lives was overwhelming professionals, meaning that they did not focus on the voice of the child and the impact of the children's experiences on their mental health, including in situations where children were clearly expressing that they needed help.

The value of robust supervision and management oversight of these or similar cases cannot be over-emphasised. It is concerning that, despite all the good work to engage with children and recognise that flexibility is needed to meet the needs of different children, there still arise situations when children clearly speak out, or their behaviours clearly indicate high levels of distress, but they are not heard or understood by the multi-professional groups working with them. These cases were small in number, but each one represents a child with mental ill health whose needs are not being met. In one stark case, when the inspector asked a child who cared for her, she replied that 'she did' as she 'couldn't trust anyone else' to do so.

Part 3: Children's access to mental health services

Improving children's access to support

The barriers to children accessing support and help with mental ill health have been well documented.[30] These include confusing and complex pathways for children to access support, including a lack of publicity about how and where children can access help, and professionals not being clear where to refer children. Other barriers include the long-running challenge of children not meeting the 'criteria' for a service for support, as well as variation across areas in how long children have to wait to access a service.

In most of the areas we visited, we found that structural changes to the way services were delivered, alongside joint working and improvements in advice for

[30] 'Review of children and young people's mental health services: phase one report', Care Quality Commission, October 2017; www.cqc.org.uk/publications/major-report/review-children-young-peoples-mental-health-services-phase-one-report; 'Are we listening? A review of children and young people's mental health services', Care Quality Commission, March 2018; www.cqc.org.uk/publications/themed-work/are-we-listening-review-children-young-peoples-mental-health-services; 'Briefing: children's mental health care in England', Children's Commissioner, October 2017; www.childrenscommissioner.gov.uk/report/briefing-childrens-mental-healthcare-in-england/.

professionals, were beginning to make a positive difference for children. For example, specialist CAMHS have been restructured in most areas to improve pathways for children in need of a range of services, as well as to provide support and advice to professionals, parents and carers. These areas had moved away from CAMHS solely being specialised services for which children either meet the threshold or do not. They have developed a more integrated system of services in which CAMHS reaches out to other agencies and professionals to develop staff's knowledge and awareness of children's mental health, as well as providing a direct service for some children.

However, areas were at different stages in improving access to help with mental ill health and there remain some significant areas for improvement. Waiting times for CAMHS have improved in some areas as a result of this work, but for some children, particularly, but not exclusively, those with ASD and/or ADHD, the waiting times for assessment and support with their mental health remain far too long.

Single point of access for support

Although most professionals working with children are not mental health specialists, they do have a role to play in supporting children's mental health needs. However, they need the support of specialist agencies to do this. They need clear pathways to refer children on who need help. They also need access to help and advice from specialists, so that children's needs can be met with a timely response.

An effective starting point is local areas providing a single point of access (called single point of advice in some areas) that professionals can contact for advice and where they can refer children when they have a concern about a child's emotional well-being or mental health. In situations where this worked best, the point of access reviewed the child's needs and referred them on to the appropriate service in a timely way. This approach then shifted the emphasis and focus away from professionals thinking that specialist CAMHS are the only or best option for all children. The point of access instead provides access to a range of support services.

In Milton Keynes, children's needs are now reviewed by the single point of access team, whereas, previously, professionals may have just made a direct referral to specialist CAMHS. If a child's needs cannot be met by specialist CAMHS or they require a different kind of support, they are referred on to another, more appropriate, service. This has resulted in a reduction in the number of children rejected by specialist CAMHS for not meeting the criteria; in addition, children do not have to wait so long for a service and they have better access to a range of services.

In East Sussex, the recently extended single point of advice triage service was working well. Children referred in by professionals were receiving timely assessments and this was reducing the number of referrals that a child experiences. This service is enhanced by the 'i-Rock drop-in service' for young people aged 14 to 25, which enables children with less serious mental ill health to directly access emotional well-being and mental health support for themselves.

The single point of access service did not operate in the same way across all areas. We found better practice where the service not only accepted referrals to specialist CAMHS but also directly referred the child on to other services. Yet, this did not happen everywhere; in some areas, professionals were only signposted to other services. This could result in further delay and the child's emotional well-being or mental health problems worsening while they waited for another referral to be considered.

Building capacity to increase children's access to support

Restructuring of CAMHS to provide outreach services and support for parents and professionals means that there is more capacity in the system to meet children's needs. This flexibility in the system and joint working with professionals, parents and carers was seen to make a difference for children and provide a wider network of professionals who could better support them with different mental health needs.

In most areas, CAMHS provided a telephone consultation service for multi-agency professionals. These services were highly valued by many professionals working with children who reported increased confidence in supporting children with their emotional and mental health needs. We saw examples of this working well during the inspections, with many professionals, including GPs in some areas, reporting that advice is now readily available when they are considering the risk and level of intervention needed for children.

Clearly then there is a role that the multi-agency partners working with a child can play to support children with mental ill health. Too often in the past a professional may have referred a child on for specialist help, without first thinking of what support they could provide. Although some children clearly need a specialist service, others can and do benefit from professionals working together to plan and coordinate a package of support and help that includes addressing mental health needs. Where professionals were able to access support and advice from mental health specialists, this was seen to benefit children.

In Portsmouth, we found that CAMHS offered consultation, guidance and advice to parents and carers who had concerns. Drop-in clinics mean that children's parents and carers are helped to develop strategies and skills to enable them to provide effective care for children with mental ill health. This type of direct support service for parents and carers was not available in all areas.

In addition, in many areas CAMHS staff also work directly with parents and carers, for example when they consider that it is not the right time for the child to receive specialist help.

Milton Keynes

Darren was a looked-after child who was not yet able to access specialist CAMHS because he was not yet feeling settled in his placement. The

CAMHS team agreed to work with Darren's carer to help her better understand Darren's needs and how to best care for him. The plan was that, as the care was better tailored to meet Darren's needs, this would enable him to feel more secure and settle more quickly, so he would then be ready to access specialist therapeutic support.

Improving access through flexible approaches

Being flexible about where children can directly access specialist CAMHS was seen to benefit children, particularly those who might not want to attend what they may see as a very formalised service.

In Plymouth, we found that CAMHS outpatient appointments were delivered in the community for some children with mental ill health. This meant that, when professionals identified children in need of specialist support, the children could access support easily in a place that suited their needs. This has resulted in a reduction in missed appointments.

We found other examples of partners working to ease children's access to specialist services by offering appointments in different venues. For example, we saw that CAMHS and schools working collaboratively to provide direct support to children worked well. CAMHS practitioners provided direct support to children in schools in most areas. For example, in Milton Keynes there are CAMHS referral clinics in two secondary schools, where assessments of children with mental health needs are carried out with prompt onward referral.

Children who responded to the Young Minds consultation highlighted the importance of their school supporting their involvement with CAMHS. This included examples such as allowing the child to take the necessary time off for their appointments. Children in the consultation also talked about the importance of schools continuing to support them while they are waiting for a service from CAMHS. However, we heard that schools' responses were inconsistent, with some children feeling 'abandoned' once the school had referred them to CAMHS.

Access to support in times of crisis

A further way in which CAMHS is improving timely access to support for children with mental ill health is by directly providing specialist services to children at a time of crisis.

In Plymouth, for example, good multi-disciplinary work between CAMHS and other health services ensures that children receive well-planned care delivered by the most appropriate service. When children present in mental health crisis at the acute hospitals, the CAMHS outreach team provides a timely response, and all children are seen within 24 hours. The CAMHS outreach practitioner helps hospital ward staff to begin an assessment as soon as the child is well enough, and this means that intervention is offered at an appropriate time for the child.

In Milton Keynes, the liaison and intensive support team within CAHMS operates 24 hours a day, 365 days a year to provide intervention at the point of crisis. This service is therefore responsive and available to children attending the emergency department at any time of the day or night, and staff can call on the service if they are concerned about a child. All children seen by the liaison and intensive support team are discussed at the CAMHS multi-disciplinary meeting so that partners can consider what further help is required in order to manage their identified needs. This is effective because children get a prompt specialist assessment and a multi-agency response to their risks and needs. It is a concern that this 24-hour response is not yet available in all areas, although in its Mental Health Implementation Plan[31] the NHS has committed to providing such a service in all areas by 2023/24.

Delays remain in accessing specialist CAMHS

Despite much of the good work seen across areas, there still remain significant delays for some groups of children who require specialist CAMHS.

For example, children who require an assessment and treatment for neurodevelopmental difficulties such as ADHD and ASD had to wait far too long in half of the areas visited. Yet, we know that these are children who disproportionately experience challenges with their mental health. For example, in one area, the waiting time between first contact and treatment was 40 weeks.[32]

In most areas, children in care had good access to mental health support, but in one area we found that children in care had to wait a significant length of time for their treatment. This was because of insufficient resources and increased demand for the services of the looked-after children mental health team. This is a significant concern given the high proportion of children in care who suffer mental ill health and it illustrates the variability in provision of services between areas.

We were interested to see if support was provided to children while they wait for a service. Young people who participated in the Young Minds consultation told us how important it was for them to get some type of support during their wait for a service from CAMHS. Young people suggested ways of 'bridging the gap' while they wait. Suggestions included 'having a scheduled phone call with someone, as waiting is awful'. Other approaches that children had found helpful included advice, information and links to support spaces, including online services. They also reported that being recommended self-help strategies would be helpful.

[31] 'NHS Mental Health Implementation Plan 2019/20–2023/24', NHS England, July 2019; www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/.
[32] The national benchmark for CAMHS waiting times, between first contact and treatment, is 14 weeks: www.nhsbenchmarking.nhs.uk/news/2019-child-and-adolescent-mental-health-services-project-results-published.

Young people also said that breaking the sense of being alone was really important to them. They advised that it would be beneficial to 'provide a service which allows [young] people to read about other [young people's] experiences'.

We were encouraged that, in three areas, services had been developed to meet the need for support while awaiting a service from CAMHS. In Milton Keynes, for example, a short-term intervention team was able to offer help to children who, for a range of reasons, could not access specialist CAMHS. This enabled this group to receive a prompt response to their needs. We saw examples of this benefiting children so that in some cases they no longer needed access to CAMHS; their needs were therefore met at a more appropriate level.

However, this type of support was not available everywhere. Areas need to think and plan carefully to ensure that children get support when awaiting a service from CAMHS. They also need to ensure that children are offered alternative services when not meeting the threshold for CAMHS.

Lack of directory of services to support children's access to support

In none of the areas visited did we identify a directory of services for children in need of support with their emotional well-being and mental health at the time of the inspection. This means that children and their families are likely to struggle when they try to find out what services are available in their local area and how to access support. Some professionals in some areas told inspectors that they did not know where to go to find out about the range of services available for children. Most notably, GPs did not always have a clear understanding of what services were available other than CAMHS. This is a concern, especially given that GPs were identified in the Young Minds consultation as one of the key professionals who children would go to if they needed support with their mental health.

Much more needs to be done, therefore, to bring together a directory of services for children and families that all professionals can access easily. This needs to include details of services provided by the voluntary and community sector with clear explanations of the type of service and the needs that it is likely to meet.

As young people made clear in the Young Minds consultation: 'Make sure young people know where to go to try to make accessing support as easy and stress-free as possible.'

Part 4: Strategic partnerships' responses to meeting the needs of children with mental ill health

Children's mental ill health cannot be addressed by any one agency working in isolation. Partners need to come together at a strategic level, alongside those who use the service, and develop a joined-up and coherent approach and ensure that services are delivered in an integrated way at the frontline. It is essential to build a

skilled workforce across and within agencies that have a shared understanding of how to identify children who may have mental health needs, where to get advice and how to access help for them.

We have seen strategic initiatives that, in most areas visited, are beginning to have a positive impact on children. We found that many areas are maximising their opportunities for partners to work jointly and imaginatively to improve responses to children with mental ill health. A thorough understanding of the needs of the local children's population is essential to inform a joint approach to developing clear priorities and joint commissioning of services to meet need. We found that wide engagement by a range of partners at a strategic level makes a real difference, as does engaging children in the development of services. Many areas were making positive progress, although all were at different stages of development. There remain areas for further development. Notably, areas need to evaluate the effectiveness of mental health provision for children more comprehensively, including evaluating the quality of services. We are still finding that not all frontline staff are receiving the training that they need in order to identify children at risk of mental ill health and help them to get the support that they need.

Identifying and understanding the local needs: the role of Health and Wellbeing Boards

With limited funding and increasing demand, especially in light of the recent and ongoing pandemic, it is essential that investment decisions are based on a good understanding of local needs, support innovation and achieve the best outcomes for children.

We saw evidence that Health and Wellbeing Boards[33] and local safeguarding partnerships could be powerful agents in facilitating a robust understanding of the needs of the local population in terms of children's emotional well-being and mental health needs. We saw that this could in turn underpin a well-planned response to those needs. We saw that partners can target investment to meet local needs by various means, notably through Joint Strategic Needs Assessments, intelligence from Public Health and the NHS, and other means of consultation with children.

In the areas visited, we found that Health and Wellbeing Boards were generally strong, mature and well established. In most areas visited, they held the multi-agency partnership to account by developing clear priorities and providing clear direction. Health and Wellbeing Boards were functioning well when they had worked with others to develop a thorough and wide-reaching understanding of the local children's emotional and mental health needs. This was seen, for example, in Milton Keynes.

[33] Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and well-being of their local population.

Milton Keynes

The Health and Wellbeing Board has ensured that consultation with children is informing its strategy and priorities. In the development of the health and well-being strategy, the Youth Parliament worked with a number of schools to seek children's views. Members of the youth council sat on the health and well-being strategy board. Findings from this consultation influenced the board's strategy to prioritise improving services so that children could easily access the help they need. This included commissioning an online service, with the aim of reaching a wider range of children, including those from a Black, Asian and minority ethnic background.

In contrast, in two areas we visited, the board's function was limited because information about children's needs was not informing planning. For example, in one area, the partners had not taken effective action to analyse and use information about children's mental health to inform decisions about which services to commission.

It is essential that areas identify the specific needs of diverse groups of children and integrate them into their strategic planning, particularly focusing on the needs of the groups of children who have increased risk of mental ill health. Significantly, most areas need to do more work to ensure that they have a clear understanding of the needs of children from different ethnic backgrounds in their local area. In one area, the partnership did not know, and had not sought to identify, the diverse needs of children in their area. We also spoke to some professionals in this area who told us that they did not feel that they had the skills or training to meet the mental health needs of children from diverse ethnic communities.

Without detailed information and analysis of the children's diverse needs in relation to mental health, leaders cannot make effective commissioning arrangements or train their staff appropriately to meet those needs.

Safeguarding partners

Arrangements across local safeguarding partnerships and Health and Wellbeing Boards need to be robust and well coordinated if children's mental health needs are to be met. We found that this worked well when the partnership had a joint and shared vision to address children's mental health, together with wide representation on both bodies from statutory and non-statutory services. Partners also needed a clear and coherent plan to develop services, underpinned by a shared model of working.

In most areas, we found that the local safeguarding children's partnership arrangements had good engagement across partners. This meant that children's mental health needs were represented across a range of strategies. For example, in Portsmouth, children's emotional well-being and mental health needs featured

prominently and were integrated into safeguarding systems and approaches, such as the strategy and vision for strengthening relationships, building resilience and carrying out preventative work.

In one area, however, the police and education providers were not involved in decisions about which services were to be commissioned for children with mental health needs. This reduced the opportunity to share information about children's needs effectively, and reduced capacity to work together to pool resources and jointly develop services.

When partners were working well together, strategic planning included developing early intervention and prevention strategies for children's emotional well-being and mental health, engaging effectively with schools, and producing a clear strategy to involve service users in the design and development of services.

In Milton Keynes, for example, partners understood the need for a strategic approach to ensure that preventative work was in place for children. They recognised the need to address problems early so that families could get help, and to prevent problems escalating and adversely impacting on children's mental health. They provided a wide range of universal and early help services to facilitate this. These included 17 children's centres that offer a comprehensive range of support, including youth counselling sessions.

Partnerships need to be nimble and alert to changing patterns and trends in the local population so that they are able to pool resources and respond quickly when new problems arise that could impact on children's mental health. In nearly all areas, we saw some evidence of this. For example, in Milton Keynes, Public Health presented findings to the safeguarding partnership on children and self-harm, which led to the partners recognising the need for frontline staff to be helped to recognise the signs of self-harm. As a result, they developed a toolkit for workers in universal services to support them to identify risks and know how to respond to children.

Engaging with the voluntary and community sector

We found that local area partnerships engaging with the voluntary and community sector at a strategic level made a significant difference. In some areas, this was embedded and working well, leading to a more integrated and comprehensive model of provision. Their engagement at a strategic level leads to a better understanding of what is available to meet local need, and they can contribute valuable local knowledge about different communities. Some groups and individuals in the community may be more likely to accept help from the voluntary sector than from what they may perceive to be a more formalised, specialised service. This then builds capacity in the system.

When this was not established at a strategic level, planning was not sufficiently well coordinated across all services, leaving the voluntary and community sector feeling isolated. The voluntary and community sector then did not have an overview of the

range of services available to children or of how to refer children on to them. We heard too frequently in these areas that they were having to work with children who required a more specialised service. This also resulted in children, families and professionals not always being aware of the mental health services within this sector.

Where we saw strong examples of engagement with the voluntary and community sector, we saw the difference that this makes for children.

Portsmouth

The voluntary and community sector work collaboratively and effectively to deliver services to vulnerable children with a range of emotional well-being and mental health needs. In Portsmouth, they are well represented strategically on several boards. This has led to integrated working where the sector feels valued and an equal partner. This means that children in Portsmouth benefit from a wide range of services to help them with their emotional and mental health.

Working with schools

The role of schools within the partnership is equally important. Across the areas we visited, we saw strong and effective work, strategically, to engage with schools. Where this was done well, local areas recognised the contribution that schools can make to identifying children's mental health needs early and in providing preventative work. This identification and prevention work in schools was a strong feature across areas.

Milton Keynes

Children have access to a wide range of services to meet their differing needs in relation to their emotional well-being and mental health. This includes support from schools through a range of school-based initiatives. A clear structure of support for schools is provided by the local authority and coordinated through the local transformation plan. The Clinical Commissioning Group has developed a programme of training for schools involving a nationally recognised charity. This has resulted in 98% of schools having a mental health lead, and 92% of governing bodies having a mental health champion.

Joint commissioning arrangements

Integrated commissioning has been a dominant policy theme for the last decade. This means bringing together agencies such as health and social care, the voluntary and community sector, schools and the police to jointly commission and provide high-quality and sustainable services to improve mental health and well-being

outcomes for children.[34] Each of the areas visited were at different stages of transition towards achieving this.

In some areas, these arrangements were advanced. Local plans were mostly well developed, with clear priorities that had been informed by good use of data and information about children's needs. Partnerships were developing their place-based commissioning systems[35] that had arisen out of, and were built on, existing and effective arrangements. Commissioning strategies were beginning to be influenced by new evidence-based models of care that respond to children's needs, and we saw that this provided flexibility in the provision of appropriate services for children with a variety of needs.

In East Sussex, recent service developments, directed through the well-established East Sussex local transformation plan, are helping to provide better access for children to a wider range of interventions for emotional well-being and mental health. The new primary mental health worker service, the extended single point of advice for support, the mental health support teams for schools and the newly commissioned emotional well-being services provided by the school health team provide greater capacity in the system. This approach helps children and young people to get more timely access to the right level of support. The local plan has made good use of existing sources of data and evidence-based research to help commissioners and partners understand the prevalence and profile of children living with mental ill health.

When plans to develop joint commissioning were less advanced, multi-agency partners were not then pooling resources to maximise capacity, and arrangements were not underpinned by a shared understanding of local need. There often remained a more rigid single-agency system of mental health care and support. This lack of cohesion between services meant that there were fewer opportunities for children to access a range of agencies that could offer support when specialist mental health services were not appropriate or necessary.

Evaluation of local service provision

Most local areas need to improve and further develop their systems for evaluating the effectiveness of local mental health provision for children. There was variability in the use of quantitive and qualitative data, and audit, to measure the effectiveness of local areas' service response to meeting children's needs, and influencing needs-led commissioning arrangements.

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[34] One of the principal requirements of the NHS Long Term Plan is that each local area establishes fully integrated commissioning arrangements. 'The NHS Long Term Plan', NHS England, January 2019; www.longtermplan.nhs.uk/publication/nhs-long-term-plan/.

[35] Place-based commissioning is based on the idea that, instead of working in isolation and one provider providing one service, agencies work together to pool resources, funding, skills and expertise, and work collaboratively to develop and provide services.

For example, one area monitors the numbers of children who receive mental health services; yet it does not currently evaluate the quality of the experiences of children within different mental health pathways or measure the impact of interventions.

Most areas need to do more, therefore, to provide not just an overview of the numbers of children receiving a service, but an in-depth evaluation of the quality of this provision. This will enable partners to better complete the commissioning cycle so that they are assured they are getting the best outcomes for children and value for money.

Involving children in developing services

Listening to and understanding children's experiences and involving them in the development of services can result in the delivery of better quality services that are more responsive to individual needs. Co-production of services with groups of children and young people helps them to feel more independent and in control of the services they use. It also gives children a sense of shared ownership of those services. Although we found good examples of this work across most areas visited, there were different degrees to which the involvement of children and feedback from their experiences and views was informing strategic commissioning decisions.

Co-production with young people is an integral part of strategic planning, commissioning and priority-setting in East Sussex. Senior leaders engage with a range of young people's groups. Recent examples, such as the 'Takeover Challenge' and the 'Make Your Mark' ballot in schools, have informed strategic priorities. Young people told inspectors that they can influence decisions and are helping to design services to support mental health and well-being, so that they are less stigmatising for children.

Strategic approaches to support staff to recognise and respond to the mental health needs of children

Models of practice

We found strong examples where leaders had developed and supported a shared model of practice for recognising and responding to the emotional and mental health needs of children. When this worked well, children were more likely to receive a consistent approach from different professionals and their needs were better understood and responded to more quickly.

For example, children in Plymouth benefited from a trauma-informed approach shared across several services, which meant that their mental health needs were better met. Partners in this area, including CAMHS, substance misuse services, police, and the voluntary and community sector, had a shared approach and understanding about the impact of trauma on children, including on their mental health.

Plymouth

Laura was a looked-after young person who had been the victim of both criminal and sexual exploitation. She was frequently missing from home, was misusing substances, and had stopped going to school. Laura had serious mental health difficulties that impacted on her safety and emotional well-being. She had not always had placements that met her needs.

More recently, agencies have worked collaboratively to improve things for Laura. A change of placement, and good, coordinated support, using a trauma-informed approach, means that professionals now have a stronger understanding of her needs and how best to work with her. A robust multi-agency approach to supporting Laura's access to mental health provision and a tailored education package have helped her to settle well in her new home. Laura's need to express her identity has been recognised and she has been given the opportunity to decorate her own personal space. Risks have significantly reduced for her. Laura now reports feeling safe and has told staff that she is happy.

Training and support for staff

As part of a whole-system approach to identifying and supporting children with mental ill health early, training, support and supervision for staff across a range of agencies that work with children are essential. We saw a close relationship between the training and support that staff could access and the level of recognition of and response to children who needed help with their mental health. We have detailed examples in Appendix A of just some of the training that local areas were providing for staff.

The children we spoke to in the Young Minds consultation recognised that professionals need support, training, supervision and clear pathways for onward referral where necessary. Notably, they talked about the importance of 'better training of GPs so they can better support [young] people' or 'educating teachers on the signs of common mental health issues so they can recognise it in students and approach students'. Children said that school staff need to be supported to develop their knowledge and confidence so that they can respond in a way that is proportionate to the level of help that the child needs.

However, there is an urgent need for local areas to review the extent and quality of training that frontline professionals receive. We found a mixed picture across agencies and areas, and not all frontline staff are receiving the training that they need in order to identify children at risk of mental ill health and help them to get the support that they need.

Conclusion

We know from previous research and reviews that many children who need support with their mental ill health are not always able to access the support that they need. We were pleased therefore to see many strengths in partnership working and arrangements to develop a more cohesive approach to the provision of children's mental health services. We have seen that when partners work together effectively, prioritise children's mental health and build a skilled and knowledgeable workforce, this improves children's access to support with their mental ill health.

Involving children in the development of services makes a real and positive difference. However, all areas need to do more to understand the needs of all children with mental ill health within their community, including those from diverse backgrounds.

Specialist CAMHS have been restructured in many areas and are working in partnership with others to broaden the range of services to children with different levels of mental health need. This is helping to integrate services locally and to provide children with the right support that is appropriate for their level of need.

However, it remains the case that availability of specialist CAMHS is limited in some areas and that resources are overstretched. Children often have to wait far too long to receive specialist help for conditions such as ASD and ADHD. This is an issue that needs urgent attention, not least because of the likely impact of COVID-19 both on children's mental health and on the ability of mental health services to provide the support that children need.

Local partnerships have an important role to play in supporting professionals across all services that work with children to have a better understanding of children's mental health. We found that work in this area can be really effective when professionals work to a shared practice model and where there is a single point of access to all services.

There are many good examples of agencies working together in innovative ways to improve services and support for children with mental health needs, such as co-location of services, involving voluntary and community sector organisations, and services being flexible in adapting to meet children's needs. Professionals building trusting relationships with children is essential, as is being able to adapt to meet individual need. Where professionals were able to access support and advice from mental health specialists, this was seen to benefit children. We saw some good examples where the multi-agency professionals working with a child with mental ill health recognised and coordinated the work they needed to do to support the child.

However, services need to get better at identifying when a child is suffering from mental ill health. There is a tendency among many professionals to focus on the issue about a child that is presented to them and not to look beyond this for a

possible mental health cause. This applies to some staff in emergency departments, GPs, police and social workers, even in circumstances where a child has self-harmed or displayed behaviour that is indicative of trauma. All too often a child's mental health problem is first picked up when they come to the attention of the youth justice system.

Training for professionals needs to improve so that they are more alert to the circumstances when they should enquire into a child's mental health. This is so that professionals can identify when the child might need support and so that they know how to get the child the help they need.

Schools play a vital role in identifying and accessing support for children who have mental health needs, but they can only do this with a cohesive and consistent package of support from other agencies. When children do not attend school regularly, this might limit access to support.

Children need to feel that they are being heard when they talk to professionals about mental ill health: they need to feel that they can trust those who are there to help them. We have seen some really strong examples where professionals identify and understand the different needs of children with mental ill health. Partners then work well together with the child to make sure they get the help they need in a way that is agreed and meaningful for the child. The aim must be for all children who have mental ill health to be able to access this type of tailored support. We hope that the learning from this report will further that aim.

Appendix A: Examples of training provided by local areas to help professionals support children with mental ill health

In Bexley, funding from the London Mayor's office has enabled the police to devise and deliver mental health training to 800 frontline police officers, from constable to inspector level. This training aims to develop an understanding of the impact of trauma and is helping officers to better identify children who may be vulnerable and in need of support. Staff in the emergency department in Bexley reported that training had improved their skills in talking with distressed children.

In East Sussex, the safeguarding partnership was dynamic in improving its training offer. For example, it created a comprehensive training package on self-harm when schools identified that this was an area where they would benefit from more training. The partnership also encourages sharing knowledge across agencies. For example, staff from the substance misuse service offer training to staff in schools, CAMHS practitioners and GPs.

In Milton Keynes, the extensive range of training for social workers and child and family practitioners means that a skilled workforce is being trained in a variety of techniques, including specialist attachment-based training, assessment of parent–child interaction and developmental trauma in childhood. All social work staff and child and family practitioners have access to clinical supervision to enhance and develop practice as well as support them in the emotional impact of their work.

In Plymouth, the police had trained enhanced crisis communicators in the force's control room. These staff had enhanced skills to help engage with children who may be suicidal or threatening self-harm as well as high-risk missing children. This has enabled the police to recognise risks early and to intervene to prevent serious harm.

In Portsmouth, an ambitious leadership was aiming to get a baseline of training on mental health for all staff who may come into contact with children. This included those working in the community; for example, park wardens have been trained in mental health and in recognising ASD. The police force has 60 autism ambassadors, who act as points of contact for advice and guidance. This enables better recognition and response to children with ASD. Staff in the young person's drug and alcohol service were trained to deliver cognitive behavioural therapy, dialectical behavioural therapy, acceptance and commitment therapy, and motivational interviewing. This 'whole-system' approach to training was seen to benefit children.

In Sefton, CAMHS are providing training to support foster carers, children's care home staff and social workers in their work with children, which includes using a 'developmental' trauma-informed approach to understanding how early life experiences can impact on children. This has increased staff's knowledge and confidence in supporting children and recognising their needs at an early stage.

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