National Assembly for Wales
Children, Young People and Education Committee
CAM 62
Inquiry into Child and Adolescent Mental Health Services (CAMHS)
Evidence from : Barnardo's Cymru

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.

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

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

- 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.

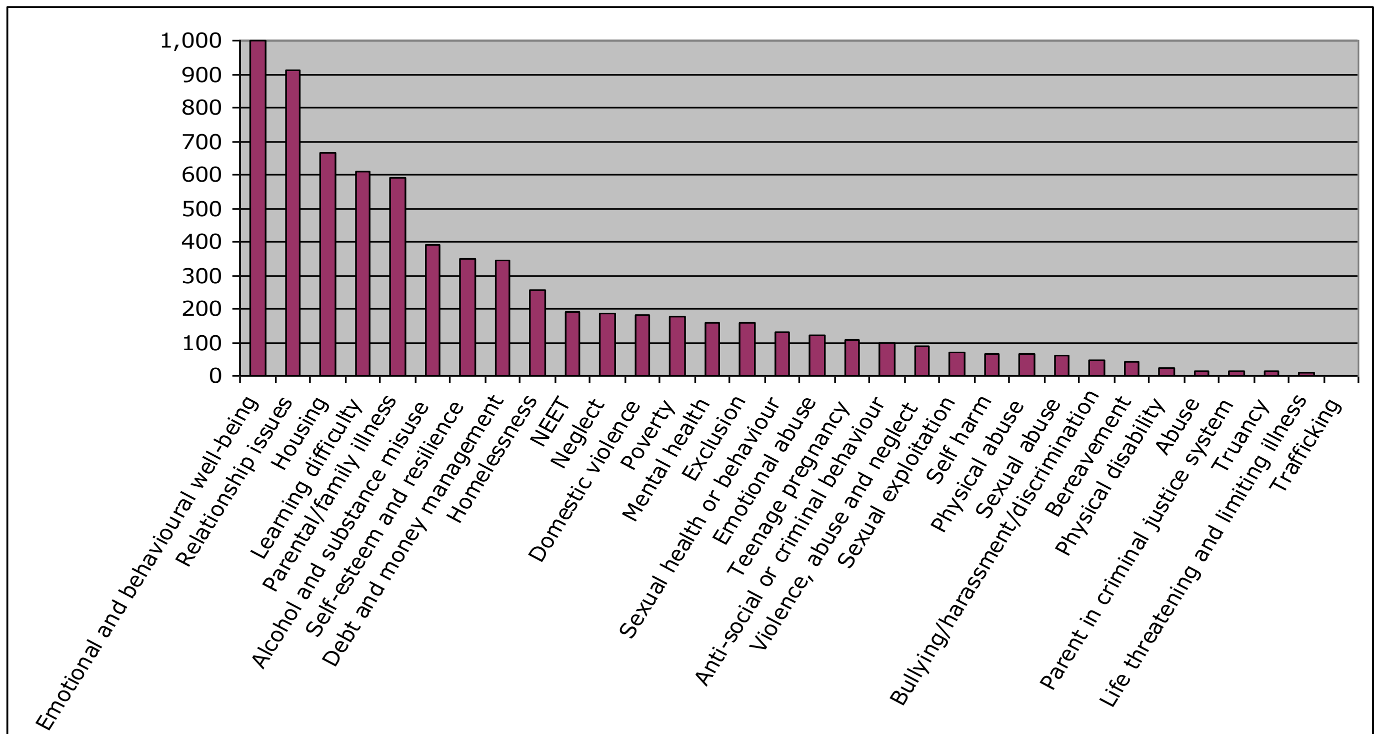
8. The extent to which the current provision of CAMHS is promoting safeguarding, children's rights, and the engagement of children and young people;

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]

[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

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 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

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07/03/14

[3] As above