THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY
(NORTHERN IRELAND)

A VISION OF A COMPREHENSIVE CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

July 2006

CONTENTS

FOREWORD **PAGE**

INTRODUCTION

CHAPTER 1

A vision of a comprehensive Child and Adolescent Mental Health Service 1

CHAPTER 2

Who needs a CAMH Service? 3
Terminology 3
Contextualising the development of Mental Health difficulties 4
Demographics and Epidemiology 5
Lifestyle 5
Social Environment 6
Children with Complex Health Needs 6
Children with a Learning Disability 7
Children with Autistic Spectrum Disorder (ASD) 7
Children at Risk of Suicide and Self Harm 7
Children with Attention Deficit Hyperactivity Disorder (ADHD) 7
Children with Feeding and Eating Disorders 8
Looked After Children (LAC) 8
Demand on Social Services Departments 9
Children who have experienced Abuse 9
Children who misuse Alcohol and Substances 10
Children in conflict with the law (Youth Justice) 10
Children from Ethnic Minorities 11

CHAPTER 3

Current CAMH Services and deficits in provision 13
User and Carer views of current service provision. 13
Age range for children's services 13
Community Services 14
Community Services at Tier 1 and Tier 2 14
Specialist Community Services Tier 2/3 15
Mental Health Inpatient and Secure Residential Care Units – Tier 4 16
Transition to Adult Mental Health services 17
First Episode Psychosis 17
Assertive Outreach 17
Out of Hours and Emergency Provision 17
Paediatrics/Child Health 18

Learning Disability Services 18
Children with Autistic Spectrum Disorder (ASD) 19
Looked After Children (LAC) 19
Alcohol and Substance Misuse 20
Children that are victims of Trauma 20
Feeding and Eating Disorders 21
Services for Children and Adolescents with Challenging Behaviour 21
Education 22
Forensic Services 22
Voluntary and community organisations and the statutory/non-statutory interface 23
Children with Sensory/Physical Disability and Enduring Physical Illnesses 24
Gaps and deficiencies in current CAMHS provision 24

CHAPTER 4

The Future Organisation of CAMH Services 27
Developing an Integrated Childrens' Service System 27
Education 28
Environment 29
Managed Networks 29
Models of Service Delivery 30
The 4 Tier Model 31
Tier 1 31
Tier 2 32
Tier 3 32
Tier 4 33
Integrating Mental Health Promotion into Tiers 33
Care Pathways 34
Multi-disciplinary working 34
Paediatrics/Child Health 35
Age Range of Services 37
Community Services 38
Legal provision for Children 38
Involving Users and Carers 38
Ethnic Minorities 41
Implementing the Vision 41

CHAPTER 5

Future Services to promote child mental health and prevent mental ill-health 43
Primary Prevention Strategies 43
Secondary Prevention Strategies 44
Tertiary Prevention Strategies 46
Progressing prevention and mental health promotion 48

CHAPTER 6

Future services to those with mental ill-health 51
Carers and Family Members in CAMH services 51
Mental Health Inpatient Units 51
Transition to Adult Mental Health Services 52
Early Intervention in Psychosis 52
Assertive Outreach 53
Out of Hours and Emergency Services 54
Emergency Provision 54
Learning Disability 54
Autistic Spectrum Disorder Assessment and Treatment 55
Looked After Children 56
Alcohol and Substance Misuse 56
Feeding and Eating disorders 57
Children that are victims of Trauma 57
Services for Children and Adolescents with Challenging Behaviour 57
Youth Justice and Forensic Services. 58
Ethnic Minorities 58
Voluntary and Community Organisations and the statutory/non-statutory interface 59
Children with Sensory/Physical Disability and Enduring Physical Illnesses 59

CHAPTER 7

Enhancing the capacity of CAMH Services 63
Current Budgetary Situation 63
Information Management 63
Workforce 64
Education, Training and Research 68
Psychotherapy Services 68
Speech and Language Services. 69
Occupational Therapy Services 69
Clinical and Social Care Governance 70

RECOMMENDATIONS 73

ANNEXE 1 The Bamford Review of Mental Health and Learning Disability 79
ANNEXE 2 Terms of Reference 81
ANNEXE 3 The CAMH Review process 83
ANNEXE 4 Membership of the CAMH Committee 85
ANNEXE 5 References 89
ANNEXE 6 Glossary 99

FOREWORD

This report from the Bamford Review of Mental Health and Learning Disability (Northern Ireland) is the latest to be endorsed by the Steering Committee and deals with child and adolescent mental health services.

As with the other Expert Working Committees in the Review, the Committee examining these services adopted an evidence-based approach, drawing upon existing relevant information and research, and, where necessary, commissioning research.

Its members consulted widely with stakeholders from both the statutory and voluntary sectors in the production of this report, learning from best practice initiatives across both sectors, here, nationally and internationally. Consultation meetings were held with children and young people themselves, giving them the opportunity to present their personal experiences of and views on the services designed for them. Their comments and contributions were enlightening and invaluable.

The report is, therefore, firmly grounded, and this adds weight to its findings and recommendations. These detail major deficits in child and adolescent mental health service provision in Northern Ireland. Many of the recommendations are aimed at correcting these shortfalls, in provision. While we recognise the resource implications of implementing these recommendations, we urge Government to begin this process as quickly as possible, so that children and young people can benefit from a range and level of mental health services, which will appropriately meet their needs.

I thank all those involved in the development of this report for their efforts and time over the last 2 years in developing this report and I commend it to you.

Roy McClelland (Professor)
Chairman
July 2006

INTRODUCTION

The Bamford Review of Mental Health and Learning Disability (NI) recognises that any review of Child and Adolescent Mental Health (CAMH) services must take a holistic view of the child. To this end a wide spectrum of views has been sought which we have represented in this report.

Mental health disorders in young people impact significantly on the lives of those affected, and on the quality of life of those around them. Wider society pays a high price for the failure to tackle these problems effectively. Collectively the cost is reflected in social disruption, poor educational attainment, physical and mental ill health, anti-social behaviour, and the financial cost related to each of these. Of specific significance in Northern Ireland (NI) has been the growing awareness of the impact of "Troubles related Trauma", the effects of sectarianism and the associated violence on children and young people.

The link between childhood disorders and the development of mental health problems in adulthood is now well established. Failure to address holistically children's mental health will condemn future generations to suffer from social exclusion with all its associated problems. In short, child and adolescent mental health is a public health issue and is everyone's business.

In NI, 27% of the total population are children, compared with 22% of the population in England. NI has a higher level of deprivation and has suffered from 30 years of civil conflict. Yet the staffing levels and resources allocated to CAMH services do not reflect this. At present the workforce profile of Child and Adolescent Mental Health services clearly shows them to be wholly inadequate. Despite many examples of good practice the overall quality, consistency and accessibility of services is so inadequate that urgent strategic action is needed to tackle these shortages.

This report addresses those groups with the most pressing needs and those which pose the most significant challenges to the delivery of services. It has not considered exhaustively the totality of mental health difficulties, or bio-psycho-social issues which may present to CAMH services. Nevertheless the vision outlined in Chapter 1, and many of the recommendations, will have significant read across to any child with a mental health difficulty which presents to CAMH services.

The report also recognises that children and young people have rights under the United Nations Convention on The Rights of the Child (UNCRC), to which the UK Government is a signatory. Any proposals for a comprehensive child and adolescent mental health service need to take account of all the rights contained in the UNCRC.

The structure of the report is as follows; Chapter 1 explains the principles that underpin the vision of a comprehensive CAMH service. In Chapter 2, demographic and epidemiological evidence are provided on the client base to which a CAMH service should be available. Chapter 3 provides an overview of the gaps in present services and the conditions in which CAMH services currently operate - a situation characterised by overwhelming need and chronic under-investment.

Chapters 4 to 7, address the specific developments urgently required to implement the vision for a reform and modernisation of CAMH services. Improvements to the organisational structure of CAMH services are considered in Chapter 4, particularly on the need for expansion of the conceptualisation of CAMH services from tradition 'mental health' workers, to the entire network of professionals and services surrounding and supporting the child.

Chapter 5 recommends services that should be developed to promote good mental health and prevent mental ill health amongst children. Chapter 6 details recommendations which will address the gaps in current services. Chapter 7 provides recommendations for enhancing the capacity of all CAMH services.

This report provides a new vision, a detailed roadmap for service development, and recommendations for the reform and modernisation of services for our children and young people. It presents key recommendations that are central to correcting the current shortfalls in provision. We urge Government to implement these recommendations, which are essential for a healthy future for the children, young people and the families of NI.

CHAPTER 1

A VISION OF A COMPREHENSIVE CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

"I think CAMH services are good but sometimes they don't give you what you're looking for." - *Young person's comment,*

1.1 The vision contained within this report is of a comprehensive CAMH service. This involves an integrated array of statutory, voluntary and community services that have a shared goal of safeguarding the mental health of children in Northern Ireland (NI).

1.2 Child mental health has been defined in terms of:

- the ability to develop psychologically, emotionally, intellectually, and spiritually;
- the ability to initiate, develop and sustain mutually satisfying personal relationships;
- the ability to become aware of others and to empathise with them; and
- the ability to use psychological distress as a developmental process, so that it does not hinder or impair further development. [1]

1.3 The definition above describes mental health as both personal and social as well as providing the necessary foundation for both personal and social development. Recognition of the social aspects of mental health clearly delineates the need for 'systemic' and 'public health' approaches as well as individually-oriented therapeutic approaches to mental health provision.

1.4 It has been asserted that adopting a "dual continuum" conceptualisation supports a broad consideration of the needs of individuals experiencing mental ill-health. [2] Individuals may be understood at the same time to have some degree of *mental disorder* while also having personal resources, skills and attributes that indicate their level of *mental health*. This view promotes the need for equal consideration of the types of provision that aim to treat disorders and those that promote mental health.

1.5 The Review believes that the goals of a comprehensive CAMHS should embrace the promotion of mental health, the prevention of mental ill-health, and the provision of accessible and effective treatment services to those who have developed mental ill-health. Such goals require the integrated provision of services from a range of agencies including health and social services, education, youth justice, and the voluntary sector.

1.6 This vision of a comprehensive CAMH services is reflected in the recommendations of this report and is informed by the following principles which are shared by many service planners and providers and owe much to the joint work of *Stroul* and *Friedman* [3, 4.]

Comprehensive services. Children should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs in order to promote positive mental health.

Individualised services. Children who have mental health needs should receive individualised services. These services should take a holistic view of the child including family and community contexts. They should be developmentally appropriate and build on the strengths of the child, family and community in support of the child's mental health.

Minimum restriction. Children should receive services within the least restrictive, most normative environment that is clinically appropriate. Whenever possible, community resources such as social, religious and cultural organisations should be partnered with mental health and provider agencies to promote the child's healthy community participation.

Family-focus. The child's family or surrogate family should participate as a full partner in all stages of treatment planning and provision including implementation, monitoring and evaluation. The development of mental health policy at regional and local levels should include family representation.

Case management. Services to children with mental health needs should be organised by case management or similar mechanisms to ensure that the child can avail of multiple services in an effective, co-ordinated manner that can change in accordance with her or his changing needs.

Early intervention. CAMHS should incorporate systems and services to support the early identification and intervention for children with mental health needs to maximise the likelihood of positive outcomes.

Service transition. Young people with ongoing mental health needs should be guaranteed a smooth transition into the adult service system when they reach the age for adult services. This requires the provision of transition planning protocols to complement the case management process.

Cultural competence. CAMH services should be provided by individuals and teams with the skills to recognise and respect the values, beliefs, customs and language of Northern Ireland's increasingly culturally rich and diverse population.

Inclusivity. All children who require mental health services should be able to access those services regardless of physical, mental or developmental ability.

1.7 Mental health services for children in NI have received too little attention for too long and have suffered from a lack of coherent planning and investment. The recommendations in this report represent the minimum requirements for the realisation of the vision of a comprehensive CAMH service for NI.

CHAPTER 2

WHO NEEDS A CAMH SERVICE?

"I feel the service provided has been very useful, to my children and myself, discussing issues and learning little things about my children has helped me to cope with my child's illness and also encourages my eldest son. Being a single parent I feel it is a support." - *Parent/carer's comment*.

TERMINOLOGY

2.1 A CAMH service has responsibilities to children who experience, or are at risk of, experiencing mental ill-health. Different terminologies used across the medical, educational and social-care settings to describe the problems that children and adolescents develop may present some confusion. These reflect the varied training backgrounds of different professional groups and the differing emphases between disciplines in conceptualising issues of health and ill-health. Within specialist CAMHS, broadly speaking the bio-psycho-social model is influential. In health settings such as community paediatrics a more focussed medical model prevails. In order to better understand terms that may be used the following paragraphs will attempt to explain some of the differences.

2.2 Using the terminology of health professionals, mental ill-health is often thought of in terms of three categories: mental health problems, mental or psychiatric disorders and mental illness.

(1) 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.

(2) Mental or Psychiatric Disorders are terms used to describe problems that meet the requirements of ICD 10, [5] 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.

(3) *Mental Illness* is the description used for a small proportion of cases of mental disorder. Usually, it is reserved for the most severe cases. For example, more severe cases of depression, psychosis and Anorexia Nervosa could be described in this way. [1]

2.3 In the Educational sector, educationalists may use the term *emotional and behavioural difficulties (EBD)* when the problems they encounter are severe, persistent and associated with other areas of difficulty. Another term in common use is s*pecial educational need (SEN)* and this may apply to developmental/learning problems as well as to behavioural and mental health problems. EBD and SEN may overlap with each other and with mental health problems and mental disorders.

2.4 Within the social care sector there are a number of terms used to describe young people whose difficult behaviour is challenging to others and can cause distress. In the main these terms tend to describe behaviours that focus on those aspects perceived as negative. Behaviour difficulties in young people can be viewed as a common pathway by which a variety of underlying circumstances show up. Sometimes there is dissatisfaction with definitive medical diagnoses in that they can conflict with holistic models encompassing underlying social, emotional and psychological causes used in social care and educational approaches. Any focus on children's deficits must not ignore the environmental factors that contribute to behaviours and the fact that children will also have strengths or assets, which can be the basis for intervention. Supporting and encouraging the development of strengths, skills and assets rather than focussing largely on the eradication of "problems" is an important and increasingly recognized strategy in interventions and in building resilience to mental health difficulty. [6]

2.5 The advice contained in the Public Health Institute of Scotland Needs Assessment Report on CAMH [2] is worth repeating here. "No medical/psychiatric diagnosis should remove a child from the potential assistance available within the range of multidisciplinary children's services. In practice this will mean that practitioners both within teams and across each local area will need to engage in discussion about their differences, with a view to developing shared accounts of the young person's needs and negotiation of the most appropriate paradigm for interventions."

Contextualising the development of Mental Health difficulties

2.6 Mental health outcomes are perhaps best understood as a function of the person, the environment and the interaction between the two. Risk factors are cumulative and have been identified as residing within the person (for example genetic vulnerabilities or psychological variables such as low self esteem) and within the wider systems with which the child interacts. These might include family variables such as marital discord, poor parenting or difficult relationships between family members. It may also include factors in the wider community such as inadequate networks of social support or the impacts of crime and poverty.

2.7 Bronfenbrenner [7] provided a model for understanding the impact of social systems on individuals. At the *micro-level* individuals are influenced by systems with which they have regular, direct contact such as family, school or home. At the *meso- and exo-levels* influence results from the links between micro-level systems such as home and school, or the family; and health service providers. The *macro-level* represents the manner in which prevailing ideology and social structure influence the individual's experience; for example, through the impact of gender roles and family structures or the impact of government policy.

2.8 Despite this established need to view the person in context, mental-health provision generally focuses its attention on assessing and addressing the feelings, thoughts and behaviours of individuals. Within CAMH services it is more likely that a family perspective will be included. A contextual approach, however, would suggest that CAMH services should have input to the range of systems, such as school and community that affect young people.

Demographics and Epidemiology

2.9 NI has a population of approximately 1.7 million cited in the Census 2001 of which:

- 451, 514 are less than 18 years (27%); and
- 398, 056 are less than 16 years (23%) (OFMDFM 2004). [8]

2.10 Very little epidemiological study of child mental health problems has been carried out in Northern Ireland and the rates of many problems and disorders have to be extrapolated from British and international studies. The influential study of 10,000 children aged 5-15 published by the Office of National Statistics (ONS) was only carried out in England, Wales and Scotland and did not extend to NI. [9]

2.11 In Great Britain (GB) it has been shown that 30 to 40% of young people may at some time experience a mental health 'problem'. Up to 20 % (depending on environment and circumstances) will have a diagnosable mental health disorder. [10]

2.12 However NI is distinguished by higher levels of socio economic deprivation, ongoing civil strife and higher prevalence of psychological morbidity in the adult population. It is likely therefore that the prevalence of mental health problems and disorders in children and young people will be greater in NI than in other parts of the United Kingdom (UK). The Chief Medical Officer's report *'Health of the public in Northern Ireland',* estimated that more than 20% of young people are suffering "significant mental health problems" by their 18th birthday. [11]

2.13 The prevalence of CAMH problems and disorders is clearly linked to deprivation. Vulnerable children include those exposed to a wide range of problems including social and educational disadvantage. Looked After Children (LAC), abused children, asylum seekers, refugees and homeless children may be particularly vulnerable and in need of protection and intervention.

2.14 Thus at the lowest estimated prevalence rate of 10% approximately 45,000 children and young people aged 5-15 will have a moderate to severe mental health disorder and require intervention from specialist CAMH Services in NI. [9] Lowest estimates suggest that 0.075% (340) will require inpatient services. [12]

2.15 The following are demographics/epidemiological factors that will inform and shape future development of services and practice.

Lifestyle

2.16 The health and wellbeing of young people was surveyed through the Young Persons Behaviour and Attitude Survey, 6,000 pupils aged 11-16 took part in the survey. The questions covered were smoking, alcohol, solvents, drugs and sexual experience. The proportion of pupils smoking, taking alcohol, misusing solvents or drugs and engaging in sexual activities increased with age. This survey indicates a need for health promotion. [13]

2.17 With reference to sexual orientation of young people in NI, 3 reports "Towards Better Sexual Health", "A Mighty Silence", and "SHOUT" identified the need for further developments to support young people with issues related to sexual orientation. [14] [15] [16]

Social Environment

2.18 There is considerable stratification of the population of NI. Many young people experience the benefits and opportunities that accompany affluence while many others live in poverty and deprivation in social circumstances that harbour personal dangers and discouragement. Social and environmental factors have been shown to have an effect on the wellbeing of young people and their families. In the prevalence study carried out by the ONS mental disorder was associated with factors such as gross weekly household income, number of children within the home, family type (e.g. lone vs. couple parenting) and educational qualifications of parent. [9]

2.19 Within NI 38% of all households presenting as homeless in 2001/2002 were families with children and young people. [17] Lone parent households reflect 22% of the 36% of households who have dependant children and young people. [8] 2,392 children and young people under the age of 16 were affected by divorce in 2001. [18]

2.20 Although NI is emerging from conflict, it is still a deeply divided society. Children and young people are inevitably affected and influenced by community tensions and can be directly caught up in violence. 1 in 6 of those who died in conflict were aged 19 or younger. Research continues to show the impact that the conflict has both on shaping the lives of children and young people and directly impacting on them as individuals. [19] [20] [21] [22] [23] [24]

2.21 It is important to note that NI has a higher overall prevalence of mental illness of a magnitude estimated to be 25% higher than England. [25] This is an estimate of mental illness mainly in the adult population, however it can be assumed that rates in children may be similarly higher than in England.

Children with Complex Health Needs

2.22 Children with physical disability are at higher risk of developing mental health problems. [26] The rates of psychiatric disorder in 5-15 year old children with epilepsy were found in one study to be 37% compared to 11% in children with diabetes mellitus and 9 % in a control group. [27]

2.23 According to the 2001 Census of Population, 5.5% (24,966) of people aged under 18 reported having a limiting long term illness. This compares to 19.7% of the total population in NI. At November 2003, 13,102 people aged under 18 were claiming Disability Living Allowance. This equates to 2.9% of the population aged under 18 living in NI. A total of 552 children with visual or auditory impairments were in contact with health care in NI during 2002/2003. [8]

Children with a Learning Disability

2.24 "Children and adolescents with learning disabilities are children first, with health, developmental, social and family needs, within which their disabilities are only one set of contributory factors". [28] Children and adolescents with learning disability are proportionately more vulnerable to the full range of mental health disorders – typically about 40%. [29] Prevalence rates are 3-4 times higher in those with significant learning disability. [30]

Children with Autistic Spectrum Disorder (ASD)

2.25 Prevalence estimates for autism vary across studies. However according to recent reviews there is general agreement that ASD affects approximately 60 per 10,000 under 8 year olds of whom 10 – 30 per 10,000 have narrowly defined autism. [31] The need for a more integrated cohesive assessment and treatment service for this client group has been highlighted in a number of key reports including:

- Priorities for Action 2003/2004, [32]
- ASD: a guide to classroom practice [33]
- The Education of Children and Young People with ASD. [31]

Children at Risk of Suicide and Self Harm

2.26 Suicide and deliberate self harm are closely related phenomena although they differ in important ways. For example for some young people self harm is a coping strategy. The current UK National Inquiry into deliberate self harm (www.selfharmuk.org) which began in 2004 in the light of concern about increasing rates of self harm over the last decade reported that 1 in 10 teenagers deliberately self harm and more than 24,000 teenagers are admitted to hospital in the UK each year after deliberately self harming. These rates in the UK are the highest in Europe.

2.27 Suicide is a relatively rare event in childhood but increases in frequency in adolescence particularly among adolescent males reaching a peak in the early to mid twenties. Attempts at suicide are made by 2-4% of adolescents, rates being higher in those over 16 than those under 16. [34] The overall suicide rate in NI during the 3 year period from 1997 was 9.9 per 100,000 and those under 25 accounted for 21.5% of the total. Anecdotally media reports seem to suggest that suicide is on the increase amongst older adolescents and young adults in NI in recent years. The DHSSPS established a Suicide Prevention Taskforce to closely examine the issues involved which has reported back to Minister.

Children with Attention Deficit Hyperactivity Disorder (ADHD)

2.28 The estimated prevalence of this disorder is somewhere between 3 and 7% of school age (0-15) children. [35] It is reasonable to assume that the lower prevalence figure refers to the more severe cases necessitating referral to specialist services. On the basis of 2001 NI census figures of 476,906 children under the age of 18 this would approximate to 10,000

children. Currently only a small proportion of school age children with ADHD get referred to specialist CAMH services for assessment and treatment. A slightly larger percentage gets referred to Community Paediatric services. With increasing recognition of this condition in the community the numbers of referred children are likely to increase with significant resource implications for specialist CAMH and Community Paediatric services.

2.29 It is important to consider the significant criticism of the medical-diagnostic view that represents ADHD solely as a neuro-behavioural disorder and supports the widespread use of medication in the treatment of diagnosed children. A recent critique of the ADHD concept offered the following caution:

"*In our clinical experience, without exception, we are finding that the same conduct typically labelled ADHD is shown by children in the context of violence and abuse, impaired parental attachments and other experiences of emotional trauma*" [36]

Clearly there is a need to ensure that young people who present with such behavioural profiles receive the full range of appropriate assessments to identify the nature of their needs. Such provision should not be denied to any child or family on the basis that a young person's behaviour coincides with a diagnostic label. CAMH services should be resourced to provide such assessments, both relevant medical and non-medical.

Children with Feeding and Eating Disorders

2.30 The incidence of new cases of Anorexia Nervosa has increased to 11 per 100,000 per year, and bulimia to 18 per 100,000 per year. [37] Anorexia Nervosa is cited as the 1/3 commonest chronic illness of adolescence [38] with over 50% of parents reporting one problem feeding behaviour, and over 20% report multiple problems, [39] in children aged between 9 months and 7 years old. Despite this, parents presenting at specialist services often describe difficulties in accessing treatment for their child, suggesting that at best care pathways are far from clear, and at worst that adequate services are not available to some patients.

Looked After Children (LAC)

2.31 It is by now well established that young people in care have markedly higher rates of mental health problems than the general population. [12] [40] Children looked after by Social Services in children's homes, foster homes and other residential placements often face complex and enduring interpersonal and mental health problems affecting every aspect of their lives and making it difficult for them to accept help and support and for staff and carers to maintain therapeutic relationships. The risk of breakdown of placements in foster care is anything between 40% and 60% and the risk of school expulsion and later social exclusion is extremely high. [41]

- There were 2,446 LAC in NI at 31st March 2003. Research conducted in Craigavon/Banbridge Trust indicated that up to 60% of young people in care within the Trust had diagnosable mental health disorders. [42] This is comparable to rates found in studies from other parts of the UK.

Demand on Social Services Departments

2.32 Demand on social services departments gives another measure of the scale of the challenge:

- In 2001/02 16,733 (approx 1 in every 27 children) children were referred to social services a total of 24,185 times.
- Of the children referred in 2001/02; 25% were under the age of 5, 33.3% were 5-11 years old, 30% were aged 12-15 years and 10% were aged 16 and over.
- There were a total of 15,167 episodes of involvement for children referred to social services in 2001/02, a slight increase (1.4%) from the previous year.
- 54.9% of these episodes of involvement were in relation to childcare issues, 25.5% were in relation to child protection issues, and 7.5% related to children with a disability. A further 5% to children whose well-being is likely to be prejudiced as a result of their behavioural, emotional, psychiatric or psychological disturbance and 3.0% were in relation to emotional, physical or developmental impairment as a result of family breakdown. Over the past 3 years there has been a decrease in the percentage of episodes of involvement for child protection while there has been a corresponding increase in those children involved with social services for childcare issues.

Children who have experienced Abuse

2.33 A significant proportion of children and young people in Northern Ireland has experienced or experience child abuse. On the 31st March 2002, there were 1,531 children and young people on the child protection register.[43] There were 2,270 child protection investigations in 2001/02 (50.3 per 10, 000 child, approx 1 in every 200 children), a figure that has been decreasing every year since 1998/99. [44] During 2003/04 the PSNI recorded a total of 5,335 offences (including assault, manslaughter, murder and cruelty) against children under 17.[45]

2.34 However it is important to note that many children who have experienced abuse do not tell of their experience at the time. The abuse may not come to light until much later in adulthood, if at all, and consequently, the number of children and young people impacted by abuse is much greater. [46] Many of these children are likely to have complex mental health needs.

2.35 Many children and young people at school in NI experience bullying as a serious problem. [47] In 2002, research reported by the Department of Education highlighted that 40% of primary school pupils had been bullied to some degree at school in the previous few months. [48] Research carried out on behalf of the Northern Ireland Commissioner for Children and Young People (NICCY) in 2005 identified bullying as a key priority for action.

Children who misuse Alcohol and Substances

2.36 As in the rest of the UK alcohol and substance misuse by children and adolescents in NI has increased. It has been shown 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 to those who use it less often or not at all; [9] [49]
- the pattern of drug misuse and its impact is different in young people compared to adults - many adolescent drug misusers develop co-existing mental disorders but only a tiny number becomes dependent on the substance they use;
- 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;
- substance misuse in NI has increased among 11-15 year olds throughout the 1990s. Population surveys addressing this age band show that 42% currently drink alcohol at least a few times each month. In addition 32% of boys who drink monthly report being drunk more than 10 times. Current drug use has increased from 5.6% in 1994 to 27.2% in 2003 in year 12 children;
- the risk factors for transition from use to misuse are known - poverty, inequality, social exclusion and homelessness contribute to serious drug problems; and
- the combination of alcohol misuse and smoking tobacco is a powerful gateway to illegal drug misuse.

2.37 Additional information of the specific alcohol and substance misuse issues amongst children and adolescents in NI is available in Chapter 8 of the report of the Alcohol and Substance Misuse Working Committee at www.rmhldni.gov.uk/

Children in conflict with the law (Youth Justice)

2.38 Criminal activity was surveyed in NI. [50] The results of the survey of young people (aged 14-18) show that young males are much more likely to experience adverse activity with the police than young females. The 1999 Juvenile prosecutions statistics show that 607 males aged 10-17 were proceeded against at the Magistrates' Courts compared to 69 females. 301 young people were admitted to custody. [51] The report "In our care" [52] makes important points about the relative lack of provision of mental health services to this group of children.

Children from Ethnic Minorities

2.39 NI is becoming an increasingly multicultural society and the needs of minority ethnic groups must be assessed and addressed. The needs of children of ethnic minority and migrant families have been unrecognised in NI and with the increase growth in numbers of migrant workers living in NI it is imperative to discover:

- can psychiatric disorders be recognised in these groups;
- do these children have specific symptoms and psychiatric disorders; and
- are psychiatric disorders more common in ethnic minority and migrant children.

2.40 The challenge for CAMH services is how to provide services to children and adolescents from ethnic minorities in an accessible and non discriminatory way. The response by the NI Council for Ethnic Minorities to the mental health review by O'Rawe on behalf of the Children's Law Centre 2002 is a helpful contribution.

CHAPTER 3

CURRENT CAMH SERVICES AND DEFICITS IN PROVISION

"I know my daughter more than you will ever know her…. I think my views are very relevant." - *Parental comment*.

In this chapter the current deficits in services to core client groups are explored more fully. A situation characterised by overwhelming need and chronic under-investment.

User and Carer views of current service provision.

3.1 The Review consulted widely with children and young people and their carers. In one particular consultation exercise, carried out early in the process, focus groups and a questionnaire study were used to explore service user and carer views and opinions about CAMH services. A more detailed account of this is described in Chapter 4 of this report and the full report is available at www.rmhldni.gov.uk It was suggested that there are fairly high levels of satisfaction with aspects of the service among people who are in ongoing contact with CAMHS. Significant areas of dissatisfaction, however, were also indicated.

3.2 Many users/carers spoke of their frustration with long waiting times and the limited availability of specialist services. There was concern about the lack of information available to the public about young people's mental health issues and the services available to young people and their families. While many users/carers described good relationships with CAMHS staff, many also described their disappointment with the outcomes of their contacts with CAMHS and some described how they felt CAMHS staff had not worked collaboratively with them and that they had not felt 'heard'.

3.3 The Review recognises the importance of working closely with users and carers to establish priorities for service design, delivery and evaluation

Age range for children's services

3.4 The upper age limits for access to services across and within health, education and social services can lead to difficulties accessing a comprehensive service across disciplines and can also lead to inequality of services. The situation is not entirely reconcilable as Education and Library Boards (ELBs) and social services departments are given differing age ranges of responsibility. Within the health personal social services (HPSS), there are certain disciplines and roles which have client age ranges built into them (e.g. school nurses, paediatric nurses) whereas the activities of other professions are more generic. The practice of specialist CAMH varies across the province in ways that are not dissimilar to services in other jurisdictions within the UK. In NI the upper age limit for acceptance into CAMH services varies from 14 to 16 to 18.

3.5 No CAMH services are adequately resourced at present to comprehensively address the needs of 16 and 17 year olds. Some flexibility is however essential. In some provider areas there has been flexibility with adult services taking responsibility for some or all 16 and 17 year olds but in other areas such flexibility has been lacking because of demands on adult services. In some provider areas CAMH services have continued to treat over 18 year olds.

Community Services

3.6 A detailed overview of the 4 Tier model is given in Chapter 4 of this report. The 4 Tier model has not been formally adopted in Northern Ireland regionally. However specialist professionals have tended to conceptualise current NI provision within this model.

3.7 NI CAMH services are delivered by a range of providers across the 4 HPSS Boards. The current services uphold the aspirations of the 4 tier approach [1]. However against a backdrop of resource constraint (workforce, financial, education, governance) progress in developing the 4 Tier model has been difficult and too many services, which are at present working with mental health issues in children and young people, are not conceptualized as part of CAMH services.

Community Services at Tier 1 and Tier 2

3.8 There has been limited development of Tier 1 services. Where developments have been made, for example in the Education and Voluntary Sectors, many of these services and projects do not yet conceptualise themselves as part of CAMH services. There is a need to ensure that those in contact with children have knowledge of children's mental health needs, and know how to refer to the appropriate specialist services. Collaboration between education, CAMH professionals, and colleagues in the non-statutory sector may aid the early identification of problems, however such collaboration is lacking.

3.9 Likewise developments in Tier 2 have been limited. Along with community paediatricians some areas have developed services for children with ADHD and ASD. For example some health visitors and clinical psychologists have developed services at Tier 2 using a behavioural and family counselling model addressing the developmental needs of young children up to final year in primary school. These developments are not NI wide. Other examples are as follows:

At Tier 1 and Tier 2

- Adolescent support services/projects are provided by a range of professionals and providers across the 4 current Boards. Links with specialist Tier 3 CAMH services are stronger in some providers than in others. Anecdotal evidence suggests that where links are stronger, projects can more successfully manage more complex problems without the need for full Tier 2/3 specialist team management of cases.

- Sure Start Early Intervention programmes continue to be established across the 4 Boards.

- Statutory and voluntary family centres contribute to Tier 1 and 2 services.

- A range of voluntary and community providers contribute to both Tier 1 and 2 services (i.e. befriending, advocacy services, educational input to schools)

- Education departments provide pastoral care and school based counselling services at Tier 1.

- Educational psychology, Educational welfare officer, emotional and behavioural support teams contribute Tier 1 and 2 services.

- Youth justice services are developing to support vulnerable young people with mental health needs.

Specialist Community Services Tier 2/3

3.10 Across NI there are specialist CAMH services in each of the Board areas. These are delivered by psychiatrists, clinical psychologists, specialist nurse therapists, and social work practitioners, and in some cases, family therapists and child psychotherapists. In reviewing the structure of these teams it became apparent that there are many differences in the operational and strategic policies, which define the roles of their services. Examples of these differences include:

- age limit for acceptance into services vary from 14 to 16 to 18;

- referral differences: although there are similarities in the core types of work that the teams tend to be involved in, there is a wide variation across teams in the type of cases with which they work. Special interests and specialist training acquired by staff and supported by their providers, have led to the development of services and innovative practice e.g. eating disorders, younger children team, Asperger's assessment clinics and social skills training in some teams;

- there is a wide variation in the length of waiting lists across NI ranging from 3 months to 'closed except for emergencies';

- teams are supported by other services within their own Board areas e.g., family centres, special social work projects for adolescents, clinical psychology and health visiting working at Tier 2 level and voluntary and community agencies, thereby facilitating specialist CAMH professionals to more effectively function as Tier 3 teams;

- a referral coordinator system operates in a number of providers. The link worker concept has also been developed in some providers. Only one service in NI has a dedicated full time manager;

- clinical networking with other services varies from provider to provider, and this impacts on the nature of the work in which the different specialist CAMH teams become involved;

- specialist CAMH services are under different directorates in different Boards e.g. children's services, mental health and disability, acute paediatric services;

- day hospital services are very limited; and

- specific Trauma services for children and adolescents exist in some areas.

Mental Health Inpatient and Secure Residential Care Units – Tier 4

3.11 Inpatient services and secure residential care services are delivered on a regional basis by separate providers.

- Child inpatient services under 14 years are delivered by Greenpark Health Care Trust on the Forster Green Site. 15 in-patient places but owing to operational difficulties only 10 can be used. 10 day patient places. The South Eastern Education & Library Board (SEELB) provides education through the Lindsay School.

- Adolescent services 14 years - 17 years delivered by South & East Belfast Trust currently on the Knockbracken site. 16 inpatient places are funded but owing to operational difficulties not all can be used. There is a day hospital service at College Gardens, Belfast.

- Muckamore Abbey Hospital is the site of a 15 place assessment and treatment inpatient provision for children with severe learning disabilities and challenging behaviour and delivered by North and West Belfast Trust. There are plans to relocate this service in the community.

- Secure residential provision for children and adolescents in the care system, many of whom have significant mental health needs, is delivered by the Ulster Community and Hospitals Trust in the Lakewood Unit.

3.12 However due to problems in recruiting staff neither of the first 2 units can admit to full capacity. A new build for adolescents (14- 17 years old) is planned for the Forster Green site, Belfast. This will provide 16 places and 2 intensive care places.

3.13 The NICAPS study of inpatient places in England and Wales showed that current provision of beds was not based on need. [53] The average was 3.4 beds per 100,000 under 18 population. Based on work by Kurtz et al [54] and NICAPS it is recognised that around 20 to 40 CAMHS beds are required per one million total population. [55] This includes places for younger children and for adolescents.

3.14 For NI, the above recommendations equate to between 32 to 64 places in total. The planned expansion of inpatient services on the Forster Green site would bring total inpatient places to 33 (18 for adolescents aged 14 – 17 and 15 for younger children aged under 14). Critically however, increasing the complement of inpatient places for adolescents will be dependent on the development and recruitment of an adequately trained workforce.

3.15 The "Secure Care Report" [56] made a number of recommendations in relation to the mental health needs of children and young people in secure accommodation including the development of protocols with CAMH services to inform the appropriate retention of children within secure accommodation or where necessary their transfer to inpatient adolescent facilities and the development of fast track procedures for assessment. Work is on this is ongoing.

Transition to Adult Mental Health services

3.16 The transfer of care between child and adolescent services and adult services usually occurs around the age of 18. Arrangements in NI at present could be considered informal and too dependent on local networks and professional relationships. Clearer guidelines and greater flexibility are required.

First Episode Psychosis

3.17 The incidence of psychosis begins to rise during the 15-18 year age range. There is some suggestion that the incidence in NI is higher than other parts of the UK but this needs further study. [57] Because of the differing age limits of services some are looked after by CAMH services and some by adult services with the result that in NI these young people get a very uneven quality of service. Early intervention services for psychosis have not yet been developed in NI.

Assertive Outreach

3.18 Assertive outreach provides frequent contact and co-ordinated intensive treatment with the young person and/or their carers by a multidisciplinary team. This is provided by a multidisciplinary team and can operate exclusively at outpatient level (outpatient assertive outreach model) or in conjunction with day patient and inpatient services.

3.19 In England and Wales some Tier 4 services have moved away from exclusive inpatient care and have developed models of assertive outreach and crisis intervention. This has provided much needed greater flexibility in meeting the needs of young people with complex mental health problems. It is recognised that improvement in provision for children and young people at specialist Tier 2/3 CAMHS will impact positively and decrease the number of those requiring Tier 4 service. However there is no capacity in existing CAMH teams in NI to provide such services.

Out of Hours and Emergency Provision

3.20 There are 3 main types of problems that commonly present as an emergency:

i) those with an identified serious mental health problem e.g. psychosis, depression, and rarely very serious eating disorder. There is often a need for immediate admission (within 24 hrs);

ii) young people presenting to a general hospital ward via Accident and Emergency (A&E) departments following an episode of or attempted self harm. The treatment needs are less clear in this group and in most cases admission to an acute paediatric or medical ward followed by next day assessment and follow up by Tier 2/3 CAMH services is appropriate; and

iii) children and adolescent with conduct disorders, out of control and challenging behaviour about which there is often inter-agency confusion and disagreement.

3.21 It would be expected that improved emergency provision in CAMH services would reduce Tier 4 demands.

3.22 No community CAMH service in NI can, within existing capacity, provide 24 hour cover to general hospital A&E departments. In some areas cover is provided by combinations of social services duty social workers for under 16s, and adult psychiatric services for over 16s in consultation with the limited numbers of CAMH consultant psychiatrists.

Paediatrics/Child Health

3.23 The NHS Health Advisory Service [1] and Audit Commission [58] reports on CAMH services estimated that 25% of the workload of community paediatricians is in the field of mental health. At this level many children with mental health problems and disorders (e.g. ADHD, ASD) are being seen in community child health settings. Apart from general practice this is the most common setting where children with mental health problems present.

3.24 Children with ADHD place considerable demands on both community paediatric and specialist CAMH services. Assessment involves consideration of whether there are alternative causes for restless inattentive and impulsive behaviour and whether comorbid conditions are present. Management involves liaising with schools and considerable time is taken up in coordination of services. Ongoing review of management programme and medication is required as the child gets older and transfer between community paediatric and specialist CAMH and adult mental health services can be difficult.

3.25 The extremely limited capacity of both community paediatric and specialist CAMHS in NI has mitigated against the development of joint clinics for assessment of ADHD and ASD locally although there are good examples of close collaboration for consultation and second opinions. Some community paediatric services have dedicated specialist nursing or psychology input to deliver psychological interventions in ADHD clinics.

Learning Disability Services

3.26 Current services are fragmented, differ in each provider and there are a variety of service models. There is a lack of clear referral pathways and processes. Intelligence Quotient (IQ) less than 70 is often seen as a cut off point between CAMH services and learning disability services in some Board areas and 55 or 65 in others. Lack of capacity in specialist CAMH service restricts the services that can be provided to moderate and mild learning disabled children and there is a significant shortfall of staff with the specific competencies to work with learning disabled children with mental health difficulties.

3.27 Children and young people with an IQ less than 50-55 generally come under the umbrella of services for severe learning disability. These teams may be part of a children's directorate or a general learning disability directorate and there is usually access to social services, community nursing learning disability services, allied health professionals, psychiatry of learning disability, psychology services and paediatric services.

3.28 Children and young people with a mild degree of learning disability, in health service terminology, receive a less structured service than those with severe learning disability and may be seen by CAMH services and other mental health services co-ordinated by the paediatrician and general practitioner. It is these children and young people who are likely to have difficulty accessing appropriate mental health services within either learning disability services or CAMH services due to the debates which occur regarding the cut off points by which services will accept referrals.

3.29 At Tier 4 children and young people with severe learning disabilities currently access inpatient facilities in a hospital for those with a learning disability.

Children with Autistic Spectrum Disorder (ASD)

3.30 Most of the difficulties have arisen due to inadequately resourced services for this client group. Higher functioning ASD is increasingly recognised. 75%, of the children who are now being diagnosed with ASD do not have a learning disability. [59] These children are therefore being referred to specialist CAMH and Community Paediatric services rather than learning disability services. This has led to an increase in the waiting times for specialist CAMH services and community paediatrics.

3.31 Children and adolescents referred to specialist CAMH services and community paediatrics in NI for assessment and treatment are in the main placed on routine waiting lists meaning that the families can wait for a considerable length of time. Such waiting times are unacceptable. There are often significant delays between diagnosis and the provision of support/treatment for children and families, causing further anxiety for the family.

3.32 Children with ASD have been described as 'perfect victims' when it comes to victimisation by their peers because of their profound lack of social skills [60] and long-term negative health outcomes for children in the general population have been attributed to peer victimisation with higher incidences recorded for depression, low self-esteem, anxiety, loneliness, and lower academic achievement. [61] [62] Interventions which focus on reducing isolation and integrating individuals into society are key to addressing the needs of these young people. [63] The need to promote social competence and integration for young people with ASD is not sufficiently addressed by current services in NI.

Looked After Children (LAC)

3.33 Children in substitute care are at increased risk of developing mental health problems. Risk factors for mental ill-health reside within the interacting domains of the child, the family and the environment, all of which are elevated for children who have entered care from homes that may be conflictual, seriously neglectful or abusive.

3.34 In most cases attachment experiences with carers may have been disturbed and self-esteem, interpersonal, emotional and intellectual skills inadequately developed. They may have difficulty making and sustaining friendships. They may be experiencing failure at school. Loss of significant relationships is almost always a significant issue and environmental contributors to emotional and psychological vulnerability – such as poverty, homelessness and discrimination are often present.

3.35 Coming into care can bring protective factors into the lives of young people who need this type of support - physical safety, better living conditions, fair and consistent rules to live by, understanding and acceptance from attentive carers and residential workers - all of which can support positive emotional and psychological development. Despite the best of intentions, however, the care system cannot emulate the constancy of family life and many young people in care have been so disturbed by their experiences that the activities and requirements of recovery can seem beyond their grasp.

3.36 These children have significant need for mental health supports in view of the levels of difficulty identified. [42] The delivery of services to this population is complex and can meet with impediments such as the impacts of high staff turnover rates in residential care [64] or multiple foster placements and unclear planning. [65] Traditional CAMH services have been limited in their ability to meet the needs of LAC, hampered by a number of factors including the unattractiveness of these traditional services due to stigma and a general lack of belief on behalf of the young people that services have any relevance to them. Within Great Britain (GB) the Quality Protects initiative has provided both impetus and resources for improved services to young people in care. [66] Within NI in recent years providers have begun to dedicate posts and, in some cases, teams to the provision of mental health services for young people in care. Developments are patchy, however, and there is a lack of regionally coherent planning and investment. Calls have been made for a specific mental health strategy for looked after children [67] which would assist the development of tailored, equitable services for this population.

Alcohol and Substance Misuse

3.37 The Alcohol and Substance Misuse Expert Working Committee of the Review have produced a report exploring in depth many of these issues. The report is available at www.rmhldni.gov.uk/ and specifically Chapter 8 deals with services to children and young people aged 17 and under.

3.38 In NI services are mostly delivered by voluntary and community sector but there is little multi-agency or partnership working between voluntary and community and statutory services at either Tier 2 or Tier 3.

3.39 The Health Advisory Service (HAS) report 'The Substance of Young Needs' [68] in arguing for the development of a 4 Tier approach to this problem, highlights a potentially crucial role played by CAMH services including:-

- arranging to add addiction skills to the assessment and treatment capabilities within CAMH Services;
- arranging to work more closely with drug and alcohol services;
- considering the feasibility of suitably trained staff being appointed to joint posts across a range of disciplines.

Children that are victims of Trauma

3.40 Recent research findings support observations gained through clinical practice that there are parts of NI severely affected by the legacy of the conflict. [69]

3.41 However it is important to remember that children suffer from the consequences of other traumatic experiences e.g. from experiencing road accidents, fires, assaults and other crimes. The Family Trauma Centre in Belfast and NOVA in SHSSB provide trauma services which include but extend beyond those who have experienced trauma from the conflict.

Feeding and Eating Disorders

3.42 At present, services for eating disordered children in NI are mainly provided by specialist community CAMH teams, using local paediatric wards or regional inpatient units when admission is necessary. Inpatient places in regional units have not always been sufficient to meet demand, resulting in considerable pressure on overstretched outpatient services in managing very ill young people in the community. Liaison with paediatric services is generally good. Adult mental health services generally assume responsibility for 18 years olds but some 16 and 17 year olds can be seen by adult disorder teams. Dietetics services provide services to some less severe eating disordered young people and support CAMH professionals in provision of both inpatient and outpatient services. 'On the ground' liaison between CAMH and dieticians is variable. Good initiatives with parent and carer support groups developed in association with regional units and local voluntary groups were noted.

3.43 The NICAPS study [53] found that, in addition to an eating disorders diagnosis and the burden of care on family members, factors that contributed to inpatient admission included ease of access to services, clinical experience of the referrer, the range of alternative to inpatient care, and the general backdrop of service organisation. The DHSSPS regional working group on eating disorders will develop service provision to this group of children and young people.

Services for Children and Adolescents with Challenging Behaviour

3.44 Children and young people who exhibit challenging behaviour and who also have complex needs present a major challenge for all the agencies involved. Agencies, both voluntary and statutory often struggle to find appropriate ways of meeting needs and enacting planned intervention. A lack of resources, long waiting times for Tier 2/3 CAMHS, and increased public expectation have led to many of these children and young people being managed within their own communities. This situation often leads to conflict in the management of the case with their carers and their community.

3.45 Community services often have to run with high levels of risk with little or no access to appropriate services, resources or consultation. Some children are managed in the community rather than residential care settings due to concerns that risks may multiply when they are placed in 'open care settings'. Community service capacity must be increased and services flexibly delivered to meet the needs of these young people.

3.46 The 'Children Matter' Review [70] reported a need for a small children's residential sector for those with emotional and psychological needs to support community and hospital services for adolescents. In other parts of the UK this is provided by the independent sector and such provision is almost nonexistent in NI.

Education

3.47 Schools in NI make a significant contribution to the positive promotion of mental health through enhancing self-esteem, encouraging sociability and promoting resilience in young people. More could be done through activities such as Circle Time, Circle of Friends, Nurture Groups, the teaching of emotional skills and also various Anti-Bullying programmes. Much of this work is pro-active and preventive and can act as a filter prior to the entry to Tier 1.

3.48 Schools however can also have negative effects on children's mental health. In NI pastoral care in some schools has not fully achieved its potential and when schools put too much emphasis on academic achievement, vulnerable children are often missed and may suffer as a result.

3.49 The work of specialist CAMH teams necessitates close liaison with teachers and educational psychologists and includes school observations and consultations. In NI there are different examples of joint practice in different areas of the province but all are limited by capacity issues. Joint working is known to require greater time investment. [71]

3.50 In addition to these areas of work, many schools in NI have dedicated counselling services available to vulnerable children and young people. These services are provided in a range of ways including individual counsellors employed by individual schools and services provided by independent providers. Evaluations of such services indicate they are highly valued by children and young people, parents and teachers, and that they benefit the mental health and wellbeing of children and young people who present with more serious problems. [72] [73] Many providers identified the need for close consultation and partnership work with local specialist CAMHS teams.

3.51 The development of Behaviour Management Teams and Autism Advisory Teams has also made an important contribution to supporting teachers which in turn has benefited young people's lives in many schools

3.52 It is recognised that non-attendance at school can be a pre cursor to other difficulties, many of which have mental health consequences and here the role of the education welfare services is evident. The development of Education other than at School (EOTAS) services has made a significant contribution to this issue and through networking; training and consultation, capacity to respond to mental health issues could be improved.

Forensic Services

3.53 There is no dedicated forensic CAMH service in existence in NI. Limited services are provided to individual young people by Tier 2/3 specialists on the basis of catchment area and by contracted psychology input to the secure residential facilities. Specialist Tier 2/3 CAMH professionals occasionally 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. Most specialist services are not resourced or trained to respond.

3.54 A review of the mental health needs and services available to young people in regional care services and in the justice system has been jointly commissioned by DHSSPS and the Northern Ireland Office (NIO) and the report will read across to this Review.

3.55 The target group is those young people who present with severe disorders of conduct and emotion and neuro-psychological deficits or serious mental health problems who exhibit high risk behaviours and who have become (or are likely to become) involved in criminal proceedings through such behaviours as fire setting, physical and sexual assault. Those who raise most anxiety and sense of system powerlessness usually include:

- mentally disordered offenders (2 groups challenging behaviour and forensic);
- sex offenders and abusers;
- severely suicidal and self harming adolescents;
- very severely mentally ill adolescents;
- adolescents who need to begin psychiatric rehabilitation in secure circumstances; and
- brain injured adolescents and those with severe organic disorders.

3.56 Children and adolescents who fall into the client group appropriate to a forensic CAMH service are often highly mobile and frequently known to more than one agency. Sometimes their moves between agencies and sectors of care are planned, but, all too often, referrals are made by the processes of exclusion, result from exhaustion of the capabilities of particular services, or are made in desperation as a last-ditch attempt to help. All too rarely does it seem that the care of individuals is subject to rigorously planned integrated care pathways.

Voluntary and community organisations and the statutory/non-statutory interface

3.57 In the course of the Review, note was taken of imaginative, successful and pioneering work in the broad CAMH field by voluntary organisations. Some examples of good practice are projects involving Belfast Central Mission, Barnardos, Contact Youth, New Life (Ardoyne) NI Association of Mental Health, NSPCC, Opportunity Youth, Extern (Turning Point), STEER, Threshold, and VOYPIC.

3.58 They are prominent in the direct provision of mental health services through helpline and other support services and through residential and day care provision. Their active role in the general promotion of good mental health among children and young people is self-evident. 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. There are a number of voluntary organisations working in partnership with CAMH services at all Tiers to support young people and their parents/carers. Voluntary groups can provide additional and innovative approaches to tackling mental health issues and promoting recovery after ill health. Church youth groups and organisations such as the YMCA also contribute at a community level to the promotion of good mental health in children and young people.

3.59 However, voluntary organisations are often prevented from long-term planning because of uncertainty about funding, thus services are often provided for a limited term and provision can be patchy, which leads to geographical inequity. The absence of a regional strategy for CAMH services has contributed to the situation where complementarity between statutory and non-statutory services is difficult to maximise. There can also be problems of communication such that statutory providers and service users are not always aware of services which are available through voluntary groups and partnerships, which could be mutually beneficial, do not exist.

Children with Sensory/Physical Disability and Enduring Physical Illnesses

3.60 Children who have physical disabilities and long-term health problems have higher rates of mental health problems. [27] 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.

3.61 A small minority of children require care and treatment for their healthcare problems within the regional specialty centres. Examples are plastic surgery for children undergoing cleft lip corrections or for burns and neuropsychological treatments for head injured children or children with severe epilepsy. These may require specialist input from all sectors - education, social and psychiatric services.

Gaps and deficiencies in current CAMHS provision

3.62 As is demonstrated above, it is acknowledged that within NI there are limited services in a range of areas. Some services have been more developed in certain areas by professionals with a specialist interest e.g. eating disorders, autistic spectrum disorders and LAC. These services, where they exist, are limited and not equitably distributed across NI. Furthermore it is obvious that NI has a deficit in many areas when compared to other parts of the United Kingdom, Ireland and Europe.

3.63 It is revealing that the user and carer consultation summarised at the beginning of this section portrays dichotomised views which might be characteristic of NI CAMHS over the past 25 years. Positive experiences of CAMHS provision reflect the considered attention of committed staff as well as local-level innovation and good practice. The frustration expressed with regard to long waiting lists and the unavailability of specific services and information, on the other hand, reflects failure to develop services adequately due to a lack of regionally co-ordinated planning and investment.

3.64 O'Rawe [74] in her review of CAMHS in Northern Ireland carried out on behalf of the Children's Law Centre points out that the capacity of NI CAMHS to build on local examples of best practice is enfeebled by *"[t]he regional lack of priority and absence of accountability and co-ordination for NI CAMHS..*" She identifies an "*..ambivalence towards providing a comprehensive CAMHS..*", characterised by a regional lack of monitoring data and associated with the absence of regional strategic coherence and with "*profound and longstanding*" inadequacies in service provision on the ground.

3.65 Developments in the past 2 years have not significantly altered the situation noted by O'Rawe that, despite 25% of the NI population being younger than 18, expenditure on CAMHS represents less than 5% of the total NI mental health budget. Her assertion remains pertinent that failure to address the inequity of this situation will "…*potentially violate the [European Convention on Human Rights] and the statutory equality duty toward the most vulnerable mentally ill children and young people*".

3.66 In NI over the last 11 years, CAMH services have been developing from a very low baseline with a particular focus on the enhancement of Tier 3 community services and on an adolescent inpatient service. These developments have been hindered by the lack of a strategic or operational plan that lays out a phased and managed approach. The 1998 Policy Statement on Child and Adolescent Mental Health Services [75] addressed a number of key areas of policy and it is of concern that relatively little progress would seem to have been made since then, particularly in the areas of partnership and interagency/interservice cooperation and establishing user/carer involvement. This would seem to be related to difficulties in the Children's Service Planning (CSP) process. When implementing the existing and future strategies for the wider children services agenda, the development of a comprehensive CAMH service should be addressed across health, social services, education, and youth justice.

3.67 We contend that Child and Adolescent Mental Health is a public health issue, as evidenced by the demographic and epidemiological evidence in Chapter 2. A process for identifying public health needs of children with mental health problems should therefore be established to assist with the design and commissioning of statutory and non-statutory services.

3.68 One of the targets set in the CAMH policy statement was that a commissioning strategy for delivering services based on identified need, and meaningful and measurable objectives should be in place by 1 April 2000. While there has been some progress towards a commissioning strategy the issue of properly identifying need was never addressed. Any commissioning strategy without this will inevitably only be partially informed. A study of the mental health needs of children in Northern Ireland should be commissioned as soon as possible.

3.69 NI CAMHS remains a disaggregated service. O'Rawe noted the "fundamental need for a coherent, comprehensive regional CAMHS framework linked to an effective province-wide network of statutory and voluntary bodies promoting mental well-being in children and young people" (p. 13). The following chapter attempts to begin to address this primary deficit and addresses the observation made by O'Rawe that: "*NI CAMHS does not need a structural review – it needs a structure"*

RECOMMENDATIONS

1. The development of a comprehensive CAMH service should be facilitated by establishing a structured implementation process and, addressed across health, social services, education, and youth justice. It should include a process for identifying public health needs of children with mental health problems. *Para 3.66, 3.67, 4.66*

2. A study of the mental health needs of children in Northern Ireland, should be commissioned as soon as possible. *Para 3.68*

CHAPTER 4

THE FUTURE ORGANISATION OF CAMH SERVICES

"…maybe they need to say 'Right well maybe this isn't working, maybe we need to look at something else'. There seems to be a proliferation of ongoing treatment, just carrying on because we're there, something's better to be seen to be done than nothing, but there is no realisation, 'Hold on a wee minute, maybe we should look at some alternatives or maybe I'm not helping, we should change.'" - *Parental comment*.

This Chapter provides detailed proposals and recommendations for the re-organisation and expansion of the management and commissioning arrangements and relationships within child and adolescent mental health services. Together with chapters 5, 6 and 7 these recommendations, if implemented, would substantially reduce the gaps and deficits outlined in the previous chapter and deliver on the vision of a comprehensive CAMH service.

Developing an Integrated Children's Service System

4.1 In 'The optimal location for CAMHS – A response by Young Minds' [76] the following arguments were made for the organisation of CAMHS within children's health services:

i. there are significant differences between children's mental health services and adult mental health services particularly in relation to the developmental perspective integral to the former. Children's mental health services also have an important role to play in relation to prevention and early intervention issues and network with significantly different services to adult practitioners - notably education. Effective CAMHS planning needs to relate closely to the children's services planning process;

ii. there is a risk that adult services are always prioritised over children's services;

iii. both families and young people themselves are very concerned about the issue of stigmatisation and a link with adult mental health would compound this problem;

iv. the ethos of CAMHS is better understood by practitioners who work within children's health services than by adult psychiatrists;

v. medical referrals for mental health problems in children are as likely to go to paediatricians, especially those based in the community, as to child psychiatrists or clinical psychologists. School and pre-school children with behavioural problems are often seen by community child health services - where much Tier 1 and Tier 2 work takes place. Acute mental health problems frequently present to paediatric inpatient services. Structures which enhance close child health and CAMHS links are essential;

vi. community child health services, including health visitors and school nurses are actively involved in mental health promotion and preventative services; and

vii. professional contacts between psychiatrists will ensure that links with adult mental health are in any case maintained.

4.2 These points were considered when examining possible management and commissioning arrangements for a future comprehensive CAMH service. It was also noted that concerns had been expressed that the location of CAMHS within Children's Services Directorates, whilst promising considerable potential benefits in the provision of seamless care to children and their families, also carried with it a corresponding risk. That is, that within a management structure of such breadth the specific requirements and developments of CAMH services might be diluted by the requirements of the wider Children's Services agenda.

4.3 In consultation with colleagues in NI and the UK it was concluded that there was no weight of evidence which would suggest that this risk was greater within Children's Services Directorates than it was within existing relationships with adult mental health directorates. However to offset any risk of a dilution occurring it would be vital that the contribution of CAMH professionals is maximised within directorates. Existing models of good practice in this regard are available from Wales and the NHSSB.

4.4 It is recommended that, providers should develop Children's Services Directorates bringing together all aspects of children's services – Family and Child Care, Child Health, Disability and CAMHS – as a single system under common management. These HPSS services should then operate in partnership with children's services in other agencies – particularly education, youth justice, police and voluntary sectors – effectively as a single system.

4.5 It is vital however that any development is an evolutionary process which ensures that where existing management arrangements are working well service effectiveness is not compromised for the sake of an artificial deadline.

Education

4.6 There is a need to recognise the role of the education sector and its interface with children and young people. For this to be achieved, the place of schools within the service delivery framework must be specifically addressed rather than just added-on. The Department of Education and DHSSPS should set up an inter-departmental group to facilitate joined-up planning and commissioning of services in mental health and education and to develop the necessary collaboration in this field.

4.7 Schools have been found to be very effective settings for intervening in aggressive and acting out behaviours. [77] [78] This was recognised in the Audit Commission Misspent Youth report. [79] When interventions are delivered in schools it is vital to involve pupils in any initiatives to promote better behaviour. [80]

4.8 The crucial role and potential contribution of colleagues in the education sector (both through schools and youth services) must be recognised. Within this context the importance of school ethos and the characteristics of effective schools must be recognised. Any strategic development must enhance the capacity of such staff and ensure appropriate linkages to other parts of the CAMH service. Partnerships with other agencies will enhance the effectiveness of school based interventions and are to be encouraged in line with one of the key recommendations of this report. Practitioners in education need to have greater access to training in the necessary skills and knowledge to address children's and young people's mental health needs, including fostering positive mental health in the classroom, and referring to more specialised staff when appropriate.

Environment

4.9 CAMH services should be located in appropriate child friendly, non-stigmatising environments. Where possible they should be located on the same site as or as near as possible to other children's services as this facilitates networking and joint working.

Managed Networks

4.10 The concept of Managed Clinical Networks was first set out in the report of the Acute Services Review. [81] It was followed in February 1999 by Management Executive Letter (MEL), [82] which defined Managed Clinical Networks as: 'linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure equitable provision of high quality clinically effective services….' [83]

4.11 The key ideas behind Managed Clinical Networks are as follows:

- emphasis on connection and partnership;
- distribution of resources rather than centralisation;
- maximising the benefits for all patients;
- erosion of barriers between secondary and primary care;
- emphasis on the term 'managed' in managed clinical network to underscore the importance of accountability and professional responsibility with a lead clinician having central importance; and
- networks are consistent with a renewed emphasis on the role of primary care in acute health care.

4.12 Managed Networks cross institutional and other organisational boundaries. Consequently they challenge existing planning and budgetary processes which are based around facilities or geographical areas. They rest on top of, or weave their way through static components of the overall service. They demand high levels of partnership between all those within the system as well as shared professional rotas and common clinical protocols. Clinical life needs to flow evenly across the network. [84]

4.13 In NI, fragmentation has resulted from services being delivered by multiple providers, some of whose focus has been acute health services. This has impacted upon the service delivery and efficiency of the specialist CAMH service. It is recommended that managed networks should be developed across all CAMH services in NI.

4.14 The evidence on managed networks suggests that when establishing networks, it is essential to get the balance right between formality and informality. Network organisations should be dynamic and fluid operating through trust and strong relationships. Although networks need some hierarchy to operate effectively, too much bureaucracy will wipe out the benefits that a network organisation is designed to bring to the service. It is envisaged that networks would be both regional and local. The variety of health, social, educational, and voluntary sector inputs required in a CAMH service will necessitate local networks. When care requires strong links from general CAMH care to subspecialists then the region will be the only viable scale at which all elements of the service can be included, for example regional inpatient units.

4.15 Without good management and leadership in CAMHS, any refined systems will be useless. There is a need to strengthen the planning, commissioning and general management of CAMHS in NI. The roles and attributes of leaders and general managers, while overlapping, can be distinguished. CAMHS require management both at planning and service delivery levels. The skills required are not found solely in any one profession. Full time CAMHS managers should be recruited to cover populations of approximately 240 - 300,000.

4.16 A CAMHS Development Co-ordinator should be appointed by the new Strategic Health and Social Services Authority (SHSSA) to facilitate the development of management structures at both a local level and also of local and regional Managed Networks across NI. These developments would lead to a meaningful partnership between CAMH users, carers, commissioners, managers and providers in the identification of need, planning and evaluation of CAMH services for NI.

Models of Service Delivery

4.17 The Review undertook an extensive local consultation and a wide literature review, to identify the key components that any model of service delivery should have. It was agreed that any model must ensure prompt access into the system for young people and their families, as well as general practitioners, and other referrers. Any service model also needs to ensure that appropriate levels of care and effective transition arrangements for young people moving on to adult services are in place.

4.18 A number of different potential service delivery systems were examined. These are discussed in some depth in a paper available at www.rmhldni.gov.uk. It was clear that some of the organisational structures explored were unsuitable as models of service delivery, however cognisance was taken of the best practice ideas contained within each of them.

4.19 Of those systems and models examined, both within this report and by the Review in general, it was concluded that the 4 Tier model was the most effective at bringing together the diverse number of services from which children and young people might receive help, ranging from primary care, paediatrics, clinical psychology to specialist community services and highly specialist inpatient units. The model also has the flexibility to encompass services outside health and social services such as education, youth justice and the voluntary & community sector.

4.20 In addition, one of the recurring themes identified through-out the Review was that services and projects established by social services departments, youth services of the Education and Library Boards and by the voluntary sector are often doing preventative and interventive CAMH work. However they do not think of themselves as involved in the delivery of CAMH services. Such projects and services are integral to an effective service and there is a need for the development of relationships between them and specialist CAMH services. This would allow referrals to be directed most appropriately, and where needed, consultation by specialist CAMH services could be facilitated. It was concluded that the 4 Tier model would be most effective at cementing these relationships.

4.21 To ensure that all services are known to all agencies and to facilitate more effective collaboration and planning it is recommended that a CAMH service mapping exercise should be carried out across all sectors by an independent research institute, and repeated at regular intervals.

The 4 Tier Model

4.22 The Tiered framework has 3 main purposes, first and foremost it is intended to be a strategic and planning tool, secondly a communication tool. The third use is as a blueprint for how services are practically delivered on the ground. This framework allows for a more effective focus on the service functions required of a mature, effective and efficient CAMH service that spans the agencies involved and their working practices.

4.23 It is important to stress that whilst the 4 Tier framework is a useful conceptual tool, it should not be seen as something constraining or limiting to the development of CAMH services. The model is not meant to be hierarchical. Children and services do not fit neatly into Tiers and nor should they try to. There is a misconception that children and young people will move up through the Tiers as their condition is recognised as being more complex. In reality there will be some children and young people that may require services from a number or even all of the Tiers at the same time. The management of the networks across the Tiers will be crucial to maintaining flexibility. It is recommended that the 4 Tier model should be developed in NI, re-emphasising the flexibility of the model as it was originally conceived. When this vision is being implemented consideration should be given to which agency takes the lead responsibility for each Tier.

4.24 The model is divided into 4 Tiers of service with specific, but overlapping areas of responsibility. The diagram is an attempt to illustrate the functionality of the Tiers. These are described below:

Tier 1

4.25 Tier 1 offers interventions to children with mild to moderate mental health problems. Many of these are self limiting but may cause considerable distress in the child or family and disruption to the child's learning. It is usually the first point of contact between a child and family with primary care, Education and/or voluntary and community agencies. Tier 1 staff includes GPs, other primary healthcarers, staff of child health services, school staff (teachers and counsellors), non-specialist children's social workers and many non-

statutory sector workers. This Tier should be accessible across NI. Only a very small proportion of children with these problems present to services and when they do present problems, they are frequently missed. The professionals will need generic training at this level. Services provided at this level will include:

- health promotion to prevent or interrupt the development of mental health problems;
- identification of mental health problems early in their development with early intervention;
- advice, and in some incidents treatment for less severe mental health problems (including emotional and behavioural problems);
- provision of support to enable families to function in a responsive manner to behavioural cues;
- enable families or carers to resolve parenting difficulties effectively;
- enable children to resolve their own emotional and or behavioural problems; and
- inclusion of children, young people and families as partners in the intervention process.

Tier 2

4.26 Tier 2 is the first line of specialist services. The staff include members of health-provided specialist CAMHS, community paediatricians, educational psychologists, specialist teachers, specialist children's social workers and some staff of voluntary organisations. They will need to have completed a dedicated training in the assessment and treatment of a range of mental health disorders. Tier 2 workers operate as individual practitioners, offering interventions for mental health problems and mental disorders. Not infrequently, staff will work as members of teams to which they may refer. Together, the functions delivered at Tier 2 are those required in each locality.

4.27 This Tier should be in a position to:-

- enable children and their families to function in a less distressed manner;
- promote services and activities to facilitate children to address and manage their mental health problems;
- assessment and intervention for children and their families with mental health problems;
- contribute to training, advice and consultation for people working at Tier 1 and 2
- assessment and appropriate referral to a range of other services; and
- inclusion of children, young people and families as partners in the intervention process.

Tier 3

4.28 Tier 3 services are more specialised. They are staffed by specialist CAMHS professionals from Tier 2 (para 4.26) who become Tier 3 workers when they function together as teams for particular children and families. Interventions are offered by professionals working in specialist multidisciplinary teams. They provide specialist services for more severe, complex and persistent mental disorders and illness. This group of professionals require specialist training opportunities. This service should be accessible across NI at a number of centralised sites. Tier 3 will provide:

- assessment and treatment of child and adolescent mental health disorders working with children and their families or carers;
- contribute to the training, advice and consultation to Tiers 1, 2 and 3;
- advice and education for families;
- feeding and Eating Disorder service;
- signposting to a range of other services;
- participation in research, development and audit projects;
- co-ordinating transition of children, adolescents and families to other Tiers; and
- inclusion of children, their families or carers and other agencies as partners in the process.

Tier 4

4.29 Tier 4 services deliver very specialised interventions and care for the most complex or uncommon disorders or illnesses. 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 residential social care. Partnership between education, youth justice, health and social services is essential at this level. This group of professionals require specialist training. These services will normally have the same profile of professionals as at Tier 3 and the range of services delivered may include:

- child & adolescent in-patient and day-patient services;
- secure and forensic services;
- feeding and eating disorder service;
- specialist team for neuro-psychiatric problems;
- specialist service for sensory impaired young people;
- specialist service for gender identity disorders;
- inclusion of children, their families or carers and other agencies as partners in the process; and
- contribute to training, advice and consultation to Tiers 1,2,3 and 4

Integrating Mental Health Promotion into Tiers

4.30 The key theme of this Review is the development of a holistic and integrated mental health service for children and young people that crosses organisational and institutional boundaries. Close partnerships and working relationships are vital to achieving this vision. Given that the Review has recommended the adoption of the 4 Tier model, it would be a missed opportunity not to examine the various planning and service commissioning models which exist in Social Services, Education and Youth Justice etc. Of particular note is the Hardiker model [85] of 4 levels of need, which is used extensively in Children's Services Planning (CSP). Given the similarity that exists between Hardiker and the 4 Tier model, we believe that an opportunity exists for health and social services planners and commissioners to co-ordinate their services much more effectively. This would encourage the development of a common language across social care, education and mental health services and should be included in the remit of the interdepartmental working group recommended in para 4.6.

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Care Pathways

4.31 The notion of the care pathway is central to adopting the perspective of children, young people and their families, and in making patient-centred service improvements. The Scottish Executive's document 'The Mental Health of Children and Young People' [30] stated:

"A particularly important quality of functioning as an intelligent network is that participants envisage the care pathways which children and young people may need to take, and then act with their partners in the network to make that pathway – and inter-agency transitions in particular – as smooth as possible"

4.32 Clear pathways of care both into and out of services should be developed. Models for improving the links between the 4 Tiers will necessitate the development of posts from the range of disciplines involved in CAMHS that can bridge both inpatient/residential and community services. These developments will help improve post discharge care and ongoing work in the community and will be a benefit accruing from a managed network.

4.33 As a priority the care pathway into Tier 4 services for children and adolescents with high risk, complex mental health needs must be defined. In most cases referral to CAMH Tier 2/3 services should provide the initial assessment and consultation with the child and family. In general, the Tier 2/3 service will remain involved with the young person in order to ensure continuity of care, maintain local community and family links and facilitate the resettlement of the child back into the community as they move from care in a Tier 4 service. Tier 4 services will need to work with the key agencies involved with children and young people to define the supported care pathways back into the local community.

Multi-disciplinary working

4.34 Multi-disciplinary teams can operate like small locally based networks, as ideally, they ensure that the appropriate professional provides intervention or that interdisciplinary support and advice are available. In practice, however, there is often a lack of clarity about a range of issues of importance to team function, such as the differing roles of core professionals. As well as having impacts on effectiveness, such issues can lead to tension within the multi-disciplinary team. One professional in a submission to the Review suggested:

The tensions involved in multi-disciplinary team working are extremely pertinent in terms of the direction and quality of the service delivered… (I)n terms of the stresses that can be generated, it is important that the tensions involved within such teams are recognised, acknowledged and addressed… A team...that does not address these issues is inherently flawed and will inevitably fracture. This may have devastating consequences for all concerned, but particularly for users.

4.35 It has been suggested that the requirements for effective team-working include: clarity about rules, boundaries and expectations; autonomy; a high degree of participation; and

supportive relationships. [86] With such clarity seemingly as elusive as the process involved in establishing it, it is not always easy to achieve 'supportive relationships'. The same issues arise in relation to multi-agency teams and the findings of the MATCH study [87] illustrate the nature of the difficulties. For example, the study demonstrated how team beliefs could impact on practice, and how such processes could marginalise some team members. The report offers practical strategies for good practice in multi-agency team-work at structural/organisational, ideological and procedural levels.

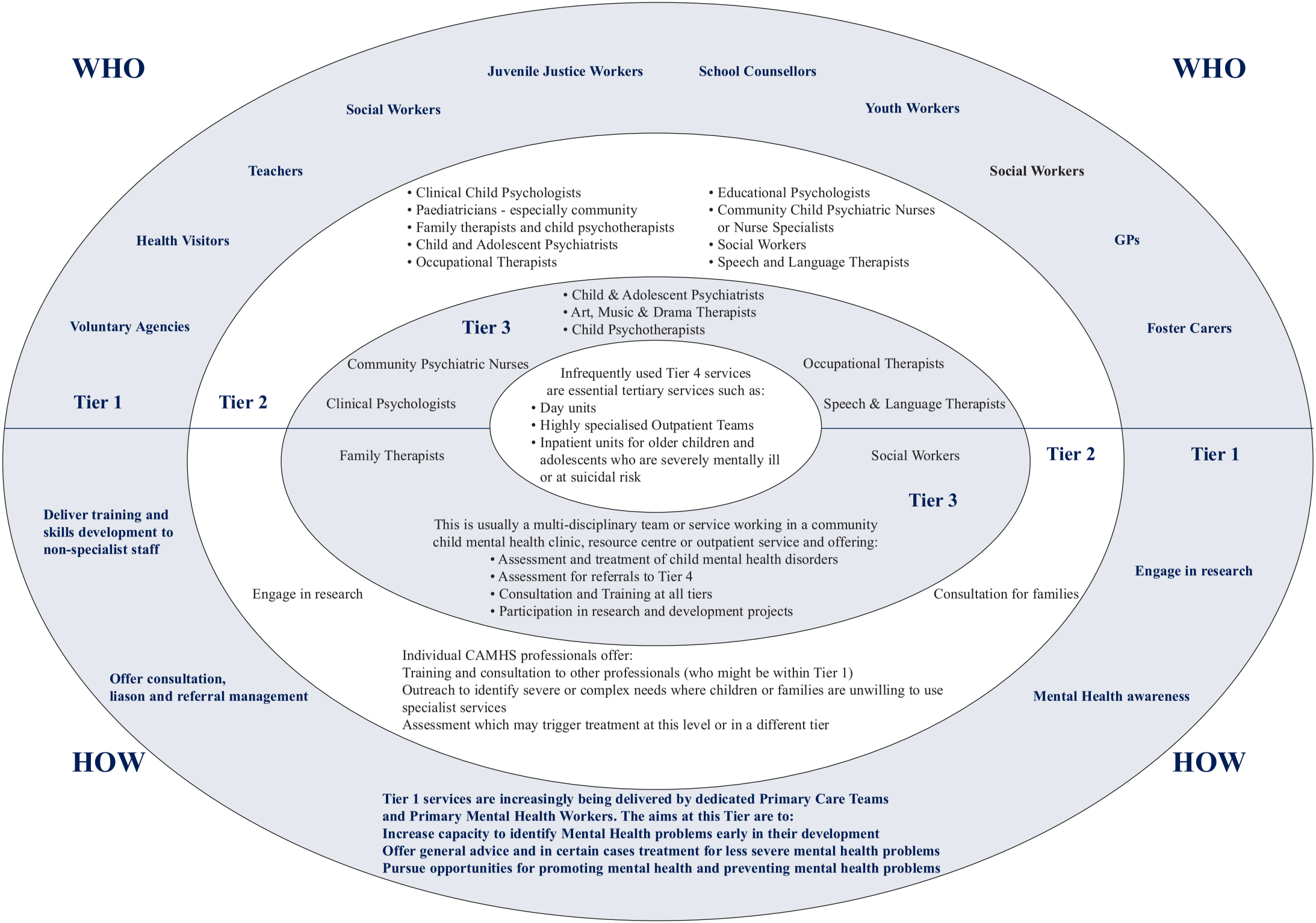
4.36 The professions currently represented in multidisciplinary CAMHS teams and how they relate to the aims of multidisciplinary assessment and treatment is subject to variation. A range of disciplines may be involved in gathering information relating to the bio-psycho-social perspectives of a comprehensive assessment. Systemic, narrative or psychodynamic perspectives might be added to enhance the assessment's holistic value. There is, however no widely agreed set of components to such an assessment, and therefore no clear consensus on the competency requirements within a team to achieve it. Also the hierarchical organisation of teams is not explicitly related to their function. Within NI, for example, a majority of teams appear to be 'psychiatry-led'. Examples exist in Great Britain and elsewhere of teams where professional inputs are specified but the lead can be provided by any of the professions involved.

4.37 In view of these issues we consider that a review of multi-disciplinary and multi-agency CAMHS working is required to inform the future planning and commissioning of services at Tiers 3 and 4. Clarity is required with regard to purposes, methods of functioning, and required competencies for specialist mental-health teams. This should include a review of which are the 'core' disciplines and competencies required in specialist teams and the implications in terms of representation of professional groups. Such a review - which would be consistent with the current Knowledge and Skills Framework agenda - should also address the stresses involved in multidisciplinary working, and should form an aspect of the early working brief of the CAMHS Development Co-ordinator.

Paediatrics/Child Health

4.38 Paediatricians and staff of most other disciplines who work in child health services have a vital role to play in developing mental healthcare. They have an influential place inside of a web of professional relationships involving education, social services departments and primary healthcare as well as voluntary and community agencies. They are best thought of as a part of Tier 2 services.

4.39 Child health services should be seen by all concerned as an essential part of a system of integrated CAMH service. Conversely specialist Tier 3 CAMH services should be viewed as making a key contribution to children's health and to paediatric care. This is a two way process and specialist CAMH services should aim to develop closer links with paediatricians. For many Tier 2 staff this can be provided by offering access to Specialist CAMH colleagues for consultation and support.


WHO
WHO
Juvenile Justice Workers
School Counsellors
Social Workers
Youth Workers
Teachers
Social Workers
Health Visitors
GPs
Voluntary Agencies
Foster Carers
Tier 1
Tier 2
Tier 3
Tier 2
Tier 1
• Clinical Child Psychologists
• Paediatricians - especially community
• Family therapists and child psychotherapists
• Child and Adolescent Psychiatrists
• Occupational Therapists
• Educational Psychologists
• Community Child Psychiatric Nurses or Nurse Specialists
• Social Workers
• Speech and Language Therapists
• Child & Adolescent Psychiatrists
• Art, Music & Drama Therapists
• Child Psychotherapists
Community Psychiatric Nurses
Occupational Therapists
Clinical Psychologists
Speech & Language Therapists
Family Therapists
Social Workers
Infrequently used Tier 4 services are essential tertiary services such as:
• Day units
• Highly specialised Outpatient Teams
• Inpatient units for older children and adolescents who are severely mentally ill or at suicidal risk
Tier 3
This is usually a multi-disciplinary team or service working in a community child mental health clinic, resource centre or outpatient service and offering:
• Assessment and treatment of child mental health disorders
• Assessment for referrals to Tier 4
• Consultation and Training at all tiers
• Participation in research and development projects
Deliver training and skills development to non-specialist staff
Engage in research
Consultation for families
Engage in research
Individual CAMHS professionals offer:
Training and consultation to other professionals (who might be within Tier 1)
Outreach to identify severe or complex needs where children or families are unwilling to use specialist services
Assessment which may trigger treatment at this level or in a different tier
Offer consultation, liason and referral management
Mental Health awareness
HOW
HOW
Tier 1 services are increasingly being delivered by dedicated Primary Care Teams and Primary Mental Health Workers. The aims at this Tier are to:
Increase capacity to identify Mental Health problems early in their development
Offer general advice and in certain cases treatment for less severe mental health problems
Pursue opportunities for promoting mental health and preventing mental health problems

4.40 Specialist CAMH services should continue to develop their services for ADHD and ASD in conjunction with Community Paediatric services. These services should agree and develop clear referral pathways and guidelines for the assessment and treatment of ADHD and ASD. Within a number of Trusts in NI, specialist CAMH posts have been established at Tier 2 to work with paediatricians to provide assessment and psychosocial intervention alongside or in place of medical care. Such service models support quality provision. When resources permit, joint clinics should be developed for assessment and management of the more complex cases.

Age Range of Services

4.41 The provisions of the key legislation that underpins child care, the Children (Northern Ireland) Order 1995, should guide the policy decision on the appropriate age range of services for CAMH services.

4.42 It is recognised however that this policy is not applied or applicable in the HPSS in all areas currently and that extending the age range for CAMH services at local level will need to take account of the resources required to meet the increasing incidence of mental illness in later adolescence. [88] It is estimated that because 16 and 17 year olds are particularly likely to have expensive to treat mental health problems the cost of a comprehensive CAMH service that includes 16 and 17 year olds may be twice as much as a service for 0 -16 years olds.

4.43 Adult mental health services need to be able to allow young people with mental illnesses, who are developmentally mature, early access to adult facilities. This is particularly important in the matter of early intervention services for psychosis. Generally however CAMH services should ordinarily cover children and young people up to their 18th birthday.

4.44 With regard to inpatient services the committee share the widespread concern about adolescents being admitted to adult psychiatric wards and note the view that such admissions are "unacceptable." The Royal College of Psychiatrists [89] has already recommended that young people under 16 should not be admitted to adult wards, and those aged 16 and 17 should be admitted only under special circumstances. We support this view and recommend that young people requiring inpatient treatment should be treated in developmentally appropriate settings.

4.45 At times, children and young people with psychiatric disorders will be admitted to general paediatric or adult wards, or to adult psychiatric wards, in a crisis situation and because it is not feasible to transfer the patient to a psychiatric inpatient facility for children or young people. This may be because such facilities are remote, or because they are unable to offer a place. Admission to general wards or to adult psychiatric wards can provide a temporary place of safety and care, but must only be a short-term arrangement.

4.46 Psychiatric inpatient units for young people must be the preferred placement in most situations and suitable facilities must be urgently developed in NI (see para 3.13-3.16.)

They provide treatment based on a model of care which takes account of the developmental needs of the young person, but at times, those needs may be better met in adult services. [90] For example, those young people under the age of 18 who work, live independently from their family, are in partnerships, or are parenting children may find that adult services are more appropriate. Those approaching the age of 18 at the time of first onset of major mental illness e.g. psychosis may similarly find the resources of adult services better orientated to their needs. There are "special circumstances" where admission to an adult ward may be acceptable and an inflexible policy is to be regretted if in the absence of an age appropriate place it precludes a seriously ill young person from the inpatient care they need.

4.47 We also believe that the personal preference of a young person aged over 16 to be admitted to a local adult facility rather than a remote young people's psychiatric inpatient unit must be considered and respected wherever appropriate. Good practice guidance on admissions of young people to adult psychiatric wards is available [91] [92] and every effort should be made to achieve compliance with such guidance.

Community Services

4.48 There is a need to ensure that those in contact with children have knowledge of children's mental health needs, and know how to refer to the appropriate specialist services. Collaboration between education, CAMH professionals, and colleagues in the non-statutory sector is lacking and vital to the early identification of problems and to maximise the health outcomes of children.

Legal provision for Children

4.49 The main legislation underpinning CAMH services is the Children (Northern Ireland) Order 1995. Part I of that Order provides core principles for legal decision-making concerning children. In addition, the principles in the Order 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 under powers in the present Mental Health (Northern Ireland) Order 1986. Despite this, the Review considers that 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 [93] is equally important.

4.50 The Review's Legal Issues Working Committee will report separately on a new legal framework. This will include principles for care and treatment of children and young people.

Involving Users and Carers

4.51 A clear intention of the Review was to engage consumer expertise as a means for testing out its ongoing work and proposals. The Review employed a range of consultation methods to elicit the views, opinions and advice of interested individuals and groups.

Within the CAMHS expert working group and its sub-committees, a range of stakeholders was represented. These included workers from statutory health, education and voluntary service backgrounds as well as representatives from service user/carer groups.

4.52 The benefits to health services of involving users and carers are well established. [94] The NHS Executive has detailed a range of such benefits including: increasing the likelihood that services are appropriate and effective, based on identified needs; meeting users' and carers' increasing wishes for more openness, accountability, and adequate information about their health condition, treatment and care; improving healthcare outcomes and client satisfaction; and providing access to reliable and relevant information that may help clients to assess clinical effectiveness for themselves. [95]

4.53 The Audit Commission's Report – Children in Mind [58] stated that CAMHS commissioners and service providers needed to take a holistic approach and assess needs systematically by consulting widely, including children and their parents. The need to involve children in service planning and evaluation has become clearer since the UK Government ratified the United Nations Convention on the Rights of the Child (UNCRC) and since the implementation of the Children (Northern Ireland) Order 1995.

4.54 Pressures placed on parents and carers when young people experience mental ill-health can be significant, and in Britain the requirement to engage with carers to assess and meet their needs has been established through the National Service Framework for Mental Health, Standard 6. In a broader sense the importance of engaging carers' expertise in helping to shape individual care plans and in contributing to service planning and evaluation is also widely recognised and methods for doing this have been described e.g. Carers Northern Ireland, 2000. [96] In view of these issues the case for involving service users and carers in the most significant review of CAMH services ever undertaken in NI was clear.

4.55 Consequently the Review commissioned a series of consultation exercises to explore service user and carer views. These involved a number of client groups including specific users of CAMH services, their carers, as well as targetted consultations with young people from ethnic minorities, children 'at risk' as well as representatives from young people in general. This focus on consultation provided a wealth of feedback and this material is available at www.rmhldni.gov.uk.

4.56 Of note was the specific exercise with CAMH services users and carers, whilst not an exhaustive or comprehensive investigation of user and carer views of services in the region it does provide a useful indication of the types of opinions and concerns that people hold based on real experiences of using services.

4.57 The investigation employed a 2 stage qualitative approach consisting of an open ended questionnaire and a series of 4 focus groups. Findings from the questionnaire study showed that to a large extent service users felt positive about their contact with CAMH services. Clearly the interpersonal contact and communication between users and providers is a strength of current provision. However, considerably more detail was captured through discussions with users and carers in the focus group study.

4.58 On the whole, participants in these discussions were more critical of services than were those who completed questionnaires. Some participants stated that they did not feel consulted or heard during their treatment or during the treatment of their children. The most common criticism voiced by many people was about the unacceptable length of time they found themselves waiting to be seen once they had been referred. A number of carers commented on the absence of specialist services such as for eating disorders or attachment difficulties. Difficulty with accessing respite was also a concern.

4.59 The issue of a lack of information provision and understanding about the role of CAMHS in the community was something highlighted in both questionnaire and focus group responses. Participants felt that CAMHS needs a higher profile to contribute to public understandings about mental health issues and to alert families who might benefit from the services. Many stated how they regretted not knowing what CAMHS had to offer sooner as they felt this delayed their receiving help for their children. Young people described how stigma affected their lives and could be an impediment to connecting with services.

4.60 One of the clearest lessons from the consultation is that carers as a group, as well as young people, have complex needs and sophisticated views about CAMHS. Research has indicated that professionals can hold confused views of carers, seeing them as resources or co-workers or clients or some combination of more than one of these roles. [97] The type of support offered will be shaped by these conceptualisations, but these complex issues are rarely taken into consideration when planning service development. Further detailed consultation with carer groups at local and regional levels would help to clarify carers' needs, what carers can bring to services and what might be the best ways of negotiating around these issues.

4.61 In addition the views of carers were also sought by offering various groups and individuals the opportunity to present verbally or in writing to the Committee. It was clear that the development of information for users, carers and other agencies explaining the range and scope of CAMH services was a priority.

4.62 As well as indicating satisfaction with many aspects of CAMH services, the users and carers consulted in the course of the CAMHS review highlighted much dissatisfaction and offered many suggestions about how their concerns might be addressed. The following are among the areas signposted for development:

- the need to prioritise developing service capacity at all tiers of provision to improve general accessibility, reduce unacceptable waiting times, and address limited or absent availability of specialist services to specific groups was emphasized by users and carers;

- it appears that there is a need to establish public health information projects with regard to child and adolescent mental health, and to improve information provision to communities about their local services;

- users and carers indicated willingness to work collaboratively with providers in terms of developing care and treatment plans and sharing information; models of treatment and service provision should be developed along lines that will facilitate such collaboration;

- there is a need to implement assessment models that evaluate the needs of carers and other family members as well as identified patients, and that utilise the expertise available within families about how help should be provided; and

- in terms of CAMHS outputs, user-focussed evaluation of services should be established as standard practice, to include investigation of their overall public health impact;

4.63 A next stage in this process of engagement may be a commitment to quantifying user concerns in areas highlighted by this consultation. Crucially, methods and organisational structures should be established to ensure user/carer involvement in the future shaping and monitoring of CAMHS.

Ethnic Minorities

4.64 The views of children from ethnic minorities were also of particular note. Lack of trust, and concerns about confidentiality, as well as language difficulties were all identified as barriers to children and young people seeking help and advice. The young people also emphasised the importance of their family circle and how it played a very significant role in the young person's life. Notably family was viewed as being both a cause of strain and a support.

4.65 Participants also felt that they were more likely to be bullied or teased because of their ethnic origin, and they felt that more needed to be done to enhance seem esteem. However there was mixed feelings about the provision of formal school based information etc on ethnicity as there was a fear that this would further identify them as different. The clear lesson from the consultation is that much more research is needed in collaboration with children and young people from an ethnic minority background.

Implementing the Vision

4.66 In order to realise the vision of a comprehensive CAMH service for Northern Ireland, the Review considers that a structured implementation process is required. Central to this process will be the CAMHS Development Co-ordinator who would work with an implementation Advisory Group comprised of commissioners, providers and users. The work of this group will be facilitated by a sub-committee structure which will address the following 4 areas:

- **Commissioning**. A sub-group, ideally short-lived, would address clarification and agreement of commissioning arrangements for CAMHS in Northern Ireland.

- **Informatics**. This sub-group would address issues such as the commissioning of a regional needs-assessment study, CAMHS mapping and the development of information systems.

- **Service delivery**. This group would focus on the implementation and further development of a service model for CAMHS, addressing such issues as establishing lead agencies and service delivery models for CAMHS tiers, developing managed clinical networks and, reviewing multi-disciplinary and multi-agency working.

- **Work-force develpment**. This group would address issues such as developing capacity throughout the tiered CAMH service and addressing the training and continuing professional development needs of service providers.

RECOMMENDATIONS

3. Providers should develop Children's Services Directorates bringing together all aspects of children's services as a single system under common management. *Para 4.4*

4. The Departments of Education and DHSSPS should set up an inter-departmental group to facilitate joined-up planning and commissioning of services in Mental Health and Education. *Para 4.6, 4.30*

5. Practitioners in education staff must be given training in the necessary skills and knowledge to address children's and young people's mental health needs, including fostering positive mental health in the classroom, and referring to more specialised staff when appropriate. *Para 4.8*

6. Managed networks, both local and regional should be developed across all CAMH services in Northern Ireland. A CAMHS Development Co-ordinator must be appointed to facilitate the development of these management structures. *Para 4.13, 4.16*.

7. Full time CAMHS managers should be recruited to cover populations of approximately 250 - 300,000. *Para 4.15*

8. A CAMH service mapping exercise should be carried out across all sectors by an independent research institute and repeated at regular intervals. *Para 4.21*

9. The 4 Tier model should be developed in Northern Ireland, re-emphasising the flexibility of the model as it was originally conceived. *Para 4.23*

10. A review of multi-disciplinary and multi-agency CAMHS working is required to inform the future planning and commissioning of services and should form an aspect of the early working brief of the CAMH Development Co-ordinator. *Para 4.37*

11. Community paediatric services and specialist CAMH services should develop clear referral pathways and guidelines for the assessment and treatment of ADHD and ASD. *Para 4.40*

12. CAMH services should ordinarily cover children and young people up to their 18th birthday. At all times they should be located in developmentally appropriate settings. *Para 4.9, 4.43,4.44, 4.46, 4.47*

13. The development of information for users, carers and other agencies explaining the range and scope of CAMH services is required. Methods and organizational structures should be established to ensure user/carer involvement in the future shaping and monitoring of CAMHS. *Para 4.61, 4.63*

CHAPTER 5

FUTURE SERVICES TO PROMOTE CHILD MENTAL HEALTH AND PREVENT MENTAL ILL-HEALTH

5.1 Mental health promotion can in part be understood as an approach to preventing the development of mental health disorders. Prevention has been understood in terms of 3 related types of activity. [98]

(i) Primary prevention aims to reduce the incidence of disorders by preventing new cases from developing. Primary prevention interventions are aimed at those who do not show any sign of disorder but may be at risk of developing disorder.

(ii) Secondary prevention aims to detect disorder early on and provide effective treatment. An aspect of such treatment is that it seeks out its recipients, as opposed to waiting for them to present.

(iii) Tertiary prevention aims to minimise the accruing disabilities or handicaps that may be associated with the presence of disorder.

5.2 Among the advantages of using this conceptualisation of mental ill-health prevention is that it demonstrates the continuity between 'prevention' and 'treatment', emphasising that prevention is future oriented. [99] Prevention is a core aspect of any comprehensive CAMH. The following are examples of some of the types of prevention work that need to receive significantly more attention within NI:

(i) Primary Prevention Strategies

5.3 Schools have a vital role to play in primary prevention work. There is strong international evidence to suggest that a whole school approach is vital in effectively promoting emotional and social competence and well being. The 'healthy school' approach, which has been promoted by the WHO, recognizes that it is the overall climate and context of the school that is supportive of development. This contrasts with programmes aimed only at the behaviour of individuals. The Personal, Social and Health Education/personal development curricula presents opportunities to promote the mental health and wellbeing of all children and young people at school across the primary, special and secondary school sectors in NI.

5.4 A number of more targeted programmes have been developed and shown to be effective in promoting emotional and social competence within a wider supportive environment. There is sound evidence from the literature that such work has a wide range of educational and social benefits including greater educational attainment and work success, improved behaviour, increased inclusion, improved learning, greater social cohesion and improvements to mental health. Moreover it seems that work, which aims to target particular groups of children or young people, has also a wider benefit for the whole school

community. Schools that are effective with vulnerable groups, tend also to be effective schools.

5.5 Bullying can have a serious negative impact on individual children and young people even after a short period resulting in lost confidence and diminished self-esteem. Children who have experienced bullying are likely to have suffered loss of self-esteem, coping and resiliency and some may develop depression as a consequence of their experience. Effective appropriate early intervention is required to support the mental health needs of both the victim and the perpetrator. Strategies for the provision of services for children and young people who have experienced bullying and for the provision of assessment and treatment services for children and young people who display bullying should be considered.

5.6 In 1997, the British Medical Association produced a report that suggested that sex education should include information on homosexuality as part of the National Curriculum. This was based on the position that,

"Young lesbian, gay or bisexual people may be exposed to mental or physical health problems as a result of social isolation, bullying or lack of self-esteem" [100]

5.7 The Review supports this suggestion recognising that delivery of such education must take into consideration the complexity arising from differing religious and societal influences on young people. The SHOUT Report [16] highlights the figures in relation to negative experiences of young people who identify as Gay, Lesbian or Bi-sexual (G.L.B). The findings of the Shout Report indicate that 24% of the respondents have been medicated for depression and 29% have attempted suicide and 26% have self-harmed. These figures correspond with figures for young G.L.B in Britain and America. The picture is emerging of serious issues of mental health for young G.L.B people. A cautious response is however required to ensure that young G.L.B people do not acquire another label of being mentally ill. Further investigation needs to take place into the specific mental health needs of young people who identify as gay lesbian or bisexual.

(ii) Secondary Prevention Strategies

5.8 Health promotion and other preventative strategies have been aimed at very young children (infants) and parent-infant relationships in particular and are often referred to as 'early intervention' or 'infant mental health' initiatives. In 'at risk' communities or families such interventions attempt to promote good parent-child relationships and should be more cost effective than trying to repair damage at a later stage. They may prevent the development of attachment disorders and other problems that are sometimes labelled as Attention Deficit Hyperactivity Disorder (ADHD). Health visitors have a vital role to play here and a focus on training in infant mental health, promotion of healthy attachments and accurate early detection of difficulties would greatly enhance their impact in this area.

5.9 a number of early intervention programmes have been developed and evaluated. Factors contributing to effective outcomes in early intervention include:

- multisystemic involvement including teacher training, an educational focussed component for the child and a supportive parent focussed activity;
- intervention beginning with very young children;
- intervention sustained over time; and
- community based intervention with partnerships between parents, the community and professionals.

The Incredible Years Programmes [101] is one such example of a well established and validated intervention which focuses on the behavioural problems of young children (2 - 8 years)

5.10 There is also a need for educational, health and mental health professionals to work in schools to provide early help for individual children who are beginning to show evidence of mental health difficulties. Independent Schools' Counselling services provide children and young people with a listening ear and someone to turn to in the school setting. These services provide accessible one to one support to vulnerable children and young people in coping with a range of issues that include domestic violence, bullying, parental alcohol abuse and family separation. Referrals are received directly from children and young people themselves as well as from parents and teachers. These services complement the work of the pastoral care team in school, fostering coping skills as well as a culture of accessing support among children and young people.

5.11 Homestart, and more specifically Sure Start, programmes are examples of such programmes, and may involve a range of Tier 1 professionals and trained volunteers. It is our conclusion however that the best programmes will take place across the tiers and will involve Tier 2 and 3 CAMH services for consultancy, evaluation and training. This will necessitate increased capacity at all these levels. Early intervention should not be thought of as purely a Tier 1 matter.

5.12 The development of infant mental health and early intervention services should be pursued as a preventative strategy throughout NI. The essence of such services is that they should be multiprofessional and multiagency, bringing together those working in the primary health field with Sure Start Workers, adult mental health services and CAMHS.

5.13 Tier 2 & 3 services are aimed mainly at behavioural problems that may present at home, in the school or both. Parent management training programmes have been shown to be the most effective method for intervening in behavioural problems in children. [10] Programmes which combine parent management training with problem solving skills training for children may be more effective than those programmes which only train the parents. [102] Therefore when parenting programmes are set up for established behavioural problems they should incorporate both of these elements. A strategy for the evaluation of these programmes should also be developed.

5.14 Experiencing mental ill-health can significantly interfere with parents' ability to make use of parent management programmes. Professionals should be aware that interagency working and possible onward referral to Adult Services might be required when parents have significant mental health needs. Equally interagency working is also required to protect and safeguard the welfare of children and young people in some cases of parental psychiatric illness. The recommendations of 'Patients as Parents' [103] are endorsed which highlight the need for education, training, audit and development of shared protocols to improve practice across this important interface. A video produced by the Royal College of Psychiatrists – "Being seen and heard" [104] explores this interface and is very useful for raising awareness and for training purposes.

5.15 Suicide and self-harm have been highlighted in this report as a pressing issue to be addressed by CAMHS. A suicide prevention strategy for NI is required and recommendations are made in the report of the Mental Health Promotion Expert Working Committee of the Review. The report is available at (www.rmhldni.gov.uk)

5.16 Risk factors for suicide have been identified at the individual, family and social-demographic levels. Among these, the presence of depression is the strongest health-related risk factor. Consequently it makes sense to orientate prevention work towards identifying and effectively treating young people with emotional disorders placing them at risk of suicide. Good follow up procedures after attempted suicide are also an essential component of CAMH service provision. A recent review has concluded, however, that "…child-focussed multi-modal programmes which include some combination of didactic instruction and discussion, bibliotherapy, and behavioural skills training may be very effective in increasing suicide-related knowledge, willingness to seek help if suicidal, and willingness to encourage potentially suicidal peers to see professional help." [105] Consequently there is a need to address the prevention of suicide through multi-modal programmes, probably best delivered via education services.

(iii) Tertiary Prevention Strategies

5.17 Children who have experienced child abuse, be it physical, sexual, emotional or neglect are likely to have complex physical, educational, social, psychological and protection needs. These needs require a multi-disciplinary, multi-agency response which addresses the needs of the whole child, and CAMH services at all 4 Tiers have a role to play in helping children recover and ensuring that they are protected.

5.18 In addition, children with pre-existing mental health needs as well as those with physical and/or learning disabilities are likely to be at more risk of child abuse or repeat abuse. These children need effective services, which recognise the complexity and multiplicity of symptoms rather than treating symptoms in isolation. Services need to be delivered in a manner that avoids labelling and stigma. This labelling presents problems for some children particularly when their abuser may have given them messages that they were 'mental' or defective as part of the grooming/control process.

5.19 Children and young people who display sexually harmful behaviour also have complex mental health needs that need to be considered by a comprehensive CAMH service. The complex mental health needs of all children who have experienced abuse as victims or perpetrators should be addressed early to avoid likely presentation to adult mental health services later in life.

5.20 As such, strategies for the provision of post-abuse intervention services for children and young people, and for the provision of assessment and treatment services for children and young people who display sexually harmful behaviour, should be developed and implemented. These strategies may need to include the contribution of CAMHS and set out how treatment and protection services will be co-ordinated and integrated across disciplines and agencies.

5.21 The disturbingly high levels of mental ill-health among looked-after children have been mentioned elsewhere in this report. The limitations of both the social care and medical models as the basis of organising mental-health supports and interventions for looked-after children have been described. [106] Organising child mental-health services around a medical model approach – reliant on the presence of symptoms as the basis of referral – tends to result in multiple referrals for assessment and treatment once difficulties and symptoms have already emerged.

5.22 There is a clear need, when organising mental health services to LAC, to consider developmental processes, and the types and timing of interventions required to support these processes. Care providers need support from dedicated LAC mental health services organised along such lines to encourage the alignment of service contacts with key developmental stages, therefore providing more opportunity to support care providers and engage specialist mental-health workers in issues of prevention.

5.23 The needs of young people with autistic spectrum disorders have been referenced within this report. In particular the need to help young people develop their social and communication skills to minimise social exclusion and prevent the mental health difficulties that can result from such exclusion has been highlighted. Many CAMH services have provided social skills training for young people with ASD, yet evidence suggests that young people do not easily make links between what they do in social skills groups and real settings. [107] Within Craigavon and Banbridge Health and Social Services Trust, the Tier 3 CAMH team have developed partnerships with the Southern Education and Library Board's Youth Division and Craigavon Borough Council to provide social skills interventions linked with activities designed to promote social integration. The usefulness of such approaches has been demonstrated. [108] Wider application and evaluation would help determine the utility of such programmes in preventing the development of mental health difficulties.

Progressing prevention and mental health promotion

5.24 The need for public information campaigns with regard to child and adolescent mental health has been highlighted by the Review's CAMHS user/carer consultation. The need for a specific public health approach with regard to the impact of civil conflict has also been highlighted.

5.25 This could prove helpful, particularly in a society emerging from a period of protracted conflict, with many families still continuing to struggle to come to terms with the consequences of the events over the past 35 years.

5.26 Health promotion strategies could also incorporate training and education for CAMH staff regarding the impact of the 35 years of civil conflict on the population of NI. The need for this has been consistently highlighted in all Government consultation documents such as the Bloomfield Report etc [109] all relating to the needs of those affected by the conflict.

5.27 The benefits of promoting good mental health have been asserted in the report of the Review's expert working party on mental health promotion. The Review welcomes and endorses the recommendations in this report that will result in adequately resourced mental health promotion in NI and help realise the aspiration of effective health promotion as an essential component of a comprehensive CAMHS.

5.28 The development of a CAMH community psychology service to be delivered regionally via the CAMHS network is recommended. Community psychology as a discipline has emerged worldwide over a number of decades, but particularly in areas that have been affected by profound socio-political conflict such as North America during the period of the civil rights struggles or South Africa following the abolishing of apartheid. It provides contextual analysis that is cognisant of social issues and environmental stressors and supports mental health workers in orienting their activities towards a broader public health portfolio embracing advocacy, lobbying, community networking and mobilisation. [110]

5.29 A community psychology service would work with the regional health promotion service, locally based community development services, and other statutory and community partners. Its purpose would be to identify, develop and deliver in collaboration with local communities, projects that support those communities in increasing the emotional well-being and resilience of their young people and protect them from developing mental ill-health

5.30 In NI there are also legacies to the conflict, one such area causing much concern is the extent of the influence of paramilitary organisations and how many public housing areas have extensive paramilitary activity and control, causing many problems for local populations, particularly young men. During the last 5 years alone more than 9,500 families have been forced to move from their homes due to the impact of the civil conflict. [111]

RECOMMENDATIONS

14. Further investigation needs to take place into the specific mental health needs of young people who identify as gay, lesbian or bisexual. *Para 5.7*

15. Mental health promotion and prevention in the school setting should be developed across all schools, to include Independent School's Counselling services, the health promoting school, and pastoral care initiatives. *Para 5.10*

16. The development of infant mental health and early intervention services should be pursued as a preventative strategy throughout Northern Ireland. *Para 5.12*

17. Parenting programmes should be expanded and incorporate both parent management training with problem solving skills training for children. *Para 5.14*

18. A suicide prevention strategy for Northern Ireland is required. *Para 5.15*

19. Post-abuse intervention services for children and young people, and for children and young people who display sexually harmful behaviour, should be developed and implemented. *Para 5.19*

20. A CAMH community psychology service should be developed and delivered regionally through the CAMHS network *Para 5.28*

CHAPTER 6

FUTURE SERVICES TO THOSE WITH MENTAL ILL-HEALTH

In this Chapter detailed recommendations are provided which will go far to addressing the gaps in current services identified within Chapter 3.

Carers and Family Members in CAMH Services

6.1 Accessing appropriate services for children and young people is a major issue for carers. While early intervention is widely recognised as highly beneficial, long waiting lists and lack of services mean that it is often impossible to put this into action.

6.2 Carers recognise the unacceptable nature of the admission of young people into adult units. Families sometimes feel excluded from and ill-informed about treatments being provided by CAMH Services. They would favour a co-operative approach, which includes families as equal partners in care and recognises their expertise with regard to the young person.

6.3 The emotional needs of carers need to be addressed, not least because responsibility for the ongoing care of a young person often falls heavily on family members after discharge. Support should be provided for parents and carers of young people admitted to inpatient units, both on an individual and group basis. Support for family members should include age-appropriate support and information for siblings and young carers.

6.4 Voluntary and community groups have an important role to play in supporting carers and parents of service users. The Valuing Carers Strategy Document [112] asserts that, "All carers should have access to local carer support services which we believe are best run and managed by the voluntary and community sector particularly when cares themselves are involved in the management arrangements".

6.5 Young carers of mentally ill parents have special needs and we support the recommendations in sections 5.89 – 5.91 of the Adult Mental Health Committee report [113] to be found at www.rmhldni.gov.uk.

Mental Health Inpatient Units

6.6 Comprehensive Tier 4 adolescent inpatient services must include both acute care inpatient provision which is able respond to emergency admissions of acutely disturbed or high risk young people with a mental disorder and medium to long-term planned therapeutic inpatient provision. Both types of adolescent inpatient places should be available for a given population. There must be close working links between the acute care and medium/long-term therapeutic inpatient provision and the capacity and flexibility for young people to move between the two as appropriate.

6.7 The number of inpatient places required for a given population must be based on a comprehensive, multi-agency needs assessment. This must take into account the known prevalence and incidence of mental health problems as well as local demographics including measures such as the child poverty index and multiple deprivation indexes for the area concerned. Local geography must also be taken into account when planning services.

6.8 Further expansion of inpatient provision after the current planned expansion is implemented should depend on a reassessment of need that should be multiagency and take into consideration the impact of the proposed regional specialist social/emotional/psychological unit.

Transition to Adult Mental Health Services

6.9 The transfer of care between child and adolescent services and adult services usually occurs around the age of 18. There may be circumstances when it is in an adolescent's best interests for a CAMH team to continue to care for them beyond the age of 18 while plans for transfer to adult services are put in place. Conversely, it may be appropriate to transfer some adolescents to the services for adults before their 18th birthday. Care pathways and protocols should be developed between adolescent and adult mental health services to allow optimal patient care during the transition from one service to the other. In all cases it is vital that collaborative arrangements between adult mental health services and CAMH services is put in place to ensure that the suffering in a child or parent does not go undetected or untreated

Early Intervention in Psychosis

6.10 There is a body of evidence which suggests that early intervention in psychosis, including both medication and psychotherapy approaches, is associated with better psychosocial functioning, both in the short term and at 20 year follow up. Mental health services to this group of young people should not only provide effective and appropriate interventions but also be sufficiently competent to work sensitively to address their distinctive needs and everyday culture. Early intervention teams specialising in working with young people aged between 14 and 25 who are experiencing their first episode of psychosis are one possible way of delivering services. They provide a range of services including antipsychotic medications and psychosocial interventions tailored to the needs of young people. They take an optimistic view of the person's ability to recover and eschew conventional preoccupation with symptom management and diagnosis. Such services need to be designed and delivered using a partnership approach involving CAMH, adult mental health, primary care, education, criminal justice users/carers and have yet to be developed in NI. [114]

6.11 There is a clear opportunity to link adolescent Tier 4 services with emerging services for early intervention in psychosis. The relationship with adult community mental health teams is vital in cases of older adolescents, particularly with the transition to adult mental health services. Some Tier 4 services in England are developing link posts with a specific

remit to provide regular input into the local Tier 3 teams and adult community mental health team. Clear guidelines are needed in the absence of age appropriate and consistent mental health services for 16-19 year olds. The interface between CAMH services and adult mental health must be addressed and links established between Tier 4 specialist CAMH and adult community mental health teams as well as Tier 3 CAMH services. Collaborative working arrangements are essential. Separate age appropriate services geared towards early diagnosis and interventions should be developed. We refer readers to sections 4.51 – 4.56 and recommendation 42 of the Adult Mental Health Committee report.[113] This can be found at www.rmhldni.gov.uk.

6.12 Effective early intervention requires greater public awareness of Psychosis. The Adult Mental Health Committee have addressed this as a priority area for future services. [113]

Assertive Outreach

6.13 It is recognised that improvement in provision for children and young people at specialist Tier 2/3 CAMHS will impact positively and decrease the number of those requiring Tier 4 service. In other cases improved Tier 2/3 provision and closer links between Tier 3 and 4 will ensure that an interagency working approach and increased flexibility of service. This could help to facilitate movement of the young person through the tiers of CAMH service.

6.14 Assertive outreach provides frequent contact and co-ordinated intensive treatment with the young person and/or their carers by a multidisciplinary team. It could be delivered by collaboration between Tier 4 and Tier 3 services in conjunction with other agencies. It can take place in an inpatient setting or exclusively as an outpatient assertive outreach model, or in conjunction with day unit provision but day units are more readily applicable to urban populations than to scattered rural populations because of distances of travel involved in the latter case.

6.15 Intensive treatment can be developed as a result of collaboration between CAMHS and social services or education or both. This can be achieved through joint work between Tier 2/3 and Tier 4 CAMH or by collaboration between CAMH services and paediatrics, or CAMH services and adult mental health. In order to function effectively there needs to be close links with, and support from, adequately resourced Tier 2/3 specialist CAMH teams as well as age appropriate Tier 4 inpatient beds for children and adolescents. Models of assertive outreach/intensive treatment/day unit treatment for young people with complex needs should be developed and implemented by commissioners and providers as a priority.

Out of Hours and Emergency Services

6.16 No community CAMH service in NI can, within existing capacity, provide 24 hour cover to general hospital A&E departments. In some areas cover is provided by combinations of social services duty social workers for under 16s, and adult psychiatric services for over 16s in consultation with the limited numbers of CAMH consultant psychiatrists.

6.17 Although 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 young people on the same day. Where residential or inpatient facilities are concerned, emergency cover by appropriate professional staff and/or managers at a number of levels must be available on a 24 hour-a-day basis.

6.18 The interface with the crisis response and home treatment initiative within the adult mental health report should be developed with the inclusion of the 16 – 18 age group in these services. Out of hours services should be developed to meet need while responding to the demands of the European Union (EU) Working Hours Directive.

Emergency Provision

6.19 Improved emergency provision in CAMH services will reduce Tier 4 demands. There should be improvements in emergency access to service Tier 2/3 provision and closer links between the Tier 4 services, will ensure interagency working and increased flexibility of service.

Learning Disability

6.20 A requirement that no child should be excluded from receiving a mental health service on the grounds of having a learning disability is key to meeting the principles of accessibility, non-discrimination and social inclusion. Specialised training and skills 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.

6.21 The Review's Learning Disability report [115] anticipates that 'mainstream services will take the lead for those with a mild and moderate learning disability with joint working for those with a more severe learning disability.' To achieve this mental health services are required for children and adolescents who have a learning disability at all Tiers.

6.22 No one particular service model is recommended but any model should be delivered by staff experienced in working with children & young people with learning disability and who also have training and expertise in specific mental health problems. Specialist CAMH services need to continue to develop close working relationships with the learning disability services.

6.23 Inclusive policies need to reflect partnership working between the education, social, and child mental health services and learning disability. There should be clarity in the local arrangements for future CAMH/learning disability services to ensure that a coordinated and integrated package of care is delivered.

6.24 Specialist mental health services for children and adolescents with learning disabilities should be commissioned as part of specialist mental health services for all children. A small number of key staff should be trained in both learning disability and mental health disciplines to lead development. Locally provision will depend on increased capacity of CAMH Services and any change must therefore be incremental. However it is recommended that future severe learning disability inpatient provision should be in a community-based child and adolescent specific units. Developed and more effective working relationships in the local arrangements for future CAMH/learning disability services should ensure that a co-ordinated and integrated package of care is delivered.

Autistic Spectrum Disorder Assessment and Treatment

6.25 The Review has produced a paper detailing recommendations for services to individuals with ASD. We endorse the recommendations made within this paper and in particular would wish to highlight the recommendation that a service manager in each Provider should have overall responsibility for the development and coordination of services for children and adults with ASD. It is agreed that creation of a separate programme of care would divert scarce resource from the development of direct service provision for those affected by ASD. We acknowledge the need for CAMH professionals to acquire greater knowledge and experience in assessment and diagnosis of ASD. All local area services will need to plan for increased levels of demand on already overstretched existing services. The following recommendations are consistent with the National Autistic Plan. [31]

6.26 A service is required specifically to assess children who are suspected to have ASD regardless of learning ability which can then provide follow up treatment, management, education and support and which will also support them in the transition to adulthood.

6.27 ASD services should be locally available, multi-agency and multidisciplinary including an educational specialist and a family support worker. Clinical and Care management should be across the broad children's service and come under the Children's Services Directorates recommended in paragraph 4.4 of this report. A senior manager within the Directorate should be responsible for co-ordination of ASD services for children. Community paediatric services may be the base service for early assessment and diagnosis but specialist CAMH input will be required for consultation, second opinions, joint-working and referral for treatment of mental health issues. Social care packages including the promotion of social skills and social integration will be necessary after diagnosis with a keyworker responsible for ensuring delivery of these services.

Looked After Children

6.28 Children looked after by social services in children's homes, foster homes and other residential placements often face complex and enduring interpersonal and mental health problems affecting every aspect of their lives and making it difficult for them to accept help and support and for staff and carers to maintain therapeutic relationships. This is especially so for older adolescents as they anticipate leaving care.

6.29 Social workers and mental health professionals have much to contribute to each other's practice in this area. Close collaboration between social services and CAMH services should be a cornerstone of LAC services.

6.30 The complex and long term needs of looked after children have consistently challenged the Trusts and community and voluntary service providers. Any intervention, plans or treatment is complicated by the reluctance of looked after children to attend formal therapeutic services. A range of service options needs to be developed to allow the intervention best suited to meet the young person's needs.

6.31 Those who deliver the services require support, training and high quality supervision and, in addition, consultation from specialist CAMHS professionals to enable purposeful intervention and to allow young people in public care to meet their full potential and make the most of their life opportunities.

6.32 Furthermore a model that prioritises and meets the needs of LAC throughout NI should be developed in consultation with social services and other professional groups working with LAC and their carers. Such development has already begun in some providers. However services should not be developed piecemeal, but should be developed equitably across NI.

6.33 Clinical aspects of LAC should include the liaison with and consultation to the network surrounding the child, comprehensive assessment of need, intervention with the child and carers, supervision and training, audit, research and evaluation.

Alcohol and Substance Misuse

6.34 Prevention and treatment strategies for alcohol and substance misuse problems in young people under 18 should be incorporated together in a co-ordinated, multi-agency and specific strategy for the long-term. The recommendations of the Alcohol and Substance Misuse report are supported in this regard. Details can be found in Chapter 8 of their report. www.rmhldni.gov.uk

Feeding and Eating disorders

6.35 The NSF for Mental Health [116] recommends that treatment of severe eating disorders be commissioned from specialist services.

6.36 NICE [117] emphasises that "most people with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a service that is competent in giving that treatment and assessing the physical risk of people with eating disorders". They also state that "admission of children and adolescents with anorexia nervosa should be to age-appropriate facilities (with the potential for separate children and adolescent services), which have the capacity to provide appropriate educational and related activities." In practice this may involve a range of settings.

6.37 The NICAPS study [53] found that, in addition to an eating disorders diagnosis and the burden or care on family members, factors that contributed to inpatient admission included ease of access to services, clinical experience of the referrer, the range of alternative to inpatient care and the general backdrop of service organisation.

6.38 Children and adolescents with eating disorders should be cared for within CAMH services providing quality care. [118] However flexible arrangements where specialised adult eating disorder teams with CAMH professional input manage older adolescents are applicable in those aged 16 and above. Working relationships between paediatric, medical and psychiatry in-patient services should be developed for continuity of care.

6.39 The nature of service provision for feeding and eating disorders in NI needs to change with a particular increase in specialised outpatient services, and more specialist teams within generic settings, both inpatient and outpatient. Specialist outpatient services for feeding and eating disorders should be developed in NI.

Children that are victims of Trauma

6.40 The development and expansion of evidence based services to address psychological trauma in children should be taken forward as a priority. The expertise gained in all sectors should inform the developments. Care pathways should include the contributions of Specialist CAMHS and Trauma Advisory Panels.

Services for Children and Adolescents with Challenging Behaviour

6.41 As with services for LAC, specialist community-based teams need to be developed or enhanced through training, support and access to consultation. There are some good examples of such teams working well in parts of NI; teams flexibly delivering 'outreach' services with an emphasis on community development. Further development of such services will necessitate some enhanced capacity at Tiers 2 and 3.

6.42 The 'Children Matter' Review [70] reported a need for a small children's residential sector for children with emotional and psychological needs to support community and hospital services for adolescents. In other parts of the UK this is provided by the independent sector and such provision is almost nonexistent in NI. We support plans for a regional specialist social/emotional/psychological unit to complement acute psychiatric hospital provision.

Youth Justice and Forensic Services.

6.43 Mental health is a risk factor associated with offending. Specialist CAMH services should develop close working relationships and care pathways with the Youth Justice Teams. The NI strategy on young offenders calls for the effective attention to the mental health needs of young offenders, which will avoid them being inappropriately dealt within the youth justice system.

6.44 Preventing youth offending and re-offending requires a multi-agency approach. Delivery of effective programmes requires training in the specific intervention programmes and there is evidence that without quality assurance programmes they may not only fail to reduce re-offending but may actually increase it. [119]

6.45 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. A focus on analysing patient flow (patients journeys) and the design of appropriate care pathways are important matters for appropriate Research and Development (R&D). A regional forensic CAMH service should be developed in NI. The objective should be planned care, initiated at the local level, being the basis on which integrated services are delivered.

Ethnic Minorities

6.46 As outlined earlier in the report, the Review conducted a consultation exercise with a number of children and young people from an ethnic minority background. Whilst it provided some useful insight into the needs and requirements of this particular group it is clear that much more research is required, in partnership with them and their families. However some concrete recommendations can be drawn from their responses as to how CAMH services might best meet their needs. Firstly, in their service delivery strategy local CAMHS services should include plans to meet the mental health needs of children and adolescents and families from ethnic and other minority groups in their community.

6.47 Services that are culturally competent should be supported by individuals who have the skills to recognise and respect the language, behaviour, beliefs, customs, and characteristics of people from different ethnic backgrounds. Of particular note from the consultation with young people was a feeling of frustration that an interpreter was often required when they spoke with service providers. They urged CAMH to make a greater effort to recruit staff capable of speaking their native language.

6.48 A process of engagement with minority groups was clearly required and it is recommended that services should devise relevant strategies for communicating with local minority ethnic groups to inform them of the nature and range of services available and encourage them to access services.

Voluntary and Community Organisations and the statutory/non-statutory interface

6.49 Funding arrangements for voluntary and community agencies should be extended to a minimum of 3-5 years rather than on an annual basis. This would allow them to plan on a longer-term basis and facilitate their engagement as full partners with statutory agencies when developing CAMH services.

6.50 The extension of CAMH mapping exercises to the full breadth of voluntary and community as well as statutory services will allow evaluation of progress in addressing these needs. Statutory agencies should include the appropriate voluntary sector agencies as full partners when developing CAMH services.

Children with Sensory/Physical Disability and Enduring Physical Illnesses

6.51 Mental health services to children with physical and sensory disabilities and illnesses should continue to expand in support of regional paediatric specialties. Provision should be both regional and local. This is likely to require planning and commissioning on a regional basis and will require consideration when the specialist services are commissioned.

RECOMMENDATIONS

21. Support should be provided for parents and carers of young people admitted to inpatient units, both on an individual and group basis. Support for family members should include age-appropriate support and information for siblings and young carers. *Para 6.3*

22. The need for inpatient provision should be kept under continuing review. *Para 6.8*

23. The interface between CAMH services and adult mental health must be addressed and more effective collaborative arrangements established to ensure that the suffering in a child or parent does not go undetected or untreated. *Para 6.11*

24. Models of assertive outreach/intensive treatment/day unit treatment for young people with complex needs should be developed and implemented by commissioners and providers. *Para 6.15*

25. Out-of-hours services should be developed to meet need while responding to the demands of the European Union (EU) Working Hours Directive. *Para 6.18*

26. Specialist mental health services for children and adolescents with learning disabilities should be commissioned as part of specialist mental health services for all children. A small number of key staff should be trained in both learning disability and mental health disciplines to lead development. *Para 6.24*

27. Future severe learning disability inpatient provision should be in a community based child and adolescent specific unit. *Para 6.24*

28. A service is required specifically to assess children who are suspected to have ASD regardless of learning ability which can then provide follow up treatment, management, education and support and which will also support them in the transition to adulthood. *Para 6.26*

29. Clinical and care management for ASD should come under the Children's Services Directorates and a senior manager within the children's directorate should be responsible for co-ordination of ASD services. *Para 6.27*

30. A model that meets the needs of LAC needs to be developed. A cornerstone of the model must be close collaboration between social services and the network surrounding the child. Clinical aspects must include a comprehensive assessment of need, and appropriate evidence based interventions. *Para 6.29, 6.32, 6.33*

31. Prevention and treatment strategies for alcohol and substance misuse should be incorporated together in a co-ordinated, multi-agency and specific strategy for the long-term. *Para 6.34*

32. Flexible arrangements between CAMHS and specialised adult eating disorder teams, paediatric, medical and psychiatry inpatient services should be developed. Specialist child and adolescent outpatient services for feeding and eating disorders should also be developed in Northern Ireland. *Para 6.38, 6.39*

33. The development and expansion of evidence based services to address psychological trauma in children should be taken forward. The expertise gained in all sectors should inform the developments. Care pathways should include the contributions of Specialist CAMHs and Trauma Advisory Panels. *Para 6.40*

34. Specialist community based teams with an emphasis on outreach, service flexibility and community development should be developed for young people with perceived challenging behaviours. These teams need to work closely with other agencies and in particular need to be effectively integrated with specialist CAMH teams for support, training and access to consultation. *Para 6.41*

35. Specialist CAMH services should develop close working relationships and care pathways with the youth justice teams. *Para 6.43*

36. A regional forensic CAMH service should be developed in Northern Ireland. *Para 6.45*

37. In their service delivery strategy, local CAMHS services should include plans to meet the mental health needs of children, adolescents and families from ethnic and other minority groups in their community. This should include communication with these groups to inform them of services available and encourage them to access services when needed. *Para 6.46, 6.48*

38. Statutory agencies should include the appropriate voluntary sector agencies as full partners when developing CAMH services ensuring funding arrangements for these organisations are extended to a minimum of 3-5 years. *Para 6.49, 6.50*

39. Mental health services should be provided to children with physical and sensory disabilities and illnesses, in support of regional paediatric specialities. *Part 6.51*

CHAPTER 7

ENHANCING THE CAPACITY OF CAMH SERVICES

"This service is vital to the community, many people have benefited from this. This clinic should expand as there is such a big demand from it. More staff."- *Parent/carer's comment*.

"We had to wait a long time to be seen. I would say more staff and also more financial resources."- *Parent/carer's comment*.

This Chapter provides recommendations for enhancing the capacity of services. It includes detailed proposals on the development of an enhanced CAMH workforce, as well as more effective methods of information technology and financial resource management.

Current Budgetary Situation

7.1 It is difficult to find out what resources are allocated to CAMH Services in NI. O'Rawe [74] has shown that the available regional hospital activity information upon which presumably the strategy for equity investment is based, fails to comprehensively represent CAMH outpatient activity both in pattern and volume. She has ascertained that although children under 17 years represent 27% of the population, the proportion of expenditure on NI CAMH Services represents less than 5% of the total NI mental health budget. She also points out that the location of CAMH services within the overall programme of care model upon which the Regional Capitation Formula is predicated is not immediately apparent. Budgetary arrangements for CAMH services are not sufficiently clear and increased allocation of resources in proportion to need in order to support CAMH services in NI is urgently required. It is recommended therefore that CAMH services should have their own identifiable budget.

Information Management

7.2 Although a vast amount of data on the health of children is gathered within computerised health information systems in general practice, and hospital and community child health, very little is gathered on child mental health specific problems. There are difficulties with regard to confidentiality and also terminology in relation to mental health problems. Currently there are no agreed universal terms, definitions and indices of severity for use across disciplines and agencies for conditions such as autistic spectrum disorder, depression, and specific learning difficulties. Sharing information about LAC and those at risk of abuse is a significant challenge both in terms of practical difficulties in keeping the information up to date on this frequently mobile population and also in terms of confidentiality and data protection. An understanding of the background of health and social concerns as well as the current situation of the child is vital to the successful planning of the way forward. A robust information technology system such as PCIS should underpin the work of CAMH services. The Strategic Framework for Adult Mental Health Services [113] (paragraphs 7.7-7.15) recommends a regional information strategy for mental health and we recommend that this includes CAMH.

7.3 Adequate administrative support is essential to facilitate gathering of data and although administrative support to CAMH services in NI varies considerably between services it is too often insufficient. This impinges on data gathering and outcome measurement.

Workforce

7.4 Achieving the goals of this review and improving the mental health of children depend on the development of the professional workforce. This includes planned expansion of both the capabilities of current staff and their numbers.

7.5 Currently within NI existing staffing levels do not even meet present requirements. Vacancies exist in all disciplines. Limited career pathways with underdeveloped supervision and the high clinical demands hinder the recruitment and retention of staff across NI. There needs to be a sustained drive to increase both the number of training places and the number of such posts across NI. This will even out the present patchy provision of services and help to make careers more rewarding. In turn, this should promote recruitment and retention and create a virtuous circle. There is an urgent need for the delivery of a workforce plan for all disciplines involved in CAMH services.

7.6 There are a number of key drivers for the development of modern mental health services across both community and hospital. Service user expectations of standards of service have been raised through the increased use of advocacy services together with generally a louder voice for service user groups. The National Strategy for Carers [120] places additional demands on staff to ensure the wider needs of the family are also addressed. The carer's education and support programmes piloted in partnership with Rethink, the Sainsbury Centre for Mental Health and local trusts serves to demonstrate how this area can be further developed.

7.7 From the perspective of clinical and social care governance as highlighted in Best Practice Best Care [28] a statutory duty of quality has now been placed on Chief Executives across the HPSS system, issues such as risk management and health and safety are receiving due prominence. Staff are more focused on improving standards of care through the application of evidence informed practice that makes best use of resources and ultimately generates better experiences and outcomes for service users.

7.8 Whilst recognising the obvious advantages of modern atypical anti-psychotic medications with much reduced side effect profiles, there is adversely (due principally to less sedating properties of the drugs) an increased demand on nursing staff to support service users through the most acute phases of their illness in a safe and secure environment with an increased emphasis on therapeutic intervention. This also generates increased demand for 1:1 supervision within acute admission and psychiatric intensive care units, which significantly impacts on existing manpower resources. Preparatory training for enhanced specialist practitioners is therefore urgently required.

7.9 Clinical supervision is an integral component in the maintenance of professional standards, however current staffing complements pre-date the emergence of clinical supervision for nurses. Unlike other professional colleagues, who have time incorporated into their work programmes to facilitate supervision, nurses attempt to fit supervision around many other commitments. Within the DHSSPS best practice guidelines [121] it is argued that clinical supervision is essential in the provision of safe and accountable practice. There is obviously a significant workforce challenge in taking forward these guidelines.

7.10 The pattern of training and the qualifications held by social workers employed in CAMHS across the tiers reflects the diversity of service. They 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 and play therapy. Practitioner posts at senior and principal levels should be developed at Tiers 2 - 4.

7.11 Awareness and foundation training in child and adolescent mental health issues should be incorporated into undergraduate training specifically in the following areas;

- Occupational therapy;
- Speech therapy;
- Family therapy;
- Play therapy;
- Art therapy, Music therapy; and
- Drama therapy.

This must be complemented by accessible post graduate training programmes.

7.12 In the management of service users with very complex conditions, e.g. ASD / Asperger's Syndrome, all staff may work across a number of sectors which includes private, independent, voluntary and other statutory partners such as Education & Library Boards. Isolated examples exist where models of excellence are being developed which require dedicated funding to ensure that all CAMH professionals have the necessary knowledge, skills and expertise to provide high quality care within these dynamic environments.

7.13 It is clear that service development plans in the future will dictate the development of a workforce sufficient to address all of the following areas:

- Eating Disorder;
- Alcohol and Substance Misuse;
- Forensic;
- Looked After Children;
- Autistic Spectrum Disorder (ASD);
- First Episode Psychosis; and
- Learning Disabilities.

Further work is required to explore these areas. The DHSSPS should establish small working groups to address the specific service development of service and training needs for these specific areas.

A small number of other issues that impact more indirectly include:

- the integration of the principles of Investing for Health in all aspects of service delivery;
- the GMS contract and the evolution of new roles for nursing within;
- primary care e.g. out of hours services;
- the European Working Time Directive,
- the new consultant contract;
- the role of the nurse consultant; and
- the review of public administration.

7.14 There is a clear need to consider the role of primary care and the function of primary care professionals in relationship to CAMH services. Early and accurate intervention is proven as key to good services. It is vital to get Tier 1 right. The tendency to immediately refer all children with mental or emotional difficulties to the specialist elements of the HPSS 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.

7.15 One response recommended by the HAS was the development of Primary Mental Health (PMH) worker posts. These posts could be by professionals from any discipline with training and expertise in CAMH services and their role includes: [1]

- consolidating the skills of primary care and supporting education regarding CAMH services;
- aiding recognition of CAMH disorders and referral on; and
- assessing and treating some individuals with mental health problems who were considered appropriate for management at Tier 1 and Tier 2.

7.16 A Department of Health Review on PMH [122] workers concluded, “the development of CAMH services in primary care seems to be highly dependent on the new PMH worker posts”. It noted that 33.3% of providers surveyed had developed such posts and a further 25% had plans to do so.

7.17 In England and Wales there are up to 700 PMH workers in post and the National Service Framework [30] identifies that by 2006 all CAMH Service teams will have 5 such posts. This development has been patchy in NI, some providers are aiming at the continued development of the Tier 1 and Tier 2 services that contribute to CAMH services.

7.18 For NI, with a bigger child population and greater deprivation indices and the civil conflict factor, higher staffing levels will be required. In NI the percentage of children in the population (27%) is greater than the percentage in England (22%) by a factor of 1.2. It is difficult to calculate a weighting for deprivation and civil conflict but it is estimated that for NI an equivalent number of PMH workers associated with each CAMH team would be 6. It is recommended that the role and complement of PMH workers be expanded within NI.

7.19 At Tier 3 a critical mass of staffing is required for services to be safe, timely and effective and able to respond to a wide range of demands from specialist multidisciplinary assessment and treatment, to specialist consultation and liaison, teaching and training, research and audit and finally to support and provide consultation in primary care.

7.20 The precise level of staffing will vary according to indices of deprivation, urban and rural differences, the number of local partnerships required and teaching responsibilities. As services take on new responsibilities additional staffing will be required locally. Where services have a critical mass of staffing they are able to offer a greater range of community outreach services.

7.21 The NSF [30] has estimated that in England a generic specialist multidisciplinary CAMH service Tier 2/3 team with teaching responsibilities providing evidence based interventions for 0-17 year olds would require a minimum of 20 whole time equivalents (WTEs) per 100,000 total population and a non teaching service, a minimum of 15 WTEs. These figures are backed up by the work of Kelvin [123] who calculated similar figures based on a service specification model to enable evidence based service development in keeping with good clinical governance. The NSF points out that these figures do not allow for dedicated staff time from Tier 2/3 services to services such as Sure Start, looked after children teams, or youth justice teams and would not necessarily be sufficient to provide specialist services like a day unit. It also states that these figures do not reflect demographic variations. Thus using as a minimum the factor of 1.2 already referred to above we estimate that in NI specialist CAMH teams would be needed of 25 and 20 WTEs respectively. For this reason additional revenue funding should be provided on an incremental basis to ensure that a workforce is developed in sufficient numbers to provide the range of services required within the 4 tier model in CAMH services in NI.

7.22 It is worth emphasizing the importance of an attractive working environment for professionals and with this in mind considers 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. To enhance recruitment and retention, career paths should be developed for all professionals, inclusive of new role developments in CAMH services.

Education, Training and Research

7.23 The above profile illustrates that the existing provision for CAMH services is inadequate and unsatisfactory. The lack of capacity has led to pressure on existing services. Despite many examples of good practice the overall quality consistent and accessibility has suffered to the extent that urgent strategic action is needed to tackle the services and work force shortages in NI.

7.24 Insufficient numbers are being trained to meet health and social services needs let alone other initiatives. Training programmes at all tiers for all disciplines are not yet fully developed in NI. Universities, FE colleges, and in service training providers should develop the range of educational and practice development opportunities required to equip a variety of mental health practitioners with the knowledge necessary to develop the competencies for their work with children and their families.

7.25 Important research is going on for example in epidemiology, basic sciences and social services based at the Centre for Child Care Research at Queen's University. There has been collaboration between mental health specialists and social work academics. Such partnerships often generate significant synergy and enhance the capacity of each party. Nonetheless opportunities for participating in research that relates to child and adolescent mental health are limited in NI. To foster a local climate of research and critical enquiry, academic posts from the range of professions involved in CAMH service should be developed.

7.26 Governance and quality mechanisms in CAMH services should be further developed and implemented across NI.

Psychotherapy Services

7.27 Relationships within the family may contribute to or compound the mental health problems of children and the systemic training of a family therapist has a key role in CAMH services. Systemic Family Therapy is a method of conceptualising difficulties/problems within the context in which they occur. It is based on the idea that the behaviour of individuals and families is influenced and maintained by the ways other individuals and systems interact with them. It involves engaging the whole family system as a functioning unit and also embraces smaller systems (including individual work) and bigger systems than 'the family'. Carr's meta-analysis [124] found that for child focused problems**,** family therapy and systemic consultation was an effective treatment either alone or as part of a multi-modal or multisystemic treatment programme in child abuse and neglect, conduct problems, emotional problems and psychosomatic problems.

7.28 The specialist contribution which a child psychotherapist makes to CAMH services is the assessment and psychotherapeutic treatment of children adolescents and their parents based on psychodynamic concepts and application of related clinical techniques." Other functions of both family and individual psychotherapists in CAMHS include consultation to other professions and agencies.

7.29 The psychotherapeutic approach should be more strongly integrated into CAMH services in NI. There are very few dedicated family therapist and child psychotherapist posts in CAMH services in NI and the role of these disciplines should be further developed and enhanced.

Speech and Language Services.

7.30 Speech communication and language skills are essential for developing relationships, understanding social contexts and behaviour and expressing individuality. Children and young people with severe speech communication and language needs (SCLN) often present with marked emotional and behavioural difficulties and clinical depression.

7.31 Estimates of the incidence of SCLN vary. Estimates range from 3% to 20% of the school population presenting with some need, with the figure of 10% commonly accepted by academics and policy makers as the percentage of children with SCLN.

7.32 Although more detailed local demographic information is needed on the number of young people with Speech and Language difficulties and associated mental health difficulties, it is now recognised that many conditions resulting in communication disability in children and young people also have associated mental health issues i.e. brain injury, mild/moderate learning difficulties, dysfluency, ASD and ADHD.

7.33 The current availability of Speech and Language Therapy (SLT) provision to children and adolescents with mental health difficulties is not meeting existing requirements. Service development has evolved in patches within the NHS. Some regions within the UK now have a well established SLT service for people with mental health needs.

7.34 The role that speech and language therapists (SLTs) play within CAMH services should be recognised. SLT services should be adequately planned and resourced, based on local demography and need.

Occupational Therapy Services

7.35 Occupational Therapists hold a unique, key role in CAMH services, working across the age range and within various settings that offer mental health services to children and young people. This role was recognised within the HAS [1] document where occupational therapists were identified as one of the core professions that offer services within child and adolescent mental health.

7.36 Occupational therapists are the only health care profession with core skills and expertise in analysis, assessment, treatment and evaluation of occupational dysfunction that is contributing or consequent to psychological problems. [125]

7.37 Occupational therapists bring specialist rehabilitation expertise to multidisciplinary CAMH teams, which enables the child or young person to access meaningful occupation, by developing confidence and skills in occupations in the areas of productivity, self care and leisure. [126]

7.38 "Standards for Child and Adolescent Mental Health Services" [127] recommends that multidisciplinary resources are comprised of a range of disciplines inclusive of occupational therapists. Currently there are no occupational therapists in the CAMH services workforce in NI.

7.39 This gap in service provision in CAMH services needs to be addressed with occupational therapy representation being a core element of CAMH provision and service and workforce planning in NI. [128]

Clinical and Social Care Governance

7.40 Clinical and social care governance has been adopted by health services as a way of integrating financial control, service performance and clinical quality [129] and is the framework whereby service providers take corporate responsibility for the quality of the service delivered. Clinical and social care governance therefore forms the overarching principle of the management of good quality CAMH Services, with the central expectation of an adequately trained workforce, involved in continued professional development, and of sufficient size and diversity to meet the needs of the population served.

7.41 This Review welcomes and endorses the framework of clinical and social care governance. Throughout the Review reference will be made to the principles and tools of clinical and social care governance, such as service development, benchmarking, standard setting, effective management, risk management, user and carer involvement, evidence based practice, audit and research.

7.42 There is a recognition that much work has to be done to achieve the objectives of clinical governance to provide locally delivered high quality CAMH services across the 4 Tiers and throughout NI. However it is important to note that as clinical governance risk assessment procedures begin to examine the adequacy of service infrastructure, capacity issues in CAMH services may become more pronounced.

RECOMMENDATIONS

40. CAMH services should have their own identifiable budget. *Para 7.1*

41. A robust information technology system such as PCIS should underpin the work of CAMH services. *Para 7.2*

42. Small working groups should be established to address the specific service developments and training needs for Eating Disorders, Alcohol and substance misuse, Forensic, LAC, ASD, First episode psychosis and Learning disabilities. *Para 7.13*

43. The role and complement of Primary Mental Health (PMH) workers be expanded within Northern Ireland. *Para 7.18*

44. Additional revenue funding should be provided on an incremental basis to ensure that a workforce is developed to provide the range of services requested within the 4 Tier model in CAMH services in Northern Ireland. *Para 7.21*

45. To enhance recruitment and retention, career paths should be developed for all professionals inclusive of new role developments in CAMH services. *Para 7.22*

46. Universities, FE colleges, and in service training providers should develop the range of educational and practice development opportunities required to equip a variety of mental health practitioners with the knowledge necessary to develop the competencies for their work with children and their families. *Para 7.24*

47. To foster a local climate of research and critical enquiry, academic posts from the range of professions involved in CAMH service should be developed. *Para 7.25*

48. Governance and quality mechanisms in CAMH services should be further developed and implemented across NI. *Para 7.26*

49. The number and role of family therapist and child psychotherapist posts in CAMH services should be enhanced and further developed. *Para 7.29*

50. The role that speech and language therapists (SLTs) play within CAMH services should be recognised. SLT services should be adequately planned and resourced, based on local demography and need. *Para 7.34*

51. Occupational therapy services should be developed as a core element of CAMH provision. *Para 7.39*

RECOMMENDATIONS

"I look back to what it was like last year or the year before…you kind of notice what a big change it can make" - *Parental comment*.

1. The development of a comprehensive CAMH service should be facilitated by establishing a structured implementation process and, addressed across health, social services, education, and youth justice. It should include a process for identifying public health needs of children with mental health problems. *Para 3.66, 3.67, 4.66*

2. A study of the mental health needs of children in Northern Ireland should be commissioned as soon as possible. *Para 3.68*

3. Providers should develop Children's Services Directorates bringing together all aspects of children's services as a single system under common management. *Para 4.4*

4. The Department of Education and DHSSPS should set up an inter-departmental group to facilitate joined-up planning and commissioning of services in mental health and education. *Para 4.6, 4.30*

5. Practitioners in education must be given training in the necessary skills and knowledge to address children's and young people's mental health needs, including fostering positive mental health in the classroom, and referring to more specialised staff when appropriate. *Para 4.8*

6. Managed networks, both local and regional should be developed across all CAMH services in NI. A CAMH development co-ordinator must be appointed to facilitate the development of these management structures. *Para 4.13, 4.16*.

7. Full time CAMHS managers should be recruited to cover populations of approximately 250 - 300,000. *Para 4.15*

8. A CAMH service mapping exercise should be carried out across all sectors by an independent research institute, and repeated at regular intervals. *Para 4.21*

9. The 4 Tier model should be developed in NI, re-emphasising the flexibility of the model as it was originally conceived. *Para 4.23*

10. A review of multi-disciplinary and multi-agency CAMHS working is required to inform the future planning and commissioning of services and should form an aspect of the early working brief of the CAMH Development Co-ordinator. *Para 4.37*

11. Community paediatric services and specialist CAMH services should develop clear referral pathways and guidelines for the assessment and treatment of ADHD and ASD. *Para 4.40*

12. CAMH services should ordinarily cover children and young people up to their 18th birthday. At all times they should be located in developmentally appropriate settings. *Para 4.9, 4.41 – 4.47*

13. The development of information for users, carers and other agencies explaining the range and scope of CAMH services is required. Methods and organizational structures should be established to ensure user/carer involvement in the future shaping and monitoring of CAMHS. *Para 4.61, 4.63*

14. Further investigation needs to take place into the specific mental health needs of young people who identify as gay, lesbian or bisexual. *Para 5.7*

15. Mental health promotion and prevention in the school setting should be developed across all schools to include Independent School's Counselling services, the health promoting school and pastoral care initiatives. *Para 5.10*

16. The development of infant mental health and early intervention services should be pursued as a preventative strategy throughout NI. *Para 5.12*

17. Parenting programmes should be expanded and incorporate both parent management training with problem solving skills training for children. *Para 5.13*

18. A suicide prevention strategy for NI is required. *Para 5.15*

19. Intervention services for children and young people that have suffered abuse and for children and young people who display sexually harmful behaviour, should be developed and implemented. *Para 5.19*

20. A CAMH community psychology service should be developed and delivered regionally via the CAMHS network. *Para 5.28*

21. Support should be provided for parents and carers of young people admitted to inpatient units, both on an individual and group basis. Support for family members should include age-appropriate support and information for siblings and young carers. *Para 6.3*

22. The need for inpatient provision should be kept under continuing Review. *Para 6.8*

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43. The role and complement of PMH workers should be expanded within Northern Ireland. *Para 7.18*

44. Additional revenue funding should be provided on an incremental basis to ensure that a workforce is developed to provide the range of services needed within the four-tier model in CAMH services in NI. *Para 7.21*

45. To enhance recruitment and retention career paths should be developed for all professionals inclusive of new role developments in CAMH services. *Para 7.22*

46. Universities, FE colleges, and in service training providers should develop the range of educational and practice development opportunities required to equip a variety of mental health practitioners with the knowledge necessary to develop the competencies for their work with children and their families. *Para 7.24*

47. To foster a local climate of research and critical enquiry academic posts from the range of professions involved in CAMH service should be developed. *Para 7.25*

48. Governance and quality mechanisms in CAMH services should be further developed and implemented across NI. *Para 7.26*

49. Family therapist and child psychotherapist posts in CAMH services in NI and the role of these disciplines should be enhanced and further developed. *Para 7.29*

50. The role that speech and language therapists (SLTs) play within CAMH services should be recognised. SLT services should be adequately planned and resourced, based on local demography and need. *Para 7.34*

51. Occupational therapy services should be developed as a core element of CAMH provision. *Para 7.39*

ANNEXE 1

WHAT IS THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY

Introduction

1.1 In October 2002 the Department of Health, Social Services and Public Safety (DHSSPS) commissioned an independent review of law, policy and service provision affecting people with mental health needs or learning disabilities. The main factors influencing the decision to establish the Review were:

- recent reviews of mental health legislation in neighbouring jurisdictions;
- the need to ensure that law, policy and practice is in keeping with human rights and equality law; and
- the need to reflect current evidence of best practice.

1.2 An overall Steering Committee, whose terms of reference are shown at Annexe 2, manages the Review. They are guided by inputs from Expert Working Committees, each of which is examining a particular area:

- Child and Adolescent Mental Health
- Learning Disability
- Adult Mental Health
- Forensic Issues
- Dementia and Mental Health Issues of Older People
- Social Justice and Citizenship
- Mental Health Promotion
- Needs and Resources
- Legal Issues
- Alcohol and Substance Misuse

The Review is also working closely with DHSSPS on a workforce planning group on mental health and learning disability services.

1.3 The Working Committee tasked with taking forward the review of CAMH Services (membership at Annexe 4) recognise that 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. Of specific significance in NI has been the emerging awareness of the impact of "Troubles related trauma" and the manifestations of sectarianism and associated violence within children and young people.

1.4 Society pays a high price in terms of social disruption, education failure, ill health, anti-social behaviour and hard cash for the failure to tackle these problems effectively. Links between childhood disorders and adult mental health problems are now well established.

Failure to break this pattern can result in generation after generation suffering from social exclusion with its attendant problems.

1.5. The Working Committee acknowledges that 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 savings on expenditure by society on later, more expensive treatments and interventions by a multitude of agencies. Perhaps most importantly of all, the Working Committee came to the conclusion that no one agency can tackle the problems on its own.

ANNEXE 2

TERMS OF REFERENCE

1. To carry out an independent review of the effectiveness of current policy and service provision relating to mental health and learning disability, and of the Mental Health (Northern Ireland) Order 1986.

2. To take into account:

   - the need to recognise, preserve, promote and enhance the personal dignity of people with mental health needs or a learning disability and their carers;
   - the need to promote positive mental health in society;
   - relevant legislative and other requirements, particularly relating to human rights, discrimination and equality of opportunity;
   - evidence - based best practice developments in assessment, treatment and care regionally, nationally and internationally;
   - the need for collaborative working among all relevant stakeholders both within and outside the health and personal social services sector;
   - the need for comprehensive assessment, treatment and care for people with a mental health need or a learning disability who have offended or are at risk of offending; and
   - issues relating to incapacity.

3. To make recommendations regarding future policy, strategy, service priorities and legislation, to reflect the needs of users and carers.

ANNEXE 3

THE CAMH REVIEW PROCESS

How did we involve people in developing the vision for the Child and Adolescent Mental Health Review?

1. The approach to developing the vision took account of Government Policies, the views of children and their families as well as professionals in both statuary and voluntary organisations. This information was gathered through extensive consultation and research from October 2003 to December 2004.

2. The CAMH review is a result of information generated through consultations, research, and good practice initiatives from October 2003 to March 2006. These included;

   - the establishment of the CAMH committee that managed the Review; and
   - the establishment of three working groups to review specific elements of CAMH service provision identified as;

     - Tier 1/2 services working group;
     - Tier 3/4 services working group; and
     - Psychological and Social Wellbeing working group

   - the organisation of a range of events to give all stakeholders the opportunity to present information to the CAMH committee: People and organisations were invited to give information to the committee in keeping with the Reviews terms of reference, with the specific emphasises on the needs of children, adolescents and their families;
   - additional people and organisations made submissions and presentations to the committee;
   - a content analysis of all presentations and submissions was completed;
   - workshops were held to explore issues regarding education, mental health promotion, adult mental health, alcohol and substance misuse, forensics, learning disability, social justice and citizenship;
   - user and Carer consultations were conducted utilizing both survey and focus group methodologies;
   - a critique of national and international service models was commissioned;
   - a meeting took place with the carer reference group within the Review;
   - a province wide review of service provision took place;
   - three newsletters were circulated to disseminate the work of the committee;
   - many members of the public and professionals making comments to and asking questions of the committee accessed a free phone line;
   - meetings were held with relevant people in the province; and
   - letters were received from many members of the public and professionals addressing the committee with issues and concerns regarding CAMH services.

ANNEXE 4

COMMITTEE MEMBERS LIST

Ms Moira Davren
Convenor – CAMH Committee

Professor David Bamford
Former Chair of the Review of Mental Health & Learning Disability

Dr Noel McCune
Consultant Child and Adolescent Psychiatrist

Dr Tom Teggart
Consultant Clinical Psychologist

Mr Stephen Dornan
Children Services Manager

Mr Maurice Devine
Thompson House Hospital

Ms Stephanie Wilson
Primary Mental Health Practitioner

Ms Jackie Nelson
Senior Clinical Nurse Specialist/
Clinical Nurse Manager, CAMHS

Ms Brenda Byrne
Head Occupational Therapist
Occupational Therapy Mental Health Managers Forum

Mrs Arlene Healey
Centre Manager/Consultant Family Therapist

Mrs Billie Hughes
Clinical Services Manager

Mr Billy McCullough
Senior Lecturer (retired)

Mrs Maureen Ferris
Assistant Director of Nursing

Dr Carolyn Mason
Nursing and Midwifery Advisory Group

Dr Janet MacPherson
Consultant Psychiatrist

Ms Linda Hutchinson
Carer Advocate,
C.A.U.S.E. for Mental Health.

Ms. Cathy McCullough
Young Persons representative

Mrs Joelle Gartner
Teacher, Psychotherapist

Ms. Kimberley McConkey
Young Persons representative

Mr Seamus McGarvey
Sperrin Lakeland Trust

Dr Lisheen Cassidy
Consultant Child & Adolescent Psychiatrist

Dr Harry Rafferty
Educational Psychologist

Dr Aisling McElearney
Education Advisor, NSPCC

Dr John Hunter
Inspector
ETI

Ms Bronagh Muldoon
NSPCC

Dr Maura McDermott
Consultant Child and Adolescent Psychiatrist

Mr Sean Ferrin
Secretary to the Committee

Psychological Wellbeing Sub-Group

Mr Stephen Dornan
Children Services Manager

Dr Tom Teggart
Consultant Clinical Pscyhologist

Mrs Arlene Healey
Centre Manager/Consultant Family Therapist

Mr Billy McCullough
Senior Lecturer (retired)

Mrs Marie Roulston
Children's Services

Mr Hugh Griffiths
Senior Lecturer in Social Work

Tier 1 & 2 Sub Group

Ms Moira Davren
Convenor – Child and Adolescent MH working Committee

Dr Noel McCune
Consultant Child and Adolescent Psychiatrist

Ms Bronagh Muldoon
Children's Services Manager

Mrs Maureen Ferris
Assistant Director of Nursing

Dr Carolyn Mason
Nursing and Midwifery Advisory Group

Mr David Gilliland
Childcare Directorate

Dr Janet Bothwell
Consultant Community Paediatrician

Dr Aisling McElearney
Education Advisor, NSPCC

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Clinical Nurse Manager, CAMHS

Ms Brenda Byrne
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Dr Karen Kearney
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Dr Lisheen Cassidy
Consultant Child & Adolescent Psychiatrist

ANNEXE 5

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ANNEXE 6

GLOSSARY

(ADHD) Attention Deficit Hyperactivity Disorder

(A&E) Accident and Emergency

(AHP) Allied Health Professionals

(AHR) Acute Hospitals Review

(ASD) Autistic Spectrum Disorder

(CAMH) Child Adolescent Mental Health

(DHSSPS) Department of Health, Social Services and Public Safety

(EOTAS) Education other than at School

(EU) European Union

(HAS) Health Advisory Service

(H&PSS) Health and Personal Social Services

(IQ) Intelligence Quotient

(KSF) Knowledge for skills framework

(LAC) Looked After Children

(NI) Northern Ireland

(NICAPS) National Inpatient Child and Adolescent Psychiatry Study

(NICE) National Institute Clinical Excellence

(NIO) Northern Ireland Office

(NSF) National Service Framework

(PCIS) Patient Centred Information System

(PMH) Primary Mental Health

(RCSLT) Royal College of Speech and Language Therapists

(R&D) Research & Development

(SEHD) Scottish Executive Health Department

(SHSSA) Strategic Health and Social Services Authority

(SLCN) Speech, Language and Communication Needs

(SLT) Speech and Language Therapy

(UK) United Kingdom

(WTEs) Whole Time Equivalents