

# An evaluation of the provision of mental health services for looked after young people over the age of 16 accommodated in residential settings

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This report draws on visits to 27 children's homes in eight local authorities. It identifies how the mental health needs of young people in care aged 16 and over are met. It illustrates the use of mental health resources in the children's homes visited, as well as good practice and the problems found, and considers how well staff respond to the needs of young people in their care. The report emphasises the importance of different agencies working together to improve and develop services for young people.

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Royal Exchange Buildings  
St Ann's Square  
Manchester  
M2 7LA

T: 0300 123 1231  
Textphone: 0161 618 8524  
E: [enquiries@ofsted.gov.uk](mailto:enquiries@ofsted.gov.uk)  
W: [www.ofsted.gov.uk](http://www.ofsted.gov.uk)

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## Executive summary

Between October 2008 and February 2009, Ofsted carried out a survey of 27 children's homes, including one secure children's home and a residential special school registered as a children's home. These were located in eight local authorities. The settings were selected because they had current or very recent experience of providing for young people aged over 16 in care who had mental health needs. The settings had a range of inspection outcomes.

The target group for the survey comprised young people who were receiving support from child and adolescent mental health services (CAMHS) or specialist services to meet a specific mental health need. The target group did not include young people receiving a service which focused on behaviour management. For a variety of reasons the number of young people with mental health needs who talked directly to inspectors during the survey was very small. Some young people were either absent at the time of the visit or unwilling to meet the inspector. In some cases, the young people had left the setting by the time the planned visit took place.

The survey found inconsistent mental health provision for young people in care. The features that were most helpful in meeting the needs of young people in the children's homes visited included:

- comprehensive assessments on entry that identified mental health needs
- access to a range of specialist services
- good communication and collaboration between mental health professionals and care staff
- no unnecessary delay in funding or providing suitable services
- staff with a good understanding and awareness of young people's needs
- effective engagement and consultation with young people.

Various factors worked against this group of young people in terms of positive achievement. These included their unwillingness to engage with specialist workers because of prejudices linked to mental health; poor arrangements for transfers from child to adult mental health services; the lack of services in rural areas; and difficulties with the sharing of information.

The report illustrates good practice found in some of the children's homes visited and shows what can be achieved. The key findings will add to the work already undertaken by the Department for Children, Schools and Families following the final report of the National CAMHS Review.<sup>1</sup>

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<sup>1</sup> *Children and young people in mind: the final report of the National CAMHS Review*, Department for Children, Schools and Families, 2008; [www.dcsf.gov.uk](http://www.dcsf.gov.uk).

## Key findings

- Some young people were severely disadvantaged because of differences in mental health provision across the country. In contrast, there was evidence of successful outcomes for young people who received specialist input.
- Inadequate assessments on admission to a children's home often led to delays for the young people in receiving specialist mental health support. This led to poorer outcomes for them and made it harder to call on specialist support when needed.
- Young people in specialist children's homes received appropriate specialist therapeutic care from competent staff with a good understanding of their specific needs.
- Access to CAMHS was inconsistent. Provision varied from a good service to none. Young people in local authority homes with a service level agreement were the most likely to access CAMHS easily. Access was generally worse when young people were living in a private children's home and placed outside their local authority. Thirteen of the 27 children's homes visited reported delays in a service being provided. Of these 13, 10 were privately run.
- Staff were able to provide consistent and continuous support when communication and working relationships between carers and specialist providers were good.
- Despite a lack of specialist training and qualifications, staff in non-specialist children's homes had developed a wide range of skills, knowledge and expertise.
- Good working relationships between the different agencies promoted opportunities for consultation with young people and a commitment to develop and improve local services.
- There were no suitable forums for representatives from the mental health sector to meet providers and managers of children's homes to monitor and evaluate services.
- Some of the young people had a negative attitude to mental health. This meant that they could miss opportunities to use suitable services.
- The transfer from children's mental health services to services for adults was inconsistent and sometimes led to services for young people being discontinued.

## Recommendations

The Department for Children, Schools and Families should:

- ensure that Government Offices provide opportunities for professionals from different sectors to work together to develop integrated services for children and young people with mental health problems
- in liaison with the Department of Health, request strategic health authorities to produce directories of the mental health resources and services available to young people in their areas.

The Department of Health should:

- establish clear guidelines and criteria that ensure all young people in care have equal access to CAMHS and that:
  - placement moves do not cause delays in access to services
  - out of area placements do not disadvantage young people
  - young people in public and private placements are treated equally

review the arrangements for transferring young people to adult mental health services

- work with mental health and other services to deal with the stigma associated with mental health problems so that young people can overcome their reluctance to receive care and support
- assist with the development of forums within primary care trusts, where professionals from different sectors, agencies and social care providers can develop integrated services for children and young people in care with mental health needs, and develop a procedure to share feedback with the appropriate Government Office regional network.

Local authorities should:

- ensure that all assessments include specific details relating to mental health needs and that a Strengths and Difficulties Questionnaire is completed for each young person<sup>2</sup>
- ensure that information on the emotional and behavioural health of each young person in care is collected by the main carer in line with requirements<sup>3</sup>

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<sup>2</sup> Further information on the questionnaire is available at:  
[www.dcsf.gov.uk/datastats1/guidelines/children/pdf/SDQ%20guidance.pdf](http://www.dcsf.gov.uk/datastats1/guidelines/children/pdf/SDQ%20guidance.pdf).

<sup>3</sup> The Strengths and Difficulties Questionnaire on the emotional and behavioural health of children and young people in care must be completed by the young person's main carer. For young people in care, this might be either the residential care worker or a foster carer. The DCSF asks for the data to be submitted annually.

- establish service level agreements with CAMHS teams, identifying the services provided to children and young people in care and the criteria to be applied.

## The assessment process

1. On admission, all children and young people who are looked after should have their needs effectively and comprehensively assessed, including their emotional and healthcare needs (National Minimum Standard 2.1).<sup>4</sup> All the children's homes visited had received assessments of the young person's needs before admission, except when there was an emergency admission or a placement of a young asylum seeker. However, in only four of the 27 children's homes were young people involved or supported in completing the assessment.
2. The quality of the information received was also inconsistent. In 16 of the 27 children's homes visited, the quality of the assessment information was good and in one of these it was outstanding. The staff in these homes were positive about the pre-placement material. They felt that that the information was comprehensive, accurate and up to date and that it referred to the young person's mental health needs. In two cases, the material did not include a section on mental health, but other suitable information was supplied. The staff spoken to reported that young people benefited from early identification of mental health problems. In one authority, care staff could view the young person's main care file for additional information. One manager said:
 

'Pre-placement material is good and provides detail of any mental health issues. Generally, social workers are very good at passing this information on.'
3. It was beneficial when a relationship already existed with a particular local authority or placing social worker. This led to better planning and more suitable placements. In one case, for example, senior managers attended a weekly 'referral and matching meeting' to match the referral with provision that suited the young person's needs.
4. In seven of the children's homes visited the quality of the assessment information was satisfactory and in four it was inadequate. This finding was supported by staff. Two assessments referred to psychiatric and therapeutic reports, but when staff in the home asked to see them they were told they were confidential to CAMHS. Staff were clear that inappropriate placements could result from limited information, since the staff would not be fully aware of

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<sup>4</sup> *Children's homes: national minimum standards, children's homes regulations*, Department of Health, March 2002;

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4010076](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010076).

a young person's needs. Limited information also delayed correct treatment and support. In one home, for example, the inspector was told:

'No information was provided, as it was deemed confidential. The placement broke down and the young person was admitted to a psychiatric ward and sectioned under the Mental Health Act.'

5. Two of the children's homes reported that mental health problems were sometimes referred to as 'emotional difficulties'. This reduced the stigma attached to mental health and aided a placement which might not otherwise have been made.
6. In the case of emergency placements, information was provided after admission. One children's home specialised in the care of young, unaccompanied asylum seekers. Children arrived in this country with no information about them, but staff in the home were prompt in organising planning and review meetings and completing risk assessments. Through general observation of the young person and the use of interpreters, staff began to identify individual care needs, including any mental health problems.
7. Four specialist settings visited worked exclusively with young people with eating disorders, young people who self-harmed, or young people on the autistic spectrum. In these settings, staff reported that the majority of their referrals came from health professionals, usually through a hospital. Comprehensive assessments, including psychiatric reports, were always provided. In addition, detailed and useful assessments were undertaken by internal specialist staff.
8. Ten of the children's homes confirmed that access to mental health services continued after a change in placement. Examples of good practice included the following:
  - a young person keeping in contact with a previous CAMHS team
  - a service level agreement which enabled a young person to transfer to a new CAMHS team
  - continued appointments with a hospital psychiatrist (illustrated below).

A 17-year-old was placed with very good information about his mental health problems. These included concerns about sexualised behaviour and risk to younger children. The in-house assessment was completed and staff in the home worked closely with the psychiatrist involved. CAMHS accepted a direct referral and although the placement was made by a different local authority, there were no problems about who funded the continuing support from the CAMHS service.

9. In the secure children's home, young people were taken through a detailed mental health screening questionnaire on admission. If required, they received input from CAMHS, a psychiatrist and a psychologist.

10. The young people in the children's homes visited benefited from continuing assessment. After the young people were admitted, staff monitored and reviewed placements regularly and updated care plans as required. Seven of the children's homes employed or used a private psychologist, psychiatrist or therapeutic company to carry out a comprehensive assessment of each young person's mental health needs. This enabled them to provide a therapeutic programme.
11. Three of the children's homes used the Strengths and Difficulties Questionnaire introduced by the Department for Children, Schools and Families in April 2008.<sup>5</sup> This aims to provide details of the emotional and behavioural health of young people in care up to the age of 17, and therefore to guide any decision to ask for specialist mental health assessments and treatments through CAMHS or specialist teams set up in partnership with local mental health providers.

## Staffing

12. A key strength of the children's homes that were visited was the care and support that young people received from staff. Over time, the staff had developed skills and a good awareness and understanding of mental health. Such skills and understanding helped the staff to achieve good outcomes: they were able to identify young people's needs, observe changes in behaviour and what triggered them, and intervene effectively. By building good relationships, staff helped young people to manage their own mental health.
13. Managers looked for staff with key attributes such as empathy, good listening skills, life skills experience, robustness and the ability to handle difficult situations. As well as recruiting staff with experience of children and young people's mental health, managers recruited staff who had worked in adult mental health services, services for those who had learning disabilities, or teams dealing with alcohol and drugs misuse.
14. Managers in four of the children's homes recognised that their current staff had limited knowledge and experience of mental health. Because of this, they felt that the young people in their care could be at a disadvantage. In specialist children's homes, however, staff with specialist training and qualifications had been appointed, linked to the specific service provided.
15. Access to training and development varied across the children's homes visited. In the specialist children's homes, there seemed to be a greater commitment to

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<sup>5</sup> At the time of the survey visits, the requirement to complete the questionnaire had been introduced only recently. Of the children's homes visited, a number of them were unaware of the need to provide this information; others either did not meet the criteria for needing to complete the questionnaire or would be submitting completed forms later.

staff receiving relevant training and updating their practice. Available resources included access to internet links and library material.

16. In the children's homes visited, staff had gained, or were working towards, at least a National Vocational Qualification in Caring for Children and Young People. A very small number of staff had a specific professional qualification in counselling, psychotherapy, psychology or therapeutic childcare. Additional training generally took the form of one day or short courses, mainly in-house, with a small number of external events. Such training focused on topics such as: attachment, separation and loss; self-harm, alcohol and drugs misuse; bereavement; self-image; and promoting positive relationships. Two of the children's homes raised the concern that foster carers and field social workers within their local authority had priority in terms of receiving training on mental health.
17. One of the children's homes had a rolling programme of training which had been designed to include mental health issues such as self-harm and Asperger's syndrome. Generally, where joint training with other professionals existed, including CAMHS, managers reported better outcomes for both the staff and the young people. Service level agreements with CAMHS included support and training for staff, as illustrated by a member of staff in one of the children's homes who said:
 

'CAMHS run the training for staff and we can highlight a particular need. They give us some very practical strategies and have helped us to develop a good understanding of mental health issues.'
18. The majority of managers reported that they evaluated the impact of training by observation, by encouraging staff to reflect on their practice in supervision and team discussions, and by reviewing record-keeping. Managers encouraged good communication skills and a consistent approach by staff in caring for young people. Regular monitoring and reviews helped staff to identify changes and improvements in the young people's behaviour. Positive outcomes included reductions in self-harm, mood swings and absences, and fewer changes in eating and sleeping patterns.
19. In seven of the children's homes visited, staff had received no additional training in mental health. Lack of resources, limited funding and high costs were identified as prohibitive factors.

## **Provision and accessibility of mental health resources**

20. In addition to CAMHS, the children's homes visited were able to identify a variety of mental health resources and specialist services that young people could use within their locality. These could be provided by the local authority, private or voluntary sectors. A wider selection of services was available in towns and cities than in rural areas. All the children's homes visited had good links

with services provided by the local authority such as the Connexions service, nurses for looked after children and the youth offending teams. They used the private and voluntary sectors, particularly for specialist services dealing with drugs and alcohol misuse, sexual health and sexual exploitation, risk taking and anger management. They also used their advocacy, counselling and therapeutic services. Inspectors saw good outcomes for young people where interventions were tailored to meet individual needs, as illustrated in the following four examples.

Manchester Link offers a service for young people with mental health problems. The service has been working with one young person for over a year and the young person's mental health has stabilised dramatically. There is no self-harm, there is contact with the family, the young person is in full-time education, and no restraints or sanctions are being used. Success has been achieved through working closely together to give the same message and through quick feedback and good communication.

The involvement of CAMHS led to a marked stabilisation in a young person's mental health. Depression and anxiety became manageable without medication and there were no further expressions of self-harm or suicidal thoughts.

Once involved, CAMHS provides a really good service. The young person has severe attachment problems and is having regular psychotherapy. This is having a positive impact on rebuilding her relationship with her mother.

Therapeutic work with individual young people has reduced the level of self-harm from several times a week to once a month. It has improved the young people's self-esteem and functioning and helped them to recognise when they need help.

21. However, six of the children's homes visited found it difficult to judge the impact of mental health interventions because of their limited contact with CAMHS. The main difficulties that managers identified were poor communication and a reluctance to share information or carry out reviews without reference to the specialists involved.
22. In the homes visited, access to CAMHS was inconsistent. Some young people experienced excellent support and treatment. Nine of the children's homes reported no delays. These included four children's homes where a service level agreement existed between the local authority and CAMHS.
23. Others experienced no service or considerable delays in getting an initial assessment. Eleven of the children's homes visited reported that they had

experienced delays of between three and 12 months before receiving a service. Reasons given included:

- high demand
- failure of the social worker to make a prompt referral
- insufficient resources.

In these situations, staff were left to manage young people's needs and difficulties without direct support or guidance. One service reported that young people went to the bottom of the waiting list after a placement move, even when they had been on a waiting list at their previous placement.

24. The following example from a local authority illustrates the timescales and delays that can be experienced in receiving a service from CAMHS:

After a settled period, there was a steep and rapid decline in the young person's mental health. The young person became parasuicidal, self-harmed and exhibited manic behaviour.

To access CAMHS, a referral is made through the social worker. This then goes to a panel meeting which happens every two or four weeks for allocation to one of the CAMHS workers. If the young person is accepted, an appointment is then made. The process can take between eight and 12 weeks.

25. The staff interviewed acknowledged that young people's attendance at CAMHS could be unpredictable, with young people sometimes cancelling their own appointments at short notice. Some CAMHS teams were flexible and offered a further appointment. However, two children's homes had experienced a CAMHS team which either terminated the service or put the young person back on the waiting list, meaning that the young person had to wait even longer.
26. Young people were more likely to receive a service if they had lived in the same local authority. When a service level agreement existed, they were given priority. Little or no delay was experienced and staff reported good contact and positive relationships with CAMHS.
27. Five managers of private services told inspectors that CAMHS teams did not accept referrals from out of county placements or that young people might not receive the same level of support if they were accommodated in private children's homes. The manager of a secure unit in a local authority said that if a young person came from the neighbouring county, it was difficult to obtain a service. These staff also said that young people might not receive the same level of support if they were accommodated in private children's homes. As a result, two of the homes had established private contracts for young people to receive therapeutic services. In one of the children's homes, young people had

to travel back to their placing authority to maintain an input from CAMHS. The nature of the difficulties faced by young people is illustrated here:

'There are serious delays in the CAMHS services for young people who are placed from outside the authority. We had one young person who was considered to be at a very high risk of self-harm. We made a referral to CAMHS for emergency support but we have not had a response. The previous team has asked for the case to be transferred but the local CAMHS team will not accept it.'

28. Staff reported that young people find it hard to acknowledge their specific mental health needs and have a limited understanding of the role of CAMHS and the range of available mental health resources and support. Young people can also be put off by the terminology used in this field of work. More significantly, they have negative feelings about mental health problems and a reluctance to acknowledge that they may have such problems themselves. Staff feel that these views can be a barrier to using mental health services. One children's home felt that the title CAMHS was unhelpful and that a more user-friendly name would be more acceptable.
29. Four managers in the children's homes visited felt it necessary to subvert the usual referral procedures. Examples given included taking the young person to a hospital's accident and emergency unit and accessing CAMHS that way; setting up meetings with healthcare professionals to look at the needs of specific groups such as unaccompanied young asylum seekers; continually making contact until an assessment was agreed; and getting additional funding from the placing authority for private therapy when the young person was initially assessed by CAMHS as not needing a service.
30. Three children's homes in the private sector were unclear about the role of CAMHS and the services it could offer. There was a perception that CAMHS provided only medication. There was the risk that young people were not being assessed, diagnosed or given appropriate support and treatment.
31. Inspectors made contact with two CAMHS teams. One had a service level agreement with the local authority and had introduced a CAMHS intervention team. This offered a specific service to young people in care within the authority; the same service was not available to young people in private children's homes. If the private children's home provided therapeutic care, only a CAMHS consultation service was available. Across all children's homes, it was reported that the waiting list for eligible young people to receive a CAMHS appointment was short, with young people being seen within 15 to 22 days of the referral being received.
32. The second CAMHS team reported that, although it worked with all young people in care, the service was not equitable. Young people in local authority homes received an enhanced service. This included accepting referrals directly

from the young person's social worker, monthly consultation and regular visits to these homes. In addition, the CAMHS team offered guidance on managing young people's behaviour and specific advice to staff if they had been traumatised by an incident or a disclosure. When a young person was in private care, referrals were made through the young person's doctor and staff could not get the same support. When young people were placed outside the area, the primary care trust in the area from which they came was responsible for their healthcare and CAMHS would not provide a service.

33. In the children's homes visited only a small number of young people moved into adult mental health services. Experiences varied. In four of the children's homes, good planning and consultation for the transition were successful when the young person reached 18.
34. In three of the children's homes, arrangements for the transition were poor, with no continuity of care. Placements could be terminated and funding withdrawn without any consultation. The provider of one children's home described a case where a young person was unable to receive a mental health service because he was in the transition phase between being considered a child and an adult. This led to an unsatisfactory outcome:
 

'We worked with a young person with a personality disorder who was receiving a service from CAMHS. He discharged himself from care at 16. He was then considered too old for CAMHS but too young for an adult service. He slipped through the net and ended up engaging in criminal behaviour.'
35. One of the CAMHS teams reported that it was seeking to appoint a specific worker to improve and assist with transitions to adult services. The process begins at the age of 17 years and six months. A meeting is held to consider the transition plan and young people will stay either with the CAMHS service or transfer to adult services, depending on their needs. The other CAMHS team found the process less positive because adult services work with young people only when they have reached the age of 18.
36. In discussion with inspectors, both of the CAMHS teams agreed that the threshold for adult mental health services is higher than for young people. They reported that adult services will take referrals only for young people with what the CAMHS teams described as 'very severe' mental health problems. This means that the young person may not meet the criteria to receive a service and that the service is discontinued. Resources would then need to be found from the local or voluntary sector for support to continue.

## Consultation with young people

37. A considerable strength in all the children's homes visited was the recognition by staff that consultation with young people was a key part of their role. Staff

used formal mechanisms such as social care reviews, Regulation 33 visits and meetings with social workers, as well as meetings with key workers and daily community meetings.<sup>6</sup> These enabled young people to share their views about aspects affecting their lives, including their mental health needs. Other strategies included the use of questionnaires, comment cards and, if necessary, the complaints procedure. If young people had communication or language difficulties, advocates and interpreters were used.

38. Managers generally felt that young people were old enough to make their own choices about the type and level of intervention needed, as shown by the following three examples:

After two and a half years' involvement with CAMHS, the young person decided it was the right time to withdraw, as she felt more secure within the children's home and was no longer self-harming. Although, initially, the staff in both CAMHS and the home had concerns, they supported her decision. Staff in the home worked with her and any problems that emerged as a result of her decision were managed successfully.

A young person was included in the referral process. He was given copies of all the paperwork and opportunities to discuss what support he felt he needed. He attended the first counselling session but found it too difficult and chose not to continue. The manager discussed the outcome with CAMHS and negotiated for the sessions to resume if the young person wished. The young person did not take up the offer.

A young person asked to stop taking his medication for attention deficit hyperactivity disorder. This was discussed with his social worker and CAMHS. Following a programme of withdrawal and with appropriate support, he successfully stopped taking his medication. He was delighted with the outcome.

39. Although the children's homes had no formal systems for consultation, there were good opportunities for young people to share their views with mental health professionals. This could work well in a variety of ways. For example, the 'open door' policy of an alcohol support service enabled young people to control their decision to seek help rather than be restricted by having to make an appointment. One home had introduced partnership files with the CAMHS team; these detailed the individual initiatives and were agreed and signed by the young person concerned. Another home used questionnaires to evaluate its service.

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<sup>6</sup> Monthly unannounced visits are carried out in accordance with Regulation 33 of the Children's Homes Regulations 2001.

40. Two of the children's homes felt that there was limited or no consultation between mental health professionals and young people. These homes found this detrimental in developing effective partnerships with CAMHS. Another children's home was aware that its local CAMHS team had evaluated its own service and felt that the young people in the home would have welcomed feedback about the results.

## **Involvement of providers in developing services**

41. A key failing identified by most of the children's homes visited was the absence of suitable forums within the local authority children's service and the healthcare trust where they could share their knowledge and expertise to shape and improve mental health services. This was the case both strategically and locally. Children's homes in only three of the local authorities attended monthly or quarterly meetings with other healthcare professionals to discuss topics such as waiting lists, transfers, funding and delays. Two providers of private children's homes said they felt professionally isolated because of a lack of effective partnerships.
42. In 13 of the 27 children's homes visited, the managers felt that local working relationships with CAMHS teams needed to be improved to encourage more effective joint working. When service level agreements were in place, this was not a problem and young people benefited from better relationships, regular reviews and greater opportunities to specify the service required. The staff interviewed found mental health projects and services in the voluntary sector more receptive to suggestions and more likely to adjust their services to meet young people's needs. Specialist services considered themselves to be expert and looked to their national organisations and associations to develop services and improve practice.

## Notes

Between October 2008 and February 2009, Ofsted visited 27 children's homes, including one secure children's home and one residential special school registered as a children's home. They were selected because they had current or previous experience of young people aged 16 and over who were or had been receiving support from mental health services, including CAMHS.

During visits to the children's homes inspectors held discussions with a range of people, including the registered provider or responsible individual, managers and staff. If appropriate, they looked at relevant paperwork. Only one young person met an inspector. All the other young people were either absent at the time of the visit or unwilling to meet the inspector. Two CAMHS teams were contacted by telephone. Following the interviews and discussions, inspectors assessed the impact on young people.

Following the fieldwork for this survey, in November 2009 the Department for Children, Schools and Families and the Department of Health jointly published new statutory guidance: *Statutory guidance on promoting the health and well-being of looked after children*, Department for Children, Schools and Families, 2009. The guidance can be found at:

[www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/childrenincare/healthycare/healthycare/](http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/childrenincare/healthycare/healthycare/).

## Further information

*National minimum standards and regulations for children's homes*, Department of Health, 2002;

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4010076](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010076).

*Children and young people in mind: the final report of the National CAMHS Review*, Department for Children, Schools and Families, 2008; [www.dcsf.gov.uk](http://www.dcsf.gov.uk).

Further information on the Strengths and Difficulties Questionnaire, '*Guidance on data collection on the mental and emotional health of children and young people in care*,' is available at:

[www.dcsf.gov.uk/datastats1/guidelines/children/pdf/SDQ%20guidance.pdf](http://www.dcsf.gov.uk/datastats1/guidelines/children/pdf/SDQ%20guidance.pdf).