British Psychological Society response to the House of Commons Health Committee

Children’s and adolescent mental health and CAMHS

About the Society
The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is “to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge”. We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries
We are content for our response, as well as our name and address, to be made public. We are also content for the Committee to contact us in the future in relation to this inquiry. Please direct all queries to:-

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About this Response
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We hope you find our comments useful.

David J Murphy CPsychol
Chair, Professional Practice Board
Children’s and adolescent mental health and CAMHS

The current state of CAMHS, including service provision across all four tiers; access and availability; funding and commissioning; and quality.

Summary

The Society would welcome the opportunity to contribute to the evolving work of the review by initially giving verbal evidence to the select committee and we are committed to ongoing collaboration.

We welcome this review as there is an urgent and crucial need for a full review across the whole range of child and adolescent mental health services. Including the NHS, Local Authority and third sector providers.

The Problems:

Lack of comprehensive national data on prevalence of mental health problems and provision for CAMHS The need for a full review of CAMHS across tiers and agencies is urgent and crucial – there is a scarcity of hard data for anyone to know the full-scale of the problem. A survey of clinical psychologists conducted recently by the Society found the majority of respondents reported significant reductions in the services provided.

In addition the feedback from Clinicians working in CAMHS services is that:

- The number and severity of cases referred to CAMHS has increased significantly whilst services have suffered loss of staff and other forms of cost-cutting and there has been depletion and fragmentation in the provisions for children, young people and families which focus on early intervention and prevention with obvious knock-on effects on specialist services.
- Specialist CAMHS criteria appear to be becoming more and more restricted and the remit of services is narrowing with more focus on risk and urgent assessment.
- Access into CAMHS is difficult. Many referrers find it very difficult to get children accepted by specialist CAMHS.
- It was generally believed that CAMHS operate more on a diagnostic and individualistic model. Such a diagnostic approach is seen as unhelpful for complex family cases, such as those cases where there is transgenerational trauma.
- Clinicians feel that children are often falling in between Primary Care Mental Health Support Services, which have become increasingly limited, fragmented and in places non-existent, and Specialist CAMHS.

Chronic understaffing of CAMHS

Staffing levels in NSF (2004) recommended a minimum 20 whole time equivalents (WTEs) staff per 100,000 of the total population. This figure that has never been realised in CAMHS

Cuts/service reductions

On top of this Chronic understaffing of CAMHS, services are experiencing cuts to service funding which is resulting in further staffing reductions

Downgrading of the current workforce

Cuts across NHS and Local Authority budgets, where this does not lead to staffing cuts has led
to downgrading of skills amongst the workforce

Young people are not 'mini adults’ – the creeping agenda of adult mental health models of understanding and service provision/design is being applied to young people inappropriately.

New commissioning arrangements
Do not meet the needs of children and young people Oliva & Lavis, (2013) for the Children and Young People’s Mental Health Coalition found that -Two thirds of Joint Strategic Needs Assessments (JSNAs) did not have a section that specifically addressed children and young people’s mental health needs. One third of JSNAs did not include an estimated or actual level of need for children and young people’s mental health services in their area. Additionally there is a risk that the costs of re-tendering CAMHS services creates a drain on already inadequately resourced services.

The solutions should include the following elements-

- Increasing the workforce to meet the demand
- Up-skilling the CAMHS workforce through the continued roll-out of CYP IAPT
- Early intervention
  Increasing the provision in universal and targeted CAMHS to provide early intervention before problems escalate to need specialist CAMHS - this will lead to substantial cost savings across the whole health economy.

The Society specifically recommends that:

- That the nation’s child mental health be re-surveyed as recommended by the CMO alongside an audit of expenditure on child mental health services,
- That a working party is set up to review current commissioning arrangements for all child mental health services to ensure effective delivery of evidence-based treatments. It is crucial that work with children, young people and families is commissioned and organised across Tiers on mental health provision, across mental and physical health and across the various agencies which are in touch with them e.g. education and social care, voluntary sector.
- That CAMH services are required to annually demonstrate how they provide each of the currently NICE recommended interventions for child mental health disorders as a minimum AND what clinical leadership they have in place
- That, given that the weight of evidence in favour of psychological rather than pharmacological interventions for the majority of child mental health presentations, clear leadership structures should be in place to support the delivery of effective, evidence-based psychological therapies.

Comments:

We do not know the scale of the problem - The review is crucial because we simply do not have accurate information from which to gauge the state of children and young people’s mental health nationally. Information from ChiMat Intelligence Network March 2014 notes, “In summary the ability to provide robust national data to support local service planning is at best limited and planned improvements to this position have suffered from significant delays” Since the last ONS review in 2004 there have however been significant social changes and pressures (e.g. economic crisis, austerity, changes in social media) which are likely to have had an impact both on the scale and the form of the need. We are concerned that the within child medical/diagnostic framework currently in use to conceptualise child and adolescent mental health is not fit to capture and respond to these changing needs. The limited research available supports feedback from clinicians that the severity of mental health problems has increased over recent years - e.g. 68% increase in self-harm amongst adolescents (Mental
Health Foundation, 2006). However, comprehensive data on mental health need in children is out of date and needs urgently updating (Child Health Outcomes Forum 2013).

We recommend that we take this opportunity to take stock not just of the capacity of CAMHS provision etc, inherently narrowed down to provision of interventions for ‘identifiable mental illnesses’, but also the direction of travel in CAMHS service provision as a whole.

Funding and capacity

Chronic Understaffing of CAMHS

The National Service Framework (2004) recommended a minimum 20 whole time equivalent staff (WTEs) per 100,000 total population – a figure that has never been realised in CAMHS.

We would wish to highlight the serious impact of cost saving and cuts to capacity in children’s mental health provision in recent years whilst at the same time noting that, Prior to these cuts, there was already an urgent need for improvement in community based mental health care for children and families across sectors: a concern based on research data from several authors documenting serious limitations of the effectiveness of “usual care” (for a review see Garland et al., 2013).

We undertook a membership survey within the Division of Clinical Psychology Faculty for Children, Young People and Families last week and obtained the views of 63 Clinical psychologists representing 43 Provider Trusts. 32% were part of CYP-IAPT, 51% provided support to Tier 2 and 57% provided Tier 2 services, 82% provided at Tier 3 and 51% provided at Tier 4.

The results are incorporated throughout this evidence.

The survey shows that the number and severity of cases referred to CAMHS has increased significantly whilst services have suffered loss of staff and other forms of cost-cutting and there has been depletion and fragmentation in the provisions for children, young people and families which focus on early intervention and prevention.

It is widely acknowledged that mental health services for children have been chronically underfunded relative to need e.g. Getting it right for children and young people. A review by Professor Sir Ian Kennedy, 2010, . Equity and Excellence: Liberating the NHS. DH, 2010. Child mental health spending has consistently lagged behind adult mental health spending – despite making up 20% of the population they attract only 5% of the mental health spending (Fonagy 2013). The projected benefits of investment in children on preventing adult mental health problems are evident. Half of all lifetime cases begin by age 14; three quarters have begun by age 24. National Comorbidity Survey Replication (NCS-R) (Kessler et al 2005)

Our survey responses revealed that 62% services had decreased overall WTE in last 3 years - 15% had increased and 24% had stayed the same. However, as anticipated many are expecting further cuts - and 42% are aware of further cuts in provision being planned

Waiting times and Quality of Service

It was clear from the responses to our professional survey that young people are often waiting longer for effective interventions. There appeared to be a very different picture between the wait for an assessment and ‘internal waiting lists’ for interventions. 21% said waiting time to first non-urgent appt was under a month. 54% said between 5-12 weeks, 26% said 13-18 weeks and 5% more than 18 weeks. However - 70% said there was then an internal waiting list for treatment, and 50% said this was over 18 weeks.

66% of our respondents felt quality of their service had decreased in the last 3 years. 56% said availability of psychological therapies had decreased in last 3 years.

Provision across the Tiers

The service criteria of CAMHS needs to be addressed. The majority of CAMH services in
mental health trusts are now operating at the level of moderate to severe mental health difficulties (Tiers 3 and 4). In the past there was much more specialist mental health provision operating at the community or Tier 2 level, on models of early intervention and prevention and support to the Tier 1 staff who came across troubled children and young people and families in their work e.g. school nurses, health visitors. However, only 22% of our respondents’ services provided support to Tier 1,

The ambition was to have “comprehensive CAMHS” which provided the right level of input at the right time and place to reduce the numbers of children and young people who developed long-term and more difficult to treat conditions. Many of these services have been decommissioned over recent years during various reorganisations and the provision at Tier 2 is now often haphazard and idiosyncratic due to the variety of commissioners and providers and very poorly integrated within and between the Tiers. This also has a knock on effect on the Tier 3 services as more children are referred to them as there is nowhere else for them to be seen. They are also being referred at a point of crisis and with severe problems due to lack of help at earlier stages of their difficulties.

Increased Demand

However demand continues to increase - 89% of respondents said there had been an increase in referrals over last 2 years, percentages ranged from 20-70%. Many respondents noted a change in the mix of referrals seeing an increase in self-harm, complexity and severity.

Access

Despite this increasing demand it was clear that in response to funding and capacity pressures services have made access more difficult for children and young people experiencing psychological distress.

71% said that their service had tightened the acceptance criteria for a referral to the CAMHS service. Even more concerning was that 88% said there were insufficient other services to signpost non-accepted referrals to.

Collaboration and integration

This is crucial to work with children, young people and families across Tiers on mental health provision, across mental and physical health and across the various agencies which are in touch with them e.g. education and social care, voluntary sector. The move towards far less integration over recent years has been accelerated by the latest health reorganisation. We would welcome the strengthening of links and integration between health, social care, education and mental health, and we echo the Committee’s view (p.7) regarding the importance of better integration to support intelligent commissioning and service provision. We would also agree that joining up services and extending them might increase the likelihood of services seeing the benefits of what they invest in in terms of mental health care.

The Society believes that this should be supported by integrated commissioning arrangements. However, we are concerned that in the evolving commissioning environment including CCGs, Social Care, NHS England etc can sometimes mean that evidence-based and cost effective services aren’t funded. This is because they fall between the stools, with commissioning bodies arguing that they should not fund a provision as the net savings are to someone else. There are also significant issues in the education sector with local authorities and academies buying in their own provision to try to meet the shortfall which are not joined-up, evidence based or quality-controlled.

Defining ‘mental health’ for children and young people

We believe that one of the key difficulties in the current organisation of CAMHS is that the term ‘mental health problem’ is poorly defined and as such, the threshold for access to any particular CAMHS service at any particular ‘tier’ is unclear. In practice, many young people are referred to specialist CAMHS, when other systems are struggling to find the ‘answer’ in terms of helping the child/young person. Similarly, CAMHS then become overwhelmed with referrals for young
people that may (or may not) fit their referral criteria, which are invariably based on functional diagnostic criteria, but map poorly onto multi-factorial presentations of psychological distress in children and young people.

At this point, it should be noted that functional psychiatric diagnoses for young people such as bipolar disorder, ‘emerging’ personality disorder, attention deficit hyperactivity disorder, conduct disorders etc. due to their limited reliability and questionable validity, provide a flawed basis for evidence-based practice, research, intervention guidelines and the various administrative and non-clinical uses of diagnosis. This has been a matter of cross-professional concern for many years (DCP Position statement on Diagnosis – 2013) (e.g. Barker, 2011; BPS, 2000, 2011; Boyle, 2002; Bentall, 2004; Bracken et al., 2012; Coppock & Hopton, 2000; Johnstone, 2008; Moncrieff, 2010). However, 53% of respondents from CAMHS services had seen a move to more diagnosis led, medicalised approaches.

There is also the overlapping use of other terms by commissioners and service such as emotional health and well-being. This may be done to reduce stigma and include what others may refer to as mental health but may also be used to distinguish problems and services from those labeled as mental health.

Often in response to being overwhelmed and lack of clarity regarding referral criteria, CAMHS services appear to be tightening their criteria to only include children with ‘an identifiable mental illness’ and exclude, for example, those presenting with ‘behavioural difficulties’. However, as described earlier, for children and young people (and arguably for all people), behavioural problems are best understood as a manifestation of emotional and psychological distress/difficulty. Therefore “mental illness” vs. “behavioural difficulty” is a false dichotomy and prevents access to services and ultimately fails children and their families. The same pattern has also been found in regard to emotional problems and those located largely in the family or the school.

In practice, young people and families with ‘difficulties’ become shunted between CAMHS, Social Care, Education and the Criminal Justice system, or are too often left without any support, because they do not ‘fit’ into any one system in terms of their presentation. E.g. education may view the difficulty as a learning problem, CAMHS view it as behavioural and Social Care may view it as a mental health difficulty – often because no one system has the ‘answers’ or intervention on their own to treat the presenting concerns.

The Society would like to draw attention to several concerning trends.

- **Young people are not ‘mini adults’** – the creeping agenda of adult mental health models of understanding and service provision/design is being applied to young people – despite the clear evidence that this is not appropriate. Historically, services have been designed to replicate adult mental health services for children, young people and families and, as such services are often not developmentally appropriate and they fail to match the need (e.g. Birchwood & Singh, 2013) There are some examples of services that have attempted to address this although the evidence for whether they have done so effectively is not yet widely available (McGorry, Bates & Birchwood, 2014).

A move towards pathologising/medicalising typical childhood experiences/responses

The Division of Clinical Psychology of the Society have recently highlighted this concern - “serious concerns have been raised about the increasing medicalisation of distress and behaviour in both adults and children” (BPS, 2011; Conrad, 2007). This also acts to prevent children and young people getting the help they need as they do not fit into narrow diagnostic categories and their problems need to be viewed in terms of their family/social/educational experiences and in a developmental context.

**Improving Access to Psychological Expertise**

The Society recommends increasing access to ‘quality’ psychological provision (in the context of very real concerns about the overall reduction in psychological practitioners / clinical psychologists being reported by members) In some areas we hear that CAMHS provision has
moved to a very narrow model of mental state review & medication treatment with little else.

- In order to meet the needs of children and young people we would ideally see a change from the increasingly predominant biomedical model towards a psychological assessment/formulation model leading to formulation driven interventions. This capacity to assess and formulate an intervention across theoretical models cannot be delivered by someone trained in one model of therapy alone and increasingly the workforce in CAMHS fits this profile. In order to use of the skills and capacity in CAMHS services effectively it is crucial that there is multi-modal psychological expertise in the assessment stage rather than limiting triage to staff with fewer models to draw upon. High quality assessment should be completed quickly and effectively for all referrals so that the most effective and efficient treatment can commence from the start.

- This is a natural extension to the work of CYP-IAPT in increasing the number of CAMHS practitioners able to deliver evidence-based interventions in 4 psychological therapy modalities. We suggest that this cross - psychological capacity is provided by practitioner psychologists who are able to determine, from considering the relevant (and ever-developing) scientific knowledge base, what type of psychological intervention would be most appropriate for a particular mental health problem / presentation. A psychological therapist (who might be a nurse or social worker with therapeutic training, a CBT therapist, or systemic therapist) may be more skilled than the psychologist at actually delivering that intervention but both levels of practitioner are required.

We were keen to understand the situation specifically for the skilled applied psychological workforce within CAMHS (Practitioner Psychologist grade e.g. Clinical Psychologists)

Encouragingly 80% of respondents to our professional survey felt that psychological approaches and skills were valued in their service, but qualified often with statements that these were valued in their teams but not by managers and/or commissioners who wanted ‘cheaper psychological provision’ not practitioner grade psychologists. 46% had lost psychology WTE in last 3 years, 18% had increased and 36% had stayed the same although many noted re-grading to lower bands and loss of senior posts. In order to develop services that are excellent for children, and that are truly preventative the needs of children, young people and their families have to be at the centre. At the preventative/ early intervention level it is necessary to ensure that all services coming into contact with children and young people (such as nurseries) have staff that are psychologically minded, that the services are based on an attachment and developmental approach. Where problems arise, these problems should then be considered within the context of the child’s family/home and the child’s life experience and not solely located at the level of the individual child/young person. Staff working in Tiers 1 and 2 need access to training, supervision and support.

CYP-IAPT
Successive Governments have demonstrated continuing commitment to improving the mental health of young people through CYP-IAPT. This project is mandated to run from 2011 to 2015.

In January 2014, the Government made a very welcome commitment to continue to roll out then CYP-IAPT programme to 2018. Children and Young People’s IAPT was founded on the learning from the adult IAPT programme, but, acknowledging that the needs of children and young people and the systems that support and surround them are different to those of adults. Crucially it has not mirrored the adult model, although it shares certain key features and principles.

The demand for further CYP-IAPT service transformation is clear with a recent report from the NHS Benchmarking club reporting that 70% of existing CAMHS want to be part of the CYP-IAPT programme.

CYP-IAPT is a whole service transformation model that seeks to improve the quality of services
to young people and their families through:

- Increasing the availability of best evidence based interventions
- Better collaborative practice between mental health professionals and families and young people – facilitated by the use of feedback forms and questionnaires
- Goal focussed, client centred interventions
- Better service user participation at all levels of the organisation
- Rigorous outcomes monitoring to be able to share outcomes with young people and families and demonstrate effectiveness to commissioners
- Improving leadership capacity across services
- Encouraging and supporting cross agency collaboration: health, Social Care and Voluntary sectors

The Society continues to be active in providing expertise and support to the development of CYP IAPT - an intelligent attempt to spread best practice organised in an innovative, cost effective and efficient way to bring about service transformation. We believe that this requires ongoing support. The principles of CYP-IAPT continue to respect the complexity of effective interventions for children young people and their families. However it has become apparent that the local interpretation of this has varied significantly and a significant number of services have not been adequately resourced with staff with the appropriate training and skills to provide high quality, evidence-based psychological therapies or to provide appropriate clinical supervision.

Evidence based treatments/ adherence to NICE guidelines are not always offered within the breadth of child and adolescent mental health / psychological wellbeing services, although evidence suggests that this is slowly improving certainly in the area of depression (e.g. Majumder, P., Gatsou, L. & Hay, A. (2014) and this is something which CYP- IAPT is working hard to try and address. The Society welcomes this. However in some areas progress remains slow and is being met with significant resistance.

The Society welcomes the focus on routine outcome measurement within CYP-IAPT as there is great evidence that they improve services and outcomes for young people and families, but these are still not used consistently and evidence suggests that the key reason for the lack of consistent implementation is a lack of time and resources within services (e.g. Batty et al., 2012). This is a capacity issue impacting on the quality of provision. It is concerning that at a recent CYP-IAPT Critical friends meeting March 2014 it was reported that 5 of the first 18 programmes have experienced cuts despite assurances that this would not occur at the point of application.

**Commissioning**

It is recognised that there is a large pool of potential commissioners of child and adolescent mental health services including health, social care, local authorities, head teachers etc. It is crucial that the same principles of insisting that children and young people are offered timely and effective – evidence-based interventions regardless of who commissions this input are reinforced by clear guidance.

The Society believes commissioning should be needs driven and based on local population data. This would enable services to be delivered according to the local context, and only on this basis can the drive towards cost savings be effective. Such a model needs to recognise the need for provision across Tiers and integration across Tiers and agencies.

CAMHS clinicians note almost continuous transformation for the past ten years. In practice this has meant posts are frequently under threat which impacts on stability in clinical care and makes maintaining a quality and consistent service extremely difficult. There has also been a significant loss of the most senior and experienced members of the workforce usually due to cost-cutting pressures.

The Society would welcome the opportunity to contribute to the evolving work of the review by initially giving verbal evidence to the select committee, we are committed to ongoing collaboration and at this stage we would like to make the following specific
**recommendations:**

- That the nation’s child mental health be re-surveyed as recommended by the CMO alongside an audit of expenditure on child mental health services, as the Society is concerned that despite it being unlikely that there has been a reduction in child mental health disorders, there has been a reduction in spend. We would expect expenditure to remain in step with need, in order not to further increase the lack of parity with both adult mental health and with physical health.

- That CAMH services are required to annually demonstrate how they provide each of the currently NICE recommended interventions for child mental health disorders as a minimum and what clinical leadership they have in place to ensure that appropriate psychological interventions are being offered and checked for efficacy by a suitably multi modally trained scientist practitioner where the presentation does not have a recommended manualised intervention or where the recommended intervention has not been effective.

- That a working party is set up to review current commissioning arrangements for all child mental health services, as the current arrangements, although well-intended, have meant that evidence based services have not received funding when they do not fit neatly within the remit of a single commissioner.

- That, given that the weight of evidence is currently considerably in favour of psychological rather than medical interventions for the majority of child mental health presentations, the role of psychological as opposed to medical leadership needs to be increased in CAMH services at this point in time to reflect this.

**Trends in children’s and adolescent mental health, including the impact of bullying and of digital culture**

**Comments:**

Online bullying (or cyberbullying) is a rapidly growing concern amongst young people - with ChildLine reporting an 87 per cent rise in contacts related to the issue, self-harm up by 41 per cent and a 33 per cent increase in young people talking about suicidal thoughts compared to 2011/12. (Can I tell you something: what’s affecting children in 2013 [http://www.nspcc.org.uk/news-and-views/latest-news/2014/childline-report/can-i-tell-you-something_wda100359.html])

The Prince’s Trust Macquarie Youth Index published earlier this year found that more than three quarters of a million young people believe they have nothing to live for, with jobless youngsters facing “devastating” symptoms of mental illness. (Youth Index 2014 [http://www.princes-trust.org.uk/about_the_trust/what_we_do/research/youth_index_2014.aspx])

A report published by YoungMinds and the Transition to Adulthood Alliance found that very little has changed in services for young people with mental health problems in the criminal justice system in the last 20 years. ([http://www.youngminds.org.uk/assets/0000/9472/Barrow_Cadbury_Report.pdf](http://www.youngminds.org.uk/assets/0000/9472/Barrow_Cadbury_Report.pdf))

**Social and economic disadvantage** - Those from socially disadvantaged backgrounds have always had poor uptake of CAMHS. Resource pressures can undermine attempts at outreach and active engagement with DNAs often leading to cases being closed due to ‘non-engagement’ in relation to these families. The impact is that often some of the most vulnerable young people and families are failed by services. There is growing evidence about how to improve the engagement of these families in CAMHS (Michelson & Day, 2014).

**The voices of young person service users and their families need greater prominence in re-shaping CAMHS services** - Young people are consistent in stating clearly the difficulties...
with the current models of CAMHS and to date insufficient weight has been given to their views (e.g. Plaistow et al., 2014). There is also significant evidence and clinical experience of the inappropriateness of using adult services for young people which continues to happen repeatedly despite the knowledge of the damage this causes and studies indicating cost effectiveness of alternative services (e.g. Duffy & Skeldon, 2012). England-wide data from the Health and Social Care Information Centre (HSCIC) shows that from April 2013 to November 2013, 250 under-18s spent time on adult mental health wards. There were also 303 admissions for under-18s to these wards, and they made up 10,424 "bed days" in the units. This compares to 219 under-18s spending time on adult mental health wards in the whole of 2012/13 and 236 admissions.

There has been an increase in the numbers of young people presenting at A&E following deliberate self-harm and needing therefore admission at least overnight onto paediatric wards whilst they wait for a CAMHS assessment. NHS hospitals treated 18,037 girls and 4,623 boys aged between 10 and 19 after they had deliberately harmed themselves, according to official figures. During the same period, cases involving children between 10 and 14 rose from 4,008 to 5,192 – an increase of 30 per cent (October 2012) This has a significant impact on the acute hospital sector as well as not meeting the needs of young people.

### Data and information on children’s and adolescent mental health and CAMHS

**Comments:**

Research suggests there is often poor skill sharing (particularly as funding becomes an increasing problem) between tier 2 and 3/4 resulting in lack of training/expertise/detailed up to date knowledge of evidence base for some disorders within CAMHS (e.g. Madge, Foreman, & Baksh. (2008) Findings such as Woolgar and Baldock (2014) indicate the significant different results seen between tier 3 and 4 services at times.

This again highlights the importance not only of better collaboration and knowledge sharing between Tiers and across sectors but also the ongoing need for highly qualified professionals who are able to apply the full range of psychological understanding and research base to assessment and treatment and not limiting capacity within child and adolescent mental health services to professionals trained in only one psychological modality.

### Preventative action and public mental health, including multiagency working

**Comments:**

The Society recognises the need for a parallel public health approach to address the mental health problems amongst children and adolescents; this will help reduce pressure on CAMHS services and ensure that we are preventing problems from developing for many young people rather than treating them when they emerge. Within this we would include infant and perinatal mental health provision and high quality, evidence-based parenting support delivered early. Initiatives like the Family Nurse Partnership are making significant improvements and should be extended.

**Primary prevention**

The Society recommends adopting a Community Psychology approach to work with communities and policy makers to deal with the issues that lead to the development of mental health problems e.g., bullying, social deprivation, economic inequality. Community psychology is a sub-discipline of psychology that brings community participation and social change to the forefront of the way that we understand and promote psychological wellbeing. Community psychology injects critical, liberal and human rights perspectives into psychology and is concerned with political processes and value-based enquiry.

More of our evidence in regard to this is contained in earlier sections of the evidence and we
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consider it to be both integral and crucial to good CAMHS provision.

The Society has supported the development of MindEd as a consortium member – MindEd is a Department of Health (England) funded educational and advice programme to improve mental health outcomes for children. The 2 year project to develop and implement a mental health e-portal aims to support all adults engaging with Children and Young People in the UK in preventing decline in children’s mental health.

| Concerns relating to specific areas of CAMHS provision, including perinatal and infant mental health; urgent and out-of-hours care; the use of S136 detention for under 18s; suicide prevention strategies; and the transition to adult mental health services |
| Comments: |
| In our survey we asked about the range of provision provided by CAMHS services – across 43 trusts - 43% of respondents said the range of provision had decreased in last 3 years, 25% had increased range and 33% had stayed same. We explored provision further and as can be seen below many areas of provision were felt to be at a level that was a concern/deterioration in service/increased risk |
|  |
| • Crisis/ intensive intervention 54% |
| • DSH/suicide prevention 70% |
| • ASD/ADHD 61% |
| • Early intervention and prevention 27% (and 48% offering no service) |
| • Out of hours provision 28% (and 46% offering no service) |
| • LAC/F&A 43% |
| • Older teenagers/adult beds 67% |
| • Transition to adult 60% |
| • LD 57% |
| • Criminal justice 55% |
| In the care system: many looked after children have complex needs and high levels of mental health problems, frequently as a result of abuse, neglect, loss or attachment difficulties prior to coming into care. This makes CAMHS support vital, yet there is sometimes local confusion about who pays and who provides CAMHS when a child is placed out of area, which can result in a lack of support for those who are most vulnerable. Many services report less effective provision for this crucial group. |
| In the criminal justice system: children and young people in the criminal justice system are far more likely to experience mental health problems than their peers. In secure settings, mental health needs are known to be considerable, severe and complex, with rates of psychosis, self-harm and suicide well above those of other children. There are complicating factors of substance misuse and learning difficulties, and of the children’s distress and anxiety at being locked up and away from home. Again many services report less effective provision for this group of young people. (Department of Health, 2007). |
| Early Intervention in Psychosis – Rethink report ‘Lost Generation’ looks at the impact of cuts to Early Intervention in Psychosis (EIP) services on young people and reveals that Early Intervention services in England are struggling to survive in the face of major funding cuts. This could result in tens of thousands of young people with psychosis missing out on this vital support. 50% of EIP services say their budget has decreased in the past year, some by as much as 20% |
| • 58% of EIP services have lost staff over the last 12 months |
| • 53% say the quality of their service has decreased in the past year |
| • Many young people face unacceptable delays in accessing EIP services, greatly reducing their chances of recovery |
Children with Neuro disabilities

**Learning difficulties and disabilities:** children with learning disabilities are six times more likely to have mental health problems than other children and more than 40% of families with learning disabled children feel they do not receive sufficient help from medical professionals, social workers or mental health services. Emmerson and Hatton. 2007

**Autistic spectrum:** the National Autistic Society cites data showing that one in 100 children have autism, and that more than seven in ten children with autism have a co-morbid mental health problem. They argue that many of these problems are preventable with the right support and that changes to the way that CAMHS are delivered can stop them from occurring. The National Autistic Society. 2010. You Need to Know. London: NAS. The CYP-IAPT programme has specifically not included skilling up of CAMHS professionals to meet the psychological needs of this population and/or adapt/modify approaches.

An additional area of concern in terms of specialist psychological understanding and provision within CAMHS services noted was that of neuro-developmental difficulties resulting from an acquired brain injury (ABI; such as from trauma, brain infections, vascular problems, hypoxia, surgery or tumour) in childhood are known to be associated with a wide range of poor longer term outcomes in the domains of cognition (Anderson, Catroppa, Haritou, Morse, & Rosenfeld, 2005), educational attainment, (e.g. Ewing-Cobbs, Barnes, Fletcher, Levin, Swank and Song, 2004) and emotional and behavioural problems (Max, Schachar, Levin, Ewing-Cobbs, Chapman, Dennis, Saunders and Landis, 2005).

CAMHS services will typically work with young people who have encountered a wide variety of problems including trauma, psychosis, bereavement, anxiety and behavioural and developmental disorders. It may well be that an ABI could have contributed to such disorders, either significantly, or, at least, in part. However, such underlying conditions may well not be routinely accounted for. Without accounting for Neuro-developmental Disability due to ABI in this population, the cause may not be made apparent and clear without the psychological expertise to assess them. Without such clarity, there may be inappropriate treatments.

In conclusion, for CAMHS services to accurately assess and meet the highly complex interacting psychological and neuro-developmental factors children and their families present, it is crucial that multi-modal psychological expertise is available in these services so that the most effective and efficient treatment can commence from the start. The Society are committed to ongoing collaboration and would welcome the opportunity to contribute to the evolving work of the review.

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