



Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Child and Adolescent Mental Health Services

Everybody's Business

Strategy Document

September 2001

IMPROVING MENTAL HEALTH SERVICES IN WALES:

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) STRATEGY

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FOREWORD BY JANE HUTT AM



In introducing and commending this first ever All Wales Strategy for Child and Adolescent Mental Health Services, I wish to begin by quoting some words from the report of the independent Advisory Group which struck a particular chord with me.

"Yet the effectiveness of certain interventions is proven both in terms of restoring damaged young people to full health, social potential and educational achievement".

These words sum up the importance of the task we are beginning here. Our aim is to produce coherent, high quality services of proven effectiveness uniformly accessible across Wales. If we succeed, then we shall have made a major contribution to improving society as a whole while rescuing many young people and their families from despair. The realisation of the far reaching, beneficial potential of this Strategy led the Advisory Group to call their report "Everybody's Business". With their permission, I have decided to adopt this title for the Strategy itself as it sums up succinctly the nature of the improvements I seek.

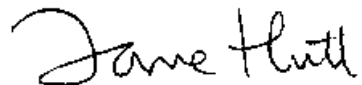
The title stresses, too, the importance of all agencies working together to make this Strategy work. The Group report refers to the "Holy Grail" of good joint working. It is true that we have sought constantly to achieve this over a wide range of initiatives for many years. I believe that recent Government reforms have removed the organisational barriers to good joint working and there is no valid reason now why the NHS, social services, education and the voluntary sector cannot come together to achieve the aims of this Strategy. I was pleased that the wide-ranging consultation exercise led other agencies such as the police to come forward to offer their co-operation. These offers must be welcomed and accepted.

Staff working in CAMHS have been at the forefront of the drive for this All Wales Strategy. The report acknowledged their dedication and excellent work but identified the establishment of an All Wales Strategy as the first step in tackling deficiencies in the system which were preventing services receiving the full benefits of this input from staff. I believe we now have the opportunity, through this Strategy, of ironing out inequity of access, of spreading good practice across Wales and of linking with other Government initiatives to tackle underlying problems which contribute to social exclusion and thus to the vicious circle of issues which affect all of society.

Many of the reforms we want to see will be achievable through better planning and organisation. However, full implementation will require additional funding. The National Assembly has made mental health a priority and has supplied extra funding to support this. I want to see results from this injection of hard won cash and I expect to see CAMHS receive its fair share of it. We cannot put all the problems right overnight but the Assembly has played its full part in beginning the programme of improvement.

It is now the turn of services to produce. This Strategy document provides both guidance and a template against which we shall monitor, measure and judge services. Let no one be under the illusion that it is simply some sort of wish list which can be read and then disregarded. I expect concrete results based on its recommendations.

Finally, I wish to pay tribute to Dr Jennifer Lloyd who chaired the Advisory Group, to Professor Richard Williams, professional advisor, and to all the members of the Group. They have produced a report which has won widespread support and I am grateful to them for their hard work and skilled input.

A handwritten signature in black ink that reads "Jane Hutt". The signature is written in a cursive, flowing style.

Jane Hutt AM

1. INTRODUCTION

The National Assembly has made mental health one of three key health priorities. It has allocated substantial new funds to ensure that practical action can be taken to support this political commitment. Child and Adolescent Mental Health Services (CAMHS) must be allocated a fair share of these extra funds. Not all deficiencies can be put right at once and this All Wales Strategy should be seen as a ten year programme aimed at establishing comprehensive, effective and high quality services across Wales. The vision we have is of CAMHS which are effective and efficient and which, above all, unite all professions in a determination to put the needs of children and young people at the heart of our approach to CAMHS in Wales.

The Strategy draws heavily on the report of the independent Advisory Group set up to advise the Assembly on CAMHS. That report received strong support from all sectors during the full consultation that we held on its findings. Several sections of that report have been incorporated verbatim into the Strategy **but this document is issued now as National Assembly guidance against which services will be monitored and assessed.** It is aimed not just at health services, managers of healthcare services at all levels and health professionals, (such as child and adolescent psychiatrists, paediatricians, nurses and therapists) but also at staff and management of social services, education, youth justice agencies and the voluntary sector. All have a part to play and all are vital to the joint endeavour to tackle mental health problems which affect young people, their families and carers, and which contribute significantly to wider problems in society. **A core principle of this approach is that no sector or component of a sector should be absolved from playing its full part in CAMHS.**

Both mental health problems and disorders in children and young people are symptoms of a deeper malaise in society generally. Our approach to CAMHS must take account of other Government initiatives aimed at these underlying problems. Initiatives to tackle social exclusion, for example the Sure Start scheme, the Substance Misuse Strategy and the appointment of a Children's Commissioner for Wales are just some of the projects which read across to this Strategy. The lessons from the Waterhouse inquiry into child abuse must be learned and built into CAMHS. There need to be strong links, too, with the impending All Wales Strategy for Adult Mental Health Services and the Primary Care Strategy, recently published.

Our intention is that this Strategy should be one aspect of our response to the United Nations Convention on the Rights of the Child. We recognise that children are a vulnerable group and are keen to see that services are developed to provide the care and assistance they need. This Strategy is also compatible with Government measures to raise and monitor standards in statutory services through mechanisms such as clinical governance and initiatives that include Best Value. It should be used to support general planning initiatives such as Health Improvement Programmes, Children's Services Plans and Behavioural Support Plans. It is written in the context of existing strategic arrangements but is flexible enough to be adapted to the changes facing the NHS in Wales with the

planned abolition of Health Authorities and the reformation and strengthening of agencies to replace the current Local Health Groups. It is intended to apply to all children and adolescents normally resident in Wales whether cared for in Wales or elsewhere. Care must be taken by all responsible for commissioning services to ensure that those provided by agencies of all sectors outside Wales for Welsh children achieve at least equivalent standards.

Government proposals to amend the Mental Health Act 1983 will have a major impact on services and we discuss these later. Also, we have appointed a Panel, chaired by Lord Carlile of Berriew, to review Safeguards for Children and Young People Treated and Cared for by the NHS in Wales. We will consider adjustments to this Strategy in the light of any recommendations made by that panel.

Mental health problems and mental disorders in young people can devastate the lives of those affected and destroy the quality of life of those around them. Society pays a high price in terms of social disruption, education failure, ill health, anti-social behaviour and hard cash for failure to tackle these problems effectively. Links between childhood disorders and adult mental health problems are now well established. Likewise, we recognise the impact on children of their being thrust into the position of carer. While the roles that some children may take for adults and siblings may reflect the strength and importance of family relationships, inappropriate responsibility taken on too early can take a toll on children's development and on their well-being and mental health. Failure to break these patterns can result in generation after generation suffering from social exclusion with its attendant problems.

Yet the effectiveness of certain interventions is proven both in terms of restoring damaged young people to full health, social potential and educational achievement and in terms of hard cash through savings on expenditure by society on later, more expensive treatments and on interventions by a multitude of agencies.

Mental health promotion and prevention of problems and disorders are key to this approach because good mental health in children is a positive indicator of the future well being of the adults they become. It could also be considered as an indicator of the quality of our society and its services. For example, forming meaningful relationships and coping with the responsibilities of parenthood depends largely on learning during childhood. The value of timely and effective intervention from an appropriate source for children and young people with mental health problems or mental disorder is recognised as assisting and maintaining their progress towards healthy development.

The existence of poor mental health in children and adolescents, of ineffectively managed mental health problems and of ineffectively or untreated mental disorders and illnesses is damaging to children at the time. These experiences, and any problems arising from them, may prevent attainment of the normal developmental milestones thereby hindering maturation and resulting in longer-term and enduring problems in later life. For these reasons, we believe that the mental health of our children is everybody's business.

It would be wrong to paint a picture of existing CAMHS in Wales that was totally gloomy. In 1995, the NHS Health Advisory Service found that CAMHS had attracted "knowledgeable, keen and committed workers who...showed considerable potential for creativity and innovation in their practice." There are many examples of good practice and many dedicated professionals in the statutory and voluntary sectors who are providing excellent services, tailored to local needs, with imagination and enthusiasm. While the best services in Wales stand in comparison with the best anywhere, we acknowledge that the volume and diversity of services and the numbers of trained staff at all levels and in all sectors are presently too low to deliver fully on this potential. There is a need to systematically spread good practice through training and recruiting staff to enhanced services with the intention of ironing out inequities. The staff who deliver our present services are among the strongest supporters of the proposal to establish an All Wales Strategy to tackle the acknowledged problem.

2. THE AIMS, OBJECTIVES AND PRINCIPLES OF THIS STRATEGY

2.1 Aims

This Strategy has at its core the following overriding aims:

- *Relief from current suffering and problems with the intention of improving, as soon as possible, the mental health of children, adolescents and their families;*
- *Longer-term interventions to improve the mental health of young people as they grow up and when they become adults and, thereby, to positively influence the mental health of future generations; and*
- *Partnership with families, substitute families and all those who care for young people.*

2.2 Objectives

In order to achieve these aims, services are required that have the following among their objectives:

- *to involve parents and carers in a meaningful way in planning and commissioning services;*
- *to establish child-centred services which take into account the views of young people and families using them;*
- *to improve overall the mental health of children and young people and to provide effective and timely intervention for those presenting with mental health problems and disorders;*
- *to make services equitably available across Wales on the basis of need;*
- *to build child protection measures into all services at every stage and throughout every service and sector so as to provide safeguards for children and young people wherever and whenever they are cared for or treated;*
- *to remove the stigma surrounding mental health services;*
- *to promote a multi-agency, multi-disciplinary approach and integrated service provision;*
- *to consider the problems of ethnic minority children and young people;*
- *to draw upon and disseminate good practice both from within and from outside Wales;*
- *to link to Government programmes on social inclusion, substance misuse and reduction in offending with particular emphasis on reduction of violence;*
- *to replace responses to crisis with commissioning mechanisms and services which manage demand and the projected rise in demand;*
- *to cultivate an atmosphere of mutual support among professionals, academics and the public across the statutory and non-statutory sectors;*

- *to build in Wales services which are based on sound evidence but which are open to new ideas;*
- *to encourage in Wales an environment in which sound, practical research can flourish and be properly assessed and disseminated; and*
- *to be compatible with other strategies and initiatives on services and care provision for children.*

2.3 Principles

It is essential that certain key principles underpin and guide implementation of this Strategy. The principles that we wish to see guide our services in Wales are summarised here.

Child-centred Services

The welfare and protection of children in law is of paramount importance (Children Act 1989). This concept must be reflected in commissioning, designing and delivering services in all sectors of care.

There should be an increasing focus on:

- *children's rights (as represented by the United Nations Convention on the Rights of the Child);*
- *advocacy services for children;*
- *development of child friendly services; and*
- *active steps to hear the voices of children.*

The views of children and young people who use the services should be actively sought by planners, commissioners and practitioners and incorporated wherever possible into plans and service delivery.

Child centredness means that services must be holistic, flexible and centred on the needs, opinions, cultures and life-styles of children and adolescents. Professional practice, regardless of discipline should:

- *view each child as a developing person in his/her context;*
- *view problems in the ways in which children experience them;*
- *empower good parenting;*
- *include a focus on prevention and health promotion;*
- *develop relationships that aid young people in tackling their problems; and*
- *be realistic.*

Services should be Respectful and Protecting of Children and Adolescents

This principle requires services to value parental responsibility and be compliant with duties given to the agencies to protect young people. The Waterhouse Report (February, 2000) has emphasised the vital significance of:

- *high quality child care;*
- *effective child protection procedures;*
- *comprehensive training, supervision and support for staff who work with other people's children; and*
- *commissioning and provision of services that are able to respond to the wide educational, social, healthcare and mental health needs of children in public care.*

Services should be Lawful

Services should operate within the spirit and intentions as well as the fact of the law. Among other matters, this requires good human resources, policies, and training for staff regarding:

- *the requirements of the Mental Health Act 1983, its Code of Practice, future legislation relating to mental health and the Children Act 1989;*
- *the conditions concerning consent given by and/or for children relating to health, social care and education;*
- *the conditions concerning consent given by and/or for children relating to forensic medical examination or interviewing by the police and criminal justice services;*
- *the law on restriction of children's liberty;*
- *confidentiality, and when it may be breached;*
- *child protection procedures;*
- *appointing, checking the status of and managing staff;*
- *provision of professional supervision;*
- *enacting complaints policies;*
- *the impact of the Welsh Language Act; and*
- *guidance on children visiting adults in mental illness units.*

Equitable and Responsive Services

Services must be:

- *accessible, fair, non-discriminatory and without stigma;*

- *of sufficient volume, composition and distribution as to be able to offer services that exploit contemporary knowledge and skill as close to where people live as is appropriate for reasonable efficiency;*
- *sensitive to the cultural and language diversity of ethnic minorities;*
- *appropriate to the cultures, languages and racial backgrounds of the people of Wales;*
- *appropriate to the population of Wales of both genders and able to meet the needs of people of both heterosexual and homosexual orientations; and*
- *designed to have the abilities to serve and, thereby, promote inclusion of otherwise excluded groups, especially those in which morbidity is higher.*

Services should be Comprehensive and Appropriate

The design and expectations of CAMHS in Wales should be determined with reference to:

- *knowledge of the needs of the child population of Wales;*
- *the assessed needs of local populations of young people and their families;*
- *the best of the present and potential capabilities of these services; and*
- *plans drawn up to meet the specific needs of individuals.*

Integrated Services

Integrated CAMHS are collaborative and co-ordinated both within and across agencies. Boundaries between departments, within services and agencies, and boundaries between agencies should not be allowed to be reflected as fault lines in the experiences of children, adolescents and their families. This implies that services should be:

- *considered from the perspectives of their users;*
- *commissioned by the responsible authorities on a co-ordinated basis to avoid replication and gaps; and*
- *based on awareness of the requirement of many young people for their needs to be dealt with by a number of different agencies concurrently and according to agreed plans, timetables and distributions of responsibility between the agencies and sectors of care.*

This principle requires all the relevant sectors of care and agencies within them to work to jointly agreed models for sharing their assessments, when and where appropriate so as to avoid duplication, gaps and lack of clarity about their mutual responsibilities. Integration and co-ordination also require the agencies to subscribe to agreed models of care and/or case management for inter-agency work.

Services should be Competent and Accountable

Delivering competent CAMHS requires not only effectiveness and efficiency in service provision but also high quality in their conception, design and commissioning.

This requires good skills in assessing need and risk both for populations of children, adolescents and their families and for individual children. The responsible authorities should work together to develop realistic local CAMHS strategies that are inclusive of the thinking, approaches, experience, expertise and opinions of a range of disciplines. These should include social, educational, medical, occupational, nursing, psychological, psychiatric, therapist and managerial perspectives. Crucially, the responsible authorities and local services should strive to learn from the opinions of service users, their families, carers, the voluntary (non-statutory) sector, and from the general public.

Competent services provide blends of assessment, care, intervention, treatment and management skills. A core feature of high quality services is that they offer an appropriate and sufficient blend of responses in a timely and co-ordinated manner to each person who is assessed as needing them. Users of services should be helped to make informed choices.

Planned intervention requires that each department in each agency should be able to state and agree with partners its aims, objectives and contribution within the wider CAMHS framework. The process of delivery of service should itself be open to development and accountable within the framework recommended in this document. All CAMHS should be evaluated with regard to their contribution to the intended framework of competencies.

Effective, Efficient and Targeted Services

Whenever possible, the services offered to the public should be of known effectiveness (evidence-based) and efficient (good value for their cost). In common with most other health, education and social services, the evidence about current service capabilities is far from complete but it is expanding rapidly.

For the present, services should not be denied on the basis of insufficient evidence alone. As the evidence-base expands, it will become increasingly appropriate for services to be clear about their client groups, the interventions required of comprehensive CAMHS, effective and efficient pathways for care, the roles assigned to agencies within planned care and the consequent staff training required.

2.4 The Legal Framework

The main legislation underpinning designing and delivering CAMHS is the Children Act 1989. Part I of that Act provides core principles for legal decision-making concerning children. These same principles provide a solid framework for planning and delivering all children's services.

Relatively few children and adolescents are made the subject of compulsory care and treatment within powers given by the present Mental Health Act. However, the ability to do so, when appropriate, is vital to the effective care of certain young people. The ability to provide the protection afforded by law to detained people and the inclusion of principles relating to consent by minors and restriction of children's liberty within the

Code of Practice are equally important. The White Paper on reform of the Mental Health Act 1983 makes some key references to children and young people, which are:

- *the provisions of any new Mental Health Act will apply to children and young people;*
- *special steps will be taken to safeguard the welfare of minors while receiving care and treatment for mental disorder;*
- *the new Tribunals will be required to obtain expert advice about children and young people and to consider the location of compulsory admission and treatment of young people;*
- *changes will be made to enable 16 to 18 year olds to refuse care and treatment for mental disorder unless compelled to do so by their being made the subject of an order under the new Act; and*
- *ways will be found to safeguard the interests of both informal and detained children and adolescents who require care and treatment for serious mental disorder.*

The National Assembly is in very close touch with the work on the revision of the Act and will ensure that the principles underlining this Strategy are taken fully into account when the legislation is framed.

3. THE NATURE AND SCALE OF THE PROBLEM

Here, we consider the needs of young people as reflected in recently collected information and we provide an account of the Advisory Group's findings about current services in Wales. We also summarise the common themes taken from advice on service development published in the last seven years. Towards the end of this document, we review the measures that will be required to sustain and develop the workforce. This section begins with an overview of language and conceptual matters that frame a challenge to the agencies in working together better.

We agree entirely with the Advisory Group's recommendation that our strategy for Wales should be based on clearly understood principles that place children and young people and their families at the centre of our considerations. It must take well-informed account of:

- *our best understanding of the problems that beset children and young people and those who care for them;*
- *the current state of our services and the challenges they face; and*
- *the needs of the staff who work in them for development and support.*

3.1 *Concepts, Models and Language*

At present, the language adopted tends to have a medical bias, perhaps as a consequence of the rapid advances in research in this arena, but this is by no means a complete description. The lack of a common CAMHS 'language', or shared terminology, has created particular inter-agency difficulties. In part, this reflects the differences of conceptual approach, models of care, intervention and practice that have been adopted over the years by different agencies and the professions within them.

When harnessed positively, this diversity of approach can have enormous benefits for children and young people. We have taken it as axiomatic that no one agency and no one profession has the monopoly of understanding and capability when trying to help troubled young people. Partnership is required in all but the most straightforward of instances if inputs are to be maximally effective. However, this richness can give way to tensions between agencies and their staff. Recent research shows how differing expectations and misunderstandings, between agencies may flow from:

- *assumptions;*
- *lack of familiarity;*
- *different organisational and professional cultures;*
- *lack of agreement about how competing pressures are handled so that each child does not pass serially from waiting list to waiting list; and*

- *different perceptions of role and priority.*

Inevitably in these situations, it is children, adolescents and families who fail to receive the best from our services, and Staff who feel exposed and unsupported.

We do not diminish the challenges of partnership and the continuing work required to secure it. However, we do wish to see fresh endeavours in this direction and we intend to make available the means to do so through this Strategy. Work on organisational culture and roles is required. Further work on language is needed and we shall consider commissioning work to investigate breaking down these barriers. We shall make use, of some relevant work already carried out in other areas of the National Assembly's responsibilities.

We regard the terminology we use here as a base from which to work with the aim of achieving as soon as possible common terminology and language across the professions working in the field. We cannot hold up this Strategy while this is being developed and the following paragraphs draw on those terms in usage now.

While precise definition that meets all circumstances is a challenging task, it is important to define the terms adopted here. In the absence of an agreed language, this document uses the terms *mental health problem*, *mental disorder* and *mental illness* to provide a picture of the nature and extent of the tasks that face families and our service agencies. In the context of this Strategy, these are not phrases with interchangeable meaning.

The terms used in this Strategy are summarised here:-

- *Mental Health Problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the capacity for play and learning, development of concepts of right and wrong, and in distress and maladaptive behaviour. They may arise from any number or combination of congenital, constitutional, environmental, family or illness factors. Mental Health Problem describes a very broad range of emotional or behavioural difficulties that may cause concern or distress. They are relatively common, may or may not be transient but encompass Mental Disorders, which are more severe and/or persistent.*
- *Mental Disorders are those problems that meet the requirements of ICD 10, an internationally recognised classification system for disorder. The distinction between a Problem and a Disorder is not exact but turns on the severity, persistence, effects and combination of features found.*
- *In a small proportion of cases of mental disorders, the term Mental Illness might be used. Usually, it is reserved for the most severe cases. For example, more severe cases of depressive illness, psychotic disorders and severe cases of Anorexia Nervosa could be described in this way.*

There are at least two limitations to the language used here. First, each of the major sectors of service provider and the professions may use different terminologies. For example, educationalists may use the term Educational and Behavioural Difficulties (EBD) when the problems they encounter are severe, persistent and associated with other problems. Another term in common use is Special Educational Need (SEN) and this may apply to learning

problems as well as to behavioural and mental health problems. The Warnock Report of 1978 intended that the latter general term should replace other terms then in use.

Educational and Behavioural Difficulties and Special Educational Need may overlap with each other and with mental health problems and mental disorders. A recent survey of children and adolescents in England, Scotland and Wales, conducted for the Office for National Statistics and published in April 2000, shows that children with a mental disorder are three times more likely than those without to have officially recognised special educational needs (49% compared with 15%). The survey also showed that 6% of children who did not have special educational need also had a mental disorder and 40% of those who had been issued a Statement of SEN (i.e. at Stage 5) had a disorder. While these figures show the overlap, they also show the distinctions. The relationships between the use of these and other terms need to be further clarified.

The second limitation concerns the position of young people whose difficult behaviour, including anti-social behaviour, aggression and violence, causes distress to others. Behaviour problems in young people can be viewed as a common pathway by which a variety of underlying circumstances show up. There is widespread opinion in Wales that use of the term Conduct Disorder is unsatisfactory. Responses to our consultation add weight to the Advisory Group's view. The boundaries are unclear between this syndromic medical conception, problem-based social welfare and educational approaches and legal definitions. Experience suggests that children and young people whose conduct is most problematic or challenging have an array of social, educational, physical and mental health problems. So, while we have used the term 'Conduct Disorder' sparingly, this is not to diminish the needs and impact of people with behaviour and conduct problems, but to acknowledge how the difficulties with the suitability of the descriptive languages we choose should not blind us to the need to look across a wide range of approaches to find solutions to difficult problems.

All too frequently, issues over definition are translated into tensions and, sometimes, disputes about access and responsibility between agencies, particularly those under strain. This tends to arise around cases in which conduct is a major issue, pointing up the need for a fresh approach to this challenge. Later, we propose an initiative that should be based on developing multi-agency commitments.

This should not mask a parallel finding, which is that young people with serious problems may not come to the notice of any service if their conduct is not problematic or does not present particular challenges. For example, the remediable suffering of depressed, anxious and worried children may not come to the notice of services when help is most needed.

3.2 The Scale of the Problems Affecting Children and Young People

The Advisory Group estimated the scale of mental health problems and disorders in children and young people in Wales. Precise data needs more detailed work but we consider the Group's figures illustrative of the scale of the problem:-

- *More than 40% of young people have recognisable risk factors;*
- *30% to 40% may at some time experience a problem; and*
- *Up to 25% (depending on environment and circumstances) have a disorder.*

These projections do fit in order of magnitude with findings from the recently published survey commissioned by the Office for National Statistics (ONS). The ONS data clearly indicates that the rates overall are very similar in England, Scotland and Wales.

The prevalence of child and adolescent mental health problems and disorders is clearly linked to deprivation. Vulnerable children include those exposed to a wide range of problems including social and educational disadvantage. Abused children, asylum seekers, refugees and homeless children, may be particularly vulnerable and in need of protection and intervention.

Substance use by adolescents in Wales is endemic and the rate of misuse is predicted to be higher than in England as it, too, is related to indicators of deprivation, alienation and exclusion. The ONS survey showed that 24% of young people who drank alcohol more than once a week had a mental disorder, three times the proportion among the group who had never drunk any alcohol. About one half of the 11 to 15 year olds who frequently used cannabis (more than once a week) had a mental disorder compared with one fifth of the less than once a month users and one tenth of those who had never used cannabis. Binge drinking by teenagers is now one of the most worrying aspects of recent changes in patterns of substance use. The risk factors for substance misuse and mental health problems are similar and some sources estimate very high rates of co-existence of both types of problem.

Demand on social services departments gives another proxy measure of the scale of the challenge. The primary healthcare, paediatric, dental, educational, social and mental health needs of children who are clients of those services are substantial. There were 3,313 children 'looked after' by local authorities on 31 March 1999. 76% were in foster placements and 7% were in Wales's 28 registered homes. 2,413 children were on child protection registers and 344 were offered respite care. In the same year 2,867 children were on learning disabilities registers, 692 supervision orders were made and there were 56 admissions (1.8 per 10,000 of the 10 to 17 year old population) to secure units.

Similarly, the numbers of children with special educational needs provides its own picture. The recent ONS survey showed that 1 in 5 children had officially recognised special educational need (SEN). 28% of those with a disorder and 13% of those without had been issued with a Statement of SEN (SSEN) by a local authority. For the survey, the criteria for selecting children who had a specific learning difficulty (SpLD) were set at including only the 5% who had the most extreme scores on the tests set. Using this definition, specific learning difficulty was found in 12% of children with a disorder and 4% who had no disorder. 25% of children with emotional disorders had been absent from school for 11 days or more in the past term compared with 21% with serious conduct problems and 14% with hyperkinetic disorders. Anecdotal self-reports showed that 33% of children with a

disorder had played truant as had 9% of those with no disorder. Predictably, the rate was highest for children with problematic conduct (44%).

The needs of young people could be considered a moving target as changes in the cultures that surround them impact on the level and nature of need and the kinds of services that are required. Services need to be flexible but the key to this is good up-to-date information. One illustration of this relates to the importance of taking into account in Wales the mental health needs of asylum seekers.

We accept that a full scale needs assessment needs to be commissioned to build on this work and the ONS survey in order to establish an accurate baseline for planning and commissioning services. We are preparing to commission such a study. It will take into account any likely changes within local populations and include specifically the needs of ethnic minorities, the priority and collaboration groups identified later in this document, as well as the requirement to provide services in the Welsh language. Inevitably, the results will not be available for some time, but, in the meanwhile, we do not wish to see activity to implement other aspects of this Strategy stalled.

3.3 *CAMHS in Wales*

Comparatively our best evidence of the state of CAMHS in Wales comes from studies into NHS facilities and so much of the detail in this section focuses on the NHS contribution. While evidence provided to the Advisory Group on local authorities was thin when compared to recent studies of the NHS, anecdotal evidence suggests that we can take the findings we present as reasonably accurate for all sectors. Opinion presented to the Advisory Group suggests that the potential of the voluntary sector is insufficiently understood. Its contribution has not been systematically developed and we are keen that this too should be remedied.

Local Authority Services

CAMHS are provided by all sectors including local authorities through their **social services** and **education** departments. During the course of its work, the Advisory Group received reports that neither the education nor social services departments have been able to play their full parts in planning or delivering mental health services. Among the pressures, the demands of our education policies and a necessary focus on child protection have very appropriately placed considerable tasks before Wales' local authorities.

A number of responses to the consultation drew attention to the problems of recruiting and retaining social workers. Such a situation has not supported the long-term approach the children and young people require. Others pointed out the problems with the stability of placements for looked after children. The latter is being tackled through the National Assembly's Children First programme and associated work to develop guidance on placement strategies which ensure needs are met and stability improved.

Similarly, while policies on tackling bullying have made considerable impacts, their implementation remains incomplete. Much more remains to be done in establishing schools as emotionally literate organisations.

Our awareness of the increasing need in all areas and especially of the possible long term impact of mental health problems now draws us to review the contribution of local government services within a broad approach to CAMHS. As a result, our intention is that there should be an expansion of the services provided by the local authorities in parallel and in collaboration with developments in the NHS. Also, we are currently reviewing approaches to planning and commissioning placements for children who are looked after.

The NHS

A picture of services in the UK and, within that, of CAMHS in Wales, emerged from a review conducted by the NHS Health Advisory Service (HAS) in 1994. With exceptions, the HAS found in England and Wales:

- *absence of strategy;*
- *ineffective commissioning;*
- *poor collaboration between the NHS and the local authorities;*
- *patchy service provision that was unrelated to need;*
- *problems in the availability and accessibility of services;*
- *limited standardisation and replication of capability, of role and of interventions across different services in different parts of the country;*
- *poor levels of general managers and low managerial knowledge of CAMHS; and*
- *widely varying expenditure per head of population between different authorities that was unrelated to assessed levels of need.*

The Advisory Group found that the main weight of expectation for the provision of more specialised CAMHS has fallen on the NHS in recent years. Within that sector, the services identified as specialist child and adolescent mental health services have been under enormous and growing pressure. Consequently, other services, including particularly the paediatric and child health services, have provided invaluable yet insufficiently resourced and trained contributions to a wider 'virtual' mental health service. We are keen to see these recognised in the move towards a more comprehensive and better-integrated service based on good flexible training that involves all sectors of care and all relevant disciplines.

There has been progress since 1994. While many of the responsible authorities are now either endeavouring to move forward or aware that they should do so, the view of the Audit Commission from its survey work conducted in 1998-99 to follow on from the work of the HAS substantiates the general trend and the nature of the HAS findings from 1994. For example, within the UK, the Audit Commission found that expenditure on the specialist CAMHS funded by the NHS varied by a factor of seven.

The Advisory Group's more anecdotal enquiries found widespread opinion among service commissioners and providers in Wales that:

- *the distribution of services owes more to historical patterns and local advocacy of service development than it does to assessed need;*
- *access to good services depends more on geography than on need;*
- *good practice is being disseminated slowly but incompletely and not systematically;*
- *the capability of first line, direct access services is very thin due to:*
 - *widespread lack of training;*
 - *uncertainty about the legitimacy of taking action outside more specialised services; and*
 - *uncertainties about their role, which needs to be clarified and developed;*
- *there is general opinion across Wales that the present children's services provided by the social services departments, the educational psychology and special education services, the community and hospital paediatricians, the child and adolescent psychiatry and child clinical psychology services are valued but under enormous pressure;*
- *specialist CAMHS **at all levels and in all sectors** are in danger of being swamped by rising levels of demand and increasing yet competing expectations;*
 - *many services have long waiting lists and times; and*
 - *some services still do not have separately identified budgets for CAMHS;*
- *the distribution, role and volume of more specialised services need to be re-thought;*
 - *the capacity and spread of capabilities of the most specialised services, including the day-care and inpatient services, is too low and needs to be increased;*
 - *the report on the Government-funded NICAPS study of adolescent units in England and Wales is to report in 2001; it is understood to show that Wales has the lowest ratio of psychiatric inpatient places to the population under 18 when compared to all the English regions;*
 - *the psychiatric inpatient services may lack the most appropriate focus;*
 - *the very specialised services may not cover sufficient of the client groups in need; and*
- *the present commissioning arrangements are not suited to the more specialised NHS services - there needs to be a Wales-wide approach to commissioning them.*

Our consultation revealed not only a general consensus of agreement with the reality of the Advisory Group's assessment but also identified some particular gaps.

One of these was brought to our attention by Guardians ad Litem and solicitors with experience of CAMHS. They make plain the needs of the legal services in both private and public law and also the requirements of the criminal justice system for expert mental health advice. This expertise often falls outside the provision of the statutory services and is poorly commissioned, if at all.

While we do not under-estimate the issues to be resolved and acknowledge the many competing pressures on the few experts, we are keen to see this situation resolved and the need for mental health expertise in legal contexts to be planned into future developments to our mental health services. In our view, the demands might be eased if the sectors were to come together to plan these services, led perhaps by a multi-agency forensic mental health service for Welsh children, with the object of all disciplines and agencies developing greater expertise. This might reduce current reliance on certain practitioners being prepared to work outside their contracts with, for example, the NHS.

4. THE STRATEGIC PLAN FOR CAMHS IN WALES

4.1 *Lessons from Research - Common Themes and Key Steps*

In the last four years, several respected bodies in the UK have published high quality and well researched documents relating to design, commissioning and delivery of CAMHS.

The reports include:

- *The NHS HAS Thematic Review, Together We Stand, 1995;*
- *Wallace, Crown, Cox and Berger, Health Care Needs Assessment, 1997;*
- *House of Commons Health Committee Report, Child and Adolescent Mental Health Services, 1997;*
- *BMA, Growing up in Britain, 1999;*
- *Mental Health Foundation, Bright Futures, 1999; and*
- *Audit Commission, Troubled Children, 1999.*

Each of these reports approaches the issues from its particular viewpoint. The Advisory Group commissioned a content analysis of these and other documents. It clearly identifies six common themes that are regarded as essential or core in the development of modern value-led CAMHS in the UK.

- *Establishing multi-agency ownership of the CAMHS Concept. This means achieving shared, multi-agency ownership of a broad approach to the definition of children's mental health and, consequently, of approaches to resolving those problems;*
- *Basing services on the CAMHS Concept in which all relevant sectors of care play their key and acknowledged roles to achieve the goal of delivering integrated and comprehensive services;*
- *Basing service planning on the Assessed Needs of the child population in each locality in order to break away from provision built on historical patterns of supply or anecdotal levels of demand;*
- *Conducting Audit and Mapping of Current Services in order to determine local priorities for development;*
- *Adopting an Evidence-based Approach to practice and thereby Targeting services according to more explicit criteria; and*
- *Adopting a Strategic Approach to designing and delivering CAMHS based on a common Strategic Framework that is used as a tool for future understanding and development.*

These themes are reflected in the principles adopted by us. In the next section, we summarise our strategic plan for Wales and develop the multi-agency approach, otherwise referred to as the CAMHS Concept, and recommend a Strategic Framework.

4.2 *Putting Principles into Practice*

We have set out above the scale of the challenge that faces the responsible authorities in Wales. Briefly, there is a need to raise service availability, co-ordination, capacity and capability on a planned and considered basis. This requires a shared vision and an agreed programme of action jointly owned by families and carers, the National Assembly for Wales, the responsible authorities and the service providers of all relevant agencies. Each needs to be committed to a partnership in which the agencies work together to design and deliver shared local strategies and services. **No sector can be absolved from the duty to play its full part in CAMHS and to co-operate across professional boundaries** to better meet the needs of:

- *children and adolescents; and*
- *family adults, siblings, carers and staff who work with children.*

Our concept of CAMHS is inclusive. **That is, we take the term CAMHS to mean all of the services provided by all sectors that impinge on the mental well-being, mental health, mental health problems and mental disorders of children and young people before their majority. This is what we term here ‘The CAMHS Concept’.** Its adoption in Wales will bring into the arena of CAMHS some services, on the basis of their ability to influence young people’s mental health, that, previously, had not considered themselves to be within this field.

Commonly, the term CAMHS is taken more narrowly to imply those specialist services provided, mainly but by no means exclusively, by the NHS. These NHS services are of key importance to us in delivering this Strategy and we acknowledge that they are under great pressure. They will need to be developed in order to:-

- *better match contemporary demands on them; and*
- *support our intention to develop those other services we now wish to see drawn into CAMHS and developed to become part of an integrated and effective frontline of provision.*

With this in mind, in the rest of this document, we use the term ‘CAMHS’ to refer to the whole enterprise and to include services that do not have mental health or providing for children as their only or key tasks. We use the term ‘Specialist CAMHS’ as shorthand to depict those services that have a particular role and expertise relating to child and adolescent mental health. In short, we see as lying at the centre of our plan the leadership and expertise that the staff in our Specialist CAMHS can and should be enabled to offer.

Our strategic vision for developing services that are consistent with the principles described above should build on three key components. They are:

- *a multi-agency approach;*
- *the four tier strategic concept; and*
- *partnerships between children, young people, their families and professionals.*

Each has received overwhelming support from responses to the consultation document. The first and second are required to deliver the third and they are described in the paragraphs that follow.

4.3 The Multi-agency Approach

Good joint working is the Holy Grail of all attempts to improve delivery of health, education and social services. It is easy to see its vital importance but it has been very difficult to achieve. The Government's reforms, which have introduced increased budgetary and commissioning flexibility, have made it easier than ever before to overcome these traditional barriers and successful joint working now depends largely on good will and clear joint purpose between agencies. There is no excuse now for lack of co-operation or disjointed approaches.

It is essential that the mental health of children and adolescents should be a genuine partnership between the statutory agencies involved and between them and the non-statutory sector. Of key importance is the partnership between service agencies and carers. The non-statutory sector and carers need to be enabled to play their full roles. Local structures should be organised to support this partnership approach.

The NHS, social services and education are the key statutory bodies involved and all of them should have an equal commitment to services and a real sense of ownership. Room should be created for these bodies in each area to get together to organise a joint approach to CAMHS. These arrangements should include full participation by carers and the non-statutory sector. The outcome may differ from area to area but in every locality there should be a clear agreement of the role of each group and agency and the role of individual disciplines within each. An imaginative approach to joint training would help to accelerate proper integration of services.

While health, social services and education are the key statutory agencies, there is an absolute necessity for them to look across boundaries and to involve other agencies as part of an inclusive approach to CAMHS. For example, the statutory and voluntary organisations involved in primary care and in services for children and adolescents who use and misuse substances must be seen as partners. But, we are reminded by the consultation that even this list is too small. Some of the Police Forces in Wales are engaged in innovative work with young people on the fringes of trouble. They and the legal and criminal justice services must also be regarded as partners in the ambitious plan we promote in this Strategy.

Within our broad action plan, there should be specific and additional considerations for children and young people with mental health problems and disorders to enable them to achieve their full potential in modern society. Without the appropriate support, these vulnerable children may remain disadvantaged, unable to recover from their poor start in life. This principle requires all the relevant sectors of care and agencies within them to work to jointly agreed models for sharing their assessments, when and where appropriate, so as to avoid duplication, gaps and lack of clarity about their mutual responsibilities.

There is clear evidence that early intervention by one agency might have no costs savings for that agency but may well save money in terms of reducing or eliminating later intervention by another statutory agency. This wider picture needs to be taken into account when the economics of CAMHS is addressed and the perverse incentive factor needs to be acknowledged and overcome.

This means that the roles of each sector should become more explicit. **Collaboration needs to be driven from the top of each agency and reflected in good working relationships on the ground. Joint training is a potent force in fostering inclusive attitudes to inter-agency and professional-carer co-operation.**

There needs to be clarification of the roles and responsibilities of local authority and healthcare agencies in order that all the required components of CAMHS are developed in a co-ordinated way such that gaps between agencies are removed and the services are better able to work together to meet the needs of children and young people. To this end, we wish to see the Four Tier Strategic Concept adopted throughout all sectors and services in Wales.

4.4 The Four Tier Strategic Concept

In 1995, the NHS Health Advisory Service published a thematic review of CAMHS called Together We Stand in which it described this concept. Recent work on CAMHS carried out by the Audit Commission took that four tier strategic approach as its baseline and its report confirms the applicability of this approach to future planning.

The tiered framework is intended, first and foremost, to be a strategic and planning tool. Its second purpose is as a communication tool. Only third is it a blueprint for how services are practically delivered on the ground. The importance of this framework is that it promotes a better focus on the service functions required of mature, effective and efficient CAMHS through a model that spans the agencies involved and their working practices.

We are convinced by the work of the Advisory Group and the positive opinions in the vast majority of responses to the consultation that adoption of this system in Wales would be acceptable to most sectors of care, be applicable to and useable by all, and provide a basis for tackling the need to develop a language that spans the remits of the many relevant agencies and the work of the professions within them. It does not seek to choose between the differing organisational models of existing services but views services from the experience of families. We consider that this is likely to foster inclusiveness in planning and cut across previous flaws in articulation that have occurred when each sector has adopted its own separate template. In Wales, this framework should:

- *convey a conception of CAHMS as a multi-sector responsibility within which a number of agencies including commissioners and providers will work together;*

- *integrate the many elements of a truly comprehensive service for young people into an understandable whole, no matter which agency or sector provides each component. This requires better communications within and between agencies;*
- *encourage the development of networks within and across the agencies to better support those people who work with children and their families through consultation and skill enhancement;*
- *work around the differing organisational frameworks used by the various agencies in order to reduce the barriers between them; and*
- *better match young people's and families' assessed needs to delivery of co-ordinated interventions at the most appropriate levels of specialism. This will require better service and care planning within and between agencies.*

The four tier model of services offers two key advantages for providers:

- *a structure for both horizontal and vertical integration and co-ordination of the many agencies and services for children and young people; and*
- *inter-agency support to facilitate skills transfer, development and training*

The model offers the following advantages to commissioners seeking to develop a strategic approach to CAMHS:

- *a basis for assessment and audit of current provision, including the location and diagnosis of service failures;*
- *a range of information to guide effective and efficient planning, increase understanding of organisational relationships and support communications within and across commissioning agencies.*

It is worth restating the inclusiveness of the Four Tier Concept. None of the tiers are specific to any agency – in fact, all relevant agencies are likely to find that they have responsibilities in a number of tiers.

In summary, the four tier system offers particular advantages to CAMHS in Wales because, applied intelligently, it provides a framework which can be adjusted for the widely varying conditions to be found here. So, we agree with the Advisory Group that the four tier system the review recommended should become the basic tool for planning and delivering services in Wales. In so doing, we accept the need for some re-thinking and re-definition of local services in Wales around this approach. For the sake of clarity we provide now the updated definitions of the tiers that we wish to see adopted in Wales.

Tier 1: Primary or Direct Contact Services

Regardless of sector, Tier 1 describes the frontline of service delivery as the public has direct access to its components. Its staff are not necessarily trained as specialists in mental health. But, by virtue of their first contacts with, and their continuing responsibilities for young people and/or their families, staff in front line direct contact services, are well placed

to recognise, assess and intervene with children's mental health problems. These staff require basic skills in assessment and intervention practices.

It is neither best for the young people nor an effective or efficient use of slender specialist resources if children and adolescents who may or may not have a mental health problem generally go immediately or directly to more specialist services. In order to discharge their responsibilities, staff at Tier 1 require training, consultation and support from Tier 2 and ease of access for cases to it.

Tier 1 staff include GPs, many other primary healthcare workers, health visitors, school nurses, teachers and other school staff, non-specialist children's social workers, foster carers and many non-statutory sector workers.

Tier 2: Services Provided by Individual Specialist CAMHS Professionals

Tier 2 is the first line of specialist services. The staff include members of health-provided specialist CAMHS, the staff of the education support services including educational psychologists and specialist teachers and specialist children's social workers as well as some staff of voluntary organisations.

Usually, families are directed to Tier 2 Services by staff working in Tier 1 though this does not have to be the only referral route. Together, the functions delivered at Tier 2 are those required in each local authority area. Frequently, staff work as members of teams to which they may refer. Families may meet single members of staff from each agency involved. While effective liaison between service components is important and potentially time-consuming at Tier 2, this factor in itself does not define such a service as a Tier 3 service.

Tier 3: Services Provided by Teams of Staff from Specialist CAMHS

Services at Tier 3 are more specialised. Some young people and their families may require access to them as a consequence of the complexity of their need, the concentration of skill required or the crucial nature of the inter-service and/or inter-agency planning required to deliver a targeted programme of interventions and care. It may not be efficient or appropriate to provide all modalities of such specialised care in each local authority area but each service at Tier 2 requires access to a definable range of Tier 3 services. Many NHS-based specialist CAMHS are now moving towards working on a 'hub and spoke' model with Tier 2 functions delivered locally and Tier 3 provided at central but accessible locations.

Services at Tier 3 include a variety of specialised clinics, day-care services, special units in certain schools, specialist fostering and social services-led specialised family intervention centres.

An example of the distinction between Tiers 1, 2 and 3 is that of the family work required by many cases. At Tier 1, this might amount to simple family assessment, discussion or counselling. At Tier 2, there should be the ability to routinely conduct systematised family therapy while, at Tier 3, certain young people may require particular forms of focused and intensive family therapy practised by a team that works together regularly. These teams may be composed of staff drawn from a variety of different agencies.

Tier 4: Very Specialised Interventions and Care

Very specialised services that may not need to be available in each district but to which the local specialist CAMHS require predictable access are termed Tier 4 functions. They include very specialised clinics that are only supportable on a regional or national basis, inpatient psychiatric services for children and adolescents, residential schools and very specialised and residential social care.

5. DELIVERING THE PLAN FOR WALES

5.1 *Priorities for Action*

We accept, the recommendations of the Advisory Group as to the broad priorities for action. The range of activities required includes:

- *developing co-ordinated planning, and delivery of a greater diversity of local service responses through the shared efforts of agencies from all sectors working together;*
- *developing skills in planning, commissioning and managing local services that are well-adapted to the changing organisational context of the statutory sectors in Wales;*
- *improving the disposition, effectiveness and complementarity of current services;*
- *developing the range, scope and diversity of services;*
- *increasing the present volume of local services; and*
- *improving the capacity of present services particularly within the fields of:*
 - *training and staff development;*
 - *prevention;*
 - *early intervention; and*
 - *provision of services for people with the most serious problems.*

5.2 *A National CAMHS Implementation Group*

In order to ensure that this Strategy is implemented throughout Wales, we will establish a multi-disciplinary body to work under the auspices of the National Assembly.

It will be vital to plan the structure of this body carefully to avoid the risk of it unnecessarily complicating or duplicating the responsibilities of existing and future bodies, in particular local authorities and local health boards. The Group will work through the established commissioning structures and will adapt to the forthcoming changes in them. It will be established in a way that dovetails its role into that of the authorities locally and their community plans, children's services plans and behaviour support plans and work on Health Improvement Programmes.

The remit and constitution of the Implementation Group will be worked out carefully by the National Assembly in consultation with all relevant agencies and further advice on this will be issued in due course.

We are aware from the consultation that some respondents are seeking advice on the composition of local CAMHS that are resourced to offer at least a basic minimum level of services. We consider this a difficult matter for a broad document as so much rests on local

levels of need, geography and the capacity and capabilities of other local services. We shall ask the Implementation Group to be prepared to work with local agencies and to advise them on the way forward.

The Minister for Health and Social Services will make a separate announcement about the membership of the Implementation Group and its terms of reference.

5.3 Managing CAMHS

Planning and Commissioning CAMHS

We consider that this document is consistent with and interprets our existing policies on children and young people in a Strategy for Wales but leaves scope for the agencies locally to develop services that reflect the differing needs of differing populations across the nation.

CAMHS at all tiers are, or should be, commissioned by the statutory education, health and social services. The commissioning roles and activities of all the agencies should be better integrated around our four tier strategic framework. The intention is that each child's care should be integrated through a shared framework for multi-disciplinary assessment and intervention.

There should be effective cross-agency working at all levels of planning and commissioning of CAMHS. The intention is that policy should translate into strategy and strategy into realistic and effective common programmes of action to achieve consistent and comprehensive service improvements. **This principle mirrors one of the most consistent and significant recommendations arising from all of the existing literature as well as from anecdotal reports of the problems that presently beset the delivery of effective CAMHS.**

As this Strategy goes to print, there are well advanced plans for implementing the NHS plan for Wales. This will involve a major re-organisation both of health structures and of the relationships of the NHS with local government and the voluntary sector. The proposals for Local Health Plans and for Health and Well Being Strategies developed and implemented by a partnership of the local authority, the new local health boards, together with NHS trusts, CHCs, the voluntary and independent sectors have particularly significant implications for mental health planning and commissioning. This chapter of the Strategy will be revised as soon as the new structures have been clarified. In the meantime, we lay down general principles which apply whatever system is in operation.

Existing structures and statutory and mandatory planning processes should be harnessed to deliver the CAMHS agenda that stems from this Strategy. The forthcoming changes to the NHS structure in Wales will pose an additional challenge for all sectors but we believe the principles in this Strategy are flexible enough to apply during any intermediate stage and once final structures are in place.

At local authority area level, this is likely to result in local authorities and the proposed local health boards (LHBs) working together to develop effective partnerships in pursuit of our common strategic intent and direction. The direction taken by these partnerships should reflect local experience, local profiles of need and the requirements set in the relevant Health Improvement Programmes (HIPs), Children's Plans and Behaviour Support Plans. The development plans, roles and expectations of and resources for CAMHS should be clear within these mandatory documents.

The focus of planning, commissioning and service co-ordination at local authority area and LHB level is likely to centre on Tier 1 and, to a lesser extent, Tier 2 services. The Advisory Group foresaw a need for the work at LHG and local authority area level to be harmonised if existing services are not to become fragmented and this challenge will continue to exist in the new arrangements. However, the size of many LHB/local authority area populations in Wales is small and the volume of specialised (Tier 2, 3 and 4) services in the larger areas of the present health authorities is also small. This creates a challenge to the new commissioning arrangements if complementarity, equity and economy is to be achieved. The Advisory Group was clear that, in most instances, effective planning and commissioning of Specialist CAMHS within the health service will require commissioning at levels that cross the boundaries of several LHBs. Certainly, the more specialised services at Tier 3 will require planning and commissioning arrangements at above local authority area level and LHB level in all instances and the Advisory Group recommended an all Wales approach to commissioning Tier 4 services in all sectors.

The Advisory Group, which was working prior to our recent plans to change the structure of the NHS, saw cross-agency bodies within each health authority area (consisting of representation from the health authority, local authorities, NHS trusts, the non-statutory sector, and the LHGs) as the appropriate level at which effective commissioning of CAMHS at Tiers 1 to 3 could occur. This approach had the advantage of integrating local authority and NHS planning for CAMHS at all tiers within a jointly owned HIP.

We accept the principle in this advice on commissioning and recognise that arrangements to replace these structures, where they exist, and to enable effective commissioning of CAMHS to occur will be necessary in the new system. We are mindful of the advice from the voluntary sector body **Young Minds** of the importance of setting appropriate frameworks for partnership. **We wish to see neither the Four Tier approach nor the goal of comprehensive well integrated CAMHS compromised or lost during the modernisation of the NHS and its structures.**

We will be asking the Implementation Group to advise us on appropriate approaches to commissioning as our plans for the NHS are developed. In particular, we agree that the most specialised services (Tier 4) will require an all Wales approach to planning and commissioning.

Leading and Managing Services

It is vital, too to consider the need for good management and leadership skills in CAMHS without which any refined systems will be useless. There needs to be provision within planning to allow key personnel to receive appropriate training in these skills. We have identified the need to develop the roles and abilities of general managers and professional service leaders within CAMHS. We believe that the roles and attributes of leaders and general managers, while overlapping, can be distinguished. CAMHS require this at planning and service delivery levels. **Overall, there is a need to strengthen the planning, commissioning, leadership and general management of CAMHS.**

The management and leadership skills necessary to develop and deliver services successfully differ from tier to tier. The skills required are not found solely in any one profession. The different professions have different commitments, spheres of action and responsibility within each. **We agree with the Advisory Group's recommendation that individuals should be chosen for leadership and management roles on the basis of their personal qualities, training, qualification and sphere of responsibility rather than on their professional background alone. We also agree that basic leadership and management skills should be taught to all professionals who work in CAMHS. People with key clinical leadership and management roles will require more advanced skills. We accept the advice of the Advisory Group that personnel with these key tasks must be given adequate protected time to discharge them.**

Information Sharing and Confidentiality

Delivering the integrated services we see as key, will require attention to information sharing. Some of this, for instance about service plans, roles, availability and accessibility is non-controversial but still requires continuing attention. Other matters such as sharing information about individual patients and their families presents more demanding challenges. We are aware that sharing information in a timely way can be the cornerstone of effective working together.

Reports such as the Caldicott Report rightly stress the importance of having protocols for information sharing and of protecting the confidence of patients through not sharing inappropriately Patient Identifiable Information (PII). Yet this has to be balanced against the ethics of putting children's needs first and protecting their best interests. The latest version of Working Together identifies the principles and practices to be applied within the field of child protection. We take this opportunity to restate the over-riding importance we attach to the effective implementation of the requirements in that document.

We believe the core principle of information sharing to be that of ensuring that all our services are able to work to the best advantage of young people and the families that support them. This will require all agencies that provide CAMHS in each local authority area to negotiate between them effective information sharing protocols. We will require the responsible authorities in each local

authority area to ensure that this takes place and the Implementation Group to monitor and advise us on progress.

Care and Case Management

Inherent in this Strategy is better management of the services provided to individuals when several agencies need to work together to conduct effective assessments and intervention.

Our approach is consistent with the framework for inter-agency assessment that we issued recently. Such a framework is particularly important when individuals have multiple or complex needs that should be reflected in co-ordinated multi-agency treatment plans.

At this point, we do not wish to take a position about how partnership around each child's care is managed. **We do concur with the principles underlying the approach in Together We Stand**, which emphasises sharing and clarification of the roles of each agency. Integration and co-ordination also require the agencies to subscribe to agreed models of care and/or case management, particularly when inter-agency planning is required. One model presented in Together We Stand involves one agency being designated as the lead agency in each case together with explicit agreements about the level and nature of support to be provided by each of the others. Together We Stand envisaged that the lead role might pass in a negotiated way over time between the agencies to reflect changes in the priority of a young person's need.

We are keen to see local agencies come together to agree mechanisms for care and case management. In particular, we wish to see care delivered in a way that avoids responsibilities being passed un-negotiated from agency to agency and young people going from one waiting list to another.

5.4 Functional and Structural Organisation of Specialist CAMHS in the NHS

There are presently different approaches in Wales to the management of the specialist CAMHS. The Advisory Group heard a range of opinion on whether Specialist CAMHS in the NHS should be part of mental health services, stand alone as services in their own right, or be part of a broader approach to children's specialist health services. This is reflected in responses to the consultation document. **We believe that the important issue is not where these services are located but how they are able to draw upon and contribute to all relevant expertise to meet the needs of individual children.** It is where organisation gets in the way of good cross-discipline working that there should be grave cause for concern.

We recognise that there are choices to be made about the location of specialist CAMHS provided by the NHS within the structure of local services. The present situation is diverse and the evidence incomplete. There is a need for a broad network of relationships between mature and effective CAMHS and the many other statutory and voluntary sector services

for children. These relationships are among the key defining features of the quality of CAMHS.

In Wales, better integration between CAMHS and most services for children is needed and this includes much closer and more effective working relationships between the child health and paediatric services and CAMHS. We are keen to see development of effective functional partnerships between the nation's child health and CAMHS orientated around the needs of children and families. This must be reflected in their philosophy, plans, purpose and activity.

Functional coherence of child health and CAMHS is an important aspect of the child centredness we seek.

We need to better integration of CAMHS with other mental health services is also required. Examples include situations in which:

- *children have a learning disability;*
- *parents or carers of children in need are in receipt of mental health services for adults; and*
- *older adolescents require to transfer to mental health services for adults.*

We agree with the children's charity, *Young Minds*, that getting partnership arrangements right is more important than where CAMHS are located. Structure should support function rather than dictate it. Lead professionals must ensure that there are intelligent and fully co-operative links across to other services whatever the management arrangements

Considerable effort is required to develop and maintain good networks that are centred on the needs of young people and that work across boundaries. This requires expert management. This situation was recognised in *Together We Stand*. Recently, work has been undertaken in the NHS to develop and test concepts of managed networks of care that are functionally determined around the needs of groups of patients. There is evidence from Scotland that the following are core to their effectiveness:

- *appointing a person, be it a professional or a manager, who has overall responsibility;*
- *all involved must agree to participate;*
- *involving patients, their carers and advocates;*
- *documenting the evidence-base for the work to be conducted together for the good of the patients;*
- *agreeing a statement of the service improvements expected; and*
- *designing an appropriate system of quality assurance.*

These findings are consistent with the principles in this Strategy. We consider that this work on Managed Clinical Networks may be useful in resolving ways of better managing the web of functional relationships required by services for children including the integration required between CAMHS and other services.

We will expect the Implementation Group to monitor this situation and offer further guidance on the structural issue as the circumstances develop and as evidence and opinion is produced by other reviews and activities, such as the Carlile Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales.

6. THE ROLES OF THE MAJOR SECTORS OF CARE IN DELIVERING THE PLAN

In the following paragraphs we set out, first, some general comments on the roles of the major sectors of care before applying the Four Tier system to producing a more detailed agenda for change that we wish to see taken-up by the agencies working in conjunction with the Implementation Group.

6.1 The NHS

We wish to see the responsibilities of the NHS within mature CAMHS clearly agreed and understood. We will be looking to the Implementation Group to lead on this matter and to provide guidance to local services.

The contributions of the NHS to well-developed CAMHS include the primary care services, specialist services provided mainly by the identified NHS child and adolescent mental health agencies and, often unrecognised or non-commissioned but, important contributions from the child health services.

Specialist CAMHS

We recognise that there are significant challenges to be overcome before the NHS or the local authorities are able to provide an array of services that reflect their potential. The responses to our consultation make plain the wishes of many services outside the specialist CAMHS for greater access to them. There is a reasonable wish for the scope of these services to be increased and for greater responsiveness. We are also aware by the same means of the sincere desire of the staff in those services to do more and to work in conjunction with the other services. It's apparent that they are very stretched and that the volume and diversity of the specialist CAMHS are insufficient to meet the current, let alone the projected, levels of need. There is a very strong case for their development in conjunction with developments of role, capability and capacity in each of the other sectors. In a later section, we identify the areas in which particular developments are necessary.

In order to move forward in a planned way, the place of the specialist health services within the NHS contribution and within CAMHS as a whole must be clarified. Later in this Strategy, we identify areas for development. We will be looking to the Implementation Group to guide local services.

Primary Healthcare

A key aspect of our approach is that the relationship between the specialist and primary healthcare services needs to be developed. We wish to move to an approach to CAMHS in which primary care services come to see themselves as playing a core part. The role of the

primary care services (designated as within Tier 1 in this Strategy) is insufficiently developed.

The Advisory Group found that one consequence is that many more cases are referred to the specialist services than is appropriate. Another result is that opportunities are missed for health promotion, prevention and early intervention with more minor problems within the services provided by Tier 1.

Part of the problem lies in low levels of training in child emotional development and matters relating to child and adolescent mental health of staff in all agencies at Tier 1, including the NHS. Another part of the problem is reflected in the levels of support and training that can be offered to primary care by the Tier 2 services. Though rising, they are less than is required to catch up on the backlog of training.

We are encouraged to see the progress that has been made in areas in which posts for primary mental health workers have been developed and we are keen to see these initiatives supported and developed further in the light of evaluation.

We are convinced by arguments that indicate that development of the roles and capabilities of health visitors and school nurses has much to offer to the development of the scope and impact of primary healthcare as an important part of CAMHS. We are keen to see the job descriptions of both health visitors and school nurses reviewed and developed to include expansion of their roles including taking a key part in providing Tier 1 CAMHS. They will, require training and ongoing support to discharge these expanded commitments.

A key part of this Strategy is our wish that the role of the primary healthcare services within CAMHS be clearly understood and developed.

This will require the roles of, and training required by, the staff of primary care services to be defined and plans made to deliver what is necessary. The staff involved include general practitioners, practice nurses, health visitors and school nurses.

The roles and expectations and training required by the staff of secondary care services should be identified. This includes psychiatrists, psychologists, specialist children's and mental health nurses, paediatricians and the allied health professions. Their jobs may need to be re-defined to make greater recognition of the tasks of consultation, training and support to Tier 1 and other Tier 2 services that this Strategy requires.

The Roles of Child Health, Paediatric and Other Services for Children

We received a number of responses to the consultation document relating to the relationship between paediatric services and CAMHS. All called for greater proximity between these services. We are aware from these contributions that, the paediatric and child health services do see many young people whose needs lie primarily in the mental health domain and that few children with physical disorders do not also have at least some level of need in the arena of mental well-being. Some respondents evidently wish to see

development of the NHS-provided specialist CAMHS in order to release the paediatric services for other tasks, some called for greater levels of joint working, while others see a greater role for child health services within CAMHS and with children and young people who might otherwise be referred to the psychiatric services.

On the basis of this advice, we are convinced that paediatricians and staff of all other disciplines who work in child health services have a vital role to play in developing better systems of mental healthcare. They have an enormously influential place at the core of a web of professional relationships involving the various departments in the local authorities, primary healthcare and the specialist echelons of the NHS. Many of them already have good relationships with voluntary sector agencies. We agree with the Royal College of Paediatrics and Child Health that child health specialists should have greater access to training in matters relating to mental health in order for them to contribute fully to the care of children in the NHS. We agree, too, that specialist CAMHS practitioners have much to offer children in the care of the NHS.

Paediatricians should be encouraged to develop their roles in and their relationships with CAMHS. All concerned should see child health services as a key integral part of a system of integrated CAMHS. CAMHS should be viewed as making a key contribution to children's health and to paediatric care. Of course, this is a two way process and CAMHS should aim to develop close links with the paediatric and child health services.

Without detracting from the important position in the NHS of paediatrics and child health and specialist child and adolescent mental health services, we recognise that the NHS treats many children, probably the majority, outside services that are specialised in, or primarily orientated towards, children and families. While we are keen to see the contribution of these services recognised, we also wish them to be drawn within the principles set in this Strategy.

6.2 The Local Authorities

We have explained our wish to see partnerships between all appropriate sectors and agencies in our broad approach to CAMHS. This means that all sectors have an important role to play in improving the mental health of our nation's children and responding to their needs.

There are strong crossovers in all directions between problems in learning, social disadvantage and social welfare and mental health. The parts to be played by the statutory education and social services departments in CAMHS are vital. This Strategy requires much greater functional integration than has been the case so far between these departments in our local authorities and the NHS. This will require them to make additional investments in their mental health related services and part of any new development monies will go to support this. We shall expect the Implementation Group to bring forward advice about the development of local authority contributions to CAMHS and their integration with services provided by the other sectors.

Local Education Authorities, Schools and School Support Services

Schools and LEA support services have a major role to play in the early identification of difficulty. This can be accomplished only from a secure knowledge base. Input from LEA support services, such as Educational Psychology Services or the Behaviour Support Services can assist schools in establishing systems and procedures to benefit the mental health and life skills of young people. We agree with the teaching professions in wanting our schools to become more emotionally literate.

Curriculum developments, often in the context of personal and social education (PSE) programmes, allow schools to address elements within young people's culture that constitute risk factors. The services provided in schools must go further than recognition of risk. They must be capable of identifying young people who have problems and intervening to help them. Given training and support, there is much that can be done in schools and in conjunction with families by the staff of schools and by the education support services to assist many young people without referring to other agencies. In other instances, it will prove appropriate to bring in contributions of other agencies in a timely and planned way.

For example, drug and alcohol awareness, sex and relationship education, stress management, non-aggressive conflict resolution and access to individual support and counselling through school pastoral systems are all capable of making a significant impact on children's education, social development and mental well being. Bullying is now recognised as a potent risk factor to children's mental health and active school-based approaches to its recognition and management are vital. There is a mandatory requirement on schools to produce anti-bullying policies but they can only be effective if they are afforded educational priority and good support services.

We want to recognise the huge potential of the staff of our education services in health promotion, preventing mental health problems and in recognition of and intervention with more straightforward cases. The role of classroom teachers, special needs co-ordinators, education welfare officers, educational psychologists and specialist teachers within CAMHS should be agreed as should the types of problems that fall to them. This should include the roles of home tutors, peripatetic staff and other 'non-classroom' teachers. We are encouraged in this direction by responses to our consultation, which support the view that better school-based services would reduce the gap between services provided by the education departments, social services and the NHS.

Our approach is likely to be most effective when it is developed within a multi-agency context and through multi-agency training initiatives. In many instances, our approach recognises and legitimises the tasks in which some teachers and school support staff are already engaged. In other circumstances, we are calling for development. In all cases, school-based staff are likely to require training and support in discharging the wider duties we envisage. We wish to see the Implementation Group develop guidance in this area.

Social Services Departments

Local authority social services departments play a key role in inter-agency strategic planning of children's services, the development of the Children First Management Action Plans and the co-ordination and administration of the Area Child Protection Committees.

Some services are provided direct by the local authorities while others are provided through partnerships with other agencies. For example, many family centres are provided through partnerships between local authorities and the voluntary sector. Some authorities provide social work staff for specialist CAMHS teams and all contribute to the Youth Offending Teams. Other services include family support and child protection services, day care, foster care and residential services, and adoption services.

Assessment and care planning in respect of work with children and their families frequently involves consultation and joint working with other professionals from within the local authority and other agencies. Examples include the provision of services for disabled children, children who are looked after, and child protection.

Social services need first to recapture their former full range of CAMHS skills and expertise and then to go beyond them. Although a number of responders to our consultation, including some county councils, make a case for employing social workers to work within the specialist and support services that are run by other agencies such as LEAs and the NHS, this does not require or imply any return to past structures that may have proved unsatisfactory to a number of local authorities. It does require a renewed analysis of the important contribution that social services can make. For example, the roles of foster carers, family support workers, social workers, specialist children's social workers, child protection officers and residential social workers need to be agreed and developed. Enabling the voluntary sector to be part of this is very important.

We recognise the pressure under which our social services departments work. They will require professional support to develop the enhanced capability we envisage in this Strategy and financial assistance to deliver it.

6.3 The Non-statutory Sector

We refer throughout this document to the voluntary sector. We believe that voluntary organisations should be encouraged to expand their role in CAMHS and should be regarded as full partners in all areas. Of particular value is the child-centred approach they bring to bear in all their activities.

Their active role in the general promotion of good mental health among children and young people is self-evident. They are prominent, too, in the direct provision of mental health services through helpline and other support services and through residential and day care provision. Much of their other work in the field is provided under the guise of generic children's services and therefore the full extent of their work is often hidden.

We have seen examples of imaginative, successful and pioneering work in the CAMHS field by voluntary organisations. We want to see an atmosphere created in Wales whereby this energy and enthusiasm can be harnessed and the role of the non-statutory sector expanded. Statutory agencies, when developing CAMHS, should look always to include the appropriate voluntary sector agency.

6.4 Services Provided by the Sectors Together

Youth Offending Teams

The Government is concerned about levels of youth crime and the way in which the criminal justice system functions with regard to young people. Several years ago, the Audit Commission demonstrated the substantial problems with the system. The Crime and Disorder Act 1998 addressed some of the issues, created the Youth Justice Board and required the responsible authorities locally to establish multi-disciplinary Youth Offending Teams (YOTs).

As the needs of young offenders may be complex, YOTs staff require a very broad range of skills and good external relationships with other agencies. These skills include the abilities to assess the mental health needs of the clients and ensure that services are realistically targeted at those with most need. Staff require initial and continuing training. Little is known about the scale and nature of the problems facing young people in these circumstances. It is essential that there is close co-operation between YOTs and CAMHS if the best outcome is to be achieved.

6.5 Relationships with Mental Health Services for Adults

Good inter-agency working includes good co-ordination between specialist CAMHS (at Tiers 2, 3 and 4) and the mental health services for adults. At present, there are often difficulties at the inter-face. One of the issues that affects this is uncertainty and lack of a general policy about the upper age of children and adolescents covered by the specialist CAMHS. Another concerns local policies for handing over cases between the specialist services at the age boundary. A third issue lies in the differing policies about service priorities and consequent differing approaches to the core business of services for adults as compared with those for young people.

In each of these matters, practice varies across the UK. The Advisory Group was told that all of these issues affect local authority providers as well as NHS services. For example, we are aware that within local authorities, there are widespread problems around so called 'transitional care' at the boundary between services for children and local authority mental health teams. We want to see progress on resolving service delivery problems here and will look to the Implementation Group for a lead.

A second example is that of young people being admitted to adult mental health services either for lack of a more appropriate bed in a unit for adolescents or because an emergency had arisen and a local adolescent unit was unable to respond in a timely way.

In 2001, the Mental Health Foundation published its report, *Turned Upside Down*, in which it cites the views of young people and professionals in coming to its opinion that a national programme of community-based services for young people facing a mental health crisis should be drawn up as part of "a radical new look" at mental health service provision for 16 to 25 year olds. The report says that some young people are falling into gaps between services for children and those for adults.

The pattern is variable in Wales, as regards age of transition between child and adult mental health services. This is complicated by the large number of young people who leave school to attend a college. A common solution is for CAMHS to take all children up to school leaving age but also to include responsibility for 16 to 18 year olds who are still at school (and within the responsibility of the education support services) rather than attending a college. Despite this, there is continuing tension between staff in the mental health services over the transition age and this appears to be especially problematic when combined with the task of finding beds for admission of adolescents from 15 to 18 years of age.

Service Styles, Roles and Cultures

Our general policy is that young people up to 18 should only be admitted, when necessary, as day or inpatients to facilities of a style and culture appropriate to young people and which are staffed by professionals who have been trained to work with young people. Awareness of the importance of child protection also demands policies of this kind and for staff to be cleared through police checking and assessments of their capabilities and character as suitable to work with children and young people. The Report of HAS 2000 made recommendations about the quality of services in Wales that we wish to see implemented.

We recognise that our services will not be able provide sufficient dedicated beds in adolescent psychiatric units within Wales without further development. This wider picture does demand a further review of these very specialised services including determination of priorities for the client group for our current inpatient units and an assessment of the level and nature of the requirements for expansion in day-care and inpatient psychiatric facilities.

6.6 The Age Range of CAMHS

In coming to a recommendation of an appropriate upper age for CAMHS, the Advisory Group considered the differing circumstances arising from legislation for the education, social and health services. It came to the view that the situation is not entirely reconcilable as LEAs and social services departments are given differing age ranges of responsibility. Within the NHS, there are certain disciplines and jobs that have client age ranges built into them (e.g. health visitors and school nurses) whereas the activities of other professions are generic.

The Advisory Group took the view that the provisions of the key legislation that underpins child care, the Children Act 1989, should guide the policy decision. In general, we concur with this advice. It recommended that CAMHS should ordinarily cover young people up to their 18th birthday (i.e. 0-17 years inclusive) but recognised that this policy is not applied or applicable in the NHS in many areas presently. It recommended that moving towards this age range for CAMHS should be the goal. Its achievement would be a key part of local strategic planning and implementation that would require consideration of the substantial resource and training issues consequent on this plan.

The consultation exercise produced much support for the Advisory Group view but also support for the status quo. Some considered that there are circumstances in which it is sensible for a specialist CAMHS team to continue to care for particular patients beyond the age of 18 and, conversely, that it may prove appropriate to transfer some adolescents to the services for adults before their majority. Others drew attention to the need to resolve the transition between the differing profiles of mental health problems of adolescents, young adults and adults that result in differing service priorities. In addition, there was considerable support for developing specialist services especially for older adolescents and young adults that cover people from around 15 to around 25. There is much to commend this more radical advice. We do not wish to duck this issue but we do consider it wise to proceed cautiously to ensure that the plainly significant implications for human and financial resources are fully understood before a final decision is made. We propose to commission a study to achieve this full understanding of the issues.

In the meantime, in all instances, our core principle is that the responsible authorities should together clarify current service provision to reduce present uncertainty and ensure that there are no gaps. A second principle is that, whatever the arrangements, we wish services to retain the possibility of some flexibility, based on the needs of each young person.

We wish to clarify the present situation. We now require specialist CAMHS in the NHS, which have not already gone beyond this stage, to adopt the practice of taking all children up to school leaving age but also to include responsibility for 16 to 18 years olds who are still at school (and within the responsibility of the education support services). Reciprocally, we wish to see the mental health services for adults accept responsibility for young people from 16 years of age who are attending college or no longer in education. Once this is achieved, we wish local services to adopt the goal of moving their interfaces in a planned and negotiated way so that the CAMHS ordinarily cover young people up to their 18th birthday (i.e. 0-17 years inclusive).

7. THE AGENDA FOR CHANGE

7.1 *Application of the Four-Tier System to the Developments to Services Required in Wales*

The Four Tier system is key to this Strategy. Together we need to ensure that:

- *Tier 1 is defined and developed;*
- *Tiers 2 and 3 are reviewed and strengthened;*
- *Tier 4 services are better identified, stabilised and developed;*
- *services provided by the agencies within the same tier are able to relate to each other in a better planned way (horizontal integration); and*
- *services provided by the agencies at different tiers are able to relate to each other in a better-planned way (vertical integration).*

7.2 *Tier 1 Services*

Tier 1 has four key partners in education, health, the non-statutory sector and social services. We believe that the partnership concept has to be re-visited and strengthened so that all partners play their full and proper roles. All agencies need to be clear about their role, about the roles of others and about where the roles meet and overlap.

The tendency to immediately refer all children with mental or emotional difficulties to the specialist elements of the NHS is both dangerous and wasteful. It leads to congestion of health services and may miss children with serious need, but whose problems cause fewer burdens to be experienced by adults around them. It often forces inappropriate referrals to Tiers 2, 3 or 4 so that they in turn have their effectiveness blunted. For families, another risk of inappropriate referrals, due to gaps at Tier 1, is otherwise avoidable stigmatisation.

Within the health services, there is a clear need to consider the role of primary care and the function of primary care professionals in relations to CAMHS. Confusion is not confined to the roles of health as compared with other agencies. Early and accurate intervention is proven as key to good services.

In this respect, considerable research and development (R&D) is already underway in the UK in the wake of recommendations contained in Together We Stand. More work of this kind is needed. The National Primary Care R & D Centre in England has conducted a review of the research. On this basis, Macdonald and Bower make the point that, "Developing and expanding the expertise of primary care and community practitioners in child and adolescent mental health offers an opportunity to improve access to services that are acceptable to children and their families, leaving specialists free to work with children and families who have complex and severe needs". While their research was aimed at the NHS contribution to CAMHS, we see their conclusions as summarising our approach to

developing CAMHS in Wales across all sectors of care. They see the role of Tier 1 as including:

- *identification of mental health problems early in their development;*
- *providing general advice and intervention with less severe problems; and*
- *pursuing opportunities for mental health promotion and problem prevention.*

We agree but, in addition, we can see the opportunities for disseminating good practice through better contact between Tier 1 and the more specialised services.

We are keen to follow this line. We consider it vital to this Strategy to get Tier 1 right but realise that this cannot be achieved without considerable development to Tier 1 and without improved support from enhanced specialist services.

Increasingly, services in the UK are introducing Primary Mental Health Workers. Primary Mental Health Workers are Tier 2 specialists but their prime task is that of supporting the development of Tier 1 CAMHS. Evaluations are emerging of the impact of this approach, the contents of the job and best practice in its implementation. There is some evidence that improving support to Tier 1 reduces strain at Tier 2. Professional organisations are appearing in the UK to support staff in these new services. The Flintshire Primary Child and Adolescent Mental Health Service is a good example of what can be achieved by supporting Tier 1. Elsewhere in Wales, a number of authorities are using the short-term Children and Youth Partnership Fund to take their first steps in developing Primary Mental Health Workers but there is a need for evaluation and for more and better co-ordinated investment in Tier 1.

We accept the Advisory Group's recommendation that:

- ***Tier 1 services are better defined in a way that removes any doubt about who delivers this tier and about which agency delivers each component. This understanding should be reflected in locally agreed plans, which should take into account the skills needed to match local needs.***
- ***The relationship between Tier 1 and Tier 2 should be reviewed, with particular emphasis on examining and developing the links that are necessary and appropriate between the two. This includes developing the capability and capacity of Tier 1 for mental health problems. Referral systems from Tier 1 to Tier 2 need to be re-examined with greater emphasis on ensuring that support and education flow in both directions.***
- ***The capacity and capability of staff at Tier 1 should be developed so that they feel confident, trained and authorised in taking actions to recognise and deal with children's mental health problems rather than referring them directly to Tier 2. Training and provision of support and advice given by, for example, Primary Mental Health Workers will be key features in this ambitious plan. There is a need for more, long-term and better co-ordinated investment in Primary Mental Health Workers. These***

developments will aid Tier 1 staff in identifying the children who should be referred to Tier 2, when and to which Tier 2 resource they should go.

- *People who are not specialist mental health workers but whose work brings them into contact with young people (for example, non-specialist children's social workers, GPs, school nurses and general classroom teachers) must have easy and structured access to specialist staff within their own and other agencies when this support is needed. Specialist workers must be trained to recognise when this support is necessary and in the techniques of consultation. Local protocols should be used to cement these relationships.*

7.3 Tier 2 and Tier 3 Services

The work of the HAS (1995), Audit Commission (1999), Welsh Office Value for Money Unit (1998) and anecdotal evidence arising from our work suggests strongly that Tier 2 services provided by all the sectors of care are under considerable and rising pressure. These services are doing a large volume of valuable and valued work.

Most statutory sector agencies either operate policies to restrict access to services to manageable levels that fall far short of the need and/or have substantial waiting times. In many parts of Wales, there is a choice for the specialist services between imposing delay or limitations on accessibility. Many Tier 2 services consider that cumulatively across the agencies and within them, they have insufficient numbers of staff of an insufficient range of disciplines. It is likely that this situation contributes powerfully to differences in practice and accessibility across Wales and applies across each of the statutory sectors.

The situation at Tier 3 is similar. The enthusiasm and enterprise shown by many professionals in developing these services on slender resources should be recognised.

While professional capability is advancing continually, there does not yet exist a full range of responses of proven efficacy for all the mental health problems and disorders. Faced with pressures of demand, many agencies have yet to develop anything approaching a full range of the more specialised services that present and projected professional capability can support. For example, cognitive behaviour therapy shows much promise but very few staff are trained in its systematic application with children and families. Many Tier 3 services require multi-agency approaches to their construction and delivery. An example is the lack of specialised multi-agency services for young people who develop problems because of abuse.

We recognise the need to increase the amount, variety of types of, and the geographical distribution of day-care within the NHS as well as that provided by local authorities and the voluntary sectors. The aim should be to enable more young people who do not need 24 hour a day inpatient or residential care to benefit from specialised Tier 3 services while remaining in the care of their families or of substitute families. This might reduce the pressure on inpatient and residential provision and enable a better and more strategic needs-based approach to the use of inpatient and residential facilities.

We recommend that plans should be agreed locally for reviewing and strengthening Tiers 2 and 3 in all sectors of care. All these services should be considered in relation to access, range, availability and service configuration.

7.4 Tier 4 Services

The volume of Tier 4 services within Wales does not match demand either in capacity or the diversity of service available.

Within healthcare, significant amounts are spent outside Wales on, for example, forensic, eating disorder and substance misuse services. In the local authority sector, considerable sums are spent on funding out-of-county and out-of-Wales placements in education and social care. Some particularly disruptive, dangerous or very ill children may become hard-to-place, suffer recurrent changes in placement or require very expensive services. This is not to say that placements of this nature can always be avoided. We recognise the complexity of need and the crucial nature of multi-agency approaches for some very disadvantaged, challenging or ill young people who, all too often, have multiple problems and multiple needs that no one agency can meet alone.

We believe that the numbers of children and adolescents who require Tier 4 residential services would be minimised if the multi-agency tiered strategic approach we recommend is implemented. We accept that additional funding is needed if this is to be achieved and stress the need for CAMHS to receive its full share of the extra resources now flowing into mental health services in Wales. We anticipate that our initiative on behalf of looked after children will contribute significantly.

Within the NHS, there are two adolescent psychiatric in-patient units in Wales. They have a valuable part to play in the spectrum of services that is required. Both have experienced different uncertainties of role and funding. As it is not feasible for each local CAMHS to have its own dedicated in-patient unit, there is a need to:

- *bring greater certainty to each unit;*
- *enable planning to shape the services they provide according to need and best practice;*
- *better define the client group for which inpatient care is required as a priority, which is likely to require additional inpatient services;*
- *develop day-care and inpatient services that can admit young people in emergencies;*
- *develop the volume and diversity of capability of adolescent inpatient services in Wales; and*
- *enable commissioning to provide mechanisms for review and quality monitoring*

We accept the need for the National Assembly to adopt a central role in this planning for better use of our in-patient centres

We agree with the Advisory Group's endorsement of the move towards orientating the style and volume of adolescent inpatient provision in Wales

towards those with the most serious disorders and illnesses. Places must be available for adolescents across Wales who present in emergencies.

Some young people require and can benefit from residential psychiatric care for other conditions. However, many could be dealt with effectively on a day basis if there were a larger number of day and intensive care units dispersed in the centres of population across Wales. Development and better targeting of inpatient services (i.e. at Tier 4) cannot be seen in isolation from the role and extent of the day-care and residential facilities provided by the other sectors as well as the NHS. An expanded capacity for day-care programmes at a greater number of centres of population will be required to facilitate this move.

The Advisory Group met with HAS 2000 which was commissioned by the First Secretary to review the standards in the two residential adolescent psychiatric units in Wales. The report, published in May 2000, makes recommendations for safeguards. We endorse the findings of that report and have been working with the appropriate authorities to ensure full compliance with its recommendations.

The Specialised Health Service Commission for Wales accepts that it has a valuable role to play in establishing the appropriate level and standard for inpatient services for Wales.

There are also other very specialised regional-level healthcare services used by Welsh children within and outside Wales. Examples include the cardiac, plastic surgery and neurosurgical facilities. The Advisory Group has made us aware of the much higher levels of education, social and mental health problems of children and siblings who use these very specialised services. Their needs present challenges to the present commissioning and service delivery structures but we are keen that their needs should be met. We shall be asking the Specialised Health Service Commission for Wales to become responsible for commissioning mental health services for patients who use these highly specialised resources and their families.

The Waterhouse Report draws attention to the imperative of ensuring that services for children in public care are at least able to deal effectively with their substantial, and often complex, needs and should minimise the risk of any additional problems or harm. We will consider the recommendations of the Carlile Review in the same light.

We accept the Advisory Group's view that:

- a Tier 4 (including the NHS funded components and those financed by the local authorities e.g. special schools and specialist social care residential services) is considered on an All Wales basis and that the commissioning and budgetary implications of this are thoroughly investigated;***
- b the cost effectiveness of referring children and adolescents to residential services outside Wales, should be reserved and compared with the cost effectiveness of developing and funding a wider range of day and residential facilities closer to home within Wales;***

- c the Specialised Health Services Commission for Wales has a key role to play in working in conjunction with requirements set by the Implementation Group to commission all Tier 4 health services. This includes inpatient services, very specialised outpatient services and mental health services to support other national and regional level services;*
- d a mechanism is required to bridge the responsibilities of individual local authority areas to commission and monitor the quality of out-of-county educational and residential placements for children on an All Wales basis; and*
- e steps are taken to raise the status, skills, training, supervision and resources available to all who work with children and adolescents in residential units.*

The National Assembly shall play its part in putting these recommendations into practice.

7.5 Client Groups Posing Particular Challenges in Wales

Application of the 4 tier strategic framework reveals obvious and serious gaps in provision in Wales. There is a need for further strategic thinking about particular services to fill them.

Some consultation responses suggested that certain groups, often based on medical diagnoses, should be identified within this Strategy. We have given careful thought to this but have come to the view that advice at this level might better come from the Implementation Group which we intend should be able to meet with key local people to discuss provision across Wales. We are aware of the concern that is widely held that services should be improved for children with eating disorders, autistic spectrum and neuropsychiatric disorders, attention deficit/hyperactivity disorders and early onset psychosis.

Although we have reservations about identifying in this Strategy a list of conditions from among the many mental health problems that may beset our young people, we are aware that certain groups do provide some particular challenges in moving forward more as a consequence of their circumstances rather than the particular disorder affecting them. We provide a commentary on a selection of them. This list is not exhaustive, but as this part of the consultation document received very strong support, we consider it to describe areas in which we wish to see a particular focus of activity as we move forward.

Services for 'Looked After' children

Children who are in the care of the local authorities, whether on the basis of a Care Order or at the request of a person with parental responsibility, are a small but significant proportion of the child population of Wales. There is clear evidence that as a group they are cumulatively and disproportionately disadvantaged in many spheres when compared to other children. 'Looked after' children is by no means a homogenous group and within it there are a number of subgroups defined on the basis of need. **We accept the Advisory Group's view that there is an urgent need for further research to create a better**

basis for planning. We will require the responsible authorities to pay particular attention to this group of children.

All too often, children looked after may move between placements during which their access to primary healthcare services may be lost or continuity of care and education broken. We accept the Advisory Group's view that there is an urgent need to improve the capability of services to track the placements of children looked after to better ensure that their needs are met.

In March 2000, we published our consultation document on *Promoting the Healthcare of Looked After Children*. The Advisory Group supported the direction taken in it and the emphasis it gives to providing adequately and effectively for 'looked after' children. In particular, we are grateful for advice received from the Advisory Group supporting strongly the proposal to move to annual healthcare rather than medical assessments of looked after children and its strong advice to us on improving their continuing access to primary level services (including primary healthcare, dental care, education, social welfare services and advocacy) rather than fast tracking to a variety of specialist services.

The approach taken by the Advisory Group was to ensure that looked after children have good access to primary level (Tier 1) CAMHS and that the specialist CAMHS (at Tiers 2, 3 and 4) respond rapidly when looked after children are referred on to them. They felt that it is likely to produce better integrated and more carefully considered planning. We are considering this advice and will be publishing our policy in due course. We also await more detailed advice from a task group that we have established to assist us in developing a framework for a strategic approach to planning and commissioning placements for looked after children. As we accept that the stability and dependability of placements can have a most significant impact on the development of young people, this, should be beneficial to the mental health of looked after children.

Services for Children and Adolescents with Behaviour and Conduct Problems

Earlier in this document, we identified a need to attend appropriately to a large and rising number of young people whose behaviour presents significant and consistent problems. While only a portion could be said to have disordered mental health, there can be no doubt of the needs of those who have a disorder associated with problem behaviour and of the great concerns that a much larger group of young people presents to parents, carers, teachers and staff in contact with them.

The Advisory Group recommended that the responsible authorities should establish new cross-agency services for children who are seen as in trouble because of their behaviour and conduct. Services of this kind should be multi-agency and developed as partnerships between the LEAs, social services departments and the NHS. They could be based upon the initiatives that are required in each local authority area through the Behaviour Support Plans.

We wish to see a coherent range of accessible services developed at Tier 1 for young people whose behaviour is the source of concern. They should inter-link with the Youth Offending Teams (also considered here to be at Tier 1). The Advisory Group envisaged that this initiative would improve greatly services for this client group. We agree that certain young people seen by them will, after assessment, require ease of access to the more specialised services provided by all sectors. Other key partners include voluntary sector projects, primary mental health workers and the Tier 2 services provided by all sectors. They will need to be strengthened to play their part by carrying out more specialised work when it is required.

These services for children with behaviour problems should also link with the new forensic mental health services for young people also recommended by the Advisory Group, the social care system and the closed and secure facilities of the Youth Justice Board and the Criminal Justice System.

Our intention is to create a network with an agreed responsibility for helping a growing number of troubled children and burdened families. This would improve the services they receive and free the existing services to respond better to children and adolescents who have serious emotional disorders. Services of this kind such as the Braunstone and New Parks Child Behaviour Intervention Team (currently being evaluated) and the Improving Behaviour in Primary Schools Project in South London may have lessons for Wales. Generally, educational models of intervention appear more promising than therapeutic ones.

Clear promise has been shown by approaches of the Webster-Stratton type together with systematic application of family therapy. The consultation has made us aware of the important initiatives that are being taken in Wales with regard to children and young people whose behaviour is a substantial problem. Some are based on academic institutions, some are emerging from the voluntary sector and others are being supported by the statutory services. All of this reinforces our determination that multi-disciplinary, cross-sector approaches may prove of greatest impact. We can see here leading roles for child clinical psychologists and staff of the education support services and the need for the various initiatives in Wales to be pulled together behind planned endeavours to get to grips with a substantial problem.

Recent surveys have shown that, at the extreme, is a small but very challenging and needy group of children and adolescents who are regarded as 'disruptive' or 'difficult to place'. They are among children with the greatest unmet needs and this group may partially overlap with the group of 'looked after' children and those who require forensic mental health services. They may show very low levels of educational attainment, unmet needs for both physical and mental healthcare and high levels of substance misuse.

Forensic Mental Health Services

Most specialist CAMHS commit resources to advising the courts on matters relating to the welfare and needs of children when litigation or prosecution involves them. The volume of

cases is such that contributions by mental health professionals are only possible in a minority of cases. In the future, there are likely to be more demands for mental health opinions arising from the Youth Offending Teams (YOTs) initiative. We recognise that most specialist services are not yet resourced or trained to respond.

At the other end of the spectrum, a small number of children and adolescents present major challenges to services because of their pattern of extreme problems and/or the circumstances that they require for effective treatment. The work they require is disproportionate to their numbers and, in some cases, solutions to severe problems cannot be found at local or regional levels.

In 1997, work was undertaken for the High Security Psychiatric Services Commissioning Board on the level and nature of need of the group with 'forensic' problems as a background to the development of a national strategy. This showed that there is need for very specialised forensic mental health services for children and adolescents who are:

- *mentally ill and either:*
 - *severely suicidal and self-harming; or*
 - *in need of a secure setting in which to undergo treatment or begin psychiatric rehabilitation;*
- *brain injured with severely challenging behaviour;*
- *sex offenders and abusers;*
- *mentally disordered serious offenders; and*
- *learning disabled in addition to one of the above problems.*

Surveys indicate the very high levels of substance use and misuse by young people in these groups. A minority of adolescents with these problems require secure inpatient or other secure residential services.

We accept the need for an integrated multi-agency multi-disciplinary child and adolescent forensic mental health service to be developed for Wales. We shall work with the Specialised Health Services Commission for Wales and all other relevant organisations to decide how this should be achieved.

Children with a Learning Disability

No child should be excluded from receiving a mental health service on the grounds of having a learning disability. This is key to meeting the principles of accessibility, non-discrimination and social inclusion. We also recognise the specialised training and skills that are required to provide effective mental health, educational and social assessments and interventions for a number of young people with a learning disability. These skills cannot be assumed and require training and suitable resources.

There is a need at all tiers (1 to 4) for a mental health service for children and adolescents who have a learning disability. There are a number of solutions to providing local specialist (Tier 2 and 3) services including:

- *appointment of a specifically designated and trained team within the specialist CAMHS that is able to advise the other teams (at Tier 2) within the same specialist service on the learning disability issues and take over direct management of certain cases (at Tier 3);*
- *provision of a separate child and adolescent team(s) (for Tiers 2 and 3) within a learning disabilities service that liaises closely with local specialist CAMHS for advice and shared care of certain cases.*

While we lean towards the former integrated children's services approach, we recognise that there are in Wales effective services based on the second model. We would not wish to see structural change to effective services made solely on doctrinal grounds as local networks and experience of success are also to be taken into account. Whichever solution is chosen, the key issues are that there should be:

- *provision of services for children by staff who have been trained to work with them and their families;*
- *inclusive policies reflected in good working relationships between the education, social, child health, learning disabilities and mental health services; and*
- *clarity in the local arrangements.*

Provision of Tier 4 services requires an all Wales multi-agency approach. The healthcare component at Tier 4 should be included within the task that the Specialist Health Services Commission is asked to take on.

Children with Disabilities and Enduring Physical Ill Health

Children who have disabilities and long-term health problems have higher rates of mental health problems and vice versa. Their parents may have higher than average rates of social welfare problems and relationship breakdown and their siblings higher than expected rates of mental disorder. This group includes children with sensory disabilities. As an example, our estimate is that there are more than 1,000 profoundly deaf children and very many more with partial hearing in Wales.

There needs to be development of the capacity of local specialist CAMHS to respond rapidly and effectively to the requirement for mental health services input for children with poor physical health or disability.

A small minority of children require care and treatment for their healthcare problems within the all-Wales regional specialty centres. An example is plastic surgery: children undergoing cleft lip and palate corrections or treatment for burns may require specialist input from all sectors - education, social and psychiatric services. We recognise the need to provide mental health services in support of the all Wales specialties in addition to local provision. As identified earlier, this requires planning and commissioning on an all Wales basis and consideration when the specialist services are commissioned.

Services for Children who Use or Misuse Substances

Government information published several years ago indicates that:

- *the minimum cost of drug-related social problems is at least twice the Government's expenditure on law enforcement, supply reduction and prevention and treatment of substance use and misuse;*
- *£3 is saved for every £1 invested through reducing criminal acts;*
- *drug use by teenagers is endemic - around 50% of mid adolescents report use of an illegal drug - mostly cannabis - and a larger percentage misuses alcohol episodically;*
- *drug use is rising, particularly among girls, with increasing poly-drug use, lowering of the age when use begins and high rates of binge drinking by adolescents;*
- *the risk factors for transition from use to misuse are known - poverty, inequality, social exclusion and homelessness contribute to serious drug problems;*
- *the combination of alcohol misuse and smoking tobacco is a powerful gateway to illegal drug misuse;*
- *the pattern of drug misuse and its impacts is different in young people compared to adults - many (some report up to 90%) adolescent drug misusers develop co-existing mental disorders but only a tiny number becomes dependant on the substance they use; and*
- *the number of adolescents seeking help is rising*

Despite recognition of these features and the likelihood that the present position is at least as challenging as that described above, there are few services for children and adolescents who use and misuse substances in Wales. With notable exceptions that are worthy of study, what services there are in Wales are provided by the voluntary sector.

The Government's cross-departmental 10 year substance misuse strategy for the UK, Tackling Drugs to Build a Better Britain, published in 1998, stresses a focus on young people and recognises the importance of education, prevention and treatment. Similarly, the National Assembly's refocused strategy Tackling Substance Misuse in Wales: A Partnership Approach, launched in May 2000 placed the same emphasis as the previous one on prevention work with children and young people.

In 1999, the National Assembly made project funds available through the Drug and Alcohol Action Teams (DAATs) and Local Advisory Teams (LATs) to develop treatment and care services, particularly for younger people in vulnerable groups. This funding is continuing and there are plans to double it by 2003. This has resulted in a number of very different projects being put into effect locally in the last two years. There is a clear need to ensure the competence of staff in these new services to work with the mental health problems of young people is becoming clear.

An evaluation project has been commissioned as a part of this initiative across Wales. We will place the outcome from the evaluation before the Implementation Group and ask it to

work with the Welsh Drug and Alcohol Unit to bring forward advice for developing substance misuse services for younger people in Wales.

In 1995, the HAS report, *The Substance of Young Needs*, provided a four tier strategic framework for developing services for young people who use and misuse substances. It described the components of comprehensive drug and alcohol services for young people. Many developments in the UK since 1995 have been based on the concepts and the approach to training described in that report. In 1999, the Standing Conference on Drug Abuse (SCODA) endorsed this plan and identified 10 key principles. Most recently, the United Kingdom Anti-drugs Co-ordination Unit has commissioned a review to update for England the advice offered by the former NHS Health Advisory Service. The results are likely to be informative for Wales.

The Advisory Group recommended that at least one full scale multi-agency pilot of a comprehensive service be set up in Wales and evaluated in order to test planning, commissioning and service delivery mechanisms. We accept that this would be useful and we will ask the Implementation Group and Welsh Drug and Alcohol Unit to advise us further and to formulate advice for Wales.

Services for Children and Young People Post Abuse

One of the groups of children in great need mentioned frequently in the responses to the consultation is that of young people who have been physically, sexually and emotionally abused or neglected. The professional literature suggests that a considerable number of children in these circumstances may suffer short-term and/or long-term impacts on their mental health. The evidence on preventing the longer-term effects is uncertain at present, but this is plainly a group of young people who may require a range of forms of support and professional help at the time, at intervals afterwards and in the long term.

We are keen to see new evidence-based services developed to assist traumatised and neglected young people and agree with the advice that we have received that this is best done on a multi-agency, multi-disciplinary basis.

Children who are Carers or whose Parents Have Ill Health

Other circumstances highlighted by the consultation include those affecting children who are forced by circumstance to become carers prematurely by virtue of situations affecting their families. There is, for example, growing evidence of the impact on children in the short and the longer terms of parental mental health problems and otherwise healthy children may suffer when siblings have a mental disorder. Many young people assume caring roles when their parents or sibling suffer physical ill health. All of these scenarios frame risk situations for children's mental health.

We are keen that our services for adults as well as those for children should adopt a family orientated approach to their work in which they think beyond the individual to potential impacts on other family members.

Mental Health Services Provided in Emergencies and Out of Office Hours

We wish to see further consideration of the needs of children who present to services as emergencies or as requiring urgent assessment and intervention. In all probability, this group includes children whose needs have become urgent as a consequence of the more routine services being unavailable to them in a timely way, children who have rapidly developed a more serious problem, children about whom adults are seeking reassurance and support and young people whose needs have not been recognised earlier.

We know that children and young people may be presented to a wide variety of agencies out of office hours. Sometimes on call or Approved Social Workers are called in while, on other occasions GPs and the NHS provided specialist CAMHS are involved. Probably most frequently, children are taken to NHS Accident and Emergency Units or to paediatric on call facilities. All of these must be able to respond effectively to children with mental health problems in emergencies by performing at least a competent initial assessment of the issues. We accept that this may well have implications for training and staffing for primary care, social services and of hospital departments and specialisms. We want to proceed towards all emergency services having available staff that are trained to work with and assess young people. This presents a substantial challenge to training but we are keen that all the relevant specialties, including A & E, general practice, social work and education, should consider and respond to what is involved in producing child-centred out-of-hours services.

The Mental Health Foundation's recent report, *Turned Upside Down*, draws attention to services for young people in crisis and presents the views of young people on their experience of crisis. Our impression is that improving the scope of our existing services and designing them to reflect the opinions of young people may do much to reduce unpredicted demands out of hours. We wish to see exploration of the requirement for services that can respond to crises and we will be looking to the Implementation Group for advice on this matter.

Although true emergencies that relate to mental disorder in young people are relatively small in number, all sectors should provide services that are able to respond to the needs of certain young people on the same day. Where residential facilities are concerned, emergency cover by appropriate professional staff and managers must be available on a 24 hour-a-day basis. The Approved Social Worker and Section 12(2) services (and whatever replaces them in a new Mental Health Act) should also be available to respond to emergencies.

We recognise that the pattern of out-of-hours services varies considerably across Wales with some services able to mount 24 hour-a-day services that are staffed by children's specialists while others do not. There is the potential for some adjacent services to share cover arrangements. Serious consideration might be given in many areas to focusing out-of-hours services in innovative rather than traditional ways in order to better meet need while responding to the demands of the EU Working Hours Directive.

We agree that the National CAMHS Implementation Group should be asked to review a general policy for emergency and crisis services and that the responsible authorities should review local arrangements to ensure that they are adequate.

8. EFFECTIVENESS

The Advisory Group spent considerable time in examining the evidence of effectiveness of interventions in each of the disciplines. This threw up some important findings. The effectiveness of certain interventions is proven both in terms of restoring damaged young people to full health, social potential and educational achievement and in terms of hard cash through savings on expenditure by society on later, more expensive, treatments and on interventions by a multitude of agencies. In this section, we provide a small selection of examples.

8.1 *Healthcare*

A survey of the literature on the effectiveness of a range of healthcare interventions makes clear that, while the evidence-base on effectiveness is far from complete, it has grown impressively in the last decade and it continues to grow rapidly. There is also accumulating information on effective strategy, the design of services and their delivery.

For example, there is a considerable weight of evidence as to the applicability and effectiveness of cognitive behaviour therapy with a number of mental disorders. The modality of consultation with other professionals has acquired professional support and technique. There is a range of tested and some new models. More recently, the impact and health economic benefits have been demonstrated for the Webster Stratton approach to parenting for certain individuals who show highly problematic conduct. However, training in these techniques is not yet available systematically.

8.2 *Schools and Education Support Services*

Effective interventions in schools generally depend on creating a climate that enables staff to:

- *understand the children's emotional needs;*
- *foster children's self esteem;*
- *value individual differences;*
- *inculcate mutual respect; and*
- *support children in anxiety provoking situations.*

The 'health promoting schools' approach to school-based health (including mental and social health) promotion is a new, complex but developing initiative. The evidence for its impact on pupils and staff is promising. Continued investment in pilot schemes, evaluation and research is justified. A second approach, 'health promotion in schools' can have a positive impact on children's health and behaviour. A multifaceted programme is likely to be most effective, combining a classroom programme with changes to school ethos and school environment alongside family/community involvement.

Clear, well-articulated and high expectations of children, active anti-bullying policies and effective links with parents, carers and other significant adults are all hallmarks of emotionally effective (and academically effective) schools. Techniques such as personal problem solving, anger management, Circle Time, relaxation strategies and use of the Pacific Institute materials, for example, all contribute to the development of emotionally stable and mature individuals who fulfil their potential for emotional health. There is evidence that the effectiveness of school strategies is increased when co-ordinated and integrated within a multi-agency approach to support. It is important to identify a need for additional educational needs at the earliest possible stage and ideally this should be before the age of 5, in the nursery or pre-school context.

8.3 Social Services

Local authorities are involved in the provision of social services, at all four tiers, for children in need and their families. Staff work with individuals, families and groups in community, day care and residential settings. Methods of work range from straightforward practical support and advice through assessments and management of risk in complex situations to therapeutic approaches.

During the 1990s, there have been important evidence-based developments in the field of risk management and the application of lessons learned from research on effective social care to the care of children by social services departments and other children's agencies.

8.4 Conclusion

We accept the Advisory Group's view that the review of effectiveness demonstrates that this is a fast moving field. We consider that it is crucial that steps are taken to actively promote planning for continuing training of the workforce. The work done already on effectiveness shows promise but much more is required. A programme of research is vital to support the move towards evidence-based practice. We shall attempt to find the resources to enable us to contribute to this effort.

9. RESEARCH

Much research has been undertaken in recent years into CAMHS and much more is underway. We see no need to duplicate this in Wales. However, a strong research base helps to create a favourable environment and we do see the potential to make Wales the centre of a thriving research scene.

Both qualitative as well as quantitative approaches should be supported as should a range of investigations of the needs of children and young people and how best to meet them, service design and functioning and the sciences and social sciences that may have a longer-term impact on the mental health of our young people. The Advisory Group recommended that priority be given to making Wales a centre for practical research and pilot projects conducted in all the sectors by all relevant disciplines. It stressed that care must be taken to pick projects that have the capacity to produce benefits across all of Wales. We agree that this is desirable and support the aim subject to appropriate funding being available.

Systems should be developed to ensure that research results are disseminated properly and that good practice is identified and likewise disseminated. We agree with the Advisory Group that there is exciting evidence of radical thinking on CAMHS in education, health, social services and the voluntary sector and this innovative skill needs to be tapped. The National Assembly will co-ordinate this dissemination but this does not mean that other organisations should not attempt to take this task on in their own field.

We agree that the mechanism must be created to ensure that the results of research and pilot projects are disseminated systematically across the country, to avoid the danger of such studies being an end in themselves with no tangible results. This should be the responsibility of the Implementation Group.

10. PERSONNEL AND WORKFORCE PLANNING

10.1 General Principles

Achieving the goals of this Strategy and improving the mental health of children in Wales depend upon the development of the professional workforce. This includes planned expansion of both the capabilities of current staff and their numbers. This will, require a long-term approach.

Staff are under pressure from the volume and nature of their work and there are shortages in most CAMHS disciplines. Even where there are no vacancies, we accept that there will need to be sustained increases in all professional disciplines in order to deliver our ambitious Strategy. These challenges are not confined to Wales and to tackle them we need to participate in wider policy development as well as considering how best to recruit and retain trained people in Wales. Clearly, both of these objectives require long-term planning. We accept that the National Assembly should assume responsibility for CAMHS workforce planning in its widest sense. It needs to work with partners in the field and in academia to develop its plans. We believe that sensible joint training across professional divides should form a key element in manpower planning.

It is important that Wales has an attractive working environment for professionals and we agree that links between operational services and academic institutions should be developed and strengthened. The existence of such a mutual support system is a powerful recruitment tool.

The workforce plan should assess the skills required to discharge the service functions that are agreed to be key within locally comprehensive CAMHS, predict the numbers and disciplines of the staff required, consider this demand against the national supply and the current skill-base of each discipline, consider possible actions in the case of discrepancies and, crucially, align training with the skills required.

Effective basic training in mental health related topics and child development is required by all professionals likely to come into regular contact with children and young people. During its work, the Advisory Group heard evidence that training for many professionals in the front line of contact with young people is thin and, if anything, declining in importance as pressure on curricula grows. We see this as one reason why many professionals feel uneasy about responding to the growing volume of the mental health needs of the young people that they meet. We understand fully that the training agenda for people like teachers, nurses, doctors and social workers is already crowded but we accept that this issue is so important and so far reaching that it should become a priority. This may require action on a UK wide basis.

Despite the pressure on our specialist services, developments of knowledge and skill in fields that relate to children's mental health have been particularly rapid in the last three decades. We are aware that the pace of development is increasing. This raises the pressure on and expectations of our services in all sectors and at all levels and tiers. We agree with statements made by a number of responders to the consultation that all professionals who work in the specialist CAMHS, regardless of sector of service, must have a basic minimum level of training in core knowledge and skills including child protection. We go further by recognising the advantage to working relationships and partnership of delivering this training on a multi-agency, multi-disciplinary basis.

The Advisory Group made us aware that there is now a further challenge to ensure that all specialist staff are adequately aware of and able to offer up-to-date and validated packages of assessment and intervention. In the following paragraphs we discuss the implications for different sectors and professions.

In 2000, we decided to establish a Workforce Development Group to review healthcare workforce planning and to introduce initiatives to improve recruitment and retention, including developing a more multi-professional approach and introducing more flexible working practices. We instigated a review of the Education and Training Group (ETG) within the National Assembly. Subsequently, we have received advice on these linked topics from the Auditor General for Wales.

We will ask the Implementation Group to work with the relevant bodies to assess the needs of local authority staff for training and for increases in numbers.

We will look to the Implementation Group for advice on the developments to the NHS workforce and its training in the light of the more detailed advice that it prepares as this Strategy moves into action.

We will expect the Education and Training Group and the Implementation Group to work together to ensure that the staffing developments and training identified as necessary to this Strategy are put in hand as funds and priorities permit.

10.2 Parents, Carers and the Role of the Non-statutory Sector

The training agenda stretches outside that required by the professions to include carers and parents. They and voluntary sector workers require skills and an appropriate understanding of the problems. We recommend that training packages produced, for example, through associations between local services and local colleges are explored as a part of an integrated approach to training.

This is not one way traffic - the voluntary sector has a valuable role to play in teaching other professionals the value of the child centred approach to CAMHS and in the involvement of children and young people in the development of services. It should be a full partner in the local, regional and national establishment of CAMHS training strategies and programmes.

10.3 Education and Education Support Services Staff

All staff in schools and support services need access to continuing opportunities for professional development to build on skills acquired during initial training. This is needed to ensure staff are appropriately trained for the task and their skills regularly updated. Staff need skills in behaviour management techniques and in planning to meet both individual and group emotional and social needs with the same rigour that they plan to meet academic needs.

We agree with this advice. There was strong support from educationalists in our consultation for developing the "emotional literacy" of teachers and staff of the education support services.

10.4 Staff of Social Services Departments

Local authorities provide in-service training, sometimes in collaboration with other agencies, for staff at all levels. The local authorities set their own priorities for in service training and the National Assembly's Training Support Programme (TSP) supplements this.

The pattern of training and the qualifications held by personnel employed in staff in social services for children reflects the diversity of services and the workforce. Field social workers and managers generally hold a recognised social work qualification and some also hold other relevant qualifications, for example in counselling, child protection, family therapy, mental health social work, play therapy and management. The post-qualifying award in complex child-care is to be launched this year and will be promoted through TSP.

The proportion of managers and staff of children's homes who hold a listed qualification is improving and the National Assembly expects that all managers and the majority of other staff will hold a listed qualification by 30 September 2003.

The workforce also includes a proportion of staff who do not hold a listed qualification and who are not included in any formal programme of training towards such a qualification.

We received strong advice in our consultation on the importance of recognising the vital tasks undertaken by foster carers. Their contribution to parenting looked after children and in helping to remedy their problems is immense. We recognise that they bring structured tolerance, concern and much self-sacrificing attention, to children and young people in great need.

Recent research identifies the multiple problems and high levels of past abuse, neglect and behaviour problems of looked after children. In these situations, simple interventions are insufficient to bring about change but active support can produce substantial positive benefits for foster carers that could well be translated into better-sustained placements with benefit to the children in the longer term. Simply put, foster carers require better support and training to do what they do well and to be sustained in their tasks. The benefits are to accrue to the foster carers themselves and also to young people who, as a result, are likely

to experience greater permanence of placement. We concur wholeheartedly. We are keen to see renewed efforts in this direction as foster carers have so much to contribute to the mental health of children who have the greatest needs.

10.5 The NHS

We received a considerable weight of evidence suggesting that increases in the numbers and training are needed in just about all of the disciplines that might be engaged in mental healthcare which are employed by the NHS. GPs and community paediatricians are often at the frontline of services and this draws attention to their needs for enhanced training in mental health related knowledge and skills.

The role of the allied health professions in CAMHS is considerable and potentially greater. They include physiotherapists, occupational therapists, speech and language therapists, dieticians, and art and music therapists. We received evidence showing how very poorly developed are posts for child psychotherapists. We acknowledge that more advice will be required from pharmacists. All will have an important part to play in CAMHS in Wales in the future.

In the remainder of this section, we concentrate our commentary on the key groups of nursing, psychology and psychiatry as we consider that we may not be able to implement core parts of this Strategy without developments in these disciplines.

Nurses in Child and Adolescent Mental Health Services

It is important to draw particular attention to the training issues that have an impact on nurses. The need for nurses trained in mental health skills appropriate to young people is rising rapidly. This applies to those in Tier 1 including school nurses and health visitors and also to specialist children's and mental health nurses. Yet the training of nurses in the CAMHS field is probably the least organised and coherent when compared to other disciplines.

New, short-term funding initiatives related to mental health, including Sure Start, the Children and Youth Partnership, the Young People Substance Misuse Fund and the Youth Offending Teams have created opportunities for staff development and many of the responsible authorities are looking to nursing to fill new posts. These initiatives have highlighted the deficiencies in nurse training. There are very few post-registration training programmes for CAMHS nurses and none that arm them to take up the new roles offered. Training developments have been left to local ad hoc arrangements.

The Audit Commission Report *Children in Mind* notes that nurses make up the largest professional group (approximately 26% of professionals) within CAMHS. Most nurses who work within CAMHS are Registered Mental Nurses (RMN), although there are a few Registered Sick Children's Nurses (RSCN). Neither of their pre-registration courses is designed to qualify them to deal with the mental health needs of children and adolescents. The English National Board for Nursing Midwifery and Health Visiting (ENB) 603 course

is the only recognised post registration course in this area with the Welsh National Board for Nursing Midwifery and Health Visiting (WNB) course Children and Adolescents: Development and Crisis offering some elements. The roles that nurses are undertaking are becoming far more diverse with extended responsibilities. This must be harnessed in CAMHS but achievement of that goal depends on meeting nurses' needs for continuing training and education.

We agree with the Advisory Group's concern about nurse training, are grateful for the initial steps that have been taken to generate new flexible purpose-orientated post-registration courses at a variety of levels and will be entering dialogues with the profession and the academic bodies with a view to remedying in Wales the evident gaps of nurses trained in child and adolescent mental health nursing.

The All Wales Senior Nurse Group for CAMHS is currently working with the University of Glamorgan to address some of these issues. This group has also produced a standards document for nurses, which has been agreed by the Executive Nurse Group for Wales. This document should be considered in the light of this Strategy to address consistency and best practice for nurses in CAMHS.

Clinical Child Psychologists

Clinical Child Psychology is a small professional group and there are long-standing difficulties in recruiting and retaining staff. Many psychology graduates are denied training as clinical psychologists because of lack of training places. This results in UK-wide shortages of newly qualified staff. The problem is compounded by the perception that this specialty offers a poorer career path than other psychology disciplines.

The Advisory Group recommended that any audit of the training requirement must take into account not only the need to qualify clinical child psychologists but also the importance of meeting the continuing training needs of psychologists in post. The role of psychologists in training and in delivering supportive services to Tier 1 could be developed substantially. Frequently, psychologists are well placed to contribute powerfully to research in the field and this too should be recognised as a factor in workforce planning. **We accept these findings and intend to ask the Implementation Group to assume responsibility for an audit of the number of additional posts that can be justified by the spread of roles for which child clinical psychologists are required in CAMHS.**

We are aware that the number of clinical psychology students in Wales has remained more or less static in the last six years. The Advisory Group told us that there needs to be a sustained drive to increase both the number of training places and the number of consultant posts across Wales. It is intended that this will even out the present patchy provision of services across Wales and help to make careers more rewarding. In turn, this should promote recruitment and retention, bring psychologists into mainstream planning

processes and create a virtuous circle. **We accept the Advisory Group's finding and propose to initiate a dialogue with the university departments responsible for training child clinical psychologists with a view to increasing the number of trainees to balance our projections of the need for additional consultant child clinical psychologists.**

Child and Adolescent Psychiatrists

One of the enduring challenges in Wales, as throughout the UK, is to recruit and retain child and adolescent psychiatrists up to the present establishment. Although vacancies in Wales overall are lower than in many parts of the UK no service has a staff establishment that is adequate to undertake the wide role for which there is demand and which modern training could enable. Also, we recognise that the problem of recruiting and retaining experienced psychiatrists is longer-term and greater in some parts of Wales than in others.

The Advisory Group found that developments of the kinds that we have agreed in this Strategy inevitably call for uplift in the staffing of CAMHS at all tiers and across a broad range of disciplines. Within that requirement must be included an increase in the number of posts for psychiatrists. This solution also requires for increased teaching and we agree that this has staffing implications. The approach taken in this Strategy includes vital developments to Tier 1, which must also be accompanied by increased consultation, support, and training delivered by Tiers 2 and 3 and an increase in Tier 4 services. Also, we are concerned that no child and adolescent psychiatrist should work in isolation or under great pressure.

It is likely that new consultant posts will be required to:

- *even out service provision across Wales;*
- *develop the more specialised services that are identified as priorities in this document; and*
- *contribute to an increasing need for training, consultation, supervision and research.*

There are a number of challenges inherent in this requirement which include:

- *training, recruitment and retention of psychiatrists to fill the present establishment;*
- *training, recruitment and retention of psychiatrists to fill new posts; and*
- *provision of training to prepare the present psychiatrists to support developments in CAMHS and delivery of this strategy. For example, more training will be required to develop:*
 - *consultation services;*
 - *forensic mental health services; and*
 - *substance misuse services.*

We accept the Advisory Group's view that there should be an increase in the number of consultant child and adolescent psychiatrists. We are mindful of the present shortages in the UK and of the need to increase trainee posts and recruitment to them. These are not easy problems to tackle. **We will require the Implementation Group to discuss with relevant professional bodies how the present situation might be tackled, with a view to achieving an increase in consultant numbers.**

The National Assembly is responsible for manpower planning, the Specialist Training Authority (STA) soon to be replaced by the Medical Education Standards Board, controls the content of training in child and adolescent psychiatry, the Royal College of Psychiatrists appoints educational supervisors and advises the STA on training requirements, while the Postgraduate Deanery in the University of Wales College of Medicine has a core role in delivering Specialist Registrar training in Wales. **We accept the need for them to work together to increase the number of trainees in the specialty in Wales and to align training packages and their contents to projections of the changing roles of consultants.**

11. FINANCIAL RESOURCES TO IMPLEMENT THIS STRATEGY

The Advisory Group estimated that implementation of their recommendations would require around £10m recurrent additional funding for the first three years to cover extra training, development of services and extra personnel. The Implementation Group will be reviewing this level of investment regularly, and will advise on future funding requirements. The National Assembly notes this as a working estimate although any build-up in extra resources will be subject to the Assembly's annual Budget decisions and will have to be spread over the planned 10 year life span of this document. The task of providing this extra funding has already begun with the provision of extra resources for the NHS generally and for mental health in particular. The Minister for Health and Social Services has made it clear that CAMHS must share in the extra resources and must do so whether services in a particular area are based in the mental health directorate or in children's services. It is vital that this Strategy is implemented by a coordinated approach by the National Assembly, the NHS, Social Services, Local Government, Education and the Voluntary Sector.

The Implementation Group will have an important role to play in assessing the precise level of investment needed to deliver the Strategy over the next 10 years. It is vital that this Group is representative of all relevant interest groups and we shall be producing our proposals for membership very shortly.

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