National Assembly for Wales
Children, Young People and Education Committee

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Inquiry into Child and Adolescent Mental Health Services (CAMHS)
Evidence from : CAMHS Clinician working in South Wales

I write as a concerned CAMHS clinician working in South Wales and will confine my comments to the service provided by the S.Wales CAMHS Network in the Health Board areas of ABMU, Cwm Taf and Cardiff & Vale.

- **The availability of early intervention services for c&yp with mh problems.** There appears to be a range of services working at the early intervention level which have emerged as a result of the Families First initiative. The Team around the Family model aims to work with those children, young people and their families whose needs are below the threshold for specialist services from CAMHS or Children's Social Services. However the title TAF does not mean the service offered is the same. Often it is simply a vehicle for attempting to get other services to become involved with families identified by them. Although Families First funding has helped in the establishment of various early intervention services there are substantial variations across this part of Wales and overall major gaps in provision are evident in every area. For instance access to Parenting Courses, school based initiatives to support challenging young people, etc.

- **Access to community specialist CAMHS at tier 2 and above for c&yp with mh problems including access to psychological therapies.**

  It is the simple case that CAMHS in Wales has never received the financial investment required to meet the needs of c&yp with mental health difficulties. Occasional 'gifts' such as the recent £250k for use on specialist eating disorder services is a typical example of how services have been invited to develop. The sum of money is too small to make much difference to what is therapeutically available and too simplistic in believing it will produce service change of any duration. However it will manage to distort services for

a period in the direction of c&yp with eating disorders to the detriment of other potential service users with less clearly defined but nonetheless severe mental health difficulties eg young people who repeatedly and compulsively engage in high risk behaviours such as self-harm, entering exploitative relationships, substance misuse etc. etc.. I believe this is in part a product of Welsh services being too heavily shaped by the medical model and psychiatrists. This professional dominance acts as a brake on the financial and creative investment in more psychologically framed services. Most of the mental health difficulties of young people will benefit from a psychological therapy sometimes with a pharmaceutical element that requires monitoring but the key element is usually in helping the young person to establish a means of managing their own areas of difficulty more effectively.
Psychiatrists are very expensive professionals whose ongoing role in the management of most of the mental health difficulties of c&yp is minimal (except at the most severe end) and whose conceptualisation of mental health difficulties is too diagnostically organised. This inevitably means many many young people with significant mental health difficulties cannot get past the psychiatric thresholds and filters operating at tier 2 CAMHS. However it would be equally inadequate to simply replace psychiatry with teams of therapists seeing young people individually as many of the difficulties they experience are hugely influenced if not caused by the social and physical environments in which they live. Significantly better links with schools and Children's Social Services, or even joined up teams as for adult clients of mental health services, could improve the services provided to young people who are being looked after or placed in non-mainstream schooling.
The medical domination of service orientation has resulted in two severe service inadequacies for c&yp. Not enough skilled therapists to respond to those who could be assisted through individual or family based therapies and too much of a service focus on the 'pure' mental illnesses of c&yp where biology and genetic factors are major factors but are nonetheless relatively rare in young people.

- **The extent to which CAMHS are embedded within broader health and social care services.**
  CAMHS is not even well linked into the social care services let alone embedded. The service languages, legislative agendas and schedules appear to force them apart rather than into collaborative working. The issue is I

believe another case of diagnostic criteria determining which service is left with often sole input into the support for a yp. Troubled yp without a diagnosable mental disorder are not regarded as warranting a CAMHS input while yp whose symptoms are diagnosable are frequently left to CAMHS even though social care factors are apparent.

It is also vital to recognise the huge role played by Education where even the troubled young people spend much of their time. However the educational agenda for schools is clearly a first priority and the capacity to support and address the welfare needs of some of their pupils inadequate. A greater involvement of CAMHS in and around schools would perhaps help to create more imaginative approaches to the needs of young people. Some schools have developed whole school approaches to support the emotional wellbeing of their pupils but this type of venture is not coordinated across LEA areas.

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

  It is unlikely CAMHS receives appropriate priority in service planning since it is often the case that young people despite early signs of emotional and mental health difficulty will continue to attend school and even socialise and therefore are not regarded as being in great need. However it has been shown that early intervention is more effective than later intervention when difficulties and patterns have become entrenched and an appropriate allocation based on predicted long term gain rather than on current level of need would be a justifiable sea change in the way allocation of resources are made.

- **Whether there is significant variation in access to CAMHS across Wales.**

  A common service template has only very recently been developed for CAMHS in Wales by the Delivery Assurance Group of Welsh Government. Notwithstanding its preoccupation with diagnosable conditions as opposed to 'need' arising from mental health difficulties it does for the first time lay out a service specification of a kind that would reveal the quite unsupportable differences in service arrangement and provision. This is partly related to the way in which Welsh Government has funded service development in a uncoordinated and often knee jerk manner eg £250k for Eating Disorder services without any consultation with CAMHS as far as I am aware of whether this was the best use of such a sum of money in CAMHS. The issue of rurality is also a factor that has never been fully recognised in service arrangements and provision.

So the simple answer is that yes there is huge and persisting variation in the service models and delivery of CAMHS across Wales.

- **The effectiveness of arrangements for c&yp with mh problems who need emergency services.**
  NO COMMENT
- **The extent to which the current provision of CAMHS promoting safeguarding, children's rights, and the engagement of c&yp; and**
  I believe services are sufficiently aware of these areas of practice. However the different perceptions of CAMHS and Children's Social Services about the level of safeguarding concern can be a serious point of difference between the services.
  The training provided by the LSCBs is also frequently very poor and unlikely to greatly improve practice or understanding across agencies.
- **Any other key issues identified by stakeholders.**
  NONE