Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Plant a Phobl Ifanc
The Children and Young People Committee

Dydd Mercher, 23 Mai 2012
Wednesday, 23 May 2012

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Angela Burns	Ceidwadwyr Cymreig Welsh Conservatives
Christine Chapman	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Keith Davies	Llafur Labour
Jocelyn Davies	Plaid Cymru The Party of Wales
Suzy Davies	Ceidwadwyr Cymreig Welsh Conservatives
Julie Morgan	Llafur Labour
Lynne Neagle	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Trish Booker	Rheolwr Gwasanaeth Mabwysiadu a Maethu, Gogledd Cymru, Barnardo's Cymru Adoption and Fostering Service Manager, North Wales, Barnardo's Cymru
Gerry Cooney	Prif Weithredwr, Cymdeithas Plant Dewi Sant Chief Executive, St David's Children Society
Dr Mike Davies	Seicotherapydd Ymgynghorol Annibynnol Independent Consultant Psychotherapist
Melanie Jones	Mabwysiadu a Maethu, Rheolwr Gweithrediadau, Barnardo's Cymru Adoption and Fostering, Operations Manager, Barnardo's Cymru
Joan Price	Rheolwr Mabwysiadu, Cymdeithas Plant Dewi Sant Adoption Manager, St David's Children Society
Yvonne Rodgers	Cyfarwyddwr, Barnardo's Cymru Director, Barnardo's Cymru
Allison Williams	Conffederasiwn GIG Cymru Welsh NHS Confederation
Dr David Williams	Conffederasiwn GIG Cymru Welsh NHS Confederation

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Kayleigh Driscoll	Dirprwy Glerc Deputy Clerk
Claire Griffiths	Clerc Clerk
Siân Thomas	Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 9.14 a.m.
The meeting began at 9.14 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Christine Chapman:** Good morning, everyone, and welcome to this meeting of the Children and Young People Committee. I remind everyone that their mobile phones and BlackBerrys should be switched off, because they affect the sound. The Assembly operates through the medium of both Welsh and English languages, and there are headsets available to hear the simultaneous translation. Just to let the witnesses know, there is no need to touch the microphones when you want to speak. We have had no apologies this morning.

9.15 a.m.

Ymchwiliad i Fabwysiadu
Inquiry into Adoption

[2] **Christine Chapman:** Today, we will be taking evidence today from St David's Children Society and Barnardo's Cymru, and I welcome our witnesses. Could I asked you please to introduce yourselves for the record?

[3] **Ms Price:** Good morning. My name is Joan Price, and I am the adoption services manager for St David's Children Society.

[4] **Mr Cooney:** My name is Gerry Cooney, director of St David's.

[5] **Ms Rodgers:** I am Yvonne Rodgers, director of Barnardo's Cymru.

[6] **Ms Jones:** I am Melanie Jones, operational manager of Barnardo's Cymru.

[7] **Ms Booker:** I am Trish Booker, children's service manager of Barnardo's Cymru's adoption and fostering service.

[8] **Christine Chapman:** Thank you for that, and for sending in your papers, which Members will have read. I know that Members are looking forward to hearing your evidence, but, given the time constraints, we would be happy if, say, one person could be nominated to answer questions. However, I am sure that there will be some time at the end of the session to add anything else that you feel we may have missed.

[9] I will ask the first couple of questions. The first is to do with recruitment and application processes. Will the Welsh Government's proposals for a national adoption service improve the current system of recruiting adopters?

[10] **Mr Cooney:** Yes, I think that it will. As adoption agencies, one thing that we have not been very good at is capturing information. For example, research from Adoption UK in 2010 showed that one in every three adopters who went on to adopt did not find the process—the front-door approach—all that helpful, initially. At least one third of those, or 33%, had to approach more than three agencies before their application was successful. There is a question mark over how many families we lose because of a poor front-door response.

[11] Looking at other broader data, we see that it is generally accepted that one in 10 families who wish to have children will remain childless. We also know that, even clustering all the infertility treatments together, the success rate is only about one in three. There is a huge pool of potential adopters that is not being tapped. Adoption has a poor image, which we need to address and tackle. Aside from the childless population, there are reconstituted

families, families with older children, same-sex couples and single carers, who form a huge pool of potential adopters, and we need to welcome and bring them into the system. It will help recruitment if we treat these families with the dignity and respect that they deserve rather than putting obstacles in their way. So, yes, there is a huge recruitment issue and we should not be dismayed that the families are not there. We need the resources to support them, but the families are there.

[12] **Ms Rodgers:** I agree with everything that Gerry has said about the current recruitment issues. Having a one-Wales adoption service, which was the core of your question, would improve the situation. As Gerry said, investment could be focused on a unified recruitment campaign that would scoop up all the agencies that deliver adoption, including local authorities and voluntary adoption agencies. Barnardo's Cymru has its own targeted recruitment campaigns, but we would much prefer, for the sake of Welsh children, placements and people's choice of who they would go to, to bring that under one banner and to improve the reputation of adoption. Anyone applying to be an adopter might have been put off by a number of issues, including concerns about the latest media coverage on the delays and lengths of time involved. If you were a prospective adopter, would you bother? Even if that is not the case in Wales compared with England, there are differences across the piece that need to be recognised. So, I agree with what has been said, but as a recommendation for a Wales adoption service, I think that having a big umbrella campaign with investment attached to it would make a huge difference.

[13] **Jenny Rathbone:** In its paper, St David's suggested setting up a free advice line for prospective adopters. Are you aware of that having been tried anywhere else? Is there any indication that the Welsh Government thinks that it might want to go for that?

[14] **Ms Price:** I am not aware of that having been set up elsewhere. However, given the geographical situation in Wales, and the number of authorities and agencies involved in adoption, it would make good sense to have one easily accessible place staffed by people who are aware of the issues on adoption and who can be responsive in a helpful way to families. One thing that we have noted over the years is that families getting a negative response either stop coming through the process altogether or delay making another advance. So, I think that having a central base would serve the needs of the children and the adopters better.

[15] **Mr Cooney:** Also critical to that is having experienced staff who know how to develop prospective adopters, who keep the door open, and who realise that time is on the side of the adoption agency. Some of these inquiries are made by people who are considering infertility treatments at the same time as adoption. When I say that time is on the side of the adoption agency, I do not mean that we delay prospective adopters, but that we give them the time to think, information on which to make informed decisions, and we keep the door open for them to come back—we develop them, always.

[16] **Jocelyn Davies:** Some of the families who have gone through the process have told us that they did not mind a lengthy process as long as it was appropriate. So, whether it is six or eight months or a year, that would be fine by them provided that the time spent was worthwhile. One family told us that if you cannot put up with the assessment process, you will certainly not be able to cope with the adoption. What are your views on that?

[17] **Ms Booker:** That is really important. Picking up on that point, people have to have stickability if they are to adopt children. It starts at the first point of contact. They have to know exactly what is involved. Gerry is absolutely right that we need experienced staff to ensure that people know the rewards, certainly, but also the challenges in adoption. Our sense is that if people can understand the process, if there is clarity around that, and they understand why questions are asked in the depth that they are, they are quite happy with that and they will work with us. They need to understand that we have to ask those questions to enable us

and them to make the right choices about the child who will be a part of their family for life. It is a lifelong process.

[18] **Christine Chapman:** You have talked a little about the best practice that you use. Are there any other practices that either organisation uses to prepare prospective adopters that you would want reflected in any future national adoption service?

[19] **Ms Booker:** We place a lot of emphasis on the pre-approval training and preparation, and that certainly has its place. However, at the time of that training, many adopters are very conscious of the fact that it is, to use some terminology that has been presented to me, 'a hoop that they have to go through'. A lot of information is presented during that training and preparation. There is a call for additional preparation post approval. That is my view, based on the matching and linking process, because that is absolutely critical.

[20] In that period, sometimes adopters feel that nothing much is happening. They have gone through intense weekly visits for several months and then, in their eyes, nothing happens, although work is obviously going on in the background. It is crucial that we maintain contact with prospective adopters at that point, and that we reinforce the things that we talked about in the initial training to best prepare them for the challenges that lie ahead, specifically issues relating to attachment, loss and separation. Most adopters come into the process because they have needs that they want met and, obviously, we know that the children have needs, and they will not always be that compatible, so you have to work really hard to ensure that people understand that adoption is re-parenting, really. Matching is critical, and I know that there is a section on matching later in the questioning, but it presents an opportunity to reinforce some of those initial training and preparation topics.

[21] **Jocelyn Davies:** I have a quick question. You mentioned that big untapped pool of people, but they all sounded as though they would be quite inexperienced parents, whether because they are childless or are same-sex couples and so on. They could be facing a lot of difficulties without any experience to back that up, so you could spend this period preparing people to face challenges. It is not as though the child will come with no background at all, as there are bound to be some challenges there.

[22] **Ms Booker:** It is an opportunity to enhance understanding. If we can do that in that time, hopefully, it will give a firm foundation and people will have a greater understanding of the needs of these children, which will, ultimately, benefit them.

[23] **Ms Price:** There is nothing to disagree with, but one thing that we have found helpful for our prospective adopters is engaging adoptive families in their training and preparation, and also, during that assessment process, arranging for them to go to visit a family so that they have some first-hand understanding. From feedback from the families that have gone through the process, those are the parts that they have really valued as much as, or more than, in some senses, the others. It is about managing to include that, as well as the issues that Trish has identified.

[24] **Christine Chapman:** I want to raise another issue before I let other Members come in. We have been told by some parents that they feel that there is sometimes an imbalance of power between prospective adoptive parents and social workers. Could you comment on that?

[25] **Ms Jones:** It is an interesting question because, as has already been said, it is an intrusive process and it can be perceived as a power imbalance, but that is where the skills of workers come in, in empathising with the people who want to come forward to adopt, and in knowing their situations and their motivation. It is a skill and a very specialist area of work, and so skilled workers can reduce that imbalance. The imbalance will still be there because it is an assessment process and, as you rightly say, it has to be there in the interests of any child

who needs to be placed with another family. A lot is to do with actively involving the prospective adopters all the way through the process, rather than their seeing it just as a series of appointments that have to be gone through. There needs to be a clear dialogue and a plan to the assessment.

[26] **Christine Chapman:** It is not necessary, then, bearing in mind that, with possible better training maybe—

[27] **Ms Jones:** I do not think that it is necessary for that to be a concern for people who come forward. It should not happen. The fact is that the social worker has a clear role to assess that family, but it should be done in a way that is in partnership with that family and is in their interests. At the end of the day, the assessment process is the biggest part of the matching process and cannot be done unless you know the people and they have trust in you as a worker. You also need to move that relationship on when the assessment is complete.

9.30 a.m.

[28] **Mr Cooney:** It is also important to consider the language that you use from the outset with families. We talk about power, but we tend to talk about it in terms of authority and responsibility. At the beginning of the process, there is a lot of authority and responsibility on the agencies to get it right. We make that clear to families from the outset. We try to do that in partnership, but we are also very clear with them that, as this process evolves, all of that authority and responsibility will be transferred to them, and that grows throughout the process. Framing it in that way helps adoptive families.

[29] **Julie Morgan:** On the issue of the imbalance of power, is there any difference between families who are childless—I think that Gerry said it was one in 10—and families who have children but feel they have room for another child? Is there any difference in that power balance with those families?

[30] **Mr Cooney:** Certainly not in the way we treat them.

[31] **Ms Price:** No, I am not aware of any.

[32] **Mr Cooney:** Every possible resource for a child should be considered on its merits, rather than any other factor. All resources should be treated equally.

[33] **Ms Jones:** On power, the imbalance probably becomes more apparent at the stage when a local authority social worker who is responsible for the child works with the family, because the decision on whether the match goes ahead lies with them. That power lies with that worker at that moment in time. There are panels to deal with those decisions. It is not one person's responsibility, but that level of power imbalance is something that is difficult to avoid. There are ways in which that can be worked around up to that point in the process.

[34] **Mr Cooney:** It is a fair process and, from our experience of working with local authorities and making placements, within a week or two of our families being approved we have linked in local authority social workers, who are very proactive in trying to family-find for children. That is certainly our experience. Normally, we present only one family for a child and they look at that seriously. We might have to do some chasing up to ensure that the report is read within a particular timescale, but it is not our experience that there would be a power shift to local authorities at that stage in the process, although, yes, there is a decision to be made.

[35] **Christine Chapman:** I want to move on to other areas, so I will bring Jocelyn in now.

[36] **Jocelyn Davies:** This question is for St David's Children Society. In your evidence, you suggest the creation of a permanent adoption panel to make recommendations to approve prospective parents, running in parallel to the existing local authority adoption panels. Is there a danger with this proposal of creating extra layers of bureaucracy?

[37] **Mr Cooney:** It remains to be seen how the national adoption service evolves. There is a remit for the expert working group to explore the function of a panel. However, if there is going to be some sort of external national adoption service, there will need to be a panel to approve prospective adopters. It is that particular element of panel duties and functions that I was referring to. Is it another layer? Yes. Voluntary agencies have panels and local authorities have panels, all of which carry a number of duties. Certainly, on our side, our panel approves prospective adopters. To me, that seems to fit in with that framework.

[38] **Jocelyn Davies:** At the moment, would you say that the adoption panels you refer to are fulfilling their intended roles or should certain changes be made?

[39] **Mr Cooney:** Some of the recommendations in the family justice review about duplication are fair proposals and they will hopefully free up panels to look at some of the more pressing issues, such as linking, matching and potentially approving adopters. At times, some panels have reputations for being overly rigorous in terms of the amount of detail they require. There are probably always issues to do with panel training and development. However, in a sense, I am not necessarily convinced that panels are the main obstacles in the adoption process. I think that all the processes, structures and financing are the critical issues for me that actually impact on adoption activity. The panel plays a part, but it is not the primary obstacle.

[40] **Jocelyn Davies:** Thank you.

[41] **Christine Chapman:** What about Barnardo's? What is your view on this?

[42] **Ms Jones:** I tend to agree with that. Panels have a crucial role in the final approval of adopters, and a good panel that can make good, sound decisions is the best safeguard we have for children in the system. Doing their role as panel members is in the interest of any child that needs a placement. I think that the way that panels are currently run is effective. I agree with Gerry; it does not seem to be the main obstacle in the process. It is the conclusion of the assessment for many people. You have mentioned the time taken, processes have sped up a lot and there is a lot of work that panels go through. It is important to have a good balance of people within those panels, who have some experience and are able to make sound decisions.

[43] **Christine Chapman:** Jenny has a supplementary question.

[44] **Jenny Rathbone:** I am still struggling to understand why, if one authorised body has approved a family, another body has to do the same piece of work. That seems to be a duplication of work. Why do organisations not trust each other? If one of your organisations has said, 'This family is fit for adoption', should that not be sufficient?

[45] **Ms Jones:** That would be the normal process. Barnardo's has an all-Wales panel for any adopters that we assess, and the decision is made by that panel and then the agency decision maker of our organisation. It only goes to a further panel for matching purposes, which is a different role for that panel at that moment in time. It is not a matter of double-assessing or double-confirming the decision, but—

[46] **Jenny Rathbone:** It is a matching process—

[47] **Ms Jones:** Yes. I think that it is different within the local authorities; it is a part of the whole system there, whereas ours is slightly removed. All the decisions could not be made by our panel because the responsibility for the welfare of the children still lies with local authorities. So, we move on to that level.

[48] **Mr Cooney:** Panels have three functions: to make a best-interest decision; to approve the link between the child and the adopter; and to approve the prospective adopter. Voluntary agencies tend to concentrate on the last part. Local authorities concentrate on all three.

[49] **Christine Chapman:** I want to move on to the matching process now, so, I will bring in Julie Morgan.

[50] **Julie Morgan:** I had better declare an interest because I used to work for Barnardo's. I think that both agencies say that you are quite successful in placing children, family groups and older children that you would consider hard to place. How do you manage to be so successful in placing these children?

[51] **Ms Booker:** I said earlier that it is a critical time for families or prospective adopters. However, it is also a critical time for children. When we take on adopters, we prepare them for the fact that, with our agency, they are likely not to have a healthy, white baby because we do not provide those sorts of placements. If that is what they are looking for, we would signpost them to the local authority. Therefore, we take on adopters and we give them the information about the types of children that we place. We are looking for people who can take sibling groups, older children, and children with disabilities. Historically, I think that that is where we have been for many years. There is that need. It is a matter of people's motivation because if they want the full-on baby experience, they will not always get that through our service. They may get it if they adopt a sibling group. It is a matter of ensuring that people know that, if they come to Barnardo's, this is the type of placement that they will have. It is about recruitment and word of mouth. We get a lot of people coming to us through word of mouth, having spoken to adopters who have worked with us previously. Does that fully answer the question?

[52] **Julie Morgan:** Yes.

[53] **Christine Chapman:** Would someone from the St David's Children Society like to comment?

[54] **Ms Price:** I just wanted to add to that. You take people through a process and, in that process, they learn more and more about what they feel able to deal with, and we are doing the same thing in parallel. When you get to the end of that process and you have information that the agency receives in relation to a child, one of the things that we do as an agency is to have what we call a 'scrutiny meeting', which is about looking at the child's information and looking at the information in relation to the adopters; basically, it is to make sure that this is not a one-person decision, but a decision that can be supported by the agency as a whole. If we feel that there is potential, the discussions will take place with the family, but only at the point when we believe that the family has the right skills to meet the needs of that particular child. So, it is really a follow on, before it gets to a social worker visit.

[55] **Julie Morgan:** Do you place any babies?

[56] **Mr Cooney:** No, it has been a long time since—

[57] **Julie Morgan:** The same type of—

[58] **Mr Cooney:** It is important how you develop prospective adopters. It is not unusual

for us to have an infant adoption inquiry from people who want to adopt a very white, healthy baby. That is fine, because local authorities occasionally need families like that. However, it is about entering into a journey with a prospective adopter, recognising that they have a need or a wish to adopt a baby, and entering into a discussion with them about the fact that once you are a parent to a child, you are a parent to that child for the rest of your life, but you are a parent to a baby for only a very short period. We have three, four and five-year-old children in the care system whose infancy needs have not been met; there is a lot of nurturing to do. Those needs are still there in a slightly older child, and so it is about getting families to recognise that and to bring them along in a developmental process. That process works; it is hard and it needs a lot of support, but it works. We need to feel confident that adoption works, and it does work for children.

[59] **Ms Rodgers:** In terms of the evidence that you are taking today from voluntary adoption agencies—and, as has been stated, we are very successful in what we do—our frustration is that we are not used often enough or soon enough by local authorities, on the grounds that we are perceived to be more expensive than staying within the local authority, although we could challenge that on a number of grounds. We are the experts in placing those hard-to-place children—the older children, the sibling groups and the children with disabilities. Our concern is that there is a delay at that local authority stage before people decide that they are going to come out to voluntary agencies. In that period, a child has grown—it might be a year or two, or even longer—which makes the placing of that child even more difficult and makes the issues around attachment more complicated for them.

[60] **Julie Morgan:** Would a national adoption agency be able to tackle that sort of issue?

[61] **Ms Rodgers:** That is my wish. That is why I would wish to support that. We could bring all those strands together, with proper investment and make the right choice. So, as voluntary agencies, we are not looking for an easy life, because that is not what our mission in life is. Our mission is to meet the needs of those children who are in that area of unmet need. Of these adoptions, 80% will be picked up by the local authority, but what is happening to the 20%? They are languishing or they are drifting. Our role should be brought much more to the fore in a national adoption service. That is my wish.

[62] **Aled Roberts:** Nid wyf yn siŵr os yw'r awgrym hwn yn rhy radical, ond mae'n ymwneud â'r hyn rydych chi newydd ddweud, a thystiolaeth Cymdeithas Plant Dewi Sant, sy'n cynnwys ffigurau sy'n arddangos ei llwyddiant. Roedd y Gweinidog, pan ddaeth ger ein bron ychydig fisoedd yn ôl, yn awyddus iawn bod rôl awdurdodau lleol yn cael ei diogelu, ond a yw'r amser wedi dod i dynnu'r rôl honno oddi wrth yr awdurdodau lleol—er bod materion cyfreithiol ynghlwm wrth gyfrifoldebau awdurdodau lleol yn hyn—gan nad ydynt mor llwyddiannus â'r sector gwirfoddol? A oes gan y sector gwirfoddol y capasiti i ddelio â'r holl achosion?

Aled Roberts: I am not sure whether this is too radical a suggestion, but it is to do with what you have just said, and the evidence from St David's Children Society, which contains figures that demonstrate its success. The Minister, when she came before us a few months ago, was eager that the role of local authorities should be safeguarded, but is it now time for the role to be taken away from local authorities—although there are legal matters in relation to the responsibilities of local authorities in this—given that they are not as successful as the voluntary sector? Does the voluntary sector have the capacity to deal with all the cases?

[63] **Ms Jones:** Mae hynny'n syniad radical iawn, ond credaf fod ffordd o gyfarfod hanner ffordd a chydweithio i anelu at gyrraedd y ffordd orau o gynnig y lleoliadau mwyaf addas i bob plentyn sydd

Ms Jones: That is a very radical idea, but I think that there is a way to meet halfway and to collaborate to reach the best way of offering the most appropriate placement for each child who requires one. That is a

angen lleoliad. Felly, mae honno'n sefyllfa heriol, ond hwyrach mai dyna'r ffordd ymlaen. Mae nifer o gamau hyd nes y byddwn yn cyrraedd y pwynt hwnnw. Mae Yvonne yn iawn; gallem wneud llawer iawn mwy o gydweithio gydag awdurdodau lleol o ran cynllunio.

challenging situation, but perhaps that is the way forward. There are many steps to go through before we reach that stage. Yvonne is right; we could do a lot more collaborating with local authorities in relation to planning.

9.45 a.m.

[64] Rwy'n gwybod ei bod yn anodd rhagweld plentyn yn dod i mewn i ofal, ond weithiau mae arwyddion y gellid eu pigo i fyny yn gynt a'u rhannu gyda'n sector ni—hynny yw, y syniad o allu cynllunio mewn partneriaeth yn llawer cynt. Buasai hynny'n un ffordd o geisio rhannu ein harbenigedd ar gyfer lles pob plentyn. Nid yw'n rhywbeth amhosibl, ond mae llawer o gamau y byddai angen eu cymryd.

I know that it is difficult to foresee that any child will be taken into care, but sometimes there are signs that could be picked up earlier and shared with our sector—that is, the idea of being able to plan in partnership much earlier. That would be one way of trying to share our expertise for the benefit of every child. It is not an impossible proposal, but there would be many steps to take.

[65] **Aled Roberts:** A yw'r trafodaethau i gyd am y gwasanaeth cenedlaethol yn cynnwys y cynllunio hwn a'r posibilrwydd o rôl llawer cynharach i'r sector gwirfoddol?

Aled Roberts: Do all the discussions in relation to the national service include this planning and the potential for giving the voluntary sector a much earlier role in the process?

[66] **Ms Jones:** Dylai fod yn rhan bwysig o unrhyw drafodaeth. Rwy'n teimlo weithiau fod ffocws y drafodaeth ar awdurdodau lleol, ac mae ganddynt ran bwysig ofnadwy yn y broses, ond hwyrach fod edrych ar wasanaeth hollol newydd ac unigryw yn gyfle i feddwl yn greadigol. Hwn yw'r cyfle gorau a gawn yng Nghymru. Nid oes yn rhaid i ni fynd ar hyd y ffordd mae Lloegr yn mynd. Medrwn gael strwythur hollol wahanol i ateb anghenion plant Cymru.

Ms Jones: It should be an important part of any discussion. I sometimes feel that the focus of the debate is on local authorities, and they have an extremely important part to play in the process, but looking at a brand new and unique service may be an opportunity for thinking creatively. This is the best opportunity that we will have in Wales. We do not have to go down the same route as England. We could have a totally different structure to meet the needs of the children of Wales.

[67] **Jocelyn Davies:** May I ask a technical question, Chris?

[68] **Christine Chapman:** If you are brief.

[69] **Jocelyn Davies:** I know that you work in adoption services, but do you arrange fostering?

[70] **Ms Jones:** We do.

[71] **Christine Chapman:** I want to move on. Julie has another question.

[72] **Julie Morgan:** This is for the St David's Children Society. You recommend the establishment of a national adoption register for Wales only. What benefits do you think that that would bring?

[73] **Mr Cooney:** It is important that we have information on every child with an adoption plan and every child with a placement order to identify what their needs are, what their ages are and what support services they need. That helps to shape and develop the delivery of that service and should, in due course, lead to improved outcomes for all those children.

[74] **Julie Morgan:** Would that exclude children from England being considered for placement?

[75] **Mr Cooney:** I do not think that we should ever exclude any child, but my feeling is that a national adoption service for Wales should focus on the needs of Welsh children, should have a Welsh placement strategy and should, wherever possible, try to place Welsh children in Wales. There will always be situations in which some local authorities in England will place children in Wales and some voluntary adoption agencies may place English children in Wales. That will always happen, but the bulk of the service is about recognising the needs of Welsh children and trying to have a strategy that works for them.

[76] **Julie Morgan:** What does Barnardo's think of that?

[77] **Ms Jones:** A Welsh register is an excellent idea. We were talking about being able to plan with local authorities so that we are always aware of the level of need, because there is sometimes a gap. As we have said, the assessment process does not happen overnight, so you need to build in time for building a pool of potential adopters early enough to meet the need, which will always change. Having a Welsh register would, again, be a good opportunity for this country. There will always be the UK register, so I do not think that it would necessarily exclude—it is more important to have the right match, which could be a Welsh family for a child from England, or vice versa, for a child from Wales to go—

[78] **Julie Morgan:** Do you place many children from England in Wales?

[79] **Ms Jones:** We have done.

[80] **Ms Booker:** Increasingly, we are placing children from Wales. We have good links with three south Wales authorities, and, as Melanie said, it is about trying to plan and to look at the children coming through and, as early as possible, at potential matches with adopters going through the process.

[81] **Julie Morgan:** So, what percentage of children would not be from Wales now?

[82] **Ms Booker:** Since last October, all of the children we have placed, bar one, have been from Wales. We have placed three sibling groups of two and a single child from Wales.

[83] **Mr Cooney:** Of our last children to be placed, all but two were Welsh children.

[84] **Julie Morgan:** So, the placements are generally of Welsh children already.

[85] **Christine Chapman:** I just remind Members and witnesses that we have about 20 minutes left, and there are quite a lot of questions that Members are keen to ask, so I will move on. Jenny wants to come in at this point.

[86] **Jenny Rathbone:** The St David's paper mentions the successful partnership between Coram and the London borough of Harrow, which had a 100% success rate in placing children within six months. You did not mention the name of the author of that report, so I was keen to find that out. I am aware that Coram has pioneered concurrent planning and I just wondered why nobody in Wales has ever used that approach.

[87] **Ms Booker:** It is something that we are looking at along with Barnardo's. One of our adoption agencies in the north-east is working with Coram on a pilot scheme currently, so I am in discussions with the children's service manager there just to see how that is going, but it is very early days.

[88] **Jenny Rathbone:** What are you going to do to help convince people in Wales that this is a great idea?

[89] **Mr Cooney:** We are looking at concurrency planning, but at the moment the structure is one in which we would need to be a fostering agency as well as an adoption agency to provide concurrency services. We have a meeting on 8 June with Family Care in Belfast, which has also just introduced concurrency planning, and one of the things it is looking at is the dual registration of adoption agencies that wish to do concurrency planning as fostering agencies with a very specific purpose, without having to go through with the whole inspection regime. If there is a possibility of dual registration for concurrency planning, that would certainly make the process much easier for an organisation like ours.

[90] **Ms Rodgers:** From the perspective of Barnardo's, we do both. We have adoption and fostering services, so, in terms of concurrency planning, if structures were fixed towards that, it would be very easy for us to do that.

[91] **Jenny Rathbone:** Why have you not done it up until now?

[92] **Ms Rodgers:** We have done it in some respects, with some individuals.

[93] **Jenny Rathbone:** You are talking about the north-east of England.

[94] **Ms Rodgers:** No, I am talking about things in Wales, because children are placed with foster carers who, on occasion, go on to become adopters of those children. We are able to do that within our placements, but it has not been established within the structure as the way to go, because people are always challenging the best way to work on adoption: should it be from the outset or not?

[95] **Christine Chapman:** Could you provide us with a note on that, please?

[96] **Ms Rodgers:** Yes, I have the evidence here, because I know that we are short of time.

[97] **Christine Chapman:** We move on now to Suzy.

[98] **Suzy Davies:** Both of you have mentioned the importance of the professional skills and expertise of the professionals in the process, and you were both talking about social workers and this perceived balance of power. Those are the terms in which you expressed it. Yet we have had evidence from witnesses, particularly at the local authority end, that there seems to be a high turnover of social workers involved in the process, all the way from application through to matching. What strategies do you have in place? You seem to manage to avoid that.

[99] **Ms Jones:** I think that our staff retention levels are quite high within the service, and that makes a real difference in being able to provide assistance.

[100] **Suzy Davies:** How do you keep them?

[101] **Jocelyn Davies:** Is it by paying more than the local authorities?

[102] **Ms Jones:** It is not that, actually. That is probably the last thing that we do. This is an area of work where I am a convert. Trish has always worked in fostering and adoption, and I think that, if you start in fostering and adoption, and work in the right environment, it is almost a nurturing process for a worker, because it is such a specialist area of skill. There can be very few rewards in social work, so to be able to place a child within a family and feel that that is a home for the rest of that child's life is a big reward for a worker. To do that consistently you must have good support, good supervision, and there has to be the fire in the worker to keep the momentum going, because it is a specialist area of work. It is very difficult in local authority services where there is a constant stream of new staff. We have had examples of children who have been adopted, and by the time they are placed, they have had lots of social workers—quite a high number, sometimes. Sometimes our workers know the child as well as the local authority does. That is not to disrespect social workers within local authorities because they are under a lot of pressure.

[103] **Suzy Davies:** I am just trying to establish how you manage to keep one social worker with one child or family, and yet local authorities really struggle to do that.

[104] **Ms Jones:** One of the important things is to be able to develop the specialism. If you have a generic caseload, it is probably quite difficult to balance. In some respects, if a child is in a foster placement waiting for adoption, it is sometimes not as much of a priority as other cases. There are different levels of priority.

[105] **Suzy Davies:** It is not generic casework, either.

[106] **Ms Jones:** That is possibly an issue.

[107] **Christine Chapman:** Do either of you, Gerry and Joan, have anything to add on the workforce issue?

[108] **Ms Price:** It is about recognising that social work in local authorities, particularly child and family work, is very pressurised and difficult. There is a lack of continuity and training opportunities at the moment, because the baby P case has had the knock-on effect of driving up people's caseloads. I have been a social worker for 30-odd years, and at various points during that time, there has been recognition that there have been shortages of staff. Sadly, that situation has not changed fundamentally. I think that social workers find it very difficult to stay motivated.

[109] **Mr Cooney:** I do not want to get hit for this, but I think that Joan is a great adoption manager, and a very good adoption manager makes a difference. We actually recruit our staff from local authorities, as they are very well trained, very experienced and very committed. There is a question about whether the structure supports them to do the same job in local authorities as they do in our agency. One of the things we are very good at is focusing on missions and outcomes and feeding information back to staff. Supervision, training and development all work, but staff need to know about the positive outcomes they achieve for the kids, to feel good about the work they are doing. As I said, these are local authority staff that we recruit.

[110] **Lynne Neagle:** You mentioned the pressures on social workers since the baby P case, but departments are now also under pressure because of constricting resources. Do you have any observations on the impact of that on your work?

[111] **Ms Booker:** In our service, we have looked at resource issues and time management. It is really important that social workers, who are the qualified workers, are out in the field, recruiting and assessing, and supporting placements and families and children. We have a full-time all-Wales post covered by two people who are not trained in social work, and they

help us with matching and linking. That has benefits, because they are office-based; they are not out in the field and are therefore relatively easy to get hold of with regard to adopters going through the process. We are saving money in a way, because we do not have to pay a full social worker salary. They do a really excellent job, and we are very clear about the point at which things should be handed to social workers. I am not saying that they take decisions that should be made by social workers, because that is hugely important, but in terms of chasing information, they are very good, and they are very good at keeping in touch with adopters and giving them updated information about what is happening with regard to links.

[112] **Mr Cooney:** One of the things of concern to me is the greater use by local authorities of self-employed social workers, or social workers from disciplines outside fostering and adoption, to undertake adoption assessments. The research points to clear evidence that if adoption social workers do not know the work, it will likely lead to inadequate assessments and a higher breakdown rate. So, there are risks to children from the cuts, and there are risks to children from the way some of these services are currently being delivered.

[113] **Lynne Neagle:** Both organisations referred to post-adoption support in the papers. We have heard pretty heartbreaking evidence from families about the lack of real support once an adoption has gone through. The Government is consulting on proposals to commission an adoption support service as part of the national adoption service. Do you think it realistic that one national service could meet the long-term needs of adopted children? What are your views on what elements should make up such a service?

10.00 a.m.

[114] **Ms Rodgers:** As a general comment, any national adoption service would fail at the first hurdle if the concept that adoption is not a single event or a single process, but a lifelong process, was not built into that service. So, post-adoption support is important, as you said. Both of the voluntary agencies seated here today are fortunate that, because of the support that we are able to give, which is ongoing after an adoption, we have a very low rate of adoption breakdown. However, that is not true across the board, because of the lack of post-adoption support. Sometimes, we think of that advice and support as social-worker support, but I think that it needs to be widened out so that we think of post-adoption support in terms of the child within a particular community and so that post-adoption support is built into the education system, because some of the attachment issues are linked to difficulties that the children have in school or in the general environment. Trish and I have been talking about this in more detail to see what else we can do. Do you want to add to that, Trish?

[115] **Ms Booker:** I think that there needs to be a more holistic approach. Once again, some of the things that we have been thinking about have been about creating time to go into schools to talk to teachers about the difficulties that children have and to explain that they are not being naughty, they cannot help it. It is about recognising that it is not always social-worker support that families need; it may be practical support or mentoring for the children. We talk a lot about support for the families, which is right, but individual children need support as well. It is unrealistic to rely on child and adolescent mental health services to meet those needs entirely. So, we have to look at having more of a structured approach. It should be there as a right.

[116] **Christine Chapman:** May I stop you there? We have taken quite a lot of evidence on this, and I think that you are right to highlight it. However, as an organisation, you are quite small to be expected to go into individual schools. Is there a strategic way in which it should happen? Are you experiencing this, or is it not happening at all?

[117] **Ms Rodgers:** Yes, exactly. As I said, we are speaking as voluntary agencies about what we have decided, with our own structures, we can control and develop, because of the

commitment that we have to the families that we work with and the children whom we place. However, as I said earlier, if we could be part of a national adoption service, it would then become part of a Government structure. Barnardo's would be very keen to sign up to that and to be able to improve post-adoption services for all children across Wales, whoever they were placed with.

[118] **Ms Price:** I would agree with everything that has been said. The key issue is how to achieve a multi-agency approach. It is as much the responsibility of the various health boards and the education system as it is of children's services in local authorities.

[119] **Mr Cooney:** I would like to see Adoption UK at the heart of an adoption support service. It is an adoptive parent to adoptive parent support organisation. These people commit the rest of their lives to children who carry all sorts of emotional histories, and who have all sorts of emotional issues that need to be unpacked. If they are committing the rest of their lives to these children, they should be trusted with the significant part of the adoption support service. That is my view. I do not have any strategic interest there with regard to Adoption UK, but I think that we should let parents develop, design and advocate for the type of service that they need.

[120] **Lynne Neagle:** At the moment, adopted children and their families have the right to an assessment, but they do not have the right to have those needs met. Would you recommend that we ask the Minister to change that so that there is something more formal and a statutory right there?

[121] **Ms Booker:** Yes, that would be my view, so that adopted children can have the same rights to services and facilities as looked-after children.

[122] **Mr Cooney:** I would like someone to take apart the budgets in relation to adoption, from beginning to end. We have a system where quite a number of authorities across England and Wales—this is not just Wales-specific—will keep children in care at two, three or four years of age and then, suddenly, at five years, they will find an inter-agency fee for them for a voluntary agency. We know that the placement order is in place at two years of age, but some agencies will actually park children for three years. In a sense, it is about the structure of budgets. The adoption budget is a small one, whereas the fostering budget is a huge one. Local authorities quite often do not have any significant moneys to spend on their adoption budgets and if they make savings in their fostering budgets, they lose those at the end of the financial year. So, there is a vested interest in keeping budgets together and intact. I think that the same thing happens with adoption support. The budgets dictate the service that the child receives, rather than meet the child's needs. The budgets have to be looked at; they need to be taken apart.

[123] **Christine Chapman:** Many Members are indicating that they wish to speak, but I just wonder whether this is a question that we should ask the Welsh Local Government Association. It is really important; it is a critical question for the association.

[124] **Angela Burns:** Yes. It is a very important question.

[125] **Ms Rodgers:** There is no malicious intent here; it is the unintended consequence of people looking at how they can make their money stretch. Gerry and I have had discussions outside about the fact that sometimes people may want to come to us and say, 'It's too expensive'. It is too expensive find this money in a lump sum, for instance, because under the Consortium of Voluntary Adoption Agencies, of which we are members, it is paid in three parts. We are able to be flexible within that, because we have had discussions to say, 'If this is a difficulty and a barrier for local authorities, we would consider looking at different methods of payment. So, if it cannot be a lump sum, because the budget is small, let us look

at it quarterly, monthly or whatever works for the local authority'. That is because, as I said earlier, our mission is to ensure that those children are placed. As Gerry said, the budgets need dismantling to make this successful.

[126] **Jocelyn Davies:** I have a question on fostering. We know that a lot of children are in permanent fostering. They are in their permanent homes, but they are being fostered. Obviously, those families then receive a fostering allowance. So, perhaps it is not just in the best interests of the local authority—perhaps some families find that that is the only way that they can afford to keep that child. Would you agree that perhaps this is not as bad as it might appear on the surface, but a way of supporting children in their permanent homes?

[127] **Ms Booker:** I think that there is a case for the Government to look at payment to adopters to allow them to have time at home with the child, certainly during that all-important settling-in stage. It should not be about only the rich being able to adopt, but about making the best placements for children. If people are on a low income, we should look at supporting adoption financially.

[128] **Jocelyn Davies:** I know that Mr Cooney mentioned earlier that finance was a big barrier. Is it the ability of families to afford to adopt that is the barrier, or were you making a comment about this issue of the way that the finance is structured within local authorities? You mentioned that right at the beginning, when you started giving evidence.

[129] **Mr Cooney:** I think that it is about how the budgets are structured in local authorities. When we look across the globe, we see that families in the direst circumstances have a desire and a need to have children, and have them. I do not think that finance should be seen as an obstacle to adoption. There is a very worrying comment in the WLGA consultation paper in that, in terms of one adoption service, a family was not able to secure receipts for second-hand goods bought for a child entering a placement—probably a bed and a wardrobe. The response of that particular adoption service was that families should be able to afford to adopt. It said that it currently looks at giving families five weeks' boarding out allowances, but expects them to be financially independent. The message that sends is that we can keep a child and care for him or her for 15 years, but we cannot give a family £500 to buy a bed and a wardrobe for that child. That culture has to be dismantled. Hopefully, a national adoption service will do that, because then the children will become the nation's children and the resources will become the nation's resources.

[130] **Christine Chapman:** Aled has a question on cost. Do you want to ask that question now, Aled?

[131] **Aled Roberts:** Yes. There is reference in the evidence of both your organisations to the costs, and you are able to cite what you think your costs are as far as placements are concerned—I think that you mentioned £27,000. There is an indication that such a placement in a local authority in England would cost about £36,000, but the information at a Welsh level is quite scant. Before the national adoption service is set up, do you believe that the Welsh Government needs to undertake more research into the costs of adoptive placements through local authorities?

[132] **Mr Cooney:** If we look at the cost of fostering and compare that to what the adoption service costs, the fostering service is a service that can go on until the child reaches the age of 18. We know that the fostering fee is around £23,000 to £25,000. We also know that every year that a child stays in care, there are potential legal challenges from birth families. Those costs have to be embraced. There are independent reviewing costs and officer costs. There are also the costs of medicals, education, social workers' time, managers' time, supervision, corporate governance, buildings and everything else that have to be proportioned to each particular case. When we talk about budgets, all these things are spread across a varied

number of budgets, but each one of them has to be proportioned in our agencies to a particular placement. That is how we survive. We have to distribute those costs in terms of how we invoice. However, they are all compartmentalised in local authorities. Martin Narey suggested a figure of around £50,000. 'Costs and outcomes of non-infant adoptions' by Julie Selwyn suggests that it costs around £50,000 per year to keep a child in care. We are not very good at gathering the full costs. Do we need to delay the establishment of a national adoption service to gather those costs? No. In the round, we can grab a figure. There will be some arguments and disputes about the totality of that figure, but it has to rest at about £50,000, and an adoption placement costs £27,000. Fifty thousand pounds buys one year of service, whereas £27,000 buys 15, 16, 17 or 18 years of service. It is about outcomes for children first and savings for ratepayers and a better use of local authority resources second.

[133] **Christine Chapman:** We are coming to the end of the session, but before we close I want to give you the opportunity to suggest any recommendations that you feel that the committee should make.

[134] **Ms Rodgers:** It is about what I said earlier in terms of a campaign to encourage people to come forward for adoption. We would recommend that, as part of setting up a national adoption service, there should be a huge push, supported by appropriate investment, to do that. I am also going to throw in another one: post-adoption support has to be seen in the holistic way that we described.

[135] **Christine Chapman:** Thank you. Does St David's Children Society have anything to add?

[136] **Ms Price:** I would like to return to the point made by Lynne in relation to assessment of need with regard to post-adoption support, rather than just assessing the need around delivering the service. I think that we need to hang on to the fact that, when children enter the care system, their needs are assessed, as they are at various points throughout their care journey. They have to be given a foster care placement, because that is an emergency situation. However, there are various other points throughout their journey in care where their needs are assessed and known, but are not acted upon. I think that that is the priority—if adoption is the need, it should be delivered when it is needed and not in three or four years' time.

[137] **Mr Cooney:** I saw somewhere recently that, in the last financial year, 184 or 185 children had been placed. There are currently nearly 200 children waiting for placements; we all know that. There are more children waiting for placements now than were placed last year. The national adoption service should provide a seamless service. I know that we have talked about helplines and a register, but it has to be a seamless service. The risk is that we compartmentalise all these things, and then it becomes a very broken, fragmented service. There has to be a continuum for families. It works in organisations such as ours. A family can go back to an agency in three, four or five years' time and have confidence in an agency, partly because they see the agency—Barnado's or ourselves—as their agency. In doing so, we free up foster placements, as there is an acute shortage. However, these are Welsh children, the nation's children, and they deserve a national response.

[138] **Christine Chapman:** Thank you very much. I know there were some unasked questions because we ran out of time, so if you are happy, I will write to you and perhaps you could send us a response. I thank you all for attending today. It has been a very interesting session and Members have learned an awful lot, so thank you for that. We will send you a transcript of the meeting, which you can check for any inaccuracies. Thank you very much for attending. We will take a break now until 10.30 a.m..

Gohiriwyd y cyfarfod rhwng 10.15 a.m. a 10.29 a.m.

The meeting adjourned between 10.15 a.m. and 10.29 a.m.

Ymchwiliad i Fabwysiadu
Inquiry into Adoption

[139] **Christine Chapman:** I reconvene our session on our inquiry into adoption. Today, we will take evidence from Dr Mike Davies. Welcome, Dr Davies. Could you introduce yourself for the record?

[140] **Dr Davies:** I am Dr Mike Davies, a consultant psychotherapist and trainer. I work independently and have done so for the past 11 years next week—I remember the day. I have four different categories of work: I am an independent expert to the courts; I do direct work with children and families; I act as a consultant to a number of different agencies on childcare and child mental health matters; and I provide training and teaching to various organisations.

10.30 a.m.

[141] **Christine Chapman:** Thank you for re-arranging your schedule. I know that you had prior commitments, so we are very pleased that you have been able to come to this session.

[142] **Dr Davies:** I am pleased to be here.

[143] **Christine Chapman:** We have had your paper, and Members have read it with interest, so if you are happy to do so, we will go straight into questions, and I am sure that things will develop.

[144] **Dr Davies:** That is fine.

[145] **Lynne Neagle:** Thank you for coming. There is a very strong focus in your paper on the importance of attachment. I wonder whether you could say a little more about that. You talk particularly of issues as a result of neurodevelopmental problems, and say that some children who have had a particularly bad time will have additional significant difficulties with long-term physiological functioning. Can you explain a little more about that?

[146] **Dr Davies:** Yes. I should say that I am not a neuroscientist or a neurologist, but, having a special interest in attachment, I have had to become familiar with the literature on neurodevelopmental difficulties in babies and infants and how that affects their development through the various stages of child development to young adulthood.

[147] There is an impact on the developing brain of a small proportion of maltreated children because of the severity of their experiences. I need to tell you a little about the developing brain during the first two years of life. The brain doubles in size during the first two years of life and, during that time, all the wiring, the neurology, connects up. Naturally, that is an extremely important part of development. We do not normally have to think about that, because it is looked after by nurturing experiences: good childcare and attachment experiences. However, in a small proportion of cases, some babies and infants have very severe experiences where the development of the brain is affected and/or the neurology is affected in a particular way. It is also affected by severe trauma. We have the benefit of recent research in understanding how the brain might be affected and how that affects children's development in the long term.

[148] A small proportion of children who find their way into the adoption system—and I am very concerned about this, as are other clinicians across the UK—are not screened well enough pre-adoption to filter out those who will have major difficulties. They will clearly not

be your average child, but it is not always easily spotted during the first two years of life. Some of these children will find their way into the adoption system and create enormous difficulties for adopters at later stages in their care, and that is compounded, I believe, by professionals who are not able to recognise the nature of the difficulties. I am talking about a small proportion of adopted children, and I am only involved with those children at the severe end, as I mentioned in the paper. So, those are the children I am most concerned about.

[149] **Lynne Neagle:** On your concerns about professionals, you said that that there is an inability on the part of professionals to understand the nature of attachment problems. That is quite a sweeping statement, really. Can you tell us a bit more about what you mean by 'professionals'? Are you referring to mental health professionals, those involved in social work or is it an issue across the board? Could you say a bit more about the significance of that as a problem?

[150] **Dr Davies:** In a sense, it is a criticism of my own training. I provide training to a wide variety of professionals, including social workers, who are absolutely key in this. There are some social workers who are developing an understanding of attachment and how that can be employed in their day-to-day professional activity. However, the agency, the social services department, does not necessarily accept the significance of it. I will be critical again here, and make another sweeping statement, but I believe that children are often processed for adoption, and I use that word advisedly, based on age, very often, without adequately screening for significant attachment issues, especially the small proportion of children who may have some neurodevelopmental difficulties, as I describe them in the paper.

[151] **Jocelyn Davies:** You say that some children should not be placed for adoption, and I guess—

[152] **Dr Davies:** That, of course, is an opinion.

[153] **Jocelyn Davies:** Yes, we fully accept that everything you say to us is an opinion. What do you suggest should happen to those children? You also have strong views on post-adoption support. Earlier, we heard that it is not uncommon for two-year-olds to be parked in foster care for several years before adoption is seriously pursued in order to find them a permanent home. We would like your view on what is happening to that child in that period of time—

[154] **Dr Davies:** That is two questions then.

[155] **Jocelyn Davies:** Yes, and who should carry out the screening you mentioned?

[156] **Dr Davies:** I will deal with your second question first because it is easier. The parking business is a serious problem and to have a long delay before the adoption of those children who are clearly suitable for it and who will benefit from it is not a helpful process at all. The earlier that children can be appropriately adopted and matched—which is very important—and the better that process is conducted in terms of supporting prospective adopters, the better the situation will be in terms of all sorts of outcomes, and particularly the child's development. The earlier you make inroads into a child's developmental difficulties, the better the projected outcome. Therefore, the parking issue is really important.

[157] However, of course, I am suggesting that with a relatively small number of children we have to be cautious. In terms of identifying those children, it is not always that difficult in my view, at least for the first stage of the screening of these children. We need to look at what we know about their experiences. I read these reports all the time because of the expert opinion I give in court; I read everyone else's evidence. It is quite clear that some babies, infants and toddlers have had such severe experiences that, even if they are cared for

reasonably well by skilled foster carers, they are going to have major difficulties. You can project that. Simply by looking in detail at the child's experience, we can make those judgements. Beyond that, we have to look more carefully at who is going to provide the best care for these children. That may be with adopters in perhaps three or four years' time, but they need to be with foster carers who can do the therapeutic bit, with other people assisting in that. Further down the road, these children might be able to be adopted by people with greater expertise than people I would describe as 'conventional adopters', who come to adoption with very little experience.

[158] **Christine Chapman:** I just want to bring Angela in on this point, and then I will bring Jocelyn back in.

[159] **Angela Burns:** Can you clarify whether this developmental issue that this small cadre of children may have is quite different from having global developmental delay, foetal alcohol syndrome or any other kind of special need? Are you talking about something over and above such issues?

[160] **Dr Davies:** Yes. It is similar in the sense that you could argue that a part of the brain is affected so that there is some physiological or constitutional damage; however, it is different in terms of its outcome. For example, for a child with developmental delay, the part of their brain that is affected will affect their functioning across a wide range of areas. The children I am talking about may well be intellectually very able. In fact, many of the children I see are very able. However, their ability to perform is undermined by a part of their brain not functioning very well. It affects them in a number of different ways. I know that this is really difficult to understand. I have spent a long time trying to get to grips with this and talking to other people about it. It can affect their ability to perform psychologically; for example, a child I saw the other day has not developed the ability to think sequentially. While you were talking to me, I picked up a glass, turned it round, picked it up, poured water in, and I am just recounting to you the sequence. The child I am seeing quite regularly, who is 12, cannot do that. She is very intellectually able—well, within the average range—but her ability to put things into sequence has been damaged. If you think about the way that we unpick social interactions, we do it sequentially. Does that make sense to you?

[161] **Angela Burns:** Yes. I was to trying to ensure that you made the statement that these children should not be adopted, or certainly not to begin with—

[162] **Dr Davies:** A small proportion of children should not be adopted.

[163] **Angela Burns:** I just wanted to identify that small proportion, so that we do not walk away with a view that if someone has global developmental delay or foetal alcohol syndrome, they should not be adopted.

[164] **Dr Davies:** People know what they take on with the global developmental delay. With foetal alcohol syndrome, again, we know a great deal about that and the outcome as far as children are concerned. Prospective adopters will know, or will have some understanding, what they are taking on. With children who have had severe experiences, it is very difficult to extrapolate from the experiences exactly how they are going to be through the various developmental stages, because we have to wait to see what will happen. We know it will be difficult, but we are not sure what will happen. A lot of prospective adopters are not informed about what the potential outcomes might be, so they go into it naively and unknowingly, and that is a really dangerous place to be.

[165] **Jocelyn Davies:** With regard to the issue of sequencing, a child such as that may not realise what consequences might come from—

[166] **Dr Davies:** That is correct.

[167] **Jocelyn Davies:** Okay. So, in normal everyday life, consequences could be, because that is—

[168] **Dr Davies:** So, what they do and the impact it has on others is not connected.

[169] **Jocelyn Davies:** In the pack that we have had prepared for us on this, there is the Welsh Government practice guidance for assessing the support needs of adoptive families. I do not know whether you are aware of this document; it is for social workers who practise in the field. It talks about attachment and it says that there is an awareness of attachment disorders. It says that children with serious difficulties, if they are assessed, should have more specialist therapeutic services with specifically designed programmes to address those difficulties. I know that you do not disagree with that. Does that happen?

[170] **Dr Davies:** No, and it does not happen very much across the UK. This is not a specifically Welsh problem. It is probably more of a problem in some parts of Wales than others. Certainly, in rural parts of Wales, I do not know how people access special services.

[171] **Jocelyn Davies:** You are an independent professional in this field, and you are an expert. I should not think that we have thousands of them in this specialism. Do you have children referred to you from local authorities for special therapeutic services?

[172] **Dr Davies:** Yes, I do.

[173] **Jocelyn Davies:** But it is not common.

[174] **Dr Davies:** No. I get them because the local authorities have no other option. They are being pushed to the limit and parents are on their way to the Children's Commissioner for Wales or they have lawyers chasing them. That is how people access me.

[175] **Jocelyn Davies:** So, you are the last resort for local authorities.

[176] **Dr Davies:** Yes, I am a last resort. It is a wonderful description, but I am a last resort. I think that there are a couple of other people like me.

[177] **Christine Chapman:** A few other Members want to come in. We will go to Julie then Lynne. I want to ask you, Dr Davies, for the record, we talked about screening and whether that has been done adequately. Who do you think should be responsible for that screening?

[178] **Dr Davies:** I say towards the end of the paper that I would like to see professionals much more much informed about attachment issues. Social workers involved in adoption could be better informed and understand the issues rather than just being generic and just like other social workers. It needs to be a specialism that is developed, and they need to have this level of expertise. I do not mean the same level as people like me who are quite passionate about these things, but I do believe that it should be at a much higher level than it is. Many of these children could be screened for special attention at a much earlier stage. The agencies need to be told that this is important, and I underline the world 'told', and practitioners need to be helped to understand what it is about.

10.45 a.m.

[179] **Julie Morgan:** I was concerned about this small group of children who, you say, are not suitable for adoption. Would you not say, with all the screening and the expert help that

could be available, that they could be considered for adoption? That is, if all that help was available.

[180] **Dr Davies:** If it was available—that is a big if.

[181] **Julie Morgan:** I know that it is a big if, but it seems dramatic to say that there is a small group that cannot be adopted.

[182] **Dr Davies:** I think that a very small proportion of children would be difficult to place for adoption once you knew the nature, extent and severity of their difficulties and how that is likely to work out through the various stages of their development. In theory, it might be possible if you put enough in early enough—it is a question of recognising difficulties earlier and intervening during the very early stages of development to make a difference—and found extraordinary adopters. That is absolutely key; you must have people who will be committed to caring, knowing and understanding what they are taking on, not naively hoping for something else, who also have a range of abilities to become closer and distanced and to move away and come closer to fit with the child's needs. It is extremely difficult to do that on a day-to-day basis. You have to be super parents to do that. There are people out there who can do that, but we are a long way from being able to recruit them effectively and prepare the child and a context whereby that can happen. We do not even have therapeutic foster care established in Wales yet, or in the UK that much, and that would help with some of these children in terms of preparing the way towards adoption. Some of these children will have a different route to adoption compared to children who are less damaged.

[183] **Julie Morgan:** Thank you; that has cleared that up for me.

[184] **Christine Chapman:** I have a few other Members who want to come in on this specific point and then I want to move on, because I am looking at the time, so I ask Members to be as brief as possible.

[185] **Lynne Neagle:** I have two points. I am still not entirely clear what becomes of those children who are not suitable for adoption, given that none of the other services that you describe, like therapeutic fostering, seem to be in place. Can you say where you think that those children should go? Secondly, we are hearing from the NHS Confederation after this and its paper paints quite a rosy picture of CAMHS and, in particular, tells us that every service has a child psychotherapist who can provide attachment therapy to the children. Is that a picture that you recognise?

[186] **Dr Davies:** You would wonder why we had any problem at all, would you not? [*Laughter*.] I do not know whether I can say anything else really.

[187] The issue about CAMHS is that, over the years, its focus has become narrower, despite the marketing. The medical model that it has adhered to has become stronger and that has, effectively, been a gatekeeping tool for it as well. You just have to look at the comments from adoptive parents and professionals who have tried to access services. If you are going to provide these services for these children and adopters, you have to be passionate and motivated about doing it. It must not be an add-on. CAMHS has become an agency that is focused on other client groups; that is the nicest way that I can describe it.

[188] **Lynne Neagle:** Where would you put the group of children who, you say, cannot be adopted?

[189] **Dr Davies:** They will have significant mental health difficulties throughout their development. What will happen to those children who are at this stage now, who are aged two, three, or four? Some of these children will not even be managed all that well in specialist

foster care. They will use up everything that some foster carers have before the placement may come to an end. It may be spent, as I describe it, before they have to move somewhere else. Some of these children, unfortunately, are innately damaged in such a way that, as they go through different stages of development, they almost need different carers. That is the challenge in terms of meeting their care requirements. It is hugely challenging. Frankly, it is a depressing picture at the moment.

[190] **Jocelyn Davies:** However, they exhaust people.

[191] **Dr Davies:** They are absolutely exhausted. These children that have severe disorganised attachment difficulties are so damaged and so difficult that they have major relational problems. What commits us to our children is the bonding process and the attachment process. It is very difficult to be close to a child and to like a child when you are messed about so much; you are worn down by the day-to-day demands of caring for children like this.

[192] **Christine Chapman:** Suzy, do you wish to ask a brief question before we move on?

[193] **Suzy Davies:** It is still a question relating to screening. You are painting a very serious picture of a small number of children who have unidentified needs going to adoptive parents who may not be able to cope and would never have known about the damage that these children have. Are you going as far as suggesting that, if you think that a child has had traumatic experiences, there should be MRI scans at very early ages? You are not talking about going that far, are you?

[194] **Dr Davies:** No, we are not. It is my understanding of the literature, at this point, that they cannot be screened in that way. We do not always know what experiences these babies, infants and toddlers have had, so it is challenging from that point of view. We could be caught out, even with the best of screening, sometimes. However, there are occasions when we really do know; it is in the history or care proceedings of the babies, infants or toddlers for all to see. There are dreadful experiences. When I read these things, I know that there is no way that an infant could survive intact. Something will happen—it will be unprocessed trauma for babies, infants and toddlers. Previously, many people would have thought, 'They do not understand what is going on, so they will not be damaged'. They are more damaged at that vulnerable early stage of development than they are at 10, 12 or 14 years of age.

[195] **Suzy Davies:** Are you saying that they are physiologically or neurologically damaged?

[196] **Dr Davies:** Potentially, they are physiologically damaged as well as in other respects. It is a kind of psychic lesion.

[197] **Christine Chapman:** I am jiggling things around slightly. I will ask Jenny to ask her question about the evidence base because it is to do with the confederation and its views on the sorts of services that it provides.

[198] **Jenny Rathbone:** The Welsh NHS Confederation says that the evidence base for the effectiveness of child psychotherapists is mixed. It asserts that it has child psychotherapists in each child and adolescent mental health service, over which I would put a huge question mark. However, it says that, even if they have them, the evidence base for the effectiveness of the therapies they can provide is mixed. In what way is it mixed?

[199] **Dr Davies:** That is fair comment. I generally support the role of child psychotherapists. They have a valuable part to play. Again, it depends on the nature of the child's difficulty and what you are intending to try to change. For some children and young

people, if you are taking a long-term view of trying to address a child's inner world, they are very appropriate professionals to do that and have some very appropriate modality. In terms of severe attachment difficulties, people are developing a way of working, attachment-wise, which involves seeing the child, seeing the child with whoever is involved in their care, seeing the carers, and mixing and matching to try to make the caring environment a therapeutic environment. That is what people like me are doing at present across the UK. Rather than making therapy something isolated and separate from the day-to-day experience of the child and the carers, it is a matter of making it an integral part. To me, this is the preferred way of working with these children and their families, be that in therapeutic foster care or with adopters. It is not easy but, to me, that is the preferred way.

[200] I do not think that accessing child psychotherapists in CAMHS, for example, will be the answer. For many of these children who have been in adoption for a long time and have lower level difficulties, where it is holding up, but where the child has difficulties that can be addressed in the long term, child psychotherapy could well be a preferred option.

[201] **Jenny Rathbone:** Okay, but when they say that the effectiveness is mixed, is that because the damage is so great in some cases?

[202] **Dr Davies:** We are getting into the research semantics a little bit.

[203] **Christine Chapman:** I want to move on to the wider issue of CAMHS. Aled?

[204] **Aled Roberts:** You mentioned a few moments ago that CAMHS is very occupied with other client groups. Given that your paper is critical of the current provision, can you tell us more about the current criteria and thresholds that are applied by CAMHS, as far as this particular group of children is concerned?

[205] **Dr Davies:** I could not, really. You will have to ask the people in the next session about that. If you had asked me that question 11 years ago, I could have given you an informed response, because I was still part of CAMHS. However, I cannot give you that now.

[206] **Aled Roberts:** You say that this group of children has very little priority as far as the service is concerned.

[207] **Dr Davies:** As I said at the beginning, my information for that is based on my contact with adoptive parents, foster carers who prepare children for adoption and with post-adoption professionals.

[208] **Aled Roberts:** However, if their behavioural difficulties are such, you would expect that the tier system that CAMHS applies would trigger engagement by the service.

[209] **Dr Davies:** You might expect that, but the difficulty, which someone mentioned in one of the other papers, is that the behavioural problems of adoptive families tend to be treated in the same way as the problems of families that have functional difficulties and need advice on parenting. There is a good argument to be made for these families requiring a different kind of assessment and a different model. However, to my knowledge, CAMHS does not currently have that model.

[210] **Aled Roberts:** Can you explain the relationship as far as the interaction and the overlap between CAMHS, local authority mental health services and the therapeutic services for adopted children are concerned?

[211] **Dr Davies:** No, not really. I cannot give you an informed view on that. I know that it exists and that it varies across Wales, but I do not know more than that.

[212] **Keith Davies:** Adoption UK recommends that adopted children should be given the same access to mental health services as looked-after children. In your experience, what kind of support do looked-after children get and would you agree with that statement?

[213] **Dr Davies:** Adoptive families deserve at least the same as those of looked-after children in terms of access to services. After all, these adopted children were looked-after children, but the thinking is that, now that they are adopted, a nice family will address all of the difficulties and that good care will change everything. However, that is often not the case. So, yes, I think that they should have access to services. That is good in terms of their rights. The services are definitely not good enough for looked-after children and, sometimes, the marketing is better than the service. There is a need for expertise in these kinds of services and although there are tiers of service provision in CAMHS, I really do not think that it hits the spot.

[214] Returning to something I said earlier, looked-after children and adoptive families is a particularly special client group. It must therefore be of interest; people need to be passionate about it to make a difference. However, the inherent difficulty for CAMHS is that it is an add-on, and, in that respect, it does not provide the best service. Some people and clinicians who I have met across Wales are involved in trying to provide services and they are doing a good job, but this is not a priority generally in CAMHS.

11.00 a.m.

[215] **Angela Burns:** I was going to ask you about recommendations for future provision, but, to be honest, you have been crystal clear on that subject. So, I want to ask you a slightly different question, because we are talking about CAMHS and its lack of provision for people with adopted children and even looked-after children. I was at a pupil referral unit earlier this week, and there is no doubt that a number of children in that unit are under the CAMHS umbrella and certainly have specific needs. What I was told by a range—not one, but three or four—of the people I met, including a parent, was that CAMHS is very based on waiting lists, and, in fact, you could have a huge need, but if you happen to be number 99 on the list, you do not get seen until 99 comes to the top of the list, and there is no way to leapfrog a child in. I was told about children who went in at five and had to wait seven years before they were seen and treated. Seven years—I was so shocked. What I really want to do is use this question to ask whether that chimes with your experience.

[216] **Dr Davies:** The seven years does not, but it does resonate with experiences that I have had. It comes back to medical models and waiting lists. With cases like these, someone needs to be screening them in terms of urgency and what needs to be done sooner rather than later, because if you think about the adoption population, there are some children and families who can easily wait some time, because the nature and severity of their difficulties is at the lighter end of the spectrum, so they can wait longer. There may be others who, for a variety of reasons, need attention much earlier. To delay with those families just compounds difficulties and creates secondary difficulties, and the whole thing just becomes far more difficult—by the time I get to see these people, it is far more difficult to make a difference, which is very disheartening.

[217] **Angela Burns:** I understand that the CAMHS process is also key to unlocking additional funding to help a child and, therefore, the educators who are involved in that child's life can be relatively up to speed and ready to rock and roll with the next thing that they need to do. However, they actually need the CAMHS tick in the box to progress on the educational side.

[218] **Dr Davies:** I do not know about that.

[219] **Angela Burns:** Just to go back to my question briefly, you are categorically saying to us that a specialist service should be developed away from the CAMHS system that concentrates solely on these very difficult and challenging children.

[220] **Dr Davies:** I do not completely know how that could be structured. There may be potential in some areas for working in conjunction with CAMHS, or commissioning bits of services from CAMHS—I do not know. However, I fear that, if the money was located there, the families who most need it would not be able to access it in a timely fashion. I underline the word 'timely' because the families with the greatest need have to access services earlier rather than later. Delays create far more significant difficulties for these families, who are then more likely to suffer adoption breakdown and more likely to be producing damaged individuals who become damaged adults. This becomes the next cycle.

[221] **Angela Burns:** I have one final question on future provision. Do you think that there is a case or any empirical evidence that shows that perhaps a child such as that would be better off in a children's home, but a specialised one with a whole support network, where there might be two or three of those children? I know that that kind of place exists for older children in Wales, and I just wondered what your view was on those.

[222] **Dr Davies:** There is some private residential provision for older children. It is highly specialised with education on the premises, and it is very good. That can be very helpful for some children, and helpful for them over a period of time, maybe even feeding them back towards foster carers or adoptive parents. In a small minority of cases that might be an option, because you do not want to strike anything out from your list of options. At the moment, there are very few. I would want to enhance each of the options that we have and maybe add one or two. There may be many colleagues who would disagree with me on this, but, for some older children, that highly specialised residential option with a therapeutic component should be considered.

[223] **Christine Chapman:** Before I close this session, would you like to add anything, Dr Davies, about possible recommendations that you would like the committee to make in relation to this inquiry? You have been very clear, but I would like to give you an opportunity in case there is anything else that you would like to add.

[224] **Dr Davies:** I just hope that one outcome of this inquiry is that some resources are made available and that something specialised is provided for these families, which are absolutely desperate, as I said in the paper. Some resources should also be put aside to increase the level of expertise among key professionals, who make very important decisions for these children and their prospective families.

[225] **Christine Chapman:** Thank you. Lynne has a quick question.

[226] **Lynne Neagle:** So that we can try to understand the impact on the families, would you perhaps provide us with a note on how much it costs a family to see you for a course of therapy, how many of those families are funded by the local authority and how many of those are funded privately? I do not expect you to provide that information now, but perhaps you could let the committee have a note on that.

[227] **Dr Davies:** Do you mean the people I have seen over the last few years?

[228] **Lynne Neagle:** Yes.

[229] **Dr Davies:** Do you want me to look back at a number of cases? I could almost tell you that now.

[230] **Lynne Neagle:** It does not have to be scientific. I think that it would be useful to have a flavour of how much it costs a family if they have to pay independently to get that kind of therapy.

[231] **Dr Davies:** If they have to pay for different kinds of therapists—from a lower level than me up to my level—it costs families anything from around £30 to £40 per hour to £120 or, in some cases, £140 per hour. I am at an independent expert level, which is £120 per hour. I end up doing this work for free sometimes because I am commissioned to do it and the funding runs out, or I become involved and it is very difficult to stop working on a case when the money runs out. That is difficult.

[232] **Christine Chapman:** Thank you, Dr Davies. This has been a really enlightening session for us. I thank you for attending. We will be sending you a transcript of the proceedings so that you can check it for any factual inaccuracies. Thank you very much for attending and good luck with your work.

[233] **Dr Davies:** Thank you for listening.

11.07 a.m.

Ymchwiliad i Fabwysiadu
Inquiry into Adoption

[234] **Christine Chapman:** I welcome our witnesses from the Welsh NHS Confederation. As you know, we are currently gathering evidence for our inquiry into adoption. I welcome Allison Williams, chief executive of Cwm Taf Local Health Board, and Dr David Williams, clinical director of Aneurin Bevan Local Health Board. I welcome you both. This morning, you are representing the Welsh NHS Confederation.

[235] We have received your paper and Members will have read it with interest. So, if you are content to do so, we will move straight on to the questions. Given the time constraints, would you decide between you who will answer each question? Are you happy with that? I see that you are.

[236] I will start with a general question. What level of demand is there from adoptive families for the specialist child and adolescent mental health services?

[237] **Dr Williams:** I am the clinical director of child and family psychological health in Aneurin Bevan Local Health Board and I am also a practising child psychiatrist for the Caerphilly county borough. Adoptive parents place a significant demand on NHS services at the moment, as does the attachment issue for looked-after children and other children who present to the services through other means. It is difficult to give you a proportion, but certainly the request for help is very often there. The discussion that then takes place on what will be done varies hugely across Wales. It depends on the services and the level of engagement and interaction with local authority children services. What is then done depends on that. There are several areas of Wales that have good models of integrated practice between social services and health services but, for children who are adopted, one end of the bridge is missing, because they do not have the same level of support from the local authority.

[238] **Suzy Davies:** You mentioned significant demand from adoptive families. My first question is: is that demand being met? The evidence that we have had from several adoptive families is that they really have to battle for any kind of child and adolescent mental health services, particularly at the more expensive end of the spectrum.

[239] **Dr Williams:** We do not, by ourselves, meet the demand of the adoptive parents, and the key words here are 'by ourselves'. The treatment of attachment disorder—I am sure that Dr Davies has talked through this—is a balance between direct work with the family and work with the caring organisations and respite support for the families. The evidence for just one bit of that treatment, without the other half of the treatment, is pretty poor. The time constraints and the availability of services vary enormously. It is aided in certain areas where children and young people's partnerships have funded particular psychologists or psychotherapists to do some work so that there is some service available. The size of that service is limited and variable across different local authorities. So, if an adopted child comes with a non-attachment disorder, he or she will get the same level of service as any other child. However, when it comes to attachment disorder that requires an integrated, more multi-systemic way of working, it would be variable.

[240] **Suzy Davies:** Are you saying that the impression that parents have, that their specific detachment disorders have very little priority and that they spend a long time on a waiting list, is down to the fact that they have to work with other agencies as well?

[241] **Ms Williams:** It is important that we look at this as a spectrum of care needs for children in adoptive situations, looked-after children or children in traditional family set ups. Often, CAMHS is the safety net that is sometimes perceived as the required service to capture the needs when other parts of the system are not working particularly well, or not working particularly well together. If you look at the clinical intervention that is very much around the specialised end of CAMHS, it is the very interventional end of the spectrum, meeting a specific mental health need.

[242] **Suzy Davies:** That is what the children have.

[243] **Ms Williams:** Some of those children have that, and when those children have a specific mental health need, CAMHS is absolutely the right place for them to be. Their needs are prioritised alongside children with all sorts of mental health problems and have to be clinically assessed. The resources have to be deployed accordingly. As a multi-agency requirement across health, social services, education and all agencies, we recognise that we must work with families right at the very outset in preparing them for adoption and preparing them for dealing with some of the natural and normal reactions that children have to difficult circumstances, right through to the therapeutic end of the needs of families when there are significant mental health issues for those children.

[244] I think that what Dr Williams is saying is that, in response to the specific question, where there are children in adoptive, looked-after or traditional family set ups who have significant attachment disorders, we must priorities those within CAMHS, according to clinical need. However, we must also work with other agencies to intervene early in that child's and family's journey, so that we act much more preventatively to be able to help the adjustments in families early so that we minimise the number of people who get to that end of the spectrum where therapeutic intervention is required.

11.15 a.m.

[245] **Suzy Davies:** Can you explain to us the significant disconnect between the evidence that we are getting from parents and your assertion that you prioritise these very difficult cases?

[246] **Ms Williams:** The issue there is that we have to prioritise the mental health needs of all children in our service, whether they are from adoptive families or whether they have totally unrelated psychosis or mental health challenges, and that has to be done on the basis of clinical priority like any other NHS service.

[247] **Jocelyn Davies:** May I ask a question?

[248] **Christine Chapman:** I have Aled and then Lynne, but I will come back to you, Jocelyn.

[249] **Aled Roberts:** In the papers that we received, it is stated there are four tiers to CAMHS. From what you say, is it the reality that, if you are just dealing with specialist clinical need, unless you are provided with funding from other agencies through the children and young people's partnerships, the therapeutic work, to all intents and purposes, does not happen?

[250] **Dr Williams:** It does happen, but to a lesser degree than we would want. There are two psychologists working in my team, and if you look at their caseload, at least 50% of it is on attachment disorder, and that will be whether they are looked-after children, whether they are adopted, whether their parents have suffered domestic violence and there was an impact in their first two years of attachment as a result, or where there is parental mental illness. If you look at the amount of work that is done on children with attachment disorder, including adopted children, at the specialist end, a significant amount of work is being done. It probably is patchy, partly due to the size of services full stop across south Wales. In the Aneurin Bevan Local Health Board, we are a medium-sized service, and in places like Powys, it is a very small service, where you are talking about fewer than 10 professionals covering the population of Powys and struggling with the demands of a deliberate self-harm episode or something like that is very tricky. These cases require long-term intensive treatment, and you might be involved with them for several years, so turnover is very slow.

[251] **Aled Roberts:** You have mentioned the word 'patchy' on a number of occasions. Given the evidence that we heard last week regarding neonatal services, and the differences with regard to the number of professionals on the ground in different parts of Wales, are there any standards that you would expect for the establishment levels of CAMHS, given the child and adolescent population throughout Wales? Is that information available?

[252] **Dr Williams:** Yes. There are national standards across the UK about what sort of staffing levels there should be. Mapping has also been done; between 2008 and 2010, there was a staff census every year to see what the size of services was. At the moment, we have approximately 50% of the funding that England has and we employ 70% of the staff, so we employ more lower grade staff with the money that we have. The caseloads of the staff are 1.7 times what the recommended caseload should be.

[253] **Aled Roberts:** When you say 'we', is that the Welsh NHS, or is that Aneurin Bevan?

[254] **Dr Williams:** That is the Welsh NHS.

[255] **Lynne Neagle:** One point that I had was about the tier system, which I still do not really understand. It would be useful for the committee to have a note on how attachment disorder fits within that model.

[256] **Dr Williams:** I would be able to do that. The tiered model was essentially aimed at mapping the services rather than mapping the care pathway. It does not fit care pathways very well, because children should be receiving services at level 1, 2 and 3 simultaneously sometimes.

[257] **Lynne Neagle:** My other point was in relation to waiting-time targets. I know, from a case that I dealt with in the constituency, that there are waiting-time targets in operation for CAMHS. Can you say what they are, whether all health boards are complying with them, and

to what extent?

[258] **Dr Williams:** The waiting-time targets are for urgent cases. For example, those who have persistent low mood and suicidal intent should be seen within four weeks by the specialist service, and routine cases should be seen within 16 weeks. As far as I am aware, the last performance targets, which came out around a month ago and all services were, by and large, complying with them. If there were one or two exceptions, they were 17 and 18-week waits. One thing that the performance targets have done is focus on the out-patient side of the service. So, in services where you need to do other work with other agencies that also support the services, when you are prioritising your routine and deciding how much of your resource you can allocate to certain things, you tend to start skewing towards those who you see in the out-patients clinic. However, the remit of and how you should deliver CAMHS is wider than just out-patients; it should also be delivered through working with the social workers, through consultation and liaison with the system. I am not sure that the waiting-list targets, which are focused purely on out-patient times, have been helpful in developing this multi-agency working.

[259] **Christine Chapman:** I have a question, and I am sure that Angela wanted to ask about this as well: you mentioned the four-week waiting time and talked about possible suicidal tendencies in some people, but is that a normal amount of time to have to wait?

[260] **Dr Williams:** If you are actively suicidal and have committed self-harm, you will be seen sooner than that. There is an on-call service and there are emergency staff at all times, but unfortunately certain youth sub-groups use self-harm as a way to manage stress. We know that, for example, 30% of young people consider self-harm at any one time during the course of a year and 10% will actually do it. If we were only to tackle self-harm with CAMHS, and see all of those people, we would need to decuple the size of the staff in CAMHS, if the NHS had sole responsibility for that.

[261] **Angela Burns:** I want some clarity, because, to be honest, I do not recognise your figures. I have constituent cases where we have fought to get a child seen by CAMHS and those children have waited half a year, a year and a couple of years. I have two constituent cases where the individuals in question have tried to commit suicide, have self-harmed and have an eating disorder. Again, we have fought—and they have had to involve their Assembly Member—to get them seen by CAMHS. As I said earlier, only on Monday, I was in the pupil referral unit, and was told that they have children who have waited up to seven years—and I talked to the parent of one of the boys there—to be assessed by CAMHS. All of that anecdotal evidence does not tie in with you saying that everything is absolutely great within 18 weeks and four weeks.

[262] **Dr Williams:** I am not saying that it is absolutely great, but it emphasises that there is a lot of ‘Will you accept the referral?’ battling going on. People will say that tier 1 needs to do more work on this before this person is accepted by specialist services. As there is an out-patient-focused target, if they are accepted as a referral, they will be seen within 16 weeks. The trouble is that they are not accepted as referrals. I am not sure which service covers your constituency.

[263] **Angela Burns:** Pembrokeshire and Carmarthenshire.

[264] **Dr Williams:** That area also suffers from huge recruitment difficulties. So, even though the health board is willing to fund the posts—there should be three consultants covering the Hywel Dda Local Health Board region—there is only one in post. A third of posts are vacant, not because the health boards are not advertising these posts, but because you cannot recruit CAMHS staff to certain areas. If you looked at the caseloads of the people in Pembrokeshire and Derwen, they would be well over and above the recommended levels;

if you looked at their activity levels, those are also over and above the recommended levels. As a result, they set an extremely high threshold before they accept individuals on to the waiting list, so that they can then say that they meet the waiting-list targets within 16 or 4 weeks.

[265] **Angela Burns:** I accept your point, but I am flabbergasted that a child who is bulimic, has tried to commit suicide and is self-harming is not deemed mentally ill enough to even get a referral. That is an absolute disgrace beyond all belief. I am not having a pop at you, Dr Williams, but that is utterly shocking.

[266] **Dr Williams:** One of the wider issues is how we deliver sustainable specialist CAMHS and how we work with the agencies. It is clear that, in certain areas, there needs to be a greater pooling of resources so that you do not have a divide along the Loughor, if you like, about what you can get when you are in Swansea or in the Hywel Dda region.

[267] **Christine Chapman:** I want to move on. That is obviously very relevant to the inquiry into adoption, but I want to take us back to our main issues.

[268] **Julie Morgan:** Before I ask this question, I just wanted to check, did you say that the funding in Wales was 50% of what it was in England, and that that is taking into account the population?

[269] **Dr Williams:** Yes, per head.

[270] **Julie Morgan:** I think that you told us that it is on the basis of clinical need that you make the decision to see people, but parents who adopt feel that children who are looked after are seen more quickly. Is there any reality to that?

[271] **Dr Williams:** I think that they are seen by a mental health professional sooner, but that is because the looked-after services, as I said, with the children and young people's plans, have embedded mental health professionals in those primary-care services. Several of the local authorities have placed psychologists, psychotherapists or nurses to work in the looked-after care system.

[272] There is an idea of primary mental health care work—I am not sure how much you are aware of—that is about full-time people who are available to consult and liaise with primary-care services. There are certain CYPPs that have developed particular posts for the looked-after population. They will then decide whether more specialist direct work from the specialist CAMHS is appropriate at that time, or whether more basic interventions or greater support or training for the family is required. It is that sort of model that is not available for children who are adopted, because they are outside of that primary-care system.

[273] **Julie Morgan:** Adoption UK wants adopted children to have the same sort of treatment as looked-after children. So, is that where they should have the access?

[274] **Dr Williams:** That is the best port of call to get a response to identify the best people to be involved. I met Ann to discuss precisely that a year ago, and we agreed on that as a way forward.

[275] **Ms Williams:** This links back to Angela Burns's question on the tiers of services as well. If you look at our briefing paper—we will be happy to provide further information on that—specialist CAMHS is only one part of a holistic spectrum of care for children with mental health problems. The difference, and often the access, at the bottom end of that spectrum, compared with the very highly specialist end of the service, is more significant to families in terms of the immediacy of the response and the support that can be made available

to them.

[276] What you described in terms of looked-after children is a much greater provision at the lower end of the spectrum, which helps with early assessment and support, which is very much linked in with the integrated social services model of family support. That enables some of what you were describing to happen, around that early assessment of need, so that making the way through the gateway into specialist service is more rapid and often more appropriate as well, because that early assessment in intervention is able to be done appropriately with the family in a non-medical model; one thing that none of us would condone is labelling a child with mental health problems when what they and their family needs is support and help for them to adjust to a normal reaction to a difficult situation.

[277] What Dr Williams was describing earlier about CAMHS was that we need to separate the amount of time that we spend as an interventional service in direct intervention with families from providing technical advice, support and help to the lower tiers to enable them to manage people at the very early stage in the interventional need in that family. So, it is a mixed-economy model, but the challenge that families often have—understandably, because navigating their way through the care system can be incredibly difficult—is that they sometimes believe that the specialist end of CAMHS is the ultimate destination, where they will get the best intervention and care, whereas it may actually be somewhere else in that spectrum. However, navigating it and making sure that it is available on a multi-agency basis is the challenge for some groups. I very much suspect that that is a very difficult challenge for adoptive parents navigating the system.

11.30 a.m.

[278] **Lynne Neagle:** Obviously, the GP will be the gatekeeper for many adoptive parents. To what extent are you satisfied that GPs have a good handle on the challenges and issues facing adoptive parents?

[279] **Ms Williams:** There are three groups of people involved here: there is the GP, the health visitor and the social work team working with the family. I was interested in the question that you asked Dr Davies at the end of his evidence session. If we are looking at really helping in terms of intervention, training and support for those people in early intervention, early identification of challenges and signposting parents and families to the right services to help them are probably the most critical parts of that pathway. I would acknowledge, as I am sure would Dr Williams, that there is still a considerable amount of work to be done to help support the skills and confidence of those primary healthcare workers in that team to put the support around the family. That is a role that CAMHS can, should and does play.

[280] **Dr Williams:** The reality is that, over the course of their five years of undergraduate training and five or six years of postgraduate training, GPs are likely to spend a day at most on child and adolescent mental health training among the other stuff. In fact, social work and education no longer teach child developmental or mental health issues as part of the core curriculum in training for those services. Therefore, the gap between primary care expertise and specialist expertise has only got wider. Although the specialist service has got a bit bigger, it cannot bridge that size of gap.

[281] **Christine Chapman:** Are you satisfied that, if a GP refers someone, there would be access as far as waiting times go? Have you discussed this at all?

[282] **Ms Williams:** There are two issues here. If a GP makes a referral to the out-patient service, it is assessed by the referring doctor for appropriateness. If it is appropriate, the referral is accepted into the system in line with the waiting-times response that was given.

The challenge is what we need to do as a whole system to ensure that the right children are being referred at the right time. That is the challenge. Some children are referred inappropriately, because they have a different health need, not an acute mental health need. Other children, as you described, Angela, are sometimes not making it through the gateway and getting that referral. We have got to get that right.

[283] **Angela Burns:** May I clarify that? Say I was referred to the orthopaedic service, the referral would eventually get to orthopaedics and I would be on the list to be seen by a specialist. Are you saying that, in CAMHS, there is someone at the other end who looks at the referral and decides whether that should be accepted?

[284] **Ms Williams:** Yes, but it would be the same in orthopaedics.

[285] **Dr Williams:** The system in orthopaedics is the same. If you were referred to an orthopaedic surgeon for a heart complaint, the referral would not be accepted. That is the level of some of the referrals that we get. We did a survey and found that, in 38% of referrals, the referrer had not seen the child. So we say that they cannot make a referral unless they have actually seen the child and carried out an assessment themselves. That is a General Medical Council standard. Or it may be the case that the referrer is asking at the wrong time or for something that needs to be done in collaboration.

[286] For children, the model of referral is a bad one, because that implies giving their case to someone else. In social care, we are looking at having a team around the child and a team around the family, increasingly, so that you invite professionals to mutually discuss the case and take away the pieces of work. Many of the referral battles have been where GPs have said, 'It's yours' and other services have said, 'No it's not, it's yours', and that does not meet the family's needs at all. A model, which the Mental Health (Wales) Measure 2010 seeks to address, where the first engagement for the majority is a discussion with a professional to clarify the needs of the family and to identify, together, the most appropriate services to meet the needs of the child is a far better model of care than having turf wars where people worry about their waiting list targets.

[287] **Angela Burns:** However, if your GP is not a specialist, because they have had only one day's worth of training in 10 years, they will surely not know where to refer the child because they cannot decide whether that child has obsessive compulsive disorder or a phobia or whatever. So, would it not be better for them to get into the CAMHS service to be seen by one of your guys who then says, 'You need to go there, you go over there, and you are in trouble so you go this way'?

[288] **Dr Williams:** That is what the mental health Measure does. It is an all-age mental health Measure. It seeks to employ a primary mental health care worker, so the GP refers patients to a trained mental health worker who will do an assessment and identify the needs. It is slightly separate from specialist CAMHS, because there are only 200 professional CAMHS workers across Wales, so the capacity of the service would be grossly inadequate if we were the first point of call. The mental health Measure seeks to have a specialist adviser on site, working alongside GPs in practices. So, a GP who might be unsure of what was going on with a patient and might be thinking that it is a mental health issue could ask for an assessment from the point of view of the adviser, and that patient could then access specialist NHS provision as well as third sector or local authority care, or whatever the appropriate care is, alongside that as a package.

[289] **Angela Burns:** Is that adviser role not in place now, then?

[290] **Dr Williams:** No, it is due to be launched. The teams have to be in place by October.

[291] **Angela Burns:** Is that person a doctor?

[292] **Dr Williams:** No, there will be a set number of disciplines deemed appropriately competent to do the job. So, it is could be a mental health nurse, a psychologist, a doctor, an appropriately trained occupational therapist or physiotherapist.

[293] **Ms Williams:** The issue is how we appropriately signpost people to the service that is appropriate to their needs. The CAMHS professionals are the high-end trained specialist therapeutic intervention people, and it would not be a good use of their therapeutic intervention skills for them to be doing the signposting. We need them to provide the care and intervention with the family when it is needed. This is where Wales has been instrumental in adopting the mental health Measure, because it will be significant for adults and children. The other challenge that we have is transitional care for people who move between child, adolescent and adult services, so that signposting needs to be appropriate. The whole intention is to ensure that the right people get the right level of care at the time that it is needed.

[294] Returning to your point about the CAMHS service, it is no different from general surgery or orthopaedics. Even today, someone who is referred to the orthopaedic service with, for example, a foot problem will be screened by the consultant as a referral and may be referred on to podiatry because that could be a more appropriate route to get that person's problem resolved.

[295] **Lynne Neagle:** Are you confident that every GP practice will have one of these professionals in place from October?

[296] **Ms Williams:** They will have access to one, so that may be in collaborative practices. Every individual practice will not necessarily have one, but groups of practices will have access to that service. The Measure requires that service to be in place by October.

[297] **Dr Williams:** Each health board has to submit its plan in two weeks' time for approval by the Assembly. There are prescribed numbers of primary health professionals who need to be available across the whole of the patch. With regard to children's specialties, we do not want a generic person who is trying to cover all ages from birth to 100. Increasingly, health boards have arranged their GP practices into neighbourhood networks or groups of practices, and it is likely that each of those areas will have designated people. Part of the Measure—and there is a legal requirement on the NHS executive body to deliver it—requires that those services be delivered alongside and in primary care practices. So, it is not about sitting in a clinic somewhere five miles away; these people need to be walking through their GP practices regularly. They may not be there every day, but it is a 24-hour service.

[298] **Jenny Rathbone:** I want to clarify that the fundamental problem here seems to be that teachers, social workers, primary healthcare workers, and, I would add, magistrates and judges do not have the most basic understanding of child development. They all get shovelled up to your specialist services. Is that right?

[299] **Dr Williams:** Yes.

[300] **Jenny Rathbone:** Right. Excellent. Can you tell us about the specific problems of not having social services attached to CAMHS teams?

[301] **Dr Williams:** It is a huge problem, because CAMHS needs to bridge several services, so we need to work strongly with our education partners, our social service partners, our children's health service partners, our public health nursing partners and our adult mental health partners. Over the course of the years, the mapping data have shown that social

services have gradually decreased in different areas of Wales and some areas of Wales did not have any in the first place. There are currently five provider health boards across Wales for CAMHS. They range from the Powys service, which, as I have said, is a handful of people, to the Cwm Taf service that covers Abertawe and Bro Morgannwg, Cardiff and the Vale and the Cwm Taf areas.

[302] If you look at the configuration of the professionals involved, you can tell where they came from, because, by and large, services have just been involved where they started, if you like. So, three of the services were in-patient services 30 years ago, and their staff almost entirely comprised nurses, doctors and the odd therapist. Other areas, such as Cardiff, were more integrated, and the child guidance clinic had some of that support, and had social work as a vital part of that. I worked as a trainee with Dr Davies when he was providing looked after care services and the attachment work as part of the Cardiff CAMHS. Over the years, for whatever reason, social work has disappeared from core CAMHS, which means that the discussions with local authorities, as we seek to work in partnership, have become a bit more strained, because we talk in a slightly different language. We are not sharing targets and direction, and the child then misses out a vital bit of the social care perspective, namely the therapeutic social work that used to be a core part of social work. So, it is a huge loss. It is not because we would not welcome social workers as part of the team, by and large, but simply about agreeing on who will pay for them.

[303] **Jenny Rathbone:** It is also about how we commission services, surely. It is a fundamental problem about not commissioning the services that our population needs.

[304] **Dr Williams:** Over the past 15 years, there have been three different commissioners—different health trusts have amalgamated as health trusts, then we have had the health boards amalgamate, we had regional planning networks and now we are in the organisation that we have at the moment. It is interesting that CAMHS are now coming onto the radar of all the health boards and we are now starting to think about it. Just last week, a proper discussion about the appropriate planning of CAMHS on a multi-agency basis was prepared. The idea is that each health board will have a multi-agency planning group, held together by an all-Wales multi-agency group to look at the more specialist services, to set similar standards and to look at where services need to be delivered in partnership, and to define how locally it is practical to deliver certain services. There has not been a planning framework. I have been clinical director for 11 years and there has not been a single point to which I can go to deliver that. I have to go to six different meetings across Gwent, five different children and young people's partnerships, plus meetings at an all-Gwent level and an all-Wales level. I also have to deliver the clinical service, but it cannot be done.

[305] **Jenny Rathbone:** No, absolutely not.

[306] **Ms Williams:** To expand on that briefly, first, children with mental health problems rarely just need support from the health service. They also need support from social services, their families need support, and they need support from education services. So, unlike some clear surgical intervention services, it is one of those services that cannot be considered in isolation. The social work and education input into the care management of children with mental health problems is critical to the outcome for them and their families. I took over chairing the south-east Wales network, and, literally in the past three months, we commissioned a piece of work urgently, which went to the chief executives of the NHS bodies in Wales last week. In that, we recommend the establishment of a national planning forum for CAMHS in Wales and that that should link in to the delivery advisory group, which is the Welsh Government body that we both sit on, and that acts as part of the advisory infrastructure in the machinery of Government.

11.45 a.m.

[307] We are also looking at a very quick option appraisal of the delivery mechanism, to be done over the next three months. We are very concerned about the point that you made earlier, Mr Roberts, to do with the disparity in the models of delivery. It is very difficult for families, as the sense is that access differs depending on where you live. We are looking at a number of options, from a single delivered service at one end of the spectrum for the whole of Wales through to collegiate services around health board boundaries or groups of health board boundaries. However, we are very clear that the success of that is entirely dependent on its being a multi-agency delivery arrangement, because, when we discuss these issues, we find that all roads link back to the difficulties that families have in navigating the care system. For families who are at a difficult juncture in their lives and have children who have problems, the last thing they need to be doing is fighting the system and trying to find where on earth they need to go to access the appropriate care. So, that is very much on our agenda, and we will be bringing forward proposals for the NHS to consider with its partners over the next three months.

[308] **Aled Roberts:** On Jenny's point, can you provide us with evidence of this withdrawal of social services staff over the past five years? Can you give us some kind of geographical view of the matter?

[309] I sat as a member of a children and young people's partnership until 12 months ago, and what was frustrating was the examples of health professionals who were also withdrawn. You mentioned the delivery model that you have been working on, which you presented to the NHS chief executives two weeks ago. Was that drawn up in consultation with local authorities and other agencies? One of the frustrations for me is that both empires draw up their own plans when, in reality, what you need on occasion is for people's heads to be knocked together.

[310] **Ms Williams:** When the initial proposals went to the NHS, we sought agreement with the chief executives on our desire to have a national planning framework for Wales. At the moment, we have three planning networks: north Wales; mid and west Wales; and south-east Wales. That set-up is itself creating different sets of priorities and different directions of travel. So, the next phase is to work through, with our local authority partners, the mechanism by which we would make that work. That would be about very high-level planning and standard setting, so that we had a consistent approach across the whole of Wales. However, the crux of the matter on delivery is that we will have to look at it, because we currently have 22 local authority boundaries and seven health board boundaries. We have to look at the regional framework to see how we can consolidate those boundaries. Do we do it around health board boundaries, so that local authorities are working together and sharing? In my area, Cwm Taf, that has been made very easy, because the two local authorities work very closely together. We are moving to a single integrated children and young people's partnership for the whole area, and the issues of sovereignty at local authority level have been dealt with positively, so that we can work as one partnership.

[311] In north Wales, there are seven local authorities, and in Gwent, there are five. So, we have to find a mechanism with those local authority colleagues so that we start to break down some of the boundaries, while recognising that the sovereign accountability for social services still sits with the individual local authority.

[312] **Christine Chapman:** We are getting a bit short on time. We have about five minutes left. I ask Members for quick and specific questions now, because we have heard graphic evidence from adoptive parents about this. Jocelyn, would you like to go next?

[313] **Jocelyn Davies:** Yes, and, after all, this review is about the effect on adoptive families.

[314] Dr Williams, we heard evidence earlier on from Dr Davies—and I can tell from the answers that you have given that you were able to hear that evidence. Do you think that harm is being done to children, in the form of an attachment disorder, who are being parked in fostering from the age of two until they are found a permanent home several years later?

[315] One comment that I would make, Chair, is that, when I read the paper that you submitted, it did not identify all these terrible fundamental deficiencies that we have heard you describe now. I am grateful that you have been prepared to put that on the record, although I must say that the written evidence made everything seem fine.

[316] Also, Dr Davies said that your marketing is very effective, but that the therapy is not. I imagine that you heard that. He said that you were wedded to the medical model at the very specialist end. From what you said, Ms Williams, it sounded as if that, at the lower tier, it is not so much the medical model, but as you move through it, specialism is the medical model. His point is that, in extreme cases, small numbers need that specialism, but not on a medical model. Therefore, my first question was whether children are being harmed by being parked in foster care that results in attachment disorders. Secondly, I asked about the appropriateness of the medical model for very specialist services.

[317] **Dr Williams:** Yes. Without appropriate foster carers, trained and specialised in identifying attachment disorder, children will be harmed by doing that. The increasing evidence is that, in the first six months, or in the first or second year, the harm is done. Biological changes have already occurred in the brain by the time that you are two years old. That needs to be responded to as soon as possible. Good enough, appropriate parenting is important, but a greater sensitivity to the differences is just as important. Essentially, children who are put through early attachment difficulties either become hyperaroused or withdrawn—those are the two broad spectrums—and you need to have foster carers who are responsive to that and who can tune their responses to the child appropriately. We do not have that preparation and training, and we do not have enhanced infant mental health and early mental health services in Wales, which would be really important for all children with attachment disorder.

[318] Secondly, the response to the medical model is one of the issues that have arisen. It depends on which service you go through. Some of the services are not very medical at all, possibly because they have not had any consultants there for a long time. There are certain areas in Wales where you cannot possibly have a medical model because you do not have many consultants. Certain areas are very medical, whereas other areas are not established agreed models.

[319] **Jocelyn Davies:** My point is that Dr Davies talked about extreme cases and small numbers needing very specialist—

[320] **Dr Williams:** Yes; they do.

[321] **Jocelyn Davies:** However, not based on the medical model.

[322] **Dr Williams:** Absolutely 100%—

[323] **Jocelyn Davies:** So, you say that we have non-specialist professionals—

[324] **Dr Williams:** No, they are specialist; they are just not medics.

[325] **Jocelyn Davies:** Okay; they are not medics. Are they delivering the very specialist therapy that these children require, regardless of where they live, or was he right in saying

that your marketing is more effective than delivery on the ground? According to the paper that you submitted to us, your marketing is very effective, but we have heard today that the reality is quite different.

[326] **Dr Williams:** We were asked a week last Wednesday to prepare the paper, for submission by Tuesday; the turnaround was very quick. We were not certain on the questions to which we would have to provide a response. It was very much a case of being told to provide a paper. I also held two clinics at the same time as preparing the paper. So, I apologise for the quality of the paper—

[327] **Jocelyn Davies:** It is not about the quality. It describes a situation that people are not experiencing in reality. You told us that you have been part of the service for 11 years. Today, we have repeatedly heard you saying that CAMHS is failing to provide effective early intervention because you cannot do it. We have to wait for legislation. I would say to the adoptive families, 'Roll on, October, because at least then you will know whether you have been referred'.

[328] **Dr Williams:** I am saying that, in certain areas, you get a good service, whereas in other areas, you do not get a good service. I am not saying that it is uniform. There are areas of good practice. I would like to say that my service does it, but it only has a very small capacity. As the capacity is not big enough, there is a wait for that highly specialised care. I have a half-time psychotherapist whose whole job is to deal with attachment disorders. As I said, we also have a high-grade psychologist whose whole job is to deal with attachment disorders, and we have workers in primary care who are supporting families with attachment disorder, but that is not replicated across the whole of Wales.

[329] **Christine Chapman:** The message is clear that there are inconsistencies, but thank you for bringing it to our attention. Lynne, would you like to come in on the final question?

[330] **Lynne Neagle:** I think that the question has been covered; it was about whether specialist services should be developed outside CAMHS, given the overreliance on the medical model. Do you have anything to add on that?

[331] **Dr Williams:** There needs to be collaborative work. I would welcome a service that is not developed on the medical model. That can be developed within or outside of CAMHS, depending on the style of leadership within CAMHS that you are building with. Part of the task for the national group is to get an established model, which I argue should not solely be a medical model. Clearly, any services developed need to be integrated with the specialist services, because, as we rightly point out, there are a small number of people who need highly specialised services. For example, in relation to the continuing healthcare budget for children who end up being placed out of county in secure care, you need senior professionals who know what they are doing involved in that service. Those children can go on to develop psychosis, depression and all of those sorts of things, so you need those professionals involved in the service.

[332] **Christine Chapman:** There are now very brief questions from Aled and Jenny, before we wind up, because we are running out of time.

[333] **Aled Roberts:** We are talking about a national adoption service. If we set up a national service that is dependent on service provision that is very different in different areas of Wales, we are almost setting ourselves up to fail. Could we be provided with a paper showing the differences in the service provision in CAMHS throughout Wales and, if possible, point to what you consider to be best practice and the areas where the needs of parents are provided for better than in other areas? We need to see that information as a committee.

[334] **Ms Williams:** We would be happy to provide you with a paper. We must look at that in the context of the recommendations that you may make as a committee and also the work that we are looking at to try to get greater consistency. So, we are currently at a moment in time when we are also recognising the need to look at national consistency around service provision. A word of caution for the committee, however, is that we must look at this as a whole system, because in order to support families with their mental health needs, whether in relation to adoption, looked-after children or families in transition, there must be a multiagency approach. One of the understandable consequences of not having those other services is that we end up in a medical model.

[335] **Jocelyn Davies:** I would not argue with that, but a holistic approach—placing children in better environments—would not harm children. So, you could then reduce the medical model.

[336] **Ms Williams:** Yes, absolutely. I think that we are saying the same thing here. We should not knock the medical model, because that is the right service to meet the needs of some children. However, for a lot of children, it is not, and in the absence of anything else, that is often where children and their families end up. That is not right and we all recognise that. I would be comfortable in providing that information for you, but the hazard warning that I would give is that the work that we are currently doing to develop a national and more holistic model will take several months to be completed.

[337] **Jenny Rathbone:** I just want to double-check something. Dr Williams, you say in your paper that there are child psychotherapists in each single service within CAMHS. So, there are child psychotherapists across Wales.

[338] **Dr Williams:** Yes, but, normally, along the lines of a day or two a week in total. Cwm Taf Local Health Board has a whole-time equivalent, but they are very small-scale.

[339] **Jenny Rathbone:** It would be useful to have the actual number of full-time child psychotherapists across Wales.

[340] **Dr Williams:** We can supply you with those figures.

[341] **Christine Chapman:** We have run out of time. I thank you both for attending today. This session has shined a spotlight on this important issue on behalf of the adopted young people of Wales and their parents. We will send you a transcript of the meeting so that you can check it for factual accuracy.

[342] Before I close the meeting, I remind Members that the next meeting will be next Thursday, 31 May, when we will be discussing neonatal care with the Minister for Health and Social Services. We will also be taking evidence on the School Standards and Organisation (Wales) Bill. I now close this morning's meeting.

Daeth y cyfarfod i ben am 12.00 p.m.
The meeting ended at 12.00 p.m.