Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Plant, Pobl Ifanc ac Addysg
The Children, Young People and Education Committee

Dydd Mercher, 2 Ebrill 2014
Wednesday, 2 April 2014

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

These proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Keith Davies	Llafur Labour
Suzy Davies	Ceidwadwyr Cymreig Welsh Conservatives
Rebecca Evans	Llafur Labour
Ann Jones	Llafur (Cadeirydd y Pwyllgor) Labour (Chair of the Committee)
Lynne Neagle	Llafur Labour
David Rees	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Simon Thomas	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Mary Greening	Cynrychiolydd Cymru, Cymdeithas y Seicolegwyr Addysg Wales Representative, Association of Educational Psychologists
Claire Leahy	Seicolegydd Addysgol Educational Psychologist
Dr Rachel Williams	Pennaeth Seicoleg Plant a Theuluoedd, Bwrdd Iechyd Lleol Aneurin Bevan Head of Child and Family Psychology, Aneurin Bevan Local Health Board

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Sarah Bartlett	Dirprwy Glerc Deputy Clerk
Marc Wyn Jones	Clerc Clerk
Sian Thomas	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:31.
The meeting began at 09:31.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Ann Jones:** Good morning, everybody. Welcome to the Children, Young People and Education Committee. May I just do the usual housekeeping rules, before we start? Would Members check that their phones are turned off? They affect the broadcasting and the translation, so we need to make sure that they are off. Translation, as you know, is from Welsh to English; it is on channel 1 on the headsets. Channel 0 is the floor language, for amplification, should you need it. We are not expecting the fire alarm to operate, but if it operates, we will take our instructions from the ushers, or, as I always say, you can follow me because I will be one of the first out of the building. I think that I asked at the start of last

week's meeting whether Members needed to declare anything that they have not already declared. I see that they do not. Thank you. We have had apologies from Bethan Jenkins and I think from Angela Burns, but Angela may appear later. We have no substitutions, so we will move on.

09:32

Ymchwiliad i Wasanaethau Iechyd Meddwl Plant a'r Glasoed—Sesiwn Dystiolaeth 3
Inquiry into Child and Adolescent Mental Health Services—Evidence Session 3

[2] **Ann Jones:** We are going to continue our inquiry into child and adolescent mental health services, or CAMHS for short. We are delighted to have with us the Association of Educational Psychologists for our first session. We have Mary Greening, who is the Welsh representative of the Association of Educational Psychologists, and Claire Leahy, an educational psychologist. Thank you for agreeing to come in. We have some sets of questions that we have looked through, and we have decided which way we think we should be taking this inquiry, which is a massive subject area to cover. We have some questions, so if that is all right with you, we will go into them. If you feel that you want more time to answer them and you want to send us a note, we understand that and that will be fine. Simon, you are going to start on early intervention.

[3] **Simon Thomas:** Rwy'n mynd i ofyn fy nghwestiynau yn Gymraeg. Diolch am y dystiolaeth rydych wedi ei chyflwyno i'r pwyllgor. Mae'n amlwg o'r dystiolaeth rydych wedi ei hanfon atom ni bod amrywiaeth yn y ffordd mae ymyrraeth gynnar, yn arbennig, yn digwydd, sef y camau cyntaf o adnabod y problemau a gwybod pa gamau i'w cymryd. Rydych yn gweld bod amrywiaeth yn gwahanol rannau o'r wlad a bod amrywiaeth hefyd yn y technegau sy'n cael eu defnyddio i helpu plant yn gynnar iawn. A fedrwch felly ddisgrifio i ni beth fyddai'n berffaith, fel petai? Pa fath o system fyddai'n edrych orau o'ch safbwynt chi o ran adnabod y problemau ymyrraeth gynnar a'r dulliau sy'n cael eu defnyddio i gefnogi'r plentyn sydd yn y sefyllfa honno?

Simon Thomas: I will be asking my questions in Welsh. Thank you for the evidence that you submitted to the committee. It is clear from the evidence that you submitted to us that there is variation in the way in which early intervention, in particular, happens, that is those first steps of recognising the problems and knowing which steps to take. You see that there is variation across the country and that there is also variation in terms of the techniques that are used to help children at that very early stage. Could you therefore describe to us what would be perfect, as it were? What system would look best from your point of view in terms of recognising these early intervention problems and the methods that are used to support the child in that position?

[4] **Ms Greening:** It is a difficult question to answer, because, obviously, there are different problems that children exhibit. Also, they often exhibit different problems in different settings. When you are talking about early intervention, do you mean mainly in the school setting?

[5] **Simon Thomas:** It does not have to be in the school setting, but I was thinking mainly of the school setting for you.

[6] **Ms Greening:** In the school setting, a lot of psychologists would like to operate in schools in a much more flexible way than some systems currently allow. By that I mean that in some services they use a consultation approach, where the psychologists would go into a school and ask the school staff about children who are exhibiting difficulties at quite an early

stage of difficult problems. If we adopt that approach, we can help in a variety of situations and advise teachers without the child necessarily being formally referred and having a formal assessment—a psychometric assessment or another assessment by a psychologist. So, what we are actually doing in that context, which I think is very important, is aiding the school improvement, because I think that educational psychologists have a huge role to play in school improvement, which is not recognised. In some ways, for various reasons, we have been straitjacketed into the special educational needs arena, where we are seen very much when a child has very specific special educational needs. We are the ones who come in and do an assessment, et cetera. However, we have an important role at a much earlier stage. A lot of psychologists, depending on issues such as staffing levels and what kinds of contacts they have with other services, get quite involved with pre-school children as well.

[7] **Simon Thomas:** I will question you a little further on that, just for me to understand, because, from my perspective, I know of your work because, usually, a constituent's child has been referred to you. So, it is a referral process that I am aware of. You are describing a different process, which is early intervention of a different kind—a whole-school kind of intervention. Do the two happen commonly in Wales, or is one much more common than the other? You said that you have been straitjacketed. Do you feel that the referral process has taken over?

[8] **Ms Greening:** I think that the formal referral process has taken over. Certainly, I have found when I go to meetings, representing Wales on the national executive of the Association of Educational Psychologists, and in the contact that we have with other services, that the situation in some areas of England is quite different, where psychologists offer much more in terms of this early intervention approach. A lot of services there will offer a lot of training to teachers and other school staff, such as classroom assistants.

[9] **Ms Leahy:** It depends on the service agreement model. Ideally, we would want a systemic approach. I think that the system that you are talking about is the statutory assessment system, with a referral. Most services in Wales now run a request service, where you request our input, which gives that joint ownership: you are not giving us the problem; we will work on it together. It is the 'Everybody's Business' agenda: you cannot pass it to someone else; it is still with you, but we work on it together.

[10] We do multidisciplinary fora and they involve lots of the professionals involved with the young person, if that young person is at a specific tier. Lots of services have a tiered approach. We offer universal services and more intense services. As the young person's needs become more intense, we will offer team around the school approaches, such as the multidisciplinary fora, and team around the child approaches, which will involve medics as well as educationalists and all the people who are involved with that young person, and that is our ideal approach.

[11] The individual development plan process that the Welsh Government is in the process of looking at is a very good way forward, because it is based in psychology. However, it is labour intensive, which clashes with what is actually going on on the ground. Things are being cut, and the ideals are very labour intensive.

[12] **Simon Thomas:** We almost had to cut the only course doing educational psychology in Wales. We had to fight for that to continue. Could you say a little more with regard to how that link now works with, say, teachers or the medical profession? You are getting into the tiers when you start to do that, are you not? Do you find that teachers are skilled enough to know when to engage you with that? Is there a consistency of approach throughout Wales so that, basically, a child in any area will get a similar opening of a gateway they may need, according to their needs?

[13] **Ms Greening:** I think that there is a lot of variability across Wales in terms of what happens. Certainly, some of the psychological services are quite poorly staffed in terms of the number of psychologists. We have certainly lost posts over the last four or five years where people have left and not been replaced. Also, because of the age and gender of the profession, we have a lot of young women entering the profession of educational psychology who, of course, then go off on maternity leave and, when they come back to work, they often want to work part time. That, again, has implications in terms of the workforce—

[14] **Simon Thomas:** The implications are for training, though, are they not?

[15] **Ms Greening:** I beg your pardon.

[16] **Simon Thomas:** The implications are for the trained numbers—

[17] **Ms Greening:** Yes, there would be implications for how many psychologists we would train in Wales. However, there are also implications in terms of the staffing of services. I can remember a colleague phoning me up and asking whether I knew of anyone who would do locum work because 50% of her staff were off on maternity leave.

[18] **Simon Thomas:** I do not know whether you want to say something on this. I cut across you—

[19] **Ms Leahy:** Yes, could you repeat the question because I am lost in maternity leave, sorry—

[20] **Simon Thomas:** I was asking whether you found the link with either teachers or the medical profession was working correctly, particularly when you go into tier 1 and so forth.

[21] **Ms Leahy:** It is patchy, and it depends on the service. It depends on the numbers and it depends on the interest and expertise within the service. There are lots of tier 1 programmes in schools that we work with. I know that TaMHS, targeted mental health in schools, in England got a lot of publicity, whereas, in Wales, we did wellbeing agendas and wellbeing plans. For instance, there are emotional literacy support assistants in schools that psychology services have trained. They do psychosocial teaching. It is meant to be a universal service and, actually, it is meant to be tier 1. However, what we are finding is that the people we have trained—because we offer ongoing supervision to the ELSAs, monthly supervision—. What we are finding is that it is not tier 1 children they are working with. They are working with very complex young people. Finding the avenues to get extra support is quite a challenge. They have to go through the GP, and what we are finding there is that, unless an adult works with that young person and goes with them—particularly if they have decided that they are going to use their Gillick competence and they do not want their parents to know, and if it is not a child protection issue they are quite entitled to do that—they fall at the hurdle of going to the GP. That is nothing to do with GPs. Lots of GPs are fantastic and welcoming and will listen. However, for that child, it is another person that they have to tell everything to, so that is a hurdle.

[22] They have good relationships with the school-based councillors and, obviously with the young person's consent, they will give information. However, the young person has control over that, because of the UN rights of the child and the code of ethics. However, they can give that feedback and that is very useful for teachers. We promote things like measuring wellbeing. There are things like PASS, which is the pupil's attitude to self in school. There is PATHs, promoting alternative thinking strategies—. No, that is the curriculum. That is something else we promote. There is the ENFA project, which I think the Assembly was involved in. The questionnaire involved in that is used by lots of schools so that they do not miss vulnerable children.

09:45

[23] A lot of the time, because it is a priority-led service, it is the young people who create the most challenge for that system that get identified, rather than the young people who are possibly experiencing quite a lot of distress and discomfort in terms of their mental health, but are very quiet and hold back in the system.

[24] **Simon Thomas:** From the point of view of success of early intervention, that is a counter-productive tendency in the system, is it not, because you are missing perhaps the opportunity to deal with someone early on and to help them before they need to access the other levels of care?

[25] **Ms Leahy:** Yes. This is why you we are looking at—. Of course, we cannot direct people, but we are encouraging schools to do these kinds of surveys. I know that one local authority, where it is very well embedded, uses this for tier 1 and tier 2 services to target those people. It has said that there are a lot of young people that it would not necessarily have identified.

[26] **Simon Thomas:** You mentioned school counsellors there. We have seen other evidence—not from you, but from other organisations that have put in evidence to us—that suggests that school counsellors work in a sort of person-based framework, in a particular framework, that does not necessarily help with CAMHS and the more psychology approach. Is that the case? You mentioned them in a positive light there, but I just wondered whether you found that, sometimes, that was not necessarily a good route for identifying issues that need to be tackled, or whether that was a bit of a red herring.

[27] **Ms Leahy:** I think that there is a need for both. You need systemic systems, which look at the systems around the child, support the child and the changes that people around that child need to make. A lot of the distress that is caused to our young people is not actually about the young person; it is about the people and the systems around them, possibly not understanding the need. However, there is also that need for a young person who has identified themselves that there is something in their life that they would like to change and they would like support. There are clashes, because we are used to sharing information, but I think that there is that need. Personally, I do not think that that need is as strong in primary schools, because young people do not have the power to change even if they have identified something that they would like to change. Actually, in terms of lots of things that they would like to change, they do not have the power to change. However, as a young person gets older we do become more introspective and we look at ourselves in how we interact, and you have that skill. When you are younger, play therapy and things like that, or a systemic family approach, is—.

[28] **Ms Greening:** There is a lot of variability with the school-based counselling across Wales. Certainly, in some areas, they work very closely with the educational psychologist. However, in other areas, that would not be the case.

[29] **Simon Thomas:** Is that just a matter of practicalities, or is it because of fundamental differences in approach?

[30] **Ms Greening:** In some areas, the school-based counselling is managed by the principal educational psychologist, or someone who is an educational psychologist would have general oversight and management. Obviously, when that happens, there is a lot of co-ordination, which is very helpful. I understand that, in some areas, that is not the case. Therefore, the contacts would be not as strong.

[31] **Ms Leahy:** On an all-Wales level, each service gives feedback on the general trends. So, although the sessions are private, there is information that is given to schools about the trends. There will be lots of young people presented to the service, and the main issue is bullying. Lots of young people presented to this service, and the main issue was domestic violence. So, that will be fed into the school system. The school will also have measures of their wellbeing at the start and at the end, to see the road travelled. That is on a national level, and it is presented at the all-Wales meeting. It is patchy, and some services are so big that they have had to be commissioned out; they could not be held within the local authority. Along with the local authorities' need to delegate budget, you could not keep them within the service. So, that is another thing that is stopping that co-ordination, because you have to procure services rather than keep them within—

[32] **Simon Thomas:** They do not happen naturally, as it were.

[33] **Ms Leahy:** No.

[34] **Ann Jones:** Keith has a brief point on this.

[35] **Keith Davies:** Byddaf yn siarad yn Gymraeg. Roedd trafodaeth ar Radio Cymru ddydd Llun gyda rhywun a oedd yn gweithio dros wasanaeth cwnsela Gwynedd ac Ynys Môn a rhywun o Hafal. Fel rhan o'r drafodaeth, roeddent yn dweud nad oedd digon o bobl mewn siroedd eraill yng Nghymru yn gallu gweithio gyda chwnsleriaid oherwydd nad oeddynt yno a bod prinder pobl. A yw hynny'n wir?

Keith Davies: I will be speaking in Welsh. There was a discussion on Radio Cymru on Monday involving someone who worked for the counselling service in Gwynedd and Anglesey and someone from Hafal. As part of the discussion, they were saying that not enough people in other counties in Wales could work with counsellors, because they were not there and that there was a lack of people. Is that true?

[36] **Ms Leahy:** In some areas, it would be true, to work with someone and for the counsellor, once their piece of work is completed, to be able to pass them to a service that is more intensive. So, yes, there is a gap.

[37] **Keith Davies:** Fodd bynnag, roeddent yn dweud bod y bobl a oedd yn rhoi gwasanaeth cwnsela yn brin mewn ambell i sir, nid y seicolegwyr.

Keith Davies: However, they were saying that there was a shortage of people providing counselling services in some counties, not of psychologists.

[38] **Ann Jones:** I think that that is just a comment, really. I do not think that you can ask psychologists to comment on that.

[39] **Keith Davies:** The counsellor on the radio this week worked across Gwynedd and Anglesey, and she said that the service that they provide is not provided in other authorities in Wales.

[40] **Ann Jones:** I think that you have acknowledged that. You have said a couple of times that the service is variable across Wales. We will move on to look at community specialist CAMHS at tier 2 and above. David and then Suzy have some questions on that.

[41] **David Rees:** You have answered some of the questions in relation to the intervention aspects and the variability across Wales. You have also identified the shortages of psychologists. Can you just confirm, before I go on, whether we are talking about a shortage of staff across the whole CAMHS team, or just in the educational psychologist area?

[42] **Ms Greening:** I think that it is both. The anecdotal evidence that we have as the AEP

is that there are staff shortages in specialist CAMHS in a lot of areas. There can be vacancies, but also CAMHS has always been fairly poorly resourced, and now, with the increasing demands and what is happening with the mental health Measure, it is becoming a much more crucial issue.

[43] **David Rees:** In relation to the mental health Measure, we have had evidence to say that, actually, that has a major impact, as does the raising of thresholds as a consequence of that. How do you see that impacting on the children—young children in particular—and perhaps even the 16 to 17-year-olds?

[44] **Ms Greening:** It made access to services more difficult when they raised the threshold. Also, what seems to happen in certain areas is that the referral must come via the GP to specialist CAMHS, whereas, prior to that, that was not necessarily the case. So, in some ways, it has made it more difficult for certain young people to access CAMHS and then that has had an impact on other services. I do not know whether you would like to add to that.

[45] **Ms Leahy:** I think that we are finding that the role of the primary mental health workers who used to offer a lot of help and support to schools and tier 1 professionals by coming to a conclusion as to whether a referral would be a good one or whether it might not meet the threshold and suggesting, 'You might like to try x, y and z', which were already in the community, has been depleted. Now, they have to be involved in the assessments—at four hours, eight hours and at 21 days. So, there is quite a big demand on them, because what they have found, I think, is that the request for assessments has risen sharply. So, for instance, some authorities, like I said, used to run multidisciplinary fora, and a member of the CAMHS team would always be there. It was a high school intervention; we never went to primary schools. That would look at young people with emotional health and wellbeing and behaviour distress. A member of the team would always be there, and you could have that conversation. In a morning, you could discuss four or five young people and decide, 'Well that's inappropriate. This isn't. How can we support that young person's referral?' They are not in that situation. A young person goes to the GP, a referral is made and, weeks later, they are told, 'Actually, you don't meet our threshold'. That has a huge impact on that young person's wellbeing. The letters are sometimes not very useful and they can be perceived by the family as being a little bit persecutory, because they will say, 'Why don't you try the family parenting classes that are available?' To be fair to the specialist services, they refer to what is available. Sometimes, it is parenting classes and, actually, that is not the issue within the family, or, sometimes, they have already been to them.

[46] **David Rees:** In your evidence, you actually identified the large number of requests that are being made, and that, as a consequence, we have long waiting lists. I think that Simon alluded to the point that that is actually counter-productive in one sense. Are we seeing evidence of that being counter-productive, and therefore that the waiting lists are creating more people who require the higher levels as a consequence?

[47] **Ms Greening:** I do not have statistical evidence for that, but that is the case from the anecdotal evidence that we have had from members—that it does cause issues. Children and families have difficulties. Obviously, then, if there is not the input and support that they need, those difficulties often tend to get worse. That will often impact then in the school setting, where a child's behaviour may become increasingly disruptive and schools do the best that they can, but there comes a time when, perhaps, the child will either decide not to attend school, or they get excluded.

[48] **David Rees:** I have just one more question. You have also talked about the medical model in the delivery, is the clinical-based approach really another factor that is causing difficulties for families and vulnerable children, because, again, there is a logistical problem in certain areas, but there is perhaps more of an institutional problem as well in some people's

minds?

[49] **Ms Leahy:** It is both, I think. In rural and urban areas there is the logistical issue. Take Cardiff, for example; depending on where you are in the city, it could mean getting three buses and you could have a child who, because of their mental health, is having difficulties functioning socially. So, getting on one bus is a challenge. In rural areas, if you do not have a car, there is no transport. Research shows that it is more effective to have the input where the young people are—they are a captive audience and they engage more, because it is seen more as the normal provision that is provided within a school. It is a case that everyone gets mental distress now and again, so what we would do is look at where you are and what you need, and provide that in a school or in a youth club. The take-up in those places is much better than in a clinical setting.

[50] **David Rees:** Could I make one final point? There is one other point that you mentioned and that is perhaps the lack of information coming back sometimes as to why things are rejected. As a constituency Assembly Member, I have had cases where exactly that has happened. The family has gone through the process where they were denied, but did not have a clue why they were denied, and, therefore, they could not decide how to progress that. Is that common across Wales?

[51] **Ms Greening:** It certainly happens. How common it is, I am not sure, but I think that it probably happens quite a bit now, partly because of the problems that CAMHS themselves are facing, because of raising the thresholds. There may not be well-defined protocols between the various services. Schools and educational psychologists may not have clear ideas about what it is that CAMHS need to accept a referral. Although, having said that, in a lot of areas, there are clear protocols. However, as I said earlier, a lot of referrals now have to go via the GP, so it might be that the issue is that the GP, perhaps, has not provided sufficient information.

[52] **Ms Leahy:** There is only a narrow group of people who can undertake an assessment of need under the mental health Measure and I think that that has caused issues as well. In terms of the counselling services in particular, whereas they used to be able to make a referral, now, because of the assessment process, they are not able to do that—they have to refer to someone who can make that assessment. So, it seems to be another—

10:00

[53] **David Rees:** Another tier of bureaucracy.

[54] **Ms Leahy:** Yes.

[55] **Ann Jones:** Before we move on to Suzy, Simon has a question.

[56] **Simon Thomas:** Yes, I just wanted to ask a bit more about that, actually. It strikes me that what you are saying—and other evidence that we have received—is that there is more and more of a narrowing of the diagnostic tools to allow access to services, and that there is less ability, therefore, for what I asked about earlier, which is early intervention—you know, things that would actually, perhaps, in national terms, save money, as well as saving a lot of grief for the individual concerned. However, the rhetoric is still about early intervention and, if you like, approaches that work with the individual. So, is this clash almost becoming a real problem now, in terms of delivering the services on the ground? Is that something that you come across almost every day? I suppose that ‘tension’ would be a better word than ‘clash’.

[57] **Ms Leahy:** I think that there needs to be clarity about what specialist CAMHS are, and what their remit is, as well as about what a normal response to abnormal events is. There

is a tendency in the tier 1 service, when something goes wrong in a young person's life, to panic, I suppose, and to think that they need specialist CAMHS. I think that a lot of what our service—the primary mental health service—does and did more of before the changes was to help with that anxiety and say, 'Look, resiliency and risk is part of life. We need to see how this develops; if we put interventions in, will we need specialist CAMHS?' I think that, because of the way that specialist CAMHS have been squeezed, it is the young people who very much need the specialist CAMHS who will get a diagnosis. There is the whole issue, with the squeeze in terms of young people with neurological conditions, such as ASC and ADHD, sort of clogging up that system—

[58] **Simon Thomas:** But there is a real quandary here, is there not? The more specialist CAMHS try to, if you like—and I am not sure whether I am using the right term here—medicalise down the ladder, and evolve themselves into people who perhaps, as you say, really need resilience built around them, the more pressure there is on specialist CAMHS, and the less likely they are to actually be able to—. You know, we get people just waiting in queues for this diagnosis. The whole thing just seems to be getting to a stage of a real—

[59] **Ms Leahy:** I think that that is the 'everybody's business, nobody's business' issue still, is it not? That system needs to be refrained so that people know that specialist CAMHS do the specialist work and that the rest of us work with lots of young people who are in distress—

[60] **Simon Thomas:** However, a lot of behaviour now could be dealt with as a kind of—As you say, the resilience support—which, again, we have a lot of evidence on—is being almost specialised, and it is being labelled. Once it has been labelled, it seems that it must, therefore, go to a specialist level.

[61] **Ms Greening:** There are interventions that can be used in schools. There is SEAL—social and emotional aspects of learning—and quite a lot of schools do use that. There is also peer mentoring. So, there are various things that could be used at the school-based level. A lot of those interventions have been designed by psychologists. However, if you do not keep, in a sense, topping up, what happens is that staff leave, somebody else comes in and, for whatever reason, it loses its impetus. I think, again, that it all relates back to the role of the psychologist in the school. I think that one thing that happens is that a lot of schools just want an individual child assessed, and they want the psychologist to do a psychometric assessment, which, from our point of view, might not be the most helpful thing to do. We would prefer to operate within the schools in a much more flexible fashion, and perhaps pick up some of these early issues at an early stage, so that they do not progress.

[62] **Ms Leahy:** I think that the understanding between the two services as a whole needs to come together, and needs to work more systemically, because some specialist CAMHS will write to a school and say, 'Please ask your educational psychologist for a cognitive assessment'. Personally, I think that that is about semantics, and that what they are actually saying is, 'Utilise your psychologists and get them to do some assessments'. However, unfortunately, they use the words 'cognitive assessment' and when a parent sees that they will demand that of our services. A lot of the time it is neither ethical nor appropriate because that young person does not have a learning need and that is what a cognitive assessment does.

[63] **Ann Jones:** Suzy, do you want to ask your questions?

[64] **Suzy Davies:** I wanted to ask some specific questions around emergency admissions. You have talked about increased demand and an increasingly limited capacity at tier 2. Do you have evidence to suggest that more tier 2 clients are presenting with acute crises at A&E?

[65] **Ms Greening:** If a child requires emergency admission, they would have to go to

their GP or present at A&E. Educational psychologists on the whole are not involved in that process. We may have known of the child, but if it is a crisis and an emergency admission, it usually comes via the GP.

[66] **Suzy Davies:** I understand that, it is just whether you know—whether that is from anecdotal evidence or from recorded evidence—that more children who are waiting for tier 2 assistance end up going to A&E because the wait is so long. It may be far more complex than that.

[67] **Ms Greening:** I do not have that information.

[68] **Ms Leahy:** Anecdotally, I would say 'yes', and there appears to be a sharp increase in self-harm, which is one of the reasons why they present at A&E, for example when the wound has been so bad when they are at school that they have needed to go. They would then get an assessment in that way. There is also evidence that when young people are hitting a huge crisis in school, and they get involved with the community intensive teams at tier 4, it is when they have not responded to the school and the school has said, 'Look, this young person is in our school, they are in crisis and something needs to be done.' I know of one example where that was not taken up and then there were ambulances and police, the child was sedated and taken from the school, which was traumatic for the system as a whole. That is only one case.

[69] **Suzy Davies:** It suggests that outside the medical setting, few people are equipped to deal with sudden escalations in a child's mental health condition.

[70] **Ms Leahy:** Some services, such as the youth mental health first aid service, offer that so that teachers and those in tier 1 get trained in youth mental health first aid. That is about training in escalation. There is a lot of what we would describe as behaviour management—schools like to call it anger management—which is about de-escalation. The issue is that because it does not happen that often, schools that are used to dealing with young people that present with difficulties manage quite well, but if it escalates in a school whose population is generally is engaged, it is traumatic for everyone.

[71] **Suzy Davies:** It is a shock to the system. That is what I was coming to, really. May I ask whether you have any experience of children who have been through that escalation—perhaps they have been admitted for a short period because of their particular crises—then recover and come back to school? Are they treated in a different way by the CAMHS system or do they go back to where they were before? Some will possibly be on a waiting list for tier 2, I do not know.

[72] **Ms Leahy:** Most of them will have an emergency assessment and then their needs are assessed. If that has happened and they have been an in-patient, they will then be with the community intensive team, but there might be a delay before they meet the workers because of the demand on the service. They will come back to school if they are able to; they will have something bespoke dedicated to them. They may come back on a limited timetable, or they may go to some other kind of provision, like those who we would generically tend to term 'anxious non-attenders'.

[73] **Suzy Davies:** So, the team around the child would possibly look different then, would it?

[74] **Ms Leahy:** Yes.

[75] **Suzy Davies:** In those circumstances, are the educational psychologists who work in that individual school tasked with extra vigilance duties or something like that?

[76] **Ms Leahy:** It is difficult, especially as we go to delegation because it is up to the school to prioritise. Usually, schools would prioritise a case like that, but, particularly with services that have been delegated to schools, they decide. If they think that, 'Actually, that child is on an hour a day and we're managing them', they are not a priority and they might prioritise something else within the school.

[77] **Suzy Davies:** That is interesting. Thank you very much.

[78] **Ann Jones:** Aled is next, very briefly, please.

[79] **Aled Roberts:** Hoffwn ofyn cwestiwn ynglŷn â'r ffaith bod y cyllid yn cael ei drosglwyddo i'r ysgolion, sef yr hyn rydych newydd ei ddweud. A oes unrhyw dystiolaeth bod yr ysgolion, ers iddynt dderbyn y cyllid yn hytrach na'r cyngor, yn penderfynu mai dim ond asesiadau unigol sy'n cael eu cynnal o fewn yr ysgol, yn hytrach na'r ymyrraeth fuan hon yn gyffredinol ar draws yr ysgol?

Aled Roberts: I would like to ask a question about the fact that the funding is being transferred to schools, which is what you have just said. Is there any evidence that schools, since receiving the funding rather than the council, are deciding that only individual assessments will be undertaken within the school, rather than this early intervention more generally across the school?

[80] **Ms Greening:** As funding is delegated, schools have quite a lot of choice in the way in which they would utilise certain services. Obviously, there might well be a statutory element, where certain things have to be done in terms of meeting statutory requirements, but, really, schools can decide, or have a large measure in deciding, how they want to utilise the services of the educational psychologist.

[81] **Ms Leahy:** And how much they want to buy back.

[82] **Aled Roberts:** How many of the 22 authorities have moved to this budget being delegated to the schools? If you cannot tell us that now, perhaps you could—

[83] **Ms Greening:** I know that it has happened in a few authorities, and certainly there are proposals in other authorities to come up with models of delegation.

[84] **Ann Jones:** If that is different, perhaps we could have a note. It might be helpful to have a note on what the situation is, if that is okay.

[85] **Ms Greening:** Yes, that is fine.

[86] **Ann Jones:** Thank you. We will move on to the role of educational psychologists in schools, as we have started to touch on that. Rebecca, Lynne and Keith have questions on this. Rebecca is first.

[87] **Rebecca Evans:** I wanted to ask whether you have any experience of specialist child and adolescent mental health services limiting the number of referrals that they will take from individual schools.

[88] **Ms Greening:** I have no information about that. Do you know anything about that, Claire?

[89] **Ms Leahy:** As far as I am aware, they do not take direct referrals from schools.

[90] **Rebecca Evans:** What about from school counselling services?

[91] **Ms Leahy:** Again, lots of school counselling services cannot refer directly to CAMHS; they have to direct the young person to the GP. So, we would have to—

[92] **Rebecca Evans:** It seems that there are different models and some confusion there.

[93] I also wanted to ask you this. You referred in your answer to David Rees to children being excluded from schools because they have been unable to access CAMHS. Could you give us an idea of the scale of that issue?

[94] **Ms Greening:** No, I do not have specific figures about that.

[95] **Rebecca Evans:** You are aware that it takes place, though. What would the impact be on that child in terms of their education, and what sort of support would they receive while they are excluded from school?

[96] **Ms Greening:** When a child is excluded from school, if it is a permanent exclusion, the authority would try to place them in another mainstream school, if that was appropriate. If that is not appropriate or if, perhaps, they have already been excluded from a previous school anyway in the locality and this was their second school, then, depending on the age of the child, they would be looking at alternative provision. If the young person is in years 10 or 11, it might be a matter of looking at some kind of education other than at school. If it is a young child, it can be a different situation, obviously. However, while that is happening, and while a placement is being decided upon, the young person should be entitled to home tuition.

[97] **Rebecca Evans:** However, in terms of support for their mental health, is there any continuity of care beyond primary healthcare for them?

[98] **Ms Leahy:** If they have been excluded and they were using a school-based service, they can still access that provision. It can be difficult, because some schools say, 'No, it's off the premises', but lots of the services work from outreach centres, so they go there if the schools say that they cannot have access on the premises. However, other schools view it as a keeping a link, so that that child has some kind of routine whereby they will come back into the school, and they are still getting that support.

10:15

[99] In terms of exclusions, local authorities are delegating lots more budget to schools, so they are expecting that tiered system. So, they would expect an awful lot of support to go in before they got to that point, and they would be asking questions as to what support the child was given. If there was nothing, they would be challenged quite strongly by the local authority that the duty of care to that young person had not been followed, because they did not provide the appropriate staged intervention. Each authority highlights what they have got, and it is different in each authority because of Families First funding and things like that, which also provide support within schools. So, it would depend on what the local authorities commissioned.

[100] **Rebecca Evans:** It seems that there is a great deal of difference between authorities and between schools in the way that they approach this.

[101] **Ms Leahy:** Yes, and it seems that, if the authority is big and not sparsely populated, it is difficult for it to manage with the budgets and to provide equality of service for young people.

[102] **Rebecca Evans:** On a different topic, the Wales Audit Office report published back

in 2009 said that,

[103] ‘the input from educational psychologists to meeting the needs of children and young people with a mental health problem has been variable’.

[104] Do you think that is still the case, or what kinds of improvements have been made in the last five years?

[105] **Ms Greening:** I think that it is still variable. Part of it has to do with other demands. Part of it has to do with staffing levels, and also, as Claire said, if budgets are delegated to schools, what it is the school wants the educational psychologists to do. That is becoming quite an issue, and it will become an increasing issue with more delegation of budgets.

[106] **Ms Leahy:** I think that, for most educational psychologists, someone in their team is involved with the wellbeing strategy of the local authority and they input into research-based strategies and things that have worked. We also work with those who self-harm. Most authorities provide guidance, which is going to be updated when the ‘Talk to me’ document is updated, which will include what to expect from young people, why, what you can do to help, how to be, and leaflets for young people if they think their friend is using this as a way to cope. For critical incidents, most local authorities have someone who works for the critical incident team within an authority, looking at the psychological impact and helping schools on that level. Sorry, I have brought loads of stuff, because I knew I would forget otherwise. [*Laughter*.] On autistic spectrum disorder, lots of local authorities produce, with educational psychology services and ASD teams that work within them, guidance for schools at various levels, such as how to help a young person who has ASD to live within an environment that they do not understand, and we do not understand them, so we have to come to some common ground.

[107] So, although it is patchy and variable, there are key things in terms of support. They is also bereavement support and that kind of work that we do with schools on what to expect, and not to panic if a young person is upset. Particularly with young children, if children are playing things out in their play, schools panic. Our service often works with them to say, ‘Actually, that is helping them’, because they do not have a voice, and they do not have the language to explore it, that helps them to explore, resolve and process what has happened. So, although it is patchy, there are a lot of key things that we are involved with across Wales.

[108] **Ms Greening:** A lot of psychological services will have information that can go out into schools, and a lot of psychological services will, if asked by the school, provide training on a range of issues to do with behaviour, literacy and emotional wellbeing.

[109] **Lynne Neagle:** We have taken some written evidence that says that the relationship between education and specialist CAMHS is ad hoc in Wales, and is not being driven by policy the way it is in England. Have you got any comments on that assertion?

[110] **Ms Greening:** The liaison between educational psychologists and their local specialist CAMHS team varies from area to area. In some areas it is quite good: there will be regular liaison meetings between the psychologists, or a representative from the educational psychology team, and the psychiatrist and members of the specialist CAMHS team. There will be regular meetings, a sharing of information, et cetera, and at times joint working. In a lot of areas, an educational psychologist will be part of the multi-agency assessment panel assessing children with autism spectrum disorder. In other areas, the liaison is quite poor. There will be practically no liaison whatsoever. In one service, the information that I have had is that they get no information back whatsoever from their local CAMHS team. When a child has been referred via the GP, they do not know whether the referral has been accepted. They do not know what input there has been. They get absolutely nothing back in terms of

feedback. It is quite a variable scene across Wales, from pretty good in certain areas down to nothing.

[111] **Ms Leahy:** I would say that it is relational rather than systemic. I do not think it is systemically driven. I think it is about individuals on the ground creating relationships and creating good practice. There is a lot of good practice out there, but it is about the communication between individuals, I feel, rather than a systemic approach. With specialist CAMHS, at the moment I think that they are caught up—and this is not any sort of judgment on that—on crisis, where beds are, and where young people can go in crisis. It seems that end is where they are focusing at the minute. Lots of the liaison that did happen—.To be fair to them, lots of people were seconded. For example, one local authority used to have two specialist therapeutic social workers seconded to CAMHS to do therapeutic input with looked-after children and young people, and that service has been withdrawn. They no longer sit with CAMHS. I am not sure whether the therapeutic intervention is still offered because their service has been squeezed as well, I think. So, where there used to be good relationships solidly formed, I think that they are being withdrawn.

[112] **Lynne Neagle:** I have dealt with cases locally where there has been poor communication and, as a result, children with problems have ended up not only in the CAMHS system, dealing with all that, but have found that they are out of the education system as well. How common is that experience where, due to lack of liaison between the specialist services, there is no understanding on the ground of the special educational needs that a child has, and the child finds themself either out of education altogether or receiving education that is not suitable?

[113] **Ms Greening:** Well, it certainly happens. I do not have precise figures for that, but it certainly happens.

[114] **Ms Leahy:** Maybe it is the system of identifying needs, and the robustness of the—. They should come under our statutory assessment process, should they not? If their needs are not being met, that should be covered under the statutory assessment process, but unfortunately, anecdotally again, lots of those young people will have a statement of need, but there is nothing within the local authority that can meet that young person's need a lot of the time. Lots of things are being explored, such as alternative provisions and learning pathways, and that young person, for whatever reason, has not been able to access that learning at the time, maybe because their distress is so acute that, actually, learning is the last thing they need because they are not actually coping with life. So, it is quite complex to tease out why that has happened, I think.

[115] **Lynne Neagle:** Okay. I have one final question. You said that the problems with working together are relational rather than systemic. However, do you think that there is a case for saying that, because the variability is so widespread, only a systemic approach to tackling this will work? Do you think that there is something that the Welsh Government should be doing, because this is meant to be everybody's business, and that is clearly not working on the ground, is it?

[116] **Ms Leahy:** I have been to the CAMHS NERG meetings when they were running and I have been to other meetings. I think that it is a very specialist CAMHS-focused approach and it does not look at what the local authority—. As far as counselling goes, they have been very interested in that, so that is part of it. However, lots of other initiatives and things that other people have been doing have not been included in that. I think that it is going the same way with the individual development plan agenda and looking at something other than statements. That seems to be very local authority-focused. Children's services have been more involved but health—. There seem to be two separate things developing.

[117] **Ann Jones:** Suzy, I think you have a question on crisis, do you not?

[118] **Suzy Davies:** It was on the difference between systemic and relationship issues. I just want a quick answer on this. Has anyone tried to explain the fact that they are not communicating about a particular child on the basis of confidentiality, that you are aware of? It seems that there are a lot of people involved with one individual child in these circumstances, and I wonder whether anyone is hiding behind that.

[119] **Ms Greening:** Well, there can be issues to do with confidentiality, but what a lot of services do when the parents—or the child if they are the age to do it—sign the referral form, often on the referral form, there is an agreement so that they are also giving permission for us to share information with other services. Certainly, certain specialist CAMHS teams do that as well—they ask that they can share information with other services. However, of course, if the parent refuses, that can be an issue.

[120] **Suzy Davies:** Okay, thank you. That is all I need on that.

[121] **Ann Jones:** We still have Keith to come. We are running out of time, but I know that Aled has some points to do with prescription drugs, so I ask people to be brief.

[122] **Keith Davies:** There has been a reduction in special needs provision in a lot of authorities, but what is the issue between a special needs provision in authorities and the pupil referral units? Lynne was asking whether children are taken from school and put into the right setting. I was just wondering who gets into PRUs and who gets into special needs provision. Who decides where they go?

[123] **Ms Leahy:** There is usually a multidisciplinary meeting at which all young people are discussed. For example, one authority called it a fair access panel, where schools have shown that they have provided interventions from their delegated budget and that they are still not meeting the young person's needs. Then, they will decide what best suits that young person. There are nurture provisions within schools as well, so they might not go to a PRU because it is outside. There might be some kind of nurture provision in a high school that a young person may access. There are also things like flexible learning centres, as some people call them, where a young person looks at the timetable and has a discussion with the school and says, 'That lesson I am okay with, but I know that I can't cope with that other lesson at this point in time'. So, they take the work that they would have done in that lesson and do it in a quiet working environment. So, there are lots of things that happen before they go to PRUs. However, usually, it is a multi—sorry, it is one of those words—[*Laughter.*]

[124] **Ann Jones:** Several people round a table.

[125] **Ms Leahy:** Yes, it will be health, children's services and education.

[126] **Keith Davies:** We have had evidence that the CAMHS teams in many areas are primarily based on a health focus rather than on an educational focus.

10:30

[127] **Ms Leahy:** Yes. I think that it is paediatricians from health who are represented on that, rather than CAMHS. Lots of steering groups, with the school-based counselling as well, did have a member of CAMHS on there, but, since the changes, they have had to say, 'Look, we haven't got the capacity for somebody to attend these meetings'. So, things like that are starting to sort of break down.

[128] **Ms Greening:** It is quite a difficulty—the capacity issue—in terms of getting the

relevant professionals to a multi-agency meeting, whatever the multi-agency meeting is for. It is a problem arranging meetings. I think that this will have implications when the new statutory assessment procedures come in. With IDPs, and the focus on a lot of multi-agency working, will there be enough capacity to do that?

[129] **Keith Davies:** Thank you.

[130] **Ann Jones:** We will now come on to prescription drugs. Aled Roberts has the first questions.

[131] **Aled Roberts:** Wrth inni sôn am gyfarfodydd aml-broffesiynol, mae eich tystiolaeth ysgrifenedig yn sôn am bryderon sydd gennych ynglŷn â'r ffaith bod CAMHS yn cynnig cyffuriau i blant cyn bod trafodaeth rhwng gwahanol broffesiynau. A ydych chi'n barod i ddweud mwy am hynny wrthym ni fel pwyllgor?

Aled Roberts: While we are discussing multidisciplinary meetings, your written evidence talks about the concerns that you have about the fact that CAMHS offer drugs to children before there has been a discussion between the different professions. Are you willing to say more about that to us as committee?

[132] **Ms Greening:** It can be an issue. Certainly, there seems to have been an increase in ADHD diagnosis—

[133] **Ms Leahy:** And Tourette's.

[134] **Ms Greening:** And Tourette's, and ASD. There could be more of a change as well with the DSM5 coming in.

[135] **Aled Roberts:** What is the DSM5?

[136] **Ms Greening:** DSM5 is the 'Diagnostic and Statistical Manual of Mental Disorders'. It gives the classifications, as well as how children and young people and adults are classified in terms of ASD, ADHD, as well as a lot of other mental health issues. However, those are the ones that would probably be of more focus to those working with children and young people. So, when children are diagnosed with ADHD, it is an issue of whether there has been a multidisciplinary assessment, because, sometimes, children will show different behaviours in different settings. So, are they showing those kinds of behaviours in school, or is it just in the home setting that they are showing those quite difficult behaviours? If it is just in the home setting, it might well be a parenting issue, or there may be things happening within the family, and those issues should be addressed, rather than by giving medication, because these are quite powerful drugs. They should not really be given to children under six years of age. When they are given, are they given in conjunction with other kinds of behaviour management strategies and therapies, so that they will be much more effective? Are they going to be given on a short-term basis, because, sometimes, it seems to almost go on forever? Certainly, it used to be the practice that, if a child was on this kind of medication, they would be taken off, say, during school holiday periods. They would be taken off that medication to give the system a rest, because it does have an impact—it can depress appetite and it can cause other problems. Also, we do not really know, if you give a young child that kind of medication, what kind of effect it is going to have on their neurological development in the long term.

[137] **Aled Roberts:** The growth in the prescription of Ritalin is more marked in Wales—the amounts being prescribed, and the growth in prescription—than in other countries, even in the UK. Have you had any discussions with the Welsh Government regarding understanding why that is occurring, and whether there is a need—and there is, again, reference in your written evidence—for guidance with regard to the steps that we go through before moving to

prescribing drugs as an answer to all problems?

[138] **Ms Greening:** I think that this has been mentioned when the AEP has met with individual AMs.

[139] **Ms Leahy:** Yes, we would welcome that.

[140] **Ms Greening:** However, I think that more could be done, and what you are suggesting would be a way forward. Certainly, I think that there should be a multidisciplinary assessment of the child, and the information of what that child's behaviour is like in a variety of settings should be looked at.

[141] **Ms Leahy:** It is not just ADHD. There are young people being given Risperidone with ADHD, which is not licensed for younger children. Some young people as young as 12—I am sorry, I do not know the medical name for it—are on Prozac, so I think that there is an issue. As applied psychologists, we are not medical, but we know that they are not licensed for children of that age, and we are very concerned. When we raise it, sometimes there are flippant 'I'm the medic' responses, but, at other times, there are more useful discussions where they will explain. However, often, the only course of action by the specialist CAMHS team is medication. That is not to say that that young person is not getting interventions elsewhere; it just means that they are not joined up and the team would not necessarily know what interventions are going on elsewhere within the school.

[142] **Ann Jones:** Simon, go on—this is the very last one, very quickly.

[143] **Simon Thomas:** Very quickly, and you might want to give us more written evidence if this is too much to answer in the time that we have, but I have these concerns and they also come out in the evidence. I want to put to you something that I certainly find as a Member, and I do not know whether other Members find this, but, increasingly, more and more parents are coming to me in my surgeries and, basically, demanding a medical diagnosis of some of these conditions for their children. They are demanding that that has to happen, because they see that as the way that opens the door to medication and other support services. Yet those other support services are not necessarily joined up and, from what you told us, that might just open the door to a kind of CAMHS medical intervention that is not necessarily helping that child. I am very concerned about this, because I see it increasing, in the last two or three years, even. It is seen as the way to get access. All the evidence that you have given us today is that early intervention, including the psychology that you can use, should be much more available in the school and working with children, and we should not be getting to this situation, but we are. Some parents are almost—I do not know how to put this, in a way—but they seem to use their child as a battering ram against the doors that are closed to them, and they think that that way they will get access to the services. Is it just me, or is that something that you also perceive that is happening within this system now?

[144] **Ms Greening:** Yes, I think that it does happen. A parent is concerned about their child, but they will very much want a diagnosis, because, as you say, the diagnosis will open certain doors and might open up various things like attendance allowances or disability living allowances. In quite a lot of areas, to get the various provision, support, help and so on, or to get the relevant educational placement, there has to be a diagnosis, rather than, perhaps, looking at need and asking, 'What is it that the child needs?', because once they have a diagnosis, that could follow them through life and, certainly, with very young children, it can be quite difficult to give a diagnosis. Should one give a diagnosis when one is a bit unsure about what the long-term prognosis for that child might be?

[145] **Ms Leahy:** Should support be defined by a label?

[146] **Simon Thomas:** That is something that we will look at.

[147] **David Rees:** May I follow on from that?

[148] **Ann Jones:** Very briefly, because we are 10 minutes over time.

[149] **David Rees:** Does that follow on as a consequence of the fact that the clinical model is dominant? Are parents looking for a diagnosis because the clinical model is dominant?

[150] **Ms Leahy:** Yes, but I think that there are other forces at work in schools as well, like the inspection system. I think that, at the moment, the wellbeing strand of inspection has diminished. Again, this is personal experience, so I do not know how wide it goes. Some schools have said to me, 'Look, Claire, what is the point of spending that money on our wellbeing agenda if we get 'satisfactory' or 'poor' on our attendance? It doesn't matter what interventions we've got going on. We just spend the money on going in and dragging the children out.'

[151] **Ann Jones:** We have run out of time, but thank you ever so much for that. In fact, we are over time. May I thank you for your evidence today? We will send you a copy of the transcript to check for accuracy, so that we have not included anything that you did not say. Could we have a note on the number of authorities that are dealing with delegation? Thank you very much for coming.

Gohiriwyd y cyfarfod rhwng 10:40 a 10:49.
The meeting adjourned between 10:40 and 10:49.

Ymchwiliad i Wasanaethau Iechyd Meddwl Plant a'r Glasoed—Sesiwn Dystiolaeth 4
Inquiry into Child and Adolescent Mental Health Services—Evidence Session 4

[152] **Ann Jones:** We will now reconvene and take our next witness and start our evidence session. We are delighted to invite Dr Rachel Williams to join us. She is the head of child and family psychology in Aneurin Bevan Local Health Board. I believe that you are also representing the applied psychologists specialist advisory group for Wales. Is that right?

[153] **Dr Williams:** Yes.

[154] **Ann Jones:** Okay. Thank you very much for your written evidence and for coming along. We have a set of questions, basically around early intervention, community specialist CAMHS at tier 2 and above, regional variation in accessing specialist CAMHS at tier 2, and then a few others around prescription drugs et cetera. So, those are the four areas that we are going to try to get through, but we will see how we go. Simon is going to start off on early intervention.

[155] **Simon Thomas:** Yes; thank you. Thank you for your evidence, and also for your other evidence, because I believe that you are responsible for another piece of evidence that we have had.

[156] **Dr Williams:** They are saying similar things.

[157] **Simon Thomas:** They say very similar things.

[158] **Dr Williams:** We are saying it twice.

[159] **Simon Thomas:** Yes. I want to start by talking about early intervention. You made a statement in one of the things that you presented to us that there are no resources within CAMHS dedicated to early intervention.

[160] **Dr Williams:** That is right.

[161] **Simon Thomas:** What do you mean by that, exactly?

[162] **Dr Williams:** In terms of early intervention, for me, when we are talking about children, we have such an opportunity. We have children who are, by their very nature, in transition, developing and growing, and we know from all of the literature that the interventions are exponentially more effective, in every measurement, the earlier that you get there—and I mean even before birth.

[163] **Simon Thomas:** What is it about CAMHS that does not allow for that kind of approach to take place? I assume that it links into the other evidence, where you have said that there is not a child or family specific approach at all in all of this.

[164] **Dr Williams:** CAMHS, as we know it now, is not based on child development. It is based on medical intervention, and it is becoming more like that despite the philosophy of 'Together for Mental Health'. In my experience, it has become more diagnosis focused and diagnosis treatment based. So, early intervention is not part of the language of CAMHS now.

[165] **Simon Thomas:** Is that approach being driven by philosophy or by finance?

[166] **Dr Williams:** Finance.

[167] **Simon Thomas:** So, initially, when you go back to 2001 or whenever it was, to 'Everyone Together' or whatever it was—

[168] **Dr Williams:** It was 'Everybody's Business'.

[169] **Simon Thomas:** That is the one. The approach there would have been more suitable to early intervention.

[170] **Dr Williams:** I completely endorse the philosophy of 'Everybody's Business', and I think that we have moved away from it hugely. I think that that is pressure of demand and capacity, in balance. As people become more and more stretched and overwhelmed with demand, they become more linear in their thinking. They cannot think creatively and we get more and more pushed into tight diagnosable 'illnesses' or disorders, and just looking at those. We are not looking at the context that the children are living in and intervening there. That takes more complex thinking and more complex formulation.

[171] **Simon Thomas:** Does it take more time?

[172] **Dr Williams:** It takes more time; it takes more time to liaise. I watched a bit of your meeting with the educational psychologist. We used to have more meetings with educational psychologists, to attend a meeting at a school about a child to help that environment to understand why a child might be hiding under the table, running out of the room, or trashing their classroom because of the many traumas in their life. Just attending that meeting will take a whole afternoon and that may be three or four clinic spaces. That is three or four children that you are not seeing and ticking off your list. Everyone knows that it is time well spent, but the demand is to get through the waiting list and to reach targets.

[173] **Simon Thomas:** Is this practical difficulty, which is also changing the practice on the

ground, now being reflected in some of the structures that are being put into place? What I am trying to get to is that, if you read the Welsh Government documents, you will see that they still talk about this kind of philosophy. Early intervention is still there—

[174] **Dr Williams:** Yes, it is.

[175] **Simon Thomas:** As well as the ways of working, is it actually becoming fossilised into the structures of organisations and the way that they expect CAMHS and you to interface? Do you understand what I am trying to get to? Is the practice on the ground having an effect on the structures that you are working in? In other words, is it perpetuating the problems?

[176] **Dr Williams:** Absolutely, because in our CAMHS, for example, the referral criteria have changed and that has been explicit. There has been a launch of the new referral criteria, which are diagnostic based. Previously, we—

[177] **Simon Thomas:** Is that only GPs then?

[178] **Dr Williams:** It is not only GPs, although I think that more referrals are coming through GPs because children's distress has been looked at through a medical lens. People think that they need to go to a GP to get that medical endorsement. So, it does perpetuate itself. That is what people look for, so that is what people see. Again, it has been crisis driven because the threshold is going up and up. We are getting further and further away from early intervention. We are not even getting to the routine waiting lists. It is hard enough to get a child onto a CAMHS waiting list, but what is happening in reality is that only the urgent cases—where there is a significant risk of self-harm—are being seen. That is doing nothing; it is like an accident and emergency—

[179] **Simon Thomas:** It is sticking plaster, is it not, or not even that? Can you say more about what you said earlier about the referral criteria being changed? In what way have they changed? In what way has the practice on the ground changed the way that young people are now treated?

[180] **Dr Williams:** Previously, there were referral criteria—. It is slightly different where I work because we have had a stand-alone psychology service, so our referral criteria would be about complexity, the longevity of the problem and the family's interest in working psychologically. There are lots of conversations and discussions about whether this would be a suitable referral, whether it can work and whether we can put that resource into them. There are also lots of ways of accessing psychological intervention in other contexts, through consultation to health visitors and school health nurses, and consultations to social services. So, the philosophy is—as is consistent with 'Everybody's Business'—that working with a child in the context in which they live is so much better than pulling them out and giving them the stigma of having to attend a CAMHS clinic. It is also much more effective.

[181] Now, because of the pressure of demand, it is much harder to give time to that. In addition, the criteria that people are being asked to meet are around 'self-harm, risk and diagnosable mental disorder'. I use inverted commas because that is not how I understand children's distress.

[182] **Simon Thomas:** So, it has become—in my layman's terms—a more hard-edged approach to the problems that children exhibit, rather than an interventionist, building resilience kind of approach.

[183] **Dr Williams:** There is no time for building resilience from CAMHS. It has no resource left to do that.

[184] **Simon Thomas:** Is that happening at all then? In the evidence that you have given, you have cited studies on how building resilience can work in the long term; it is not just your opinion. It is an investment, in that early intervention works over a period of time. Is it happening at all? If it is not happening in CAMHS, if we assume that CAMHS is now a completely medical service, is it happening elsewhere?

[185] **Dr Williams:** There are examples. We have two days of a clinical psychologist working in Flying Start in Torfaen where that person is working with nursery nurses, specialist health visitors and schools to promote emotional wellbeing at the very start with some of the most vulnerable families, through working on the attachment relationship. That is great, but it is two days; it is a tiny resource. We also have two days of a child psychotherapist working at a Monmouthshire Flying Start, in a similar vein.

[186] **Simon Thomas:** However, they would be working with several families, would they not?

[187] **Dr Williams:** Oh, yes. They are working with the workforce. I think that we have to try to engender a culture shift and work much more universally in getting psychological health as a priority right from the start.

11:00

[188] It is interesting that there is talk about making emotional cruelty a criminal act. Whether that is a good or a bad thing and how that will be policed is another issue, but the fact is that it raises the profile. If people are not emotionally healthy, they cannot learn, they cannot relate, and they cannot behave in ways that allow our society to function. That starts right at the very start.

[189] **Simon Thomas:** Is there any evidence to date that the slide away from the philosophy in terms of practical application is, in turn, leading to more severe crises among young people and children?

[190] **Dr Williams:** The number of urgent referrals has gone up hugely. So, yes, there is. The amount of self-harm—

[191] **Simon Thomas:** So, it is exhibiting at a later date in a much more severe form.

[192] **Dr Williams:** Yes, it is. I heard you talk earlier about the number of those on Ritalin medication.

[193] **Simon Thomas:** Yes, that has gone up significantly in Wales as an intervention, when perhaps early intervention would have—

[194] **Dr Williams:** It is an intervention that tells us that people do not have the capacity to think. They do not have the time or the capacity. When you are overwhelmed and too much is demanded of you, your thinking becomes linear and less complex, and that is an easy solution.

[195] **Simon Thomas:** You can prescribe in 10 minutes and achieve something that you have just said would otherwise take an afternoon's meeting.

[196] **Dr Williams:** Yes, and more conversation. May I carry on with that point, because I feel very strongly about it? It is probably a scandal that we will look back on in 20 years' time and think, 'What were we doing to our children?' Obviously, the effects of drugs on a

developing brain are massive and frightening, but also, psychologically, what are we teaching our children? Are we teaching them that their behaviour and their mood can be controlled only by drugs? That is a really frightening message to give to our young people, and we do not know what the consequence of that will be.

[197] **Simon Thomas:** It opens a can of worms about other drugs, even legal drugs like alcohol.

[198] **Dr Williams:** Yes, absolutely.

[199] **Ann Jones:** Aled, do you want to ask your questions on prescribed drugs now, and then we will move on?

[200] **Aled Roberts:** Yes. The educational psychologists said that there had been initial discussions with the Welsh Government, but even the information that is held with regard to the extent of prescribing, or whatever, is patchy. Within your own health authority, are there discussions regarding the tendency to prescribe ever more drugs?

[201] **Dr Williams:** No, not that I am party to, and I go to a lot of meetings with a lot of people. So, it is quite surprising. It is a bit of a closed conversation, as far as I am concerned.

[202] **Aled Roberts:** Are you aware of the discussions that are taking place, as I understand it, in America, where there are real discussions taking place in certain states with regard to—'outlawing' is probably too strong a word—minimising the extent of the use of prescribed drugs for young people in the circumstances that you have described?

[203] **Dr Williams:** I have read a lot about the rise of the use of Ritalin and amphetamines for children and how incredibly profitable it is. It is frightening that that can be allowed to dominate. So, I am really pleased to hear that somebody is finally getting hold of that. We should be really cautious and scared of letting that slide and having that situation here.

[204] **Ann Jones:** Lynne, you have a question on this and then you can move on to your other questions.

[205] **Lynne Neagle:** In relation to drugs, I was quite shocked in the earlier evidence session to hear that children are being prescribed Risperidone, which is an anti-psychotic that we know has serious side effects for adults who are taking it. I had a word with the lady on the way out and she said that she has known it to be prescribed for children as young as three. I do not know anything about Ritalin, but how widespread is the use of anti-psychotics in managing children's problems?

[206] **Dr Williams:** I have not come across a child being prescribed it at three years of age, but you do hear of those anomalies. It is not widespread, but it should not be there at all. With regard to Ritalin, there are side effects to Ritalin in terms of—as I believe my colleague mentioned—appetite, growth, heart function and epilepsy. There are all sorts of health implications, not to mention the psychological implications, of putting children on drugs.

[207] **Rebecca Evans:** On the use of anti-psychotic drugs, would it not be entirely appropriate to use them for people under 16 who are experiencing psychotic episodes? Is that not entirely within NICE guidelines to do so? You said that it was inappropriate, so I am trying to—.

[208] **Dr Williams:** It is an extremely powerful drug, and the brain of a child at 16 is still developing hugely. In fact, we know that around the ages of 14 and 15, there is something called synaptic pruning, where the brain undergoes a massive change, as big as the change it

undergoes in toddlerhood, hence all the weird behaviour that we get from adolescents. It is a fact. So, when drugs are put in that mix, I do not think that we know what we are doing regarding that.

[209] Also, I would question the usefulness of understanding a young person's experiences as psychotic. I have had children come to me who tell me that they are hearing voices and that they see people, and these people that they see feel very real to them and will make them do things that are self-destructive. However, when you listen to them and you work with that as their experience, and you understand it differently, not as an illness, but in terms of something that they have compartmentalised off from themselves in their psyche, you will see that it is all the bad and scary things that have happened, and they disassociate from that. If you treat it as a real experience, they can start to integrate that and then they do not need to do that. In a way, it is like an imaginary friend for a younger child; older children have imaginary enemies that tell them to do horrid things that can be integrated, processed and incorporated in a psychological way. It has a psychological function, and we should be listening to that, and not trying to suppress it with drugs.

[210] **Ann Jones:** Lynne, do you want to go on to community specialist CAMHS at tier 2?

[211] **Lynne Neagle:** You have been very clear that you feel that the resources situation is very serious, and that that is driving this dependence on medicalisation. Yet, we know that, since the Assembly was set up, the mental health budget has been ring-fenced and that is an ongoing commitment. In your experience, what is happening to those resources on the ground? Where are they going, and why are they not finding their way to CAMHS?

[212] **Dr Williams:** I do not know the answer to that, but my experience is that we are told that CAMHS budgets are ring-fenced. However, with the Agenda for Change—I do not know if this accounts for it, but it is one explanation—the margin of people's salaries was higher, but there was not an uplift. Do you see what I mean? So, you only have the same amount of budget, but you can pay for fewer resources.

[213] I have been head of service of psychology for 12 years now, and in that service for 15 years, and in that time the service has not grown at all, yet the demand has grown hugely. The only growth that we have had in the accessibility of psychology is through the third sector, by working with our partners in Action for Children to get psychologists into projects that work with children. That was an example of early intervention that I was going to mention. May I talk about that?

[214] **Simon Thomas:** Yes.

[215] **Dr Williams:** There are examples of early intervention, but they are not within CAMHS. For example, the family intervention team in Caerphilly, which works with families before they get into statutory services, has up to 12 weeks intervention in their homes, working with the whole family. Clinically, it is led by a psychologist, and the people who work with them are youth workers and people who have had experience of working with children, and they are not necessarily professionals, but they work to a psychological formulation that is tailor made for that family in those circumstances at that time. It has been evaluated and it has been evaluated really well. I think that I said in my evidence that, according to some socioeconomic calculation, for every £1 spent, they save £7, and yet it still confuses me why that model is not rolled out. Why are we not saying, 'We've found something that really works for very disadvantaged children'? Also, it impacts on CAMHS hugely. Of 32 requests for ADHD assessment, only two went through to the full assessment.

[216] **Lynne Neagle:** You said that the service has not grown at all in Aneurin Bevan. How does that work locally? Presumably, the mental health services come together. Are there ever

any discussions or representations made to the board? Does the board know that you are feeling like you are groaning under the weight of it all?

[217] **Dr Williams:** I am sure that it knows. I think that every service would be saying that. The message is that there is no more money; just work more creatively and more efficiently. I think that everyone is doing their absolute best at that.

[218] **Lynne Neagle:** Okay. On this issue of the prevalence of the medical model, are you able to give us some detail about how that is working on a practical basis? Are there examples of children you know of, who, say, need talking treatment or psychotherapy and are being pushed into taking drugs and psychiatry instead? How widespread is that?

[219] **Dr Williams:** What I can tell you is that we run a telephone advice line every week for all of the professionals who work with children in Gwent. I have been doing that for many years—15 years. The nature of the conversations changes over time and what I hear from people, for example, social workers, teachers, GPs and health visitors, is that unless they word their referral in a certain way—and even if they do that—they know that CAMHS will not take that referral, particularly for children with social problems. It is then a case of, 'Well, that's nothing to do with health; that is a social care issue and we can't deal with that. Social workers should be doing that'. There is a lot of pushing things away. So, it is more that children cannot access services than that they are being forced into psychiatric services. They cannot get any service. In our service now, access to clinical psychology is via CAMHS. So, there is no direct access to psychological therapy from a psychologist.

[220] **Lynne Neagle:** There was evidence that we heard previously; Simon was talking about people being desperate for that label so that they could get into the system, but then when they are in there, they are not getting the appropriate treatment.

[221] **Dr Williams:** Yes. I think that people are desperate for that label for a number of reasons. I think that, sometimes, parents, teachers and the adults around a child believe—. The best case scenario is that they believe that it will open doors and it will help their child. That is a genuine desire. I think that that is a myth. It does not open doors and it can be a huge disappointment. In fact, it can be worse than not having a label.

[222] The worst case scenario is that it is a mask for more sinister and concerning situations that are going on in a child's life. Those are the ones that really concern me. For example, for a child who is not attentive at school, because he or she is hyper vigilant and hyper aroused, the world is not safe or predictable, so he or she is charging around, hiding under chairs and running out. All of those behaviours, you could slot into an ADHD label. However, if you look a bit more carefully and in a more complex way, there is likely to be violence going on at home and they may have had all sorts of traumas that they are not able to articulate. Just recently, in my own practice, there have been cases of children who have been diagnosed with ADHD and one child came back to me when he was 16 saying, 'I've got this label; I knew that I wasn't that, but it meant that I didn't have to go to school. Actually, I was under the table and banging my head because I couldn't get the picture out of my head of my mum being pushed down the stairs by her partner and being kicked. I thought that she was dead, and that just keeps coming back to me. It comes back to me. I can't sleep at night, and I want to get that picture out of my head'.

11:15

[223] No-one had asked about that story because once you have a diagnosis of ADHD that becomes the child's identity. That is what people are interested in. I am telling you this, but there are hundreds of cases: there was a child with ADHD who was being used for child pornography at home, but once a label had been reached, that was kind of the end of the story.

That closes down curiosity. It also invalidates that child. If a child has a label of disorder, whatever they say is attributed to that. People will think, 'They are lying'. People stop listening, and that is dangerous. It is really dangerous.

[224] **Lynne Neagle:** Thank you.

[225] **Ann Jones:** Simon, do you have a point on this before we go on?

[226] **Simon Thomas:** Yes. I was reading something the other day that we can all tick two boxes, at least, in ADHD diagnosis.

[227] **Dr Williams:** Absolutely. Most three-year-olds would be diagnosed. [*Laughter*.]

[228] **Simon Thomas:** I am sorry to take you back, because that was very powerful evidence, but I just want to be clear about one thing. You talked about the other early interventions outside CAMHS and their success. However, we have had other evidence that describes some things that are called early intervention—some of them around counselling, and some of them around some therapies—that perhaps are not evidenced as being very successful.

[229] **Dr Williams:** Oh, right. Okay.

[230] **Simon Thomas:** I just want to be clear. Where this lies is a bigger issue, and whether it is within CAMHS or a unified social services and health agenda is something to be discussed. However, is there a clear understanding in Wales of the right early intervention approaches? Are all of the professions that are involved in this signed up to the same?

[231] **Dr Williams:** No.

[232] **Simon Thomas:** I have visited Scotland in the past and it seems that they have signed up to a much more unified approach on early intervention.

[233] **Dr Williams:** No, we have not.

[234] **Simon Thomas:** Okay. That is what I was concerned about.

[235] **Dr Williams:** We have not. If you were to ask me what that should be, I would say—

[236] **Simon Thomas:** You would say psychologists. [*Laughter*.]

[237] **Dr Williams:** I would say attachment; that it has to start with healthy attachments.

[238] **Simon Thomas:** Okay. That is something that we have looked at with previous inquiries as well.

[239] **Dr Williams:** It is so compelling. It beggars belief that we have not somehow incorporated that. I guess that it is just the weight of the huge organisation that is the NHS and that is medical politics, so that we just trundle on in the same way and do not have the courage, the resources, or the thinking space to step out and say, 'We need to do this differently'. What we are doing is nurturing human beings. We know how the brain develops. It develops in relationship, and we need to nurture those relationships so that they can be the best that they can be.

[240] **Simon Thomas:** So, although you would say that we do not have that shared understanding at a national level at the moment, you would nevertheless say that there is

plenty of evidence that we could have that.

[241] **Dr Williams:** Absolutely. I could give it to you.

[242] **Simon Thomas:** Some of it is in your evidence, to be fair.

[243] **Dr Williams:** Oh, I could give you loads more. [*Laughter*.]

[244] **Ann Jones:** We might take you up on that if we need it. Simon, had you finished?

[245] **Simon Thomas:** Yes, thank you.

[246] **Ann Jones:** Lynne, had you finished?

[247] **Lynne Neagle:** Yes.

[248] **Ann Jones:** David, do you have anything to add? I see that you do not. We will therefore move on to the regional variations in accessing specialist CAMHS. Rebecca will go first, and then we will go to Keith. I know that Suzy has a couple of questions on another issue.

[249] **Rebecca Evans:** I just wanted to ask you to expand on your written evidence that access referral criteria are interpreted differently in different parts of Wales, and that those lead to different types of CAMHS being offered.

[250] **Dr Williams:** First, the referral criteria are defined locally; so, they are different locally. In a way that is maybe not necessarily a bad thing, as long as there is some rationale around that. We work systemically, so if you have a really good educational psychology department that works with emotional development, that might take some of the work that would come to CAMHS. We work in relationship to each other. However, I think that it is open to—. What should I say? It depends a lot on who is running the service, to be honest, as to what is allowed in and not allowed in.

[251] **Rebecca Evans:** Do you have an example of where, in your opinion, people were getting it right, in terms of the criteria and then the services that followed?

[252] **Dr Williams:** Yes. I think that criteria based on complexity—I mean, we are talking about specialist services so it has to be the top end of services. I think it needs to be based on complexity, the length of time that the problem has been there and, to some extent, the ability of those people to engage with the service. I do not think that I can point to a service and say, 'That's the perfect service' because it does not exist.

[253] **Rebecca Evans:** On recruitment to CAMHS, the Wales Audit Office and Healthcare Inspectorate Wales report back in 2009 said that there were some serious recruitment problems in parts of Wales. Is that not a problem any longer?

[254] **Dr Williams:** It would depend on the profession. I think that there are problems recruiting to psychiatry. I do not know about nursing, although I think that there is a problem with the training for CAMHS nurses. There is not a problem recruiting to clinical psychology.

[255] **Rebecca Evans:** What are the problems with training for CAMHS nurses?

[256] **Dr Williams:** In my opinion, it is not a nursing—. Some of the core skills of nursing are very relevant to CAMHS, but, actually, a deep understanding of child development and an ability to work with systems and context are the two key skills you need to work with children

and families, and those are not core parts of nursing training.

[257] **Ann Jones:** Aled, do you have a question on this point?

[258] **Aled Roberts:** Yes, on this recruitment issue, when we undertook our neonatal inquiry, we were told that there were difficulties with recruiting both at consultant grade and with specialist nurses then. Yet, when certain health boards were challenged, it was apparent that they had undertaken no attempts at recruitment. They had actually kept posts vacant. So, is there a combination of factors here? Are posts kept vacant because of the financial challenges that you have spoken about or have specific attempts to recruit been made that have failed?

[259] **Dr Williams:** I do not know about neonatal services and I do not know what psychiatry does when it is recruiting, but I can say as the person who has to do the recruiting process for psychology that it is so cumbersome now in the NHS. Yes, there are delays at every point. Getting your request to recruit through the board takes a long time, and you have to chase it up, and you have to chase it up, and you have to chase it up and you have to check where it has got to. Once you have that ratified, putting it through the centralised recruitment service takes about six months now before you have someone in post. I have had people I needed to cover maternity leave that we knew about in October and they are going to start next week. That has taken up hours of my time and my secretary's time, and it did not used to be like that. Every process—

[260] **Aled Roberts:** So, does every vacancy have to go through the board before it is filled?

[261] **Dr Williams:** Yes, every vacancy. Even every increase in hours has to go through the board. So, if I have some extra money in my budget that I want to use for extra clinical time and I have a psychologist who says, 'Yes, I could work an extra afternoon', that has to go through all of that as well, and it takes a long time.

[262] **Aled Roberts:** So, there is very little empowerment for you as a service lead—

[263] **Dr Williams:** It has changed hugely in the past five years especially. I just feel like an admin person who is just trying to chase after bureaucratic systems that change and that are confusing and so time consuming. Do not start me on that.

[264] **Aled Roberts:** And presumably people are then employed to administer the bureaucratic systems.

[265] **Dr Williams:** Yes, it is a whole industry, and it is growing all the time while clinical services do not grow.

[266] **Ann Jones:** Keith is next.

[267] **Keith Davies:** You have talked about the problem of finance—that the amount seems to stay the same and, obviously, salaries and other things go up. Are there obvious differences between different parts of Wales in the amount of money that is available for specialist CAMHS?

[268] **Dr Williams:** I do not know that, Keith. I am not looking across anywhere, thinking, 'Oh, you've got more than us', so I do not know that.

[269] **Keith Davies:** You spoke earlier about what you do in Torfaen and Caerphilly with other agencies. Is that repeated elsewhere in Wales or—

[270] **Dr Williams:** No, not that I know of. We have been particularly proactive in Gwent, and I think that, because we have had a stand-alone psychology service and had access to meetings and people in social services and other parts of local authorities, it is through those relationships that these posts have been developed. So, we also have a psychologist working in Newport social services and Monmouth social services who works specifically with looked-after children, which is a population that is poorly served by CAMHS, especially now. However, it is all ad hoc. As the educational psychologist mentioned, it is about being in the right meeting at the right time with someone who can listen—

[271] **Keith Davies:** It may be ad hoc, but, to me, it seems that that is a way of generating specialisms and funding from elsewhere and getting teams working together—

[272] **Dr Williams:** It is great when it works. It takes a lot of time and a lot of resource. You are constantly fighting and swimming against the tide. Also, these posts are usually time-limited, so you can put them in post, but with social services being so strapped as well, there is always that fear that that whole service will be taken away. Again, with the projects, the family intervention team, the MIST project in Torfaen and Skills for Living, they have a shelf life, despite being evaluated so highly.

[273] **Keith Davies:** Yes, but when the shelf life comes to an end, maybe the health board will see how well they are working.

[274] **Dr Williams:** However, it does not—. Skills for Living is a perfect example, it was a project that was funded by Big Lottery money across Gwent for care leavers, so for children between the ages of 16 and 25, and it was to help them to move into independent living, particularly through promoting their emotional health, because so many care leavers end up in very poor, dysfunctional relationships and all that follows from that. It has been going for five years, the funding ended two days ago at the end of the financial year, and it has the most fantastic evaluations—the number of teenage pregnancies is down, the number of A&E—. All the economic arguments that you can make are there. The health board says, 'It's fantastic. It's fantastic and we have no money.'

[275] **Keith Davies:** We had a statement from the Minister for health yesterday about issues like that across Wales that have come down, which look very good. Simon mentioned Scotland. Are there differences between us and England, because there is a big fight now in the press as to what we are doing in Wales compared with what is happening in England? Have they got better specialist CAMHS in England than we have?

[276] **Dr Williams:** I think that they have better and worse. So, if I could cherry-pick, I would have the looked-after-children services that England has. It has services dedicated to the psychological wellbeing of children who are looked after, which is excellent and much needed, because they are not served by our CAMHS.

[277] However, I also think that the introduction of IAPT—do you know about it? IAPT stands for improving access to psychological therapies, and it was introduced for adults after the Layard report, which, in theory, sounds fantastic and, as a psychologist, I should be thinking, 'It's great'. However, the way that it has been implemented is disappointing in that it is focused on one model of therapy, which is manualised. It has been done on the cheap, I suppose. That is for adults and now, I think, England has started to introduce it for children. Again, I think that it is completely inappropriate. Most children whom we see cannot access cognitive models of therapy; they are not at that level. They are at high levels of arousal, they are not emotionally regulated, they do not have the language; it is a sort of one-size-fits-all, quick fix thing again, unfortunately. So, in some ways I am proud of what we try to do in Wales. We try to be innovative and creative, but it feels like that is getting more and more

squeezed, and it is harder to think outside of the box.

11:30

[278] **Ann Jones:** Suzy, you have some questions on crisis interventions.

[279] **Suzy Davies:** I just wanted to ask you about emergency admissions, which, judging by your evidence and the evidence of other witnesses, seems to be symptomatic of the squeeze, particularly at the tier 2 end of things. Obviously, I have read your evidence here that hospital just exacerbates this idea of medical interventions with people, at whatever stage they are meeting the service. What I want to ask is this: what happens when somebody has had emergency admission, whether that is just at A&E, or whether they have actually been an in-patient? Obviously a crisis in someone's life can change the way that they are viewed by the service. They may have just been on a tier 1 waiting list up until that particular incident. What happens after that, generally? I appreciate that people are coming in at different tiers, but what happens after that generally? Does the fact that somebody has had this crisis in a hospital setting change the expectations of those people that everything they have from there on in must be medicalised? Do they lose faith in the psychological approach?

[280] **Dr Williams:** I do not think that it starts there. I think it is a cultural thing. I think that we have become more and more interested—well, not interested. Let me start again. If a child goes into hospital having harmed themselves—that is what you are talking about, is it not?

[281] **Suzy Davies:** Yes. I am guessing that is a fairly commonplace emergency admission.

[282] **Dr Williams:** Yes. What will happen is that the duty psychiatrist or nurse will interview that child. A message will be sent to CAMHS, and every day somebody is on duty to go to meet those people in hospital before they are discharged. I would say that very few of those become CAMHS referrals—very, very few. I do not know the statistics—I am sure that we could find them—but, generally, there will be some conversation. It may be that they have school counselling in place, or they have something, and it was an impulsive act, and they are sent away to deal with whatever is going on. So, whether they see themselves as medicalising their problems or not is not really an issue in that instance, I do not think.

[283] **Suzy Davies:** In the evidence session that we had earlier, it was suggested when I asked about the fact that the waiting list for tier 2 is so long, and of course there is a capacity issue, that a child's problems can escalate, and then they end up in emergency situations. So, they are sort of already in the system, but at a very basic level.

[284] **Dr Williams:** We are using the term 'emergency' differently. We use 'emergency' to mean when somebody has gone into hospital, but I think that you are also asking me about urgency. So, we have another criterion, which is 'urgent', where people have to be seen within four weeks.

[285] **Suzy Davies:** I am talking about the first, where somebody may have been getting some school counselling, but everything seems to be taking forever; they go away and self-harm, turn up in A&E saying, 'I've cut myself', and then they just go into an incredibly medicalised system when, actually, they have not really had a chance to try out the psychological approach to things. Having been in a hospital setting, even if it is just the A&E, not as in-patient, at the end of that they are just thinking, 'Oh, medicine is my answer'. Would that be a fair observation?

[286] **Dr Williams:** Yes, possibly. I suppose that if they are in school counselling they are receiving some sort of psychologically minded service. If they end up in CAMHS they will get that medical approach.

[287] **Suzy Davies:** I think what I am asking is this: if somebody is having a tier 1 relationship of some sort, whether it is school counselling or just an initial appointment with a GP, and then they have a crisis, and then they go to hospital, is there a chance that they will look back at the psychological approach and say, 'Oh, well, that was all a big waste of time. What I need is pills'.

[288] **Dr Williams:** Yes, but not necessarily—

[289] **Suzy Davies:** [*Inaudible.*] Are you giving anecdotal evidence that that might be occurring, and it is then self-perpetuating with the more medical model?

[290] **Dr Williams:** I suppose that this brings me back to my point on urgency. I think that what is happening is that people's distress is building because they are not getting the level of intervention that they need, psychologically. Self-harm is something that people cannot ignore. So then they get into the medical system. As to whether the client thinks, 'Psychological stuff is nonsense', generally, they will not know, particularly. They will get what they are given and they think that that is what the service is. Generally, people are quite ill informed about what is possible.

[291] **Suzy Davies:** Thank you; that is what I was coming to.

[292] **Simon Thomas:** I want to approach the same thing from the other perspective. I was slightly surprised when you said that someone could present as an emergency—if they have self-harmed, for example—and that does not automatically refer you into CAMHS.

[293] **Dr Williams:** No, absolutely not.

[294] **Simon Thomas:** Maybe I am very innocent here, but I would have thought that you would have been referred straight into CAMHS if that happened.

[295] **Dr Williams:** You can take 26 paracetamol and, if it was in response to an argument, or it was considered—

[296] **Simon Thomas:** Where does the decision making lie?

[297] **Dr Williams:** It lies with a CAMHS nurse or a senior house officer. It would be somebody from CAMHS. When there has been an admission to hospital overnight, the next day, somebody from CAMHS will go to talk to that person and decide whether they should be discharged, or what should happen next.

[298] **Simon Thomas:** Once again, as a lay person, I would assume that that person does need help. They may not need CAMHS help, but I would assume that they need some other help, from you, for example.

[299] **Dr Williams:** They would not have access to that, necessarily.

[300] **Simon Thomas:** So, that does not come from access to A&E, does it? In order to access your services, you have to go back to the GP.

[301] **Dr Williams:** They would have to go through CAMHS as well.

[302] **Suzy Davies:** So, crisis help does not work. That is what you are saying. [*Laughter.*]

[303] **Simon Thomas:** That is what I am trying to get to, really.

[304] We have people presenting in emergencies, which might be a cry for help, but that cry for help is not being answered.

[305] **Dr Williams:** No, not if somebody assesses that by saying, for example, 'Well, you were in school, you were drunk, you had had an argument, and your boyfriend had just dumped you'.

[306] **Simon Thomas:** Those are all emotional wellbeing things that should be addressed anyway.

[307] **Dr Williams:** Yes. I am not leaping on that point, because there are more complex situations that are not being dealt with either, which do not present as a dramatic event, but are more sinister.

[308] **Simon Thomas:** Some people would internalise it much more.

[309] **Dr Williams:** Yes. So, there are even worse things being missed, to be honest.

[310] **Lynne Neagle:** I would like to ask about compliance with the four-week target for urgent referrals. Once again, my experience was that I was trying to get a child into CAMHS, but the only way that I could get them in under the four weeks was when the child started saying that he was going to hurt himself. Suddenly, they said, 'Oh, that is different; in you come'. Are the criteria working, or is admission largely based on whether the child is at risk of harm?

[311] **Dr Williams:** The criteria state that, if there is a risk of self-harm or suicidal ideation, then they should get an appointment within four weeks. However, an appointment within four weeks does not mean intervention within four weeks; it means an initial assessment and then they may have to wait for something more meaningful. Also, it means that routine referrals are not being seen. So, yes, a lot of the children who are being seen as urgent have been waiting on the routine waiting list. Those are the children who get through the CAMHS referral system, and there are plenty who are rejected, and there is an even bigger proportion of children for whom a potential referrer says, 'There is just no point. We go through all of this and it just gets sent back, so we are not doing it. What else can we do?' I hear that every week, because we run a telephone advice line and we offer consultations to other professionals, who tell us that.

[312] We are now setting up some focus groups for school health nurses, social workers and school counsellors to ask them specifically about the children they are not referring. They are a completely unseen group, and they really worry me. We could get statistics and we could—and we are going to do this—follow up the children who were rejected and find out what happens to them. It is a big piece of work, but we at least have their names. However, for the children who never do, people just go, 'No, there's no point in me referring'. The only way that we can think of at the moment to find out about them is to talk to the people who are going through that mind process of, 'We would, but we will not'.

[313] **Lynne Neagle:** So, for the children who are not threatening to self-harm and who are not coming in via the urgent four-week route, but who have a need for CAMHS, how long would you expect them to be waiting in Gwent?

[314] **Dr Williams:** It depends on the borough, which is divided into three sector teams. The worst waiting time is over a year.

[315] **Lynne Neagle:** Right. So, there is no focus on referral-to-treatment targets in relation

to children's mental health access. There is nothing like that that is governing that.

[316] **Dr Williams:** People are struggling to meet the urgent target. That is about capacity; it is not that people are not working really hard.

[317] **Simon Thomas:** On the follow-up work that you just mentioned that you were looking to do, is that something that could be done fairly quickly, or is that a very long piece of work?

[318] **Dr Williams:** No, we are trying to do it as quickly as we can.

[319] **Simon Thomas:** I just wondered about the length of this inquiry. We have a couple of months for this.

[320] **Dr Williams:** We are also trying to do it quite quickly, because we have placement students with us and they are brilliant at doing that sort of thing, because we do not have the capacity. [*Laughter.*]

[321] **Simon Thomas:** The reason I asked is that, several times now in different contexts, you have referred to the fact that there is the potential for a cohort of young people not to be seen because they are not presenting as emergencies or as urgent cases, but, in fact, there is a huge backlog of problems there. Of course, these problems pop up when they are 25, not now. Society will deal with those difficulties, at whatever age it might be. Apart from resources, which is obviously a big issue, is there anything else in the system that is stopping that? Is the medical approach one of the problems there? That is why I asked previous witnesses about the difficulty that I have with parents who say, 'I want my child diagnosed now because that opens the door to them'—whether it does or does not, that is the perception and that is the demand from parents. Is that part of the problem as well, and not just finances?

[322] **Dr Williams:** It is part of the problem. We need a whole culture shift. I was really hopeful with 'Everybody's Business', because the philosophy there was that it is everybody's business to give our children a good start and to attend to their emotional wellbeing. Everybody who has interaction with a child in their normal environment needs to be psychologically minded and well informed about how to make that the best possible start for them, but we have really lost that, and now we are just dealing with those children who are presenting behaviours that scare us or that will do somebody damage, and dealing with that. So, we are dealing with urgency rather than emotional development and wellbeing.

[323] **Simon Thomas:** So, we have moved a long way from the original philosophy.

[324] **Dr Williams:** Yes. Health promotion is another thing. We are struggling to just manage the number of referrals. Doing more proactive health promotion activities is going to fall off the to-do list, sadly.

[325] **Aled Roberts:** Just picking up on your point on the routine lists and the difficulty of ensuring that people are seen, what controls are in place with regard to repeat prescriptions without these—. How often would a youngster who is just on the routine list expect to be seen by a professional? What are the controls like with regard to repeat prescriptions without the person being seen to see whether other interventions are required, or whether the drugs are having an impact that was not foreseen at the beginning?

[326] **Dr Williams:** You would have to ask a medic. However, my understanding is that they have six-month medication reviews if the child is on medication. However, that is not really my bag.

[327] **Aled Roberts:** Is there any evidence that you have seen or any anecdotal evidence that you have that those six-monthly appointments are not being—. If there is so much pressure on the system, is it conceivable that somebody would not be seen every six months?

[328] **Dr Williams:** I do not know, Aled, sorry; I should not say, because I do not know. I am sure that it is conceivable, but I do not know.

11:45

[329] **Keith Davies:** In the joint report that you presented to us, you say that the ADHD diagnosis needs to be addressed—that huge amounts of resources are being wasted because of wrong diagnoses.

[330] **Dr Williams:** I did say that. This is my opinion. It comes down, again, to educating the public about what ADHD is and is not. It is a description of a cluster of symptoms that all children show at some point; it is behaviour. There is no compelling evidence that it is anything more than that. It is not an illness like other medical—. As it has been given a diagnostic label, it has the credibility of a medical diagnosis. It is not an illness; it is a description of behaviours, which are variable and unreliably consistent. It has no neurological aetiology that can be identified.

[331] **Simon Thomas:** Do we use drugs to tackle it?

[332] **Dr Williams:** If you were given amphetamines, your behaviour would change.

[333] **Simon Thomas:** It certainly would [*Laughter.*]

[334] **Dr Williams:** That is why people took them in the 1960s. It has an immediate effect, but the evidence suggests that, after 18 months, the drugs stop working anyway.

[335] **Simon Thomas:** If it is not a neurological condition, how on earth can drugs really tackle it?

[336] **Dr Williams:** Nothing has been identified. Sorry, what was your question? As services become more medicalised—you have talked about it, Simon—people want that label; it is something to hang on. It gives us a false sense of understanding something, but we have understood nothing; it helps us not at all. The behaviour is still the behaviour. Worse than that, it covers up the fact that a child is signalling distress in a very obvious way that has to be dealt with. If we make it a deficit in the child, it becomes that child's identity. That is how a child is described—'Oh, they are ADHD.' We do not need to listen to them, think about them or understand them any more than that; somehow that is the end of the story. That is really, really dangerous.

[337] **Ann Jones:** Thank you ever so much for that. Members have found your powerful evidence most interesting. Thank you very much for coming to give evidence to us today. We will send a copy of the transcript for you to check for accuracy. Members have gained a lot from this session; we may want to talk to you again and ask you to share some more thoughts with us.

[338] **Simon Thomas:** Can we follow up on the cohort study?

[339] **Ann Jones:** Yes, that would be good. We will make contact with you—is that all right?

[340] **Dr Williams:** That is fine.

11:48

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

[341] **Ann Jones:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 17.42(vi).

[342] I see that Members are in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:48.
The public part of the meeting ended at 11:48.