National Assembly for Wales

Children, Young People and Education Committee

CAM 41

Inquiry into Child and Adolescent Mental Health Services (CAMHS)

Evidence from : Dr Charles Twining OBE

The comments below arise from my recent experience supporting a parent whose child is receiving services from the local CAMHS. I am a retired clinical psychologist with over 30 years experience of work in the NHS, particularly in respect of services for older people. Currently I am a member of a local authority Adoption Panel as an adopted person. I offer two brief comments below.

Dr Charles Twining OBE

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1. Understanding everyone's views.

Families and children do not necessarily share the same view of situations and events. Both views matter. However a simple traditional medical outpatient model does not work well to achieve this. My own experience of developing Memory Clinics for those with cognitive dysfunction in later life may have something to offer here.

Both patient, in CAMHS the child, and carer, most often the family, must be heard. This needs to happen both separately and together to respect the privacy and the autonomy of all. This must be reflected in routine clinial practice. Appointmtents need to allow time for child and family to have both separate and joint time with the clinician(s). Some CAMHS practitioners use telephone contact with the family prior to the clinic appointment to achieve this. An alternative may be for there to be two professionals running the clinic jointly.

2 Interagency Working

Helping children who have mental health problems is a multi-agency endeavour. In this regard it has much in common with mental services for older people. The guiding principles for such services includes crucially the need for interagency communication and cooperation. This is best achieved by having services where the key agencies of health and social care are **co-located** with a **single operational mangement**. This is not true for the CAMHS I have observed.

Mostly communication is done through the parent who expected to carry the repnsibility for contacting other relevant agencies. This does keep the parent informed but often imposes stresses from having to be the go-between. It may be illustrated by the figure below.

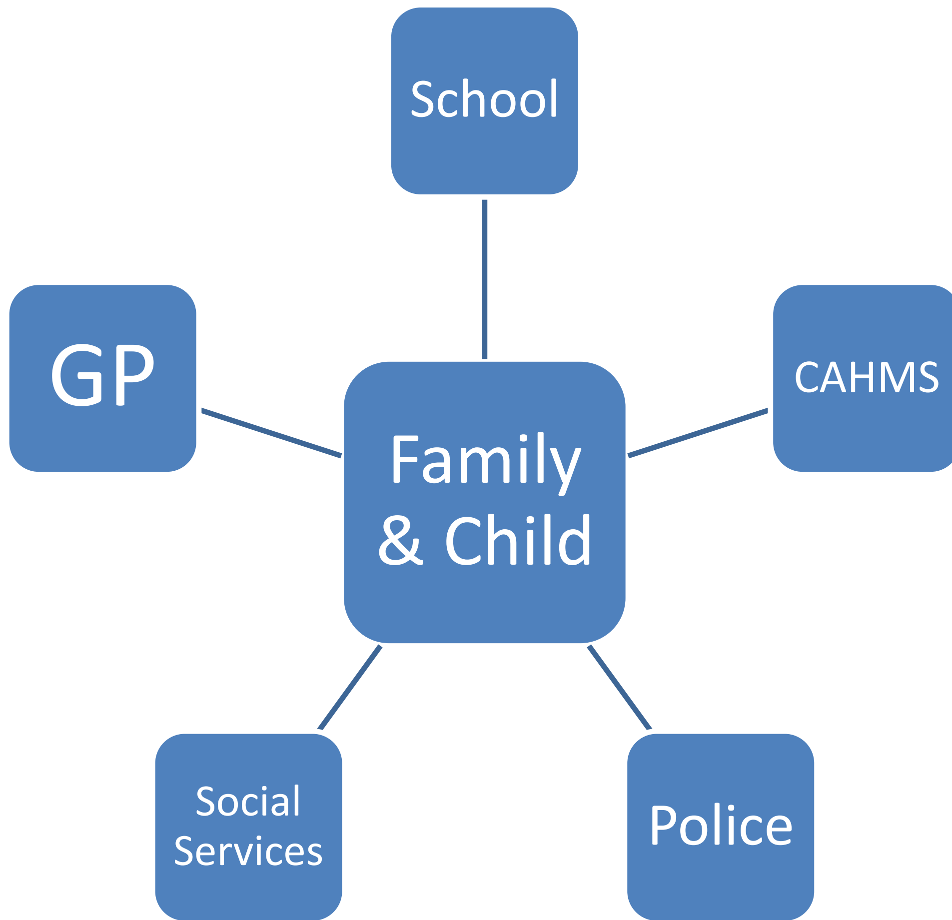

Fig 1

The current simple model where almost all communication is via the parent.

An alternative model (Fig 2) where the agencies actively communicate, led by a key working allocated to each child creates a network of support for both child and parent. It reduces the risk of the most vulnerable not getting the support they need. It also spreads the burden across the team who can discuss cases with one another on a routine regular basis rather than solely through a formal case conference.

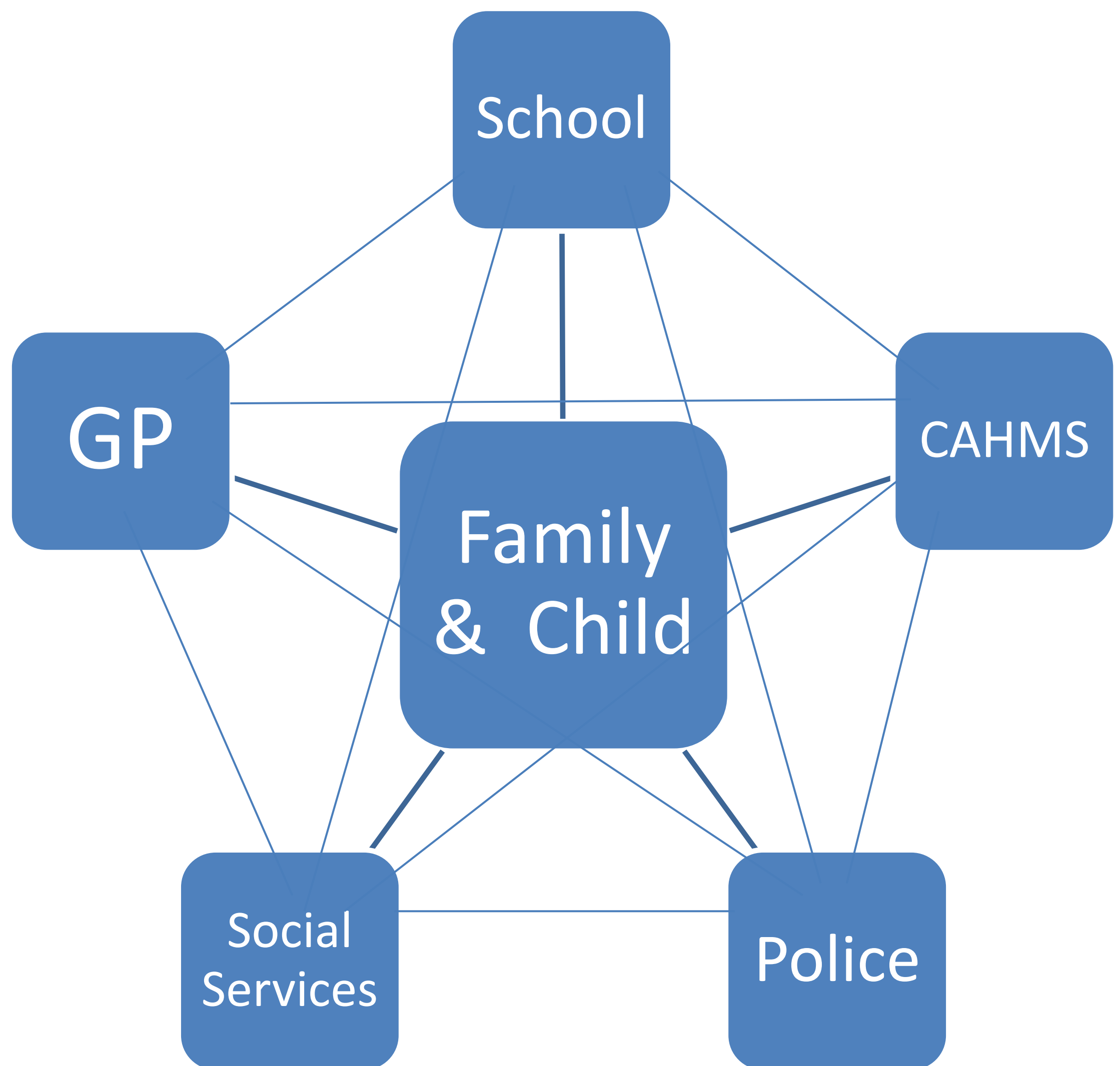

Fig 2

A network model where all agencies communicate with each other as well as through the Parent & Child, creating a network of support