National Assembly for Wales

Children, Young People and Education Committee

CAM 36

Inquiry into Child and Adolescent Mental Health Services (CAMHS)

Evidence from : Action for Children

1 Action for Children-Gweithredu dros Blant

Action for Children-Gweithredu dros Blant speaks out for the most vulnerable and neglected children and young people in Wales and the UK. Through our community based services we support children and young people to break through injustice, deprivation and inequality, so they can achieve their full potential. Action for Children helps more than 250,000 children, young people and their families through more than 650 projects across the UK. We also promote social justice by lobbying and campaigning for change.

2 Summary

2.1 Key points:

- Across Wales there are some examples of excellent early intervention services for children and young people with mental health problems, yet access to these services remains patchy with children and young people either going without or increasing the pressures on services at higher tiers of need
- In addition, access to specialist CAMHS and psychological therapies is increasingly restricted for many children and young people in Wales
- There needs to be a national mechanism for validating and sharing good practice and innovation, particularly in relation to early intervention and approaches that bridge the gap between levels of need
- There needs to be an investment in early intervention and a more co-ordinated and confident response by Health, Social Services and Education towards a joint commissioning process to funding services at a core level
- The voice of service users needs to more transparently inform decisions on service design and resource allocation.

2.2 Action for Children – Gweithredu dros Blant services from South East Wales, South West Wales and North Wales submitted evidence to this consultation response. They provide support to vulnerable children, young people and families in a diverse range of settings including young carers services; family support services within Families First; therapeutic support service for looked after children; and a multi-agency assessment and Intervention Team providing short term intervention for recently emerging emotional and behavioral problems.

3 The availability of early intervention services for children and adolescents with mental health problems

3.1 Across Wales there are some examples of excellent early intervention services for children and young people with mental health problems and their families. Over the past few years these services have worked to produce a robust evidence base. Yet access to these services remains

very patchy. This means that in some areas the availability of early intervention services for children and adolescents with mental health problems remains scarce.

3.2 Barriers persist to spreading good quality, effective service models across geographical boundaries. It would be helpful to have clear ways to bring strong service developments together for consideration for rolling out nationally. Currently, the expansion of service models appears haphazard and unclear, depending largely upon chance rather than a systematic process in which innovations can be capitalised on for the benefit of children and families. Evidence is available about which interventions work. This needs to feed through to commissioning.

Early intervention practice example: Action for Children's Family Intervention team (FIT) model

Action for Children – Gweithredu dros Blant' Family Intervention Team (FIT) in Caerphilly works with children and young people aged 5-14 and their families. They provide a multi-agency Assessment and short term intervention for recently emerging emotional and behavioural problems.

Action for Children's Family Intervention Team (FIT) in Caerphilly works in conjunction with Aneurin Bevan Health Board. The service model incorporates home visiting with a collaborative, individualised programme tailored to the family's needs. Due to the Psychology and Systemic Psychotherapy input, this is based on psychological models so that families have access to the same models that they would access in CAMHS but in a way that fits with an early intervention model and their needs at the time.

Taking a family strengths approach rather than a individual child problem focussed approach means that the child or young person's problems are seen in a normative, contextual, developmental, relational way rather than fixed within child as in a diagnostic medical model.

The service works effectively with other agencies. For example where a referrer or parent has a query about ADHD, the FIT service sees the family first for a 12 week intervention. The effectiveness of this response has led to a reduction in referrals to CAMHS.

3.3 Effective services are currently subject to spending cuts. For example, our FIT service has a proven track record of success but has been subjected to staffing cuts which have impacted on the effectiveness of its delivery. A major issue has been the increase in waiting times, going from an average of 3-4 months in 2011, to around 10 months currently. This in turn is likely to impact on CAMHS services at higher tiers as children require more crisis responses and more complex interventions having being failed at these early points.

3.4 There needs to be an investment in early intervention and a more co-ordinated and confident response by Health, Social Services and Education towards a joint commissioning process to funding services at a core level. An effective commissioning process that ensures consistency cannot be based on short term competitive tenders or time limited grants.

3.5 There are currently barriers to recognising and promoting innovation and effective practice, particularly when regarding home grown services.

3.6 Whilst intended to serve children and young people as well as adults, we have concerns that some primary care teams delivering part one of the mental health measure are minimally trained, inexperienced and not confident in working with children. Much more training and supervision is needed to develop these teams to deliver the primary mental health care that vulnerable children

and young people deserve. That said, many child mental health professionals within health boards are working hard to try to provide this, in addition to their core jobs.

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

4.1 Access to specialist CAMHS and psychological therapies is increasingly restricted for many children and young people in Wales. This is a huge worry to professionals and families. Part of the problem lays with the way that mental health difficulties are defined and understood. Psychiatric diagnosis is generally assumed to be the best way to describe psychological need. Hence access to CAMHS is restricted to those who are willing to pursue a medical understanding of children's distress. This means we overlook the enormous psychological needs of children who have experienced trauma, abuse, neglect, attachment difficulties and losses. Yet these needs are now well known to be strongly linked to the development of significant psychological dysfunction and mental health problems in later life.

4.2 For instance, children in the care system are some of the most vulnerable in society, with very poor prognoses in terms of mental health problems, relationship breakdown, offending, social exclusion, joblessness and removal of their own children into care. Yet when referred to CAMHS these children are commonly denied a service as they are not considered to have a diagnosable mental health problem. These children are excluded not only because their responses to catalogues of adverse life events are not considered to constitute significant needs, but also because CAMHS struggles to find the time to work in partnership with the broad network of agencies that have been involved. As these children move around foster placements, which commonly break due to the extreme challenges of caring for children with such significant and complex needs, CAMHS often switches the professionals and teams caring for them as patch boundaries are crossed. These kinds of practices vastly limit the chances that such children can engage in the help available. This limits children's capacity to access the help they need.

4.3 Mangers in some of our parenting projects spoke about it becoming more difficult for parents to access CAMHS services for children and young people. The requirements on agencies to provide extensive assessments and information are burdensome and waiting lists are long. CAMHS appears to have become a service which offers diagnosis but little in the way of therapy for children, young people and their families. Partly this is because Primary Mental Health services are underfunded meaning there is a patchy and unsatisfactory service at an earlier point. This in turn leads to too many people seeking access to higher tier services and then being screened out as unsuitable.

4.4 For example, in one local authority the CAMHS criteria for acceptance of referrals have been tightened significantly reducing the number of children and young people entering the service. This has a knock on impact on early intervention services who are receiving referrals for children and young people with higher levels of need. Long waiting lists for assessment and even longer for intervention have led to third sector services being asked to hold a service user while they are waiting for an appointment. Yet the sharing of good practice and innovative models can help agencies to work together more effectively to bridge the gap between early intervention services and those targeted at higher tiers of need.

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

5.1 In the main, we believe CAMHS is poorly embedded in other service settings. This is a significant problem given the way the complexity of children and young people's lives meaning that co-ordinated, multiagency approaches are so often required.

5.2 CAMHS professionals could more efficiently help those other professionals already close to a child, working with them to improve their mental wellbeing.

5.3 One area that is difficult is where a referral has been made both to Children's Services and to CAMHS. Too often Children's Services will assume that as a referral has been made to CAMHS there is no role for them unless there are safeguarding issues. This lack of join up creates problems for children and young people. There are also persistent gaps in provision, for example post diagnosis such as with ASD Asperger's, OCD and with young people with sexually inappropriate behaviour. Diagnosis is usually followed by educational input in two or three sessions. There appears to little or no support for siblings/families in these circumstances.

5.4 Some of our managers pointed to a lack of collaborative work between CAMHS and the third sector, particularly when it comes to core funding and the commissioning of evidence-based, innovative early intervention projects. That said several of our services did give examples of good working relationships with CAMHS staff, particularly with CAMHS outreach workers whose role is to provide support to colleagues in other agencies who are working with children and young people with lower level mental health issues. For example, one service benefits from regular consultation from CAMHS, with a Psychiatrist attending their team meeting once every two months.

5.5 In those instances where CAMHS professionals are embedded in other services the outcomes can be exceptional. We were given examples of CAMHS professionals leading multi-agency commissioned and funded teams, which have produced excellent outcomes and value for money, (for example MIST in Torfaen), however, again such innovations are small, patchy, and often fail to fulfil their potential to impact across larger populations in Wales.

MIST is a 'wraparound' therapeutic project established in 2004, managed by Action for Children - Gweithredu dros Blant and based in Torfaen. It works with looked-after young people, aged 11–21, who present with such significant challenging and risk-taking behaviour that their placement stability is considerably and regularly threatened. These are young people with complex needs requiring considerable resources to support them and maintain their safety.

The programme is financed via funding streams from Health, Education and Social Care and the contract is managed by the local authority (Social Services and Education) on behalf of all funding partners. It operates organisationally within a multi-agency context.

MIST provides an intensive mental health service to adolescents who either have been in 'out of county' residential care or are at risk of being placed in residential care due to their emotional and behavioural problems. Its principal operational focus is to offer an intensive support and intervention service to the young person's placement, whether this is with family members or in foster care, and as a part of this to work intensively with the young person. With the resources available to the programme, it operates in three ways by: providing and supporting therapeutic foster care placements; supporting already established foster care placements; and managing family-based care.

The programme supports carers in a variety of ways, including a 24-hour on-call service, on-going advice and supervision, training and education. The service works therapeutically with the adolescents, utilising a variety of individual psychological therapies and activity-based inputs such as drama, music, art, as well as practical support, befriending and learning support, which are guided by a psychological formulation of each young person and their system. This work with the young person involves regular meetings throughout the week in a variety of locations. Clinical features of the programme involve attempts to promote trust, self-esteem, self-value, autonomy and emotional literacy. It undertakes this by each young person having a therapeutic contract with distinct and specific therapeutic aims for each

individual. These aims are reviewed constantly, both with the young person and with the team. Different activities and supports are provided in order to meet the therapeutic aims.

5.6 In our experience many CAMHS professionals want to work in this collaborative way, but are restricted from doing so by the intense demands placed upon them within mental health services to prioritise waiting lists and performance targets. This prohibits the most effective use of CAMHS resources.

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

6.1 Allocation of resources to CAMHS is proportionally lower than adult mental health services when population numbers are considered.

6.2 It is unclear the extent to which the allocation of resources within CAMHS is driven by what is clinically effective or cost effective. Instead too often resource allocation appears to be based on historical patterns and which professionals are heard when decisions are being made. A more transparent process with equal opportunities to bring forward ideas to improve services is needed. This requires open minded, inclusive leaders who are prepared to prioritise what is good for children and families above what has gone before.

6.3 A strong user voice at the centre of resource allocation would be very useful in helping to make this shift.

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

8.1 Generally our services believe that CAMHS are good at providing emergency responses. Difficulties and inconsistencies become apparent on following on these emergency arrangements with longer-term, consistent support.

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

9.1 CAMHS could greatly improve its engagement with children and young people in shaping the way services are designed and delivered.

9.2 CAMHS services are often delivered from clinic bases, sometimes in sites which hold great stigma and fear for young people. We believe there are opportunities for CAMHS to be delivered in ordinary community settings and to work to flexible times that suit young people. CAMHS should also routinely offer drop-in services which are less daunting for some adolescents.

9.3 We would like to see peer-to-peer contact and support provided to empower young people to support others. CAMHS should work in partnership with young people and put them in the driving seat about their own care and what helps them. It seems that young people are still often 'done to' and their potential capacity and expertise is underestimated. Having more open minded and creative approaches to providing services for and with young people would radically enhance their engagement, and be a positive intervention in itself.

10 Any other key issues and contact details for further information

10.1 We believe that the Welsh Government should offer a political commitment to provide vulnerable children, young people and families therapeutic services across Wales.

10.2 Thank you for this opportunity to speak about CAMHS provision. This is a very important area of service provision and constitutes a huge opportunity to make significant positive impacts upon vulnerable children and young people's lives.

10.3 We would be pleased to discuss these issues with the Committee in more detail and to facilitate opportunities to discuss these issues with young people directly. We would also be pleased to arrange a visit to one of our support settings to meet young people and staff and discuss their experiences of emotional and mental health support.

10.3 If you would like to discuss this or any aspect of this response further, please contact Rhea Stevens, Campaigns and Public Affairs Officer for Wales, on rhea.stevens@actionforchildren.org.uk or 07889 603962.

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