Comisiynydd Plant Cymru
Children's Commissioner for Wales

Ymateb i Ymgynghoriad / Consultation Response

Date / Dyddiad: 23rd February 2022

Subject / Pwnc: Senedd Health and Social Care Committee Inquiry into mental health inequalities

Background information about the Children's Commissioner for Wales

The Children's Commissioner for Wales' principal aim is to safeguard and promote the rights and welfare of children. In exercising their functions, the Commissioner must have regard to the United Nations Convention on the Rights of the Child (UNCRC). The Commissioner's remit covers all areas of the devolved powers of the Senedd that affect children's rights and welfare.

The UNCRC is an international human rights treaty that applies to all children and young people up to the age of 18. The Welsh Government has adopted the UNCRC as the basis of all policy making for children and young people and the Rights of Children and Young Persons (Wales) Measure 2011 places a duty on Welsh Ministers, in exercising their functions, to have 'due regard' to the UNCRC.

This response is not confidential.

Introduction

Under the United Nations Convention on the Rights of the Child (UNCRC), *all* children have human rights to which they are entitled. These rights equally apply to all children aged 0-18 without discrimination of any kind.

Rights under the UNCRC include the right for every child to enjoy the 'highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health'[1]. Children also have the right to physical and psychological recovery and social reintegration if they have suffered trauma, in an environment which fosters the health, self-respect and dignity of the child (article 39); to be protected from all forms of discrimination (article 2); and for institutions of the State to act in their best interests (article 3). It is clear that, in Wales, some children do not have access to their human rights in the same way as others, and access to mental health care is a key inequity.

We do not always have the data available to us here in Wales which would assist us in establishing exactly where inequalities lie. As highlighted in my joint report with the other UK children's commissioners to the United Nations Committee for the Rights of the Child, published in December 2020[2], there is neither joined-up nor disaggregated data for expenditure on children's mental health services beyond specialist services. We do not have publically available data on interventions or treatment. While I recognise the balance that must be struck so that professionals' time is not disproportionately taken up by reporting statistics, Wales would benefit from a more comprehensive understanding of the landscape. It should also be noted that there are big overlaps between mental health, neurodiversity and learning disabilities in terms of young people with learning disabilities or neuro-developmental conditions having a higher than average likelihood of experiencing mental health challenges. We also have very little reliable data directly from services in these areas.

The data that are available to us through other sources, though, suggests a number of key indicators which mean that children are less likely to be able to enjoy their right to the best possible standard of care for their mental health. I outline some of these in this response, alongside those identified through the work of my office.

Part of the response to try to level the playing field has to be, in my opinion, work towards a No Wrong Door[3] approach. We have highlighted practice examples of taking a child-centred, early intervention approach, such as the SPACE-Wellbeing panels in Gwent[4]. The principle of these is that individual children's circumstances are taken into consideration by various agencies who can offer rapid support together, *in one place*, rather than multiple referrals being made to different services with varying waiting lists. Child-centred, timely, early intervention approaches are, by their nature, a tool for tackling inequalities because they utilise the resources of various agencies and bring wraparound support directly

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[1] https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

[2] https://www.childcomwales.org.uk/wp-content/uploads/2020/12/UN-report-2020-examination-.pdf

[3] https://www.childcomwales.org.uk/publications/no-wrong-door-bringing-services-together-to-meet-childrens-needs/; https://www.childcomwales.org.uk/wp-content/uploads/2022/02/No-Wrong-Door-Report-February-2022.pdf

[4] https://www.childcomwales.org.uk/faqs/case-study-gwent-space-wellbeing/

to the individual needs of the child and their family. This prevents families being told that they have been knocking on the wrong door for help, or that their problems do not ‘fit’ with referral criteria.

Question 1: Which groups of people are disproportionately affected by poor mental health in Wales? What factors contribute to worse mental health within these groups?

The following is not intended to be an exhaustive list of which groups of children and young people are disproportionately affected by mental health, and the disparities in accessing mental health support. This response is based in large part on two sources of evidence. Firstly, my office’s large-scale surveys of children and young people in Wales carried out in 2020 and 2021. Secondly, evidence from my office’s core work in both supporting children and their families with their individual circumstances if they feel they have been treated unfairly through our Investigations and Advice team[5]; and through our policy influencing and project work.

***Coronavirus and Me* surveys: disabled children; children identifying as an ethnic minority; and secondary school aged children.**

In May 2020, my office surveyed nearly 24,000 children and young people on their experiences during the initial lockdown period. We then repeated the exercise in a further period of strict lockdown in January 2021; this time hearing from nearly 20,000 children and young people.

We asked children and young people how they had been feeling during the lockdown periods, and gave options including levels of happiness, safety, loneliness, and how worried they felt. We also asked children whether they needed extra help during lockdown, and if they were confident knowing where to go for support with their mental health and wellbeing.

Our results from both surveys showed that disabled children and young people, and children and young people who self-identified as a Black, Asian or minority ethnic group, were statistically significantly more likely to report negative feelings across several indicators.

In January 2021[6], we found that disabled children and young people, compared to non-disabled children and young people, were:

- More likely to feel sad, unsafe and lonely
- More likely to say they need extra help, and want support to make them feel happy and well
- Less likely to know where to get help if they need support to feel happy and well.

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[5] https://www.childcomwales.org.uk/about-us/investigation-advice/

[6] https://www.childcomwales.org.uk/wp-content/uploads/2021/02/CoronavirusAndMe_Jan21_ENG_110221_FINAL.pdf

We found that children and young people identifying as a Black, Asian or minority ethnic group, compared to white Welsh or British respondents were:

- More likely to feel lonely, unsafe, sad and worried.
- More likely to say they need extra help, and more likely to say they need more help to feel safe at home
- 7-11 year olds were more likely to say they need extra help to feel happy and well.

While the results were not all the same as May 2020, several of the results from January 2021 were very similar in terms of divergence from the non-disabled population in the case of disabled children; and divergence from white Welsh or British respondents in the case of respondents identifying as from Black, Asian and minority ethnic groups.

Those aged 15-18 were more likely to report negative emotions than younger children, as demonstrated by the following two graphs taken from our *Coronavirus and Me 2* report. This pattern of increasingly negative wellbeing indicators as children get older is reflected in the School Health Research Network's National Report 2019/20[7], which used a measure of psychological attributes through the Strengths and Difficulties Questionnaire (SDQ).

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[7] https://www.shrn.org.uk/national-data/

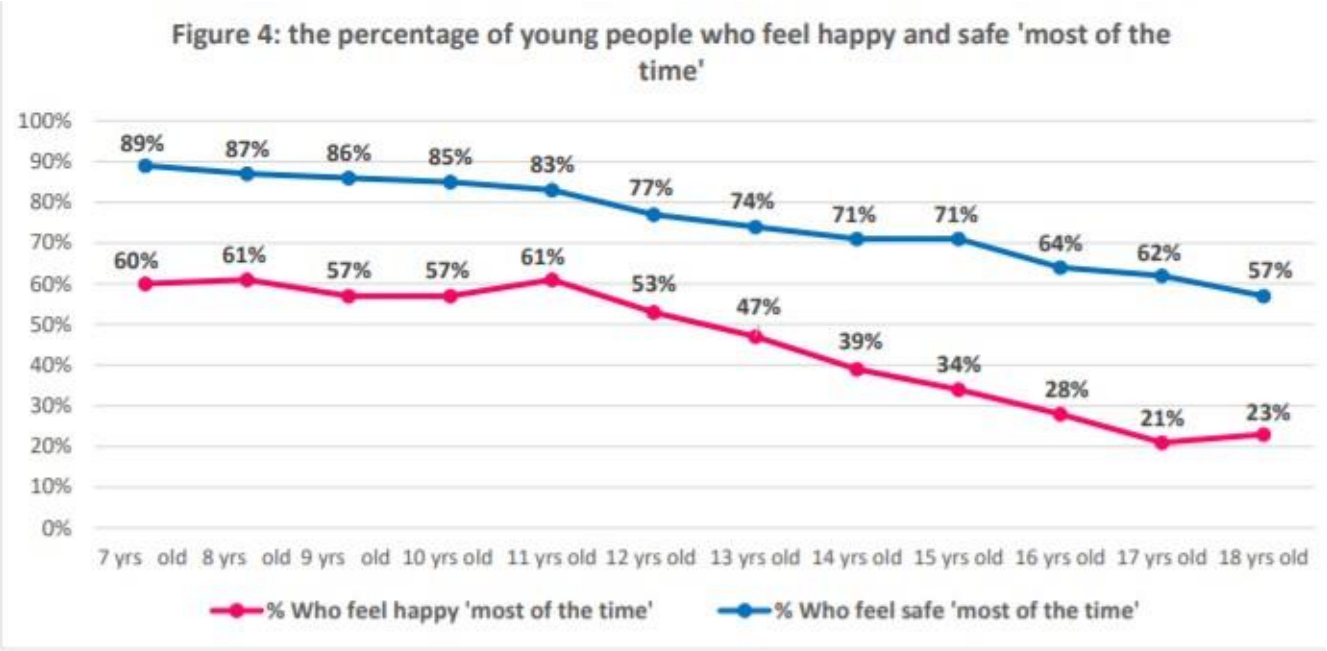

Figure 4: the percentage of young people who feel happy and safe 'most of the time'

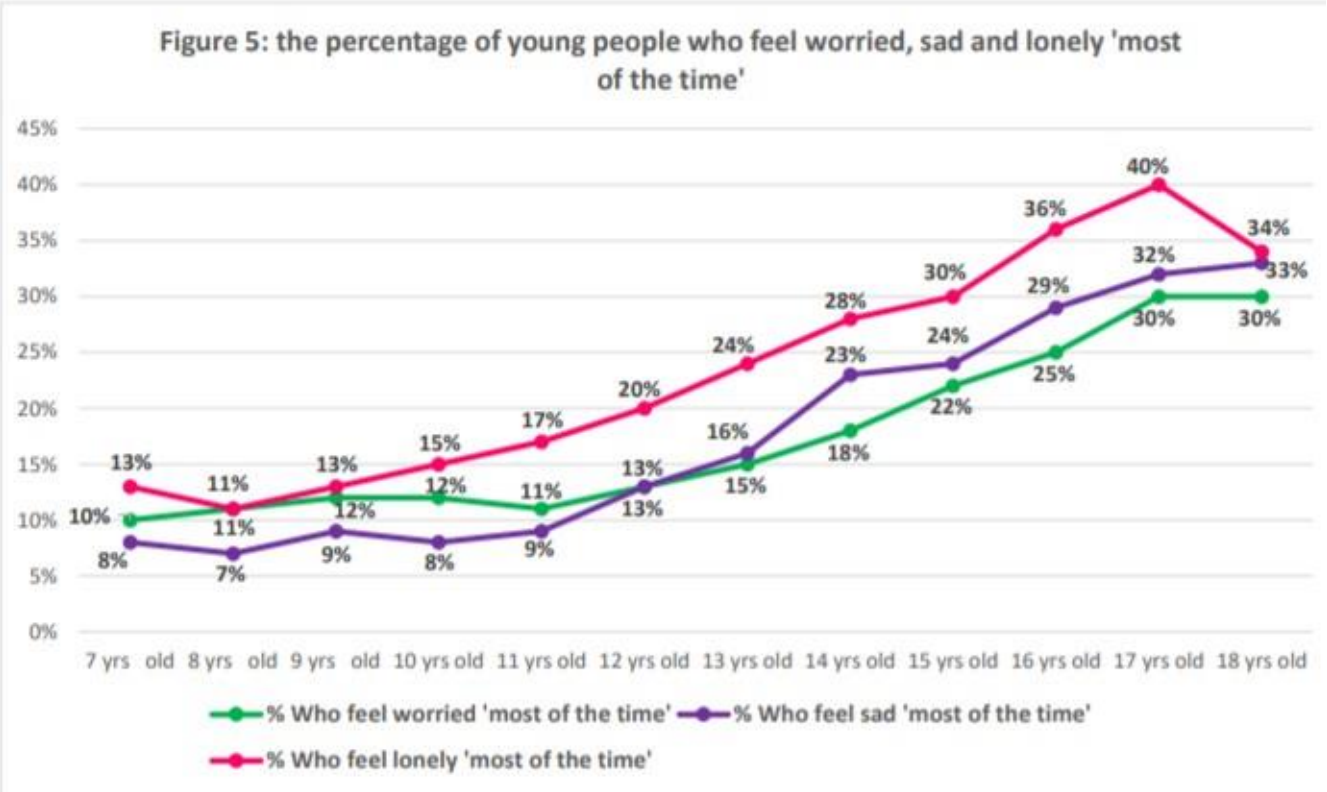

Figure 5: the percentage of young people who feel worried, sad and lonely 'most of the time'

It is important to say here that neither survey asked children and young people to identify themselves by defined categories other than age, gender, ethnicity and disability. We did not ask, for example, for information which would give any indication of family affluence / socioeconomic status. This was because the surveys were being completed at home, during periods of lockdown, and children would not have had the support of teachers to complete the survey. We therefore had to limit the number of questions asked.

Income inequality

While our surveys did not ask respondents for information which would allow us to make any comment on how income inequality affects mental health and wellbeing, the link between family income and prevalence of poor mental health is well documented. As an example, the Millennium Cohort study has shown children from the lowest income families are four times more likely to have serious mental health difficulties by age 11 than those from the highest income families[8].

The School Health Research Network's analysis of their data from a 2021 Health and Wellbeing survey of primary school aged children[9] shows that children in year 6 who had a low family affluence score were more likely to report higher behavioural and emotional difficulties scores. 10% more children from the low affluence cohort met the threshold for elevated or clinically significant behavioural difficulties than children from the medium family affluence cohort.

Neurodiversity and mental health

Figures show that children with diagnosed neurodevelopmental conditions face an often unmet clinical need for support for their mental health and wellbeing needs[10]. Our experience through our Investigation and Advice service is that there is also a high level of need for mental health services from those awaiting an assessment for a neurodevelopmental condition, or for whom their neurodiverse traits do not meet the criteria to qualify as a neurodevelopmental condition to access clinical support.

Early intervention and whole-family support

We know that 50% of mental health problems are established by age 14[11], and recent research has shown around 1 in 12 year 6 students in Wales score above the threshold for potentially clinically significant emotional difficulties and behavioural difficulties[12]. And yet the support available to children and their families before their teenage years in particular varies across Wales. We know that some families are more likely to need support for a child's mental health. As the Nuffield Trust put it:

> *there are significant inequalities in mental health disorders among young children, with disorders more prevalent among young children of families with poor parental mental health, lower incomes, and in receipt of benefits.*[13]

We should be doing all we can to support children and their families as early as possible, particularly

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[8] https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/newcentury.pdf

[9] https://www.shrn.org.uk/national-data/

[10] https://www.frontiersin.org/articles/10.3389/fpsyt.2021.649399/full

[11] https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8550448/

[13] https://www.nuffieldfoundation.org/wp-content/uploads/2021/12/Are-young-children-healthier-than-two-decades-ago-Nuffield-Foundation.pdf

those families with known risk factors.

Two health board areas have dedicated infant mental health teams (Aneurin Bevan UHB and Cardiff and Vale UHB), including the recent encouraging development of the Gwent Parent-Infant Mental Health Service (G-PIMHS)[14]

School absence / exclusion

In 2018-19, our Investigation and Advice team experienced an increase in contacts from families of children aged 8 and under who were not able to access their human right to an education under the UNCRC. These children were at risk of exclusion or being taught in isolation from their peers. Some were receiving no education at all.

Our *Building Blocks* report[15] highlighted that when children were taken out of the classroom setting there was a lack of support for their mental health and wellbeing, and that far too often they were placed in unsuitable and isolating alternative settings, or excluded completely. The experience of excluding children from their peers can of course be traumatic in and of itself. We were told about incidents including children being kept in isolation all day with two adults in the room with them.

Recent research evidences that those with diagnosed neurodevelopmental or mental disorders, or with a record of self-harm, are more likely to be absent or excluded from school. This research also demonstrates the impact of absence or exclusion from school on current or future poor mental health[16].

The pandemic has of course further affected school absenteeism. Despite Welsh Government policy placing less emphasis on fines in the pandemic period, we have received anecdotal accounts of some local authorities taking action by threatening fines on the family, without taking the time to try to fully understand and support the family's individual needs. The increased non-attendance of pupils can lead to some experiencing a phobia of going to school as they have spent so long away from the school environment.

Indications so far this year are that absenteeism is high – 2.9% of pupils have already missed more than 8 weeks of school. Prior to the pandemic between 4 and 5% were persistently absent — more than one child in every classroom. This tends to be older children.

Our Coronavirus and Me surveys showed a wide range of reactions from children in relation to their views of school and school work during lockdown. While there was a strong element of children and young people being desperate to be back in school for both socialisation and learning, some were happier out of school because of their neurodiverse needs or bullying, or both. Some enjoyed the freedom to direct

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[14] https://abuhb.nhs.wales/hospitals/a-z-of-services/gwent-parent-infant-mental-health-service-g-pimhs/

[15] https://www.childcomwales.org.uk/wp-content/uploads/2020/12/Building-Blocks-Report_E.pdf

[16] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(21)00367-9/fulltext#seccestitle160

their own learning. Many older young people reported that they had lost motivation with their school work.

The response to these inequalities requires social care, youth work, health care and education to work together to regain children and families' confidence in returning to school. Welsh Government have provided money for extra resource to tackle this specific issue, but a shortage of staff right across our public sector can mean that even with generous funding it can be difficult to deploy more staff to do the kind of individualised support that is the best way to tackle this.

Some examples of local responses to this situation include having multi-disciplinary panels (such as Gwent's SPACE- Wellbeing panels) to discuss the needs of the child and family and develop a broad support package, youth workers engaging with the young person to encourage them back into school or more pastoral staff within schools. There is also a need to provide better alternatives to the standard full school timetable and classroom setting

Gender identity

We know from contact from families and in conversations with commissioning bodies that young people wishing to access support and/or treatment from gender identity services face a very long wait, with very little support available in the meantime. There are some local support groups available across Wales, but it really is a postcode lottery. The impact of a long wait for treatment can have a detrimental impact on mental health.

In my response to the Welsh Government consultation on the LGBTQ+ Action Plan, I welcomed the intention to review the Gender Identity pathway for children and young people in Wales following the review by NHS England.

An independent review has been commissioned by NHS England to make recommendations on the services provided to children and young people who are exploring their gender identity or experiencing gender incongruence. The current extremely long wait for assessment and treatment must be reviewed.

In that response, I also welcomed the plan for guidance on trans inclusion in schools. There is a clear lack of guidance currently for schools who want to do their best to protect the human rights of all their students.

Care experienced children and young people

Care experienced children and young people are likely to have histories of adverse childhood experiences which can result in poorer mental health and lower wellbeing, reporting lower life satisfaction[17].

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[17] https://shrn.org.uk/wp-content/uploads/2017/03/Long_LAC_English.pdf

Care experienced children and young people are not currently receiving the service they should under the corporate parenting principle. Professionals report to us that local authorities are often buying in private therapy because of difficulties accessing NHS mental health services. Some regions in Wales are developing a dedicated service for supporting care experienced children's mental health, such as Gwent.

We also hear from professionals who tell us that the process of transition to adult services has led to some care leavers being unable to access the therapeutic care they were receiving previously.

Question 2: For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?

The long wait to get help

For too many children and young people, the experience of trying to access mental health support involves waiting for a very long time for an appointment, or going to an appointment only to be told they can't be helped by that service and either told they don't meet the criteria and offered no support or referred on somewhere else. All the while, for many children and young people, no practical support is offered while they wait. This can particularly be the case for those trying to access particular support services alongside mental health support, such as neurodevelopmental services or gender identity services.

The most recent publicly available figures (December 2021) on waiting times for a first specialist CAMHS appointment[18] show a worsening situation over recent months, with just 22.1% of children being seen within the 4 week waiting time target. The figures vary between health board areas. While five of the seven health board areas report over 80% of referrals receiving a first appointment within the target time of 4 weeks; in Swansea Bay (service provided by Cwm Taf Morgannwg UHB), just 2.3% of children referred, and in Cardiff and Vale just 3.5% of children referred, are seen within the target time. This is in contrast to the situation before the pandemic, when good progress was being made on waiting times in most areas.

In part, the large difference can be explained by some health board areas having a Single Point of Access system where potential referrals are discussed and often referrers are signposted to other services or immediate advice is given. This means that the numbers referred in to specialist CAMHS directly are lower than they were, where other services or supports may actually be more appropriate. But it is undeniable that there is clearly an unacceptably long wait for assessment and treatment for large numbers of children in Wales

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[18] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/specialist-child-and-adolescent-mental-health-services-scamhs/first-appointment-waiting-times/percentageofscamhspatientpathwayswaitingforafirstappointment-by-month-groupedweeks

As highlighted by my office in recent months, children far too often also do not have a suitable place to go when they are experiencing a mental health crisis[19]. I have called for 'sanctuaries' or safe spaces to be created for children and young people when they are experiencing a mental health crisis. I am pleased to say that some regions of Wales have plans in place to develop such spaces and I look forward to these initiatives developing at pace. The following are case studies taken from my *Making Wales a No Wrong Door Nation*[20] report:

> *In **Cardiff and the Vale of Glamorgan** there are plans for a new 'safe space' open access model for children and young people in severe distress, to avoid the need for hospital admission. This new provision would provide a suitable child-friendly environment staffed by multi-disciplinary professionals, to respond to the needs of young people without them needing to waiting in A&E or be placed in an inappropriate setting. There will be a clear pathway set out for accessing this provision. There will be further discussion and planning to ensure this model is right and has all of the necessary connections to wrap around the young person and offer the right support at the right time from the right person. While this model is developing, there is temporary accommodation provision for under 18s on wards , until the new safe space is operational and embedded. Cardiff & Vale UHB will also be extending the operating hours of the Crisis Team to 24/7 by March 2022.*
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> *In **North Wales** there are plans for a new 'safe space' drop in centre in Wrexham for children aged 13-18 to receive support for an urgent mental health or emotional wellbeing issue. The centre will be led by CAMHS regional clinical lead, coordinated by health and Wrexham Local Authority. The project hopes to expand further to include third sector organisations. It will be open in the evenings, nights and weekends.*
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> *The project aims to prevent or reduce deterioration in a young person's emotional, behavioural or wellbeing state which may otherwise result in an application of section 136 of the Mental Health Act ('being sectioned'), calls to emergency services, or admission into hospital or presentation at an emergently department. There will be a three-month trial in the coming months.*

Neurodiversity and mental health

As highlighted in my recent report, *Making Wales a No Wrong Door Nation*[21], children awaiting assessment for neurodevelopmental conditions face an extremely long wait (typically several years) and in the meantime their mental health and wellbeing can dramatically deteriorate, without appropriate support being offered. Those with concurrent neurodevelopmental conditions and mental health conditions (which is common) receive a very disjointed service because of the fact they require input from separated services.

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[19] https://www.childcomwales.org.uk/2021/10/no-suitable-places-for-young-people-in-mental-health-crisis-warns-childrens-commissioner/

[20] https://www.childcomwales.org.uk/wp-content/uploads/2022/02/No-Wrong-Door-Report-February-2022.pdf

[21] https://www.childcomwales.org.uk/wp-content/uploads/2022/02/No-Wrong-Door-Report-February-2022.pdf

Below I outline some themes summarising issues regularly brought to my office, and some case studies of individuals supported through our Investigations and Advice service.

Too often we hear from families where there are examples of:

- Miscommunication between agencies
- A lack of clarity over responsibility between primary and secondary or specialist CAMHS
- Families finding themselves in the position of awaiting an assessment from the neurodevelopmental team (NDT) which then prevents access to other services. This is despite the fact that the current average wait for a neurodevelopmental assessment is upwards of 2 years
- Confusion over where referrals can come from
- A lack of support while awaiting assessments, despite behaviour often described as dangerous to self and others

The following case study examples were brought to the attention of my office last autumn:

1) 15 year old

- Young person has been involved in services for 2 years and has not had an ASD assessment over this time. The referral response has always been that the young person doesn't meet the criteria
- They have just been accepted to the pathway and are on the 2 years-plus waiting list. The young person's mother asked for referral to primary CAMHS as she believes the young person has an eating disorder. Primary CAMHS told the family won't see her and that they should be seen by specialist CAMHS (sCAMHS)
- sCAMHS did a telephone assessment, then after 2 face to face assessments said the young person needs to be under primary CAMHS because they have an eating disorder.
- Young person not accessing any support in the meantime and is currently awaiting an appointment with primary CAMHS.

2) 12 year old

- Child who has been home schooled since February 2020
- October 2020 - Child is on the NDT pathway and has suicidal thoughts — been told waiting list is in excess of 19 months and appointments cannot be expedited
- Community Pediatrician won't accept a referral as waiting for an NDT appointment
- March 2021 - parents started to pay for child to see a consultant psychologist at a cost of £90 per session, who recommends medication. GP can't prescribe and child not seeing anyone in CAMHS so it can't be prescribed through them
- Reports high levels of anxiety and severe depression
- August 2021- Community Paediatrician wrote to GP advising as child is on the NDT waiting list the community Pediatrician won't see them — family will have to wait for NDT appointment as Community Pediatrician 'does not cover mental health'
- September 2021 – letter sent offering CAMHS appointment in December

3) 16 year old

- Young person who has not been in school for 2 years has been seen by CAMHS. We were told that the CAMHS nurse strongly believes that the YP has ASD and to date the mother's request for a referral has been denied.
- We were told the school have refused to make the referral stating that this young person has not been in school for 2 years, and they won't refer them to the educational psychologist who the ALNCO says is the only person that can make the referral
- GP has also stated that they cannot make a referral as it needs to come from the school
- We are concerned that this is contrary to NICE guidance, and indeed the Health Board's own public facing website which states that referrals should come from the professional who knows the young person best.

My report *Making Wales a No Wrong Door Nation* makes a recommendation to Welsh Government that they should support and deliver the joined up approach to neurodevelopmental services which recognises the full spectrum of neurodiversity, as developed by T4CYP.

The report highlights good practice case studies throughout, and there are encouraging examples we can draw on.

For example, Denbighshire CAMHS appear to have an encouraging sounding model where joint CAMHS / ND consultations can be offered through CHOICE appointments. They told us that parental consultation appointments can happen immediately, without having to wait for a diagnosis. Under their previous system they would have just been on the ND waiting list.

In Aneurin Bevan UHB, neurodevelopmental services have been streamlined into the SPACE-Wellbeing panels process to make sure the panel approach also considers neurodevelopmental needs.

But it is clear to me that neurodevelopmental services require a significant cultural change — they need to provide for both children and their families awaiting assessment, and for those who have been told they do not meet the criteria to be supported. Neurodevelopmental services need to broaden out to include support for neurodiverse children when they are suffering extreme emotional distress.

Transitions to adult mental health services

The transition from child to adult mental health services is an area where children and families often find themselves caught up in a lack of foresight for planning such a transition, and disputes between agencies over responsibility. We hear from young people, their families and professionals that they face a 'cliff edge' on reaching the age to transition to adult services whereby their nature of the service they receive changes dramatically — often meaning less direct contact with professionals for example. For children with other health and or social care needs as well as mental health needs in particular, the transition experience can be extremely difficult and distressing.

New Welsh Government guidance for Health Boards on the wider transitions landscape in health[22] is very welcome, and includes new roles created specifically to manage the caseload of young people who need support to move into adult services, and a named worker who coordinates individual support with that transition for the young person. There are also new Transition and Handover Plans designed to improve children's direct involvement in their transition. These changes should help to better manage children and young people's transitions within health. It is vital, though, that health professionals work in harmony with other agencies involved in children's care in order for transition to be a success.

Question 3: *To what extent does Welsh Government policy recognise and address the mental health needs of these groups? Where are the policy gaps?*

NEST / NYTH Framework

We welcome the work which has been undertaken by the Together for Children and Young People programme, and in particular their development of the NEST / NYTH framework. This framework will support Regional Partnership Boards and individual partners to create their local whole system approach to bringing services together for children and young people's mental health and wellbeing.

The key principles of this framework include a No Wrong Door approach, and we believe this framework reflects our priorities for creating a service which designs services to wrap around children and young people's needs, rather than expecting children and young people to fit into existing services.

Part of this framework includes improving the support given to children and young people who are neurodiverse and need support with their mental health. We are pleased that the Welsh Government has commissioned a review of the demand and capacity of neurodevelopmental services, which should assist in getting a clearer picture of the data, and the options available for improving the current system.

While this framework is very welcome, there are several important elements which are needed to ensure its success. These are detailed in my report, *Making Wales a No Wrong Door Nation*.

ICF and Transformation funding has been made available to RPBs for projects to support children and young people's mental health and wellbeing, including specific funding for Regional Partnership Boards to create new safe accommodation for children with complex needs. This provision would support those young people who don't currently 'fit' into the system we have in place because they have multiple needs

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[22] https://gov.wales/transition-and-handover-childrens-adult-health-services

beyond a mental health or social care intervention. I am pleased to say that most Boards now have plans for this accommodation, with new beds beginning to be made available this year.

A whole-school approach

There is a need to invest in preventative and early intervention in schools and communities, especially where there is more deprivation. As highlighted by my office's *Building* Blocks report, schools must also do more to create a supportive environment around children to avoid them being taken out of the classroom setting away from their peers.

The Welsh Government's whole school approach guidance[23] is welcome. It is clear that some schools will have already been on this journey and will take to the requirements of the guidance well, while others will struggle because they are further behind on the journey. A supportive mechanism which provides bespoke support to individual schools will be vital in implementing this guidance. I urge the Government to invest in replicating individual schemes which have been proven to provide support to pupils across schools where they don't yet exist. This would include examples such as nurture units — spaces made available to children who need a safe and supportive place to go during the school day.

The new curriculum of course also supports the whole school approach guidance through the health and wellbeing area of learning and expertise.

Question 4: What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

Overall, there is a lot of good will to address these issues, and there are green shoots across Wales, which I highlight here and in more detail within my *Making Wales a No Wrong Door Nation* report.

Clearly, mental health services in Wales are hampered by workforce issues which are common across the UK. However, there are examples within Wales of good practice that can be promoted and replicated throughout Wales. Single Point of Access approaches are a major step forward and can mean services come to the child together rather than expecting the child and their family to find which individual services are right for them. This approach to bringing support to the child can be embedded through whole school approaches within schools. All of these approaches are likely to support children and young people from groups that are likely to face more barriers than others to accessing support, including a lack of confidence and resources on the part of parents and carers to persist in seeking help through a complex system.

I believe that Welsh Government could provide a stronger role in ensuring good practice which maximises resources to provide a wraparound No Wrong Door approach to their young population (like the SPACE-Wellbeing panels in Gwent) is rolled out across the country. There will of course be regional variance in

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[23] https://gov.wales/framework-embedding-whole-school-approach-emotional-and-mental-wellbeing

how these initiatives are delivered, but I am convinced that we have the ideas and examples of delivery in pockets of Wales that could be scaled up to serve our children and young people equitably. We have the NEST / NYTH framework which can help us to achieve this, but it will require a huge effort of collaboration between services to achieve its ambitions.

Submitted by:

Professor Sally Holland
Children’s Commissioner for Wales