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 31
Ymateb gan: Tîm Ymyriadau Teuluol
Response from: Family Intervention team

This response is on behalf of the Family Intervention team, an early intervention service for children, young people with emotional and behavioural difficulties and their families. This is a long established partnership project between Aneurin Bevan University Health Board and Action for Children and is based in Caerphilly borough. This response should be read in conjunction with the response from the Child and Family Psychology and Therapies Service, ABUHB and the Attachment Service, ABUHB, alongside the central Action for Children response.

1. **Is Together for Children and Young people programme on track to develop 'step change' in CAMHS services that is needed?**
   T4YCP is a much needed project which has brought a number of professionals together from a range of backgrounds. This has created energy, reinforced good will and begun to look at shared understandings of values that underpin services and the hopes we share for services to be responsive to children's needs in a timely non-stigmatising way.

2. **Specialist CAMHS**
   Within ABUHB CAMHS, waiting list initiatives have reduced waiting times, however the sustainability of this needs to be monitored, once funding for these additional assessment clinics has been used. The good intention of reducing the waiting list needs to be monitored to ensure service users still have access to both the assessments and subsequent interventions they need. Our experience as an early intervention project is that it is extremely difficult to access professionals within CAMHS to enquire about waiting times and methods of working in order to ensure families receive a coherent plan of service delivery. For families who do not reach the CAMHS threshold, or are seen but are not deemed to have a mental health diagnosis, it appears to be difficult to access Psychological therapies, as within ABUHB, the Child and Family Psychology service's referrals are not separate from S-CAMHS. Anecdotally, there appears to have been a reduction in service to individual families to allow a greater number of families access, for example clinicians being advised to see families for 7 sessions or fewer or the 1+2 waiting list initiative. Working with families with inter-generational trauma, my clinical

experience of working with families with intergenerational trauma and communication styles characterised by high levels of conflict is that it that it can take parents time to engage to think about their own past trauma and current relational style and how this may affect their child's emotional regulation.

Consultation

In our view, Specialist CAMHS should be for the very few children who need a medical model and is an important and vital resource. However, there needs to be greater collaboration between Specialist CAMHS and professionals working in earlier intervention. Locally, there have been good models in the past where Consultant Child and Adolescent Psychiatrist from within ABUHB Specialist CAMHS has offered monthly consultation to our team. With a change of personnel, this has not been upheld for some time and may be due to the psychiatrist's pressures of work or the new model of service delivery, or a combination of factors. The benefits of consultation are many: Tier 1 professionals and colleagues in S-CAMHS working closely allows families access to a psychiatric/ medical view through their Family Support Practitioner and therefore they are reassured that a) a service is not being withheld, b) that it may not be helpful at this stage to see their child's difficulties in a medical/ diagnostic way and c) that the work being done by our early intervention team with the family- i.e. based on a biopsychosocial formulation which takes into account the child's development and context is seen as the most appropriate way by the Psychiatrist as well as us or d) that if a referral to S-CAMHS needs to be made then this is a detailed referral, based on meetings with the child or young person, the family, and the school.

As families can be very confused by different professionals and different agencies giving different views and opinions, this consultation which provides consistency needs to be embedded within the service delivery model, rather than on an individual staff practice or preferred way of working. Including time for consultations within job plans would ensure that this is given as much priority as direct work.

"Over referral"

The term "over-referral" may be read to imply that professionals are not considering their next steps with a family. However, in the majority of cases, professionals refer very appropriately. An increase in consultation as described above from S-CAMHS professionals such as Clinical Psychologists and Psychiatrists can provide containment to Tier 0 and Tier 1 professionals to continue the work they have begun. Their often ongoing relationship can make them the ideal people to support children and young people. Clinical Psychologists can offer Psychological formulation which helps a professional understand what may be long term bio-psycho-social factors in why a problem has begun. A psychological formulation also considers what may be

precipitating factors that make this difficulty more difficult to manage at this time (e.g. a transition, a bereavement in the family system). Possible maintaining factors are then considered and the strengths and protective factors within the child, parent and system which will allow for change to happen. Developing this way of thinking in professionals means there is more understanding of the strengths and difficulties that a family face and what this individual family system needs to manage change. In our view, when professionals feel contained and trained, this reduces the need to refer on.
The Family Intervention team is a tier 1 service for children and their families where there are concerns about emotional wellbeing, mental health and behaviour. I am the part time clinical Psychologist providing direct supervision to the team to increase their skills and confidence in working with families and particularly to be able to work in a psychologically minded way. This means that we have a highly skilled graduate workforce who are able to work with complex cases before, or without the need for referral on to statutory services.

Training for Tier 1 professionals from those in Specialist CAMHs e.g. such as that provided by the Attachment service will allow professionals to gain a wider shared understanding of children's emotional development and the importance of relationships in supporting that development.

There appears to be a widely held myth that the most complex families are seen by the most specialist services i.e. specialist CAMHS. However, it is our experience that many of the families at tier 0 and 1 are extremely complex, but may not have sought help, or may have sought help many times without being seen by the right service, or are not able to access a service in the way it requires e.g. travelling to appointments, finding their way to an outpatients clinic in a hospital, or holding their concerns for a month between out-patient appointments. The Family intervention team was designed by clinicians and managers from Health (CAMHS), Social Services, Education and the Third Sector 12 years ago in response to the feedback that we were not providing a service to those complex and "hard to reach" families. It provides a formulation based psychological service to children and their families in their own homes and schools. The team utilises a number of psychological therapies, and therefore, children, young people and their families have access to psychological therapies at an early stage. Audit has shown that consistently about half of our families are referred to us with concerns about a neurodevelopmental difficulty, however at the end of intervention, under 15% of those are referred onto S-CAMHS as the family can see the changes that occur from using a psychological formulation to understand the processes that have led to and maintain a difficulty as well as give hope to harness the strengths in a family to make changes.

One difficulty with services at early intervention links to the myth mentioned above. Perhaps by increasing thresholds and reducing access to S- CAMHS, there is a view by parents and young people, as well as by professionals, that this is the service to work towards i.e. if you believe your needs are serious (don't we all when we are the ones suffering pain or distress) and you may want the most specialist service. As part of the T4CYP strategy, professionals who work with children, young people and their families and service users need not only to look at the services provided but also at the reasons why neurodevelopmental and mental illness diagnoses are increasing so dramatically. There are a number of factors we note: diagnoses can be seen to be linked to benefits e.g. the provision of resources in schools. While this is not the case, (as resources should be linked to evidence of need) it is frequently school staff who state this to service users and to other professionals. Additionally, a diagnosis can provide some explanation of a young person's distress and behaviour, which can be seen as a problem located "within child" and therefore exonerates parents form any blame. Instead we need a culture that is able to work with whole system- both adult parents and children within a family and link to the school. An audit undertaken in this service showed that while a short term intervention created change for most families who took up the service, about one third of families needed additional service for parents' own difficulties- which may be a diagnosed mental health difficulty such as depression or anxiety or unresolved trauma from earlier life. These families needed a linked intervention is a service provided by known professionals in a known location.

A further difficulty with how early intervention services are provided is that the majority of projects are short term. They are often run in partnership with the third sector. I wholly endorse this model due to families' feedback about how they value working with a charity and how they feel valued. One major difficulty is that funding is short term and even in longer term funding is usually only 3 years. In this way, staff need to find a new job after 2.5 years and due to the tendering process we have experienced a situation where staff were made redundant/ found new jobs at the end of a project before a new similar project tender was announced. This meant that skilled staff are being lost, and referrers have to learn again about what projects are available and service users lose continuity.

Services need to be set up in a way that recognises the theory and practice of learning and attitudinal and behaviour change e.g. the Cycle of Change which expects that there will be "relapse" and plans for this. Families need continuity in staff and opportunities for drop in/top up/ repeat service at times of crisis/transition/significant family event. Such a model needs to see this a useful way of working- not failure in a family or a service!

Links with Education

Having worked in Education in the first 10 years of my career as a teacher and then Educational Psychologist, I know the value of schools as a secure base for children and young people and the vital role of the teacher. As Robin Banarjee states, wellbeing must not become a separately taught subject but permeate the whole curriculum. The wellbeing of teachers and school staff is necessary to promote wellbeing in students!

I am glad to see this consultation entitled emotionally resilient children and young people as the current focus on destigmatising mental health bring us both opportunity and risk. Projects in schools which outline different types of mental illness and suggest that one in 4 young people will develop a diagnosable mental illness are in my opinion not helpful, and bring fear rather than hope. We need to talk to children and young people (and listen to them) about ACES- what happens to you in life and how we can develop and grow and process in order to manage emotions. (This obviously needs to be in a context of Safeguarding so we are not expecting children and young people to manage situations that adults should be managing).
However there needs to be challenging discussions at Welsh Government level about how target setting and budgetary cuts can work alongside promoting wellbeing.

Early intervention support needs to be able to work in a home and school context. Staff who work in these services need to be trained in models of change, and have an understanding of some therapeutic approaches at the appropriate level e.g. Attachment, Systemic and new wave CBT such as Acceptance and Commitment Therapy. This will allow practitioners to engage families, help them to understand their child's difficulties in a developmental, normative and contextual way where difficulties are part of life and can be lived with and managed, sometimes with support. This gives realistic hopefulness for the future and emotional resilience.