National Assembly for Wales

Children, Young People and Education Committee

Inquiry into Child and Adolescent Mental Health Services (CAMHS)

Evidence from : Applied Psychologists in Health National Specialist Advisory Group

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The Applied Psychologists in Wales Specialist Advisory Committee is a subgroup of the Welsh Scientific Advisory Committee and represents clinical, counselling, educational, occupational and health psychologists working in any health setting whether part of the NHS, Local authority or third sector.

As a subcommittee of one of the seven statutory advisory committees constituted to advise Welsh Government, the Applied Psychologist in Health Specialist Advisory Committee is pleased to have the opportunity to comment on the Inquiry into Child and Adolescent Mental Health Services (CAMHS). As the role of this Committee is to provide expert professional advice to Welsh Ministers and Welsh Government officials on all matters relating to the scientific services professions, the Committee felt that it was incumbent on it to provide a view. The Committee hopes that you find the opinion expressed helpful and would be happy to engage further if required.

	<u>**The Committee is interested in hearing about**</u> **The availability of early intervention services for children and adolescents with mental health problems**
1.	1. The introduction of the Mental Health Measure Wales is an opportunity to increase access to early intervention within Primary Care Mental Health Support Services (PCMHSS) for individuals under 18 years of age. The introduction of PCMHSS across the age-span is an opportunity to take a more systemic approach to children and adults and to view their difficulties in the context of their social, familial and medical history in order to provide holistic treatment options. Concern has been expressed by Clinical psychologists working with children and adolescents in services across Wales that to date there has been a lack of training in systemic practice or in psychological interventions for children and families and as the majority of practitioners working in the PCMHSS have been recruited from services to working age adults they have continued with the practice that they are familiar with. Interventions provided by PCMHSS are not child/family specific as clinicians have little training in understanding child development or children's psychological distress. Some examples of good practice should be noted e.g. Hywel Dda University Health Board Specialist CAMHS service provides a Primary Mental Health Service although not funded through PCMHSS resources. Other services which can be identified as early intervention are localised. The FIT (Family Intervention Team) in Caerphilly works with children and families before other statuary services become involved. The service is hosted by Action for Children and led clinically by a clinical psychologist (ABUHB) – a good example of partnership working. Each intervention is informed by a psychological formulation and time limited. The external evaluation of the service has shown the high social economic value – saving £7 for every £1. An audit of the work showed that for 36 referrals requesting an ADHD assessment only 2 went on to a full assessment, thus, saving core CAMHS a huge resource. Despite this, statutory services have not yet sought to roll this out. Innovative practice and services rely on short term project money and are not embedded within core services. 2. There has been minimal investment in applied psychology posts based within PCMHSS reducing the opportunities for clinicians within PCMHSS to access high quality specialist supervision, training and support, which is likely to reduce their effectiveness and efficiency in assessing children, adolescents or families suffering psychological problems and in delivering psychological therapies appropriate for this client group. Where posts have been created the funding is often short term and time limited. In Aneurin Bevan UHB the Child and Family

	Psychology service has responded by putting together and delivering a comprehensive training package with follow up supervision. However, this has costs for service provision elsewhere, and is not a sustainable model without dedicated child expertise being funded to support the ongoing training and supervision needs of the service. There are no psychologists embedded within the PCMHSS and the time given is from the already very limited core service. 3. There appears to be little or no early psychological intervention available to children who are experiencing physical health conditions. Paediatric services appear to have high demand for such input but there is inconsistency (even within Health Boards) as to the ability to access early intervention psychological input. Again, some good practice is to be noted e.g. Hywel Dda UHB Specialist CAMHS Continuing Care Service providing consultation to the larger Continuing Care Service). 4. Funding for the only Education Psychology training course in Wales is due to be withdrawn and this will have a significant impact upon the ability of pupils to access early intervention services for emotional and mental-health difficulties. Educational Psychologists trained in England have to commit to working in England for two years following their training and without the incentives of improved salaries and working conditions they are unlikely to be attracted to working in Wales. They will also need considerable support to work within the bilingual context of Welsh and English. 5. Educational Psychology Services have a responsibility to provide interventions to address mental health difficulties of children and young people, whether at 'Tier 1' or 'Tier 2'. In practice there seems to be little access to psychological therapies within these services, thereby adding to the pressure to refer to specialist tier 2 services even where an intervention at Tier 1 might be effective. 6.The competencies of clinicians offering early intervention psychological therapies varies significantly across services in Wales and more investment in providing training in evidence-based psychological interventions is required to address this variation in access. A range of interventions will be required but should be offered on the basis of guidance about which will effectively address the presenting problems. School Counsellors tend to operate from a Person Centred/Humanistic frame, with little evidence of efficacy within this population, and anecdotal evidence suggesting that it could be unhelpful for some clients. 7. Secure emotional attachments are the building blocks for mental well-being characterised by individuals who can regulate emotion, form rewarding relationships and fulfil their learning capacity. There is a growing body of evidence from neuroscience research which demonstrates that the brain is structured to develop healthy attachments within in a dyadic relationship and on how this neurobiological development impacts on the child's emotional, cognitive and physical health (see the work of Porges, Baylon, and Shore). The emphasis in both PCMHSS and later in tier 2 CAMHS services is directed by a medical model of health care which identifies deficiency and disorder rather than on promoting mental health. Evidence of effective early intervention would therefore dictate a change in the model used to one which supports secure attachments within the family and wider community
	Access to community specialist CAMHS at tier 2 and above for children and adolescents with mental health problems, including access to psychological therapies
2.	1. Specialist CAMHS across the whole of Wales appear to be understaffed and underfunded. Figures from the Royal College of Psychiatry suggest that staff establishment in each of the Specialist CAMHS services in Wales falls below the recommended benchmark by between 30-50%. The CAMHS workforce often has additional non-clinical responsibilities which reduces their clinically available time, making the ratio of full-time staff to the population even lower. Low Staffing numbers mean that relatively tight criteria need to be implemented in order to maintain manageable workloads. This leads to the unintended consequence of reducing access to the service but also means that for those considered to have significant difficulties the response is quite rapid, though at the significant cost to those who fail to meet critieria. The prevalence of the medical model in the delivery of services inevitably leads to access criteria which focus on determining 'disorder'. There needs to be a debate as to whether this is a useful/ethical endeavour, and the risk that services reward a deterioration of difficulties, or crisis presentation because they are not able to respond to less severe presentations. 2. The emphasis in Together for Mental Health was on early intervention and building resilience. However the direction of travel seems to be in the opposite direction. CAMHS referral criteria are ever tightening towards diagnosable mental disorder which happens later in the trajectory and focusses on deficiency rather than resilience. 3. Specialist CAMHS' in different Health Boards are implementing different access criteria e.g. some CAMHS accept referrals for individuals with the developmental disorders ASD and

	ADHD in the absence of co-morbid mental-health difficulties, whereas others do not; the criteria for moderate and severe mental-health difficulties differs between services. 4. Referrers often find it difficult to access CAMHS. There is little attempt made to measure which referrals are rejected and what happens to the children once rejected. It is even harder to get an accurate picture of the number of potential referrals where the referrer has decided 'not to bother' because previous experience tells them there is no point. Subsequently, there is a huge, masked unmet need. When referrals are accepted some children and families are unable to make use of the traditional 'clinic' based delivery of service as it does not suit some of the most vulnerable, complex and traumatised families. Reaching out to these families in a more proactive/creative way is not possible with the pressure of target driven waiting times and the capacity/demand imbalance. 5. Competence to deliver an appropriate range of psychological therapies within CAMHS is variable. Not all CAMHS have sufficient establishment of clinicians to provide the appropriate range of therapeutic interventions at the appropriate intensity. There is an over-emphasis on medical model skills such as assessment and screening, and an under-emphasis on appropriately skilled delivery of psychological therapy. Further, it seems that certain therapeutic approaches have traditionally been associated with and thereby located within CAMHS' teams, despite there being a dearth of evidence supporting their efficacy and effectiveness. The provision of a particular therapeutic approach simply because it is available, rather than it being an appropriate (evidence supported) approach is an all too common occurrence and happens across all tiers, from Tier 1 to Tier 4. 6. There is a lack of recognition and understanding that for psychological therapies to be delivered in adherence to an evidence based therapeutic process it is essential for clinical supervision to be delivered by practitioners proficient in the therapeutic modality. Time and financial pressures means that there is often insufficient opportunity given to clinicians to access appropriate and competent supervision/consultation. This diminishes their therapeutic effectiveness and is a clinical governance issue. 7. There are few courses in existence that provide training in evidence-based psychological therapies for children and young people; there are even fewer in Wales. Those that are suitable are oversubscribed for a number of years. 8. Applied psychologists working in CAMHS have expressed concern that since the children and families seen come with layers of trauma (often trans-generational) and the time and skill required to allow a robust trajectory of change for a child is often not available. 9. Social media could be used beneficially to reach young people as this is a favoured communication and learning style. APHNSAG members recommend setting up a sophisticated and interactive, informative website as an initial step.
	The extent to which CAMHS are embedded within broader health and social care services
3.	1. The development of specialist tier 2 CAHMS services rather than more inclusive CAMHS which reach across all tiers of the service sometimes resulted in other parts of the health and social service organisations referring children and young people with any degree of emotional or mental health problem on to specialist CAMHS rather than recognising the extent to which they are responsible for meeting less severe mental health needs. A model of consultation and networking is used by some services. In Aneurin Bevan Health Board, networking meetings are used by the Child and Family Psychology services in order to support other professionals in their work with children. This is based on the philosophy that children are best helped within the contexts in which they live their lives and that is where the difficulties arise rather than a 'within' child problem model. There has been excellent evaluation of this work but it is difficult to sustain this model of working when existing data systems are 'patient/contact' driven. 2. CAMHS are relatively small services and require a strong identity within their organisation. Applied psychologists in Health have expressed the view that despite sitting within Health Boards they feel that specialist CAMHS are not fully embedded within any organisation. Their comments reflect a feeling that they have often been undervalued and disadvantaged in terms of resources and facilities within the larger directorates in which they are positioned. If placed within a Mental-Health Directorate they feel of secondary importance to services for working age adults and when placed within Children's (or Women and Children's) Services they are perceived as being less important than services for children and adolescents with physical health needs. 3. Within Local Authorities, Educational Psychology Services are increasingly being included within 'Children's Services', comprising Education and Social Services. However, the demands placed on Educational Psychologists means they have little time to provide input on mental

	health issues and, in effect are maintained within their traditional roles. 4. Some good practice examples of services were highlighted by APHSAG members e.g. Social Service Departments seeking to fund part posts within Specialist CAMHS for Psychologists, Psychological Therapists and Psychiatric Nurses within newly created specialist services, such as an Emotional Wellbeing Team, a service for children who engage in sexually harmful behaviours, psychologists working with Looked After Children and paid for by the local authority, psychologists working within third sector organisations (MIST, FIT, Skills for Living). These roles have shaped the services they work within and the benefit is two ways since they also bring a difference to the core services from which they come and invite innovative practice and question traditional practice. These developments are not consistent across Wales however.
	Whether CAMHS is given sufficient priority within broader mental health and social care services, including the allocation of resources to CAMHS
4.	1. Specialist CAMHS in particular, is an under valued and underfunded service. Funds are often not forwarded to such a small service, instead being absorbed by the larger organizations or services such as Adult Mental Health, Education or Social Services. For example, when specific funds are earmarked for CAMHS to provide ASD services. 2. Some specialist CAMHS report operating from inappropriate or inadequate buildings, providing poor accommodation and facilities where conditions run down, cramped, cold, damp, poorly decorated, and affording poor soundproofing and other aspects of confidentiality and security. 3. In many areas there is no access to clinical or other applied psychologists within paediatric health services despite having demonstrated the value of psychological models with diabetes, Cystic Fibrosis, feeding, encopresis. 4. In population terms there is a clear disproportionate resource given to adult services compared to children's services, see comment 2.1.
	Whether there is significant regional variation in access to CAMHS across Wales
5.	1. Access referral criteria are interpreted differently leading to different services being offered by CAMHS across Wales e.g. ASD and ADHD may be perceived as being mental health difficulties (seen in Specialist CAMHS) or developmental difficulties (seen in Pediatrics). 2. The service model adopted within Specialist CAMHS can also lead to regional variation. Services that are seen as being Psychiatry led tend to be diagnostic and rely on medication, whereas those that are more equal and multidisciplinary are more psychologically interventionist in their character. This can lead to resources within teams being allocated based on the medical model of diagnosis rather than focusing on a normative model of healthy psychological functioning which needs to begin in schools and the communities in which children live. 3. Within the wider CAMHS the failure of some Local Authorities to recognize mental health needs of children and adolescents means that services cannot be provided equally (e.g. sexually harmful behavior). The closure of the Education al Psychology course may cause difficulties in recruiting educational psychologists and have a negative impact on children's well-being in schools which will is likely to increase inappropriate referrals to CAMHS.
	The effectiveness of the arrangements for children and young people with mental health problems who need emergency services
6.	1. There appears to be little compliance to NICE Guidelines for children and young people who present at A&E having self-harmed or self-poisoned. They are sometimes admitted to wards, where their emotional and mental-health needs are not given appropriate priority. The paucity of psychology resources in paediatric services exacerbates this problem. 2. There is sometimes a failure on the part of Social Services staff to recognize children and young people who have attempted overdose as needing to be safeguarded. This a failure to recognize the very significant social elements within such behavior, preferring instead to perceive such acts as being indicative of mental illness and not their responsibility. All individuals who take an over-dose should be assessed by appropriate mental health trained

	clinicians and social services staff. The on call psychiatric assessment of children admitted into hospital often lacks psychological understanding of children's mental health and only has a psychiatric lens with which to understand the complex needs of children. 3. Feedback from parents suggests it is hard to get clear advice as to where to go in an emergency. A and E is the default option.
	The extent to which the current provision of CAMHS is promoting safeguarding, children's rights, and the engagement of children and young people
7.	1. Specialist CAMHS makes significant efforts to safeguard children by assessing risk. However, this may not be the case where children or adolescents present within other teams and the responsibility to assess risk is passed to specialist CAMHS e.g. following an over-dose the child/adolescent is often referred to Specialist CAMHS, rather than the assessment being completed in a timely way being completed by A&E or Ward staff. There needs to be a greater awareness of risk assessment for children and young people across all health care settings including the responsibility to make a Child Protection Referral or seek an assessment of home circumstances from Social Services. staff need to be able to negotiate safe, nurturing relationships and understand the importance of attachments as a basis for growth, can engage young people in meaningful activity within a living context, and are psychologically minded so all interactions are mindful and therapeutic. 2. Protecting children's rights and promoting their engagement is a major priority to Specialist CAMHS but is often poorly understood by other Services and service users. Social Workers (and occasionally parents) often fail to understand that when a child or young person is competent to make their own decisions as to their care, that their right to confidentiality needs to be respected. 3. Children may be admitted to adult wards which are not resourced to deal with children's needs at any level. Children tell us they care a lot about the physical environment. It needs to feel safe, welcoming, private but not too formal.
	Any other key issues identified by stakeholders
8.	1. The issue of ADHD diagnoses needs to be addressed. A huge amount of resource revolves around the delivery of a diagnosis which is controversial. Parents believe they need to pursue this in order to gain help and support for their children. This is a culture which should be challenged (see description of Caerphilly FIT work in comment 1.1).

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