National Assembly for Wales
Children, Young People and Education Committee

CAM 54

Inquiry into Child and Adolescent Mental Health Services (CAMHS)
Evidence from : Group of Clinical Psychologists

This response represents the experiences and views of Clinical Psychologists working with children, young people and families in a range of services (including CAMHS) across Wales. The majority of the contributions were from psychologists working in South Wales, primarily in Gwent and Cardiff. One psychologist working in services in North Wales also contributed. In summary, it appears that psychologists believe that there needs to be more early intervention and preventative work; that access to Tier 2 services is difficult, and access to psychological interventions is poor (although there is some variation in the different areas). There is variation in different parts of Wales. It is recommended that consideration is given to the development of services that are more suitable for children and that these services are based on an attachment and developmental approach, and where problems arise, these are considered within the context of the child's family/home and the child's life experience.

This response was jointly put together by the following group of psychologists:

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The views of several other psychologists are also included in this document, although they have not been named directly as contributors. Thanks to Dr Jenny Hunt who collated responses from a number of psychologists working for Cardiff and Vale and Dr Rachel Williams who collated responses from a number of psychologists working in Aneurin Bevan Health Board

	The Committee is interested in hearing about **The availability of early intervention services for children and adolescents with mental health problems**
1.	Comments: We believe that there are differences in services across Wales; however, there appears to be a universal deficit in the availability of early intervention services and in the accessibility of the services that do exist for children and families. The principles behind "*Together for Mental Health*" were to provide early access to help and support. However, in Gwent, Primary Care Mental Health Support Services appear to be

insufficiently resourced, and there are reports that the services are lacking in clinicians who are skilled in understanding children and young people and families, using a normalising, developmental and contextual approach. This has meant that clinicians who previously worked in adult services, apply adult health models to their primary intervention work. They report feeling unconfident in meeting the needs of children and families, so tend to rely on clinicians who do have this experience. This, coupled with a general lack of resource in relation to the local population, has resulted in long waiting lists. A local primary care service in Newport has one child focused clinician to serve an estimated population of 141,306 (as of 2010, http://www.newport.gov.uk/_dc/index.cfm?fuseaction=population.homepage). The clinician currently has an estimated twenty families waiting to see her for initial appointments, and this does not include any referrals for adults that they may also be expected to see.

In Gwent, the Child and Family Psychology service have tried to alleviate the difficulties by putting together and delivering a comprehensive training package with follow up supervision. However, this is a very limited resource and takes a lot of time. We believe that it is not sufficient to ensure quality delivery of services from child experts. There are no psychologists embedded within the PCMHSS and the time given is from the already very limited core service.

The emphasis of *Together for Mental Health* was on early intervention and building resilience however, the drift seems to be in the opposite direction. CAMHS referral criteria are ever tightening towards diagnosable mental disorder which happens later in the trajectory and does not focus on resilience but on deficiency. In Gwent, there are no resources within CAMHS dedicated to early intervention.

A psychologist who works with Looked After Children in Gwent commented on her experiences of working closely with Social Work colleagues. They noted that there is very little provision early on in a child's life span.

In Gwent, there are some excellent examples of innovative, responsive, early intervention projects and services that have been set up by psychologists. Examples include the FIT (Family Intervention Team in Caerphilly), MIST and Skills for Living (projects for preventing out of county placements for foster children and assisting care leavers to develop emotional coping and relationship life skills, situated in Torfaen). As these are innovative projects, set up initially as pilots in a specific area, it means that there is inequitable provision of these services across Gwent. Unfortunately, as some of these projects source their funding from charitable sources (such as the Big Lottery), in spite of having excellent evidence of their effectiveness, they have to regularly bid against other projects to try to find further funding, risking closure. This significantly impacts on the well-being of the staff of these projects, whose jobs are threatened, and their ability to provide a containing, continuous service for vulnerable young people. One such example is the Skills for Living Service in Torfaen, which teaches care leavers emotional regulation and life management skills, and by doing so, prevents the young person's need and use of CAMHS, adult mental health services, Social Services and A&E (after self-harm). Another example is the FIT which works with children and families before other statuary services become involved. The service is hosted by Action for Children and lead clinically by a clinical psychologist (ANUHB) – a good example of partnership working. Each intervention is informed by a psychological formulation and is time limited. The external evaluation of the service has shown the high social economic value – saving £7 for every £1. An audit of the work showed that for 36 referrals requesting an ADHD assessment only 2 went on to a full assessment, therefore saving core CAMHS a huge resource. Despite this, statutory services have not sought to roll this out. In summary, innovative practice and services rely on short term project money and are not embedded within core services.

Again in Gwent, the other services that offer early intervention are very limited and there is inequitability across the region. There is child mental health expertise in Monmouthshire Flying Start (2 days of child psychotherapy) and in Torfaen Flying Start (2.5 days of clinical psychology). Where it is available it is highly valued and makes a big difference to nursery nurses/health visitors in the understanding of early mental health.

In North Wales there is an Early Intervention Service for CAMHS in Central and in Flintshire. There is also a worker in Wrexham and some primary care work with West Wales too. These services mainly offer consultation to professionals and training around mental health. They

	also run targeted and universal interventions for young people. We believe that early intervention in terms of prevention work is lacking. Many psychologists working in Gwent are unaware of any prevention work. There is certainly a gap in terms of service provision in relation to working in ante-natal contexts and in relation to specifically targeting the more vulnerable sections of society with preventative type therapeutic approaches. This is not entirely the case in North Wales where some "mental health promotion" is carried out in schools. However, generally there was the view that in North Wales, staff and resources are so focussed on managing the risk that preventative work is left or not invested in. We believe that a developmental approach is not at the centre of services, such as CAMHS. It is essential that children's emotional development is at the core of services working with children. Healthy attachments are the building blocks for creating emotionally healthy human beings who can form rewarding relationships, regulate emotion, and fulfil their learning capacity (see for example, Fernivall, 2011, Hughes, 2012, Golding, 2012). If we believe in early intervention, we should be front loading our services. There is a growing consensus that early intervention is a better use of resources than waiting until more serious difficulties emerge. Both the WAVE Trust document 'Tackling the Roots of Disadvantage' and 'Early Intervention: Smart Investment, Massive Savings' promote the financial, moral and effectiveness implications of preventative and early intervention models. The latter states that; '*The traditional model – waiting until problems become apparent…is no longer enough.'* In addition, the 2009 document from the Centre for Mental Health (Childhood Mental Health and Life Chances in Post-War Britain) also recommends early intervention given that difficulties in early life can have 'profound' long term consequences.
	Access to community specialist CAMHS at tier 2 and above for children and adolescents with mental health problems, including access to psychological therapies
2.	Comments: We believe that it is difficult for families to access CAMHS at Tier 2, with some areas having greater difficulties accessing psychological therapy than others. In Gwent, CAMHS has a long waiting list across the three different areas of service provision. There is a wait both to the first appointment and then to follow ups in terms of access in psychological therapies. At the end of January 2014, there were 555 on the waiting list for an initial appointment, for all of Gwent, with 378 waiting over 16 weeks. We believe that there are too few clinicians to meet demand (in one area of Gwent there were 127 families on the waiting list (data as of October 2013) and 6.2 WTE, with weekly new referrals. This illustrates that these services are unable to provide timely interventions, early on in the development of a child/family's difficulties. This situation has resulted in a narrowing of criteria to one that is based around "disorder" and a narrowing in the remit of services. This seems to be the case across Wales, based on the comments of respondents. This narrowing of criteria has two consequences. The first is that children's distress needs to be "pathologised" into a disorder in order to access services. There is a whole debate as to whether this is a useful/ethical endeavour. The second is that a lot of children do not receive a service. GPs, professionals working in schools and social workers in Gwent make verbal complaints about how difficult it is to access help for families. A GP has reported that he has stopped trying to refer families to CAMHS as he believes his referral will not be accepted. Another psychologist working with Social Workers in Newport also commented that they have heard much anecdotal evidence that getting a referral accepted by CAMHS in Newport is so difficult that they sometimes do not even try despite working with children with very complex emotional issues. It is hard to get an accurate picture of the number of potential referrals where the referrer has decided 'not to bother' because previous experience tells them that there is no point. Subsequently, there is a huge, masked, unmet need.

	To illustrate this, a psychologist commented on a recent example that a Social Worker brought to consultation. A teenage girl with a very difficult family history, had been rejected by her mother and had come into care. She had an assessment by an on-call mental-health practitioner after having been admitted to A&E following self- harm. The conclusion from the assessment was that her difficulties were 'behavioural' rather than indicative of a mental health issue. From providing consultation to the Social Worker, the psychologist was aware that the young person's behaviour was likely to be an expression of high levels of emotional distress and complex loss, and this was manifesting in very challenging and sometimes risky behaviour. Unfortunately the young person was not seen further by CAMHS and therefore was not able to access direct psychological therapy. The psychologist had felt this would have been helpful. Through a medical lens the young person did not fit the criteria for any particular diagnosis but through a psychological lens she was experiencing very significant emotional difficulties and consequently had been putting herself at risk. They went on to comment that many social workers often complain that they cannot get referrals accepted by CAMHS and that when they do they often feel that the practitioners do not fully understand the needs of the child or have the skills to provide the most helpful interventions for children and young people who have an early history of neglect/trauma/abuse. Generally, access to relevant specialist psychological therapies is seen to be very poor. Similarly, psychologists working in services in Cardiff, commented that many of the reports / interventions carried out by CAMHS appear to be informed by a medical psychiatric understanding with less emphasis on a psychological and/or relationship/social context to difficulties. In Gwent, it has been observed that there is an increasing incident of referrals being sent back from CAMHS to Tier 1 professionals including the local Primary Care Mental Health Support Services after they have completed their Primary Care assessment. Local Primary Care Mental Health Support Service staff do not believe that they have the core competencies to be able to offer these children and young people access to psychological therapies. Examples of this also comes from feedback from School Counsellors and School Health Nurses who believe that they are being required to work with what would be more complex and enduring mental health difficulties. A clinician working in a Primary Care Mental Health Support Service reported feeling the need to try to offer a service to families that they know are "outside of their remit" because there is nowhere else to "send them for help". It has been observed in Gwent that the referral criteria in CAMHS are unreliably administered and are changeable across time, person and geographical area. There is little attempt made to measure which referrals are rejected and what happens to the children once rejected. We believe that across Wales, services are increasingly focusing primarily on urgency and risk, rather than with the people in front of them and their life situations. In Cardiff, since the departure of the social workers, family therapists and reduction in CAMHS psychologists, there is a reduction in capacity to respond therapeutically. In North Wales, within CAMHS, there was some individual tier 2 psychological work, however this was not the primary focus of the service. Standard therapy was provided if referrals reached specific criteria. The provision of therapy to targeted groups, was not well resourced. The quality of service received was therefore sporadic and not easily accessible to all. Access appears to depend on whether organisations (i.e. particular schools) were active in mental health promotion, and whether teachers were linked in with Early Intervention CAMH staff to set up groups. The key issue is an increasing number of young people needing support, resources being stretched and burnout in teams. Many psychologists working in Cardiff services have reported difficulties effectively communicating and working with psychiatric colleagues. A psychologist commented that there have been "several communication glitches" (acknowledging that this always takes two) "primarily where we have had misunderstandings that may have been helped by talking things over. A number of times when I would have liked to talk to one of the consultants I have had to relay things via a secretary or junior colleague which may have added to confusion at times".

	Another psychologist working in a different service, but the same geographical area noted that therapeutic professionals are not kept inform of changes to appointment dates. With regards to the quality and nature of the interventions children and families accessing CAMHS Learning Disability services receive, access to psychological interventions is extremely poor, particularly in Cardiff. Many psychologists working there have reported that the model of mental health is almost exclusively biomedical, with intervention limited to the prescription of psychotropic medication. Medication is being applied to complex cases with no / very little involvement of other professionals currently working with the families. Schools have commented that decisions about medication changes are taken without any input from them, which rather defeats the object of school based clinics. Medication is also being seen as a frontline approach, partly because of the lack of availability of Clinical Psychologists, other therapists and psychological therapies such as family therapy. Cases where medication has not achieved good outcomes are discharged, even when the families are at high risk of breakdown. A psychologist working in learning disabilities in a different part of South Wales, as part of a challenging behaviour team, reported that changes in their area introduced last year have improved access to services for children with learning disability, in that now the local CAMHS teams can no longer refuse to work with children. However, access to psychological and psychiatric interventions remains difficult. To receive this support, children can either be referred into generic, local CAMHS teams or can be referred to the one consultant psychiatrist who specialises in children with learning disability. The generic, local CAMHS teams are trying to offer as much of a service as possible to children with a learning disability but due to capacity issues the service is severely restricted. The one Consultant Psychiatrist covers the whole of the CAMHS South Wales network, a large geographical area. Their referral criteria is limited to children enrolled in special needs school, which means a large number of children who have learning disabilities and are enrolled in Specialist Teaching Facilities within mainstream schools cannot access the CAMHS consultant. Their input is limited to the prescription and review of medication. Previously, a part-time Consultant Clinical Psychologist worked alongside them for several months, but this post is now vacant. It is not known what the plans are for psychological input into this service. Clinical Psychologists working in the Child and Family Psychological Services in Gwent have set up innovative services to try to alleviate some of the difficulties and facilitate professionals who are involved with families to work effectively and psychologically, in a timely manner. This includes offering consultation services to professionals such as teachers, social workers, health visitors, school health nurses and a Telephone Advice Line for professionals. Consultation has also been reported in North Wales. Since July 2014, there is a single point of access to CAMHS. This is by a telephone referral/consultation with the aim that young people can be directed to appropriate services, with Tier 2 CAMHS work being one possible option. However, these services are limited and have not been reported universally throughout Wales. We believe that most CAMHS services are predominantly based on a traditional ‘clinic’ based delivery of service, which does not suit some of the most vulnerable, complex and traumatised families. Reaching out to these families in a more proactive/creative way is not possible with the pressure of target driven waiting times and the capacity/demand imbalance. Furthermore, the time and skill required to allow a robust change of trajectory for a child who is part of a family with transgenerational trauma, is often not available. Other forms of helping young people and families should be considered. For example, social media could be used beneficially to reach young people as this is a favoured communication and learning style. A sophisticated and interactive, informative website would be helpful for young people, families and referrers.

	The extent to which CAMHS are embedded within broader health and social care services
3.	Comments: We are aware that there is some close working between psychologists and broader social care and educational services, but better links are recommended. We believe that there are not always close working relationships between different services with CAMHS services. Within Gwent, the Clinical Psychologists provide excellent consultation services which are well received and valued. This is based on the philosophy that children are best helped within the contexts in which they live their lives as that is where the difficulties arise. The Psychological Services for Children and Families, as part of their recent re-structure, are able to offer a Consultation Service to broader health and social care services. For example, they offer consultations to Social Services and are heavily involved in the training of Local Primary Care Mental Health Support Service staff. This comes in the form of the development of a comprehensive training programme coupled with supervision and training clinics to develop their skills. In addition to this, consultation is offered to the School Health Nurses and moving forward potentially to School Counsellors. The Child & Family Clinical Psychologists also offer a weekly telephone advice line which any professional involved in working with child or young person can access in order to discuss situations and concerns, develop shared formulations and action plans moving forward. However, this is a very limited resource that is spread very thinly. Despite excellent evaluation of this work, has not been seen by the organisation which does not allow the recording of this work on the existing data systems. These data systems are instead based on direct, face to face 'patient/contact'. The consultation service is also a small resource and whilst there are some examples of this being used in North Wales, it is not universal across all parts of Wales. In Gwent, there are examples of services which have CAMHS professionals embedded within, but these are specialist posts. There are 2 psychologists working with Looked After Children and paid for by the local authority. There are also psychologists within third sector organisations (MIST, FIT, Skills for Living). These roles have shaped the services they work within and the benefit is two ways since they also bring a difference to the core services from which they come and invite innovative practice and question traditional practice. In Cardiff there are psychologists working into physical health, but this service is not provided in across Wales. Although, clinicians do work with children who are accepted into CAMHS and who have long term conditions. In North Wales, lots of work has gone into developing embedded services, but provision varies in different areas. In Conwy, Education services and Early Intervention CAMHS work well together and have joint meetings to plan Emotional Health provision within the county. This is not the case in other areas. It is an excellent model. Within Conwy, a member of the Early Intervention Team attends Social Workers case discussion meetings to provide psychological input, and this has been shown to be valuable. However, the psychologist's experience in general is that agencies work independently. They believe that more joint working would avoid children being 'passed around' services, and would likely avoid duplication work, providing a more comprehensive, containing and continuous service for families, whilst also reducing demands on resources. Also within North Wales, Child Learning Disabilities services are reported to be separate from CAMHS. The psychologist comments that children with intellectual disabilities have an increased risk of developing mental health difficulties. Whilst there are clinical psychologists working within the team with children who need support, more CAMH integration would be beneficial. Also there is a gap with some children who's level of disability is unclear having to wait an extended period of time for input whilst CAMHS and Children's Learning Disability services work out which service would be most appropriate. Within Central in North Wales and

	Flintshire in North Wales all resources are directed towards CAMHS, with few resources coming to children learning disability services. We believe that better links between health, social workers, education and health visitors would be helpful, along with an increased emphasis on early intervention and prevention.
	Whether CAMHS is given sufficient priority within broader mental health and social care services, including the allocation of resources to CAMHS
4.	Comments: We believe that not enough priority is given within broader mental health and social care services to CAMHS In Gwent, Newport and Monmouthshire Social Services both employ a Clinical Psychologist part time, and some consultation is provided, but we believe that this is insufficient. We believe that in population terms, a disproportionate portion of resources are given to adult services compared to children's services. The PCMHSS in Gwent is one illustration of this, with the teams comprising mainly of adult mental health nurses, who are expected to work with children and families. As there are different models for working with children compared to adults, many clinicians report that they do not feel confident to do this work (as previously mentioned in response to question 1). Psychologists in Gwent report that colleagues working in Social Services and Education appear to have received no training on the Mental Health measure. The closure of the Educational Psychology course will have a big impact on children's well-being in schools and therefore an impact on CAMHS. Gwent has no services within paediatric health services despite having demonstrated the value of psychological models with diabetes, Cystic Fibrosis, feeding, encopresis.
	Whether there is significant regional variation in access to CAMHS across Wales
5.	Comments: There is variation both across Wales, and within different regions.
	The effectiveness of the arrangements for children and young people with mental health problems who need emergency services
6.	Comments: We believe that this is not sufficient. Observations by clinicians suggest that there is an increased demand for "urgent" and emergency responses. In Gwent, emergency access is available out of hours, and 'within hours', a rota has been set up, but it diverts clinicians away from their ongoing therapy tasks and is disruptive to their work. Similarly, in the Cardiff area, a clinical psychologist reported being indirectly aware that vulnerable young people who have self-harmed sometimes receive a less than wrapped around multi-disciplinary response – these young people often present with complex challenging behaviour, family breakdown etc and are not best placed in a hospital ward. The challenges they present are not easily resolved and they sometimes have to stay longer than is

	ideal in an environment that is not designed for their needs – and where their needs conflict with the needs of sick young children. This also mirrors comments by a psychologist working with LAC in Newport, Gwent. They commented that the handful of young people that they are aware of, who have accessed emergency services, have received an assessment by someone who clearly did not have a good and thorough understanding of the consequences of a history of abuse/trauma/neglect on childhood development and the emotional/mental health consequences and merely. In other parts of the UK, Crisis Intervention teams have been set up. A team dedicated to thinking, planning and responding with families with immediate crises. Where this has been implemented involving clinical psychologists, reports are that this works well. In North Wales there are reports that in Central, a lot of work has been done developing a self-harm pathway across the region. Within this model, all staff in schools are trained to level I (awareness and first response). Designated staff are trained in Level II. These staff conduct an assessment and see consultation from CAMHS staff about the actions. Cases can be escalated to CAMHS as required. Work has also been done to train social services, school nurses and other staff. Within A and E work was also attempted to train staff in how to respond. However this proved more difficult due to resource issues (i.e. getting A and E staff together).
	The extent to which the current provision of CAMHS is promoting safeguarding, children's rights, and the engagement of children and young people
7.	Comments: We believe that in South Wales, services are organised around traditional health models rather than around children's developmental needs or around what children and young people and families tell us that they need/want. CAMHS is structured in the same way as physical health models of care with doctor and nursing hierarchies. Often based on tradition and history – not designed with a vision to promote psychological and emotional health. We need practitioners who can negotiate safe, nurturing relationships, who understand the importance of attachments as a basis for growth, can engage young people in meaningful activity within a living context, and who are psychologically minded, so all interactions are mindful and therapeutic. This requires a high level of expertise. Children tell us they care a lot about the physical environment. It needs to feel safe, welcoming, private but not too formal. We believe that more work should be done to make the contexts in which children live and learn more psychologically minded so positive emotional health is a driving focus in schools, clubs, social services, housing agencies. The health of the community is a target.
	Any other key issues identified by stakeholders
8.	Comments: The vision of promoting resilience in *Together for Mental Health* will need a different and innovative structure to be realised. We believe that most CAMHS are set up like a version of Adult Mental Health services, which are a version of physical health services. We do not believe that this is the best way of delivering a resource to children and their families to promote psychological health and resilience. The first step of a service design has to be about promoting positive attachment relationships. Human beings' healthy growth depends on this. If a person has experienced secure enough attachment, they can regulate themselves emotionally, learn and experience empathy. Research links a variety of difficulties in later childhood and adulthood with early attachment relationships in infanthood (e.g. Fernivall, 2011)

	As previously stated (in response to question 7), children and family services need to be developmental, normative, attachment and systemically focused. A focus on promotion of healthy psychological well-being, prevention and early intervention is needed, starting in prei-natal care. One consideration would be to ensure psychologically minded staff work in nurseries, child care provision, educational provision, working with an understanding of children's emotional development, normalising responses to adverse life events and understanding these in the context in which they occur. At the next level, when problems arise, the context is worked with by staff who can work across therapeutic modalities adapting the approach to the level of complexity and to the individual.

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