National Assembly for Wales

Children, Young People and Education Committee

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Inquiry into Child and Adolescent Mental Health Services (CAMHS)

Evidence from : NSPCC Cymru / Wales

We greatly welcome the Committee's Inquiry into Child and Adolescent Mental Health Services (CAMHS). NSPCC Cymru / Wales works across Wales with vulnerable children and young people and we are concerned that CAMHS services are struggling to meet the demand placed upon them and that existing service provision is highly variable.

The changing needs of children and young people can clearly be seen in the ChildLine annual report 'What's affecting children in 2013: Can I tell you something?'. In the last year there was an alarming rise in the number of young people contacting ChildLine from across the UK to discuss issues of self-harm (a 41% increase on 2011/12[1]) and suicide (a 33% increase on 2011/12[2]). Depression and unhappiness was the most common reason for young people to contact ChildLine with 35,900 young people contacting ChildLine about this issue (a total of 13 % of all counselling sessions delivered by ChildLine). A further 3% of all ChildLine counselling sessions were for mental health issues (as their main concern).

Worryingly depression/unhappiness, suicidal issues and self-harm were all in the top five most common reasons for young people to contact ChildLine amongst those aged 16-18 (ChildLine 2014:23). Clearly young people continue to be in great need of services and support. We would strongly urge that more support be offered to young people specifically addressing issues of depression, self-harm and suicide.

The availability of early interventions for children and adolescents with mental health problems

The provision of more services at Tier 1 is something that we would strongly support. There is good practice in some areas where CAMHS professionals regularly 'drop in' and meet other front line professionals to support them in their work with vulnerable children and young people who have early mental health and behavioural problems. These services are of particular importance in supporting those with low level needs and helping to prevent the need for higher interventions. Jackson *et al* (2013) in their comparison of secondary school-based counselling services and CAMHS (in Wales) noted that school-based counselling services had higher proportions of female engagement; a trend that stands in contrast to CAMHS where males are more heavily represented.

Currently the NSPCC is carrying out some action research with a Welsh local authority looking at the emotional wellbeing and mental health of looked after young people. This project adopts a holistic approach with professionals and young people taking part. The services in the local authority are being mapped and a customised action plan with suggested changes that could be made. This project has provided us with an insight into the situation not only of this county but also of other neighbouring counties. Some initial tentative findings from this project (report likely to be forthcoming in autumn 2014) indicate that self-referral (i.e. drop-in) counselling services would be of great benefit to young people.

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[1] The fourth most common reason for young people to contact ChildLine (accounting for 8% of all counselling sessions).

[2] The fifth most common reason for young people to contact ChildLine (accounting for 5% of all counselling sessions).

There is a need for a service where a young person does not necessarily have a diagnosable mental illness, but has persistent mental health needs. This was a consistent issue raised by both our own services and our partners in both the statutory and voluntary sectors. While we applaud the efforts being made by the Welsh Government to provide early intervention services further work is needed.

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

The NSPCC Cymru welcomed the requirement under the Mental Health Measure (Wales) 2010 for all service users to have individual care and treatment plans. We would urge the Committee to examine this issue in more depth, paying attention to both implementation and the quality of assessments.

The extension of funding to close the gap in service for those aged 16 and 18 is also greatly welcomed, although we remained concerned about young people transitioning from children to adult services (this is discussed further in the next section).

However our services have observed significant variation in accessing tier 2 services and above. Threshold levels are felt to be rising with our services reporting concern that unless a child presents with life-threatening behaviours they are less likely to receive a service. It is of course correct that CAMHS should focus its energy on those with the most acute need, but children and young people with behavioural issues or in need of diagnosis are felt to be missing out on the assistance they need.

Our services have also reported an increased trend of CAMHS services to undertake an initial assessment but then leave a considerable period (potentially months) between this first assessment and any treatment being provided. We recommend that the Committee examine the delay between assessment and the provision of services for referred children and young people.

The lack of a forensic CAMHS service in Wales is potentially problematic as it is felt that specialist skills are needed to work with young people who have a history mental illness and offending behaviour. While mental health nurses embedded in youth offending teams/services are able to partially fill this need, and liaise with general CAMHS services, we are concerned that this vulnerable group of young people are not being adequately supported. We would urge the Committee to look at forensic CAMHS provision in more detail as part of their inquiry.

The proposed closure of Wales only mother and baby unit in Cardiff is particularly concerning. This facility offers support to a particularly vulnerable group and the service it provides is of particular importance. We hope that the Committee will discuss this proposed closure during their inquiry.

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

Much of the literature and documentation surrounding CAMHS seems to focus on the service primarily in the context of wider health services. Social care services, and more specifically social services, are given only occasional mention. There should be a stronger emphasis on the need for collaborative working between social services and CAMHS, particularly when looking at certain populations, such as looked after children (LAC), or children whose names have been placed on the Child Protection Register (CPR). The absence of the Care and Social Services Inspectorate for Wales (CSSIW) from the recent report Child and Adolescent Mental Health Service: Follow-up Review of Safety Issues (WAO and HIW 2013) might be seen as

evidence of this issue. The need for close co-operation between social services and CAMHS is particularly important for safeguarding young people.

Transition from CAMHS to Adult Mental Health Services (AMHS[3]) adult services is a well-documented issue (Street 2000; Brodie *et al* 2011) and one we believe continues to be problematic. Lamb and Murphy (2013) in their discussion of the CAMHS-AMHS suggest the reasons for this include:

- Separate commissioning services for CAMHS and AMHS.
- Varying remits between CAMHS and AMHS – CAMHS often provides support for young people, who have autism, Attention-Deficit Hyperactivity Disorder (ADHD), issues that AMHS are unlikely to provide support for. Identifying services in adult services that might best be able to assist young people can be more complex than in children services.
- Low referral rates from CAMHS to AMHS – Sing *et al* (2010)[4] noted that over 80% of CAMHS cases would likely be considered for AMHS, but third of these were not referred on for services. ADMHS also accepted 93% of cases that were referred, however 25% of these were subsequently rejected without being seem by the CAMHS service (Lamb and Murphy 2013:42).
- Eligibility – Even where CAMHS and AMHS are providing comparable services we are concerned that there is (a) no effective handover between services and (b) that eligibility for access to services is different.
- When young people transition between services it is vital that this be done in a planned way involving both the young person and their family (Lamb *et al* 2013:43). It is currently unclear how effectively this is being done. It is essential that young people have a voice in the care they receive, especially at the juncture between children and adult services.

Our service centres have noted that relationships between CAMHS and other services are largely dependent on individual working relationships. In some areas the relationship between CAMHS and other services (in both the statutory and voluntary sectors) is felt to be positive. For example, our Swansea service centre has reported that a CAMHS worker visits on a monthly basis to provide advice on cases and discuss referrals.

However, where relationships are not so positive reported difficulties include accessing services and a reluctance to share information when it might be pertinent to do so (i.e. where there are legitimate safeguarding concerns, or to support in the therapy of a young person). Professionals need to be able to work with CAMHS in the therapies provided to young people.

Even within smaller geographical areas the provision of service is felt to be very variable. For example, our Cardiff service centre has reported some highly positive and some more negative experiences of working with CAMHS within the same health board.

One issue that has been identified as being particularly important to all our service centres is the need for a point of contact within CAMHS services. Having a contact within a CAMHS service who could answer queries and update partners on their referrals was felt to be vital for good multi-agency working. Where these links exist the working relationship with CAMHS was felt to be very positive; in areas where these links do not exist there was often a lack of engagement between CAMHS and our services. We would ask the Committee to look at how CAMHS services work with different statutory and non-statutory organisations.

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[3] Often provided through Community Mental Health Teams (CMHTs).

[4] Please note that the findings from Sing *et al* (2010) was conducted across six English Mental Health Trusts. No data on this topic has been located for Wales.

One further issue highlighted to NSPCC Cymru / Wales is the gap in services for those young people who are no longer in need of inpatient care, but for whom it is not safe or appropriate for them to return home. In these situations the need for multi-agency working is essential. Social services and health professionals should be working closely to provide an intensive personalised package of care. Examining the support packages available to young people at the point of hospital discharge would likely be a fruitful area of inquiry for the Committee.

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

We regret that we are not able to provide any evidence on this point beyond the issues raised in the previous two sections (i.e. access transition services, forensic CAMHS and the relationship between CAMHS and social services).

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

The three NSPCC service centres in Wales (Cardiff, Prestatyn and Swansea) provide services to children and young people from numerous authorities and health boards. Our practitioners have reported considerable concern about the varying levels of service across Wales. This is felt to be particularly problematic at tier 2 and above. Concerns about both the availability and quality of services have been raised. An example of this would be varying waiting times which have been observed to vary greatly between different areas.

The fluctuation in service is also felt to exist in inpatient facilities. Having just two CAMHS inpatient units in Wales, both of which have a shortage of capacity (Wales Audit Office (WAO) and Health Inspectorate Wales (HIW) 2013:13-14), means many young people are placed in out-of-county placements. Further to this the locations of these units (one in North Wales and one in South Wales means that those living in mid-Wales have more limited access to services.

Access to out-of-hours CAMHS also varies dramatically across Wales (this is discussed further in the next section). We welcome the Committees focus on this issue.

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

Wales Audit Office (WAO) and Health Inspectorate Wales (HIW) have noted that 'significant numbers of young people under 18 years of age are still being admitted to adult mental health wards' (2013:9). Worryingly the current figures on this are felt to be an under-representation of the true extent of the problems (WAO/HIW 2013:12) due to issues with how data on this topic is collated. For some older young people (i.e. those aged 16-18) being placed on an adult ward might be preferable to being on a ward with young children. However it is vital that the young person's perspective is gained (as is their right under article 12 of the UNCRC) and that safeguards are put in place to protect these vulnerable young people. This concern is exacerbated by the lack of action plans, or a failure to keep action plans up-to-date, for managing the admission of young people to adult mental health wards (WAO/HIW 2013:12). We would strongly urge the Committee to look at both the frequency of young people being placed on adult wards and the safeguards that exist to protect young people in these instances.

The availability of out-of-hours CAMHS varies dramatically across Wales. For example, there is no-out of-hours CAMHS service in Hywel Dda or Powys health boards (WAO/HIW 2013). Lamb has suggested that 'in areas where the capacity of CAMHS psychiatrists to provide comprehensive out-of-hours cover is limited, it is vital that planning takes place between

commissioners, CAMHS, adult mental health services and paediatrics in order to explore creative solutions, allowing for the possibility of assessment and consideration for admission in a crisis' (2013:42). Further examination of what procedures exist to manage out-of-hours CAMHS should be a priority area for the committee.

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

The Rights of Children and Young Persons (Wales) Measure 2011 places the United Nations Convention on Rights of the Child (UNCRC) at the centre of all work with children and young people in Wales. Supporting the mental health and emotional wellbeing of children and young people is a right afforded to young people under article 24 of the UNCRC. Having good quality mental health services is as important as good quality physical health services.

Wales Audit Office (WAO) and Health Inspectorate Wales (HIW) (2013) noted that all health boards have incorporated safeguarding training into their action plans and have training in place for staff. However, NSPCC Cymru/ Wales is concerned that not all CAMHS staff, or staff based on adult wards who have contact with young people, are having Disclosure and Barring Service (DBS) checks (WAO/HIW 2013:19). This is part of a wider issue with health authorities only checking new staff or staff in selected role. We strongly support the recommendations of the joint WAO HIW report that called for; (i) all policies, procedures and training be revised to address gaps in improve safeguarding; and (ii) ensure that all clinical staff working in CAMHS or on designated mental health wards have DBS checks that have been renewed within the last three years (WAO/HIW 2013:19).

Attendance at CAMHS appointments was found to be problematic by the WAO/HIW (2013) report; in some areas as many as one in five appointments are missed. Children and young people are usually dependent on parents and carers to enable them to access these appointments. We feel this should be addressed by CAMHS relying less on a conventional appointment model whereby young people come to CAMHS for appointments. This is supported by some initial findings from some work that we are currently undertaking with a Welsh local authority looking at the emotional wellbeing and mental health of looked after children (LAC) (report likely to be forthcoming in autumn 2014). CAMHS should be making more attempts to engage with young people in their homes to help combat the high rates of non-attendance at meetings.

NSPCC Cymru/ Wales is not aware of young people being involved in the planning or review of CAMHS services. We would ask the Committee to look at how the voice of children and young people could be better heard in the services that assist them.

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