# National Assembly for Wales

# Children, Young People and Education Committee

## CAM 53

## Inquiry into Child and Adolescent Mental Health Services (CAMHS)

## Evidence from : Hywel Dda University Health Board

| | **The Committee is interested in hearing about**<br><br>**The availability of early intervention services for children and adolescents with mental health problems** |
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| 1. | Comments:<br>i. The MH Measures 2010 have been welcomed and will considerably improve the delivery of care and treatment for children and young people however there is significant concern that the funding made available for the development of Primary Care services did not take into account the full needs of this vulnerable age group and therefore may have disadvantaged them. A lack of guidance has result in different Health Boards developing their Primary Teams in different formats. As an age inclusive service little account has been taken of the significant role that child and adolescent PMHW delivered historically across all Tier 1 agencies and has led to confusion as to their role. This undermining of the role is of significant loss and steps should be taken to address it before the role becomes completely devalued.<br><br>ii. The introduction of the MH Measures 2010 has also increased the administrative burden on small CAMHS services. The strict descriptor of who can undertake the CTP Coordinator role has also impacted with key qualified staff being excluded increasing the burden on other clinicians.<br><br>iii. It is imperative that S-CAMHS are adequately funded to strengthen and develop early intervention initiatives so that resilience in children can be developed and through early intervention / prevention strategies the emotional and mental health improved. Early intervention services should be jointly developed and integrated thus improving the interface across agencies and increasing each others knowledge and skill base. It is important to put in place a solid foundation to support the children in their early years.<br><br>Early years intervention is both efficient and cost effective because it only requires relatively short interventions.<br><br>Better support to mothers and babies can have a significant impact on a whole community with less crisis intervention at a later stage when children are older and harder to reach and the situation has become more entrenched.<br><br>It may reduce the number of children in care and the social costs linked to mental health issues.<br><br>iv. Alongside the further development of early intervention there is a lack of Psychological Therapy in Primary Care both for children within mental health services but also across Health in general. For example NICE guidelines for chronic fatigue suggest CBT but there are limited trained therapists available to deliver this. There is also a limited amount of training opportunities for staff to develop their |

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| | skills due to the economic environment and also lack of appropriate training courses.<br><br>v. CAMHS across Wales consist of very small specialist teams who are expected to deliver highly specialist services for the whole child health population, given that 1:10 children will experience mental health disorders then serious consideration should be given to how the current approx 300 CAMHS clinicians can deliver safe evidence based and sustainable services for 6% of the total population (700,000 children approx).<br><br>vi. Welsh Government should consider investing / pump priming CAMHS services to ensure that robust services can be developed which are on a par with England who have provided significant financial investment in this area. The benefits of this could ensure that all CAMHS Services are able to provide more responsive services at an earlier stage and undertake a higher level of joint work with partner agencies.<br><br>This is an area that requires an integrated approach across agencies and the key stakeholders. Early identification and intervention throughout early years is an essential requirement to improve mental wellbeing and resilience. There are services offered to children to support their emotional health and well being, however the point of transition from these to services for mental health problems is a point of contention. While ”CAMHS is Everybody’s Business” service providers outside of what is now described as Specialist CAMHS, can sometimes consider any child or young person who is challenging should be Specialist CAMHS responsibility, because they are “the mental health“ service.<br><br>vii. There is a need to encourage early intervention for children under 5 years old; whilst Robin Balbernie has supported even earlier intervention (under 2) and the creation of Infant Mental Health Services and also to promote specific services for LAC young people. It is vital that these services are embedded within broader health and social care services. Current budget and service pressures means this is an area which has limited availability therefore given the research supporting early intervention this should be a high priority. |
| | **Access to community specialist CAMHS at tier 2 and above for children and adolescents with mental health problems, including access to psychological therapies** |
| 2. | Comments:<br>i. Each Health Board in Wales has developed their CAMHS service according to the allocated funding received and in response to local need / criteria. It is only recently that national guidelines / best practice were produced to assist service planners and commissioners to compare current provision and ensure that service provision was delivered in a more equitable manner. Whilst staffing ratios have increased with additional core funding S-CAMHS generally remains significantly under resourced against the best practice guidelines. The Royal College of Psychiatry Guidelines on “Building and Sustaining S-CAMHS CR137 highlights that calculating the capacity of S-CAMHS which is a Teaching Centre is set at a ratio of 24.2wte per 100,000 population. If this gold standard were to be applied to the Hywel Dda University Health Board (HDUHB) population of 375,000 this figure should be 91.6wte. This would mean there a significant shortfall to meet the Royal College Guidance for the provision of a comprehensive CAMHS. |

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| | ii. HDUHB has adopted the CAPA model to allow the service to address the demand and capacity. S-CAMHS services are tasked to assess and deliver interventions for those young people with complex mental health presentations and needs. With the ever increasing demands upon under resourced services there needs to be an acknowledgement of the need for more focused investment and collaborative working between all the services / agencies and stakeholders.<br><br>iii. A lack of understanding and increasing expectations of the key delivery of CAMHS services by other agencies places CAMHS in a vulnerable position as it struggles to respond to the emotional and mental health needs of children and young people. With emotional and mental health referrals increasing across all services consideration needs to be given to ensure sustainable services are developed and maintained.<br><br>iv. The psychological therapeutic competencies of staff within Sp-CAMHS can vary; therefore, not all staff could provide the appropriate therapeutic interventions at the appropriate intensity. Further, it seems that certain therapeutic approaches have traditionally been associated with; and thereby located within CAMHS' teams, despite there being a dearth of evidence supporting their efficacy and effectiveness. The provision of a particular therapeutic approach simply because it is available, rather than it being an appropriate (evidence supported) approach is an all too common occurrence and can happen across all tiers, from Tier 1 to Tier 4.<br><br>v. Time and financial pressures means that there is often insufficient opportunity for clinicians to access appropriate and competent supervision / consultation. This can diminish their therapeutic effectiveness and is a clinical governance issue.<br><br>vi. There are few courses in existence that provide training in evidence-based psychological therapies for the treatment of children and young people; there are even fewer in Wales. Those that are suitable are oversubscribed for a number of years ahead.<br><br>vii. Recent information has informed us that the training for Educational Psychologists may be discontinued in Wales. Educational Psychologist also operate at Tier 2, though usually but not exclusively, outside Specialist CAMHS Teams; it is difficult to understand why consideration has been given to ceasing the funding for the only Educational Psychology training course in Wales. |
| | **The extent to which CAMHS are embedded within broader health and social care services** |
| 3. | Comments:<br>i. The concept of inclusive CAMHS (across all tiers) in contrast with Specialist CAMHS has been problematic and can lead to some organisations and services e.g. Social Services not recognising the responsibilities we have towards meeting the mental health needs of children and young people. Such thinking leads to these organisations looking to pass clients with any degree of emotional or mental-health difficulty onto Sp-CAMHS.<br><br>ii. Whilst there have been many Welsh Government documents aimed at ensuring a clear and joint responsibility for the development of integrated service provision there continues to be limited shared ownership across some agencies with Health being expected to meet the needs of all young people with emotional, behavioural and mental health problems. There needs to be a high level "sign up" in order for CAMHS to become everybody's business and ensure a seamless and responsive |

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| | approach for our vulnerable children.<br><br>iii. This is an important driver for improved integration. Integration needs to be build upon a shared understanding of each service's core business, including the limitations and therefore the appreciation that services place, at times, unrealistic expectations upon each other to deliver services that they are not resourced to do or can only deliver for a clearly defined population<br><br>iv. Health Boards should ensure that wherever Sp-CAMHS sit within organisations they should be given as high a priority as other services and appropriate resource allocated to meet the needs. As a small service there is a risk that they can often be overlooked and not fully embedded, as they span a number of specialities i.e. mental health, safeguarding, children services.<br><br>v. Within Local Authorities, Educational Psychology Services are increasingly being included within 'Children's Services', comprising Education and Social Services. However, the increasing demands placed on Educational Psychologists means they may have little time to provide input on mental health issues and, in effect are maintained within their traditional roles.<br><br>vi. Within HDUHB there is significant evidence of good integrated practice / services being developed but this is driven by key individuals actively seeking to develop the integration agenda. Whilst some good practice exists with such as Social Service Department seeking to fund part posts within Specialist CAMHS for Psychologists, Psychological Therapists and Psychiatric Nursing within newly created specialist services, such as an Emotional Wellbeing Team, or a service for children who engage in sexually harmful behaviours; other examples os less joined up and integrated services still exist. |
| | **Whether CAMHS is given sufficient priority within broader mental health and social care services, including the allocation of resources to CAMHS** |
| 4. | Comments:<br><br>i. It has been estimated for every one pound spend on adult services, about 30 pence is allocated to CAMHS resources. The Mental Health Measure and LPHMSS are good examples of how CAMHS might be viewed an after thought, and not part of the main / core business of service planning and delivery. If we invest in our children we may well save costs in the long run. In HDUHB CAMHS are taking a lead in driving forward these important agendas.<br><br>ii. It is a challenge to maintain ring-fenced budgets that Welsh Government state the Health Board should have secured for S-CAMHS. Due to the financial demands and constrains on budgets across the Health Service, the CAMHS service is asked to achieve financial prudency as are all services. This does impact on recruitment especially as the budget is largely driven by pay costs which mean the opportunities for savings are extremely limited.<br><br>iii. Specialist CAMHS services would be viewed as being an underfunded service if the gold standards are applied. In large organisations in both Health and Local Authority, prioritisation or opportunities for additional funding for smaller services such as Specialist CAMHS are often difficult to achieve.<br><br>iv. The facilities that Specialist CAMHS operate out could be improved in parts. The |

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| | accommodation is in need of modernisation and general repair work. Priority should be given to ensuring that requirements relating to confidentiality and storage of records is considered in this highly sensitive area of work.<br><br>v. In order to operate efficiently CAMHS is reliant on obtaining external funding streams ie Families First in order to develop services and meet increasing demand and expectation. These funding streams are short term and whilst excellent initiatives are developed, often there is no security for ongoing provision of the service development. This also leads to uncertainty for the staff members involved especially where additional skills have been acquired and might not be able to be used thereafter. |
| | **Whether there is significant regional variation in access to CAMHS across Wales** |
| 5. | Comments:<br>i. There are significant differences in resource allocation and provision across Wales, with no clear format for considering what % of the Health Board allocation should be considered appropriate for a significant percentage of the population. A level of clarification/guidance would be welcomed. Within HDUHB the child population is $^{1}/_{5}$ of the total population but this is not always reflected in the budget allocation for Child health (physical and mental health).<br><br>ii. Yes, this is evident in how services define their core business and the different services available across Wales. A good example is the CITT provision that stops in ABMU. Significant investments have been made but this was not spread more widely.<br><br>iii. Referral criteria being interpreted differently can lead to different services being offered. An obvious example being whether ASD and ADHD are perceived as being mental health difficulties (seen in Specialist CAMHS) or developmental difficulties (seen in Paediatrics).<br><br>iv. Cultures within Specialist CAMHS can also lead to regional variation, such that services that are seen as being Psychiatry led tend to be diagnostic and rely on medication, whereas those that are more multidisciplinary led tend to be more psychological interventionist in their character.<br><br>v. Within the wider CAMHS variations in the response of some Local Authorities in recognising needs means that some services are not being provided equally (e.g. sexually harmful behavior). |
| | **The effectiveness of the arrangements for children and young people with mental health problems who need emergency services** |
| 6. | Comments:<br>i. The current arrangements should be reviewed and could be described as ineffective or even boardering on unsafe on occasions. The service commissioned by WHSSC, provided by Cwm Taf and based at Bridgend can sometimes be unresponsive and monitoring arrangements appear weak. With limited external evidence of robust Clinical Governance process to support the unit or how the Unit achieves compliance against recognised standards ie QNCC and the WAO reports.<br><br>ii. This is significantly lacking. We have a modern, fit for purpose structural Unit in |

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| | PoW, however the "software" is not designed to accommodate this very risky and complex group of young people. Why do we continue to admit these young people to inappropriate adult beds or send them to England? Utilisation of facilities within Wales should be given the priority and used to its full potential and agree pathways that will enhance access and improve communication / case management and speedier returns to locality services with a clear formulation, including risk assessment and management plans.<br><br>iii. Children can be admitted to a local Emergency bed as an overnight stopgap prior to admission to Bridgend. Mostly this bed is a designated area on our Children's Ward, but can also be in a designate area on an Adult Psychiatric Ward.<br><br>However, admission to the Bridgend unit is not always easily facilitated and so the child might remain in the 'stopgap' environment, cared for by agency nurses until admission to an English unit is facilitated.<br><br>A logical and appropriate way forward for the commissioning of this service might be to have an Emergency Admission Unit at Bridgend, or to guarantee admission to the Unit the day after admission to a local emergency bed. In that way even if staffing had to be by an Agency Nurse the child would be properly supervised and managed.<br><br>iv. Compliance with NICE Guidelines for children and young people who present at A&E having self-harmed or self-poisoned can often be problematic. These children might not be admitted to an appropriate ward where their emotional and mental health needs can be met and can find themselves discharged with a physical assessment only.<br><br>v. Children and young people who have attempted overdose need to be safeguarded. However, there can be a failure to recognise the very significant social elements within such behaviour and such acts can be perceived automatically as being indicative of mental illness and thus a health responsibility. It is suggested that all individuals who take an overdose should be assessed by Social Services.<br><br>vi. The criteria for referral to Tier 4 means that only Consultants can refer - when there are Nurse led services, especially out of hours such as in HDUHB, this facility is not available therefore this is inequitable in the access to beds. This needs to be reviewed as a matter of urgency in order that specialist staff who can make an objective assessment of risk and need can access and refer into the most appropriate service. |
| | **The extent to which the current provision of CAMHS is promoting safeguarding, children's rights, and the engagement of children and young people** |
| 7. | Comments:<br>i. This is at the forefront of our service provision. However this can only be achieved when true multi-agency working pathways are in place.<br><br>ii. Current emergency admission arrangements do not always promote safeguarding, especially when admission even short-term is to an adult Ward. They do not meet the rights of the Child when measured against the UN rights of the child. Further work is required which considers the findings of a satisfaction survey for children, or engagement events to discuss emergency service provision to determine if the services do meet their needs. |

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| | iii. Specialist CAMHS makes significant efforts to safeguard children by assessing risk. However, this may not be the case within the more inclusive CAMHS, such that the responsibility to assess risk following an overdose for example, is often 'passed over' to Specialist CAMHS. Appropriate child protection or assessment of home circumstances from Social Services referrals, should be completed by the first line practitioners in the A&E departments or at ward level.<br><br>iv. Protecting children's rights and promoting their engagement is a major priority to Specialist CAMHS but is often poorly understood by other services and service users. There can be a failure to understand that when a child or young person is competent to make their own decisions as to their care, that their right to confidentiality needs to be respected. |
| | **Any other key issues identified by stakeholders** |
| 8. | Comments:<br>• Forensic provision - we need to consider how we best use the available estates to best meet the forensic needs of our young people.<br>• Substance Misuse services - improve the ageless agenda and the investment in these services.<br>• Sexual Harmful Behaviour - consider and develop pathways to best meet this population.<br>• Lack of Eating Disorder provision.<br>• CAMHS Liaison Clinics.<br>• CAMHS Planning and Delivery Board still not structured and the strategic direction and leadership of the service is not yet best served.<br><br>Whilst it is easy to be critical of the current service provision it is important that we recognise there is excellent practice being delivered across Wales by CAMH clinicians. Innovative practice and the development of services to meet the needs of local people have led to an improvement in the overall quality of services for Children and Young People. These innovations have been showcased and the workforce achievements recognised.<br><br>Further investment in CAMHS services on an All Wales basis should be supported if services are to be developed in line with best practice and the quality of the service maintained and improvements made. This requires urgent action to allow Service Leads to plan for the future service provision. |

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