National Assembly for Wales

Children, Young People and Education Committee

CAM 14

Inquiry into Child and Adolescent Mental Health Services (CAMHS)

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The Availability of early intervention services for Children and Adolescents with Mental Health problems

1. The introduction of PCMHSS across the age-span could have been an opportunity (and may be in the future) to take a more systemic approach to children and adults and to view their difficulties in relation to their living context. This would have been a progressive step. However, there is a serious lack of training in systemic practice or in psychological interventions for children and families. This has meant staff have continued with the practice that they are familiar with. Since the majority of the PCMHSS staff have come from adult mental health that is the model they are working to. This experience is neither early intervention nor child/family specific. This is a big concern. The lack of expertise in child and family mental health has meant that referrals to PCMHSS are not being responded to in a timely manner and also that the quality of what is available is unreliable.
In Gwent the Child and Family Psychology service has responded by putting together and delivering a comprehensive training package with follow up supervision. However, this is time squeezed out of the busy clinician and is a sticking plaster to contain the anxiety of the staff rather than a professional training that ensures quality delivery of services from child experts. There are no psychologists embedded within the PCMHSS and the time given is from the already very limited core service.

2. The emphasis in Together for Mental Health was on early intervention and building resilience. Ironically, the drift seems to be in the opposite direction. CAMHS referral criteria are ever tightening towards diagnosable mental disorder which happens later in the trajectory and does not focus on resilience but on deficiency.

3. There are no resources within CAMHS dedicated to early intervention.

4. The other services that offer early intervention are very limited and inequitable across Gwent. There is some child mental health expertise in Monmouthshire Flying Start (2 days of child psychotherapy) and in Torfaen Flying Start (2.5 days of clinical psychology). Where it is available it is highly valued and makes a big difference to nursery nurses/health visitors in the understanding of early mental health.

5. Other services which can be identified as early intervention are localised. The FIT (Family Intervention Team) in Caerphilly works with children and families before other statuary services become involved. The service is hosted by Action for Children and lead clinically by a clinical psychologist (ANUHB) – a good example of partnership working. Each intervention is informed by a psychological formulation

and time limited. The external evaluation of the service has shown the high social economic value – saving £7 for every £1. An audit of the work showed that for 36 referrals requesting an ADHD assessment only 2 went on to a full assessment, thus, saving core CAMHS a huge resource. Despite this, statutory service have not sought to roll this out. Innovative practice and services rely on short term project money and are not embedded within core services.

6. It is essential that children's emotional **development** is at the core of services dealing with children's mental health. This may sound like an obvious point but a developmental approach is not at the centre of CAMHS. The direction of drift is more and more towards assessment of disorder. The focus is **not** on early intervention nor on emotional **health**.

7. We know from the literature what creates emotionally healthy human beings who can form rewarding relationships, regulate emotion, and fulfil their learning capacity. Health attachments are the building blocks for this. If we believe in early intervention we should be front loading our services. The evidence is compelling (Waves report; Allen report; Fernivall, 2011; Scottish Attachment in action; Early Intervention Foundation). However, adherence to a medical model of 'health' care requires deficiency and disorder to attract resources.

8. The is a growing body of evidence from neuroscience research that demonstrates the way the brain is structured to develop healthy attachments in a dyadic relationship and how this impacts on the development of the child's emotional, cognitive and physical health (see the work of Porges, Baylon, and Shore).

Access to community specialist CAMHS at Tier2 and above for children and adolescents with mental health problems, including access to psychological therapies.

1. Access to CAMHS services is becoming increasingly difficult. The ever raising of the bar to access services means services are becoming driven by urgency and risk. More and more services are dealing with the 'risk' and the 'urgency' rather than with the people in front of them and their life situations.
2. The criteria are based on one view of children's mental health which i focussed on determining 'disorder'. There is a whole debate as to whether this is a useful/ethical endeavour.
3. The referral criteria are unreliably administered and are changeable across time, person and geographical area.
4. So, referrers are finding it more difficult to access CAMHS. There is little attempt made to measure which referrals are rejected and what happens to the children once rejected. It is even harder to get an accurate picture of the number of potential referrals where the referrer has decided 'not to bother' because previous experience tells them there is no point. Subsequently, there is a huge, masked unmet need.
5. Even for those referrals made and accepted children and families and to be able to make use of the traditional 'clinic' based delivery of service which does not suit some of the most vulnerable, complex and traumatised families. Reaching out to these families in a more proactive/creative way is not possible

with the pressure of target driven waiting times and the capacity/demand imbalance.

6. Access to appropriate psychological therapy is patchy. Single modal therapy has limited use (e.g., CBT). Clinicians need to be skilled in multi modal therapies and able to adapt their input in a responsive way. The children and families seen come with layers of trauma (often trans-generational), the time and skill required to allow a robust change of trajectory for a child is often not available.
7. Finally, social media could be used beneficially to reach young people as this is a favoured communication and learning style. Simply having a sophisticated and interactive, informative website would be a good start.

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

1.There are examples of services which have CAMHS professionals embedded within but these are specialist posts. In Gwent we have 2 psychologists working with Looked After Children and paid for by the local authority. We also have psychologists within third sector organisations (MIST, FIT, Skills for Living). These roles have shaped the services they work within and the benefit is two ways since they also bring a difference to the core services from which they come and invite innovative practice and question traditional practice.

2. A model of consultation and network meetings used in Gwent by the Child and Family Psychology services allows a reaching out to other professionals to help them in their work with children. This is based on the philosophy that children are best helped within the contexts in which they live their lives and that is where the difficulties arise rather than a 'within' child problem model. Despite excellent evaluation of this work, it is unseen by the organisation which does not allow the recording of this work on the existing data systems which are 'patient/contact' driven.

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

1. In population terms there is a clear disproportionate resource given to adult services compared to children's services.
2. The way the PCMHSS were operationalised demonstrates the lack of priority given to children's needs – adult mental health nurses expected to work with children and families. For example, Torfaen PCMHSS only has 0.5 wte worker dealing with all the child referrals.
3. There has been no training to education/Social Services on the Mental Health measure – they are largely unaware of the implications of this.
4. The closure of the Education al Psychology course will have a big impact on children's well-being in schools and therefore an impact on CAMHS.
5. Given the wealth of literature demonstrating the economic and humanitarian impact of front loading resources to early development the answer is a resounding 'no' priority is not given to children's mental health in the allocation of resources.
6. Gwent has no services within paediatric health services despite having demonstrated the value of psychological models with diabetes, Cystic Fibrosis, feeding, encopresis.

7. Any resources to CAMHS are allocated based on the medical model of diagnosis rather than focussing on a normative model of healthy psychological functioning which needs to begin in schools and the communities in which children live.

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

There is significant local variation across Gwent.
Services have different reputations across South East Wales.

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

Feedback from parents suggest it is hard to get clear advice as to where to go in an emergency. A and E is the fall back.
The on call psychiatric assessment for children admitted into hospital are inappropriate and lack psychological understanding of children's mental health and only have a psychiatric lens with which to understand the complex needs of children.

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

1. Services are organised around traditional health models **not** around children's developmental needs or around what they tell us they need/want. CAMHS is structured in the same way as physical health models of care with doctor and nursing hierarchies. Often based on tradition and history – not designed with a vision for to promote psychological and emotional health. We need staff who can negotiate safe, nurturing relationships who understand the importance of attachments as a basis for growth, can engage young people in meaningful activity within a living context, and are psychologically minded so all interactions are mindful and therapeutic. This requires a high level of expertise and formal accreditation in specialist child-focussed therapies.

2. Children tell us they care a lot about the physical environment. It needs to feel safe, welcoming, private but not too formal.

3. Gaps in service are not easily identified because children and young people do not have a voice politically.

4. The issue of ADHD diagnoses needs to be addressed. A huge amount of resource revolves around the delivery of a diagnosis which is itself controversial. Parents believe they need to pursue this in order to gain help and support for their children. This is a culture which should be challenged.

5. We should be working to make the contexts in which children live and learn more psychologically minded so positive emotional health is a driving focus in schools, clubs, social services, housing agencies. The health of the community is a target.

6. Children may be admitted to adult wards which are not resourced to deal with children's needs at any level.

Any other key issues identified by stakeholders

CAMHS is a version of Adult Mental Health services which are a version of physical health services but this may not be the best way of delivering a resource to children and their families to promote psychological health and resilience. If we step away from existing services and ask how we would design such a service the first step has to be about promoting positive attachment relationships. Human beings' healthy growth depends on this. If a person has experienced secure enough attachment they can regulate themselves emotionally, learn and experience empathy.

Psychologically minded universal service based o the importance of positive attachments. Nurseries, child care provision working with an understanding of children's emotional development, normalising responses to adverse life events and understanding these in the context in which they occur.

At the next level when problems arise the context is worked with by staff who can work across therapeutic modalities adapting the approach to the level of complexity and to the individual.

The vision of promoting resilience in Together for Mental Health will need a different and innovative structure to be realised.