Pecyn dogfennau cyhoeddus

Y Pwyllgor Plant, Pobl Ifanc ac Addysg

Lleoliad:
Ystafell Bwyllgora 1 - Y Senedd

Dyddiad:
Dydd Mercher, 19 Mawrth 2014

Amser:
09.15

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:
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Agenda

Cyfarfod preifat cyn y prif gyfarfod - 09.15 - 09.30

1 Cyflwyniadau, ymddiheuriadau a dirprwyon (09:30)

2 Ymchwiliad i Wasanaethau Iechyd Meddwl Plant a'r Glasoed (CAMHS) - Sesiwn dystiolaeth 1 (09.30 - 10.30) (Tudalennau 1 - 7)

Coleg Brenhinol y Seiciatryddion
CYPE(4)-08-14 - Papur 1

Dr Clare Lamb, Seiciatrydd Ymgynghorol Plant a'r Glasoed, Gwasanaeth Glasoed Gogledd Cymru a Gwasanaeth Ymgynghori a Thrin Fforensig y Glasoed - Ysbyty Abergele
Dr Alka S Ahuja, Seiciatrydd Ymgynghorol Plant a'r Glasoed - Bwrdd Iechyd Prifysgol Anuerin Bevan a Chadeirydd, Cyfadran Seiciatreg Plant a'r Glasoed, Coleg Brenhinol y Seiciatryddion yng Nghymru

3 Ymchwiliad i Wasanaethau Iechyd Meddwl Plant a'r Glasoed (CAMHS) - Sesiwn dystiolaeth 2 (10.30 - 11.30) (Tudalennau 8 - 17)

Barnardo's

CYPE(4)-08-14 - Papur 2

Menna Thomas, Uwch Swyddog Ymchwil a Pholisi
Sarah Payne, Rheolwr Gwasanaethau Cadarn yng Nghaerdydd

4 Craffu ar Adroddiad Blynyddol Estyn 2012 - 2013 (11.30 - 12.15)

(Tudalen 18)

Estyn

CYPE(4)-08-14 - Papur 3

Ms Ann Keane, Prif Arolygydd Addysg a Hyfforddiant Cymru
Simon Brown, Cyfarwyddwr Strategol
Meilyr Rowlands, Cyfarwyddwr Strategol

National Assembly for Wales
Children, Young People and Education Committee
CYPE(4)-08-14 – Paper 1 – Royal College of Psychiatrists
Inquiry into Child and Adolescent Mental Health Services

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

Royal College of Psychiatrists in Wales is an arm of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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The Royal College of Psychiatrists in Wales are pleased to respond to the call for evidence on the Committee's inquiry into CAMHS in Wales. Whilst there have been some improvements in CAMHS over recent years as highlighted in the recent Wales Audit Office report, this does not negate the need for scrutiny into where we are failing to meet the needs of this vulnerable group. The College has collected the views of our Members across Wales and our response on the pages below reflects these in general terms. We are happy to provide more detailed information during the hearings.

In this current economic climate and continued age of austerity, the lack of resources and the financial constraints along with increased demands have impacted all sectors, and many public services continue to work under capacity. This is also true of CAMHS. There is further pressure placed on these services with the implementation of the Mental Health Wales Measure (The Measure) and the unintended consequences of it and also the increased burden on CAMHS due to extension to 18th birthday from April 2012. However, we feel that despite financial and legal constraints, we can make improvements if we focus on further strengthening the ties between the NHS and social care in order to provide more holistic care to children and young people.

If you have any queries, please do not hesitate to contact the College on the number above. We look forward to working closely with the Committee on this inquiry and in the future.

Dr Alka Ahuja, Chair of Child and Adolescent Psychiatry
Royal College of Psychiatrists in Wales

The availability of early intervention services for children and adolescents with mental health problems;

1. Early detection and intervention are part of the preventative agenda, which encompasses universal, targeted and indicated preventative responses. The services designed to meet this agenda work with varying levels of success throughout Wales, in particular those involved with widened remit early intervention CAMHS work with the tier 1 and 2 services (Teachers, Social Workers, General Practitioners, Primary Mental Health Support Services Practitioners, Third Sector workers etc) at the universal and targeted level.

2. The introduction of the Measure has resulted in several changes in CAMHS with respect to early intervention and prevention and the reconfiguration of primary mental healthcare teams.

3. A recent audit of the Wales Primary Mental Health Group highlighted CAMHS as one of the biggest gaps in their competencies. We note that teacher training and Social Work training have no child development or mental Health component.

4. We would like to highlight good practice being rolled out in some areas in Wales where there are appropriate early intervention and prevention services integrated with the locality specialist community CAMHS.

5. Bilingual Websites for children and young people such as Mental Health Matters are now available in many schools.

6. Royal College of Psychiatrists (UK) is involved in the creation of MindEd an online education resource for professionals from all backgrounds who interface with children and young people. This launches in March 2014.

Access to community specialist CAMHS at Tier 2 and above for children and adolescents with mental health problems, including access to psychological therapies;

7. Providers of services to children with mental health problems report they have experienced an increased amount of bureaucracy with the introduction of the Measure, which has impacted negatively on the time spent with patients and on timely access to community specialist CAMHS. In some areas this has reduced the capacity of frontline services. This may be reasonable if there is evidence that this has improved the quality of services to children and young people. It would be helpful if this could be evaluated.

8. Following introduction of the Measure, some areas in Wales have re-prioritised their response to referrals to those meeting threshold for Part 2 of the Measure which appears to have raised the threshold for referrals seen.

9. Some areas have Early Intervention Psychosis teams whose remit crosses the age divide and is appropriately needs-based rather than age-based. CAMHS have close links with such teams resulting in better management of first episode psychosis resulting in the decrease in the duration of untreated psychosis.

10. We are concerned that access to psychological therapies is patchy. In some areas there is good integrated provision of a range of psychological therapies within specialist CAMHS. In other areas provision is very restricted. Availability and accessibility is very variable in across Wales.

The extent to which CAMHS are embedded within broader health and social care services;

11. We feel in general there is not an effective integration of CAMHS and social care services in the delivery of care to children and young people. This has not been helped by the budget constraints evident in the Local Authorities. The extent to which CAMHS is embedded in the broader health and social care services varies throughout Wales. Despite some good working relationships between CAMHS and social services in some local authority areas this often depends on individual relationships in a locality. And in other areas despite good locality relationships between CAMHS & Social Services, there is currently less joint multi-agency planning at a strategic level.

12. We still have a problem in Wales that CAMHS provision is seen to be the sole task of the NHS provided CAMHS team. The message that it is everybody's business is often missed. This greatly limits the access of children to services that can support their emotional health and wellbeing (early intervention and preventative services). In some areas as a result of the local authority budgetary problems, Special Educational Needs services and services to Looked After Children have been reduced and the Local Authority has looked to specialist CAMHS to fill resultant gaps.

Whether CAMHS is given sufficient priority within broader mental health and social care services, including the allocation of resources to CAMHS

13. Some Health Boards have given priority to resources in specialist CAMHS in line with directive from Welsh Government, and CAMHS have received allocation of monies from, for example, Mental Health Measure implementation funding. However, pressures from Acute Health Care in other specialities frequently detract from appropriate specialist CAMHS resourcing. Other Health Boards have not given appropriate priority and in these areas specialist CAMHS continues to work under capacity.

Whether there is significant regional variation in access to CAMHS across Wales

14. There is significant variation in access to CAMHS across Wales. For example:
    - The availability of tier 3 services.
    - Availability of Out of Hours Service
    - Community Intensive Outreach Teams as an alternative to hospital admission

- Community Eating disorder expertise and capacity (especially dietetics).
- The availability of evidence-based psychological interventions such as family therapy, psychodynamic psychotherapy and dialectical behaviour therapy (DBT)
- The existence of intensive social service or 3rd Sector-funded therapeutic teams to meet wider psychosocial needs of children and young people with emotional and/or behavioural difficulties.

15. Some specialist community CAMHS teams in Wales currently have a workforce approaching national benchmarking and Royal College of Psychiatrists recommendations. However, even so there are still some problems in access times, and any reductions in workforce caused by sickness, vacancy control or redeployment results in a significant reduction in capacity impacting negatively on the ability to maintain a timely high quality service. Other areas in Wales have a workforce that lacks the capacity and requisite multi-disciplinary skills to deliver effective evidence-based interventions. Some areas have workforce capacity significantly lower than those recommended by national benchmarking.

16. This is further complicated by the introduction of the Measure, which has forced an unhelpful re-organisation of the workforce in some areas. Experienced mental health practitioners with a background in paediatric nursing or mental health therapy are no longer able to carry out autonomous mental health assessments or act as Care Co-ordinators. This has resulted in a reduced clinical capacity in some teams.

17. We believe that models of service provision must be designed and financed to fit rural areas such as Powys, as well as urban parts of Wales. This is particularly important for the most unwell children who need specialist skills and intensive resources including Tier 4 CAMHS intensive outreach and inpatient beds.

18. We think the sustainable effective provision of specialist CAMHS in Wales is suffering from a lack of co-ordinated commissioning of services.

The effectiveness of the arrangements for children and young people with mental health problems who need emergency services;

19. In most areas of Wales, emergency presentations within routine working hours are responded to the same day. Most areas of Wales have a specialist CAMHS out-of-hours service but the comprehensiveness of these services varies. In some areas the Consultant Child & Adolescent Psychiatrist is the first on call out-of-hours and provides telephone support and advice for adult psychiatry and paediatric doctors. In other parts of Wales there is no out-of-hours specialist CAMHS cover.

20. The CAMHS liaison pathways for self harm/suicidality, eating disorder and other emergency mental health presentations are compromised in many areas by insufficient capacity and/or a lack of joint planning by partner agencies to create joint protocols to fully meet the medical, social and safeguarding needs, as well as the mental health needs of children and young people.

21. An unresolved area of concern in many areas is identifying an appropriate place of safety for young people detained under section 136 of the Mental Health Act.

22. For crisis presentations of children and young people with a combination of social, safeguarding and mental health risk there is frequently a lack of clarity as to which practitioners from which agency will take the lead responsibility for assessment and management of the case. This can lead to an unco-ordinated or unhelpful response which is not in the young person's or the family's best interests at a time when services should work together to meet complex needs.

The extent to which the current provision of CAMHS is promoting safeguarding, children's rights, and the engagement of children and young people;

23. Safeguarding mechanisms, training and reporting structures are in place in most places.

24. Engagement of hard to reach young people and families is something most services prioritise and put much resource into. Many services have adapted their Local Health Board DNA policies to facilitate this.

25. There is still work to do to fully engage children and young people, and their families, in the design and development of services. There are services where children and young people are actively involved in service development and in staff training. This needs to be rolled across Wales.

26. There are areas of excellent practice in specialist CAMHS in Wales, but we think that social care and specialist CAMHS could be much more integrated in their approach to the work with children and young people with mental health needs, both in early intervention and for those in crisis.

Other Issues:

Problems of access to CAMHS for children with Intellectual Disability:

27. There is a paucity of services for children and young people with Intellectual Disability. The response to the direction from the Government for CAMHS to provide specialist CAMHS learning disability services appears patchy. Some areas have designated CAMHS-LD services, but in other areas specialist CAMHS provision for Children with intellectual disability is largely through liaison to Special Schools. Therefore perpetuating gaps such as care for young people who have left school or who have been excluded. Where they exist, most CAMHS-LD services appear to lack sufficient resources around behavioural assessment and modification. Consequently psychiatrist colleagues working in adult intellectual disability report that young people transition to adult services with deeply ingrained maladaptive patterns of behaviour that impact on their quality of life. There is further concern that when local services are unavailable those with the most problems must move to specialist educational provision distant from their homes.

28. The transition process for young people with intellectual disability often does not take place within the statutory framework. We would welcome scrutiny of the current system of automatic transfer of young people with Intellectual Disability, including those with co morbid conditions such as Autism Spectrum Disorder, to Specialist Residential Colleges

29. There is confusion and inconsistency over the extent of assessment provided by CAMHS services to children and young people with intellectual disability out-of-hours, even where there is an on-call rota

Transition arrangements:

30. Across Wales there are patchy arrangements for transition from CAMHS to AMHS and a paucity of comprehensive services for youth. This is an ongoing problem which requires further exploration and implementation of effective solutions.

31. NICE is beginning to scope guidance on transition from Children's to Adult Services across health and social care in England and Wales.

Treating the Parents with Mental Health disorders:

32. CAMHS relies on adult mental health services to treat parents with mental health disorders.

This is a particular issue for parents with personality disorders, who may be seen as needing services under part 1 of the Measure for their own mental health but need much longer and complex interventions if their parenting is to change sufficiently to improve the mental health of their children. We would support the development of effective multi-model services for adults with a diagnosis of Personality Disorder

CAMHS inpatient Beds:

33. There is an absence of beds for particular groups of children and adolescents in Wales. There are currently no adolescent PICU (Psychiatric Intensive Care Unit) beds in Wales, no CAMHS–Learning Disability beds, no Adolescent Forensic beds and no specialist CAMHS beds for children under 12 years.

Admissions to Paediatric and Adult Mental Health wards.

34. We recognise that safeguarding issues, mental health need and developmental stage must be taken into account when admitting a child or young person with mental health problems to hospital.

35. Most LHBs have a protocol for the management of Self Harm presentations of under18 year olds to the District General Hospital. Good practice routinely involves the admission of a young person to a paediatric ward with referral to specialist CAMHS the following day. This group of young people rarely need admission to a psychiatric inpatient unit. Integrated assessment and management by paediatric team, specialist CAMHS and social care is required. This usually results in timely discharge home. The effectiveness of these processes varies across Wales.

36. We strongly support the view that children admitted to hospital for treatment of a mental disorder should, subject to their needs, be accommodated suitably for their age. The Mental Health Act 1983 Code of Practice for Wales states that "If exceptionally this is not practicable, discrete accommodation in an adult ward with facilities, security and staffing appropriate to the child's needs might provide a satisfactory solution". "In a few cases, the child's need to be accommodated in a safe environment could, in the short term take precedence over the suitability for age. It is important to recognise the clear difference between a suitable environment in an emergency and a suitable longer-term environment for a young person". The Child & Adolescent Faculty of the Royal College of Psychiatrists in Wales is keen to ensure that inappropriate admissions to adult wards do not take place, and that if a young person under 18 years is admitted to an adult bed that they are assessed promptly by a CAMHS practitioner who ensures that appropriate discharge or transfer to an age appropriate bed takes place promptly according to clinical need. We think the need for admissions such as these should be rare. We would welcome a robust, reliable process to ensure these events are recorded and fed back within LHB structures to facilitate close monitoring. We would welcome planning and investment that ensures that every child and young person in Wales has equitable access to age appropriate inpatient beds and an "Alternative to Admission/ Intensive Outreach Team." We think this would reduce the need for inappropriate admissions to adult or paediatric wards.

37. We recognise there is a lack of integrated health and social care crisis/respite placements in Wales for children and young people whose risk is related to safeguarding and/or behaviour issues. We would welcome consideration of planning and investment in this area.

CAMHS liaison pathways for self harm/suicidality:

38. We would welcome a review of the need for CAMHS Liaison services for children and young people presenting to the acute general hospital with mental health disorders.

S136 Places of safety:

39. There is a need to identify appropriate places of safety and clear protocols of care for under 18 year olds placed under S136 of the Mental Health Act.

Substance Misuse:

40. More must be done to address the needs of children and adolescents with substance misuse. We are concerned that there is a paucity of effective, integrated substance misuse services for children and adolescents across Wales.

National Assembly for Wales

Children, Young People and Education Committee

CYPE(4)-08-14 – Paper 2 – Barnardo's Cymru

Inquiry into Child and Adolescent Mental Health Services

Introduction

Barnardo's Cymru has been working with children, young people and families in Wales for over 100 years and is one of the largest children's charities working in the country. We currently run 88 diverse services across Wales, working in partnership with 20 of the 22 local authorities, supporting in the region of 8,500 children, young people and families last year.

Barnardo's Cymru services in Wales include: care leavers and youth homelessness projects, young carers' schemes, specialist fostering and adoption schemes, family centres and family support, parenting support, community development projects, short breaks and inclusive services for disabled children and young people, assessment and treatment for young people who exhibit sexually harmful or concerning behaviour and specialist services for children and young people at risk of, or abused through, child sexual exploitation.

Every Barnardo's Cymru service is different but each believes that every child and young person deserves the best start in life, no matter who they are, what they have done or what they have been through. We use the knowledge gained from our direct work with children to campaign for better childcare policy and to champion the rights of every child. We believe that with the right help, committed support and a little belief, even the most vulnerable children can turn their lives around.

Issues arising from our experience which contextualise the evidence presented to this inquiry.

Alongside local authority and other third sector organisations, Barnardo's Cymru has reduced the capacity and geographical footprint of its service provision over the past five years. A leaner, refocused, more targeted service provision, in line with Welsh Government and Local Authority policy has also led to a requirement for an internal refocus on how we utilize our own resources. Inevitably this has meant that we have had to carefully assess our own capacity, and scope external need, in order to ensure that we continue to serve the groups of children, young people and families in greatest need.

Children, young people and families are under increased pressure and face greater challenges within their personal, social and working lives than in previous years. However we are keenly aware that, currently, significant numbers of service users that we would have supported in previous years are no longer able to use our services due to higher thresholds of access, or more specified targeting of services. This is an important point to note within the CAMHS context. Whilst the Local Primary Mental Health Support Services (LPMHSS) and Primary Mental Health Teams are welcomed as additional resources that can be accessed by children and families, the local schemes rely heavily on the availability of '*a range of services from a variety of agencies for children and young people in and alongside primary care and other frontline professionals, aiming to promote good mental health under the 'mental well-being agenda', and increase access to preventative and early interventions for those with identified emerging difficulties'*[1]

'*Early interventions for those with identified emerging difficulties'*, are, in our experience, a dwindling resource. Inevitably this will have an impact on secondary mental health services, as problems left unaddressed early on become referrals for higher end, more resource intensive, services later.

1. The availability of early intervention services for children and adolescents with mental health problems:

We welcome the additional early intervention resource made available via Local Primary Mental Health Support Services, introduced under the Mental Health Measure.

We fully support the policy of delivering counselling to children and young people in secondary schools, and welcome the roll out of suitable counselling services across Welsh primary schools. As evidenced by the evaluation of the Welsh School Based Counselling Strategy (2011), this is a service that has led to a 'wide range of improvements' including greater levels of reduced psychological distress in those that had received counselling, compared to those that hadn't, and a reduction in the pressure experienced by year tutors and other teachers in relation to providing emotional support for pupils.

2. Access to community specialist CAMHS at tier 2 and above for children and adolescents with mental health problems, including access to psychological therapies;

[1] Specialist NHS Child and Adolescent Mental health Services. CAMHS National Expert Reference Group. Professional Advice for Service Planners. June 2013

- Barnardo's Cymru welcomes the changes that specialist community CAMHS have made, to date, in response to the requirements of the Mental Health Measure. The 'Together for Mental Health' Annual Report 2012-13 notes that 94% of those children and young people accessing secondary CAMH services now have a Care and Treatment Plan in place. We recognise the dedicated work of Welsh Government in driving improved standards of practice in CAMH services across Wales via increased scrutiny of practice and providing training to support the implementation of the Measure.

- The Care and Treatment Planning model recognises the need for a holistic approach to addressing mental health problems. We regard this holistic approach as being particularly appropriate for working with children and young people. Our experience of being involved in the implementation of Care and Treatment Plans on a practice level is mixed, with some Care Coordinators engaging with our staff and including our services in the strategy meetings. However we also have experiences of working alongside CAMHS teams who don't inform us about Care Planning, or include us in strategy meetings.

- Barnardo's Taith Service and Barnardo's Seraf Service are specialist services, the former addressing sexually harmful behaviour and the latter sexual exploitation. Referrals are taken primarily from children's social services and many of these children and young people will be receiving, or have received, a CAMH service. These are both Pan-Wales services working in a number of different localities. Both services report having good working relationships with a number of specialist community CAMHS teams, often built on professional relationships developed over a number of years. However, both services reported differences in the quality of delivery between CAMHS teams. Some of the CAMHS teams were prepared to deliver a mental health service to the service user alongside the service provided by Taith or Seraf. Others didn't do this but rather saw these services as alternatives to CAMHS, and, consequently saw engagement with these services as a reason to close the case to CAMHS. Our Taith and Seraf staff did not always think this to be an appropriate approach to take.

- Both the Taith and Seraf services had experienced having to fight very hard, sometimes alongside other statutory and voluntary sector colleagues, to get a mental health assessment for a young person for whom there was a grave

concern for their mental health, such as a perceived suicide risk. Both services are well established and benefit from having steady, experienced staff teams. The services utilise a set of psychometric tests and questionnaires to make an assessment of need and in order to plan an appropriate intervention. These tests also enable the assessment of service user progress and outcome measure. Therefore when they become concerned for a young person's mental health this is a thoroughly professional and measured judgement which, in our view, should then be given due weight and consideration by CAMHS teams.

The 'Child and Adolescent Mental Health Services: Follow-up Review of Safety Issues' WAO/HIW (December 2013) cites evidence gathered by the Delivery Support Unit as part of it's review of how prepared CAMHS were for the care and treatment planning requirements, which raised concern that despite identifying that children were '*at risk of self-harm or violence..there was no agreed plan in place to address the risk'*. This evidence fits, to a degree, with our practice experience of some CAMH teams where it is sometimes difficult to have perceived risk of harm taken onboard and addressed.

3. The extent to which CAMHS are embedded within broader health and social care services;

Barnardo's Cymru services have experienced development in the embedding of CAMH services within broader health and social care services primarily through the establishment of Families First Schemes. Barnardo's Cymru practitioners involved in delivering services as part of these schemes usually have access to a CAMHS practitioner, also operating as part of the team. Having this level of professional relationship is extremely useful in a number of ways:

- For service users there is quicker, more direct access for assessments and for early intervention.
- The interventions can be delivered in informal, accessible environments, as befits an early intervention CAMH service.
- There is an improved capacity for identifying when a referral on for assessment for more intensive CAMHS input is required.
- Other practitioners can take advice from the CAMHS practitioner and the CAMHS practitioner can benefit from information and advice from the broader multi-agency team.
- CAMHS as a service can be more readily incorporated and integrated into multi-agency work both at a strategic and practice level.

- CAMHS practitioners can get closer to the experience of children and young people by conducting home visits, meeting with their families and being in their communities.

Having a closer relationship with CAMHS practitioners at a primary mental health level enables the dissemination of learning and understanding with regard to emotional and mental health. This involves an increase in the capacity of all practitioners to understand the elements of their own practice which constitute support and guidance on emotional and mental health issues, including the limits of these capacities. It also enables better recognition of emotional signs and symptoms which merit the attention or involvement of the CAMHS practitioner.

We welcome the continued involvement of CAMHS practitioners in other community based teams such as the Youth Offending Teams. Barnardo's services, which work closely with these teams, often as a consequence of offering services to the same cohort of young people, appreciate the presence of CAMHS practitioners on these teams as this makes the CAMHS resource more accessible for advice, shared thinking and for referring on to more intensive CAMHS.

Barnardo's Cymru operate three substance misuse services in Cardiff, Newport and Denbighshire. All three services value the strong links they have with their local CAMH services. Two of these teams work with primary mental health practitioners and the third has a relationship with the local specialist community CAMHS team

Overall the experience of Barnardo's Cymru is that where policy and legislation lead to CAMH services joining other frontline services as part of multi-agency teams the experience of practitioners and, in their view, service users is improved. The CAMHS practitioners might be full or part-time members of a multi-agency team, or alternatively they may offer consultation, access to assessments and, where appropriate, treatment. Certainly in the areas of practice where we have seen this policy implemented practitioners are clearly feeling more confident that service users are able to have access to the mental health service they need in a more timely and appropriate fashion.

4. Whether CAMHS is given sufficient priority within broader health and social care services;

No response

5. Whether CAMHS is given sufficient priority within broader mental health and social care services, including the allocation of resources to CAMHS;

Our experience of tier 2 CAMH services is that they remain under-resourced. This is reflected particularly in our struggle to get referrals in to these teams. However what we are seeing currently is increased demands being made on this resource by commissioning bodies, as a result of government policy.

A comprehensive CAMHS team at tier 2 should be able to offer a range of psychological, psycho-social, educative and medical approaches to address the range of mental health problems and illnesses that it will be expected to work with. Moreover it should work closely with other services, to a Care and Treatment Planning model, if the impact of its work is to be maximised. All public services to children and families have been eroded over the past five years. However there was a very limited capacity within tier 2 CAMHS for many years prior to the recession. Extra demands have been made by commissioners to meet targets in relation to transition services and learning disability services, and some degree of additional funding has been allocated to this. However due to the pressure that the CAMHS resource was experiencing prior to these demands being made these additional areas of work seem to have added to the pressure. This is a service having to prioritise the weakest areas that have been reported as falling short. In reality many other areas of CAMHS tier 2 are falling short too due to a crippling shortage of resource which long pre-dates the recession.

Mental health problems are known to rise during periods of extensive social stress, such as those imposed on sectors of the community by economic recession. The impact of the lack of work opportunities on young people's mental health is an example of a case in point, another would be the rise in the number of children and young people entering the looked after system in Wales, many of whom have mental health need. This means that tier 2 CAMHS, like other high end children's services, have come under further external pressure from increased referrals of children, young people and families.

There is no doubt a huge pressure on CAMH services at tier 2. What this means on a strategic level is that there are barriers to working in partnership, resulting in CAMHS teams becoming quite isolated. Where we see this isolationism, it is very unhelpful, and sometimes dangerous. However this is often rooted in the extremely challenging task of trying to satisfy both commissioner

and service user demands within the context of a very limited range, quality and capacity of resource.

As a consequence of the Mental Health Measure and the Together for Mental Health Strategy we have been in a position of attending forums, at a number of different levels, which include adult service representatives. We have noticed the comparatively generous capacity of adult mental health services, who can afford to put forward strong representation on administrative groups and who consequently have the robust networks to enable them to deliver on mental health policy.

The capacity of adult mental health organisations has served to enable improvements in policy delivery with regard to transition, and we very much welcome this. However, on a regional level, where it is important that a true representation of mental health work in both areas of adult and children and families work is recorded and relayed to Welsh Government the voice of adult mental health services can dominate, particularly where strategic leads have a lack of familiarity with children's services and CAMHS work.

6. Whether there is significant regional variation in access to CAMHS across Wales;

Evidence in response to question 3 above, also relates to this question.

7. The effectiveness of the arrangements for children and young people with mental health problems who need emergency services;

The Child and Adolescent Mental Health Services: Follow-up Review of Safety Issues (WAO/HIW 2013) evidences the continued problem with placing young people on adult wards. We still have cases within our service user group who have experienced being placed, inappropriately on adult wards. In 2013 a service user who turned 16 in March of 2013 was placed on an adult ward in mid-April and remained there for over 8 weeks. This service user was discharged without medication or a follow-on plan for mental health support plan. This should not be allowed to happen.

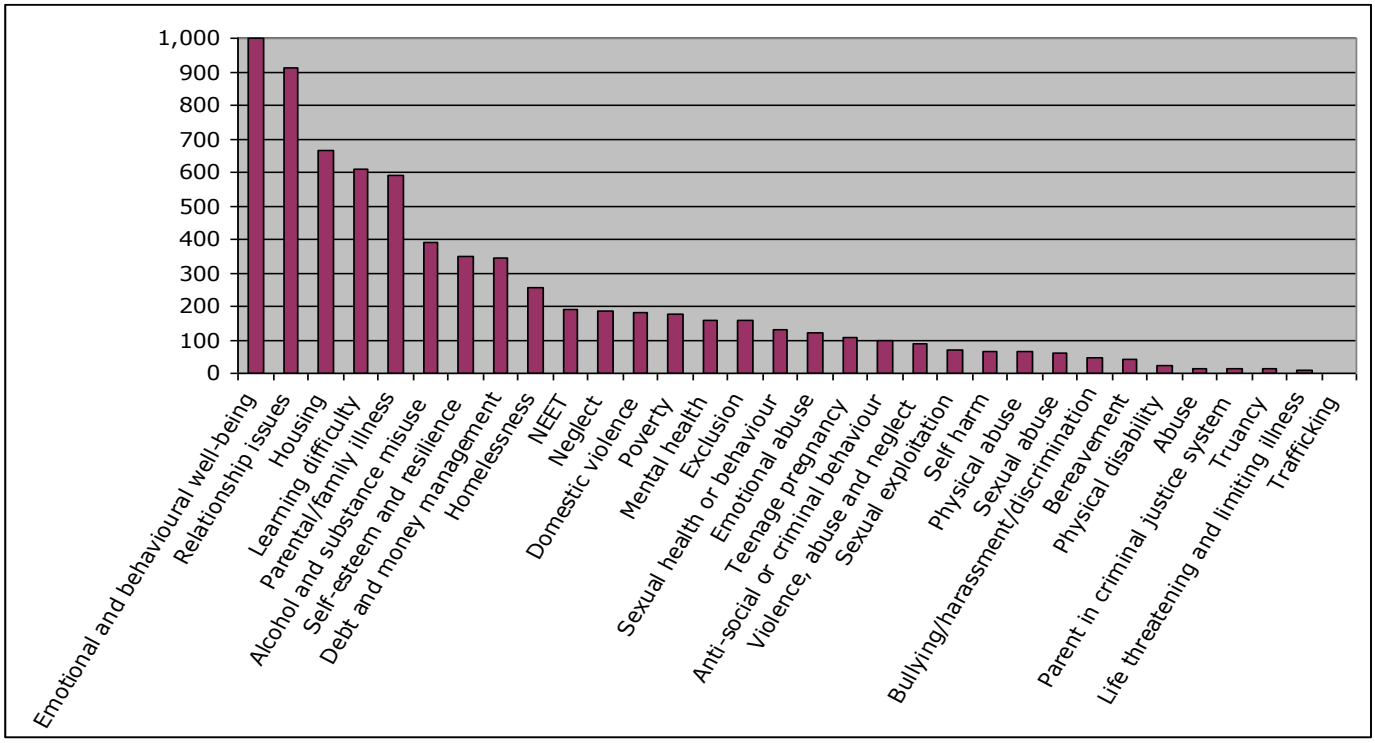
8. The extent to which the current provision of CAMHS is promoting safeguarding, children's rights, and the engagement of children and young people;

Our organisational aim is to support the most vulnerable groups of children, young people and families. Our Barnardo's Cymru service user profile for 2012-2013 is as follows.

Barnardo's Service Users' Profile – 2012/2013:

Total Service Users = 8,473 (59% female, 41% male). Looked After children = 7%, Child Protection Registered = 6%.

By far the most common issue affecting our service users is 'emotional and behavioural wellbeing'. In fact the graph below under represents the true recorded number of 2,500 by 1,500 as the graph was unable to accommodate this number.



This issue is often combined with other presenting issues and, despite there being only 7% looked after and 6% on the child protection register, many of our service users have multiple needs that require a holistic approach, inclusive of a mental health element.

A proportion of these service users will require secondary mental health assessment and, where necessary, services. These have traditionally been difficult groups for specialist community CAMH services to engage with. Emotional and behavioural problems in children and young people is a strong indicator of broader family stress and often these are the families that are prone to miss clinic appointments. The Child and Adolescent Mental Health Services: Follow-up Review of Safety Issues (WAO/HIW 2013) concluded that

'*safe and effective practices are still not in place for young people who miss appointments, with patients being discharged without sufficient attention to the risks involved'.* The reduced overall availability of services to children and families, described in the introduction to this paper highlights the imperative for good practice in response to missed appointments as there is no guarantee that other services will be involved.

The fact that the specialist community CAMHS clinic model often fails to engage with service users and their families, where there are emotional and behavioural problems and chaotic family circumstances means that these teams are not able to promote safeguarding, or children's rights, through appropriate service provision. This is an unacceptable situation.

There have been a number of approaches to delivering services to these more 'difficult to reach' groups which have provided some evidence of what might work in supporting the mental health of these children and young people. Two examples of such approaches include, firstly the Barnardo's 'Caterpillar' Service which offered outreach, group work and intensive support for a wide range of young people with mental health problems and illnesses. Secondly the Action for Children Skills for Life programme in Gwent which provides group support for young people leaving care.

Both of the above services had a number of shared practice features which seemed to serve to support the needs of young people who were moving through a period of transition into adulthood, without having internalised the emotional, cognitive and social developmental maturity required to negotiate this transition successfully. For these young people their external world often reflects this lack of internal integration. Andrew et al comment in relation to their Care Leaver group that;

'Young people at this point in the care system will often experience multiple placement moves, periods of living in unstable environments such as in a bed and breakfast or sofa surfing or a return to unhealthy and often abusive familial environments'[2]

In response to this there is a need for '*the habitual presence of an attachment figure, to maintain predictability, to plan for change, to avoid isolation, to be deliberate with surprises, to initiate*

[2] Dialectic Behaviour Therapy and Attachment: Vehicles for the development of resilience in young people leaving the care system. Elizabeth Andrews, Jessica Williams, Cerith Waters. Clin Child Psychiatry published online 17/11/13

relationship repair and be sympathetic to fears, however irrational they seem[3]*'*

Just as with the Caterpillar Service, Skills for Life is delivered in the community in places that are often informal environments that young people are familiar and comfortable with.

Due to the range and variety of innovative, short-term projects such as the ones named above, it is difficult to identify the efficacy of the work in a meaningful way, and to identify what the shared elements are that drive, or underpin any positive change. This is a research task that might be usefully pursued if lessons on how to deliver secondary community mental health support to more 'difficult-to-reach' groups is to be achieved.

Any other key issues identified by stakeholders

MT
07/03/14

[3] As above

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Linc i'r adroddiad:

http://www.estyn.gov.uk/download/publications/300409.2/the-annual-report-of-her-majestys-chief-inspector-of-education-and-training-in-wales-2012-2013/