Cynulliad Cenedlaethol Cymru | National Assembly for Wales
Y Pwyllgor Plant, Pobl Ifanc ac Addysg | Children, Young People and Education Committee
Ymchwiliad i Gwella Iechyd Emosiynol ac Iechyd Meddwl Plant a Phobl Ifanc | Inquiry into The Emotional and Mental Health of Children and Young People
EMH 05
Ymateb gan: Gwasanaeth Seicoleg Plant a Theuluoedd a Therapïau Seicolegol
Response from: Child and Family Psychology and Psychological Therapies Service

Children, Young People and Education Committee - Emotionally Resilient Children and Young People

This response is from ABUHB's Child and Family Psychology and Psychological Therapies Service. Managed within the Family and Therapies Division, the service inputs into a number of teams; including Specialist CAMHS, Primary Care Mental Health Support Services, (PCMHSS) Adoption Services, The Attachment Service, Social Service funded posts (Monmouth and Newport), the Voluntary Sector (Family Intervention Team (FIT)(Caerphilly) and MIST (Torfaen and Caerphilly), Families First and Flying Start. We therefore have a broad perspective of experiences to reflect on – both as providers and referrers to services.

Is 'T4CYP' on track to deliver the 'step-change' in CAMHS services that is needed?
There have been considerable changes within CAMHS that have made a difference that will be referred to below; and a significant increase in partnership work acknowledging the broader responsibility all services have for children's mental health and emotional wellbeing. However, the notion of a 'step-change' feels like a real opportunity that, in our opinion, risks being missed. As psychologists, psychotherapists and family therapists there are a number of fundamental observations we would like to make in respect of this:

Normative, Developmental and Contextual Model
The first is the importance of, and need for a model that underpins healthy psychological development. We believe this should be a normative, developmental and contextual understanding of children's distress that runs through all levels of service provision from universal to the most specialist services; with a particular focus on the protective value of early nurturing relationships.

Currently the Specialist CAMHS narrative (both within and outside of services) can be dominated by a medical model that locates the problem within the child, embodied by a 'diagnosis based' set of referral criteria. It implies to the lay person that specialist services are for children with 'disorders', and that these are a 'different' cohort of children to the 'norm'. It also serves to reinforce the notion that the needs of these children require a different skill set; potentially undermining the knowledge and experience

that frontline staff do have; and more importantly, the therapeutic value of the relationships they have built up with children and families over time. In our opinion it inadvertently encourages a 'refer-on' culture, setting families and front line staff on a perpetual search for diagnosis and labels for fear of 'missing something'. Referrers talk about writing the referral letter to fit the criteria, so reinforcing this potentially unhelpful cycle.

The reality is that much of the work of Specialist CAMHS, certainly in ABUHB, is directed at normalising a child's presentation given the experiences they have been through, and the use of labels and diagnosis are avoided whenever possible by all disciplines. There is, of course, an important role for a medical perspective, and for some children diagnosis is extremely helpful. However, there is also a risk of the 'tail wagging the dog' and specialist teams can feel pressured to diagnose children in order to access resources within education, for example, rather than because it is therapeutically helpful for the child. Indeed it can be counter-therapeutic; as a diagnosis locates the problem within the child, rather than validating a range of contributing factors that need to be galvanised as part of the intervention.

It is noteworthy that even within Forensic Services, arguably the most specialist of all CAMHS services, the Trauma Recovery model has been identified as the model of choice. This makes no reference to diagnosis but rather has a focus on the building blocks of early emotional and psychological wellbeing, and the gaps in these building blocks that can lead to a trajectory of offending behaviour for young people. We would argue for the relevance of a model such as this to run through Specialist CAMHS rather than one of mental disorder and illness as is currently the case.

In terms of referral thresholds, rather than symptom based, our preference would be to develop a set of Specialist CAMHS criteria that makes reference to the complexity of the presenting problems (frequency, intensity, duration,) the impact they on the child or young person's life (family and peer relationships, functioning, accessing appropriate environments, risk); and what has been tried to overcome them.

Myth of increasing complexity within the tiered model of service delivery

The next point is related, and reflects our experience that the tiered approach that places Specialist CAMHS at Tiers 2/3/4 does not reflect the reality that equally complex problems are seen and managed at tier 0 and tier 1. We input into a range of universal services (Psychology Advice Line, Health Visiting, School Health Nursing) and Early Intervention Services (Flying Start, Families First, Family Intervention Team, PCMHSS etc.) and without exception these services work with children and families with extremely complex presentations; often indistinguishable from those seen at tier 2 and above. Indeed these are often 'hard to reach' families who are unable to make use of a more traditionally delivered appointment and clinic based system generally required to access and maintain support from Specialist

CAMHS; and so require more flexible and creative solutions to equally or even more complex problems. 'Hard to reach' can flip into 'easy to ignore' as the mental health needs of these families are classified as 'social', and a less experienced and less qualified workforce are expected to undertake the work with them; often unsupported.

The ground swell of evidence from the Adverse Childhood Experiences research (Welsh Government, 2016) will hopefully challenge this, highlighting the complex interaction of early traumatic life events and their impact on both physical and mental health into adulthood. We would argue for the earliest possible intervention in families identified as at risk for ACES and would support the development of services that focus on new parents and their relationships with their babies' pre and post birth. ABUHB has prepared a business case for the development of a team with this as its focus.

With regards to Specialist CAMHS it is still the case that an unhelpful distinction is made between social issues and mental health issues in deciding on the appropriateness of referrals. There does, of course, need to be parameters set around scarce resources; but in our opinion this unhelpful division reinforces a false distinction and needs to be addressed as it has consequences for how society understands the emotional wellbeing of children and the population as a whole. Instead of a culture of 'your child has mental health difficulties' which potentially sets them on a trajectory for life with increasing numbers falling into this 'group' as demand for services grow; we would like to move to a culture of 'life experiences can have an impact on everyone's mental health and emotional well-being and here are the things everyone in the family/network can do to help ameliorate this'.

The Family Intervention Team (FIT) in Caerphilly is a health funded voluntary sector service that uses Psychological Formulation to tailor interventions around the unique needs of each family. Family support workers are then supervised by the psychologist to work creatively and flexibly with children and families in their own homes. It addresses the inflexible nature of clinic based interventions; and draws on the whole family and their context both to understand the nature of how the difficulties have developed, but also to draw on strengths and resilience factors to facilitate change. We believe there is a role for this model of service delivery to be further developed.

Social and Political Climate

The link between poverty and mental health is well documented, and in times of austerity, as more and more frontline services are stripped to the bone, it feels important to draw attention to this 'elephant in the room'. The referral rates to Specialist CAMHS services have increased at alarming rates and it feels important to ask why this is rather than simply pouring more and more resources in to fight the fire. Youth Services, Young Carers Services, one to one support in schools, health visiting, school health nursing, to name but a few are all relationship based services that have seen cuts and barriers to access in recent years. As psychologists we would argue that

there is a significant cost to this both in terms of early intervention and prevention, but also in key relationships with families and young people that can be used as vehicles by specialist services to support interventions over time.

Equally relevant is the increasingly results driven culture within our schools. Many children present with anxiety in respect of exam pressure. Schools are doing more and more to address mental health difficulties but without perhaps asking the fundamental question – what impact is the school environment itself having on our young people in the first place?

One of the key components of all psychological interventions is bringing a young person's external world in line with their internal world. If, for example, as a psychologist you assess that a parent has unrealistic expectations of their child you would work with the parent to change that expectation rather than working with the child to fit the expectation. Within a school environment a child is constantly exposed to a one size fits all model of exam expectation regardless of the individual's personal ability or individual circumstances. This has a psychological toll that needs to be acknowledged.

Indeed, for many children school is the one consistent and nurturing environment they can rely on so the importance of not giving contradictory messages about how performance is the only thing that matters to these students is vital. A school culture of 'doing your best' rather than 'being the best' is a subtle but important shift in recognising the unique circumstances of each individual child without limiting aspirations.

Relationship Based Service Provision

The final point has already been alluded to and it relates to the importance of relationship as the central thread running through all services that work with children and families. We know from the research that one positive relationship – whether it is with an aunt, a teacher, a neighbour or a support worker, can be a protective factor for vulnerable children and young people. Despite this all our services are increasingly designed around closing down episodes of care – whether it is models of brief intervention; to funding streams that cut off after 12 months with insecure staff on short term contracts. A change in the culture of care that recognises the importance of relationship and asks the fundamental question 'who knows this child and family best?' seeking to organise services around that person or people, feels like the most important step change in the delivery of services that has the needs of the child at the centre.

Linked to this is an important but subtle shift in the accessibility of specialist resources. Consultation, telephone support, opening up who can refer, employing experienced specialist staff within universal and tier 1 services are all changes that would break down barriers between the tiers; recognise the complexity that exists at all tiers, and de-stigmatise and demystify mental health support. Ironically, the opposite has been the case in recent

years. Referral criteria to Specialist CAMHS has tightened making it increasingly difficult to access; PCMHSS's have joined with adult services under the Mental Health Measure; which is dominated by an adult mental health individualised framework of assess and treat, rather than a more contextualised understanding and joint working philosophy of the previous Primary Mental Health Team model; and more and more referrals are directed through the GPs – the person least likely to know the child well and least likely to have time to offer an ongoing relationship.

We do, of course, welcome the reduced waiting times, which does mean specialist services can respond in a more timely manner. However, the cost has been an increased perception of 'them and us' (both in terms of service provision and how children with diagnosed mental health disorders are perceived), and a sense that the vast majority of families and professionals feel unsupported. Half of all referrals to Specialist CAMHS are turned away, and yet we have not once come across a professional who doesn't think carefully about why they are referring; and who only refer those children they are most concerned about. Indeed, anecdotally many professionals say that they no longer refer to CAMHS because the referral will not be accepted.

1. **To what extent have changes addressed the over-referral to Specialist CAMHS?**

Hopefully some of the points made above address our reflections on this question. Our experience is that referrers see S CAMHS as a scare resource and only refer those children that they are most concerned about. The fact that 50% are turned away leaves us concerned that those referrers feel unsupported and at a loss regarding what to do next. That doesn't mean the referral needs to be accepted, but it does mean that the referrer needs to be supported. The Gaps Analysis undertaken by our service in 2015 highlights this, and the growing groups of children who do not meet the increasingly tighter service criteria – children with behavioural and relationship difficulties being a key co-hort.

Our preference would be to open up access to specialist CAMHS staff using a 'light touch' model of informal consultation, telephone discussion. One way of facilitating this is for the referrer to offer to do the work alongside a SCAMHS colleague as an alternative model of intervention promoting joint working. As an example our experience of offering psychological formulation appointments to support staff in Families First, is that this empowers them to do the work, contained by the knowledge that it is 'therapeutic' in the broader sense of the word, and at a pace and in a place that the family is able to manage.

One advantage we have observed of an increasingly difficult to access Specialist CAMHS, is the partnership developments of broader 'CAMHS Services' (for example, Multi-agency Intervention Service Torfaen (MIST) and posts in Social Services and Families First etc.). This is a very positive step forward, locating specialist support in front line services. However, it has developed in an inequitable and piecemeal way.

2. **Referrals and access to CAMHS by including the restrictions and thresholds**

We have been concerned about the increasingly high thresholds to Specialist CAMHS services, dominated by a diagnosis based understanding of children's distress. Whilst we understand this to be about protecting a scarce resource, ironically we feel concerned it will have the reverse effect in the long term. It sets up a false distinction between those children with a 'mental disorder' and those without – rather than a continuum that we all exist along. The bigger the barrier to this distinction, the more concerned families and referrers will be that they are 'missing something' and the more likely they are to refer to find the missing piece in the hypothetical jig saw. Open access, consultation, availability, open relationships, joint working, and a shared language and model of understanding distress are the potential solutions from our perspective.

3. **Whether the changes have helped to improve specialist CAMHS' ability to respond out of hours**

This has been a very noticeable and positive development within Specialist CAMHS in ABUHB. The newly appointed Emergency Liaison Service have done an excellent job both in improving relationships with A & E and the Paediatric Wards, but also in taking the pressure to respond to emergencies away from the S CAMHS Community Teams. The impact has been tangible and has improved working relationships both within and across services. Similarly, the development of the Crisis Outreach Team has been another welcome addition – allowing the tier 2 community teams to focus on waiting lists and core business rather than being crisis driven and reactive in their delivery model. The one disadvantage of these developments is that the Tier 2 Community Teams can feel like the Cinderella service – especially as staff are often recruited internally.

4. **Whether there is sufficient in-patient capacity in Wales.**

There should **never** be a situation where a young person is placed in an inappropriate setting overnight – particularly as they are invariably at their most distressed and vulnerable on such occasions. In our opinion this is the only criteria for establishing if there is sufficient capacity.

5. **Annual expenditure on CAMHS in cash terms and as a percentage of the overall spending**

We do not have access to this information. However, it is important to note that funding for Children's Mental Health Services are hindered by being located within generic children's health services. For example, spending cuts are applied to all services regardless of ring fenced status, and delays in recruitment processes particularly around sign off by finance have caused significant delays and missed recruitment opportunities in training cycles. The advantages of being managed within children's services are many though, and we are certainly not advocating a return to being managed within Mental Health. Rather, a clear directive and checking system regarding the ring fenced budgets and new investments is required.

6. **The extent to which access to psychological therapies for young people has improved.**

There has certainly been a drive to increase the therapeutic training of all staff within Specialist CAMHS, regardless of their profession and this is to be welcomed. However, the waiting time targets mean that there is a pressure to close work with families as quickly as possible. The evidence base for psychological therapies means that some interventions can take many months, (even years) and this is not recognised in the CAPA model (with an average of 7 sessions) – particularly now that SCAMHS is reserved for the most severe and challenging cases so the average involvement is necessarily increasing. Therapy as a viable alternative to medication needs to take into account the length of time these interventions can take, and SCAMHS services need to be resourced accordingly.

7. **How the additional funding has improved provision for in local PMCHSS**

One of the key difficulties within the Primary Mental Health Support Services has been recruitment of suitably trained staff with a background in child and family work. This is beginning to shift and ABUHB has developed a mentor system of supervision, and worked with the University of Caerleon to develop a training programme to 'grow our own' staff. However, a fundamental problem has been the dominance of an adult model in service provision as a direct consequence of the age blind vision. Our concern is that services have been applying an adult mental health model that focuses on direct work with the individual, rather than a consultation and facilitation model that draws on the rich resources within children's services.

In a recent stake holder's event the key gap for children's services identified was expert advice to direct the work of front line staff who already exist. This is very different to adult services, where the priority has been the development of low intensity mental health workers. This clash of cultures, models and priorities has, in our opinion, set the PCMHSS's (Primary Mental Health Teams as was) back in their impact and status within children's services. Long waiting times and referrals that are often indistinguishable from those made to Specialist CAMHS have been a burden that has hindered the team's momentum and potential impact.

8. **The extent to which the funding has met the needs of vulnerable children and young people**

The previous CAMHS Enquiry highlighted a gap in service for the cohort of children and young people who have experienced early adversity, disrupted attachment, and developmental trauma. The Gwent Attachment Service was therefore a response to that gap in service, using funding targeted at increasing access to psychological therapies. The team provides training with regular follow-up skills development sessions to frontline teams in social care, education and health thereby increasing their level of understanding, skill and confidence in attachment theory and developmental trauma and associated therapeutic approaches. One of the Attachment Service's aims is

to support the development of a shared approach in order to improve the experience of vulnerable groups who come into contact with the three main agencies.

The investment into Neuro-developmental Services and the development of a pathway for these children has been welcomed. The forward looking plan of locating these resources within the Integrated Services for Children with Additional Needs (ISCAN) feels like a real opportunity to unpick the complex needs of these referrals, identifying the most appropriate services to undertake the work in the first instance.
Our priority would be to develop a Family Intervention Team, referred to above, in each borough. An internal audit of referrals to this team with a query ADHD/ASD Diagnosis found that following the family based intervention, only 3 out of 27 went on to require specialist assessment. This as the front door to an ADHD/ASD pathway would prevent miss diagnosis of, for example, attachment and relationship difficulties – a complex task for clinic based clinicians to unpick.

9. Transition to Adult Services

There is still variability on a case by case basis despite clearly agreed pathways.

10. Links with Education (emotional intelligence and healthy coping mechanisms)

We welcome the integration of emotional intelligence and healthy coping mechanisms into the national curriculum and believe strongly that it should be embedded into all aspects of school life, and not simply bolted on. We advocate that any learning on these issues is more valuable if it happens through established relationships with staff and through experience rather than a more traditional 'taught subject' delivery model.
The Roots of Empathy Programme is an evidence based model that brings emotional literacy into the classroom through the experience of working with a parent and baby. The positive impact on pro-social interactions and reduction in bullying is impressive as children learn about their own and others emotional worlds through understanding the needs of the baby. The Early Intervention Foundation in England, and Scottish Government have both invested heavily in this programme recognising the multiple layers of benefits that it brings.

11. Children's access to School Health Nurses

We support the role of School Health Nursing in supporting the emotional wellbeing of school aged children and have been concerned by the historical decline in numbers and narrowing of their roles. That this has been identified as a growth area for the future is welcomed. We would place equal, if not greater importance on the role of health visitors in supporting the earliest possible interventions with families as the first 1000 days has been identified as crucial in the establishment of resilience against developing mental health difficulties. The benefits of Flying Start are clear, but the inequity this creates is a major cause for concern.

12. The extent to which health, education and social care services are working together.

The strength of the Partnership Board in ABUHB has been a welcome development and the shared agenda and joined up priorities has been refreshing and exciting to be a part of. The sharing of good practice and desire to have equitable services with a joined up vision has been particularly inspiring.