National Assembly for Wales
Children, Young People and Education Committee
CAM 47
Inquiry into Child and Adolescent Mental Health Services (CAMHS)
Evidence from : Dr Mike Davies

Short Biography of: Dr Mike Davies, Consultant Psychotherapist and Trainer.

Mike is a registered UKCP Psychotherapist who for the last 13 years has worked as an Independent Consultant and Trainer specializing in child and family therapy and child mental. He worked in CAMHS for over twenty five years as a clinician and Operational Manager where he was instrumental in setting up specialist services for abused, looked after children and refugee families. He has published articles on subjects such as child abuse, refugee mental health, and 'looked after children,' and has contributed to numerous conferences and training initiatives. He has been producing independent assessments and 'expert opinion' for Courts for nearly 20 years and in over 400 cases. He is consultant to several projects and foster and adoption agencies where he runs surgeries for carers as well as providing assessments and direct work. He is a consultant to the South Wales University Community Counselling Project based in Newport. His predominant clinical interest is in the use of an attachment/systems therapeutic framework for working with maltreated and or traumatized children and their families/carers.

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

1.1 I was not aware there were any 'early intervention services' in Wales for children and adolescents with mental health problems. If there are already such services in existence and or there are plans for such an initiative I would be supportive of that.

1.2. I really approve of the idea of 'early intervention services' in CAMHS because it implies a systematic approach to the prioritising of cases – either because the seriousness of the case requires immediate intervention and or because a particular client group is targeted for attention. This would be an improvement on the current 'waiting list' system and the part played by serendipity.

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

2.1 CAMHS is still relatively unavailable for many families in our communities especially those in rural areas. This is because it operated an appointment-based clinic system where families are expected to attend for assessment. For some of the poorest or more marginalised families in our communities there are real issues to do with finance, logistics and sometimes organisation that present significant obstacles to attending clinic-based services.

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

3.1 As I now work independently of CAMHS and other agencies and have no involvement in strategic or other planning I cannot really comment on the success or otherwise to which CAMHS is embedded within broader structures. However, it is surely accepted wisdom that agencies, should work together closely at strategic as well as operational levels to improve services. From the 'outsider looking in' perspective that I now take there is a need for improvements at all levels. I frequently encounter a misperception of what the CAMHS function and service model is amongst other agencies. I feel this is because of CAMHS relative isolation and 'defensiveness'; it has constantly to account to referrers as to why it cannot provide a service, or how long the dreaded waiting list is for a particular case. I can see the benefit of CAMHS being more transparent and embedded in broader health and social care services.

4. **Whether CAMHS is given sufficient priority within the broader mental health and social care services, including allocation of resources for CAMHS**.

4.1 CAMHS was always considered the 'Cinderella' service in relation to adult mental health that held by far the bigger share of the budget allocated to mental health. They were also considered to be 'not a proper mental health' service like adult services who dealt with serious mental health disorders such as schizophrenia, psychosis, bi-polar disorder, and depression in large numbers compared to CAMHS. Historically it has always struggled to find its identity and place in relation to other larger and often more influential agencies. It struggles also because it doesn't have much kudos with fellow

health professionals or the major children's agencies such as Social Services or Education and as a result has tended to being somewhat marginalised or disconnected from other services. It seems to have been left to its own devices and apart from demanding more resources, seems content with that position. I do not however underestimate the demand. It is so overwhelmed with potential work it fears working closer with agencies because that may mean increased demand for its services.

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

5.1 During the last 13 years I have taken my work from a large geographical area including cases in south, mid and west Wales. I have very little experience of CAMHS and other services north of Aberystwyth. While there are significant variations in the size and availability of services much of this is due to the differences in population between rural and urban communities.

5.2 However, the narrative is the same wherever I have been; CAMHS is unavailable because of geographical reasons and or waiting lists; or irrelevant because there is a perception that services provided do not meet the need.

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

6.1 I do not have experience of the emergency services and therefore cannot comment.

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

7.1 I would like to comment on the latter part of this question

'*the engagement of children and young people'*.

7.2 Firstly I would like to say that I fully appreciate the pressure of work and that CAMHS is overwhelmed with referrals. I would also add I have encountered examples of good practice where CAMHS practitioners have been able achieve engagement with young people in very challenging circumstances. However, there is a great deal of unmet need in our communities due partly to the current CAMHS model as well as the lack of targeted resources.

7.3 My concern is that poorer, more marginalised families, often cannot access clinic based services and or feel very uncomfortable or even alienated by this context. I have spoken to many young people who find the conventional clinic-based approach something they cannot engage with. I would emphasise these are often very vulnerable young people who may not have a great deal of motivation for anything let alone attending a clinic and may already be reluctant to see a CAMHS professional because of the associated stigma. It seems to me that CAMHS expect families or young people to demonstrate they have motivation to be helped by attending an outpatient appointment which potentially sets them up to fail at the start. This is an unfortunate feature of the 'medical model' that from my experience still prevails in CAMHS in Wales. In order to

help some of our most vulnerable (marginalised) families or young people with mental health problems CAMHS would benefit from a more flexible approach to engagement at that crucial early stage.

8. Any other key issues identified by stakeholders

8.1 I would like to make a case for particular client groups where it is already acknowledged there is a high rate of mental health difficulties and where from my experience services do not remotely meet the need. They are: abused, maltreated children who are in the 'looked after' system; some adoption families; and asylum seeker/refugee families. Although there are obviously significant differences in these groups I will refer to them collectively.

8.2 The Welsh Government Inquiry into Adoption in Wales has made some helpful recommendations as far as adoption is concerned following the recent inquiry. The benefit of those recommendations however, has yet to impact at an operational level.

8.3 For a long time I believed that CAMHS should be resourced so that it could be enlarged to provide specialist services for the above client groups. However, I have come to recognise in recent times that CAMHS does not have the motivation, the service model, or the expertise to provide the services these groups require. In order to provide effective, meaningful services and overcome some of the challenges to providing mental health services to these client groups CAMHS or other service providers need to understand and take account of the following: the context of each client group; understand and relate to the nature of their difficulties; as well as being highly motivated toward helping families as well as building their own expertise in relation to this work.

8.4 CAMHS has been historically more interested and therefore focused on other client groups - so apart from some notable exceptions they are often not highly motivated in this regard. 'Looked after children' and adoption are two areas in particular considered to be the responsibility of Social Services whether or not they have mental health problems. When they do become involved the limitations of the 'medical model' referred to earlier often prevents successful engagement or the case is not considered suitable. As referred to earlier engagement is usually on their (CAMHS) terms whereby the client has to fit the service model, rather than the service model have some degree of flexibility to adjust to the needs of particular clients.. I understand this is an issue of scale to some extent whereby the CAMHS resource will always be swallowed up by the overwhelming need for specialist services of this kind.

8.5 I do not now advocate for increased resources for CAMHS so that they can provide the specialist services these client groups require. I feel we need a new kind of specialist service that broadly addresses the mental health problems of children and young people and their families/carers in the above client groups. I also feel a more psycho-social model as opposed to the current CAMHS model with inherent flexibility needs to be developed. It should be based on engaging children, young people, and their families and then addressing their problems as much as possible - rather than subjecting them to relentless assessments; either to establish whether they meet diagnostic criteria or suitability for the services on offer; often to be disappointed with the result at the end. In my opinion there is a disproportionate amount of resources spent on assessment (often

as a gate-keeping exercise) as opposed to actually helping children, young people and families.

8.6 What I am suggesting here is instead of funding CAMHS to provide these services that a new (psycho-social) service model is created at a multi-agency level involving local authorities and the third sector in conjunction with CAMHS. There are some examples where this is already happening in Wales but on a very small scale. I am sure resources to improve matters will be extremely limited if available at all and we must make the most effective use of whatever we have. Until we do there will remain a great deal of unmet need for specialist services of this kind amongst the most vulnerable children, young people, and families in our communities.

Dr Mike Davies
Consultant Psychotherapist **28th February 2014**