National Assembly for Wales

Children, Young People and Education Committee

CAM 20

Inquiry into Child and Adolescent Mental Health Services (CAMHS)

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1. The availability of early intervention for children and adolescents with mental health problems

Although any child from any background can develop serious mental health problems, there is no doubt that poor mental health in children is strongly skewed to populations in poverty, with particular groups at very high risk. These groups include children:

1. living in extreme and long term poverty
2. affected by racial discrimination, including Gypsy-Traveler and migrant families
3. affected by drug & alcohol abuse
4. in the public care
5. with disabilities
6. living with violence or neglect
7. within the criminal justice system, including those incarcerated
8. who are homeless, including those in domestic abuse refuges and those living rough
9. who are carers
10. in the asylum system
11. not in education or training

They are children who in social services parlance would meet the definition of "Children in need". For the majority of such children several of these factors can be acting in synergy.

Early intervention could occur at any point when they are in receipt of health services in primary care, including school nursing and health visiting, or in CCH services (as children in need these children form the bulk of the population accessing CCH services). But these services themselves are profoundly under-resourced and are not prioritised in Health Board budgets throughout Wales. Whenever budgets are constrained Tudor Hart's inverse care law becomes more pronounced, and children like these, on the margins, have most difficulty accessing such care.[1] Thus those children with most need have least access to preventive mental health interventions by non-CAMHS NHS professionals, but acting at a CAHMS Tier 1 level. This is not the fault of individual professionals who are working in very difficult circumstances: for example Community Child Health (CCH) staff in Cardiff & Vale of Glamorgan provide CCH services with half the number of community paediatricians per head of population compared to their peers in Bristol[2].

Thus early intervention, when it exists at all, is often provided outside the NHS, and is thus not integrated into CAHMS or CCH services. It is patchy and ad hoc, with varying degrees of accessibility, and often run within short term programs, in specific localities, on time limited budgets. In some cases it is reliant on NGOs whose survival is parlous in the current economic climate – for

[1] Webb E. Children and the inverse care law. *BMJ* 1998:**316**; 1588-91.

[2] Benchmarking undertaken by Cardiff and Vale University Health Board – unpublished.

example the superb support provided to children who have been affected by domestic abuse by "Safeas", part of Cardiff Women's Aid, or the support provided to young carers by Barnados. Often children with early mental health problems are redirected to services such as Families First which were never meant to be providers of this kind of intervention. Many vulnerable young people in difficulty may only access youth groups and other safe havens provided as part of local government youth services; as these are largely non-statutory they are bearing a disproportionate burden of the budget cuts and are in many areas, e.g. Powys, facing decimation.

Attachment: Attachment disorders in very early childhood are a lifelong cause of poor mental health, drug and alcohol abuse, as well as risk markers for the poor establishment of relationships in adulthood (including as parents), poor educational outcomes, unemplyment, and involvement in crime. **This comes at a HUGE cost, socially and economically, to Wales. It is not even mentioned in the most recent All Wales Strategy**.

Currently there is very little input, if any, into attachment from CAMHS at a preventive level. If CAHMS are involved it is when older children are presenting with later serious problems in consequence of this, such as serious aggression and delinquency, or autistic like presentations, or depression and serious self harm. In service terms there needs to be:

1. CAHMS partnership with other agencies, including LCSBs, in developing, delivering and evaluating early parenting programmes to families at risk of attachment problems. The training and knowledge of CAHMS proefessionals in emotional development is crucial to developing effective interventions

2. A comprehensive nationwide programme of interventions by CAHMS services to work *intensively* with families with very young children where there is clear evidence of disordered attachment. (The only work I am aware of is in Gwent, where Aideen Naughton, a community paediatrician, developed an intervention with a psychologist with such families[3].)

School Counselling. Wales is the first country in the UK to introduce counselling into all secondary schools and there is currently an expansion into delivering a service to children in primary schools; this is an important development. It is an intervention for children in difficulty, and as such forms part of this agenda. Although many children have benefited, evidence is emerging that there are some problems. Counselling services is reliant upon a supportive head, which is not always forthcoming, rather than an infrastructure which integrates counselling within education. Lack of privacy can be a problem, with children having to wait in a corridor. Occasionally there is a complete lack of support or understanding from teaching staff.

Example: a child who had problematic behaviour, because of domestic abuse at home, was labelled as wishing to get out of lessons, so trying to access a counselling session became very difficult for that child[4].

In addition many of the most vulnerable children may not be accessing education enough (or at all) to access counselling. Enormous numbers of them are not in school because of bullying, and the bullying experience they have had, both within and out of school. Bullying has been one of the main themes that counsellors have identified, but they won't pick up the most severely affected children if these children cannot, or won't, attend in consequence of it. These services also remain busy and

[3] Keeping the Baby in Mind Infant Mental Health in Monmouthshire Dr Aideen Naughton Safeguarding Children Service (Power point presentation at: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&ved=0CEYQFjAE&url=http%3A%2F%2Fwww.childreninwales.org.uk%2F19176.file.dld&ei=YzIOU4b3MKPI0wWlr4DADg&usg=AFQjCNEBKJ8zoVbQ42mVJ2jRnVMNKbqf8w&bvm=bv.61965928,d.d2k

[4] Personal communication, Rebekah Burns, Cardiff 'Safeas'

many children wanting to access them are unable to do so. In addition a serious lack of NHS CAMHS means that children in great distress, who even 10 years ago would have seen a clinical psychologist, psychiatrist or family therapist in CAHMS (for example a child with an abnormal grief reaction, or a child on the Autism Spectrum with anxiety in consequence of some life change) are now directed to school counsellors who do not have the skills or training or infrastructure to deal with the severity or complexity of many children.

2. Access to community specialist CAMHS for children and adolescents with mental health problems

This question begs another – what is a mental health problem? The serious under-resourcing of CAMHS has forced these services to become very criteria driven, narrowing their eligibility criteria for whom they will and will not regard as their remit year on year, with many only accepting referrals for established "mental illness", as described in DSM5 or ICD10. If they can't find one they reject children as not their business, and thus are increasingly excluding mental disorders such as autism and ADHD (which have traditionally been part of CAHMS and are clearly stated to be part of the All Wales Mental Health Strategy), children with emotional and behavioural problems, and even children who have attempted suicide or shown other serious self harming. The result is that children identified as having mental health problems (as opposed to mental illness) receive little or no early intervention from NHS CAHMS services

Children can be distressed, anxious, in fear and in despair without reaching criteria for a mental illness. But if children are experiencing such levels of distress, it **is** part of the CAHMS remit to help them, along with other services, in an integrated way. It's right not just ethically, but practically, because children, whose lives are in a mess with very complex issues in their background, are at very high risk of developing serious mental health problems later in childhood or in adulthood. This is not simply a case of human cost to these individuals and their families, but economically to the NHS, to the Criminal Justice System, to Local Authorities, and to Welfare budgets. Cardiff and Vale Health Board faces the most serious problem of under-resourcing of CAHMS in Wales, a problem now unsurprisingly compounded by difficulties recruiting and retaining staff. The city serves a very complex population: the highest numbers of asylum seekers in Wales; the largest Gypsy Traveller site in Europe; many migrant families including Roma from Eastern Europe; many families fleeing violence, either within LA homeless hostels, or in one of the many domestic abuse refuges in the city. There is also a large number of Black and ethnic minority families, many affected by disability and poverty, with poor access to mainstream care across the board. If the situation here is not dealt with as a matter of urgency, the human cost to these children and their families, and the price to be paid economically downstream, is not to be countenanced.

The inverse care law built into service structures and policy is exacerbated by the culture in many CAHMS; child psychiatrists know the world out there is seething with difficulty, and they shelter in clinics rather than connecting with the wider community and identifying need. If a child doesn't turn up twice in a row, they are discharged. Most of the people who don't turn up twice in a row are children in very disadvantaged families - single parents, carers with physical or mental illness, families with disabled members, families with no transport, families who cannot negotiate the system for various reasons – can't read, can't speak English, have learning disabilities etc. This practice is a good way of controlling workloads, but leaves children in danger. In child death reviews it has been identified as contributing to suicide[5].

No progress will be made unless CAMHS are

1. Properly resourced

[5] http://www.hqip.org.uk/assets/NCAPOP-Library/CMACE-Reports/1.-May-2008-Why-Children-Die-A-Pilot-Study-2006.pdf

2. Move from an elite, crisis-orientated, diagnostic agency to a more integrated, problem-solving trajectory of care.

(2 cannot happen without 1)

3. the extent to which CAHMS are embedded within broader health and social care services

In the main there are very poor links between CAHMS and other services. This does vary between different health boards and local authorities, and is dependent on not just the CAHMS services but other partners, who all face different pressures and problems depending on where they are and the level of need and unmet need in the population they serve. However where CAHMS are managed and funded separately from other child health services, as is the case in the South Wales network, links are particularly poor.

There are examples of good practice, for example the All Wales Tier 4 forensic CAHMS, but this is a well resourced service, with highly skilled motivated individuals with the time for this work built into their structures, systems and pathways.

4. Whether CAHMS is given sufficient priority, including allocation of resources

In general childrens' services as a whole are given inadequate priority across all the health boards in Wales. This is not new. Community based health services, including CCH and CAMHS, were badly served by the purchaser/provider split that followed the Health Service Commissioners Act 1993. This was compounded by health targets in the early years of the Welsh Assembly which were almost entirely adult focussed, with the result that there has been negligible investment in children's services: the exceptions are highly specialised services in crisis, such as tertiary hospital-based paediatrics, neonatal care, and in-patient adolescent mental health. Acute children's services have lost out to adult services, and community services to hospital care.

In consequence of this, neither CCH, nor CAHMS - services which have a huge shared client group within the population of children in need - have received funding or resourcing that bears any relationship to the services they are expected to deliver.

Currently CAHMS services are seriously under-resourced in Wales – at about 20-40% of UK nationally recommended levels of staffing[6].

5. Whether there is significant regional variation in access to CAHMS across Wales

Yes there is significant regional variation in access to CAHMS, but there will be other respondents better able to comment in detail on this issue.

6. The effectiveness of the arrangements for those who need emergency services

Despite the opening of the new in-patient adolescent units, facilities for young people with severe mental health problems are still inadequate across Wales. Following the latest Mental Health Act reforms, the numbers of young people placed on adult wards should be reducing; however according to Wales Online, based on a series of Freedom of Information requests, at least 38 under-18s spent 380 "bed days" on adult wards in 2011/12 in Wales[7], and the BBC, also following a

[6] Personal communication David Williams

[7] http://www.walesonline.co.uk/news/wales-news/2012/07/10/call-for-end-of-scandal-of-under-18s-on-adult-mental-health-wards-91466-31355310/

Freedom of Information request, reported 347 instances of children held in police cells under the Mental Health Act in England and Wales in 2011. [8]

This does not include children admitted to paediatric wars with severe emotional difficulty, often after serious self harm and attempted suicide, with whom psychiatrists decline to get involved, describing them as having behavioural problems. When paediatric staff feel that it is unsafe to discharge these young people they can be on paediatric wards for prolonged periods without access to appropriate care, and exhibiting behaviours injurious to other inpatients.

7. The extent to which the current provision of CAHMS is promoting safeguarding, children's rights, and the engagement of C&YP

Currently CAHMS perform poorly in these areas.

Safeguarding: It can prove difficult to engage CAMHS staff in safeguarding. Involvement in the broader safeguarding agenda requires a mental health promotion approach based on sound public health principles, with CAHMS staff, with partner agencies, engaging with the population as a whole, rather than simply responding to individual need. This is not a role for someone working in isolation in Public Health Wales, but an area of activity that requires engagement from CAHMS staff at all levels. Examples might include

- Supporting education staff in special schools for children statemented for Emotional and Behavioural Difficulties (many of whom have been affected by neglect, maltreatment, and developmental difficulties such as Speech and language problems) to transform these schools into truly therapeutic communities.
- Engaging with specific at risk communities such as, for example, Gypsy-Travellers or children in domestic abuse refuges, to develop community interventions to promote good mental health, and protect children from factors causing emotional harm.

CAMHS staff need in addition to be much more proactive in cases of frank maltreatment leading to emotional harm. Children identified as being victims of emotional abuse and emotional neglect are, like those children registered as neglected, poorly served and poorly protected by child protection systems. Abuse and neglect are processes, whereas the current approach, based on the need for thresholds before definitive action, is much more effective in responding to events. However CAHMS staff are uniquely knowledgeable and skilled to advocate for these children throughout the child protection process. This is rare.

Children's rights: Current CAHMS services are diagnosis focussed and overly medically modelled. They are neither child nor child-rights centred, and in consequence are poor at promoting the implementation of the UNCRC.

Although there are examples of good practice in respect of the autonomy, participation, and privacy of individual C&YP who manage to access the service, the rights failures relate to those children for whom the current systems and provision are completely inaccessible or inappropriate. These children do not receive the highest possible standards of care or achieve optimum mental health, and thus Article 24 is breached for them.

The lack of early intervention at Tier 1 and 2, a powerful example of the inverse care law as described above, threatens not just the lives of these children in the most serious way, but also the anti-poverty agenda and implementation of the UNCRC in Wales.

[8] http://www.bbc.co.uk/news/uk-20377493

Example: Early intervention for victims of abuse

" ……..

- *Child maltreatment has long-lasting effects on mental health, drug and alcohol problems, risky sexual behaviour, obesity, and criminal behaviour, from childhood to adulthood*
- *The high burden and serious, long-lasting consequences of child maltreatment warrant increased investment in preventive and therapeutic strategies from early childhood …"* [9]

The conclusions of this paper, exploring the public health consequences of maltreatment, are supported by the fact that the UNCRC has a specific article relating to this:

"*Article 39 (Rehabilitation of child victims): Children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society. Particular attention should be paid to restoring the health, self-respect and dignity of the child."*[10]

This sort of rehabilitation does not occur. CAHMS, who certainly used to include it in their remit (for example the comprehensive post-abuse service run throughout the 1990s by Mike Shooter Psychiatrist, Mike Davies Family Therapist, and Eddie Street Clinical psychologist, in the old South Glamorgan) now reject such children as not having "mental illness", despite the fact that many achieve thresholds for at least a CAHMS assessment[11]. Such children usually receive no intervention apart from intermittent involvement of a social worker, often junior, inexperienced, and untrained for the task. Children only receive more specialist intervention when they present with very serious problems, often delinquency or as perpetrators of sexual abuse to other children. Even then mental health rehabilitation is lacking unless they access highly specialised and very expensive Tier 4 interventions when often it is too late to be effective.

Engagement of C&YP: CAHMS fail at many levels.

1. They fail to engage with children who are referred to their services, but then not brought.
2. They fail to engage with children in the community who need help who they either reject as not their business, or who are not referred (there is a certain nihilism creeping into the practice of other professionals who have become disillusioned by their requests for help being turned down).
3. They fail to engage with at risk communities, for example children in EBD schools, children who are homeless, disabled children, NEETs etc. However there is plenty of evidence for the importance of engaging with these groups, and examples of good practice[12].
4. They fail (but are not alone in this) to engage with C&YP to promote their participation in planning of services

[9] Gilbert R, Spatz Widom C, Browne K, Fergusson D, Webb E. Burden and consequences of child maltreatment in high-income countries *Lancet* 2009. 373: 68 - 81

[10] http://www.unicef.org/crc/files/Rights_overview.pdf

[11] Webb E. Shankleman J. Evans MR. Brooks R. The health of children in refuges for women victims of domestic violence: Cross sectional descriptive survey. *BMJ*. 2001: 323:210-213.

[12] Mental Health Interventions and Services for Vulnerable Children and Young People. *Ed. Panos Vostanis.* London 2007. Jessica Kingsley Publishers

8. Other issues

Despite promises to the contrary, here has been no definitive survey on the mental health or emotional well-being of children in Wales. Such a survey is necessary both to allow comparison with other like regions, to assess need, and to monitor future progress. In addition, unless there is comprehensive disaggregation of data, such a survey can mask an enormous percentage of mental illness in specific deprived groups, such as those in care, homeless, learning disabled etc.

However such surveys are limited, as they only pick up children who have reached criteria for the diagnosis of a mental illness, but miss those with significant emotional difficulties who are at risk of developing serious mental health problems, either later in childhood or as adults, without intervention. It is crucial to know who are these children and how many of them are there. We know from the UNICEF Well Being monitor that the UK has a lot of distressed children[13], so any survey for Wales should aim to pick these up too.

[13] http://www.unicef.org.uk/Images/Campaigns/Report%20card%20briefing2b.pdf