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Children, Young People and Education Committee Inquiry into CAMH services additional information

Additional information in response to the request that we expand on our evidence that specialist CAMHS closed cases of young people who were receiving support from Barnardo's Cymru Seraf (Child Sexual Exploitation) and Taith (Sexually Harmful Behaviour) specialist services.

The key issues illustrated by the following case examples are:

- Taith have had a number of experiences of being informed by Social Services that CAMHS are not prepared to take up the case if the case is being worked with by Taith. So this information is coming from Social Service referrers and not directly from CAMH services.
- Social services are often the service commissioner of Seraf and Taith services, and the social worker can play a pivotal role in communicating information and gate-keeping the involvement, or not, of Taith and Seraf practitioners in the care and treatment planning process.
- The current practice culture and environment of specialist tier 2 CAMHS means they can not always be flexible enough to be accessible to some young people with a diagnosis of personality disorder.

The services gave some examples of cases where the practice and the outcomes for the service user had been less successful:

- Seraf service presented a case of a 17 year old whom they worked with in 2010. This was prior to the implementation phase of the care and treatment planning process introduced by the Mental Health Measure. The young person was assessed as having a personality disorder but found it difficult to engage with CAMHS and the service was ceased. The young person was informed by the CAMHS service that they had closed the case and a re referral would need to be made via the GP. The young person went to the GP and a re referral was made but the young person, again, failed to engage. The Seraf practitioner contacted CAMHS and was provided with advice and guidance by CAMHS

on support services that the young person could access in the local community. The Seraf practitioner concluded that the services CAMHS were offering were not flexible enough to meet the needs of the young person. There were no plans in place to support the young person to engage with AMHS. The young person continues to receive medication via her GP

We also have a case example from a service working with care leavers of a young person who had been admitted to a mental health unit not being given a diagnosis. The reason given was that to diagnose would be unhelpful for the young person, however the CSM was also concerned that a diagnosis was not forthcoming as the young person, who she thought might have a personality disorder, would then be eligible for a service from CAMHS. Without a diagnosis the responsibility remained primarily with social services.

Seraf and Taith services are primarily commissioned by social services, so it may be that they get caught in the organisational politics between social services and CAMHS where there are sometimes difficult discussions to be had with regard to how the presentation of emotional and mental health problems manifest and which service is best placed to address these issues.

- Taith presented a case of an adolescent boy whom they joint worked with YOT. Both services agreed that the boy required a referral to the Community tier 2 CAMH service as they were concerned about the boy's persistent emotional disconnectedness from his crimes and the impact on his victims, and suspect that he may have psychopathic traits. The CAMHS team eventually assessed the boy on the second referral and decided that he did not have a diagnosable mental health disorder. Both YOT and Taith staff as well as professionals from social services and education remain concerned and the YOT CAMHS practitioner has now made a referral to the tier 4 FACS team

With this second case the services involved which include the YOT, the police, Taith and education were disappointed that CAMHS were unable to recognise the seriousness of the case, own it and, if necessary refer it on. In the event the CAMHS team left the case with the YOT CAMHS practitioner to refer on the FACS team. It may be more difficult to have this case prioritised by the FACS team without the support of specialist community CAMHS.

Both services also gave examples of co-working cases alongside CAMHS teams which were effective:

Taith case

This example illustrates the positive impact of having a Care and Treatment planning process in place within a Tier 2 Specialist CAMH team. This example is also one where there are good working relationships in place between the CAMHS practitioners and Taith practitioners.

This is the case of a young boy who, at the point of referral to Taith, was being treated within CAMHS for ADHD. During the course of his treatment with Taith he became very depressed and there were concerns due to suicidal feelings that were being expressed.

Taith were able to offer some support with the depression and worked with the parents to instigate some strategies for keeping him safe. However as the concerns grew it was felt that the family would need more intensive support with managing the suicidal tendencies and behaviour.

Taith flagged their concerns to CAMHS who carried out an assessment of the boys mental health and put a Care and Treatment Plan in place. Strategy meetings were established, to which all stakeholders were invited and, in the words of the Taith service manager 'CAMHS took ownership of the case'. The Care and Treatment planning meetings gave agencies an opportunity to think together about the needs of this boy and his family. Taith and CAMHS were the two key players in terms of delivering service to the family at this stage. It was identified that the boy had an autistic spectrum disorder, which had been an underlying issue in his sexual offending. He was referred for a Statement of Special Educational Need and the CAMHS evidence played a key part in securing this. The boy is now placed in a specialist education unit and the family and the boy have expressed their gratitude to the joint work that CAMHS and Taith carried out in those early stages to address his, then rapidly spiralling, problems.

Seraf case

Seraf gave an example of a 14 year old they worked with in 2012 who was also receiving a service from CAMHS due to depression and self-harm. By this time the care and treatment planning process was being implemented. The CAMHS team worked in partnership with Seraf

advising what work they were undertaking to ensure no work was duplicated and that the young person was not overloaded. The Seraf service were not part of the Care and Treatment planning process but believe the Social Worker was linked in and had this information.

Additional information with regard to Keith Davies question (Para 268) at 11.45 in the transcript.

We felt that although referring to the Welsh Governments Participation Standards we did not fully respond to the Children's Human Rights element of Keith's question.

The importance of developing and designing services with service user involvement is undeniably beneficial, however, it would be welcome if CAMHS provisions, including assessment and diagnosis, were clearly linked to the role of appropriate mental health support in the protection and promotion of a child's human rights of protection, survival and development as well as participation.

Throughout our written and oral evidence we made reference to the under resourcing of CAMH services and suggest it would be an interesting question to ask if any Children's Rights Impact Assessment has been done in relation to resource decisions.

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