Identification of Training and Support Needs
For Inter-Agency Tier One Professionals in Relation to
Child & Adolescent Mental Health Services

Final Report
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EXECUTIVE SUMMARY

I Purpose of the Evaluation

The overall purpose of this project was to conduct a training and support needs assessment of Tier 1 professionals working in Child and Adolescent Mental Health Services across Coventry and Warwickshire whilst also taking account of the national context provided by the HAS report and other national policies.

The specific objectives of the project were as follows:

- Map current training and support related to child and adolescent mental health that is in place for Tier 1 professionals that work in the three community health trusts, Warwickshire and Coventry Social Services and Education Departments.
- Identify the role Tier 1 professionals already have in relation to child and adolescent mental health.
- Identify Tier 1 professionals’ views regarding their training and support needs related to child and adolescent mental health.
- Carry out a comprehensive assessment of the ability of Tier 1 professionals to recognise, manage, and appropriately refer more complex cases onwards to the specialist CAMHS service.

A key purpose of this study was to identify barriers to successfully increasing the training and support available to Tier 1 staff and to suggest ways in which these barriers might be overcome. The report sought suggestions for further training and improved support for Tier 1 staff. Attitudes to multi-agency working and liaison and the extent to which this is already occurring were also explored.

II Research Methods

The research comprises four different components which used a variety of methods of data collection: interviews and consultations with key stakeholders, a postal survey, interviews with Tier 1 professionals and an audit. This multi-method approach generated both quantitative and qualitative data pertaining to staff experiences and opinions. Together, the data generate a rich and detailed understanding of the training and support needs of Tier 1 staff across Coventry and Warwickshire.
II.i Consultation Document and Interviews with Key Stakeholders
A consultation document was issued to 67 key stakeholders who held strategic management positions within health, education and social services. A response rate of 52% was achieved for this document. These responses were used to provide a strategic overview of training need and activities and also enabled us to identify individuals for more in-depth interviews. Those interviewed were drawn from senior management and practitioners across health, education and social services across Coventry and Warwickshire. Unfortunately it was not possible to consult or interview key stakeholders from Social Services and Education in Coventry, despite the efforts of the research team and the Project Steering Group. The themes emerging from the consultation document and the subsequent interviews were examined using qualitative analytic methods.

II.ii Postal Surveys were sent to a wide range of Tier 1 professionals across Coventry and Warwickshire. In total, the survey was sent to 873 staff and a response rate of 39.8% was achieved. Those surveyed included randomly selected GPs and practice nurses, all Special Educational Needs Coordinators (SENCOs), and all health visitors, nursery nurses and school nurses. Child social workers and education social workers from Warwickshire were also surveyed, as were a small number of staff from Learning and Behavioural Support (LABS), the Disability, Illness and Sensory Communication Service (DISCS) and the Pupil Reintegration Unit (PRU). A small number of nurse specialists and Community Paediatricians/School Medical Officers were also surveyed.

II.iii Interviews with Tier 1 Professionals
Twenty individuals were randomly selected from respondents to the postal survey that had indicated their willingness to be interviewed. They required semi-structured interviews that enabled respondents’ views on training and support needs to be explored in more depth. These interviews allowed the researchers the opportunity to clarify any ambiguities in the questionnaire and to probe further around areas of interest. Analysis of the data was carried out thematically, as with the interviews with the key stakeholders.

II.iv Audit
An audit was undertaken across the three CAMHS services in Coventry & Warwickshire during October 2002 using audit tools that examined all new referrals into CAMHS and all clients who were being seen and assessed for the first time following referral. The audit aimed to make an assessment of the timeliness and appropriateness of the referrals from Tier 1, and to reflect upon specific aspects of the referral process. It also considered the mode of
referral to the service, including who referred the client, which Tier 1 professionals had been involved in the case, and the reasons for the referral.

III Key Findings
Three over-arching findings emerged:

- Tier 1 staff have a wide range of CAMHS-related training needs and appear keen to participate in further training, although workload demands and other barriers do not readily facilitate this.
- All Tier 1 staff felt that they had access to Tier 2 and 3 support, whether formal or informal, but the support that is available needs to be strengthened.
- Relationships between Tiers 1 and 2 are reasonably good overall, but there were criticisms of long waiting times following referral and a lack of support and feedback on referral. There was evidence that multi-disciplinary working and liaison existed, but also scope for improvement.

III.i A Need to Strengthen Professional Qualifying Training
Professional qualifying training was felt by many Tier 1 professionals to be very limited in scope and had not fully provided them with the range of skills and knowledge that would adequately prepare them for their role with CAMH.

III.ii Current Continuing Professional Development (CPD)
A number of CAMH-related CPD training courses had been accessed by staff and although many of these, or aspects of these, were found to be helpful, there were criticisms of some courses. In addition to attendance at organised training courses there was evidence that some professionals enrolled themselves on courses, which they attended in their own time and at their own cost. There was also evidence that learning took place opportunistically on the job, and this type of learning was regarded as valuable.

III.iii Support from Tiers 2 and 3
The findings show that there is evidence of formal and informal channels of advice and support operating between Tiers 1 and 2/3. In the case of formal support, this has been bolstered in Coventry by the development of the PMHT and in the southern part of South Warwickshire by the appointment of a part-time PMHW. These developments have been helpful but limited in their capacity and availability, which has an impact on the amount of support provided. Furthermore, this support is not provided equally across the area as the PMHW covers only the southern part of the South Warwickshire Primary Care Trust (PCT).
Informal support is also in evidence across the three PCTs, with respondents to the postal survey saying that they could call upon people both within their own organisation and other organisations for advice and support. The professions most commonly named as being useful in this capacity were psychologists, CAMHS, CPN and health visitors. SENCOs in the eastern area mainly called upon DISCS/LABS for support, whereas SENCOs from the other areas would also call upon psychologists.

III.iv The Role of Tier 1 in Relation to CAMH
The majority of Tier 1 professionals were involved with CAMH and for some, especially many social workers; this was a significant part of their workload. All the interviewees and half of those who completed the postal survey indicated that this aspect of their workload had increased. This was most commonly reported by school nurses from all three PCTs and by SENCOs from the South, Nuneaton and Bedworth. GPs reported low levels of involvement in CAMHS yet the audit found that they were involved in the majority of referrals.

III.v Ability of Tier 1 to Recognise, Manage and Appropriately Refer more Complex Cases
Many practitioners lack the confidence to work effectively with CAMH problems, and this has implications for their ability to recognise, manage and refer cases as appropriate.

- Over a third of respondents had little or no confidence to identify a number of types of common CAMH problems.
- Over a third of respondents also expressed little or no confidence to manage a number of common mental health conditions.
- The findings show that, overall, there was greater confidence to refer conditions both to other Tier 1 professionals and to more specialised services. Despite this, there was significant evidence of low levels of confidence to refer in relation to a number of specific CAMH problems.

III.vi Main Training Needs:
- A need for training in specific conditions, especially anxiety management, depression, drug awareness, ADHD, self-harm, school-related difficulties and behaviour management. GPs, nursery nurses, health visitors and SENCOs in particular said that they required training in behaviour management.
• **A need for general training in mental health issues appertaining to children and adolescents.** Many Tier 1 staff recognise that they need to increase their understanding of mental health conditions generally and of mental health problems in children and adolescents in particular. Although this training need was widespread across Tier 1, it was particularly noted by health visitors and nursery nurses, SENCOs and social workers.

• **A need for training in all aspects of the referral process.** There was a great deal of concern expressed about the referral process, with over three-quarters of respondents to the postal survey stating that they needed to increase their awareness or understanding of which cases are appropriate for referral, the specialist services to which they could refer and the referral process. Health visitors, nursery nurses and SENCOs in particular said that they had this training need. The findings from the audit also suggest a need for training in referrals in order to reduce inappropriate referrals.

• **Training to increase understanding of CAMHS.** The role of CAMHS was not clearly understood by many respondents. Training is needed to clarify the services that are available at Tier 2, the role of the different professionals at Tier 2 and the help and support that they can offer. This training need was stated, in particular, by school nurses, social workers, health visitors and SENCOs.

• **Training in communication skills.** Training in communication skills and strategies, together with supportive literature was identified as a training need that might help Tier 1 professionals to communicate with the parents of children with mental health problems and with parents who themselves have mental health problems.

• **Training in team working with other agencies.** This is a key skill for improved inter-agency liaison and working. Training in this area was regarded as particularly important by SENCOs, health visitors and nursery nurses and health professionals from the South Warwickshire PCT.

• **Health Visitors enhanced Public Health role.** Health visitors identified a number of training needs including training in assessment skills, community working, the identification of community health needs, the funding and audit of community work and training in various aspects of group work, which would be needed to enable them to effectively carry out their enhanced public health role.
III.vii  The Support Needs of Tier 1
A range of different support needs was identified:

- Increased availability of informal support from Tier 2 or other Tier 1 professionals to enable them to manage cases effectively and to provide reassurance.
- Formal support, either telephone or face to face, once a client has been referred and during the waiting period or where families refuse a referral to Tier 2.
- Formal support where the Tier 1 professional is dealing with a case that they find difficult or complex, but is not appropriate for referral.
- Feedback following referral or a rejection of a referral. In the case of the latter, Tier 1 staff needed to know which agency it would be more appropriate to refer to and/or receive advice and support to manage cases that have been rejected.
- Updates on current and best practice to ensure that Tier 1 keep up to date with knowledge and practice.

III.viii  Identified Barriers to Meeting Training and Support Needs.

- There was a perception that there was a lack of appropriate courses for staff to attend, and/or a lack of awareness of the availability of training courses.

- There is tension between individual training needs and those identified at team, school or county level. This sometimes results in the individuals’ self-perceived training needs not being met because they do not match with organisational training programmes or priorities.

- Pressure of workload together with the feeling that staff could not take time away from their work to attend training. Staff commitment to their work responsibilities is a significant barrier, which is not easily overcome. The cost of courses and the lack of funds in the training budget was a further important barrier and, associated with this, was the cost and availability of staff cover.

- Practical problems in attending courses includes fitting training around family responsibilities or part-time working hours. The geographical location of courses was a further issue because lengthy travelling time could deter attendance.

III.ix  Relationships Between Tier 1 and CAMHS
There were many examples of good relationships with Tier 2 services, both formally and informally, and a recognition that Tier 2 services were limited and over-stretched.
This, together with the concern over long waiting lists, suggests that Tier 1 staff avoid making demands on Tier 2. The concerns of Tier 1 are mainly over the long waiting lists, the lack of feedback on referrals, and the pressure around referrals being rejected.

There was evidence of multi-disciplinary working and inter-agency working practice, particularly in relation to complex cases, but the pattern of success in inter-agency working was not widespread and further progress could be made. Generally there was evidence of support for improving inter-agency co-operation, although there does not seem to be widespread acceptance of the need for this co-operation, possibly due to a lack of understanding of the requirements of other agencies and their differing priorities.

There was also evidence that communication between agencies needed to be improved. There is also a need to increase the knowledge and enhance understanding of the various roles undertaken by other Tier 1 professionals.

IV Project Recommendations.

The main recommendations that emerge from the study can be summarised as follows:

- Written protocols and guidelines should be developed to aid Tier 1 to identify and manage CAMH conditions.
- Written protocols or flow-charts should be developed to aid the referral process.
- CAMHS should look at ways of reducing waiting times for new referrals.
- There should be feedback and a formalised support system following referral.
- An effective communication strategy between agencies should be developed.
- Inter-agency working in general needs strengthening.
- Strategies need to be developed to facilitate inter-agency meetings.
- Effective ways of notifying staff about organised training courses need to be introduced.
- Staff who have attended training courses should be encouraged to cascade information to other colleagues to ensure widespread dissemination of the skills and knowledge gained on training sessions.
- The subject of CAMH in vocational courses needs strengthening.
- Induction of new staff should include guidance on the identification of CAMH problems and, where appropriate, their management, and referral guidelines.
- The design of training programmes need to take individual needs into account as well as organisational priorities.
- A wide-ranging training programme needs to be organised commencing with mental health issues generally, the role of CAMHS and the referral process.
• Ways of overcoming barriers to attending training need to be addressed. For example, short, locally-run courses with ample advance notification would facilitate attendance.

• The PMHW role in the southern part of South Warwickshire should be extended to cover both North and South Warwickshire PCTs.

• Telephone support should be available from a named Tier 2 professional, ideally a PMHT worker.

• Regular updates on current and best practice should be provided.
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CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE PROJECT

1.1 Purpose of the Project

The overall purpose of this project was to conduct a training and support needs assessment of Tier one professionals working in Child and Adolescent Mental Health Services (CAMHS) across Coventry and Warwickshire. The specific objectives were as follows:

- Map current training and support related to child and adolescent mental health (CAMH) that is in place for Tier 1 professionals that work in the three community health trusts, Warwickshire and Coventry Social Services and Education Departments.
- Identify the role Tier 1 professionals already have in relation to CAMH.
- Identify Tier 1 professionals’ views regarding their training and support needs related to CAMH.
- Carry out a comprehensive assessment of the ability of Tier 1 professionals to recognise, manage, and appropriately refer more complex cases onwards to the specialist CAMHS.
- Consider service users’ perspectives.

A key purpose of this study was to identify barriers to successfully increasing the training and support available to Tier 1 staff and to suggest ways in which these barriers might be overcome. Hence, attitudes to multi-agency working and liaison and the extent to which this is already occurring were explored. The project was intended to inform the design and delivery of further training and improved support for Tier 1 staff.

1.2 Structure of the Report

This report provides a detailed description of the project and its findings. The project was undertaken throughout 2002 by researchers from the Centre for Primary Health Care Studies, University of Warwick.

This chapter continues with a brief account of the background to the project and its policy context. Chapter 2 describes the methods used to conduct the research, and chapter 3 presents the findings from the main part of the research. Chapter 4 reports on the audit which
was conducted, and Chapter 5 presents the main conclusions and recommendations arising from the study.

1.3 Project Background and Development

1.3a Policy Context

The Audit Commission report (1999) observed that, over the past 20 years, the importance of the mental health of children and adolescents has been increasingly recognised. This reflects increased knowledge of the emotional and psychological development of children and a greater awareness of the implications of emotional and behavioural disturbance in young people. A range of organisations are involved in providing services to help with children’s and adolescents mental health, and these have been described within the framework of a four-tier model. That model is replicated here in order to clarify the terms ‘Tier 1’ and ‘Tier 2’ which are used extensively throughout this report but which may not have been adopted by all the agencies referred to within it.

Table 1.1 Key components, professionals and functions of tiered CAMHS (Audit Commission, 1999: 7).

<table>
<thead>
<tr>
<th>Tier</th>
<th>Description of service</th>
<th>Interventions provided by</th>
<th>Main functions</th>
</tr>
</thead>
</table>
| Tier 1 | Interventions at primary level. | GPs, health visitors, social workers, juvenile justice workers, school nurses and teachers. | i) Identify mental health problems in their early development.  
ii) Offer general advice and treatment for less severe problems  
iii) Pursue opportunities for promoting mental health and preventing mental health problems. |
| Tier 2 | A level of service provided by professionals working on their own who relate to others through a network rather than within a team. | Clinical child psychologists, educational psychologists, paediatricians (especially community paediatricians), community child psychiatric nurses or nurse specialists, child psychiatrists. | i) Training and consultation to other professionals  
ii) Consultation for professionals and families  
iii) Outreach to identify severe or complex needs where children/families are unwilling to use specialist services.  
iv) Assessment which may trigger treatment at this level or in a different tier. |
| Tier 3 | A specialist service for the more severe, complex and | Usually a multi-disciplinary team or service comprising social workers, clinical psychologists, community | i) Assessment and treatment of child mental health disorders  
ii) Assessment for referrals |
The ‘Together We Stand’ review produced by the Health Advisory Service (HAS) in 1995 acknowledged that Tier 1 professionals provide an essential role as a first-line service for many children and adolescents experiencing mental health difficulties. It also acknowledged that Tier 1 professionals can play an important role in relieving some of the pressure experienced by specialist level services, although equally it is recognised that in certain cases Tier 1 services are themselves experiencing high levels of demand. The report identified professional training and continuing professional development, including support from specialist services, as a way forward in the maintenance and promotion of high quality mental health services (HAS, 1995).

The subsequent Audit Commission report, however, noted that links between specialist CAMHS and other agencies still needed strengthening as, for example, support for other agencies by CAMHS only accounted for 1 per cent of practitioners time (Audit Commission, 1999).

The HAS review underlined the fact that the ‘multi-factorial aetiology of child and adolescent mental health difficulties’ (Audit Commission, 1999, p1) requires that specialist and complementary skills, available within health and a variety of different professional disciplines, work together to address mental health needs of children and adolescents. Collaboration across agencies is not only restricted to the commissioning and delivery of services, but there are opportunities for multi-disciplinary training to complement and enhance uni-disciplinary training (HAS, 1995).

The HAS review did not espouse any one model in relation to the organisation of mental health services, and by extension the training provided for professionals. However, it argued that each component of the service should have an explicit role and objectives, which can be
integrated both within and across agencies with the aim of improving the services available (HAS, 1995).

The setting of roles and objectives can only be sensibly undertaken following local needs-based assessments, which also take account of national guidance. This in turn will lead to a strategic and comprehensive framework, which should facilitate the planning, delivery and evaluation of training for professionals.

1.3b The commissioning of this study

It was against the background of these reports that the research reported here was commissioned. The project was commissioned by the Health Service, which then included Education and Social Services, and it provided a means of obtaining an overview of training and support needs within each agency as well as reviewing the inter-agency context. Funding was provided by Non Medical Education and Training (NMET).

This research was intended to provide a local needs-based assessment, whilst also taking account of the national context. The study aimed to identify the role Tier 1 professionals already have in relation to CAMH. This role and the face of mental health care has been shaped in a number of ways and at a number of different levels, and the study sought to illuminate some of these factors. The framework for this project was used to gather information about past and current training and support, and to enable an assessment of need within agencies as well as a joint-assessment across agencies.

As CAMH is the domain of numerous agencies, it is clearly important to not only highlight training needs which are specific to professions but also to illuminate areas of common need in training and support and opportunities for, and potential benefits of, joint provision of training in particular. Hence, the degree of co-operation and understanding operating across Tier 1 was also assessed: this is important as the quality of mental health care often depends on a seamless interface across Tier 1.

The original intention was that the important role that the voluntary sector plays would also be included, however given the limited timescale and project resources that were available it was felt that we should focus solely on the statutory sector.

The project was undertaken at a time of considerable re-organisation, particularly within local health services. At the time of data collection, NHS Community Trusts and health authorities were being phased out and replaced by Primary Care Trusts. Management roles,
responsibilities and personnel within these organisations underwent significant change. For the study, this had the consequence that data collection proved much more time-consuming and complex than had been anticipated. As a result, there was substantial slippage in the project timeframe, which unfortunately meant that we were unable to meet the fifth objective, to consider the service user perspective on meeting the common mental health difficulties children and young people experience, within the resources that are available to the project.
CHAPTER TWO

RESEARCH METHODS

This study had a broad remit and aimed to achieve a number of objectives. These were to:

1) Map current training and support related to child and adolescent mental health that is in place for Tier 1 professionals that work in the three community health trusts, Warwickshire and Coventry Social Services and Education Departments.

2) Identify the role Tier 1 professionals already have in relation to child and adolescent mental health.

3) Identify Tier 1 professionals’ views regarding their training and support needs related to child and adolescent mental health.

4) Carry out a comprehensive assessment of the ability of Tier 1 professionals to recognise, manage, and appropriately refer more complex cases onwards to the specialist CAMHS service.

5) Consider the service users’ perspectives on meeting the common mental health difficulties children and young people experience.

It was determined that a multi-method approach was necessary to provide a robust means of investigating these issues and to provide internal consistency of study findings. This was used to generate a broad range of types of information, including both quantitative and qualitative data pertaining to staff experiences, opinions and confidence to carry out their roles effectively. Together, the data were intended to provide a rich and detailed understanding of the training and support needs of those Tier 1 staff for whom we were able to gather data across Coventry and Warwickshire.

2.1a Stakeholders’ Consultation Document

It was not within the original remit of the study to issue a consultation document to stakeholders, as we had only intended to interview up to 20 stakeholders. The project steering group, however, identified 67 key stakeholders, who held strategic management positions within health, education and social services. We, therefore, decided that given the importance placed on consulting as widely as possible, we would design and administer a written consultation document prior to the interview phase to give stakeholders an opportunity to comment. This document (see appendix I) was issued to each stakeholder together with a
covering letter, project information sheet (appendix II) and freepost return envelope. Reminders were sent, containing a second copy of the consultation document, in order to increase the response rate. Non-respondents were telephoned to give them a final opportunity to respond. The consultation document provided a strategic overview of training need and activities and also enabled us to identify individuals who could (and were willing to) be interviewed.

2.1b. Stakeholder interviews.
Thirteen individual stakeholders were identified for interview. These were drawn from a range of senior management and practitioners across health, education and social services, and several were members of the project steering group including a consultant nurse and systemic psychotherapist, a clinical lead for health visiting, a clinical psychologist and a senior educational psychologist. Unfortunately it was not possible to initiate links with Social Services and Education in Coventry, despite the efforts of the research team and the Project Steering Group.

The consultation document, and the respondents’ replies to the questions thereon, formed the basis for the interviews which were conducted either as face-to-face meetings or telephone interviews. The interviews were used to further explore some of the key issues around training and support at a strategic level. (See Appendix III for a sample interview schedule). Of necessity, these interviews varied slightly to reflect the responsibilities and concerns of the individual interviewees. Each interview lasted around 30 minutes, and all were tape-recorded and then transcribed. The interviewees consent to tape record the interview was obtained at the start of the interview following an explanation of the purpose of the interview and assurances that the data would be anonymised. This consent was obtained verbally for the telephone interviews and in writing for the face-to-face interviews.

The themes that emerged from the data were identified using qualitative analytic methods in order to identify both key themes and stakeholders’ views regarding training and support. This involved the repetitive reading of the transcripts, and the construction of a coding framework to identify key themes, and which also captured the full range of views about training and support.

2.2 Postal Survey
A postal survey was conducted with Tier 1 staff to elicit information about their individual roles with children and adolescents with mental health difficulties, their qualifications and training, and their views on their training and support needs. Included were questions about the
adequacy of the training that respondents had undergone and their rating of their level of
confidence in being able to identify, manage and refer a range of mental health difficulties.
These questions were designed to elicit information about their confidence to work effectively
with children and adolescents with mental health problems. We also asked questions about
their understanding and awareness of the referral process and whether they had
experienced any problems with making referrals. We also asked about the current role of the
respondents in order to find out the extent of their work with children and adolescents with
mental health problems and the length of time they had held their current role so that we
could gauge the extent of their experience.

The postal survey was designed with a mixture of questions, some of which required the
respondent to tick a box or complete a table by reference to a scale, while others were open-
ended and enabled the respondent to enter more detailed responses. The questionnaire was
kept as concise as possible, easy to complete and unambiguous.

The postal survey was piloted to test the acceptability of the questionnaire, and the validity of
responses. It was sent for comment to 5 health visitors, 1 school nurse, 4 GPs and 3 practice
nurses whose names had been suggested by the project steering group. At the same time,
three academics within the Centre for Primary Health Care Studies with experience in
questionnaire design were asked to comment on the survey. A draft copy of the questionnaire
was also issued to members of the project steering group for their comments. Five copies of
the pilot survey were returned and, as a result of this feedback and the University peer review
process, a small number of amendments were made to the postal survey.

It was intended that the postal survey would be sent to:

- One GP from each practice
- One practice nurse from each of these practices
- All health visitors, nursery nurses and school nurses/school health advisers
- All school medical officers/community paediatricians
- All child and education social workers
- All special educational needs co-ordinators and specialist teachers
  from within the areas of the Coventry, South Warwickshire and North Warwickshire
  NHS Community Trusts.

At an early stage of the project, however, the project steering group decided that it would be
impractical to include specialist teachers and consequently these were not surveyed. We
were also unable to survey education social workers, or child social workers from within the Coventry area because the project steering group was unable to obtain the relevant staff lists.

Slightly different versions of the self-completion questionnaire were sent to:

- GPs and nurses
- special educational needs co-ordinators (SENCOs)
- health visitors, nursery nurses and school nurses
- social workers

The main difference between questionnaire versions related to those sent to health visitors, which contained additional questions to elicit information concerning the impact that the changes within their profession to enhance their public health role would have, or were already having, on their work with children and adolescents with mental health problems and on their training needs. An example of this questionnaire can be seen at appendix IV. A list of common mental health problems was sent with this questionnaire and this can be seen at appendix V.

Although it had initially been agreed that the project steering group would facilitate the distribution of the questionnaires it was later decided that, where possible, the research team would take responsibility for this. It was felt that this would help to ensure that samples were randomly selected and that it would be easier to target non-respondents with reminders. The project steering group, though, took responsibility for issuing questionnaires to 116 child social workers.

In order to try to increase the response rate, the questionnaire was printed on coloured paper and we offered respondents the opportunity to participate in a prize draw to win £30 worth of vouchers.

2.2a Staff Participating in the Postal Survey

The final questionnaire was distributed to 873 recipients, comprising:

- 231 SENCO's
- 163 Health Visitors
- 147 GPs
- 147 Practice Nurses
- 116 Child Social Workers
- 32 School Nurses
- 12 Nursery Nurses
10 Education Social Workers
7 Community Paediatricians/School Medical Officers
3 Learning and Behavioural Support Teachers
3 Nurse Specialists
1 Disability, Illness and Sensory Communication Service Teachers
1 Pupil Reintegration Unit Teachers

Each questionnaire was distributed with an information sheet about the project, a Freepost return envelope to return the survey to the Centre for Primary Health Care Studies and a covering letter, personally addressed where possible, inviting the respondent to participate in the research and to enter the prize draw if they did so. Non-respondents were issued with a reminder and a further copy of the questionnaire approximately three weeks later in order to try to improve the response rate. Staff completion and return of questionnaires was taken as an indication of their consent to participate.

2.2b. Data analysis of postal surveys.
The survey provided both quantitative and qualitative data in the form of responses to open-ended questions. The quantitative data was input and analysed using SPSS v. 11. The qualitative data was used to illustrate the quantitative data and provided information to further our understanding of the data.

2.3 Interviews with Tier 1 professionals
The interviews with Tier 1 professionals were an important element in capturing the views and opinions of those workers who are in regular contact with children and adolescents with mental health difficulties. The questionnaire invited respondents to indicate whether they would be willing to participate in a short telephone interview. One hundred and thirty-four respondents indicated their willingness to be interviewed and from these we randomly selected a sample of 20 interviewees. It was not possible to interview a similar proportion from each profession because some groups were under-represented in their willingness to be interviewed. Telephone interviews were conducted with the following:

- 2 practice nurses
- 6 SENCOs
- 6 social workers
- 6 health visitors

Each interview lasted around thirty minutes, and followed the respondent’s postal survey but allowed the researcher to explore their comments in greater depth. Within this context, there was some variation within the interview schedules to reflect the roles, views and concerns of
the individual interviewees. A sample of the interview schedule can be seen at Appendix VI. As with the interviews with key stakeholders, all the interviews were tape-recorded, with the interviewees’ consent, and then transcribed. Analysis of the data was carried out thematically, as with the interviews with the key stakeholders. These interviews allowed the researchers the opportunity to clarify any ambiguities in the questionnaire and to probe further around areas of interest. The information obtained during the interviews complemented that obtained from the postal survey and provided a richer and deeper understanding of the key issues in relation to training and support needs.

2.4 Audit

An audit was undertaken across the three CAMHS services in Coventry & Warwickshire during October 2002. Two tools were developed. The first targeted all new referrals into CAMHS, and the second addressed all clients who were being seen and assessed for the first time following referral. Both were also to include previously discharged cases and those who had been re-referred. The audit process was completed by CAMHS staff (Tiers 2 and 3).

In particular, this phase of the research aimed to make an assessment of the timeliness and appropriateness of the referrals from Tier 1, and to reflect upon specific aspects of the referral process. The audit considered the mode of referral to the service, including who referred the client, which Tier 1 professionals had been involved in the case, and the reasons for the referral. We then hoped to ascertain the degree of dissatisfaction regarding the appropriateness of the referral and its timing, and the level of concordance with the assessment of the referrer.

The tools went through several draft stages before the final versions were agreed by each area. Piloting with prospective respondents revealed a number of questions seen to be misleading in the information they requested leading to further redevelopment. Appendix VII shows the final versions as used in Coventry. There was a slight variation between the tools used in this area and those used in North & South Warwickshire, with the former containing additional questions. Initially the completed forms were submitted on a weekly basis so that any problems could be identified early in the process.

2.5 The Service User Perspective

Although one of the objectives of the research was to consider service users’ perspectives, because of other parts of the study becoming more complex and time-consuming to administer than anticipated, the decision was taken that this aspect of the study could not be achieved within the time-scale and the existing budget.
2.6 Ethical Considerations

The need for ethics committee approval to conduct the study was explored with the project steering group, but was not deemed necessary, as there was no direct contact with users of the services. However, measures were taken to protect the confidentiality and anonymity of all participants. Prior to conducting each interview, we discussed the purpose of the interview and the research with the interviewee and obtained their agreement, verbally or in writing, that we could make use of their comments within this report and any subsequent papers that may be published in academic journals. All the tape recordings and transcripts resulting from interviews were kept securely in locked filing cabinets and were accessible only to the transcribers and the research team, and will be destroyed when the study is complete. In order to ensure the anonymity of the interviewees, names have not been used when attributing quotes or comments. Care was also taken to ensure that individuals’ names did not appear on the postal survey. Each questionnaire was numbered, and the master-list, which could identify individual responses, was kept securely and was accessible only to the research team. In the case of the audit, data were supplied to us in an anonymous format so that we did not know which staff member had completed the form or on which consultation they had based their report.
CHAPTER THREE

STUDY FINDINGS

The chapter provides an analysis of the sources of data that contributed to the study, followed by sections on findings from the consultation with key stakeholders, the postal survey and the interviews with Tier 1 professionals. The findings are presented separately because of the scale and complexity of the research study. Throughout, comparisons are made according to professional group and geographical location. At the end of the chapter is a summary of the findings.

Inevitably, in a study of this type response rates were variable, and not all the agencies that we wished to involve took up the opportunity to participate. In particular, it proved difficult to obtain listings of Tier 1 professionals from Coventry Social Services and eventually we had to proceed with the study without this group. Despite efforts to increase the response rate of the postal survey, overall we obtained data from less than 40% of the staff targeted, and the results should be considered within the context of these limitations.

3.1. Response Rates

3.1a Consultation Document Response Rate
In total, 35 (52%) of the stakeholders invited to comment on the consultation document did so. The timing of this phase of the research coincided with the change from health authority and community trust to PCT status. As a result, a number of stakeholders were either not available or had left their posts.

3.1b Postal Survey Response Rate
In total, after reminders had been issued, 284 (32.5%) questionnaires were returned completed, and a further 64 questionnaires were returned uncompleted giving an overall response rate of 39.8%.

3.1bi Response Rate By Professional Group
The highest response rates were obtained from school nurses, nursery nurses, health visitors and SENCOs (see Table 3.1).
Less than one-quarter of GPs and practice nurses responded, perhaps reflecting the lack of importance or impact that this aspect of their role has on their workload. Under-diagnosis of children’s mental health problems by GPs is a recognised problem (Garralda and Bailey, 1995).

The lowest response rate was from community paediatricians. This was surprising, but might be because they not regard themselves as being Tier 1 professionals.

**Table 3.1. Response Rate by Profession to which the Postal Surveys were Issued**

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number Issued</th>
<th>Number (%) Returned Completed</th>
<th>Number (%) Returned Uncompleted</th>
<th>Total Response Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursery Nurse</td>
<td>12</td>
<td>5 (41.7)</td>
<td>1 (8.3)</td>
<td>50</td>
</tr>
<tr>
<td>School Nurse</td>
<td>32</td>
<td>14 (43.7)</td>
<td>2 (6.3)</td>
<td>50</td>
</tr>
<tr>
<td>SENCO</td>
<td>231</td>
<td>89 (38.5)</td>
<td>1 (35.6)</td>
<td>44.1</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>163</td>
<td>63 (38.6)</td>
<td>7 (4.3)</td>
<td>42.9</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>147</td>
<td>36 (24.5)</td>
<td>21 (14.3)</td>
<td>38.8</td>
</tr>
<tr>
<td>Social Worker</td>
<td>116</td>
<td>39 (33.6)</td>
<td>3 (2.6)</td>
<td>36.2</td>
</tr>
<tr>
<td>ESW, Education Psychologist, LABS, DISCS, PRU</td>
<td>15</td>
<td>5 (33.3)</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>GP</td>
<td>147</td>
<td>32 (21.8)</td>
<td>16 (10.9)</td>
<td>32.7</td>
</tr>
<tr>
<td>Community Paediatrician</td>
<td>7</td>
<td>1 (14.3)</td>
<td>1 (14.3)</td>
<td>28.6</td>
</tr>
<tr>
<td>Nurse Specialists</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>873</strong></td>
<td><strong>284 (32.5)</strong></td>
<td><strong>64 (7.3)</strong></td>
<td><strong>39.8</strong></td>
</tr>
</tbody>
</table>
3.1bii Response Rate By Area
The response rate by area, excluding SENCOs and social workers, is shown in Table 3.2 below (the geographical areas in which SENCOs and social workers are based do not coincide exactly with those of the PCTs). As can be seen, the greatest response rate was from the South Warwickshire area, but there were 41 (21%) respondents that did not provide sufficient information to enable identification of the location in which they worked.

Table 3.2. Response Rate by Area – all Professions except SENCOS and Social Workers

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Respondents</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Warwickshire</td>
<td>59</td>
<td>30.3</td>
</tr>
<tr>
<td>Coventry</td>
<td>52</td>
<td>26.7</td>
</tr>
<tr>
<td>North Warwickshire</td>
<td>43</td>
<td>22.1</td>
</tr>
<tr>
<td>Not stated</td>
<td>41</td>
<td>21.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>195</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 3.3 shows the response rate by area for the SENCOs. The majority (73%; n=65) of the SENCO respondents were from primary schools, with 22% (n=20) from secondary schools and 3% (n=3) from infant schools. One SENCO said that he/she was based at a primary and a secondary school.

Table 3.3. Response Rate by Area – SENCOS Only

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Respondents</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuneaton and Bedworth</td>
<td>23</td>
<td>25.8</td>
</tr>
<tr>
<td>Central</td>
<td>20</td>
<td>22.5</td>
</tr>
<tr>
<td>Eastern</td>
<td>20</td>
<td>22.5</td>
</tr>
<tr>
<td>South</td>
<td>17</td>
<td>19.1</td>
</tr>
<tr>
<td>Northern</td>
<td>9</td>
<td>10.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>89</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The distribution of responses from social workers is shown in Table 3.4. The ‘others’ category includes those who either did not answer the question or whose responses did not allow us to determine which area they were based in.

Table 3.4. Response Rate by Area: Social Workers Only

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Respondents</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuneaton and Bedworth</td>
<td>9</td>
<td>22.5</td>
</tr>
<tr>
<td>Southam, Shipston, Stratford</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Leamington and Warwick</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>North Warwickshire</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Rugby</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
3.1biii Reasons For Non-Completion

Sixty-four respondents returned the questionnaire uncompleted. Of these, 14% (n=9) were returned without comment, while 34% (n=22) explained that their job had no, or only minimal, involvement with mental health and/or with this age group. A further 19% (n=12) stated that lack of time prevented them from completing the questionnaire. Other reasons included: the target respondent had left or retired or was due to do so shortly or they were new to the role and felt unable to comment.

The most common reason given by GPs for non-completion was lack of time, cited by 37.5% (n=6), whereas the most common reason for practice nurses was that they had no, or only minimal, involvement in this area or with this age group (67%, n=14).

3.2 Findings from Key Stakeholders

The findings presented in this section are drawn from written responses to the consultation document together with the interviews undertaken with key stakeholders. Responses were coded thematically around several headings.

3.2a Relationship Between Tier 1 and CAMHS

This section presents some of the problems identified, solutions offered and examples of good practice already in operation.

A few stakeholders expressed a high level of disillusionment with the continuum of care beyond Tier 1, but this was rare. One respondent commented: “Simply gatekeepers to a service that seems small and insufficient for patient needs.”

More commonly, stakeholders recognised that specialist services had limited, over-stretched resources, but identified several key and specific problem areas. Unsurprisingly, the biggest single problem was the long waiting times for clients to be seen following referral, and the consequences of this for both the client and the Tier 1 professionals. For example, stakeholders commented:

“Professionals are often frustrated by the length of time from referral to when a child is seen when if they had support they could be working with the family.”

“Because of CAMHS waiting lists we often have to manage very complex cases which we feel would benefit from psychiatric/psychological input…the social model and the medical model do not work well together. We offer an immediate response to crisis but
have to wait months for a CAMHS response. A family in crisis often can’t wait and children come into public care as a consequence.”

“Social Workers end up managing and supporting children/young people and their families where CAMHS have been unable to offer a service or waiting lists prohibit early or intensive support.”

A lengthy wait could not only result in deterioration in the client’s situation and increase their disillusionment with the process of care, but also had implications for the Tier 1 service provider who would, of necessity, have to provide on-going care and support. Some Tier 1 professionals expressed frustration because they felt that, by the point of referral, they had exhausted their capacity to offer advice and coping strategies to the client and now required intermediate support from specialist services.

The effects of geographical variation in the availability of services were mentioned by some individuals. It was felt that such inequities constrained the ability of Tier 1 professionals to make referrals. Further, that some clients might be dissuaded from taking up services if they had to travel significant distances, particularly, if they did not have access to a car or a reliable and straightforward journey by public transport. For example, one stakeholder explained,

“Changes have revolved around geography resulting in reduced services in Rugby and young people having to go to Nuneaton. This means many do not take up services, and disadvantages those who are unwilling/unable to travel.”

Several professionals raised the thorny issue of CAMHS’ rejection of referrals. Such rejection was felt to be highly frustrating to the referring professional, causing potentially costly delay in help. It was considered that in most, but not all, such cases feedback to Tier 1 professionals occurs. Tier 1 professionals felt that the reasons for rejection need to be clearly explained and unambiguous guidance should be given on which services might be better placed to offer assistance.

Reducing inappropriate referrals was felt to require greater understanding of why they occur in the first place. Contested ground over medical and social definitions of a problem might be one possible root cause:

“We often refer to CAMHS only to be told the problem is behavioural not mental health. There appears to be very little recognition of mental health in children.”
One stakeholder also felt that there was a need to make more strenuous attempts to bridge the divide across the continuum of care and to recognise that semantic barriers could be hampering greater understanding. S/he felt that there was a need to agree on common ground and language, and not merely export linguistic terms, which are common parlance beyond Tier 1.

3.2b Support to Tier 1 Professionals.

The HAS report recommends that a primary mental health worker or similar offer support to Tier 1 professionals in their tasks and enable appropriate access to more specialised services in Tier 2 to 4 (HAS, 1995 p138).

In this study, stakeholders also gave evidence of formal and informal channels of support and advice operating between the specialist services and Tier 1. Scheduled consultation and meetings with child psychotherapists and psychologists were found to be valuable, but limited in availability. Two different approaches were identified: in the southern part of South Warwickshire a part-time Primary Mental Health Worker (PMHW) is employed, while in Coventry a Primary Mental Health Team (PMHT) has recently been appointed. Both are seeking to be both proactive as well as reactive, and to provide both training and support initiatives, which will strengthen the links across the continuum of mental health care for children and young people.

In South Warwickshire there was greater awareness amongst stakeholders about the PMHW, and individuals gave accounts of how they had benefited. However, the limited geographical scope and part-time nature of this post was seen as constraining its impact. For example, one stakeholder commented:

“Primary Mental Health Worker consultations are a very important service. Consultations with child psychotherapists are greatly appreciated by all staff, but there are very few hours of this service [available] as only two sessions per week by one therapist employed by SW NHS Trust.”

Awareness of the Coventry initiative was less apparent until the latter phases of data collection (when the PMHT had become more proactive), but respondents felt that this type of initiative was long overdue and extremely welcome.

Other approaches to cementing links and fostering understanding included the secondment of a school nurse to CAMHS on an annual basis with plans for this to be an on-going initiative, and two social workers functioning as part of a multi-disciplinary team working with CAMHS.
3.2c Support Needs of Tier 1

Stakeholders identified several areas of particular need for support:

- Advice when dealing with difficult children
- Support when families refuse specialist help.
- Telephone support/joint visits to families with complex needs
- Group based supervision
- Updates on research findings and activities (evidence based approach)

They identified that due to increasing and more complex demands being placed on Tier 1 professionals, more support is required before referral takes place. This, in conjunction with training, would enable Tier 1 staff to manage more cases in-situ. However, there was a concern that this should not legitimise an expansion of the role of Tier 1 professionals or a transfer of ‘Tier 2’ work to Tier 1. This was stated clearly by one stakeholder:

“There are issues around whether increased training will legitimise workers taking on additional roles when capacity is so limited.”

A number of solutions were offered to counter current deficiencies in support.

- More information (written/presentations) about the role of specialist services including; the types of professionals involved, types of service available, process that clients might follow
- Written protocol to describe and facilitate the process of identification, management and referral
- Telephone and face to face support
- Joint supervision, and joint visits and management
- Psychologist attached to Children’s Teams
- More information about the various roles of different Tier 1 professionals

3.2d Multi-Disciplinary Working

Examples of multi-disciplinary or skill-mix teams were much in evidence within the NHS, and there were also examples of good inter-agency working practice particularly in relation to complex cases: “Some joint working on complex families has worked well.” Examples were cited of joint-funded posts for looked after children and inter-agency support. While these were regarded as effective, a lack of resources was felt to hamper wider implementation:

“With some young people the inter-agency support has been very effective. Deficits in resources obviously hamper this.”
There was much support for improved inter-agency co-operation, and it was acknowledged that there needed to be a sharing of skills and knowledge and better understanding of the various roles undertaken by Tier 1 professionals.

“As far as social workers are concerned, I feel that there are significant knowledge gaps which only start to be filled when they begin to become more familiar with the work of, for instance, CAMHS professionals. I imagine that the latter also have some gaps in knowledge about how social workers operate.”

“Gaps are obvious in inter-professionals’ knowledge of other professionals ability i.e. does the social worker know the level at which the health visitor can provide intervention and vice versa.”

It was suggested that joint working could be strengthened by the development of joint protocols across agencies. “Eventually they might work jointly with Tier 1 staff on group work with children or families. They might help develop protocols with Social Services and Education services.”

3.2e Examples of Multi-Agency Liaison

There were numerous examples cited of liaison between agencies that occurred on a case-by-case basis. There were also examples of more strategic level liaison, which brought together health, education, social services, criminal justice and the voluntary sector. In general, wide representation on such groups was reported, but attendance could be patchy as people had numerous conflicting commitments and priorities.

The ways in which groups worked together were felt to bring greater cohesion to the care provided to individual cases. There was a feeling within Social Services that the assessment framework, in which Social Workers often took on key responsibility, had brought a cohesive framework and lessened the uncertainty around responsibility, and had also created an opportunity to liaise with other agencies.

It was evident, though, that there are still fundamental differences in understanding of the roles of other professionals and difficulties in ensuring that there is widespread acceptance of the need for such co-operation. Stakeholders recognised that the assessment framework had provided an opportunity for better liaison and formalisation, but voiced the difficulties of bringing different professional groups together:

“But obviously the assessments framework requires us to actually have information provided to us by other agencies. And I think that’s quite different for people where we
may be sending them forms to complete, and requesting reports and information. And I think it’s about what I said about the evidence based practice, and gathering knowledge from people who’ve got a specialist knowledge. So I think certainly you know, a large part of their role is co-ordination, and it’s just getting people to I suppose be involved in that process. And the thing that gets in the way a lot of the time is that other agencies have other pressures on them. So what we may be expecting to happen might not fit in with their particular timetable. So it’s very difficult if you’ve got a GP who has surgery hours, you have a teacher who’s got you know lessons to fill, a health visitor who’s got clinics. And how do you get all those people together at the same time and share the information?……And I think the other thing is as well that increasingly we are expected to meet regularly, there’s all sorts of standards and expectations on us now. And I think people’s diaries get full, and they get more choosy about which meetings they attend, and what meetings they may choose to attend might not be the ones that we choose them to attend”

In addition to increasing mutual understanding between professionals, greater inter-agency working was also recognised as enabling practitioners to develop a consistent approach to particular issues or cases:

“I do think it’s about bringing professionals together, and giving people a chance to share their experiences, and to understand each other’s roles.”

“We have to come together, don’t we? And I think it’s not just at a practitioner level, but at a manager level really, so that we’ve you know, so that we’ve got some consistency about how we want to approach these situations. And some methods of dealing with things. So I don’t think I’m just talking about practitioners, I think managers need to be involved in that as well.”

Multi-agency working does have problems, however. These were felt to reflect differing priorities, and a lack of understanding of the requirements faced by other agencies, so that it was sometimes difficult to satisfy expectations. There was also a sense that local agencies were only just beginning to realise the impact that the assessment framework would have on their work and the extent to which multi-agency liaison would be required to achieve successful co-operation:

“I think it’s because naturally each of us has our focus…… I don’t think there’s a mutual understanding of each side really. And I think, as I’ve highlighted before in child protection cases sometimes, the planning around the adult can impact fairly greatly on the child that we’re trying to protect. And a decision made by the adult mental health
team can have a huge impact on our plan. And I think particularly as well, we’ve also got the assessment framework, which is fairly new. And I’m not sure to what extent people are aware of the contribution the multi-agency contribution needs to be make.”

Multi-agency training around the assessment framework, which has already started to happen, was seen as a way of resolving some of these issues, whilst the importance of making local links and developing clear communication systems was also recognised.

3.2f Training Needs for Specific Conditions

Although stakeholders were not asked whether they felt that Tier 1 stakeholders had training needs in specific conditions, three issues were raised by several of those interviewed: drug use, domestic violence and ADHD. These issues, which were also raised by Tier 1 respondents themselves, appear to cause particular concern:

“It would also be helpful to know particularly the impact of drug use, the impact of domestic violence. I think we’ve got a broad knowledge of these things, but I think it’s an area that’s always useful to work on and know more about. I think it’s about knowing what the impact is on their parenting ability, for instance. But it’s also about knowing how is the best way to deal with that situation.”

“We do find ADHD cases a nightmare I have to say……because it’s not a clear condition, and it’s a matter of who takes responsibility for what, and how you can be most helpful. ADHD is an area that we struggle with, both in terms of how to respond, how to give the right support, and we usually end up with very costly care packages. And it’s very difficult to know how to support them. So yeah, ADHD is a really difficult area I think, and I don’t think we do know how to handle that one.”

3.2g Barriers to Training

Several barriers were identified that either prevented people from attending training or made it difficult for them to do so.

In the case of Social Services, for example, the prioritisation of training provision according to national priorities and needs determined at county level had a major impact on whether the training needs of individuals might be met. Training needs were identified through team audits, which examined the portfolio of skills available across the team, through individual supervision meetings and through team meetings. Training needs identified through Personal Annual Performance Reviews and Team Development Needs Assessments were notified to a
countywide group that reviews team training needs in the context of national priorities. There was a view that this process sometimes failed to meet training needs at an individual level:

“But the group that makes the decision will actually have a big influence on the training that we’re offered, and they’ll be looking at priorities overall. I think there is some dissatisfaction in, you know, what’s identified by the worker in conjunction with their senior, and what actually comes out on the training programme.”

Even where the training on offer is relevant to individuals’ own perceptions of need, there are still a number of factors that influence whether or not they will be permitted to attend:

“Decisions can rest on lots of factors really. It can be whether or not it’s their developmental need, whether or not it’s a team need, and whether or not we’ve got sufficient staff around as to how many people we send on a particular training. And priorities, that’s the other thing.”

The other major barrier to attending training was workload, particularly unanticipated demands. This caused difficulty for many staff even when they had booked to attend the training:

“Workload is a big issue. What generally happens with people is that with the best will in the world they want to go on training, and they’ll book the training, something will happen, and they’re not able to go.”

3.2h On the Job Training

There was evidence that learning took place opportunistically on the job, and that this type of learning was regarded as valuable. Experienced colleagues were regarded as being a particularly valuable source of information, and it was felt that agencies should facilitate their knowledge being cascaded through the organisation. This was felt to be particularly important in agencies, such as Social Services, where there is a higher staff turnover and this knowledge can be lost.

3.3 Findings from the Postal Survey

The postal survey was intended to provide mainly quantitative data, although it also provided the opportunity for open-ended responses to illustrate and explain responses.

Questionnaire data were analysed with GPs, practice nurses and school nurses being treated as discrete professional groups, while the responses from health visitors and nursery nurses were combined except for the final section where changes to the health-visiting role are discussed. Responses from social workers and senior social workers are combined, together
with one response from a group of social workers who submitted this in preference to individual questionnaires. The responses from SENCOs are combined with those who said that their primary role was teacher, headteacher or deputy headteacher and their secondary role was SENCO. The responses from LABS, DISCS, PRU and community paediatricians have not been included because the level of response precluded meaningful quantitative analysis.

All quotes used are attributed only to the professional group for reasons of confidentiality. The acronyms used are:
GP – General practitioner
PN – Practice nurse
HV – Health visitor
SN – School nurse
SW – Social worker
SEN – Special educational needs co-ordinator

3.3a. Current Role
3.3ai Current Roles and Responsibilities
The majority of respondents (67%) had been in their current role for five years or more, with 45% having been in this role for over ten years. GPs tended to be the longest serving professionals, with 71% (n=25) stating that they had been working in this role for ten years or more, whereas SWs tended to have been in their current role for shorter periods of time with 63% (n=20) reporting this to be less than five years.

3.3aii Involvement with CAMH Problems
Just over two-thirds (68%) of respondents said that child or adolescent mental health difficulties formed 20% or less of their workload, including 8% (n=20) who said that dealing with children and adolescents with mental health difficulties formed no part of their workload. There were, however, significant differences between the professional groups (Chart 3.1). Overall, practice nurses and GPs reported this to be only a very small proportion of their work.
3.3a Involvement with Children/Adolescents with Common Mental Health Conditions

Most respondents reported that their work included patients/clients with behavioural problems (90%), family relationship difficulties (82%) and developmental disorders to include autistic spectrum disorders (80%), although practice nurses reported this less frequently than did other groups which accords with their less frequent involvement with mental health issues generally. Fewer respondents reported that they encountered significant self-harm (27%) and severe mental illness (26%). Chart 3.2 shows the proportions of each professional group who said that they encountered the three most common conditions reported.

We also asked about the frequency with which a range of conditions are encountered. The condition that was encountered most frequently was behavioural problems, with 55% (n=155) reporting that they encountered this problem 17 times or more per year.

Conversely, a number of conditions were rarely encountered. Over fifty percent of respondents said that they either did not encounter the following conditions or encountered them fewer than five times per year. These conditions were:

- sleep difficulties,
- attachment difficulties,
- bereavement or loss, eating problems,
• toileting problems,
• emotional aspects of child abuse
• developmental disorders

3.3b Changes in Workload associated with CAMH problems

3.3bi Changes to the Amount of Workload

As Table 3.5 shows, approximately half (49.5%) of respondents reported that their workload had increased during the last five years (or whilst they had been in post, if less than five years). A similar proportion reported that their workload had stayed about the same. Only 1% reported that their workload had decreased.

The majority of school nurses (80%) and over half of SENCOs (59%) reported increases in their workload. Conversely this was only reported by 14% of practice nurses.

Respondents from South Warwickshire were slightly more likely to say that their workload had increased: 47.5%, compared to 44% from Coventry and 39% from North Warwickshire. In the case of SENCOs, about two-thirds of respondents from the South area (65%) and Nuneaton and Bedworth (65%) reported increasing workload, compared to 55% from the Central area and 50% from the Eastern area.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Nurse</td>
<td>5 (14)</td>
</tr>
<tr>
<td>Social Workers</td>
<td>17 (42)</td>
</tr>
<tr>
<td>Health Visitor and Nursery Nurse</td>
<td>33 (51)</td>
</tr>
<tr>
<td>GP</td>
<td>18 (51)</td>
</tr>
<tr>
<td>SENCO</td>
<td>34 (59)</td>
</tr>
<tr>
<td>School Nurse</td>
<td>12 (80)</td>
</tr>
</tbody>
</table>

3.3bii Reasons for the Changes in the Amount of Workload

Forty-eight percent (n=136) provided reasons for the changes that they have experienced in the amount of their CAMH workload. We categorised these as actual, artefactual and situational change. Actual change refers to a real increase in workload due to an increased number of cases; artefactual change refers to changes resulting from increased awareness of conditions, services or need; and situational changes are those brought about by changes to the professional role as a consequence of national policy, increased formalisation of systems and changes in job, workload, responsibility or skill-mix.
The reasons given for changes in the amount of workload were fairly evenly distributed between these three categories.

- Thirty-eight percent of comments concerned actual change, with the majority of comments concerning increases in the numbers of young people or children with mental health problems; for example:
  ‘Children/young people have greater emotional/behavioural problems…families present as being under more pressure’\textsuperscript{SW}.

- Thirty-two per cent of comments suggested artefactual change, with most comments concerning increased awareness of CAMH problems, increased identification and increased referral; for example:
  ‘Perhaps we have become increasingly aware of problems’\textsuperscript{SEN}.

- Thirty per cent of comments concerned situational change, with most comments concerning changes in the job, workload, responsibility, skill mix or experience; for example:
  ‘I’m expected to take a lot more on board with no training. Suddenly it’s all part of my job’\textsuperscript{SEN}.

3.3biii Reasons for Changes in the Nature of the Workload

Forty-two percent (n=120) of respondents stated a reason for changes to the nature of their workload. Again, we categorised the responses as; actual, artefactual and situational change. This time, the explanations were largely due to actual change and situational change.

- Thirty-nine percent of the comments concerned actual change with the majority of comments concerning increases in the number of problems arising; for example:
  ‘More children living in dysfunctional families bringing their problems/needs to school. More dysfunctional families in which parents have difficulties and the parents bring their problems into school to be discussed’\textsuperscript{SEN}.

- Fifteen percent of comments suggested artefactual change, with most comments concerning increased awareness of problems, increased identification and referral; for example:
  ‘More recognition of emotional problems in young people, so provision has altered to suit this’\textsuperscript{SEN}.

- Forty-six percent of comments concerned situational change, with most comments concerning changes in job, responsibility, workload, skill mix or experience; for example:
  ‘Role extended e.g. I counsel and support children, I attend professional meetings concerning some children, I attend conferences/training sessions related to difficulties experienced by some children’\textsuperscript{SEN}.
3.3c Confidence to Identify, Manage and Refer a Range of CAMH Conditions

3.3ci Confidence in Ability to Identify a Range of CAMH Conditions

The questionnaire asked practitioners about their confidence to identify a range of common CAMH difficulties. Early onset phobia emerged as the condition for which there was the lowest level of confidence, with 57% having either ‘no confidence’ or only ‘limited confidence’ in being able to identify it, compared to only 9% who expressed this low level of confidence in respect of behavioural problems. There were nine conditions identified for which at least a third of respondents said that they had ‘no confidence’ or only ‘limited confidence.’ This is shown in Table 3.6.

Table 3.6. Lack of Confidence to Identify Common Mental Health Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number (%) respondents stating ‘no confidence’ or only ‘limited confidence’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early onset phobia</td>
<td>161 (56.7)</td>
</tr>
<tr>
<td>Solvent/alcohol/drug abuse</td>
<td>152 (53.5)</td>
</tr>
<tr>
<td>Emotional problems presenting with physical symptoms</td>
<td>138 (48.6)</td>
</tr>
<tr>
<td>Minor self-harm</td>
<td>127 (44.7)</td>
</tr>
<tr>
<td>Eating problems</td>
<td>109 (38.4)</td>
</tr>
<tr>
<td>Attachment Difficulties</td>
<td>98 (34.5)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>97 (34.2)</td>
</tr>
<tr>
<td>Low mood/depression</td>
<td>95 (33.5)</td>
</tr>
<tr>
<td>Emotional aspects of child protection</td>
<td>95 (33.5)</td>
</tr>
<tr>
<td>School related difficulties</td>
<td>91 (32.0)</td>
</tr>
<tr>
<td>Toileting difficulties</td>
<td>77 (27.1)</td>
</tr>
<tr>
<td>Family relationship difficulties</td>
<td>65 (22.9)</td>
</tr>
<tr>
<td>Sleep Difficulties</td>
<td>62 (21.8)</td>
</tr>
<tr>
<td>Bereavement/loss/family break-up</td>
<td>60 (21.1)</td>
</tr>
<tr>
<td>Behavioural problems</td>
<td>25 (8.8)</td>
</tr>
</tbody>
</table>

3.3cii Confidence of Different Disciplines to Identify Common CAMH Conditions

Levels of confidence in respondents’ ability to identify CAMH problems varied between professional groups and by condition. Overall, school nurses and social workers tended to be fairly confident for the four conditions shown in Chart 3.3. In part, this can be explained by the age distribution of the patient/client groups that the different professional groups commonly work with.
3.3ciii Confidence to Manage a Range of CAMH Conditions

As with their confidence to identify CAMH problems, respondents varied in their confidence to manage these conditions, with at one extreme 52% saying that they had either ‘no confidence’ or only ‘limited confidence’ to manage drug, solvent or alcohol abuse whereas only 16% expressed low levels of confidence to manage behavioural problems (Table 3.7). Over a third of respondents said that they had ‘no confidence’ or ‘only limited confidence’ to manage nine of the conditions listed.

**Table 3.7. Lack of Confidence in Managing CAMH Conditions**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number (%) saying they have either ‘no confidence’ or only ‘limited confidence’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solvent/alcohol/drug abuse</td>
<td>148 (52.1)</td>
</tr>
<tr>
<td>Minor self-harm</td>
<td>140 (49.3)</td>
</tr>
<tr>
<td>Early onset phobia</td>
<td>140 (49.3)</td>
</tr>
<tr>
<td>Emotional problems presenting with physical symptoms</td>
<td>130 (45.8)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>124 (43.7)</td>
</tr>
<tr>
<td>Eating problems</td>
<td>118 (41.5)</td>
</tr>
<tr>
<td>Emotional aspects of child protection</td>
<td>109 (38.4)</td>
</tr>
<tr>
<td>Low mood/depression</td>
<td>106 (37.3)</td>
</tr>
<tr>
<td>Bereavement/loss/family break-up</td>
<td>99 (34.9)</td>
</tr>
<tr>
<td>Attachment Difficulties</td>
<td>97 (34.2)</td>
</tr>
<tr>
<td>Family relationship difficulties</td>
<td>92 (32.4)</td>
</tr>
<tr>
<td>Toileting difficulties</td>
<td>89 (31.3)</td>
</tr>
<tr>
<td>School related difficulties</td>
<td>88 (31)</td>
</tr>
<tr>
<td>Sleep Difficulties</td>
<td>81 (28.5)</td>
</tr>
<tr>
<td>Behavioural problems</td>
<td>45 (15.8)</td>
</tr>
</tbody>
</table>
3.3civ Confidence of Different Professional Groups to Manage CAMH Conditions

Chart 3.4 illustrates the extent to which different professional groups lack confidence to manage some specific CAMH conditions. Overall GPs expressed the lowest levels of confidence. Fewer practice nurses expressed low levels of confidence to manage these conditions, but this may be because they are not expected to manage these conditions and would normally refer them to the GP.

3.3cv Confidence to Refer Common CAMH Conditions

Confidence to refer common CAMH problems to other Tier 1 professionals or to more specialised services was greater than for either identification or management of such problems. Less than one-third of the respondents said that they had either ‘no confidence’ or only ‘limited confidence’ to refer conditions, and there was very little difference in the proportion of respondents expressing low levels of confidence to refer to Tier 1 or to more specialised services (Table 3.8).

Table 3.8. Confidence to Refer Common Mental Health Conditions to other Tier 1 Professionals or to more Specialised Services.

<table>
<thead>
<tr>
<th>Conditions</th>
<th>No confidence or limited confidence to refer to Tier 1</th>
<th>No confidence or limited confidence to refer to more specialised services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural problems</td>
<td>Number (10.9)</td>
<td>45 (15.8)</td>
</tr>
<tr>
<td>Sleep Difficulties</td>
<td>48 (16.9)</td>
<td>56 (19.7)</td>
</tr>
<tr>
<td>Attachment Difficulties</td>
<td>65 (22.9)</td>
<td>70 (24.6)</td>
</tr>
<tr>
<td>Family relationship difficulties</td>
<td>58 (20.4)</td>
<td>65 (22.9)</td>
</tr>
<tr>
<td>Low mood/depression</td>
<td>63 (22.2)</td>
<td>66 (23.2)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>69 (24.3)</td>
<td>72 (25.4)</td>
</tr>
<tr>
<td>Bereavement/loss/family break-up</td>
<td>62 (21.8)</td>
<td>65 (22.9)</td>
</tr>
<tr>
<td>Minor self-harm</td>
<td>87 (30.6)</td>
<td>79 (27.8)</td>
</tr>
<tr>
<td>Early onset phobia</td>
<td>85 (29.9)</td>
<td>80 (28.2)</td>
</tr>
<tr>
<td>Eating problems</td>
<td>78 (27.5)</td>
<td>84 (29.6)</td>
</tr>
<tr>
<td>Toileting difficulties</td>
<td>56 (19.7)</td>
<td>56 (19.7)</td>
</tr>
<tr>
<td>Emotional aspects of child protection</td>
<td>61 (21.5)</td>
<td>67 (23.8)</td>
</tr>
<tr>
<td>Solvent/alcohol/drug abuse</td>
<td>82 (28.9)</td>
<td>71 (25)</td>
</tr>
<tr>
<td>School related difficulties</td>
<td>56 (19.7)</td>
<td>55 (19.4)</td>
</tr>
<tr>
<td>Emotional aspects presenting with physical symptoms</td>
<td>83 (29.2)</td>
<td>81 (28.5)</td>
</tr>
</tbody>
</table>
3.3cvi. Confidence to Refer According to Length of Time in Current Role.

There was little difference in the responses of those with less than five years experience compared to those with greater years’ experience in their confidence to refer to other Tier 1 professionals or to more specialised services.

For referring to other Tier 1 professionals, the only exception was for referring eating problems to other Tier 1 professionals. For this condition, 35% (n=33) of those with less than five years experience said that they had ‘no confidence’ or only ‘limited confidence’ to refer, compared with 24% (n=45) of those with five years experience or more.

There were greater differences in the responses made concerning referrals to more specialised services. For all conditions listed in the questionnaire, those with less than five years experience were more likely to state that they had ‘no confidence’ or only ‘limited confidence’ to refer to specialist services compared to those with five years experience or more. Over 35% of those with less than five years experience expressed low levels of confidence to refer minor self-harm, early onset phobia, eating problems and the emotional aspects of child protection to more specialised services (Chart 3.5).

![Chart 3.5 Lack of confidence to refer to specialist services according to length of time in role](chart3.5.png)

3.3cvii Confidence to Refer Specific Conditions Requiring Specialist Services

To further examine the confidence of practitioners to refer to the specialist services, they were asked to state how confident they felt to refer in an appropriate and timely fashion clients suffering from acute distress, significant self-harm, severe mental illness and developmental disorders, including autistic spectrum disorders (Table 3.9). Over a quarter of respondents
stated that they had either ‘no confidence’ or only ‘limited confidence’ to refer clients with any of the four conditions. A third of respondents stated that they had either ‘no confidence’ or only ‘limited confidence’ to refer clients in acutely distressed states.

Table 3.9. Respondents who replied that they had either ‘No Confidence’ or only ‘Limited Confidence’ to Refer Clients with More Serious Mental Health Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acutely distressed states</td>
<td>92 (33.4)</td>
</tr>
<tr>
<td>Significant self-harm</td>
<td>82 (29.9)</td>
</tr>
<tr>
<td>Severe mental illness</td>
<td>83 (29.2)</td>
</tr>
<tr>
<td>Developmental disorders, including autistic spectrum disorders</td>
<td>73 (26.4)</td>
</tr>
</tbody>
</table>

We examined these responses by area. For SENCOs, while there were some differences between the areas, no clear pattern emerged that would indicate that SENCOs in one area were any less confident than those from other areas (Table 3.10).

Table 3.10. Proportions of SENCOs stating ‘No Confidence’ or only ‘Limited Confidence’ to Refer Clients with More Serious CAMH Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Central %</th>
<th>Eastern %</th>
<th>Northern %</th>
<th>Nuneaton and Bedworth %</th>
<th>South %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acutely distressed states</td>
<td>55</td>
<td>35</td>
<td>22</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Significant self-harm</td>
<td>40</td>
<td>35</td>
<td>44</td>
<td>39</td>
<td>35</td>
</tr>
<tr>
<td>Severe mental illness</td>
<td>45</td>
<td>35</td>
<td>44</td>
<td>39</td>
<td>29</td>
</tr>
<tr>
<td>Developmental disorders to include autistic spectrum disorders</td>
<td>25</td>
<td>20</td>
<td>33</td>
<td>35</td>
<td>24</td>
</tr>
</tbody>
</table>

For other health professionals (i.e excluding social workers\(^1\) and SENCOs), there was a trend for respondents from the South Warwickshire area to state that they had either ‘no confidence’ or only ‘limited confidence’ to refer (Table 3.11). These differences, however, are not significant statistically, that is they could be attributed to chance.

\(^1\) We have been unable to compare the responses made by social workers from the different areas because the number of respondents in each area was too small to allow meaningful analysis.
Table 3.11. Proportion of Health Professionals (excluding SENCOs and social workers) stating ‘No Confidence’ or only ‘Limited Confidence’ to Refer Clients with More Serious CAMH Conditions

<table>
<thead>
<tr>
<th>Condition/percentages</th>
<th>South Warwickshire</th>
<th>North Warwickshire</th>
<th>Coventry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acutely distressed states</td>
<td>39</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>Significant self-harm</td>
<td>32</td>
<td>28</td>
<td>17</td>
</tr>
<tr>
<td>Severe mental illness</td>
<td>34</td>
<td>23</td>
<td>17</td>
</tr>
<tr>
<td>Developmental disorders, including autistic spectrum disorders</td>
<td>22</td>
<td>21</td>
<td>25</td>
</tr>
</tbody>
</table>

3.3cvii Summary: Overall Confidence to Identify, Manage or Refer CAMH Difficulties

The findings discussed in this section show that many practitioners lack confidence to work effectively with children and adolescents with mental health problems. In particular, there is concern about their ability to identify and manage a range of common mental health conditions. The main points are:

- Over half of all respondents said that they had ‘no confidence’ or only ‘limited confidence’ to identify early onset phobia and solvent, alcohol or drug abuse.
- Over a third of respondents had little confidence to identify a range of other common mental health conditions.
- Overall, school nurses and social workers tended to be more confident than SENCOs, GPs, health visitors and nursery nurses to identify a range of mental health conditions.
- Over half of all respondents said that they had ‘no confidence’ or only ‘limited confidence’ to manage solvent, alcohol or drug abuse, and over a third of respondents had little confidence to manage a range of other mental health conditions.
- GPs expressed less confidence to manage a range of mental health conditions than the other disciplines.
- Respondents were generally more confident to refer to other Tier 1 professionals or to more specialised services than they were to identify or manage mental health conditions.
- There was generally little difference between the confidence levels of respondents with more than five years experience and those with less experience, when referring to other Tier 1 professionals. There was one exception, however; in the case of referring eating problems to other Tier 1 professionals less experienced staff were more likely than their more experienced colleagues to say that they had little confidence to refer this condition.
- For referrals to more specialised services, respondents with less than five years experience expressed lower levels of confidence than their more experienced colleagues. Over a third of respondents with less than five years experience lacked
confidence to refer minor self-harm, early onset phobia, eating problems and the emotional aspects of child protection to more specialised services.

- Over a quarter of respondents lacked confidence to refer clients suffering from acute distress, significant self-harm, severe mental illness or developmental disorders.

3.3d Referral
3.3di Understanding and Awareness of the Referral Process
Practitioners were asked whether they needed to increase their understanding of various aspects of the referral process. The questions asked whether they needed to increase their understanding of the specialist services to which they can refer, of which cases are appropriate for referral, and their awareness of the referral process. Over two-thirds of respondents agreed that they needed to increase their knowledge concerning each of these aspects of referral, in particular to increase their knowledge of the availability of specialist services (Table 3.12).

Table 3.12. Stated need to Increase Awareness or Understanding of Different Aspects of Referral Process

<table>
<thead>
<tr>
<th>Number (%) stating a need to increase their understanding or awareness of…</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>…the specialist services to whom you can refer</td>
<td>232 (81.7)</td>
</tr>
<tr>
<td>…which cases are appropriate for referral</td>
<td>198 (69.7)</td>
</tr>
<tr>
<td>…the referral process</td>
<td>195 (68.7)</td>
</tr>
</tbody>
</table>

3.3dii Understanding and Awareness of Different Aspects of Referral of Different Disciplines
The professionals most likely to say that they needed to increase their awareness of which cases were appropriate for referral were health visitors and nursery nurses (80%) and SENCOs (85%), whereas this was said by only 46% of GPs. All the school nurses and 95% of the social workers said that they needed to increase their awareness of the specialist services to which they could refer, compared to 67% of practice nurses and 69% of GPs. Seventy-five per cent of health visitors and 81% of SENCOs said that they needed to increase their awareness of the referral system whereas only 47% of school nurses and 54% of GPs said this. This is shown in Chart 3.6.
3.3diii Difficulties in Making Referrals

Respondents reported various difficulties experienced in referring children and adolescents to the specialist services.

The most common criticism was of the long waiting list for cases referred to specialists, which was cited by 56% of respondents (n=160). This was reinforced by comments made, for example:

“OK when they actually get seen but waiting times can be interminable, i.e. 30 weeks” \(^{GP}\)

Thirty-five per cent of respondents (n=101) said that they did not always know who to refer to. The main groups to state this difficulty were SENCOs (38% of comments) and health visitors and nursery nurses (23%). Typical of comments made was:

“The system of referral is confused-some can be made directly and some through GPs etc” \(^{SENCO}\)

Eighteen percent of respondents (n=51) said that there was not an appropriate specialist in their locality. These criticisms came mainly from social workers (26%), GPs (25%) and SENCOs (22%).

Fifteen per cent (n=42) also said that they did not know how to refer to the specialist services. This was said by 36% of SENCOs and by 19% of social workers.

Other difficulties referred to poor communication of the agreed package of care for referred cases, and referrals being passed from one agency to another. Some comments concerned difficulties in knowing which services to access or the specialist’s criteria for accepting cases and the need for more and up to date information on the services available; for example
"Other professionals who know less about the child than I seem able to block any referral I might make." - SENCO

3.3e Professional Training

3.3ei Effectiveness of Professional Qualifying Training to prepare practitioners for the Management of CAMH Conditions

Respondents were asked whether they felt that their professional qualifying training enabled them to recognise and manage common CAMH difficulties and to refer them to other Tier 1 or more specialist services as appropriate.

Only 40% of respondents felt that their professional qualifying training enabled them to recognise common mental health problems in children and adolescents. Just over a quarter of respondents (26%) felt that it had enabled them to manage these problems. Just over half of respondents (53%) felt that it had prepared them to refer to other Tier 1 services, and 44% that it had prepared them to refer to more specialist services. The responses indicate a clear sense that many practitioners did not feel that their vocational training had adequately prepared them for CAMH (Table 3.13).

Table 3.13 Respondents Views about the extent to which their Professional Qualifying Training had prepared them for a role in CAMH

<table>
<thead>
<tr>
<th>Did you feel that your professional qualifying training enabled you to..</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
<th>Did not answer the question</th>
</tr>
</thead>
<tbody>
<tr>
<td>...recognise a range of common child/adolescent mental health difficulties?</td>
<td>45.4</td>
<td>40.5</td>
<td>9.5</td>
<td>4.6</td>
</tr>
<tr>
<td>...manage a range of common child/adolescent mental health difficulties?</td>
<td>57.4</td>
<td>26.1</td>
<td>11.6</td>
<td>4.9</td>
</tr>
<tr>
<td>...refer children/adolescents with common mental health difficulties to other Tier 1 services?</td>
<td>33.1</td>
<td>53.2</td>
<td>9.2</td>
<td>4.6</td>
</tr>
<tr>
<td>...refer children/adolescents with common mental health difficulties to other specialist services?</td>
<td>39.4</td>
<td>44.4</td>
<td>10.9</td>
<td>5.3</td>
</tr>
</tbody>
</table>
Social workers (57%), SENCOs (56%) and practice nurses (50%) were most likely to say that their training did not enable them to recognise common mental health problems. Perhaps surprisingly, just over one-third of GPs (34%) also said this.

On the question of managing common CAMH difficulties, 77% of social workers and over half of SENCOs (60%), practice nurses (56%), school nurses (53%) and GPs (51%) reported that their training had not prepared them to manage this work.

On the issue of referring to other Tier 1 services, most professionals expressed confidence that their professional training had prepared them to do this. Seventy-one percent of GPs, 69% of social workers, 68% of health visitors and nursery nurses and 60% of school nurses said that they felt confident to do this. Forty-nine per cent of SENCOs, however, were not confident about referring to other Tier 1 services.

In the case of referring to more specialist services, training was felt to have been adequate amongst school nurses (67%), GPs, (66%) and social workers (66%), but 55% of SENCOs did not think that their training had prepared them for this.

3.3eii Ways in which training could be improved

Many comments were made about the reasons why practitioners felt that their vocational training had been inadequate and suggestions for its improvement. Just under one-third (32%) of comments (n=75) concerned a lack of formal training or that training had not provided specialist assessment or clinical skills. Many stated that experience and support from colleagues had been more useful than their initial training.

Eighteen per cent of comments (n=43) concerned problems associated with the training delivery, for example that teaching was too rushed; lacked sufficient detail or depth; was too theoretical; lacked adequate practical experience or clinical practice and needed regular updates.

Seventeen percent of comments (n=40) concerned inadequate training on recognition of mental health problems in young people, together with the risks of attempting to manage cases without having had adequate training.

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2 Note that respondents could make any number of comments
A further 14% of comments (n=32) stated that their training had been a long time ago, and that it was either now out of date or their role had now changed.

Respondents’ comments suggested a number of ways in which vocational training might be improved.

- Formal training on mental health issues in general, and CAMH in particular, needs to be included in the vocational training of all practitioners who will encounter this in their workload.
- Formal training should include skills on the identification of mental health problems in young people and the management of these problems.
- Training delivery should be considered, with more time devoted to this area to enable it to be studied in sufficient depth.
- Training needs to be practical as well as theoretical, perhaps through mental health placements or the use of case studies.
- Regular updates might be provided.

3.3f Support and Advice from other Staff

3.3fi Support and Advice from Staff Within the Organisation:
Respondents were asked to indicate whether there were any staff within their own organisation to whom they could turn for advice, support or consultation without necessarily making a referral. Seventy percent of respondents (n=200) said that there were such staff within their own organisation. Ninety-four percent of health visitors and nursery nurses, 87% of school nurses and 81% of practice nurses said this compared to only 53% of social workers and 54% of GPs.

3.3fii Support and Advice from Staff Beyond their own Organisation:
Sixty-four percent of respondents (n=182) said that there were staff beyond their own organisation to whom they could turn for advice, support or consultation without necessarily making a referral. Eighty-two per cent of SENCOs and 75% of social workers said this. The staff that were most commonly named as being available for advice, support and consultation were psychologists, LABS/DISCS and social workers.

3.3fiii Support and Advice from Staff Within and Beyond their own Organisation
Some respondents, however, appeared to be confused as to which staff were within their organisation and which staff were beyond it. Combining responses to both questions indicated that the staff most commonly named as being available for advice, support or
consultation, whether within or beyond their organisation, were psychologists, CAMHS, CPN and health visitors (Table 3.14).

Table 3.14. Professional Staff who could be Approached for Advice, Support or Consultation without Necessarily making a Referral.

<table>
<thead>
<tr>
<th>Staff seen as available to offer advice or support</th>
<th>Number (%) of respondents stating that these staff would be helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists/CAMHS/CPN</td>
<td>163 (57.4)</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>59 (20.8)</td>
</tr>
<tr>
<td>GP</td>
<td>51 (17.9)</td>
</tr>
<tr>
<td>DISCS/LABS</td>
<td>50 (17.6)</td>
</tr>
<tr>
<td>Social Workers</td>
<td>41 (14.4)</td>
</tr>
</tbody>
</table>

Comparing the responses obtained from the different areas suggested that SENCOs from Central, Northern, Nuneaton & Bedworth and the South were most likely to ask DISCS/LABS and psychologists for advice and support, whereas SENCOs from the Eastern region were most likely to say that they would ask DISCS/LABS for support (Table 3.15).

Table 3.15. Professional Staff who could be Approached for Advice, Support or Consultation without Necessarily making a Referral. (SENCOs only, by area)

<table>
<thead>
<tr>
<th>Staff most commonly seen as available to offer advice or support</th>
<th>Number (%) of SENCOs stating that these staff would be helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Central (%)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>8 (38.1)</td>
</tr>
<tr>
<td>DISCS/LABS</td>
<td>7 (33.3)</td>
</tr>
<tr>
<td>Headteacher/Deputy Headteacher</td>
<td>4 (19)</td>
</tr>
<tr>
<td>School Nurse</td>
<td>2 (9.6)</td>
</tr>
<tr>
<td>Total</td>
<td>21 (100%)</td>
</tr>
</tbody>
</table>

Health professionals (i.e. excluding social workers and SENCOs) from all three PCT areas were most likely to call upon CAMHS, psychologists or CPNs for advice or support. Health

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Note that respondents could make any number of responses to these questions
professionals in South and North Warwickshire were also likely to use health visitors for support and advice whereas health practitioners in Coventry said that they would use a GP (Table 3.16).

**Table 3.16. Health Practitioners who could be Approached for Advice, Support or Consultation without Necessarily making a Referral. (excluding SENCOs and social workers)**

<table>
<thead>
<tr>
<th>Staff most commonly seen as available to offer advice or support</th>
<th>Health professionals from each PCT area stating that these staff would be helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>South Warwickshire</td>
</tr>
<tr>
<td>Psychologists /CAMHS/CPN</td>
<td>No. (%)</td>
</tr>
<tr>
<td>28 (38.4)</td>
<td>29 (43.3)</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>22 (30.1)</td>
</tr>
<tr>
<td>GP</td>
<td>13 (17.8)</td>
</tr>
<tr>
<td>Social Workers</td>
<td>10 (13.7)</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
</tr>
</tbody>
</table>

**3.3g Training Needs**

**3.3gi Most Commonly Identified Training Needs**

Respondents were asked to identify their training needs from a list of possible options. The most common training needs selected were *anxiety management* (66%); *understanding availability of help and support for families* (60%) and *team working with other agencies and role clarification* (55%) (Chart 3.7).

There were some differences between professional groups in the importance placed on different training needs. A greater proportion of SENCOs stated that they needed training in the use of referral guidelines to other Tier 1 services (69%), understanding the availability of help and support for families (72%) and team working with other agencies and role clarification (69%) than the other professional groups. GPs were the group who said that they were most in need of training in behaviour management (69%). A high proportion of all the disciplines except GPs and Practice nurses stated that they needed training in anxiety management (Chart 3.8).
SENCOs from the central area were more likely than those from other areas to state that they needed training in the use of referral guidelines to other Tier 1 services (85%) and understanding the availability of help and support for families (80%), but they were the least likely to say that they needed training in behaviour management. SENCOs from the Northern area were most likely to say that they needed training in behaviour management (67%) (Chart 3.9).
There was little difference in the perceptions of training needs from the three PCT areas, with the exception of team working. Only 39.5% of respondents from the North Warwickshire area stated that they needed training in team working with other agencies and role clarification compared to 59.3% of respondents from South Warwickshire PCT (Chart 3.10).

3.3gii Other Training Needs Suggested by Respondents
Respondents identified a number of other training needs, the most commonly stated being ADHD (10%), self-harm (10%), and school-related difficulties (6%). A further 7% of comments requested support, training and updates with all aspects of mental health. The training needs suggested by the different professional groups are shown in Table 3.17).
Table 3.17. Additional Training Needs suggested by the Different Professional Groups (Number of respondents)

<table>
<thead>
<tr>
<th></th>
<th>ADHD</th>
<th>Self-Harm</th>
<th>School Difficulties</th>
<th>All Aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Visitor and Nursery Nurse</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>School Nurse</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Social Workers</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>SENCOs</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Teacher/ESW</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11</td>
<td>10</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

3.3giii Amount of Training Need

Many respondents identified more than one training need, with 32% (n=92) identifying between one and three needs and 60% (n=170) identifying four or more training needs, while only 7.7% (n=22) did not indicate a training need or did not answer these questions (Table 3.18).

Table 3.18. Number of Training Needs Identified by Respondents

<table>
<thead>
<tr>
<th>Number of training needs identified</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to three</td>
<td>92 (32.4)</td>
</tr>
<tr>
<td>Four to six</td>
<td>94 (33.1)</td>
</tr>
<tr>
<td>Seven to nine</td>
<td>55 (19.4)</td>
</tr>
<tr>
<td>Ten or more</td>
<td>21 (7.4)</td>
</tr>
<tr>
<td>None/did not answer the question</td>
<td>22 (7.7)</td>
</tr>
</tbody>
</table>

3.3giv Number of Training Needs Identified by Professional Group

Health visitors and nursery nurses, school nurses, social workers and SENCOs identified the greatest number of training needs (Table 3.19).

Table 3.19. Number of training needs Identified by Different Professional Group

<table>
<thead>
<tr>
<th>Percentage from each profession stating training needs</th>
<th>One to Three</th>
<th>Four or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>42.9</td>
<td>45.7</td>
</tr>
<tr>
<td>Practice Nurses</td>
<td>25</td>
<td>52.9</td>
</tr>
<tr>
<td>Health Visitor and Nursery Nurses</td>
<td>29.2</td>
<td>66.2</td>
</tr>
<tr>
<td>School Nurses</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>Social Workers</td>
<td>32.5</td>
<td>60</td>
</tr>
<tr>
<td>SENCOs</td>
<td>30.8</td>
<td>66.7</td>
</tr>
</tbody>
</table>
3.3gv Training Needed to Better Manage Common CAMH Difficulties

When asked whether there were any areas of training needed to enable better management of common CAMH difficulties, 22% of the comments (n=40) concerned the identification or management of mental health problems and the need for greater understanding of the services provided, 11% (n=20) with the identification and management of anxiety, depression and distress, 5.5% (n=10) with keeping up to date with current/best practice, 5.5% (n=10) with EBD work and 5.5% (n=10) with helping parents to either manage their children or to cope whilst they were on the waiting list.

3.3gvi Training Needs that were seen as Most Important

Respondents were asked to identify their three most important training or support needs and to state why these were important. The two most commonly identified training and support need were in understanding CAMH conditions generally (17% of comments) and understanding the role of CAMHS, the referral process and the services available (16% of comments). A further 6% of comments related to EBDS, 5% to supporting parents, carers and families and 5% to interagency work and communication.

The reasons most commonly stated were that more CAMH problems now arise (20.5% of comments); the need to understand the role of others, the referral process and to identify those who can be approached for assistance or joint working/discussions (19%); and for professional development and to increase knowledge and understanding (20%). A further 14% of comments concerned the need for more effective working. These reasons were stated by a greater proportion of SENCOs, health visitors and nursery nurses than by other professional groups.

Health visitors and nursery nurses were the more likely than other groups to say that they needed training in all aspects of mental health issues generally and mental health in children in particular, behavioural difficulties/EBDS and inter-agency work and communication. This group, social workers and SENCOs were also likely to say that they needed support for parents, carers and families. SENCOs were most likely to say that they needed to understand the role of CAMHS, the referral process and the services available. This is shown in Chart 3.11. (Note that for clarity, only selected professional groups and the most common responses are shown)
3.3gvii Main Training Needs Identified for each Discipline

The table below is included in order to provide a simplified way of reporting the main training needs identified by Tier 1 professionals from different disciplines. Table 3.20 below shows the main training needs identified by each discipline. It indicates that SENCOS have a wider range of training needs than all the other disciplines, but GPs, nursery nurses, health visitors and social workers also had a wide range of training needs.
Table 3.20 Main Training Needs Identified for each Discipline. This table only shows a training need where 50% or more of the particular discipline have stated a need or a lack of confidence to deal with the problem

<table>
<thead>
<tr>
<th>Training needed to..</th>
<th>GP</th>
<th>PN</th>
<th>NN</th>
<th>HV</th>
<th>SN</th>
<th>SW</th>
<th>SENCO</th>
</tr>
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<td>identify minor self-harm</td>
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<td>identify emotional aspects of child protection</td>
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<td>identify, drug, solvent and alcohol abuse</td>
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<td>manage minor self-harm</td>
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<td>manage eating problems</td>
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<td>manage emotional aspects of child protection</td>
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<td>manage drug, solvent and alcohol abuse</td>
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<td>Increase awareness or understanding of which cases are appropriate for referral</td>
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<td>Increase awareness/understanding of the specialist services to which they can refer</td>
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<td>Increase awareness or understanding of the referral process</td>
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<td>Use of referral guidelines</td>
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Table 3.21 below shows the main training needs identified by SENCOs. There are little differences in the training needs identified by SENCOs from each area although over 50% of SENCOs from the Northern area identified a need for training in behaviour management. Over half of SENCOs from all areas except the South, indicated a need to training in the use of referral guidelines.

**Table 3.21 Main Training Needs Identified for SENCOs from each Area.** This table only shows a training need where 50% or more have stated a need for training.

<table>
<thead>
<tr>
<th></th>
<th>Central</th>
<th>Eastern</th>
<th>Northern</th>
<th>Nuneaton and Bedworth</th>
<th>South</th>
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<tbody>
<tr>
<td>Use of referral guidelines</td>
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<tr>
<td>Understanding family support</td>
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<tr>
<td>Team working</td>
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<td>Behaviour management</td>
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<td>Anxiety management</td>
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Table 3.22 below shows the main training needs for health professionals from the three PCTs. Over 50% of respondents from Coventry indicated a need for training in the use of referral guidelines and behaviour management; whereas over 50% from North Warwickshire indicated a need for training in team working.

**Table 3.22 Main Training Needs Identified for Health Professionals from the three PCTs.** This table only shows a training need where 50% or more of the particular discipline have stated a training need.

<table>
<thead>
<tr>
<th>Training needed</th>
<th>South Warwickshire</th>
<th>North Warwickshire</th>
<th>Coventry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of referral guidelines</td>
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<tr>
<td>Understanding family support</td>
<td>*</td>
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<td>Team working</td>
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<tr>
<td>Behaviour management</td>
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<tr>
<td>Anxiety management</td>
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</tbody>
</table>
3.3h Barriers/Encouragement to Undertake Post-Qualifying Training

A number of factors were identified that encouraged or inhibited individuals’ attendance at, or completion of, training courses. Just under one quarter, 24%, of comments (n=58) concerned the availability of courses, for example a lack of courses or relevant courses, little or no information about courses or that there were none in the locality.

Twenty–two per cent of comments (n=53) concerned the cost of the courses, a lack of funds in the training budget, reluctance on the part of the organisation to fund training and the cost of supply or other cover for staff absences due to training.

Twenty per cent of comments (n=47) concerned the lack of time to attend courses, and a further 18% of comments (n=44) concerned difficulties in attending training due to part-time working, work or family commitments and providing and preparing for staff to cover absences specific to training.

These comments indicate organisational and personal barriers that hinder the uptake of available courses. They suggest a need to review how courses are advertised, whether they are repeated, and whether there is flexibility in their timing and duration to encourage attendance.

Only 14 comments were received which suggested that staff were encouraged to attend training courses. This small number may be due to the phrasing of the question rather than a true reflection of the level of encouragement. These included: being encouraged by increased need amongst the client group or increased awareness of their problems (n=6); being interested in the subject (n=3); and being encouraged by management (n=2). For clarity, all these responses are summarised in Table 3.23 below.

Table 3.23. Factors which have Encouraged/Inhibited Attendance at, or completion of, Training Courses.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number (%) of comments</th>
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<tbody>
<tr>
<td>Inhibited by lack of availability of training courses</td>
<td>58 (24.2)</td>
</tr>
<tr>
<td>Inhibited by cost of training</td>
<td>53 (22.1)</td>
</tr>
<tr>
<td>Inhibited by lack of time</td>
<td>47 (19.6)</td>
</tr>
<tr>
<td>Inhibited by difficulties in attending training</td>
<td>44 (18.3)</td>
</tr>
<tr>
<td>Inhibited for other reasons</td>
<td>24 (10)</td>
</tr>
<tr>
<td>Encouraged to attend</td>
<td>14 (5.8)</td>
</tr>
<tr>
<td>Total</td>
<td>240 (100)</td>
</tr>
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</table>

Note that respondents could make any number of comments

Note that respondents could make any number of comments
3.3i. Health Visitors’ Perception of their Training Needs in relation to their Enhanced Public-Health role and CAMH

Given the importance that is now being placed on health visitors adopting an enhanced family-centred public health role, it was deemed pertinent to ask health visitors some additional questions about the impact that the change in role might be having: on them or their team generally; on their child and adolescent mental health work; and their training and support needs.

They were asked whether they had any training needs that stemmed directly from their enhanced public health role. There was a variety of responses, with the majority indicating that this had resulted in a greater need for training.

Twenty-one percent of the comments made to this question (n=12) stated that they needed training in community working, the identification of community health needs, and the funding and audit of community work. A further 17% (n=10) of comments stated that they needed training in group teaching skills, effective group work and encouraging individuals to participate in group work.

Other training needs identified included training in CAMH issues (9% of comments) and working with older children, adolescents and their families (9%). Ten percent of comments (n=6) did not yet know whether they had any training needs or what these might be.

A small number of respondents (n=4) stated that they had no training needs.

3.4 Findings from the Interviews with Tier 1 professionals

Respondents to the postal questionnaire were invited to volunteer for a full interview to explore their responses in greater depth. In all 20 interviews were undertaken. The interview data are presented here by professional group: health visitors, SENCOs and social workers. Some of the themes are crosscutting across professional and agency boundaries whilst others are particular to certain disciplines.

The main thematic areas explored were:

- Changes in Workload and Role
- Vocational Training
- Current Training including training undertaken, barriers to training and anticipated future training and support needs
• Interface between Tier 1 and Specialist Services
• Inter-agency Partnerships
• Enhanced Public Health Role (Health Visitors only)

Apposite quotes have been added, together with an identification code to indicate which profession made the comment: HV = Health Visitor, SEN = SENCO, SW = Social Worker and FSW = Family Support Worker. In addition, the ‘W’ or ‘C’ in superscript text denotes whether the professional is based in Warwickshire or Coventry respectively.

3.4a HEALTH VISITORS
The health visitors interviewed had a range of experience in terms of the number of years employed as a health visitor, and were based across both Warwickshire and Coventry.

3.4ai Changes in Workload and Role
Health visitors did perceive an actual increase in the amount of mental health work they were experiencing, although they did acknowledge some difficulty around defining and measuring mental health workload. One health visitor stated this clearly:

“It’s very hard to measure I think. And it depends on where you put the threshold really. I mean in some senses a lot of sort of conversations you have with people are about behavioural difficulties with children. But it depends on whether you call that a sort of mental health problem or not.” HV^W

They also perceived that problems were becoming more complex and deep-rooted and that the presentation of ‘problems’ with children were very often symptomatic of the wider family situation. The increased prevalence of CAMH problems were attributed to changes in family circumstances or dynamics. The most frequently cited reasons were family breakdown, lack of family/friends support networks and changes in family working patterns. Alcohol and drug taking amongst adults and adolescents and domestic violence were also cited. In a more general sense poverty or deprivation were also given as reasons for increases in mental health conditions’ surfacing.

In addition to an actual change in mental health workload there had been an artefactual increase. Health visitors felt that their awareness and expertise had grown over time. They felt that their general knowledge and awareness of conditions had improved and that they had a greater range of skills at their disposal, gained both through training and experiential learning, which enabled them to identify conditions and underlying causes linked to the family
situation. This was commented on by a number of health visitors, of which the following quotations are typical:

“In the last two or three years, we are becoming much more aware of problems to do with children, and certainly autism and behaviour problems are coming very much to the fore…when I first came into health visiting years ago there were no autistic children, but now I have got four on my caseload.” HV^C

“I’ve been qualified now probably about 5 years, and I know how I structure an interview with a client now to how I maybe performed 5 years ago is very different.” HV^C

There was also a feeling that awareness of problems had grown amongst parents and children, and that there was a greater willingness to seek out and take heed of help. It was also noted that in some cases parents felt a need to blame the child rather than look at the wider family situation for the causes of problems:

“On the whole they seem to blame the child, it’s the child’s fault rather than perhaps some of their parenting skills.” HV^C

Some of the changes in workload were situational and connected with changes in, for example, geographical location/practice/role and so increased/decreased caseloads. Closure of nursery provision in Coventry was also cited as a cause:

“Certainly in this city one of the biggest problems we have had in the last four years is when social services closed down all their social services nurseries. Traditionally, children with a problem or a parenting problem went into the nursery. With that access totally closed to us we are now taking the flack. So our role has increased in being there to manage behavioural problems.” HV^C.

Failure to replace staff that have left, or are on extended leave, was also mentioned as a factor leading to a greater burden falling on those who are left. A further important change that was noted, particularly in the case of Coventry, was the increasing population of asylum seekers with a set of very different mental health needs, cultural differences in mental health seeking behaviours, and deficiencies in the ability to negotiate help.

3.4aii Effectiveness of Vocational Training

There was a general feeling that vocational training was very limited in scope and deficient in providing health visitors with the necessary knowledge base and appropriate skills. Vocational placements were felt to be of limited value if they did not expose trainees to the spectrum of need that might be faced after qualifying.
Interviewees described a sense of struggling when first qualified, and being unsure about offering help to families and knowing how to seek out further assistance for them.

“The first couple of years I really struggled: where to go, or what to do or even where to start trying to unravel families with multiple problems.” HV^{C}

Increased confidence and expertise was gained by experience, through working with colleagues and self-directed learning.

3.4aiii Current Training

Interviewees were forthcoming about identifying their current training needs. Overall, there was a willingness to undertake further training, and recognition of their priorities for training and support.

The ways in which training needs were identified and promoted within their organisations varied from the formal appraisal process, through to team discussions and training notice boards. Individual performance reviews/appraisal systems were reported as not always occurring as frequently as intended. More commonly, training needs were identified in an ad hoc way within team meetings or on a ‘need to know’ basis when a particular situation arose.

Training notice boards were used as a way of displaying material about available courses. Health visitor journals were also cited as a further source of information. One health visitor mentioned the opportunity to set up a bulletin alert system which could be used to keep health visitors up-to-date around changes in knowledge and practice:

“I think it would be nice if somebody could just alert us to that new information because we don’t have time to keep up-to-date with everything.” HV^{C}.

This particular health visitor felt that such a system could be used as a means of improving consistency in knowledge and approach. In another example, one team used team meetings to disseminate and cascade information and literature from courses individuals had attended, although owing to time pressures individuals were often forced to miss or leave team meetings early due to workload demands.
Barriers to training included time constraints in the work setting. Although managers were supportive of colleagues undertaking training, the needs of individuals were always finely balanced against those of the team and the demands of the caseloads. Although interviewees expressed willingness to undertake study in their own time, they were conscious of the need to strike a balance with commitments at home and not bringing problems and stress from the workplace to the home environment.

The financial impact of courses, whether to the individual or the organisation, was also a decisive factor in shaping participation.

In terms of the form of training, some felt that a rolling programme of 5-6 study days over the course of a year, which could be booked into diaries well ahead of time, would be useful. It was felt that courses should be repeated in case sessions were missed, with opportunities for follow-up/updates with professional supervisors as professionals tried to put their learning into practice. Overall, small group sessions with a balance between theory and practice were favoured by most. Lunchtime meetings had been organised in the past by CAMHS in Coventry, and health visitors had found these meetings useful in terms of disseminating knowledge and practice and networking. However, this initiative was reported as having been short-lived:

“I think one of the people in CAMHS was running like a journal club on mental health issues over a 2-hour lunch break…I attended two sessions on the autistic spectrum and speech and language development…I haven’t been invited for a long time, but all health visitors found them extremely useful and it was a good networking opportunity, as well as to discuss roles and problems we have.” HV.

A similar programme was operational in North Warwickshire, and likewise was well regarded. However, attendance gradually waned as professionals found it difficult to attend because of the need to meet caseload needs.

As to the appropriateness of training recently undertaken, most interviewees focussed on the Solihull Approach, probably because it was a recent course, which had been undertaken by many health visitors in South Warwickshire and Coventry. The Solihull Approach had provided an opportunity to harmonise approaches to health visiting. The following comment was typical:

“The new booklet that we’ve had, the Solihull Approach, that’s been very valuable because across the city we’re all offering very different packages of care.” HV.
Others felt that it had not necessarily changed their way of thinking, but had given a greater legitimacy to the work of health visitors and made the role of health visiting more explicit to other professions/agencies. Overall, the response to the Solihull Approach was positive, but interviewees were unclear about whether the approach had changed professional practice. There was some disappointment that follow-up sessions had not been offered to allow further reflection on integrating the Solihull Approach into practice.

Other areas of training that health visitors mentioned having received included in-house training around school phobias and eating disorders, family systems and, more recently, training around the assessment framework.

3.4aiv Training Needs around Improving Understanding in Relation to Mental Health
The health visitor interviewees identified a number of training needs in relation to CAMH. The key ones were:

• Understanding mental health generally and improving knowledge on all aspects of mental health:
  “I would be very interested in attending further training to enhance what little knowledge I have got now” HV.

• Being kept up-to-date with current and best practice (nationally and locally) through regular updates:
  “I want to know about current trends to know whether what I am doing is typical or atypical…I want to know about the broader picture about what’s happening nationally and to know what is expected of me…it is about best practice and knowing about evidence of which approaches to use and which get the best results.” HV.

• Building understanding of what constitutes mental health difficulties and the links to the environmental and social causes of problems:
  “I find it difficult to decide whether there is a mental health problem or they’ve got a disability, a learning problem or a behaviour problem that’s been reinforced by the way they’ve been brought up or the impact of a family incident or whatever.” HV.

3.4av Training Needs around Improving Understanding of Specialist Service Provision
They also identified a number of training needs connected with improving their understanding of specialist service provision. The main training needs were:

• Understanding the role of CAMHS, service provision and the referral process to ensure appropriate referrals:
“I don’t think it would do any harm to have every so often a bit of networking with the specialist services to find out about the people who provide the service and the current things they have to offer and current demands…this might help me know whether I am referring to the right place…services change, new services develop and old services close. So it’s useful to make sure that I’m actually doing the right thing.” HVSW

• Understanding the specialist services available

“If I’ve got a child who I think has got a mental health problem I’ll get them to see the CMO who might refer them to the specialist services. Now I’ve got no idea what the specialists are going to do and so I cannot tell the parents. So maybe I need insight into how psychologists work with children.” HV.

3.4avi Training Requirements on Specific Conditions
A number of specific mental health problems were identified for which the health visitor interviewees felt further training was needed. These included:

• ADHD
• Autism
• Depression
• Families with multiple problems
• Attachment Difficulties
• Bereavement

3.4avii Support Needs
Support for families that have been referred to CAMHS and are waiting for an appointment was a key issue, as health visitors sometimes felt unable to offer what was required. They reported needing guidance about the most appropriate help to offer the client and family during this difficult period. Key support needs were:

• Support from specialist services during lengthy waiting times, and for dealing with complex cases:

  “Usually they’re just on the waiting list forever and a day and then they are constantly ringing for advice and support and just a shoulder to cry on…they become desperate and this must have an impact on the long term health of the child and we end up going around in circles together.” HV.

  “I’m thinking of children who we have worked with and who won’t be seen for over a year by the specialist services. I would like to see in this area, which is very, very deprived, a worker who would do a drop in facility for parents.” HV.
• Support and feedback when cases referred to specialist services are ‘rejected’, and guidance to help prevent inappropriate referrals. This would help to close some of the gaps in communication between Tiers. Much frustration is felt when a referral is rejected but they still have a child needing help.

“There are cases when I feel that I have clearly identified a need for referral and then I’m told by somebody else that it’s not, just send it somewhere else. And I think fine, but what do I do with it now? You know you can’t say to the mother well I’m sorry there’s nothing out there, there’s nothing I can do about it…perhaps we need flow charts to assist in the referral of families or one-off assessment with someone more knowledgeable to reassure the family…we need some support to give us confidence to know that we are on the right track.” HV.

“I have had children where we have done basic behaviour management and not got very far for various reasons, and then I have referred to the specialists and they discharged them saying that there is no problem, and then we are back at square one…we have to deal with that child until they go to school…we always get a summary of the outcome of assessment and basically it will say that there was no major problem but basic behavioural problems, but there is no particular advice about how to work things through.” HV

3.4aviii Relationship Between CAMHS and Tier 1
Some of the issues raised here link with earlier points about training and support needs, serving to demonstrate how links might be strengthened in a positive way. There is little doubt that support is welcomed, whether it takes the form of telephone advice, face-to-face meetings or joint-supervision of clients.

“It’s improved [since the Primary Mental Health Team in Coventry has been established]. We’ve got a contact presently with a clinical psychologist who will do sort of supervision and offer advice and support with families that maybe you’re trying to work with and seem to not be making progress. I’ve recently had a session with her and a family. She helped me have clarity with what I was doing and maybe try and look at it another way, and helped me see that there was little else that could be done as the problems were so entrenched.” HV

More generally, joint-assessment had been found to be a useful way of proceeding in complex cases in both Coventry and Warwickshire:
“I know there was a spell where we did some joint work, you know like health visitor and someone from mental health doing a kind of joint assessment, once a kind of verbal referral had been made, and doing some work together with families. And that was often quite helpful rather than perhaps being referred completely. It was someone from the team working with you to maintain that, or work through some of those things and see whether or not it could be resolved at that level.” HV^SW

Interviewees appreciated that such support was needed in exceptional circumstances, and that resources are limited. They reported that they only seek assistance when other possibilities have been exhausted:

“It’s about access to more expert services and I suppose I get particularly miffed about that because I have been a health visitor for a long time, and I do recognise my own limitations and I don’t think that I offload families with problems just because I don’t want to deal with them. I think that I try to refer them onto a more appropriate service…by the time I refer them I have exhausted all avenues of help and the family needs more expert help.” HV^SW

3.4aix Inter-Agency Working and Skill-Mix Teams

In general, skill-mix, particularly, between health visitors and nursery nurses was felt to be working well and was considered an asset:

“It does help that we, you know, we’re supposed to be moving towards a skill mix, and we do have nursery nurses within our team who do group work. And often that’s a great point of contact that you can feed sort of problem families, in inverted commas, into groups.” HV^C

However, skill-mix was felt to have its own problems. One area highlighted by interviewees was the fact that nursery nurses have transferred from the education setting to working more in the home or health setting have a need for further training/support:

“In our team two new nursery nurses have started…it’s been difficult for them as they’ve come from an educational setting to working in the home. And it’s been quite difficult to support them when we’re not supported ourselves.” HV^C

In terms of inter-agency working the pattern of success is patchy and the lines of communication limited:

“It’s very hit and miss. I don’t have much contact with teachers….. this particular child that’s being seen weekly, I actually worked to get him extra support but no-one from there has ever got back to me to say how well he’s done. The mother’s told me, and
I’ve seen a change in him, I’ve seen a huge change in him, but the school has never got back to me to say that he’s made progress or not or whatever.” HV\textsuperscript{C}

Transient populations were a particular problem for some health visitors, both in terms of the provision of services whilst individuals came under their care and then in terms of liaising with colleagues when they moved to other areas.

Interviewees gave examples of good inter-agency working, but these were the exception rather than the rule. Often joint working was constrained by the fact that all Tier 1 professionals feel over-worked and find it difficult to find time to meet face-to-face to discuss cases. The situation is compounded by a lack of understanding about each other’s roles and the boundaries of responsibility. This was reported as leading to duplication of effort and even contradictory advice and support:

“It gets very complicated for me, and it gets very complicated for the family as well. I can think of families where they will have multiple workers going in. With the best will in the world, you know, all agencies try to liase. But unless children are on the child protection register, you don’t know if there’s a CPN going in. And there’s confidentiality issues. And what clients might say to me might be very different to what they’ll say to another worker.” HV\textsuperscript{SW}

3.4ax Training Needs generated by the Enhanced Public Health Role

One area of need identified by interviewees in relation to CAMH concerns was the development of assessment skills and approaches to allow for the delivery of community based solutions. One health visitor commented:

“Well there’s a whole huge area of skills in community-based work, and sort of working with communities, and working with groups, which I don’t think I’ve got particularly good skills in. And I’m kind of aware there are other practitioners, community workers, who are much more practised at that kind of stuff.” HV\textsuperscript{SW}

3.4b SENCOs

All of the SENCOs interviewed were from Warwickshire. However, it is probably fair to assume that many of the themes raised by them cut across geographical as well as agency boundaries. Most of the interviewees had many years of experience between them and some were deputy heads or head teachers so had a general overview of the impact that children with mental health problems have on schools and on the workload of teaching staff.
3.4bi Changes in Workload and Role

Similar to health visitors, SENCOs perceived an actual increase in mental health workload:

“There is an increase in incidence around the school of children where they are showing signs of stress and distress. It shows up against the way that the school operates in that all the classrooms are very stable environments and the teachers are very stable.”

SEN

There was a perception that problems were more complex and sometimes more difficult to deal with now, because they often result in erratic attendance within school.

SENCOs offered some insight into the reasons for the growth in CAMH problems. They felt that many of the causes were rooted in the wider family context. Family breakdown, the complex working patterns of families, and lack of family support were all stated to contribute to families’ difficulties and thereby increase the difficulties faced by their children. A lack of parenting skills was also seen as pivotal, with many young parents regarded as lacking in appropriate behaviour management skills.

Some of the change in mental health workload was attributed to artefactual change due to increased awareness on the part of the schools, the professionals working within the setting and parents too. In some cases the greater awareness of parents presented itself as a need to seek a label for their child’s problems, which also increased the demand for help. In addition, it was suggested that parents were more likely to seek help from schools and had an increased expectation that schools could assist:

“Well I think that we’re seeing a lot of parents that can’t cope, and that affects us at school because teachers are confronted with parents that can’t cope, and as the head teacher they’re knocking on my door because they can’t cope. And they’re expecting us to come up with lots of answers, and solving it. And you know, and the comments about ‘we’ll wait until they get to school and they’ll sort it out’, that sort of thing perpetuates you know.”

SEN

To counter the drain on teacher time in dealing with CAMH problems, a ‘Parent Aid’ initiative has been operating in some parts of England, as one SENCO explained:

“Parent Aid is a Home Office funded pilot project which runs in some other parts of the country but it isn’t in Warwickshire yet. And it recognises the fact that if parents do have problems not even connected with education, like housing or death or neighbours, their first port of call is very often a school. Teachers being professional bodies often spend a lot of their own time trying to find an address or a telephone number or a door that’s
open for these parents. The idea is that local counties and towns develop a Parent Aid file of information and contact details which is then put in the school for the benefit of teachers and parents.” SEN

This SENCO clearly thought that this scheme, or something similar would be useful in his/her school.

In some cases schools felt that increased awareness and training enabled them to detect and manage problems in a more adept way:

“In terms of looking at the whole business of child protection and special needs, we’re a very inclusive school. One of the things that we’re very alert to are children who are not thriving, not engaged. You know sometimes it’s health, sometimes it’s family break up. So all of the staff, through the child protection training, and through our special needs training, are aware of issues that might impact on children’s learning. Non-teaching and teaching staff have had some training and development work on those areas.” SEN

Overall, there was understanding that many CAMH problems affected schools’ core role of educating children, and that these problems could not be ignored because children could not learn if they were unhappy or anxious. They felt, though, that more support and resources at Tier 1 were required.

Much of the change was also attributed to situational changes resulting from changes in policy, such as inclusion policies. These were felt to have resulted in more children with mental health difficulties and particular needs being integrated into mainstream education resulting in greater needs for support within schools:

“Over the last 5 years, there are more children, even in a mainstream school, with mental health issues. I think that some teachers need to be far more aware that they’re dealing with children who, you can’t just say ‘get on because I’m the teacher and you’ll do as you’re told’. That attitude just can’t be tolerated any more. They’ve got to know that when a child looks blankly at them, it might be that there’s a problem they don’t understand. And too many teachers are still imagining that all children, well most of the children in front of them are just normal every day kids. And a lot of them aren’t.” SEN

SENCOs also mentioned a number of changes to the school curriculum and local/national initiatives that had influenced a change in the role of schools and SENCOs in relation to mental health. The Personal and Social Health Education (PSHE) element of the curriculum
was seen as a cornerstone, but it was described how other demands meant that this became an add-on to be fitted in rather than being woven into the fabric of the whole curriculum.

The ‘Friends’ initiative, which was being piloted by a few schools and co-ordinated by the Learning and Education Support Service in connection with the county’s educational psychologists, was also mentioned and viewed at this early stage as showing promise. The use of nurture groups was also viewed as being a useful strategy.

3.4bii Vocational Training
In general, vocational training for teachers was viewed as lacking in several ways. SENCOs felt that many teachers lacked basic understanding of child development, and particularly their psychological development. It was also suggested that the teaching qualification does not adequately prepare teachers to have an understanding of how family problems may influence a child’s path in the school:

“They [newly qualified teachers] don’t think that this child may be in a distressed state. This child may have just lost their mum, which has happened to one of our children this year. You know this child is actually coming to school without any breakfast. A lot of those elements do not feature in their training.” SEN

“I think teachers now are very, very unaware of, you know, the psychological development of children. I don’t think child development even features on the university training for teachers.” SEN

It was felt that vocational training was not preparing students adequately for the types of problems that they might encounter on qualification, and that knowledge and strategies for addressing such issues was only built up over time, albeit often in an ad-hoc way.
3.4biii Recent Training and Continuing Professional Development (CPD)

SENCOs discussed courses they had attended. Details of some of the courses and the suggestions for improvement that were made are provided in a table format below (Table 3.24).

Table 3.24 Courses Attended by SENCOs with their Suggestions for Improvements

<table>
<thead>
<tr>
<th>Course</th>
<th>Suggestions for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection</td>
<td>▪ Primary focus sexual abuse, disappointment that other types of abuse were not considered</td>
</tr>
<tr>
<td></td>
<td>▪ No forewarning of content, needed the opportunity to talk through own cases.</td>
</tr>
<tr>
<td></td>
<td>▪ Follow up training/session to ask questions after trying to put theory into practice required about 1 month later</td>
</tr>
<tr>
<td>Looked After Children</td>
<td>▪ Needed greater emphasis on mental health issues facing these children</td>
</tr>
<tr>
<td></td>
<td>▪ Needed to include children who are looked after in informal family arrangements</td>
</tr>
<tr>
<td>Language and Communication Difficulties</td>
<td>▪ Further follow-up required</td>
</tr>
<tr>
<td>Behavioural Difficulties</td>
<td>▪ Too basic and general. Specific guidance on specific problems required</td>
</tr>
<tr>
<td>Diagnosing, Recognising and Identifying SEN</td>
<td>▪ Too basic. Needed more opportunity to address the specific needs of children in the school</td>
</tr>
</tbody>
</table>

In summary, courses need to be pitched at the right level to be appropriate to the needs of those of attending them, should be practical and have an emphasis on getting theory into practice, should be based more around case studies, and should be more on-going with follow-up. The desire of participants to bring case studies to training sessions probably also highlights a need for support for the management of such cases.

Other courses that were attended and received favourable reviews included ADHD and other autistic spectrum disorders, behaviour management in the classroom, care and control of children (restraint techniques) and dyslexia.
3.4biv Barriers to Training and CPD

The barriers to uptake of training identified by SENCOs were similar to those identified by health visitors. The most significant pressure was that of lack of time, particularly as many of the SENCOs interviewed had other responsibilities as deputy or head teachers. This sometimes led to training being neglected or abandoned part-way through the course:

“Eventually it was leading to a masters degree. But actually with running a school, and being special needs co-ordinator, and all the other things that I do, you just couldn’t do it and what you end up doing is, which is very wrong, your own professional development needs kind of come bottom of the pile.” SEN

Sometimes individual training needs could be at odds with the needs of the school, for example if the proposed training did not fit with the school’s development plan for that year.

The location of training, the cost or availability of supply staff, or the personal costs in terms of family commitments were sometimes prohibitive:

“We’re quite a long way from major training venues, so teachers and other staff don’t like to travel too far too often. So the location is an issue. And sometimes I just have to cancel my attendance on a course at the last minute because I haven’t got a supply teacher.” SEN

“Attendance has been a particular problem for me because [of home commitments]. Most of the courses are held in Leamington or somewhere like that, and by the time you’ve been at work and driven for an hour in the traffic and you know then back again it really does put people off. It’s the travelling to the courses, and sometimes the cost as well to attend and cover supply around £200 per day - both aspects…I have found locally run courses more accessible.” SEN

A final point in relation to barriers in attendance related to notification of courses and that individuals did not always feel that they were fully informed about available training. One SENCO commented that they sometimes only found out by accident that a course was planned.

3.4bv Gaps in Training and Support

In terms of gaps in training and support, the interviewees raised the following points.

1) Training needs around improving understanding in relation to CAMH
• Understanding mental health generally and improving knowledge on all aspects of mental health, including agreeing definitions of particular conditions.

• Developing communication skills, strategies and literature for communicating with parents of children that have mental health problems or with parents who have mental health problems themselves.

  “Regular courses on just dealing with - not just for SENCOs but for teachers - on special needs issues and dealing with parents. It’s a vital partnership, and sometimes parents are horrified, frightened, stigmatised when a child is first identified, and so everyone needs to be aware of how to talk to the parents.” SEN

• Defining and acknowledging the boundaries of what is possible at Tier 1, that sometimes problems can only be contained rather than resolved, and that mental health problems will affect a child’s ability to learn:

  “How do you prove as a teacher that you cannot make any more progress, in an educational sense, because the child’s mental health means that there is only so much you can do. The psychologist can say its because of their mental health, but as a teacher when my boss comes and says why haven’t you made progress I feel that s/he thinks that I am using the mental health difficulty as an excuse for my own failings.” SEN

2) Training needs around improving understanding of specialist service provision (generally education services)

• Building awareness of the support services available, both within and beyond the sphere of education:

  “The only thing that we tend to hear about are educational-based supports, but I don’t know what type of support groups there are that we can approach directly to help children in the classroom.” SEN

• Developing or increasing understanding of the referral service and the problems that are appropriate for referral:

  “I don’t necessarily fully understand which cases are appropriate for referral because it’s never been addressed in any training I’ve had…I am beginning to learn more through experience, but sometimes I talk to another school and they have referred a child in circumstances that I have not considered referring. So we need some guidelines to help us act consistently.” SEN
3) Additional training was felt to be important for the following specific conditions:

- Drug Awareness
- Autism and other spectrum disorders
- Dyslexia

4) Support needs

- The importance of feedback once a child has been referred:
  “There is a total lack of feedback from clinical psychologists and I’ve only had three face-to-face meetings with them. I think the problem stems from patient confidentiality, but we have cluster group SENCO meetings and this problem comes up most terms… At the very least I would like to know if a child is being seen by a clinical psychologist. The parents don’t always tell us, but obviously we do need to know and if we don’t hear it from the parents then we need to know from psychology. Especially as that would bring extra money into the school, as an element of the school funding is based on the number of children who are involved with outside agencies.” SEN

- Joint supervision of staff, or meetings to discuss cases at the inter-agency level and with specialist services:
  “I would like to see termly inter-agency meetings, and regular meetings between the education psychology service and heads/SENCOs… I’m aware of one school in Nuneaton in which a regular meeting involving the head, the behaviour support teacher and a clinical psychologist takes place termly to discuss a whole range of children and I think that would be an ideal way of going forward.” SEN

- Enhanced communication to prevent duplication of effort and allow better management of clients on waiting lists

3.4bvi Relationship between Specialist Services and Tier 1
SENCOs gave several examples of good relationships between Tier 1 and the more specialist services, and also some examples where links and understanding needed to be developed.

Descriptions given of relations between SENCOs and LABS and the Educational Psychology service varied considerably, sometimes being regarded as poor and sometimes as excellent. This often seemed to reflect the personalities involved and whether a good rapport was created, and whether trust and respect exists between professionals from different agencies.
It was stated that, in certain cases, the advice and strategies offered by specialist services were no different to those that had already been tried by SENCOs. There was also a sense that such referrals did no more that fulfil a bureaucratic procedure and remind SENCOs of their own failings to resolve an issue:

“I would say that the educational psychology service has been marvellous this last year or so, very very supportive, very helpful. And you know, really brilliant. But it depends a lot on personalities doesn't it. I happen to get on with this person pretty well, and we think alike. S/he's very efficient, s/he knows what s/he's talking about, so you trust him/her, you think I know s/he knows what s/he's on about. Whereas other people, from LABS, they give you recommendations for the children…. and you finish up you know at the end of reading their recommendations, you feel like throwing it straight in the bin. And then, in order to get a statement you've got to prove that you failed in all those areas. And I think I've got enough time trying to do something to succeed, without having to write down everything I've failed at. So you know it's so frustrating, because in the meanwhile a child's life's ticking away, and that's the one chance they've got. And I hate it. I think to myself can’t you believe me, I've had this child for 4 years, I'm telling you the truth.” SEN

One SENCO mentioned that the educational psychology service were operating a team approach with various named points of contact according to their area of expertise. This was considered a useful approach if it facilitated direct contact with the key individual for a particular problem.

In contrast, another SENCO had experienced difficulty because educational psychologists were not always assigned by school, and so a SENCO could find themselves having to liaise with more than one educational psychologist at a time.

Waiting times were again highlighted as an issue that militated against referral:

“With some actual diagnoses you wonder whether there is any point referring because you wonder whether anything is going to happen or whether there is just a long waiting list.” SEN

Another issue raised in terms of the relationship with specialist services was that they felt there was inconsistency in the approaches of different professionals:

“Professionals come in and say well you do this, and then somebody else comes in and says no, no you've got to do this and this. There really ought to be a co-ordinated response in which the parent is a part.” SEN
A final point relates to the possible deterioration in a family situation when problems are not swiftly dealt with. The use of the service offered by the Parent Partnership was seen as a valuable mediation service to resolve problems of this type:

“If we do have parents who come to us and complain that something isn’t happening that we have promised, such as a referral to a clinical psychologist and they haven’t heard anything for months, then they come to us cross, upset and quite desperate and we can refer them to Parent Partnership who will mediate and liaise and just you know calm things down…but I always feel we’ve failed if we have to call in Parent Partnership. We ought to be able to do something for parents before they get desperate. They will represent parents at appointments and go with them to various things like that, or for anything any problem, any education problem. If the parents think the child is dyslexic and school doesn’t, you know they can complain to Parent Partnership.” SEN

3.4bvii Inter-agency Working and Training
Examples given of inter-agency working and training initiatives were limited in number, and in terms of joint working comments were variable:

“Social services don’t particularly want to know. Unless it’s to do with a known child and it’s almost an abuse thing. That’s the problem there are problems with referrals between agencies. “SEN

Attachment of social workers and counsellors to particular schools has already been mentioned above as a possible strategy to promote inter-agency working. The fact that some SENCOs cannot make direct referrals to GPs or clinical psychologists and feel cut out from the chain of communication has already been mentioned elsewhere.

Joint training is a means for promoting better understanding of the pressures facing different agencies, but solutions to these pressures also need to be sought.

“It was a very good course but the only thing I learnt was that every agency is under as much pressure as we are. I could appreciate their working arrangements and their frustrations but it didn’t actually solve anything, it just made you more aware of the problems.” SEN

3.4c SOCIAL WORKERS
3.4ci Changes in Workload and Role
For social workers, their organisational structure is quite different from that described by other Tier 1 professionals. Many children’s social workers are organised within specific teams with a specific remit and so changes in workload will vary accordingly. In this section, we draw out general points rather than identifying particular team issues as it would be inappropriate to do
this given the small number of interviewees. In Coventry, geographic-based teams of Family Support Workers work alongside social work teams and some of the data collected and presented here derives from interviews with representatives from these teams.

In terms of the changes in workload and role, social workers placed great emphasis on the pressures of workload facing them. They felt that they had experienced an actual increase in workload. There was also evidence of artefactual change, for example, greater awareness of issues, and situational reasons, for example, fewer members of staff, changes in areas of responsibility or changes in provision of other services.

It was suggested that the nature of the workload was changing in terms of the age range of children being seen, although it was not clear whether this was an actual increase of need or due to greater awareness of issues affecting younger children on the part of particular social workers with experience of dealing with younger children:

“It used to be that we would see mainly teenagers, but now we are seeing children from six upwards. Now that may be because there’s somebody who can work with much younger children, and so they are picking up on their problems, or maybe we are identifying problems earlier or maybe problems are occurring in younger children.” FSW.

As with health visitor and SENCOs, social workers also perceive the increase in workload associated with children’s problems to be symptomatic of wider problems within the family, and commented that these problems are often numerous.

 Whereas health visitors and SENCOs focussed on their increase in awareness of mental health issues and the increase in workload this brought about, social workers articulated deficiencies in awareness or gaps in identification, investigation and provision for certain mental health difficulties. There was concern, for example, that only child protection or acute cases receive direct workers:

“It’s very much on the heavy-ended scale of the spectrum of children in need and child protection, and in fact having the two different areas is a bit of an anomaly, because often children in need is all about child protection. We’re still not very good about assessing psychological damage, emotional distress and how that impacts on the development and whatever. I think that a lot of cases are herded into children in need when actually they are a lot more dangerous in terms of mental health, which is not recognised… because we don’t receive training in it and actually there’s no practice-based evidence.” SW.
“The children’s disability team have very clear guidelines about what kind of children they can take. But then there’s the middle bit, the middle range of children that kind of have nothing and those are the children that may be have ADHD, Aspergers, undiagnosed autism, those kinds of illness. Then there are those that are kind of self-harming, but there’s been no kind of investigation. There are those children that are displaying behaviour that puts them at risk and those children that have actually tried to kill themselves, and none of these fall into other areas." SW

In terms of situational changes, the issues mentioned related to changes in professional role and the impact of certain initiatives to deal with families in crisis. Strain in one part of the care system was transmitted to strain in other parts. For example, for a Family Support Worker an increase in workload had resulted from what they perceived as a lack of provision within Social Services that had in turn resulted in restrictions in the service and response times that they could provide:

“It seems because district social workers or field workers and fostering workers don’t have any services that will take on people, particularly children and teenagers, with what you might call mental health difficulties that our services are called on more and more…we’re often in the situation of prioritisation so we may well finish a piece of work before we’re actually ready to and it might mean, although not very often, that we cannot provide a 24-hour all week response. Someone might have to wait and that can mean the difference between a child coming into care and a placement breaking down.”

FSW

With very large caseloads, social workers reported that there was a lack of time to carry out regular reviews and monitoring so that the work now had to be mainly crisis intervention.

On a more positive note, the example of brief therapy sessions for families was offered as an initiative that has been successful. Although this increases workload in the short to medium term, the interviewee believed that this was having a benefit for both children, families and the longer term continued use of services:

“Brief therapy sessions for families in crisis has increased our workload, but it has had a positive impact in that people feel supported by the service and will come back and request it again if difficulties happen in the future…solution-focused approaches have been shown to work keeping children out of care.”SW
3.4cii Vocational Training

As already described in relation to health visitor and teacher training, deficiencies in social work vocational training emerged, specifically the lack of training in the recognition, management and appropriate referral of CAMH difficulties, and the focus on adults to the exclusion of children and adolescence:

“I know this sounds a bit naïve, but when I did my training years ago we covered adult mental health only, and I never even realised that children and adolescents could get depressed and have mental health problems in the same way...as a newly qualified social worker you kind of assume that only adults have such problems, but it doesn’t take you very long to realise when you start practising that this is not the case.” SW

University social work degree courses were felt to be too theoretical and generic, and although there were opportunities to specialise in aspects of mental health, either through particular modules or practical placements, such opportunities were limited by time, the individual’s own interests and the course design. Even when such opportunities were available they did not always adequately prepare individuals for the tasks they may face once qualified:

“My training was generic social work, it wasn’t focussed on you know recognising mental health needs. Had I done a placement focussing on those sorts of issues then I would have had more experience, but because it was generic which all social work courses are really, you wouldn't really cover all aspects of mental health...I did specialise in children in the third year and we covered aspects of psychological development but there was just not time to cover issues around recognising symptoms, let alone managing them.” SW

Whilst vocational training cannot be expected to offer comprehensive preparation on qualification, this argues for the need for continuing professional development once in practice. The risk of such an ad hoc approach is that it will fail if the foundations of recognising mental health issues are not in place and this may be particularly apposite in social work where there is a high turn-over of staff. The importance was spelt out of supporting organisational learning as well as individual learning:

“Basic key information courses need to be set up as an introduction. It seems with all agencies there is a problem with induction and you’re thrown in at the deep end and pick things up as you go along, which is ok to an extent. But in social work there is a high turn over of staff and a lot of the time you have newly qualified workers and you lose the experience of longer serving staff all the time...I’m the longest serving social worker here and that’s 4 years. The average expectancy is about two years so you are
losing the basic information base all the time. You are constantly struggling to find out basic info about different agencies, areas of responsibility and referral processes, for instance, because this information is kept in people’s heads rather than being found in a database.” SW

3.4ciii Induction Training

The issue of training needs during induction was also raised in relation to agency workers who tend to be overlooked in this regard:

“I’ve worked for several authorities as an agency worker and in each case there has been no induction, and so you find yourself working in the dark around the different agencies and the referral processes…not until I became a permanent member of staff was I offered an induction, and then retrospectively I could make sense of what happened, when and why.” SW

Another social worker commented that it was not only on first appointment that induction training was needed, but that detailed information was needed about six months into the post, once the new entrant had ‘found their feet’.

3.4civ Training and Support Needs

Social work interviewees focussed their responses around future training and support needs rather than discussion of courses they had attended and their deficiencies/advantages. This may have been because they felt that opportunities for training in this area had been limited, and they recognised gaps in their training and support that still needed to be addressed.

They did, however, comment of a number of courses they had attended. Details are provided below in tabular format (Table 3.25), including suggestions for improvements. Although some of the points are specific to the individual course, some could be applied equally to other courses.

**Table 3.25 Courses Undertaken by Social Workers and their Suggestions for Improvement**

<table>
<thead>
<tr>
<th>Course</th>
<th>Suggestions for Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solution Focused Therapy</td>
<td>+ Great emphasis on relaxation techniques and hypnosis which are not skills best suited to the role of social workers</td>
</tr>
<tr>
<td>Introduction to post-abuse</td>
<td>+ Needed more on strategies to help adopted or long-term fostered children.</td>
</tr>
<tr>
<td></td>
<td>+ Needed to consider that it is not inevitable that their will be consequences for adulthood.</td>
</tr>
<tr>
<td>Child protection covering depression, self harm and forms of abuse</td>
<td>+ Needed to give greater emphasis to emotional abuse.</td>
</tr>
</tbody>
</table>
Other courses that had been attended by social workers and which were regarded as useful included counselling, transactional analysis and therapy courses.

3.4cv Barriers to Training

In relation to barriers to training, the issues mentioned by social workers were similar in general to those cited by other professional groups.

- The need to self-fund courses or attend in own time because of lack of funding or release from work available from authorities
- Lengthy application processes to obtain funding for CPD
- Limited course availability
- Lack of awareness about courses
- Focus on core training needs, such as assessment framework and physical as opposed to emotional abuse.

“I think that we need to better recognise the emotional needs of children because it’s (training) all about physical attack and not emotional damage…Management adopt the position that psychological work needs to be done in a secure background, but that excludes the majority of children because most don’t have that background or a secure placement” SW

- Management not recognising individuals’ training needs

There were several examples of individuals seeking to undertake courses in spite of having to self-fund. Self-identified needs for training were also not necessarily supported by management priorities. There was also evidence that individuals and teams sought to enhance their own professional development by reading around subjects and using literature or handouts to supplement the training on offer:

“I’ve sort of picked up things along the way through reading around and using handouts and leaflets…but really this is not always a substitute for training and support.” SW

In one instance, a team was trying to foster evidence-based learning through the purchase of relevant current texts and sharing of pertinent information resources:

“Things have moved on, there are new theories and new ways of dealing with it. So I think that it is important that we get hold of new research and new books that are out there. In our team we have started to keep useful information and buy books, but obviously our budget is limited…I mean I have access to the internet at home, but not
everyone does, and at work access is very limited and yet this could be a good resource for us to use. "SW

3.4cvi Training Needs

Social workers were able to identify a number of different training and support needs:

1) Training needs around improving understanding in relation to CAMH
   - Understanding mental health generally and improving knowledge on all aspects of mental health
   - Being kept up-to-date with current and best practice (nationally and locally) through regular updates (resource packs, email, access to the internet):
     "I need good standard advice offering a range of strategies to dealing with issues in case the first choice does not work…at the moment I sometimes feel like I'm working by trial and error." SW

2) Training needs around improving understanding of specialist service provision
   - Understanding the role of CAMHS, service provision and the referral process to aid appropriate referrals:
     "I think that we are good lay counsellors etc, but we need more confidence that we are signposting the person to the right service, that we are making appropriate referrals." SW
   - Understanding the services available to support and help them carry out their role:
     "I think that we need to know a lot more about what services are on offer, what their referral processes are, and what we can expect to receive from them in terms of sharing information, attending meetings and support." SW

3) Training needs for specific conditions/specific skill needs
   - Restraint techniques for professionals and parents
   - Behaviour management strategies to be offered to parents:
     "I feel totally inadequate when dealing with situations which require restraint. We haven't got the right to restrain a child or put our hands on them but we need strategies to help us deal with these situations…also I've never received any guidance around offering behaviour management strategies to parents." SW
   - Autistic spectrum disorders
   - Identifying and distinguishing learning difficulties from learning delay and communication problems
   - Self-esteem: resources to help overcome the problem.
   - Self-harm. There was a clearly identified need for training in this area:
• “Self-harm at all levels, and children feeling like they don’t want to continue living, is not infrequent I would say. I mean for a 9 or 10 year old to feel like that is so awful. Occasionally, I have worked with children who have tried, as they see it, to kill themselves and I feel that I really need some training in this area to allow me to evaluate this type of serious risk. What are the precursors and warning signs that I should be looking for?” SW

• Communication skills

3.4cvi Support Needs
Social work interviewees, like health visitors and teachers, drew attention to the need for guidance on how to provide support when families have been referred and are waiting for an appointment. In particular, they wanted
• Support from specialist services during lengthy waiting times and for complex cases
• Support and feedback (plugging communication gaps) when cases are rejected, and help to prevent inappropriate referrals from being made:
“Often we are faced with children who have been for some form of specialist assessment and the verdict is ‘there is nothing wrong’. But clearly there are problems of some sort - they are less motivated, they are depressed and then it is hard because we live in a culture in which social workers are not valued. And then you have to judge, well, how hard do we push for this child. In these cases I think that consultation with a mental health worker would be invaluable” SW

3.4cvi Relationship between Specialist Services and Tier 1
As with health visitor and teacher interviewees, examples of good working relations with specialist CAMH services and examples where relationships could be improved were given.

An example of good relationships included open access to advice from CAMHS:
“I know that I can pick up the phone and speak to someone at CAMHS for advice and reassurance that I am doing the right thing. I think that it is vital that that sort of open advice continues” SW

Another example given was where there is uncertainty about whether a psychology or psychiatric referral is appropriate, particularly in the cases of some adolescents, a dialogue can take place with CAMHS before referral. Alternatively, the adolescent would usually be referred to the psychology service for the specialist services to make the appropriate decision:
“I think a lot of the difficulties are when you’re talking about slightly older young people, 15-17, when there is some uncertainty about what is the most appropriate route for that young person to be referred to…in the main, I would try to run it past someone at CAMHS first to say ‘is this an appropriate referral?’ and ‘which route should we go down?’ Sometimes we will make a referral to say psychology and then it is referred on if it is more appropriate to psychiatry.” SW

Some of the particular problems resulted from a lack of clarity around referral guidelines, particularly where services change over time or without prior warning or when the social worker did not know which of the many different services might be the most appropriate:

“There are a lot of different services out there that might be appropriate, but there doesn’t seem to be a clearly identified route to the services and how they all link in together and who’s responsible for what really.” SW

The need to make some form of assessment before referral was felt to compound problems of referral pathways, but the social workers often felt lacking in the knowledge, skills and time to make that assessment. Social workers recognised that they needed to increase their base knowledge and skills, enhance co-operation with other Tier 1 services to make a joint-assessment where necessary and to enhance communication with specialist services to clarify referral guidelines and allow for some form of dialogue to seek advice in complex cases before referral.

A point that has been raised repeatedly in this chapter is the impact of waiting lists, both in terms of the burden this places on Tier 1 professionals who feel ill-equipped to offer continued support, and the risk of a family crisis deteriorating even further. This concern was shared by social workers:

“Generally, in this area, referrals to psychology would take about a year and that is a very long time for a family who is in crisis…in the meantime I feel that I am trying to fill the gap without proper training and support. I’m not a psychologist and I feel inadequate in these situations, which require specialist input. When we are successful with a referral then the families are only offered limited support say an hour a month and they would prefer more support in a crisis and so I end up ringing around different services trying to get support to stop the situation deteriorating even further, often without much success.” SW

A further point raised was about how to deal with those cases where help from specialist services is refused by the family or for some reason it is not possible for the family to take on
the help offered at a particular point. In either case the result is that the case is closed and no further help is offered to support the family. This can be frustrating for social workers, especially when they feel that there is a definite need for help but they are unable to provide the appropriate support:

“One case sticks out where a girl needed some mental health assistance. She had had an abortion, she was self-harming, she was abusing alcohol, she had no relationship/family support and she had no self-esteem. And yet they said that she did not have a mental health problem, and they said that they didn’t want to start her on a career of being with mental health services.” SW

3.4cix Inter-agency Training and Working

Generally, social worker interviewees felt that there was a need to strengthen communication across all Tier 1 agencies to foster an understanding of all those working together towards the same aim and to prevent duplication of effort:

“I think we need to break barriers down and say ‘look, we’re all in this together’ and ‘we’re all working for the same purpose’ and ‘we are all working with the same family’…I think that there is a need for all agencies to sit down and say what are we going to do, what are you doing, what am I doing, and are we doing the same work because what’s the point of us both doing the same work?” SW

Examples were given by social workers to illustrate a lack of understanding on their part, or lack of clarity about the role and responsibilities of other agencies, which could hinder the help to be offered to families:

“It is still not clear who it is appropriate to refer to when a child is refusing to attend school and who is responsible. Often it is made a welfare issue and social workers are made responsible for the whole family whereas the family say that if the child was in school then the problems would not exist…There are a lot of initiatives and support available in Education but it is just keeping up with them. And sometimes they are good at filtering information through multi-agency meetings, but it is just keeping up with it all.”SW

The need to avoid breaches in confidentiality was identified as a major problem that could hinder inter-agency working:

“Under the data protection act and assessment frameworks, we must have clear consent from a family to discuss their case. Other agencies aren’t as aware of this issue and are more willing to share other people’s information sometimes inappropriately.
And they think that we should be doing the same when we haven’t got the consent to do so.” SW

The need for agencies to work in a co-ordinated way and perhaps to offer continuity of care and support without children/families feeling overwhelmed by support from too many agencies was also felt to be an issue:

“I saw a little boy for the first time yesterday and he is just 10 years old. He said to me, ‘you’re the fourth person I’ve seen. They each asked me lots of similar questions and it was very boring and I was fed up, but your questions are nice and I’d like you to come back’…This boy was only 10 years old and had already seen 4 people. This raises questions about the whole referral, diagnostic and support system doesn’t it.” SW

3.4d Summary of Findings
The variety of research methods used to elicit information about training and support needs have provided rich sources of data that complement and reinforce each other. The main findings are summarised in this section. Many of the findings are applicable across the agencies and across Coventry and Warwickshire but, where pertinent, those that are specific to particular disciplines or geographical area are noted.

3.4di Current Role in Relation to CAMH Problems.
Over 90% of respondents to the postal survey saw children or adolescents with mental health problems as part of their caseload. The majority of respondents said that this aspect of their work accounted for less than one-fifth of their workload, although social workers reported a much higher level of involvement (3.3aii).

- The problems most commonly encountered are behavioural problems, family relationship difficulties and developmental disorders including autistic spectrum disorders. Fewer practice nurses than other respondents reported involvement with these conditions (3.3aiii)
- Just under half of respondents reported that their CAMH workload had increased during the past five years. This was most commonly reported by school nurses across the areas and by SENCOs from the South, Nuneaton and Bedworth. Only 1% of respondents said that it had decreased. The reasons for the increase in workload were fairly evenly distributed between actual change (e.g. more cases), artefactual change (e.g. increased awareness) and situational change (e.g. role changes) (3.3bi, 3.4ai (hv), 3.4bi (SENCO), 3.4ci(sw).
- Just under half of respondents explained changes to the nature of the workload as being due to situational changes (e.g. role changes), over a third said that it was due
to actual change (e.g. more complex cases) and about 15% said that it was due to artefactual change such as increased awareness of mental health problems (3.3biii, 3.4ai (hv), 3.4bi (SENCO), 3.4ci (SW).

3.4dii Confidence to Carry out their Mental Health Role with Children and Adolescents

Many practitioners lack the confidence to work effectively with CAMH problems. Our findings show a lack of confidence amongst a significant proportion of Tier 1 staff to either identify or manage common mental health problems. Some Tier 1 staff also expressed a lack of confidence in their ability to refer appropriate cases to the specialist services.

- Over a third of respondents had either ‘no confidence’ or only ‘limited confidence’ to identify a number of common mental health conditions. Respondents generally felt confident at identifying behavioural problems but least confident with conditions such as early onset phobia, solvent, alcohol or drug abuse or emotional problems presenting with physical symptoms. School nurses tended to be most confident, whereas SENCOs tended to have the least confidence (3.3ci, 3.3cii).
- Over a third of respondents had either ‘no confidence’ or only ‘limited confidence’ to manage a number of common mental health conditions. Levels of confidence were greatest for identifying behavioural problems, but least for conditions such as early onset phobia, self-harm, solvent, alcohol or drug abuse or emotional problems presenting with physical symptoms. The majority of the GPs and health visitors said that they were not confident to manage minor self-harm, early onset phobia and drug abuse. Over half of GPs said that they were also not confident to manage eating problems and emotional aspects of child protection (3.3ciii, 3.3civ).
- Respondents generally expressed greater confidence in being able to refer common mental health problems to other Tier 1 services or to more specialised services. When referring to more specialist services, those who had been in post for five years or more were generally more confident to refer than those who had been in their role for less than five years (3.3cv, 3.3cvi).
- Between a quarter and a third of respondents indicated ‘no confidence’ or only ‘limited confidence’ to refer conditions, which would require specialised services, in an appropriate and timely fashion (3.3cvi).

3.4diii Confidence in Vocational Training

There was a general feeling that vocational training was limited in scope and did not provide Tier 1 professionals with the range of skills and knowledge that would adequately prepare them for working with CAMH problems (3.4a(ii)(hv), 3.4bii (SENCO), 3.4cii (SW).

- Only 40% of respondents felt that their professional qualifying training enabled them to recognise a range of common mental health difficulties in children and adolescents.
Over half of the social workers, SENCOs and practice nurses expressed a lack of confidence in this aspect of their training (3.3ei).

- Only a quarter of all respondents felt that their professional qualifying training enabled them to manage these problems. Three-quarters of social workers and over half of SENCOs, practice nurses, school nurses and GPs expressed a lack of confidence that their training had enabled them to manage this work (3.3ei).

- Confidence was higher in the case of their preparedness to refer. Just over half of respondents felt that their training had enabled them to refer children with these problems to other Tier 1 services and 44% felt it enabled them to refer to more specialist services. About half of the SENCO’s, however, felt ill-prepared to make these referrals (3.3ei).

- The main criticism of vocational training was the lack of formal training in relation to CAMH, or that training had not provided specialist assessment or clinical skills. SENCOs were critical that vocational training did not adequately prepare students for the types of problems that they might encounter in school. Many critics commented that experience and knowledge built up over time, together with support from colleagues, had been more useful than their initial training (3.3eii).

- Suggestions for improving vocational training were to include greater formal training of mental health issues in general, and CAMH in particular, in the vocational training of all practitioners who will encounter this in their work (3.3eii).

3.4div Training Needs

Nearly all Tier 1 staff that responded to the postal survey identified training in CAMH needs, with 60% of these stating at least four training needs (3.3g, 3.3giii). Health visitors, nursery nurses, school nurses and social workers identified the greatest number of training needs (3.3giv). A wide range of training needs were identified, those most commonly requested being:

- **Training related to specific conditions**, notably anxiety management, depression, and drug awareness. There were also requests for training in ADHD, self-harm, school-related difficulties, and in behaviour management (3.2f, 3.3gi, 3.3gii, 3.3gv). Training in behaviour management was a particular need for GPs (3.3gi), nursery nurses and health visitors (3.3gvi, 3.4avi) and SENCOs (3.4bv) Social workers also raised specific skill needs including restraint techniques (3.4cvi)

- **Training related to mental health generally.** Tier 1 staff recognised that they needed to increase their understanding of mental health conditions generally. This included definitions of mental illness, recognition and management of problems, and an understanding of the environmental and social causes of mental illness. This
includes updates on current and best practice (3.3gv, 3.3gvi). This training need was stated by health visitors and nursery nurses (3.3gv), health visitors (3.4aiv), SENCOs (3.4bv) and social workers (3.4cvi)

- **Training related to referrals.** This includes increasing understanding of which cases are appropriate for referral, to which agency they should refer particular cases and the referral process (3.3diii, 3.3gvi). This need was particularly stated by SENCOs (3.4bv), especially those from the central area (3.3gi), and by health visitors and nursery nurses (3.3dii, 3.3gi)

- **Training in awareness of specialist services.** The role of CAMHS was not clearly understood by many respondents. The training need here is to increase understanding of the specialist services that are available, the help and support that these can offer and what might take place during their consultations (3.3gvi). This need was particularly stated by school nurses and social workers (3.3dii, 3.4cvi (sw), health visitors (3.4av), and SENCOs (3.4bv)

- **Training in communication skills.** This was seen as vitally important, for communicating both with clients and their families (3.4bv).

- **Team working with other agencies/interagency work and communication.** This was seen as particularly important by SENCOs (3.3gvi, 3.4bv) and health professionals from the South Warwickshire PCT (3.3gi), health visitors and nursery nurses (3.3gvi)

- **Health visitors** identified a wide range of training needs stemming from the Enhanced Public Health role. These included training in assessment skills, community working, the identification of community health needs, the funding and audit of community work and training in various aspects of group work (3.3i, 3.4ax)

- There was, however, concern that increased training should not legitimise the expansion of the Tier 1 role or lead to a transfer of work from Tier 2 to Tier 1 (3.2c).

### 3.4dv Barriers to Training

The majority of respondents identified barriers to attending or completing training courses. The reasons most commonly given were:

- Lack of availability of courses (3.3h, 3.4cv(sw))
- The cost of courses and lack of funds in the training budget, also the cost of supply cover (3.3h, 3.4aiii(hv), 3.4cv (sw).
- The difficulty in taking time off work whilst also meeting workload demands (3.2g, 3.3h, 3.4aiii(hv), 3.4bv (SENCO), 3.4cv (sw).
- Difficulties in attending training, due to part-time working, family or work commitments 3.4biv(SENCO).
Further barriers included:

- The way in which training priorities were established which could result in a mis-match between the needs of the individual and the agency. 3.2g, 3.4biv(SENCO), 3.4cv (sw).
- There appeared to be a problem in alerting staff to the existence of courses that were available 3.3h, 3.4aiii, 3.4biv, 3.4cv.

3.4dvi Availability of Support

In Coventry a Primary Mental Health Team had been established, and in the southern part of South Warwickshire a Primary Mental Health Worker had been appointed to provide support to Tier 1 professionals (3.2b).

About two-thirds of respondents said that there were staff both within their own organisation and in other organisations that they could call on for support and advice.

- The professionals most commonly identified as being available for this were psychologists, CAMHS, CPN and health visitors (3.3fiii).
- SENCOs from all areas, except Eastern, were most likely to say that they would call on psychologists and DISCS/LABS for support, whereas SENCOs in the Eastern area only identified DISCS/LABS (3.3fiii).
- Health professionals from all three PCT areas identified psychologists, CAMHS and CPNs as sources of support and advice (3.3fiii).

3.4dvii Support Needs of Tier 1 staff

The support needs most commonly identified were:

- Support when families refuse specialist help or are not co-operative 3.2c, 3.4cviii(sw).
- Telephone support/advice so that the Tier 1 worker can readily check that they are taking the right approach, and during lengthy waiting times (3.2c, 3.4avii, 3.4cvii).
- Support with difficult children/complex cases (3.2c, 3.4avii(hv)).
- Updates on research findings and current and best practice (3.2c, 3.4av(hv)).
- Support and feedback following referral and if referred cases are not accepted (3.4avii(hv)), 3.4bv(SENCO), 3.4cvii(sw).
- Support from specialist services during lengthy waiting times for appointments (3.4avii(hv)).
- Improved communication across all Tier 1 services & inter-agency case discussion (3.4bv (SENGO), 3.4cix (sw).
3.4d viii Relationship between Tier 1 and CAMHS
The quality of relationships between those working in Tier 1 and CAMHS appears to be variable. Although many respondents had good relationships with individuals within CAMHS and were able to approach them informally for advice, and formally via referrals, there were also a number of issues that caused concern. In particular these were:

- **The long waiting times following referrals.** This was regarded as detrimental to the child and caused distress to the family. It also had implications for the workload of the person referring, who commonly felt that they had already exhausted their strategies for helping and were unsure how to provide support during this lengthy period. They did, however, recognise that these specialist services were also under enormous pressures. (3.2a, 3.3d, 3.4bvi(SENCO), 3.4cviii).

- **CAMHS’ rejection of referrals.** This was frustrating to those who made referrals because they often did not understand the reason for the rejection, and did not know where else they could refer. They also experienced frustration because referrals were usually made only when they had exhausted their strategies for helping the child, so that a rejection of the referral left them without anything further to offer (3.2a, 3.3diii).

- **Geographical variation in the availability of services.** There was concern that children in some areas were unable to access the full range of possible services because these were not available across the whole PCT area (3.3diii).

- **Support from CAMHS.** Whilst CAMHS was recognised as a valuable source of support there was some concern about the extent to which this support was available. Health visitors, psychologists and the Primary Mental Health Worker were seen as particularly useful sources of support, but again, limitations in their capacity to offer support were noted (3.2b).

3.4d ix Multi-Disciplinary Working
There was evidence of multi-disciplinary working across the professions, especially around the assessment framework and there was also clear support for this concept and for inter-agency co-operation and the sharing of skills and knowledge. Some concerns were raised, mainly:

- There is a need for better understanding of other professionals’ roles (3.2d, 3.2e, 3.4aix(hv)).
- Clear communication systems need to be developed across agencies 3.4aix(hv), 3.4bvi(SENCO).
- There can be confusion over boundaries of responsibility and consistency of approach (3.2e, 3.4aix(hv)).
• There are practical difficulties in organising inter-agency conferences (3.2e).
• There is a need for multi-agency training to enhance the effectiveness of joint working (3.2e, 3.4bvi).
• The rules on confidentiality need to be clarified across agencies. Information should not be shared inappropriately but for multi-agency working to be effective, issues of confidentiality should be clarified. (3.4aix(hv), 3.4cix(sw), 3.4bvii(SENCO)).
• Skill-mixing can increase training needs (3.4aix(hv)).
CHAPTER FOUR

AUDIT

This chapter describes the audit, which was carried out on new referrals which were made to CAMHS and on those who were offered appointments with CAMHS in October and November 2002.

4.1 Referrals

In all, 258 completed audit sheets were collected during the audit period (October/November 2002) detailing new referrals to CAMHS. Of these 114 (44.2%) were returned by North Warwickshire, 59 (22.9%) by South Warwickshire and 85 (33.0%) by Coventry CAMHS.

Lacking information on total numbers of new referrals to each service during the data collection periods, the extent to which there was missing data is unknown.

4.1a Details of Clients who were Referred

There was an even split between male and female referrals in each area. The mean age of prospective clients across all localities was 9.8 years. In Coventry the mean age was 9.2 years, in North Warwickshire 10.0 years, and in South Warwickshire 9.9 years. The range of ages broken down into categories is shown in Table 4.1 below:

<table>
<thead>
<tr>
<th>Age</th>
<th>Overall</th>
<th>Coventry</th>
<th>North Warwickshire</th>
<th>South Warwickshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>31 (11.8%)</td>
<td>13 (14.8%)</td>
<td>13 (11.0%)</td>
<td>5 (8.8%)</td>
</tr>
<tr>
<td>5-9</td>
<td>92 (35.0%)</td>
<td>32 (36.3%)</td>
<td>40 (33.9%)</td>
<td>20 (35.1%)</td>
</tr>
<tr>
<td>10-14</td>
<td>98 (37.2%)</td>
<td>30 (34.1%)</td>
<td>45 (38.1%)</td>
<td>23 (49.1%)</td>
</tr>
<tr>
<td>15-18</td>
<td>42 (16.0%)</td>
<td>13 (14.8%)</td>
<td>20 (16.9%)</td>
<td>9 (15.8%)</td>
</tr>
</tbody>
</table>

The proportions of referrals known to be in full-time education were also consistent across the three areas. Overall 85.8% of those referred were known to be attending school.

South Warwickshire and Coventry both recorded whether the client had been previously discharged from the service and was now being re-referred. In South Warwickshire 12 cases (23.1%) were re-referrals, while for Coventry the figure was 13 (15.5%). This data was not available for North Warwickshire.
4.1b Mode of Referral

Overall, the majority of referrals were made by GPs (63.6%), with the next largest group of referrers being paediatricians (14.4%). However this masks considerable differences between the three areas.

In the Coventry area all reported referrals came from medical professionals, with GPs accounting for 82.9%, and other doctors a further 13.4%. Dieticians provided the final 3.7%. In South Warwickshire, there was a similar picture, with GPs accounting for 64.4%, paediatricians a further 15.3% and other medical professionals, including health visitors and psychologists, 8.5%. A small proportion also came from education (3.5%) and social services (5.3%).

In contrast North Warwickshire show substantially more variation in referring services. Although GPs (50.9%) and paediatricians (15.8%) still accounted for the majority of cases, there were more substantial numbers of referrals from education (14%) and social services (8.8%). Referrers from these professions include school health teams, head teachers, and Youth Offending Teams.\footnote{In South Warwickshire referrals from the Youth Offending Team are not included as these are dealt with internally by the health worker.}

The variation in referring agencies was reflected in the range of Tier 1 professionals identified from the referrals as having been involved in assessing and managing cases prior to referral. However, there were a very large number of cases (91, 35.3%) for which such a history of contact prior to referral was either not given in the referral letter or was not recorded on the audit sheet. This was particularly true in Coventry where no data were recorded for 60.7% of cases. Table 4.2 below gives a summary of the involvement by Tier 1 professionals in cases referred to CAMHS for the 167 cases for which data was available.

<table>
<thead>
<tr>
<th>Professions involved (Percentage of cases)</th>
<th>Overall</th>
<th>North Warwickshire</th>
<th>South Warwickshire</th>
<th>Coventry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/Consultants</td>
<td>44.8</td>
<td>15.4</td>
<td>82.1</td>
<td>36.4</td>
</tr>
<tr>
<td>Other medical staff</td>
<td>35.6</td>
<td>53.8</td>
<td>28.6</td>
<td>27.3</td>
</tr>
<tr>
<td>Education</td>
<td>27.6</td>
<td>26.9</td>
<td>17.9</td>
<td>36.4</td>
</tr>
<tr>
<td>Social services</td>
<td>18.4</td>
<td>34.6</td>
<td>3.6</td>
<td>18.2</td>
</tr>
</tbody>
</table>

Table 4.2 Professions Involved in Referrals from each Area
4.1c Reasons for Referral
Overall, the three most common reasons for referral were ‘behaviour problems’, ‘anxiety/depression/self-harm’ and ‘family difficulties’, and each of these explained approximately 30% of cases. Whilst the first two reasons for referral were evenly spread across the three areas, the latter showed more variation. In South Warwickshire 55.9% of cases cite ‘family difficulties’ as a reason for referral, whilst in Coventry this was true for only 7.2% of referrals.

Further variation was evident between areas in relation to less common problems. ‘Eating disorders’ were substantially more common as a reason for referral in Coventry, whilst ‘conduct disorder’ was more common in both North & South Warwickshire.

4.1d Appropriateness of Referrals
Respondents were asked to assess whether they felt the referral had been appropriate for referral to CAMHS. In each area the vast majority of cases were deemed to be suitable. Indeed in North Warwickshire all cases were seen as appropriate apart from two (1.8%) for which the response was ‘unsure’. For both Coventry & South Warwickshire more than 80% of cases were seen as suitable, with the remainder deemed inappropriate (15.3% & 18.6% respectively).

Respondents were also asked to assess the timing of the referral. Chart 4.1 illustrates that once more North Warwickshire showed a greater level of satisfaction with the referral process, with over 90% seen as being referred at the ‘right time’.

Of the eleven cases thought to be inappropriate within South Warwickshire, ten were felt to have been more appropriate for referral to other services or professionals, including family mediation, school support services, social services, and health visitors. Eight (13.6%) were to sent back to the Tier 1 professional that referred the case, half for further information and half seen as inappropriate for CAMHS.

In Coventry 13 cases were deemed inappropriate, eleven of which were to be referred to other Tier 1 referrer (not specified) and two back to the original referrer.
Chart 4.1 - Timing of referrals by area

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Coventry</th>
<th>North Warwickshire</th>
<th>South Warwickshire</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Referral N/A</td>
<td>Too late</td>
<td>Right time</td>
<td>Too early</td>
</tr>
</tbody>
</table>

Legend:
- Referral N/A
- Too late
- Right time
- Too early
4.1e Inappropriate Referrals

4.1ei Mode of Referral

Given that the majority of referrals came from GPs, it is unsurprising that the vast majority of inappropriate referrals were also attributed to this group. It is worth noting however that across all three areas none of the referrals from social services or education were deemed to be unsuitable.

Regarding reasons for referral, ‘Conduct disorder’, ‘Complex Developmental Disorders’, ‘Grief/Loss/PTSD’ and ‘Behavioural Problems’ all showed high levels of suitability for referral (all above 92% accepted). In contrast ‘Family Difficulties’ & ‘Eating Disorders’ seem more likely to be rejected, with 14.3% and 13.7% respectively deemed inappropriate. These figures are obviously much higher when North Warwickshire is excluded, rising to 25.6% and 17.6% respectively. It is likely that this variation is explained by the gravity or complexity of the situations referred, although no data was collected to reflect this. It is held that a large number of those referring with ‘Family Difficulties’ that are rejected are likely to be post divorce, where mediation is seen as more suitable. Similarly in South Warwickshire adolescents with eating disorders are reportedly all seen, while eating problems in infancy are usually dealt with through support to a health visitor.

4.1eii Details of Clients whose Referrals were Deemed to be Inappropriate

The following table shows the numbers and percentages of young people referred to CAMHS who were deemed inappropriate for the service or for whom the respondent was ‘unsure’.

<table>
<thead>
<tr>
<th>Age</th>
<th>Overall</th>
<th>North Warwickshire</th>
<th>South Warwickshire</th>
<th>Coventry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 4</td>
<td>4 (12.9%)</td>
<td>0</td>
<td>3 (60%)</td>
<td>1 (7.7%)</td>
</tr>
<tr>
<td>5 – 9</td>
<td>5 (5.4%)</td>
<td>0</td>
<td>2 (10%)</td>
<td>3 (9.4%)</td>
</tr>
<tr>
<td>10 – 14</td>
<td>12 (12.3%)</td>
<td>1 (2.3%)</td>
<td>6 (26.1%)</td>
<td>5 (16.7%)</td>
</tr>
<tr>
<td>15 – 18</td>
<td>6 (14.5%)</td>
<td>1 (5%)</td>
<td>0</td>
<td>5 (38.5%)</td>
</tr>
</tbody>
</table>

The numbers are very small but a couple of percentages stand out, principally the high proportion of older teenagers in Coventry and very young children in South Warwickshire whose referrals were deemed inappropriate.

Very little difference is evident, in any of the three areas, between male and female referrals, or between those who are in full-time education and those who are not.
A contrast is evident however where clients have been previously discharged and later re-referred to the service. While these data were missing for North Warwickshire, in both of the other areas those who had been within the service before were more likely to be seen as appropriate for referral this time (92% compared to 80%).

4.1eiii Outcomes
Of the 85 cases referred to Coventry that were accepted as appropriate, only 21 (24.7%) were put forward for urgent allocation. A further 44 (51.8%) were placed on the waiting list, and 3 referred to the Primary Mental Health Team. Six referrals were seen as ambiguous, with inadequate information having been supplied, five of which were sent a liaison letter (5.9%) with a further 1 (1.2%) being given a one-off assessment. The rest were deemed inappropriate as described above.

Within South Warwickshire only 9 (15.3%) were seen as needing urgent allocation, three of which were to be seen on the day of the referral. A further 12 (20.3%) were sent an opt-in letter for assessment and 21 (35.6%) placed on the waiting list. Three (5.1%) were referred to other Tier 1 professionals and 2 (3.4%) to other Tier 2/3 CAMHS professionals.

For North Warwickshire 16 (14.0%) were seen as urgent and 92 (80.7%) sent an opt-in letter. One client (0.9%) was sent to another Tier 2/3 CAMHS professional.

4.2 Assessments
The following data refers to 79 new referrals that were offered appointments at CAMHS between September and November 2002. Of these 46 (58.3%) were in the Coventry area, 25 (31.6%) in North Warwickshire and only 8 (10.1%) in South Warwickshire. Lacking data on the total number of new cases assessed by each service during the audit period, it is unclear the extent to which there was missing data.

4.2a Attendance
Overall, only 57 of the 79 appointments were kept, giving a non-attendance rate 27.8%. The non-attendance rate was similar for all three services. Of those failing to attend, 17.9% had already been offered a previous appointment. For the majority of cases the reason for non-attendance was not known. Where it was known reasons included:

- Client no longer in need of assessment
- Conflicting appointments
- Parental problems with organising attendance
- Holiday
• Illness

4.2b Mode of Referral

All referrals for whom audit data were provided had been made by medical staff. This contrasts with the pattern of referrals that occurred during this period, which showed that a range of different professions had made referrals to CAMHS. Once more in each area the majority of cases had been referred by a GP. Other referrers included (in descending order):

• Speech and language therapy
• Health visitors
• SCMO
• Paediatricians

The most common reasons for referral were ‘behavioural problems’ and ‘anxiety/depression/self-harm’. Additionally in North Warwickshire ‘grief/loss/PTSD’ was a common reason, as was ‘family difficulties’ in South Warwickshire. In Coventry the spread of problems was more even with ‘eating disorders’ and ‘complex development disorders’ occurring more frequently.

4.2c Assessments Undertaken

Of the 57 new referrals that were assessed, some were for more than one client and as a result 61 individuals were included.

4.2ci Details of Client who were Given Assessments

Overall there were slightly more female clients than males (60.7% female), although in North Warwickshire 76.5% were female and in Coventry only (57.6%). Four (66.6%) of the six assessed in South Warwickshire were male.

The mean age of those assessed across all three areas is 9.9 years, and there was little variation between the areas in age distribution. The range of age groups assessed breaks down as follows:

**Table 4.4 Age of Clients Assessed by CAMHS, by Area**

<table>
<thead>
<tr>
<th>Age</th>
<th>Overall</th>
<th>Coventry</th>
<th>North Warwickshire</th>
<th>South Warwickshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>5 (9.1%)</td>
<td>2 (6.3%)</td>
<td>3 (17.6%)</td>
<td>0</td>
</tr>
<tr>
<td>5-9</td>
<td>17 (30.9%)</td>
<td>11 (34.4%)</td>
<td>4 (23.5%)</td>
<td>2 (33.3%)</td>
</tr>
<tr>
<td>10-14</td>
<td>28 (50.9%)</td>
<td>16 (50.0%)</td>
<td>8 (47.1%)</td>
<td>4 (66.7%)</td>
</tr>
<tr>
<td>15-18</td>
<td>6 (10.9%)</td>
<td>3 (9.4%)</td>
<td>3 (17.6%)</td>
<td>0</td>
</tr>
<tr>
<td>Over 18</td>
<td>2 (3.6%)</td>
<td>0</td>
<td>2 (11.8%)</td>
<td>0</td>
</tr>
</tbody>
</table>
In North & South Warwickshire all those for whom the question was applicable were known to be in full-time education. In Coventry three cases were not.

Relatively small numbers of clients had been worked with by the services before. In South Warwickshire one was known to have been discharged and now re-referred. Similarly in North Warwickshire three had been dealt with previously and in Coventry, six young people.

4.2d Concordance with Assessment of Referrer

Chart 4.2 shows the level of concordance between those making this assessment and the initial referrer. Despite the low numbers a substantial amount of disagreement is evident in both North Warwickshire & Coventry, and in particular a higher level of ‘Complete disagreement’ within Coventry.

Reasons for disagreement include:
- Apparent additional issues not considered in making the referral.
- More complex situation. Additional assessment necessary.
- Assessment no longer necessary.
- No diagnosis made by referrer.

Disagreement was most common when clients were referred for ‘Behaviour problems’ (60% of such referrals) and ‘Anxiety / Depression / Self-harm’ (44.4%). Similarly disagreement was most common in the 5-9 age group (68.7% of referrals of this age, almost twice that of all other age groups). No such relationship is evident when male and females are compared.
4.2e Timing of Referral

Chart 4.3 shows the respondents assessment of the timing of the referral. It is clear that the highest level of dissatisfaction is apparent in Coventry, where almost a third of referrals are assessed as being at the wrong time. Although it is based on very small numbers, South Warwickshire report a 100% agreement with the timing of referrals.

![Chart 4.3 - Timing of referral for new assessment by area](image)

**4.2f Suitability of Assessor**

An additional question was asked to those responding from Coventry about whether the referral had reached the right level of the service. In all cases the respondent felt that they were the correct people to deal with the case, although in three cases only a brief intervention from them was necessary.

**4.2g Outcomes**

The following outcomes of the assessment were reported:

**Table 4.5 New Assessment by CAMHS, by Area**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Overall</th>
<th>Coventry</th>
<th>North Warwickshire</th>
<th>South Warwickshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client will be seen again by assessor</td>
<td>40 (70.2%)</td>
<td>29 (85.3%)</td>
<td>6 (35.3%)</td>
<td>5 (83.3%)</td>
</tr>
<tr>
<td>Client will be referred to other Tier 2/3 CAMHS professional</td>
<td>25 (43.9%)</td>
<td>13 (38.2%)</td>
<td>12 (70.6%)</td>
<td>0</td>
</tr>
<tr>
<td>Tier 2/3 professional to join assessor</td>
<td>2 (3.5%)</td>
<td>2 (5.9%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other agency to join assessor</td>
<td>7 (12.9%)</td>
<td>7 (20.6%)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

In all areas the high percentage of cases which will either be seen again by the assessor or referred on to another Tier 2/3 CAMHS professional reflects the high proportion of referrals seen as appropriate.

4.2f Summary of Findings from Audit

The findings from the audit to some extent complement those in chapter 3 but also shed new light on the referral and assessment process. The audit reveals that GPs are involved in the majority of referrals, and yet this group reported in the postal survey that they had little involvement in CAMH. Family difficulties and eating disorders show a higher level of rejection upon referral than other conditions, which may suggest that referrals are being made inappropriately for children with these conditions or may, alternatively, reflect a reluctance on the part of CAMHS to become involved with clients with these conditions. There were also differences in outcomes noted between Coventry and Warwickshire: in North Warwickshire all the referrals were dealt with by either sending them an opt-in letter or seeing the client urgently. No children were placed on the waiting list. By comparison, 52% of referrals to Coventry were placed on the waiting list.

In the audit of assessments, low levels of concordance were noted between the referrer and the person making the assessment in Coventry and North Warwickshire. In Coventry and South Warwickshire, over 80% of referrals would be seen again by the assessor, which indicates that the majority of these referrals are appropriate. In North Warwickshire, however, only 35% of referrals would be seen again by the assessor, which indicates a higher level of inappropriate referrals in this area.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this chapter is to draw the threads together and to make suggestions for the way forward. Before examining these issues in more detail, three general conclusions must be emphasised:
• Tier 1 staff have a wide range of CAMHS-related training needs and appear keen to participate in further training, although workload demands and other barriers do not readily facilitate this.

• All Tier 1 staff felt that they had access to Tier 2 and 3 support, whether formal or informal, but the support that is available needs to be strengthened.

• Relationships between Tiers 1 and 2 are reasonably good overall, but there were criticisms of long waiting times following referral and a lack of support and feedback on referral. There was evidence that multi-disciplinary working and liaison existed but also scope for improvement.

5.1 Current Training and Support

5.1a Professional Qualifying Training

Our findings show that professional qualifying training was felt by many Tier 1 respondents to be very limited in scope and had not fully provided them with the range of skills and knowledge that would adequately prepare them for their role with CAMH. Only 40% of respondents to the postal survey felt that their training had prepared them to recognise a range of common mental health problems in children and adolescents, and only 25% felt prepared to manage children/adolescents with these problems. Concern that their vocational training had not prepared them for their role in CAMH was particularly expressed by social workers, SENCOs and practice nurses. The main criticism was the lack of formal training in relation to CAMH or that training had not provided specialist assessment or clinical skills. SENCOs were also concerned that newly trained teachers lacked understanding in child development. Vocational training can not fully prepare staff for their work in CAMH and it is recognised that new entrants will learn a great deal from their colleagues, from supervisions and through experience gained over time, but there is still a need for vocational training to prepare the theoretical groundwork and at least expose students to the range of conditions that they will encounter through work placements. In particular, students should learn definitions and causes of mental illness and the signs and symptoms of common mental health conditions so that they have a basic understanding of mental health issues and some skills in recognition.

5.1b Current Continuing Professional Development (CPD)

A number of training courses for CPD had been accessed by staff and although many of these, or aspects of these, were found to be helpful, there were criticisms of some courses. SENCOs and social workers criticised the child protection courses that they had attended for the sole focus on physical abuse. They felt that emotional abuse, and the impact of any type
of abuse on a child’s mental health should be included. Other criticisms made generally by Tier 1 staff were that many courses were too basic and needed follow-ups.

In addition to attendance at organised training courses there was evidence that some professionals enrolled themselves on courses, which they attended in their own time and at their own cost. This commitment to continuing professional development was a way of overcoming barriers to attending training courses and ensuring that their skills and knowledge were improved or kept up to date.

There was also evidence that learning took place opportunistically on the job, and this type of learning was regarded as valuable. Experienced colleagues were regarded as being a particularly valuable source of information, and it was felt that agencies should facilitate their knowledge being cascaded through the organisation. This was felt to be particularly important in agencies, such as Social Services, where there is a higher staff turnover and this knowledge can be lost.

5.1c Support from Tiers 2 and 3

The findings show that there is evidence of formal and informal channels of advice and support operating between Tiers 1 and 2/3. In the case of formal support, this has been bolstered in Coventry by the development of the PMHT and in the southern part of South Warwickshire by the appointment of a part-time PMHW. The appointment of PMHWs was recommended in the HAS report (1999) and it is encouraging to find that this has recommendation has been adopted in Coventry and is being piloted in South Warwickshire. These roles have been found to be helpful but limited in their capacity and availability, which has an impact on the amount of support provided. Furthermore, this support is not provided equally across the area as the PMHW covers only the southern part of the South Warwickshire Primary Care Trust. There is no equivalent role in the northern part of South Warwickshire Primary Care Trust or in North Warwickshire.

Informal support is also in evidence across the three Primary Care Trusts, with respondents to the postal survey saying that they could call upon people both within their own organisation and other organisations for advice and support. The professions most commonly named as being useful in this capacity were psychologists, CAMHS, CPN and health visitors. SENCOs in the eastern area mainly called upon DISCS/LABS for support whereas SENCOs from the other areas would also call upon psychologists.

5.2 The Role of Tier 1 in Relation to CAMH
The majority of Tier 1 professionals were involved with CAMH and for some, especially many social workers, this was a significant part of their workload. All the interviewees and half of those who completed the postal survey indicated that this aspect of their workload had increased. This was most commonly reported by school nurses from all three Primary Care Trusts and by SENCOs from the South, Nuneaton and Bedworth. Although the evidence for this increase in the CAMH aspect of the workload was not independently verified, it does suggest that demand for support from Tier 2 will increase as Tier 1 work with both more cases and more complex cases. The audit showed that the majority of referrals involved GPs, despite their reported low levels of involvement in CAMH.

5.3 Ability of Tier 1 to Recognise, Manage and Appropriately Refer More Complex Cases
Many practitioners lack the confidence to work effectively with CAMH problems, and this has implications for their ability to recognise, manage and refer cases as appropriate.

- Over a third of respondents had little or no confidence to identify a number of types of common CAMH problems. SENCOs tended to be least confident to identify these problems. Yet it is essential that Tier 1 professionals feel confident to identify mental health problems because these are the professionals that clients and their families will approach for diagnoses and help with problems, and they also have an important role as ‘gatekeepers’ to more specialised services. Inability to correctly identify specific mental health problems will result in misdiagnosis that will have implications for any treatment that may be offered.

- Over a third of respondents also expressed little or no confidence to manage a number of common mental health conditions. These conditions; early onset phobia, minor self-harm, solvent, alcohol or drug abuse and emotional problems presenting with physical symptoms, are normally managed within Tier 1 so this finding is also of concern. Of particular concern is the finding that over half of GPs lacked confidence to manage minor self-harm, early onset phobia, drug abuse, eating problems and the emotional aspects of child protection. Their lack of confidence to manage these conditions has implications not only for treatment, but may also lead to inappropriate referrals.

- The findings show that, overall, there was greater confidence to refer conditions both to other Tier 1 professionals and to more specialised services. Despite this, over a quarter of respondents to the postal survey lacked confidence to refer five conditions to other Tier 1 services and seven conditions to more specialised service (see table
3.8). This greater confidence in being able to refer is not, however, supported by other information from the postal survey and from the interviews, which provide clear evidence for a need for increased information about all aspects of the referral process in order to refer cases appropriately.

5.4 Training Needs
A wide range of training needs were identified and many of these were common to all agencies and to professionals from all three Primary Care Trusts. These were summarised in section 3.4div and 3.3gvi. The main training needs were as follows.

- **A need for training in specific conditions**, especially anxiety management, depression, drug awareness, ADHD, self-harm, school-related difficulties and behaviour management. In addition to identifying these topics as training needs, many respondents to the postal survey also identified most of these conditions as ones for which they lacked confidence to identify or manage. Many of these conditions are fairly common, especially behavioural problems which were encountered by over 80% of all Tier 1 professionals with the exception of practice nurses, and was also the condition encountered most frequently, yet many GPs, nursery nurses, health visitors and SENCOs said that they needed training in behaviour management. Training in these conditions would therefore not only be of benefit to Tier 1, but might also reduce inappropriate referrals and requests for support to Tier 2.

- **A need for general training in mental health issues appertaining to children and adolescents**. Many Tier 1 staff recognise that they need to increase their understanding of mental health conditions generally and of mental health problems in children and adolescents in particular. Training in this regard might seem fairly basic, but there was a clear need for training which would include definitions of mental health problems, recognition and management of problems and an understanding of their social and environmental causes. Although this training need was widespread across Tier 1, it was particularly noted by health visitors and nursery nurses, SENCOs and social workers. Training in these issues is of fundamental importance and it is of some concern that practising Tier 1 professionals identified this as a training need. The provision of this training should help to increase the confidence of Tier 1 to identify and manage mental health conditions, whilst also helping to ensure that mental health problems in young people do not go undiagnosed.

- **A need for training in all aspects of the referral process**. There was a great deal of concern expressed about the referral process, with over three-quarters of respondents
to the postal survey stating that they needed to increase their awareness or understanding of which cases are appropriate for referral, the specialist services to which they could refer and the referral process. Health visitors, nursery nurses and SENCOs in particular said that they had this training need. The provision of training on referrals should help considerably with reducing inappropriate referrals and, in turn, save time for both Tier 1 and Tier 2 and reduce the frustration experienced by Tier 1 when referrals are rejected. The findings from the audit also suggest a need for training in referrals in order to reduce inappropriate referrals.

- **Training to increase understanding of CAMHS.** In connection with training around referrals, this will only be effective if Tier 1 staff know more about the services and the professions to which they are referring. The role of CAMHS was not clearly understood by many respondents. Training is needed to clarify the services that are available at Tier 2, the role of the different professionals at Tier 2 and the help and support that they can offer. This training need was stated, in particular, by school nurses, social workers, health visitors and SENCOs. Training in this area might lead to improved communication between the Tiers, open informal channels of support, improve formal channels of support and reduce inappropriate referrals. It would also enable Tier 1 professionals to explain to their clients the process that they would follow after a referral to Tier 2, which might reduce refusals.

- **Training in communication skills.** Training in communication skills and strategies, together with supportive literature, was identified as a training need that might help Tier 1 professionals to communicate with the parents of children with mental health problems and with parents who themselves have mental health problems. This might increase compliance with treatment recommendations and reduce rejections of offers of help or suggested referrals to Tier 2. It might also help Tier 1 professionals to deal with difficult families.

- **Training in team working with other agencies.** This is a key skill for improved inter-agency liaison and working. Training in this area was regarded as particularly important by SENCOs, health visitors and nursery nurses and health professionals from the South Warwickshire Primary Care Trust.

- **Health Visitors enhanced Public Health role.** Health visitors identified a number of training needs including training in assessment skills, community working, the identification of community health needs, the funding and audit of community work
and training in various aspects of group work, which would be needed to enable them to effectively carry out their enhanced public health role.

5.5 The Support Needs of Tier 1
A number of support needs were identified and many of these were common to all disciplines. The main support needs identified are:

- The availability of informal support for Tier 1 to enable them to manage cases effectively and to provide reassurance.
- Formal support, either telephone or face to face, once a client has been referred and during the waiting period or where families refuse a referral to Tier 2.
- Formal support where the Tier 1 professional is dealing with a case that they find difficult or complex, but is not appropriate for referral.
- Feedback following referral or a rejection of a referral. In the case of the latter, Tier 1 staff needed to know which agency it would be more appropriate to refer to and/or receive advice and support to manage cases that have been rejected.
- Updates on current and best practice to ensure that Tier 1 keep up to date with knowledge and practice.

5.6 Identified Barriers to Meeting Training and Support Needs
A number of barriers to attending training courses were identified and ways will need to be found to overcome these, as far as possible, to ensure that as many Tier 1 professionals as possible are able to participate in organised training courses.

There was a perception that there was a lack of appropriate courses for staff to attend and/or a lack of awareness of the availability of training courses. This finding suggests that the ways in which training courses are notified to staff or advertised needs to be reconsidered in order to ensure that staff are given maximum opportunity to attend courses.

There is a tension between individual training needs and those identified at team, school or county level. This sometimes results in the self-perceived training needs of individuals not being met because they do not match with organisational training programmes or priorities.

Pressure of workload together with the feeling that staff could not take the time away from their work to attend training was a major barrier to attending training. Staff commitment to their work responsibilities is a significant barrier, which is not easily overcome. The cost of courses and the lack of funds in the training budget was a further important barrier and associated with this, was the cost and availability of staff cover.
There are practical problems in attending courses, which includes fitting training around family responsibilities or part-time working hours. Our findings show that extended lunchtime sessions have been popular and this might overcome these problems. The geographical location of courses was a further issue because lengthy travelling time could deter attendance; in this regard our findings suggest that busy staff are more likely to attend local courses so that they do not have lengthy travelling times.

These comments indicate organisational and personal barriers that hinder the uptake of available courses. They suggest a need to review how courses are advertised, whether they are repeated, and whether there is flexibility in their timing and duration to encourage attendance.

5.7 Relationships between Tier 1 and CAMHS
There were many examples of good relationships with Tier 2 services, both formally and informally, and a recognition that Tier 2 services were limited and over-stretched. This, together with the concern over long waiting lists, suggests that Tier 1 staff avoid making demands on Tier 2. Despite the examples of good relationships, there is evidence of frustration with the long waiting lists and lack of feedback on referrals and when referrals are rejected. This frustration arises from concern for the impact on clients and their families and a need for a greater degree of support to the Tier 1 referrer. The long waiting times following referrals were heavily criticised and Tier 1 professionals needed strategies to help them to cope and support during the lengthy waiting times. They also needed feedback on referrals and, where a referral was rejected, continued support to manage the client without specialist support. Another area of frustration with Tier 2 arose when the Tier 1 referrer felt that their extensive knowledge of the child was not taken sufficiently into account or where they felt that the referral process was too bureaucratic or undermined their judgment about the client. The provision of support in these areas could only improve relationships between Tiers and CAMHS and would have the added benefits of opening up further channels of communication and increase inter-agency working.

There was evidence of multi-disciplinary working and inter-agency working practice, particularly in relation to complex cases. The assessment framework had provided opportunities for better liaison between agencies but had also highlighted the difficulties in bringing together different professional groups. The pattern of success in inter-agency working was not widespread, however and further progress could be made. For example, there was some evidence of confusion over boundaries of responsibility, inconsistent approaches from different agencies and a lack of shared priorities. Generally there was
evidence of support for improving inter-agency co-operation, although there is not widespread acceptance of the need for this co-operation, which suggests that further work is needed to ensure that all staff understand the benefits of inter-agency cooperation.

There was also evidence of communication between agencies needed to be improved. There is a need to increase the knowledge and enhance understanding of the various roles undertaken by other Tier 1 professionals. One particular aspect, which needs improved inter-agency communication, is the issue of confidentiality guidelines where agencies need to work together to ensure information is shared appropriately between agencies and with the clients consent.

5.8 Project Recommendations
5.8a Recommendations for the Services
Written protocols and guidelines should be developed to aid Tier 1 to identify and manage CAMH conditions.
Our findings showed that many Tier 1 professionals lacked the confidence to identify or manage many CAMH problems. This indicates a training need, but also the need for information to which Tier 1 professionals can readily refer. It is recommended that written protocols are developed, and regularly updated, which would aid Tier 1 with the process of identification and management of CAMH. These written protocols would be of particular use to new entrants to the profession or to their current post and to those who feel that they have an unmet training need.

Written protocols or flow-charts should be developed to aid the referral process
There was a clear need for further guidance on all aspects of the referral process and this also indicates a need for written guidance in addition to training. This guidance could take the form of a series of flow-charts or written protocols which would assist Tier 1 professionals to identify whether or not their client was appropriate for referral and, if so, to which agency.

CAMHS should look at ways of reducing waiting times for new referrals. The Audit Commission found that the median time for non-urgent cases was between ten and fifteen weeks (2000:46) yet some of our interviewees indicated that waits for Tier 2 services could be well in excess of this. This is a major cause of frustration at Tier 1 level and increases demands on their time to provide support during the lengthy waiting times. It is therefore recommended that CAMHS consider whether waiting times could be reduced.

There should be feedback and formalised support following referral.
A formal system of providing support following referral needs to be developed to provide support to Tier 1 during the waiting time for an appointment with Tier 2. If the referral is accepted, there should be feedback to the referrer at the beginning and end of the period of specialist intervention. If the referral is rejected, however, the rejection should be accompanied by an explanation which would help to avoid similar inappropriate referrals in future, a suggestion of a more appropriate agency to refer to (if appropriate) and advice to Tier 1 on continuing care at that level with a named Tier 2 professional nominated for support if required. Increased consultation with Tier 2 might bring a number of benefits in addition to increased support, including confidence building, empowerment, professional development and waiting list management.

**An effective communication strategy between agencies should be developed.**

It is important to develop an effective communication strategy between agencies which will have regard to: developing consistent approaches on caring for children and adolescents with mental health problems; developing shared priorities; reducing confusion over boundaries of responsibility; and, clarifying inter-agency rules of confidentiality.

**Inter-agency working in general needs strengthening.**

Inter-agency working also needs strengthening. The development of joint protocols may be helpful in this regard. Progress towards this could be made by creating links between agencies’ different policies, strategies, plans and processes.

Strategies also need to be developed to facilitate inter-agency meetings.

Effective ways of notifying staff about organised training courses need to be introduced.

It is essential to develop an effective way of notifying staff about organised training courses. The existing ways of notifying staff are ineffective as some staff report that they only find out about courses by accident, or that they are not aware of any courses. It is therefore recommended that all agencies plan more appropriate methods of advertising training courses to staff.

**Cascading of information.**

Those staff who have attended training courses should be encouraged to cascade the information to other colleagues to ensure widespread dissemination of the skills and knowledge gained on training sessions. This would be particularly valuable in organisations, which have a high turnover of staff, such as Social Services.
5.8b Recommendations for Training

Professional Qualifying Training requires strengthening. The subject of CAMH in vocational courses needs strengthening to ensure that the foundations for recognising mental health problems and an understanding of mental health problems in children are included in the curriculum. In the case of teacher training, this should include child development especially psychological development, and strategies for dealing with children with problems. Health visitors felt that vocational training should include awareness of the whole spectrum of need, and include placements to provide exposure to children with mental health problems.

Induction and CPD need strengthening

Continuing professional development is essential for all staff but is particularly necessary for new staff whose vocational training may have been inadequate to fully prepare them for their role with CAMH. Induction of new staff should therefore include guidance on the identification of mental health problems and, where appropriate, their management, and referral guidelines. The importance of learning from more experienced colleagues, in addition to organised training, is recognised and this should be encouraged by, for example, joint consultations with more experienced staff.

The design of training programmes need to take individual needs into account as well as organisational priorities.

A wide-ranging training programme needs to be organised commencing with mental health issues generally, the role of CAMHS and the referral process.

The provision of a well-structured training programme which enables professionals to become more competent, would also have the benefit of increasing confidence and empowering Tier 1 professionals in their actions.

Ways of overcoming barriers to attending training need to be addressed. In particular, short, locally-run courses are likely to be better attended. Lunchtime training sessions were advocated as one solution for encouraging attendance at training, where necessary extending the lunch-break to two hours in order to accommodate this. Ample advance notification of the training day would also facilitate attendance by allowing time to arrange staff cover and arrange workload. Small group sessions, which provided the opportunity to discuss case-studies, would be regarded as useful, as would follow-up courses.

5.8c Recommendations for Support
The PMHW role in the southern part of South Warwickshire should be extended to cover both North and South Warwickshire Primary Care Trusts.

Telephone support should be available from a named Tier 2 professional, ideally a PMHT worker. Tier 1 profs should be able to request face to face support if telephone support is not adequate for a complex or difficult case. Support should be available whether a client is being referred or not, but would be particularly valuable after referral and during the waiting time.

Regular updates on current and best practice should be provided.

5.8d Summary of Key Recommendations

- Written protocols and guidelines should be developed to aid Tier 1 to identify and manage CAMH conditions.
- Written protocols or flow-charts should be developed to aid the referral process.
- CAMHS should look at ways of reducing waiting times for new referrals.
- There should be feedback and a formalised support system following referral.
- An effective communication strategy between agencies should be developed.
- Inter-agency working in general needs strengthening.
- Strategies need to be developed to facilitate inter-agency meetings.
- Effective ways of notifying staff about organised training courses need to be introduced.
- Staff who have attended training courses should be encouraged to cascade information to other colleagues to ensure widespread dissemination of the skills and knowledge gained on training sessions.
- The subject of CAMH in vocational courses needs strengthening.
- Induction of new staff should include guidance on the identification of CAMH problems and, where appropriate, their management, and referral guidelines.
- The design of training programmes need to take individual needs into account as well as organisational priorities.
- A wide-ranging training programme needs to be organised commencing with mental health issues generally, the role of CAMHS and the referral process.
- Ways of overcoming barriers to attending training need to be addressed. For example, short, locally-run courses with ample advance notification would facilitate attendance.
- The PMHW role in the southern part of South Warwickshire should be extended to cover both North and South Warwickshire Primary Care Trusts.
• Telephone support should be available from a named Tier 2 professional, ideally a PMHT worker.
• Regular updates on current and best practice should be provided.

5.8e Recommendations for Further Research

This research could be enhanced by the addition of further research, which would increase our understanding of the training and support issues for those working in CAMH. There are three additional elements:

i) An audit of the workload of child and adolescent mental health at Tier 1. This would enable a more accurate quantification of the workload of Tier 1 practitioners than we were able to provide in this research project. It would identify the number of CAMH clients, the range of problems dealt with at Tier 1, the referrals made and the response to those referrals. In particular, it would enable us to identify where and why inappropriate referrals are made and the support given and needed during waiting times.

ii) A comprehensive literature review should be carried out to identify current and best practice in CAMH, recent policy developments and current thinking about the role of Tier 1 and Tier 2 practitioners.

iii) A service-user survey should be conducted. It was originally intended that this research should include a service-user survey but eventually this was abandoned due to substantial slippage in the project timeframe. We still believe this would be valuable, and this was also recommended by the Audit Commission (1999):58. The Audit Commission point out that children and their parents should be asked what is important to them and what they think of services. It is recommended that this service-user survey should be conducted both with clients who are referred to Tier 2 and those who are dealt with at Tier 1, to find out their opinions of the services, their views on the referral process, and their criticisms and the advantages of the services used.
References


### GLOSSARY

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMH</td>
<td>Child and Adolescent Mental Health</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>DISCS</td>
<td>Disability, Illness and Sensory Communication Service</td>
</tr>
<tr>
<td>FSW</td>
<td>Family Support Worker</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HV</td>
<td>Health visitor</td>
</tr>
<tr>
<td>LABS</td>
<td>Learning and Behavioural Support</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PMHT</td>
<td>Primary Mental Health Team</td>
</tr>
<tr>
<td>PMHW</td>
<td>Primary Mental Health Worker</td>
</tr>
<tr>
<td>PN</td>
<td>Practice nurse</td>
</tr>
<tr>
<td>PRU</td>
<td>Pupil Reintegration Unit</td>
</tr>
<tr>
<td>SEN/SENGO</td>
<td>Special educational needs co-ordinator</td>
</tr>
<tr>
<td>SN</td>
<td>School nurse</td>
</tr>
<tr>
<td>SW</td>
<td>Social worker</td>
</tr>
<tr>
<td>Tier 1</td>
<td>Primary level mental health services which includes interventions by GPs, health visitors, social workers, juvenile justice workers, school nurses and teachers.</td>
</tr>
<tr>
<td>Tier 2</td>
<td>A level of service provided by professionals working on their own who relate to others through a network rather than within a team. This includes clinical child psychologists, educational psychologists, paediatricians, (especially community paediatricians), community child psychiatric nurses or nurse specialists, child psychiatrists.</td>
</tr>
</tbody>
</table>
Appendix I

Consultation Document

I am returning the completed consultation document [please go to the first question overleaf]

I am not able/willing to be interviewed neither am I able/willing to complete the consultative document [please go to the final page of the document and follow the steps for returning the document]

Aim and Objectives of the Project
The aim of the project is to undertake an inter-agency needs assessment which will provide evidence to facilitate the strategic and comprehensive planning, delivery and evaluation of training for professionals working with children and adolescents with mental health difficulties. As a result it is hoped that the satisfaction felt by children, adolescents and families who present to Tier 1 professionals (see appendix for list of professionals) and specialist services will be enhanced.

Specifically, this research project has the following objectives

- To map current training to Tier 1 professionals related to child and adolescent mental health that is in place across the three NHS Trusts and Coventry and Warwickshire Social Services and Education Departments.
- To identify the role Tier 1 professionals already have in relation to child and adolescent mental health.
- To identify Tier 1 professionals’ views regarding their training needs related to child and adolescent mental health.
- To carry out a comprehensive assessment of the ability of Tier 1 professionals to recognise, manage and appropriately refer more complex cases onwards to the specialist CAMHS service.
- To consider the service user perspective on meeting the common mental health difficulties children and young people experience.

Instructions on completing and returning the consultation document
We hope that you will find it quick and easy to complete. We would like to invite you to comment on a number of broad headings. The headings are deliberately broad to enable you to give your views on a range of issues at this formative stage of the research. Please focus your comments on your experiences and make them specific to Child and Adolescent mental health. If you represent a single professional group e.g. health visitors then you are invited to make your responses in the light of the needs of that group. However, if you are not aligned to one
particular professional group then you should provide a more general overview unless you have specific examples to share. If you feel unable to comment on any question then please state 'No comment' and go directly to the next question. Wherever possible please add supporting evidence (anecdotal or otherwise). There may be other issues which you consider important and therefore a space has been provided for you to outline these at the end of the document. Your co-operation is most appreciated.
ABOUT YOU
Please give a brief outline of your current professional role(s) and any direct or indirect responsibility in relation to training for Tier 1 professionals. Examples of responsibility might include in-house provider, commissioner of training, professional lead, defining and voicing needs of the professional group represented. Please also print your name. (This is solely for the purpose of ensuring that we receive replies from all those to whom we have sent this consultation document.)

MAPPING CURRENT TRAINING IN RELATION TO CHILD AND ADOLESCENT MENTAL HEALTH
Please use the space below to tell us about training (vocational and post-qualification) which is currently available to Tier 1 professionals and the degree to which it serves their needs.

TO IDENTIFY THE ROLE TIER 1 PROFESSIONALS ALREADY HAVE IN RELATION TO CHILD AND ADOLESCENT MENTAL HEALTH
Which factors have been decisive in shaping the current role played by Tier 1 professionals?

How has their role changed in recent years and are any future changes in role anticipated/desirable?

ASSESSING THE SKILLS AND KNOWLEDGE OF AND SUPPORT FOR TIER 1 PROFESSIONALS
What do we know about the level of skills, knowledge and support that Tier 1 professionals have to enable them to recognise and manage common mental health conditions and to make referrals to more specialist services in both an appropriate and timely way?
Further, what do we know about gaps in skills, knowledge and support (intra-agency, inter-agency and across the different Tiers of the service) and equally are there examples where gaps in skills, knowledge and or support have been successfully plugged?

IDENTIFYING FUTURE TRAINING AND SUPPORT NEEDS
What evidence (anecdotal or otherwise) has already been collected about the future training and support needs of Tier 1 professionals?

What additional evidence is required at this stage to help us identify future training and support needs?

CONSIDER THE SERVICE USER PERSPECTIVE ON MEETING THE COMMON MENTAL HEALTH DIFFICULTIES CHILDREN AND YOUNG PEOPLE EXPERIENCE.
Have there been any recent consultation exercises with service users? If yes, what were the emergent themes?

What are the benchmarks by which to gauge firstly the effectiveness of present practice within the service, and secondly, current levels of client satisfaction with service?
PLEASE USE THE SPACE BELOW TO TELL US ABOUT ANY OTHER IMPORTANT INFORMATION WHICH YOU DO NOT FEEL HAS BEEN ADEQUATELY COVERED IN THIS BRIEF CONSULTATION DOCUMENT.

Thank you for taking the time to complete this consultation document. As stated earlier we will be contacting a sample of individuals who indicated a willingness to be interviewed. The scope of the project prevents us from interviewing all willing interviewees so please do not feel that your opinion is not valued if you are not contacted for a follow-up interview.

If you are willing to be interviewed please provide your name and contact details below. With a view to being more flexible we are able to offer telephone interviews during the day and early evening and a smaller number of face to face interviews (daytime only).

Name:

Address:

Telephone number:

Person to contact if not yourself.

Availability: e.g. Mon-Wed am

We would be grateful if you would return this consultation document by post as soon as possible. A window envelope has been provided for your convenience. You will find the address on the final page of this document. You simply need to place the completed document in the window envelope with the address showing.
Appendix To Consultation Document

**Tier 1 Professionals**
- General Practitioners
- Health Visitors
- School Health Advisors
- School Doctors
- Practice Nurses
- Child Social Workers
- Teachers
- Special Educational Needs Co-ordinators
- Education Social Workers

**Common Mental Health Problems**
- Behaviour Problems
- Sleep Difficulties
- Attachment Difficulties
- Family Relationship Difficulties
- Low mood/depression
- Anxiety
- Bereavement/loss/family break-up
- Minor self-harm
- Early onset phobias
- Eating problems
- Toileting difficulties
- School related difficulties (not primarily learning problems)
- Emotional problems, presenting with physical symptoms with no obvious organic cause
- Emotional aspects of child protection
- Solvent/alcohol/drug use

**When to refer on to Specialist Child and Adolescent Mental Health Services**
- Acutely distressed states
- Significant self-harm
- Common mental health problems not responding to primary care intervention
- Complexity of the difficult possibly affecting two or more areas of the young person and family's life
- Development disorders to include autistic spectrum disorders
- Severe mental illness
Appendix II

Information Sheet About Project

**Project Title:** Identification of Training and Support Needs for Inter-Agency Tier 1 professionals in relation to Child and Adolescent Mental Health Services (CAMHS)

**Aim of Project:** The aim of this project is to undertake an inter-agency needs assessment which will provide evidence to facilitate the strategic and comprehensive planning, delivery and evaluation of training and support for Tier 1 professionals. The project has several objectives:

- To map current training and support to Tier 1 professionals related to child and adolescent mental health that is in place across the three NHS Trusts and Coventry and Warwickshire Social Services and Education Departments.
- To identify the role Tier 1 professionals already have in relation to child and adolescent mental health.
- To identify Tier 1 professionals’ views regarding their training needs related to child and adolescent mental health.
- To carry out a comprehensive assessment of the ability of Tier 1 professionals to recognise, manage and appropriately refer more complex cases onwards to the specialist CAMHS service.
- To consider the service user perspective on meeting the common mental health difficulties children and young people experience.

**Duration:** January – December 2002

**Methods:** The project has seven phases

**Literature Review**
A review of training needs assessments and models of training for Tier 1 professionals will be undertaken. This review will form part of the final written report as well as informing the different phases of the research project.

**Consultation with Stakeholders**
A range of stakeholders, identified by the Project Steering Group, from across Health, Education and Social Services, will be consulted at this formative stage in the research process. A written consultation document will be used in the first instance. This will be followed up by a telephone and face to face interviews. We have tried to make the list of consultees as inclusive as possible to capture a range of perspectives. It is intended that this will be a scoping exercise to tease out the key issues in relation to the project's five main objectives, which can be explored in more detail in the latter stages of the research.

**Questionnaire**
A questionnaire will be distributed to all health visitors, school health advisors, school doctors, child social workers and education social workers in the project area. The questionnaires will also be sent to a sample of GPs and practice nurses, teachers, special educational needs co-ordinators and specialist teachers across the project area.

The questionnaire will gather information about the respondents’ current training, the extent to which this meets their training needs, their views about priorities for further training and how this should be supported. The questionnaire will also gather information about the frequency with which the respondents encounter mental health problems in children and adolescents and the respondents’ perceptions of their ability to recognise and manage a range of mental health conditions and to refer to specialists as appropriate.
**Interviews**
A semi-structured telephone interview will be conducted to sample the views of about 40 Tier 1 professionals to provide a greater understanding of their training needs by exploring issues raised in the questionnaire in finer detail. The interviews will also provide Tier 1 professionals with a more extensive opportunity to express their views and experiences.

**Audit**
An audit will be undertaken of new referrals and new appointments over a one or two month period in 2002 in order to increase understanding of the referral process and to gather information about the timeliness and appropriateness of referrals.

**Consultation with service users**
A consultation exercise will be undertaken with service users to enable comment on the effectiveness of present practice within the services and to gauge the level of overall satisfaction with the service.

**Outcomes**
- The final report will provide a series of recommendations including the identification of training needs within each NHS Trust and options on how these needs might be met in a co-ordinated and comprehensive approach broken down in terms of geographical area and agency.
- Face to face report back of the findings to the Project Steering Group.
- A database will be set up in each NHS Trust detailing existing training to Tier 1 professionals.

**Contact Details:**
If you have any queries about the project then please contact Dr Jan Hopkins, research fellow at the Centre for Primary Health Care tel. 024 76 572950 or e-mail: j.hopkins@warwick.ac.uk. Alternatively please contact Sandra Whitlock, Visiting Research Fellow, tel. 024 76 573956 or e-mail: s.whitlock@warwick.ac.uk

**University Research Team:** Professor Jeremy Dale, Professor in Primary Care, Dr Jan Hopkins, Research Fellow and Sandra Whitlock, Visiting Research Fellow. All based at Centre for Primary Health Care Studies, University of Warwick.

**Steering Group Members:**
(Chair) Irene Lacey, Consultant Nurse/Systemic Psychotherapist
Richard Moore, Service Co-ordinator (CAMHS)
Jess Findlay, Consultant Clinical Psychologist
Maria Barnes, District Manager North Warwickshire
Richard Crombie, Education Psychologist, North Warwickshire
Lynne Laine, Clinical Lead for Health Visitors
Appendix III

STAKEHOLDER INTERVIEW SAMPLE INTERVIEW SCHEDULE

Interview Date:
Interviewee:

Opening Remarks
My name is Sandra Whitlock and I am a researcher assisting with this assessment of the training and support needs of Tier 1 professionals (including School Nurses) in relation to Child and Adolescent Mental Health across Coventry and Warwickshire. I am based at the Centre for Primary Health Care Studies at University of Warwick and my co-researchers here are Professor Jeremy Dale and Dr Jan Hopkins.

Following the consultation document, a range of stakeholders from across Health, Education and Social Services will be interviewed in this phase of the research and we are grateful to individuals such as yourself who have agreed to be interviewed.

The interview will last around 3/4 hour so I hope that this will fit in around your commitments. With your permission I would like to tape record the interview as this will dispense with the need to take copious amounts of notes. I can assure you that anything that you say will be treated with the strictest confidence and will only be heard by the research team. Is this ok?

Before we begin do you have any questions in relation to the research project in general or the interview phase in particular? Is it ok if I ask the first question?

Opening Question
Could I ask you to begin by giving some detail about your professional background and your role as Assistant Director of Education?

What strategic functions do you perform? (in terms of within Education and also working with other agencies, eg health, social services etc)
Prompt: any strategic functions in relation to mental health specifically?

Current Training/Initiatives
Could you tell me about the training and initiatives that are currently available for the various Tier 1 professionals working within education, particularly for those working with children and young people with mental health problems?
Prompt; e.g. healthy schools initiative

Is there any across-agency training/initiatives?
Are any other initiatives/training planned/needed? Are there any barriers to putting on courses (financial)/uptake of courses? Ideal format for the courses?

Gaps in skills/knowledge and support
Could you tell me what you think are the gaps in skill and knowledge of Tier 1 professionals in education. (SENCO’s, education welfare officers, teachers, nursery nurses),

What support do they receive at present? Who from? (within Education? Other agencies?)

Can you say what support needs these Tier 1 professional have to enable them to better manage or refer onwards?

Future Training
Are you able to say whether there are any specific training needs that would help these Tier 1 professionals to better identify or manage common mental health conditions?

Are you able to say whether there are any specific training needs that would help them to refer cases requiring more specialist attention?

Are you aware of any blockages in the referral system?

Closing Remarks
If you had one message for this research project what would it be?

Are there any additional comments that you would like to make on issues which are related to the research but which have not been covered

Do you have any questions.

Thank you for taking part in the research. We will be writing up the interviews which will form one part of this research. We will be reporting to the Project Steering Group in June by way of an interim report and the final report will be ready in December of this year.
Appendix IV – Postal Survey

Identification of training and support needs for Inter-agency Tier 1 professionals in relation to Child and Adolescent Mental Health Services (CAMHS)

Instructions on completing and returning the questionnaire

We hope that you will find the questionnaire quick and easy to complete. It should only take about 10-15 minutes of your time. Most questions require you to tick the relevant box(es) with small pieces of additional information sometimes required. If a question is not applicable then please indicate it as such. At the end of the questionnaire, you will be provided with an opportunity to express your views about issues which you feel have not been addressed.

Please return the questionnaire in the prepaid envelope provided by Friday 17th May 2002. Further instructions on returning the questionnaire can be found at the end of the questionnaire.

Returned questionnaires will be entered into a prize draw. The winner will receive £30 of vouchers from a store of their choice.

This questionnaire is completely confidential and will only be viewed by the research team at the University of Warwick. Your name will not be used in our analysis of the responses. We will ask you to supply your name and contact details at the end of the questionnaire only if you are willing to be interviewed at a later stage and/ or if you wish to be entered into the prize draw.
SECTION ONE: About You and Your Role

Q1. Please enter the title of your current professional role(s).
If you have a number of professional roles in which you work with children and/or adolescents, e.g. GP and School Medical Officer, then please identify all your roles beginning with the one, which has the greatest involvement with children and/or adolescents with mental health problems.

<table>
<thead>
<tr>
<th>Role No.</th>
<th>Role Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role 1</td>
<td></td>
</tr>
<tr>
<td>Role 2</td>
<td></td>
</tr>
<tr>
<td>Role 3</td>
<td></td>
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<tr>
<td>Role 4</td>
<td></td>
</tr>
<tr>
<td>Role 5</td>
<td></td>
</tr>
</tbody>
</table>

Please answer the remaining questions in this section from the viewpoint of your principal (or only) role working with children and/or adolescents (Role 1 in the box above)

Q2. How long have you been in this role? _______ Yrs _______ Mths

Q3. What proportion of your workload currently involves dealing with child and/or adolescent mental health difficulties? _______ %

Q4. During the last five years or whilst you have been in this post (if less than five years) has the proportion of your workload dealing with children and/or adolescents with mental health difficulties?

- Increased
- Stayed about the same
- Decreased

Q5a. If the amount of your workload has changed please say why

Q5b. If the nature of your workload has changed, please say how

Questions 6a-c are for Health Visitors only – all others please go to Question 7

Q6a. What impact is the enhanced Public Health role for Health Visitors having on you and your team?
Q6b. Will this enhanced Public Health role have any impact on the child and adolescent mental health work you undertake? (If so, please describe)

Q6c. Are there any training needs which stem directly from this enhanced Public Health role? If so, please state what these are.

Q7. How many times per year are you involved with children and adolescents with the following conditions? Please tick the appropriate box for each condition. If a child/adolescent presents with the same condition four times during a year then this is to be counted as four separate episodes. Similarly, if a child/adolescent presents with a number of different conditions then please count all the conditions, not just the primary one.

<table>
<thead>
<tr>
<th>Mental Health Condition</th>
<th>Number of times per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1-5</td>
</tr>
<tr>
<td>Behavioural Problems</td>
<td>6-10</td>
</tr>
<tr>
<td>Sleep Difficulties</td>
<td>11-16</td>
</tr>
<tr>
<td>Attachment Difficulties</td>
<td>17+</td>
</tr>
<tr>
<td>Family relationship Difficulties</td>
<td></td>
</tr>
<tr>
<td>Low mood/Depression</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Bereavement/loss/family break up</td>
<td></td>
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<tr>
<td>Minor self-harm</td>
<td></td>
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<tr>
<td>Early onset phobia</td>
<td></td>
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<tr>
<td>Eating problems</td>
<td></td>
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<tr>
<td>Toileting difficulties</td>
<td></td>
</tr>
<tr>
<td>Solvent/alcohol/drug use</td>
<td></td>
</tr>
<tr>
<td>Emotional aspects of child protection</td>
<td></td>
</tr>
<tr>
<td>School related difficulties (not primarily learning problems)</td>
<td></td>
</tr>
<tr>
<td>Emotional problems, presenting with physical symptoms with no obvious</td>
<td></td>
</tr>
<tr>
<td>Acutely distressed states</td>
<td></td>
</tr>
<tr>
<td>Significant self-harm</td>
<td></td>
</tr>
<tr>
<td>Severe mental illness</td>
<td></td>
</tr>
<tr>
<td>Developmental disorders to include autistic spectrum disorders</td>
<td></td>
</tr>
</tbody>
</table>
Section TWO asks about the training you received in relation to child and adolescent mental health difficulties whilst undertaking your professional qualification.

Q8. Please complete the table with details of your professional qualifications

<table>
<thead>
<tr>
<th>Title of Professional Qualifications</th>
<th>Dates of Course</th>
<th>Which mental health topics were covered on this course?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
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</tr>
</tbody>
</table>

When answering the next question please refer to the appendix. Tick ‘not applicable’ if this is a function that you would not normally expect to perform.

Q9. Do you feel that your professional qualifying training enabled you:

a) To recognise a range of common child and/or adolescent mental health difficulties?
   Yes  No  Not Applicable

b) To manage a range of common child and/or adolescent mental health difficulties?
   Yes  No  Not Applicable

c) To refer children and/or adolescents with common mental health difficulties to other Tier 1 services?
   Yes  No  Not Applicable

d) To refer children and/or adolescents with more complex mental health difficulties to specialist services as appropriate?
   Yes  No  Not Applicable

Q10. If you answered ‘NO’ to any of questions 9a-d above, please explain why you feel that the training was inadequate and how it might have been improved.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
SECTION 3 asks about the training you have received in child and adolescent mental health since gaining your professional qualification.

Please record details of post-qualification training or study days received in the last TEN years. Please include both in-house and external training. If you have not undertaken any post-qualification training then please go to question 12.

Question 11 – Please complete the spaces in the chart below

<table>
<thead>
<tr>
<th>Course No.</th>
<th>Title of post-Qualification Training Course or Study Days</th>
<th>Duration of Course</th>
<th>Main topic areas covered</th>
<th>Was this course adequate for your training needs?</th>
<th>If not, what would have made it more useful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>Yes/No</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>Yes/No</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>Yes/No</td>
<td></td>
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<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>Yes/No</td>
<td></td>
</tr>
</tbody>
</table>
Q12. Are there any factors which have encouraged/inhibited your attendance at, or completion of, training courses?

YES  NO

If yes, please give details

SECTION 4 asks you to rate your current overall confidence in relation to child and adolescent mental health

Q13. Please tell us about the level of confidence you have in being able to identify, manage and refer the following common mental health difficulties. Record your responses by entering a rating from the following scale into the appropriate space:

0 - Not a function that you would normally expect to perform  1 - No confidence  2 - Limited Confidence  3 - Good level of confidence  4 - Total Confidence

<table>
<thead>
<tr>
<th>Identify</th>
<th>(Co)-Manage</th>
<th>Referral to other Tier 1 professionals</th>
<th>Referral to more specialised services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural Problems</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sleep Difficulties</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
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</tbody>
</table>
Q14. Please tell us about the level of confidence you have in being able to refer the following mental health problems requiring more specialised services in an appropriate and timely fashion. Record your responses by entering a rating from the following scale into the appropriate space.

**0-Not a function that you would normally expect to perform**
**1-No confidence 2-Limited Confidence 3-Good level of confidence 4-Total confidence**

<table>
<thead>
<tr>
<th>Referral to more specialised services</th>
<th>Acutely distressed states</th>
<th>Significant self-harm</th>
<th>Severe mental illness</th>
<th>Developmental disorders to include autistic spectrum disorders</th>
</tr>
</thead>
</table>

Q15. Would you say you need to increase your understanding of which cases are appropriate for referral?    YES    NO

Q16. Would you say you need to increase your awareness of the specialist services to whom you can refer?  YES    NO

Q17. Would you say you need to increase your awareness of the referral process?  YES    NO

Q18. Have you had any difficulty in referring children and adolescents to the specialist services?  YES    NO

Q19. If you answered YES to question 18 above, please indicate the difficulties: *tick as many as appropriate). Otherwise, please go to question 20.

- I do not always know who to refer to
- I do not know how to refer to the specialist service
- There is not an appropriate specialist in this locality
- There is a long waiting list for cases referred to specialists
- The specialist has not accepted my referrals
- Other, please state
Q20. Are there staff within your own organisation to whom you can turn for advice, support or consultation without necessarily making a referral? YES  NO

If yes, please give their profession

Q21. Are there staff beyond your own organisation to whom you can turn for advice, support or consultation without necessarily making a referral?

YES  NO

If yes, please give their profession and organisation

Q22. Please identify any of your own training needs (please tick as many as appropriate)
To enhance communication with parents
To enhance communication with children/adolescents
Use of referral guidelines to other Tier 1 services
Preparation of case conference reports
Presentation of case conference reports
Understanding availability of help and support for families
Ethical issues including confidentiality, duties and responsibilities
Team working with other agencies and role clarification
Behaviour management
Anxiety management
Any others? (Please list)

Q23. Are there any areas of training that you need to enable you to better manage common mental health difficulties? If so, please say what they are.
Q24. Please list the three most important training/support needs that you have.

<table>
<thead>
<tr>
<th>What is the training/support need?</th>
<th>Why is this important?</th>
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<tbody>
<tr>
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Finally, there may be relevant aspects of training and support needs which are important to you but which have not been covered in this questionnaire. Please use the space below to tell us about these.

If you are willing to participate in a short telephone interview at a later date to help us further with this study, please print your name and a telephone number where we can contact you. Thank you.

Name

Daytime Telephone Number

Evening Telephone Number

Thank you for your help. Your views are important to us. Please return this questionnaire by posting it in the prepaid envelope provided by Friday 17th May. You will find the return address printed overleaf on the final page of this questionnaire. You simply need to place the completed questionnaire in the window envelope with the address showing. Returned questionnaires will be entered into a prize draw. The winner will receive £30 of vouchers from a store of their choice. If you wish your name to be entered into the prize draw then please record your name and telephone number below.

Name

Telephone Number

Jan Hopkins
Appendix V

Appendix to Postal Survey

**Tier 1 Professionals**
General Practitioners
Health Visitors
School Health Advisors
School Doctors
Practice Nurses
Child Social Workers
Teachers
Special Educational Needs Co-ordinators
Education Social Workers

**Common Mental Health Problems**
Behavioural Problems
Sleep Difficulties
Attachment Difficulties
Family Relationship Difficulties
Low mood/depression
Anxiety
Bereavement/loss/family break-up
Minor self-harm
Early onset phobias
Eating problems
Toileting difficulties
School related difficulties (not primarily learning problems)
Emotional problems, presenting with physical symptoms with no obvious organic cause
Emotional aspects of child protection
Solvent/alcohol/drug use

**When to refer on to Specialist Child and Adolescent Mental Health Services**
Acutely distressed states
Significant self-harm
Common mental health problems not responding to primary care intervention
Complexity of the difficulty, possibly affecting two or more areas of the young person and family's life
Development disorders to include autistic spectrum disorders
Severe mental illness
Sample Interview Schedule for Tier 1 interviews.

Interview Date:

Interviewee:

**Opening Remarks**

Int Could you tell me something about your role as SENCO and child protection officer?

Int Right okay. Thank you. You mentioned that the amount of your workload, dealing with children with mental health difficulties has increased, because there have been changes in family composition, and an increase in numbers of children with challenging behaviour. Why do you think there’s been this increase in challenging behaviour? Do you think it’s attributable to the family composition, or is there some other reason?

Int Yeah okay. How has this increase in workload affected your work with the children? Are you able to manage this?

Int Okay. You also say the nature of the workload has changed because you’re liaising with other professionals with families, and because of the development of ( ) curriculum in schools. Could you expand on those change please, and tell me what affect that’s had on the nature of the workload?

Int I see.

Int Okay, yeah that’s fine, thank you. If ask some questions about training now. You mentioned that you didn’t feel that your professional qualifying training enabled you to recognise, manage, or refer children with common mental health problems. Could you say why you didn’t feel adequately prepared to do this?

Int Right okay. So the whole initial teacher training programme needs looking at then.

Int Right yes, I see.

Int Yes, I see, and then try and get release from school to ( )

Int Yes okay. You also said all training that you’ve done has been related to child protection, or to a specific aspect of special needs provision. Has there been any training available to you on child and adolescent mental health?

Int No? Why do you think that’s so?

Int Yes indeed, so what you’re saying really is that the training needs to prepare staff for the fact that you know a child is not going to be a typical case, but might you know have a more of a range of a spectrum of issues.
Int That’s right, okay thank you. Now you gave details of two courses which you’d been on since qualifying. I’ll just remind you of them. One was a child protection training for two days, and the other one was education ( ) children of one day. Could you just give us a little bit more detail about the courses. The sort of topics they covered, and whether or not they were useful?

Int Okay right thank you. Now you said on the questionnaire that pressure of work has inhibited you from attending or completing training courses. Has this actually stopped you from going on courses that would have been valuable to you?

Int Okay thank you. On the questionnaire we asked whether you’d experienced any difficulties in referring children to the specialist services. I’ll read you your response, just to remind you what you said. (…)

CT (..)

Int (..) some strong views (..)

CT (..)

Int Right, and it’s causing problems with the care of the children.

CT [Becomes inaudible]

Appendix VII

Audit Tools
AUDIT OF CAMHS NEW ASSESSMENTS

1. Please record the Date referral received / /2002
   Date placed on waiting list / /2002
   Date of today’s appointment / /2002

2. Did the client attend this appointment? Yes (go to question 4) No

3. If known, please record the reason for their non-attendance otherwise state unknown.

4. Has the client been offered a previous appointment? Yes No (go to question 6) Not known (go to question 6)

5. If known, please record here the date of and reason for previous non-attendance otherwise state unknown.

6. Who referred the client to CAMHS?

7. Please state the reason for referral given by the referrer?

   If the client did not attend today’s appointment then you do not need to complete anymore questions

8. How does your diagnosis or assessment of the client’s problem(s) concord with that of the referrer?
   I am in complete disagreement I am in partial agreement
   I am in full agreement (go to question 9)

   Please state why you are not in full agreement

9. Which Tier 1 professionals have been involved in the care of this client? Please state not known if you do not have the relevant details.

10. Do you feel that the referral was made:
11. Which of the following are outcomes of today’s consultation
   - Client will be seen by assessor again in the future
   - Client will be referred back to Tier 1 referrer
   - Client will be referred to other Tier 1 professional
   - Client will be referred to other Tier 2/3 CAMHS professional
   - Tier 2/3 professional to join assessor
   - Other agency to join assessor

   Other [please state]

12. Do you think the referral has reached the right level or tier of the service
   - Yes, appropriate to my skills/role
   - Yes, but only needed brief/one off support
   - No, needs complex/intensive intervention not readily accessible to service
   - No, case should be dealt with by Tier 1 professionals
   - No, client should have been referred to another service. Please state to whom………..

13. Please complete the following table for all the clients who have been referred. *Please list client(s) who have been referred including parents/carers. Siblings and or other individuals who accompany clients should not be included here. If a client is eligible to be in full-time education then you should answer ‘yes’ ‘no’ or ‘don’t know’ as appropriate. ‘Not applicable’ only applies to those who have completed their full-time education.*

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<th>AGE</th>
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<th>In Full-Time Education</th>
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<td>Delete as appropriate</td>
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<td>Male/Female</td>
<td>Yes/No/Don’t know/Not applicable</td>
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14. Has this client been discharged and re-referred?  Yes  No

Please use the space below to record any other pertinent information. For example, do any of the family members have any of the risk factors identified in the HAS report (1995 Please refer to the list of risk factors).

Thank you for completing this form. Please return it to Richard Moore who will return forms to Jan Hopkins, Centre for Primary Health Care Studies, University of Warwick, Coventry, CV4 7AL.
AUDIT OF NEW REFERRALS (CITYWIDE CAMHS SERVICE)

1. Please record the date the referral was received __________________________

2. Who referred the client to CAMHS? ________________________________

3. Which Tier 1 professionals have been involved in the care of this client? If not known then please state this here.

   ____________________________________________
   ____________________________________________

4. Please state the reason for referral given by the referrer?

   ____________________________________________

5. Which of the following is an outcome of today’s referral filtering

   i) Appropriate Referral
      a) Urgent allocation. Please specify date…………
      b) Waiting list (send info/gathering questionnaires)
      c) Refer to Primary Mental Health Team for Tier 1 consultation/support/joint assessment

   ii) Ambiguous/Inadequate info
      a) Liaison letter/contact
      b) One off assessment

   iii) Inappropriate referral
      a) Referred back to Tier 1 referrer
      b) Referred to other Tier 1 referrer
      c) Other. Please specify…………..

6. In your opinion, do you feel that the referral was made
   Too early   About the right time   Too late   Referral N/A

7. Please complete the following table for the client(s) who’s case you are currently reviewing. List all client(s) who have been referred including parents/carers. Siblings
and or other individuals who accompany clients, but have not been referred, should not be included here. If a client is eligible to be in full-time education then you should answer ‘yes’ ‘no’ or ‘don’t know’ as appropriate. ‘Not applicable’ only applies to those who have completed their full-time education.

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</tr>
</tbody>
</table>

8. Has this client previously been discharged and now re-referred to your service?
   Yes     No

Please use the space below to record any other pertinent information. For example, do any of the family members have any of the risk factors identified in the HAS report (1995). Please refer to list of risk factors.

Thank You For Completing This Form. Please Return To Richard Moore Who Will Return Forms To Jan Hopkins, Centre For Primary Health Care Studies, University Of Warwick, Coventry, CV4 7AL.