THE REVIEW OF MENTAL HEALTH & LEARNING DISABILITY (NORTHERN IRELAND)

VISION OF A COMPREHENSIVE CHILD AND ADOLESCENT MENTAL HEALTH SERVICE.

CONSULTATION DOCUMENT
NOVEMBER 05

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FOREWORD

This further report from the Review of Mental Health and Learning Disability (N. 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 also 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. Crucially, also, consultation meetings were held with children and young people themselves, giving them the chance 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 enormous deficits in child and adolescent mental health service provision in Northern Ireland, with many important recommendations aimed at correcting these shortfalls. We fully recognise the resource implications of implementing these recommendations, but 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 two years in developing this report and I commend it to you.

David R Bamford (Professor)
Chairman
October 2005

INTRODUCTION

The Review of Mental Health and Learning Disability (NI) recognises that any review of 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. It will be society's failure, if we do not break free from this vicious circle that condemns generation after generation 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 these services to be wholly inadequate. Despite many examples of good practice the over-all quality, consistency and accessibility of services is so inadequate that urgent strategic action is needed to tackle the shortages in CAMH services in NI.

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 one, and many of the recommendations will have significant read across to any child with a mental health difficulty which presents to CAMH services.

The structure of the report is as follows; the first chapter explains the principles that underpin the vision of a comprehensive CAMH service. In the second chapter, demographic and epidemiological evidence are provided on the client base to which a CAMH service should be available. Chapter three 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 four to seven, 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 four, focussing 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 five recommends services which should be developed to promote good mental health and prevent mental ill health amongst children. In chapter six detailed recommendations are provided which address the gaps in current services. Chapter seven provides recommendations for enhancing the capacity of all CAMH services.

This report provides a new vision for CAMH services, 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 FOR 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, focus group consultation*

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 can be 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
- The ability to use psychological distress as a developmental process, so that it does not hinder or impair further development. [1]

1.3 Children and young people have mental health needs if, for one reason or another, they experience impaired ability in any one of these areas.

1.4 The Review believes that the goals of a comprehensive CAMHS should embrace the promotion of good 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.

1.5 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* [2] [3].

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 individualized 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.

Least restrictive 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 organizations should be partnered with mental health and provider agencies to promote the child's healthy community participation.

Family focused 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 organized 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 maximize 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 NI'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.

1.6 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 the following sections of 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, Questionnaire consultation*

2.1 A CAMH Service has responsibilities to children who experience or are at risk of experiencing mental ill-health. 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 those problems that meet the requirements of ICD 10, [4] 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* might be used for a small proportion of cases of mental disorders. Usually, it is reserved for the most severe cases. For example, more severe cases of depressive illness, psychotic disorders and severe cases of Anorexia Nervosa could be described in this way. [5]

2.2 Different terminologies used across the Medical, Educational and Social care settings to describe the problems that children and adolescents develop may present some confusion. Child and adolescent psychiatrists are trained in a broad bio-psycho-social model. The training of community paediatricians tends to be in a more narrowly medical model. In order to better understand terms that may be used the following paragraphs will attempt to explain some of the differences.

2.3 In the Educational sector for example, educationalists may use the term *emotional and behavioural difficulties (EBD)* when the problems they encounter are severe, persistent and associated with other problems. 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 which 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 which 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 Asssessment Report on CAMH 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." [7]

Demographics and Epidemiology

2.6 NI has a population of approximately 1.7 million cited in the Census 2001, of which

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

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

2.8 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]

2.9 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]

2.10 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.

2.11 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. [12] Lowest estimates suggest that 0.075% (340) will require inpatient services. [13]

2.12 The committee have explored the following areas in respect of the demographics/epidemiological factors that will inform and shape future development of services and practice.

Lifestyle

2.13 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. [14]

2.14 With reference to sexual orientation of young people in NI, three 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. [15] [16] [17]

Social Environment

2.15 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 Office of National Statistics 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. [18]

2.16 Within NI 38% of all households presenting as homeless in 2001/2002 were families with children and young people. [19] Lone parent households reflect 22% of the 36% of households who have dependant children and young people. [20] 2,392 children and young people under the age of 16 were affected by divorce in 2001. [21]

2.17 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. One in six of those who died in conflict were aged nineteen 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. [22] [23] [24] [25] [26] [27]

2.18 It is important to note that NI has a higher overall prevalence of mental illness of a magnitude estimated at 25% higher than England. [28] 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

2.19 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. [29]

2.20 Children with physical disability are at higher risk of developing mental health problems. [30] 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. [31]

Children with a learning disability

2.21 "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". [32]

2.22 Children and adolescents with learning disability are proportionately more vulnerable to the full range of mental health disorders – typically about 40%. [33] Prevalence rates are 3-4 times higher in those with significant learning disability. [34]

Children with Autistic Spectrum Disorder (ASD)

2.23 Prevalence estimates for Autism vary across studies. However according to recent reviews there is general agreement that ASD affect approximately 60 per 10,000 under 8 year olds of whom 10 – 30 per 10,000 have narrowly defined autism. [35] 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, [36]
- ASD: a guide to classroom practice [37]
- The Education of Children and Young People with ASD. [38]

Children at risk of Suicide and Self Harm

2.24 Suicide and Deliberate Self Harm are closely related phenomena although they differ in important ways. 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. [39] 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. 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 from media reports suicide seems to be on the increase amongst older adolescents and young adults in NI in recent years. *(The DHSSPS has established a Suicide Prevention Taskforce, which is currently investigating the issue).*

Children with Attention Deficit Hyperactivity Disorder (ADHD)

2.25 The estimated prevalence of this disorder is somewhere between 3 and 7 per cent of school age (0-15) children. [40] 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.

Children with Feeding and eating disorders

2.26 Anorexia nervosa is cited as the third commonest chronic illness of adolescence [41] while over 50% of parents report one problem feeding behaviour and over 20% report multiple problems [42] 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

2.27 It is by now well established that young people in care have markedly higher rates of mental health problems than the general population. [43] [44] 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. [45]

- 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. [46] This is comparable to rates found in studies from other parts of the UK.

- There were 1,531 children and young people on the child protection register on 31st March 2002, the majority (40.5%) of these were in the category of neglect, 33.9% as physical abuse and 15.4% as emotional abuse, 11.2% as sexual abuse. [47]

Demand on Social Services Departments

2.28 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 a quarter were under the age of 5, a third was 5-11 years old, three in ten were aged 12-15 years and one in ten 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% were in relation to children with a disability. A further 5% were in relation 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 three 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.

- There were 2,270 child protection investigations in 2001/02 (50.3 per 10, 000 child, approx 1 in every 200 children), a figure which has been decreasing every year since 1998/99. [48]

- A total of 5335 offences against children under 17 were recorded (also known as notifiable offences) by the PSNI in the year 2003/04. These included 4404 offences against the person, 92% of which were classified as minor assaults and 2% of which were classified as serious assaults, manslaughter or murder, 3% were classified as other offences against the person, 2% were classified as cruelty to a child and 1% were classified as child abduction.

- There were 931 recorded sexual offences against children and young people aged up to 17 years. This is the highest figure for sexual offences against children recorded over the past 5 years and represents an 18% increase from 2002/03. Of these offences 54% were classified as indecent assault, 17% as indecent exposure and 15% as rape. A further 7% were classified as unlawful carnal knowledge, 3% were classified as gross indecency with a child and 3% were classified as buggery and 1% were classified as other sexual offences. [49]

Children who misuse Alcohol and Substances

2.29 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. [50] [51]

- 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.

- The combination of alcohol misuse and smoking tobacco is a powerful gateway to illegal drug misuse.

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

Children in conflict with the law. (Youth Justice)

2.31 Criminal Activity was surveyed in NI. [52] 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. [53]

Children from Ethnic minorities

2.32 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?
- Are psychiatric disorders more common in ethnic minority and migrant children?

CHAPTER 3

CURRENT CAMH SERVICES AND DEFICITS IN PROVISION

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.

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

User and carer views of current service provision.

3.1 The review commissioned a consultation to explore service user and carer views and opinions about CAMH services. This exercise was limited by the time and resources available to complete it and does not represent a comprehensive investigation of user and carer views of CAMH services in the region. It does, however, provide a useful indication of the types of opinions and concerns that people hold based on real experiences of using services. The investigation employed a two stage qualitative approach consisting of an open ended questionnaire and a series of four focus groups. Nineteen services across three tiers took part in the questionnaire study providing a 'snap-shot' of views with 63 questionnaires completed by parents/carers and young people. 23 people participated in focus group discussions, two with parents/carers and two with young people.

3.2 Findings from the questionnaire study showed that to a large extent (around 60% of comments received) 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. On the whole, participants in these discussions were more critical of services than were those who completed questionnaires and close to 90% of the comments received expressed a negative view or experience of some aspect of CAMHS. 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.

3.3 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.

3.4 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. [54] 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.

3.5 In addition to the specific consultation exercise undertaken by the Committee, 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.

Age range for children's services

3.6 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.

3.7 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 tier 1

3.8 A detailed overview of the four tier model is given in Chapter 4 of this report. The four tier model has never been formally adopted in Northern Ireland, however specialist professionals have tended to conceptualise current NI provision within this model.

3.9 NI CAMH Services are delivered by a range of providers across the four HPSS Boards. The current services uphold the aspirations of the four tier approach. [55] However against a backdrop of resource constraint (workforce, financial, education, governance) progress in developing the four 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.

3.10 There has been limited development of tier 1 services. Where developments have been made, it is the case that 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.

Community services at tier 2

3.11 Likewise developments in tier 2 have been limited. Some areas are developing paediatric services for children with ADHD and ASD. Health visitors are developing tier 1 and 2 services 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 province wide however.

At tier 1 and tier 2

- Adolescent support services/projects are provided by a range of professionals and Providers across the four 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 3 management of cases.

- Sure Start Early Intervention programme continue to be established across the four Boards.

- Statutory and voluntary family centres contribute to the 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 that compliment tier 1 and 2 services.

- 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.

Community services tier 3

3.12 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. 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 services to 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.

Mental Health Inpatient and Secure Residential Care Units – Tier 4

3.13 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. Multidisciplinary staffing.

- 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. No day places. Multidisciplinary staffing.

- 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. Multidisciplinary Staffing.

- 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. Residential social work staffing with clinical psychology sessions.

3.14 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 location Forster Green site Belfast and this will provide 16 places and 2 intensive care places.

3.15 The NICAPS study of inpatient places in England and Wales showed that current provision of beds was not based on need. [56] The average was 3.4 beds per 100,000 under 18 population. Based on work by Kurtz et al [57] and NICAPS it is recognised that around 20 to 40 CAMHS beds are required per one million total population. [58] This includes places for younger children and for adolescents.

3.16 For Northern Ireland 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.

Transition to Adult Mental Health services

3.17 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 that greater flexibility are required.

First Episode Psychosis

3.18 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. [59] 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

3.19 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.

3.20 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

3.21 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.

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

3.22 It would be expected that improved emergency provision in CAMH services would reduce tier 4 demands.

3.23 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

3.24 The NHS Health Advisory Service [60] and Audit Commission [61] reports on CAMH services estimated that 25% of the workload of community paediatricians is in the field of mental health. This is equivalent to tier 2 work. 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 are seen.

3.25 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 liasing 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.

3.26 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 part time trained nursing or psychology input to deliver behavioural interventions in ADHD clinics.

Learning disability services

3.27 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.

3.28 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.

3.29 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.

3.30 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 ASD

3.31 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. [62] 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.

3.32 Children and adolescents referred to specialist CAMH services and community paediatrics in NI for assessment and treatment are in the main placed on the 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.

3.33 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 [63] 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 [64] [65] Interventions which focus on reducing isolation and integrating individuals into society are key to addressing the needs of these young people. [66] 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)

3.34 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.

3.35 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.

3.36 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.

3.37 These children have significant need for mental health supports in view of the levels of difficulty identified. [67] 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 [68] or multiple foster placements and unclear planning. [69] 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. [70] 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 [71] which would assist the development of tailored, equitable services for this population.

Alcohol and Substance Misuse

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 HAS report 'The Substance of Young Needs' [72] in arguing for the development of a four 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.

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 http://www.rmhldni.gov.uk/

Feeding and Eating Disorders

3.40 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 by the committee.

The Review has produced a Strategic Vision for Adult Mental Health which is available on http://www.rmhldni.gov.uk/

3.41 The NICAPS study [73] 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.

Services for Children and Adolescents with Challenging Behaviour

3.42 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 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.

3.43 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’.

3.44 The ‘Children Matter’ Review [74] 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

3.45 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.

3.46 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. 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. [75]

3.47 In addition to these areas of work, many schools in NI have developed dedicated counselling services and these are viewed positively. They have proved a significant and accessible response for young people with mild to moderate mental health problems. Contact Youth provide valuable counselling services in some schools throughout NI but the committee also heard examples of excellent counselling initiatives by individual schools. Only a few of these made good use of consultation from local specialist CAMH teams. Others see the need for such consultation but specialist CAMH services are unable within existing resources to provide it.

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

3.49 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

3.50 There is no dedicated forensic CAMH service in existence in NI. Limited services are provided to individual young people by tier 3 specialists on the basis of catchment area and by contracted psychology input to the secure residential facilities. Specialist tier 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.

3.51 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.

3.52 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.

3.53 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

3.54 In the course of the review the committee learned 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.

3.55 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.

3.56 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 leading 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

3.57 Children who have physical disabilities and long-term health problems have higher rates of mental health problems. 76 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.

3.58 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 neuropsychiatric 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

3.59 As is demonstrated above, it is acknowledge 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.

3.60 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 twenty-five 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.

3.61 O'Rawe [77] 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.

3.62 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…".

3.63 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 of an adolescent inpatient service. These developments have been hindered by the lack of a strategic or operational plan which lays out a phased and managed approach. The 1998 Policy Statement on Child and Adolescent Mental Health Services [78] issued 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.

3.64 One of the targets set in the 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 through an epidemiological study was never addressed and any commissioning strategy without this will inevitably only be partially informed. An epidemiological study of the prevalence of mental disorder in children in NI identical to the Meltzer et al study should be commissioned as soon as possible.

3.65 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 wellbeing 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) 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. *Para 3.63*

2) An epidemiological study of the prevalence of mental disorder in children in NI identical to the Meltzer et al study should be commissioned as soon as possible. *Para 3.64*

CHAPTER 4

THE FUTURE ORGANISATION OF CAMH SERVICES

Chapter four 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 five, six and seven 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.

"…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 Focus group consultation*

Developing an integrated children's service system

4.1 In 'The optimal location for CAMHS – A response by YoungMinds' [79] 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.

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

4.2 The Committee considered these points when examining possible management and commissioning arrangements for a future comprehensive CAMH service. They 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 the committee concluded that there was no weight of evidence which would suggest that this risk was greater within Children's Services Directorates than within existing relationships within 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, consistent with the Draft Regional Strategy, 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. [80] [81] This was recognised in the Audit Commission Misspent Youth report. [82] When interventions are delivered in schools it is vital to involve pupils in any initiatives to promote better behaviour. [83]

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 Clinical Networks (MCNs)

4.10 The concept of Managed Clinical Networks (MCNs) was first set out in the report of the Acute Services Review. [84] It was followed by a Management Executive Letter (MEL) [85] 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….' [86]

4.11 The key ideas behind MCNs 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
- MCNs are consistent with a renewed emphasis on the role of primary care in acute health care.

4.12 Managed Clinical 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. [87]

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. The committee recommends that a MCN should be developed throughout CAMH services in NI.

4.14 The Committee recommend that a regional development worker is appointed to facilitate the development of management structures at both a local level and of a regional Managed Clinical Network 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.

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.

Models of Service delivery.

4.16 The CAMH Committee 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.

4.17 A number of different potential service delivery systems were examined. These are discussed in some depth in a paper prepared by Dr. Janice Thompson. This paper is available at http://www.rmhldni.gov.uk/. It was clear that some of the organisational structures explored were unsuitable as models of service delivery, however the Committee did take cognisance of the best practice ideas contained within each of them.

4.18 Of those systems and models examined, both within Dr. Thompson's report and by the Committee in general, it was concluded that the Four 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.

4.19 In addition, one of the recurring themes identified through-out the Committee's 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. The Committee concluded that the four tier model would be most effective at cementing these relationships.

4.20 To ensure that all services are known to all agencies and to facilitate more effective collaboration and planning the Committee recommend that an annual CAMH service mapping exercise similar to that in England should be carried out by an independent research institute.

The Four Tier Model

4.21 The tiered framework is intended, first and foremost, to be a strategic and planning tool. Its second purpose is as a communication tool. The third use is as a blueprint for how services are practically delivered on the ground. This framework allows a better focus on the service functions required of mature, effective and efficient CAMHS through a model that spans the agencies involved and their working practices. The Committee recommends that the Four Tier model should be developed in NI, re-emphasising the flexibility of the model as it was originally conceived. The model is divided into four tiers of service with specific, but overlapping areas of responsibility. These are described below:

Tier 1

4.22 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 include GPs, other primary health carers, staff of child health services, school staff, 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
- Inclusion of children, young people and families as partners in the intervention process.

Tier 2

4.23 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.

4.24 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
- Inclusion of children, young people and families as partners in the intervention process.

Tier 3

4.25 Tier 3 services are more specialised. 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
- Inclusion of children, their families or carers and other agencies as partners in the process.

Tier 4

4.26 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 Inpatient 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
- Contribute to training, advice and consultation to tiers 1,2,3 and 4.

Care Pathways

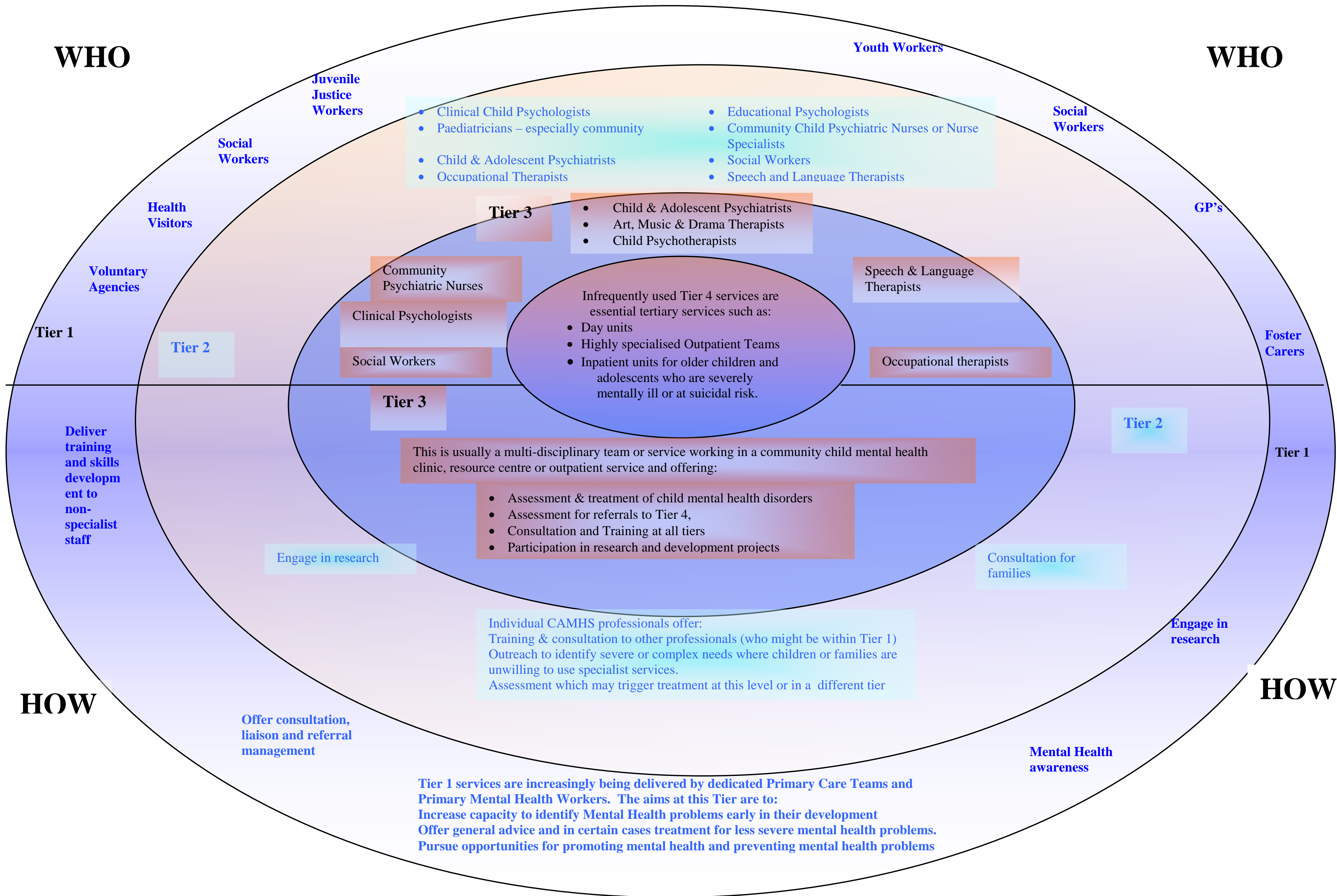
4.27 There is a need for clear pathways of care both into and out of tier 4 services. Models for improving the links between tier 3 and 4 services include the development of posts that bridge both inpatient and community services. These include social work, psychology, nursing, consultant psychiatrists and other posts. These developments have helped improve post discharge care and ongoing work in the community.

4.28 The care pathway into tier 4 services of children and adolescents with high risk, complex mental health needs must be defined. In most cases referral to CAMH tier 3 services should provide the initial assessment and consultation with the child and family. In general the tier 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.

Interfaces

4.29 The four tier model provides the core CAMH service but it is recognised that these services do not exist in isolation. CAMH services interface with a variety of other services and agencies.

4.30 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. 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. [88]


WHO
WHO
Youth Workers
Juvenile Justice Workers
Social Workers
Social Workers
Health Visitors
GP's
Voluntary Agencies
Foster Carers
Tier 1
Tier 2
Clinical Child Psychologists
Paediatricians – especially community
Child & Adolescent Psychiatrists
Occupational Therapists
Educational Psychologists
Community Child Psychiatric Nurses or Nurse Specialists
Social Workers
Speech and Language Therapists
Tier 3
Child & Adolescent Psychiatrists
Art, Music & Drama Therapists
Child Psychotherapists
Community Psychiatric Nurses
Speech & Language Therapists
Clinical Psychologists
Social Workers
Occupational therapists
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
Tier 2
Tier 1
Deliver training and skills developm ent to non-specialist staff
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 & treatment of child mental health disorders
Assessment for referrals to Tier 4,
Consultation and Training at all tiers
Participation in research and development projects
Engage in research
Consultation for families
Individual CAMHS professionals offer:
Training & 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
Engage in research
HOW
HOW
Offer consultation, liaison and referral management
Mental Health awareness
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

Paediatrics/Child Health

4.31 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.

4.32 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 tier 3 colleagues for consultation and support.

4.33 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 and, when resources permit, joint clinics should be developed for management of the most complex cases.

Age range of services

4.34 The provisions of the key legislation which underpins child care, the Children (NI) Order 1995, should guide the policy decision on the appropriate age range of services for CAMH services.

4.35 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. [89] 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.

4.36 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.

Community services

4.37 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 issues for children

4.38 The main legislation underpinning designing and delivering CAMH services is the Children (NI) 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 within powers given by the present Mental Health (NI) Order 1986. Despite this, the committee 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 [90] equally important.

4.39 A sub group of the Review's Legal Issues Working Committee is addressing all legal issues relevant to the CAMH service care area. The terms of reference for this group were;

'Consider the interface among relevant pieces of existing legislation, conventions and other standards in terms of the principles and purpose(s) for proposed new mental health and learning disability legislation for children and adolescents.'

Specifically to;

- Examine the principles and make recommendations
- Examine the purposes served by current legislation
- How to meet such principles and purposes under new legislation
- What principles should be in new legislation/Code of Practice

Recommendations

3) 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. *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 and to develop the necessary collaboration in this field. *Para 4.6*

5) 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. *Para 4.8*

6) CAMH services should be located in appropriate child friendly, non-stigmatising environments. *Para 4.9*

7) A MCN should be developed throughout CAMH services in NI. *Para 4.13*

8) A regional development worker should be appointed to facilitate the development of management structures at both a local level and of a regional Managed Clinical Network across NI. *Para 4.14*

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

10) The Committee recommend that an annual CAMH service mapping exercise similar to that in England should be carried out by an independent research institute. *Para 4.20*

11) The Committee recommends that the Four Tier model should be developed in NI, re-emphasising the flexibility of the model as it was originally conceived. *Para 4.21*

12) Community paediatric services and specialist CAMH services should develop clear referral pathways and guidelines for the assessment and treatment of ADHD and ASD and when resources permit joint clinics should be developed for management of the most complex cases. *Para 4.33*

13) CAMH services should ordinarily cover children and young people up to their 18th birthday. *Para 4.36*

14) 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. *Para 4.37*

CHAPTER 5

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

Those at risk of developing Mental Ill Health

5.1 Good mental health in children is a positive indicator of the future well being of the adults they become. It could be considered as an indicator of the quality of our society and its services. Forming meaningful relationships and coping with the responsibilities of parenthood depends largely on learning during childhood.

5.2 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 four tiers have a role to play in helping children recover and ensuring that they are protected.

5.3 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 will 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.

5.4 Schools also have a key role to play in the promotion and enhancement of mental health. Resilience can be built in childhood and adolescence which can reduce the likelihood of mental health problems developing in later life. Primary and secondary schools should implement appropriate programmes to enhance the mental health of the young. (See Mental Health Promotion Expert Working Committee report). http://www.rmhldni.gov.uk/.

Early Intervention/Infant Mental Health

5.5 Health promotion and other preventative strategies are aimed at very young children (infants) and parent-infant relationships in particular. Early intervention strategies in ‘at risk’ communities or families which promote good parent-child relationships will be more cost effective than trying to repair damage at a later stage and they may prevent the development of attachment disorders, and other problems which 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 and promotion of healthy attachments would greatly enhance their impact in this area.

5.6 Factors contributing to effective outcomes include:

- The combination of an educational focussed component for the child and a supportive parent focussed activity.
- Intervention beginning with very young children.
- Intervention sustained over time.
- Community based intervention with partnerships between parents, the community and professionals.

5.7 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 the Committee's 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.

5.8 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.

5.9 Tier 2 & 3 services are aimed mainly at behavioural problems which 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. [91] 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. [92] 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.

5.10 Parental psychiatric illness will significantly interfere with parents' ability to make use of parent management programmes. Professionals should be aware that multiagency working and possible onward referral to Adult Services maybe required when parents have significant mental health needs. The committee endorse the recommendations of 'Patients as Parents' [93] which highlights 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" [94] explores this interface and is very useful for raising awareness and for training purposes.

Suicide and Self Harm

5.11 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 (http://www.rmhldni.gov.uk/) As suicide is nearly always associated with

mental health disorders and illness it makes most sense to orientate prevention to identifying and effectively treating young people with disorders which place them at risk of suicide. Good follow up procedures after attempted suicide is an essential component of CAMH service provision.

Recommendations

15) 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. *Para 5.3*

16) The development of infant mental health and early intervention services should be pursued as a preventative strategy throughout NI. *Para 5.8*

17) A strategy for the evaluation of parenting programmes should be developed. *Para 5.9*

18) A suicide prevention strategy for NI should be developed. *Para 5.11*

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 [95] 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 Information should be developed for users/carers and other agencies explaining the range and scope of CAMH services, as a priority.

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 which should be multiagency and take into consideration the impact of the proposed regional specialist social/emotional/psychological unit. (see para 6.40)

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. [96]

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. Services geared towards early diagnosis and interventions in an age appropriate setting should be developed.

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. [97]

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 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. This can take place in an inpatient setting, or exclusively as an outpatient assertive outreach model, or in conjunction with day unit provision. It could be delivered by collaboration between tier 4 and tier 3 services in conjunction with other agencies.

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 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. The development of models of assertive outreach/intensive treatment for young people with these complex needs should be considered by commissioners.

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. To facilitate this, 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

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

Learning Disability

6.19 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.

6.20 The Learning Disability Working Committee report [98] 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.

6.21 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.

6.22 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.

6.23 Future commissioning of specialist mental health services for children and adolescents with learning disabilities should become an integral part of the commissioning of specialist mental health services for all children. 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 locally 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

6.24 The review has produced a paper detailing recommendations for services to individuals with ASD. The CAMH committee endorses 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. The CAMH committee agree that creation of a separate programme of care would divert scarce resource from the development of direct service provision for those affected by ASD. The committee acknowledges 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. [99]

6.25 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.

6.26 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

6.27 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.

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

6.29 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.

6.30 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.

6.31 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.

6.32 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

6.33 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. The Committee supports the recommendations of the Alcohol and Substance Misuse Expert Working Committee report. Details can be found at. (http://www.rmhldni.gov.uk/)

Feeding and eating disorders

6.34 The NSF for Mental Health [100] recommends that treatment of severe eating disorders be commissioned from specialist services.

6.35 The National Institute Clinical Excellence [101] 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.

6.36 The NICAPS study [102] 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.

6.37 Children and adolescents with eating disorders should be cared for within CAMH services providing quality care. [103] 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.

6.38 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.

Services for Children and Adolescents with Challenging Behaviour

6.39 As with services for Looked After Children, specialist community based Tier 2 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 some parts of NI. but further development will necessitate some enhanced capacity at tiers 2 and 3.

6.40 The 'Children Matter' Review [104] 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. The Committee supports plans for a regional specialist social/emotional/psychological unit to complement acute psychiatric hospital provision.

Youth Justice and Forensic Services.

6.41 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.

6.42 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. [105]

6.43 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

Minority Groups

6.44 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.

6.45 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 particular groups of people.

6.46 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

6.47 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.

6.48 The Committee 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.

6.49 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

6.50 Mental health services should be provided to children with physical and sensory disabilities and illnesses, in support of regional paediatric specialties. This should be in addition to local provision. This is likely to require planning and commissioning on a regional basis and will require consideration when the specialist services are commissioned.

Recommendations

19) 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*

20) Information should be developed for users/carers and other agencies explaining the range and scope of CAMH services, as a priority. *Para 6.5*

21) Further expansion of inpatient provision after these places are operational should depend on a reassessment of need which should be multiagency and take into consideration the impact of the proposed regional specialist social/emotional/psychological unit. *Para 6.8*

22) 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. *Para 6.9*

23) 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. Services geared towards early diagnosis and interventions in an age appropriate setting should be developed. *Para 6.11*

24) The development of models of assertive outreach/intensive treatment for young people with these complex needs should be considered by commissioners. *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 6.17*

26) Specialist CAMH services need to continue to develop close working relationships with the learning disability services. *Para 6.21*

27) 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. *Para 6.22*

28) Future commissioning of specialist mental health services for children and adolescents with learning disabilities should become an integral part of the commissioning of specialist mental health services for all children. *Para 6.23*

29) Future severe learning disability inpatient provision should be locally based child and adolescent specific units. *Para 6.23*

30) 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. *Para 6.23*

31) 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 6.25*

32) ASD services should be locally available, multi-agency and multidisciplinary including an educational specialist and a family support worker. *Para 6.26*

33) Clinical and care management for ASD should be across the broad children's service and come under the Children's Services Directorates. *Para 6.26*

34) A senior manager within the children's directorate should be responsible for co-ordination of ASD services for children. *Para 6.26*

35) Close collaboration between social services and CAMH services should be a cornerstone of LAC services. *Para 6.28*

36) A model that prioritises and meets the needs of LAC through-out 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. *Para 6.31*

37) 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. *Para 6.32*

38) 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 6.33*

39) Children and adolescents with eating disorders should be cared for within CAMH services providing quality care. *Para 6.37*

40) 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. *Para 6.37*

41) Specialist outpatient services for feeding and eating disorders should be developed in NI. *Para 6.38*

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

43) Specialist community based Tier 2 teams for children with challenging behavious need to be developed or enhanced through training, support and access to consultation. *Para 6.39*

44) Specialist CAMH services should develop close working relationships and care pathways with the youth justice teams. *Para 6.41*

45) A regional forensic CAMH Service should be developed in NI. *Para 6.43*

46) 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. *Para 6.44*

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 particular groups of people. *Para 6.45*

48) 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. *Para 6.46*

49) Funding arrangements for voluntary and community agencies should be extended to a minimum of 3-5 years rather than on an annual basis. *Para 6.47*

50) 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. *Para 6.48*

51) Statutory agencies should include the appropriate voluntary sector agencies as full partners when developing CAMH services. *Para 6.49*

52) Mental health services should be provided to children with physical and sensory disabilities and illnesses, in support of regional paediatric specialties. *Para 6.50*

CHAPTER 7

ENHANCING THE CAPACITY OF CAMH SERVICES

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.

"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, Focus group consultation*

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

Current Budgetary situation

7.1 It is difficult to find out what resources are allocated to CAMH Services in NI. O'Rawe [106] 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. The Committee therefore recommends that CAMH services should have their own identifiable budget.

Information Management

7.2 Although 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, 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. 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

7.3 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.

7.4 Currently within NI existing staffing levels do not even meet present requirements. Vacancies exist in all disciplines but especially in psychiatry, psychology, community paediatric and nursing posts. 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 Northern Ireland. 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.

7.5 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 [107] places additional demands on staff to ensure the wider needs of the family are also addressed. The carers 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.

7.6 From the perspective of clinical and social care governance as highlighted in Best Practice Best Care [108] 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.

7.7 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.

7.8 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 their many other commitments. Within the DHSSPS best practice guidelines [109] 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.

7.9 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.

7.10 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
- Drama therapy.

7.11 In the management of service users with very complex conditions, e.g. ASD / Aspergers 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.

7.12 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 disorders
- Alcohol and substance misuse
- Forensic
- Looked after children
- Autistic spectrum disorder (ASD)
- First episode psychosis
- Learning disabilities.

Further work is required to explore these 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.

7.13 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.

7.14 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: [110]

- Consolidating the skills of primary care and supporting education regarding CAMH Services.
- Aiding recognition of CAMH disorders and referral on
- Assessing and treating some individuals with mental health problems who were considered appropriate for management at tier 1 and tier 2.

7.15 A Department of Health Review [111] on PMH workers concluded, "the development of CAMH services in primary care seems to be highly dependent on the new PMH worker posts". It noted that 1/3 of providers surveyed had developed such posts and a further 25% had plans to do so.

7.16 In England and Wales there are up to 700 PMH workers in post and the National Service Framework [112] 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.

7.17 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 the committee estimate that for NI an equivalent number of PMH workers associated with each CAMH team would be 6. The Committee recommend that the role and complement of PMH workers be expanded within NI.

7.18 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.

7.19 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.

7.20 The NSF [113] has estimated that in England a generic specialist multidisciplinary CAMH service tier 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 [114] 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 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 the committee estimate that in NI specialist CAMH teams would be needed of 25 and 20 WTEs respectively. For this reason the Committee believe that 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 four tier model in CAMH services in NI.

7.21 Finally the committee would emphasize 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. A developed career path for all professionals inclusive of new role developments in CAMH services would also greatly enhance recruitment.

Education, Training and Research

7.22 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.

7.23 Insufficient numbers are being trained to meet health and social services needs let alone other initiatives such as Sure Start. 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

7.24 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 which relates to child and adolescent mental health are limited in NI. Academic posts from the range of professions involved in CAMH service should be developed to foster a local climate of research and critical enquiry. An academic department of child psychiatry should be a priority.

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

Psychotherapy services

7.26 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.

7.27 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.

7.28 There are very few dedicated family therapist and child psychotherapist posts in CAMH services in NI and the role of these disciplines should be enhanced and further developed.

Speech and Language services.

7.29 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.

7.30 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.

7.31 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.

7.32 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.

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

Occupational Therapy services

7.34 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 [115] document where occupational therapists were identified as one of the core professions that offer services within child and adolescent mental health.

7.35 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. [116]

7.36 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. [117]

7.37 "Standards for Child and Adolescent Mental Health Services" [118] 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.

7.38 This blatant gap in service provision in CAMH services needs to be addressed urgently with occupational therapy representation being a core element of CAMH provision, and service and workforce planning in NI. A minimum of one occupational therapist is needed per 100,000 population to work in day unit/community/outpatient services. An additional occupational therapist is required for every in-patient unit. [119]

Clinical and Social Care Governance

7.39 Clinical and social care governance has been adopted by health services as a way of integrating financial control, service performance and clinical quality [120] 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.

7.40 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.

7.41 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 four 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

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

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

55) The Committee recommend that the role and complement of PMH workers be expanded within NI *Para 7.17*

56) 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 four tier model in CAMH services in NI. *Para 7.20*

57) A developed career path for all professionals inclusive of new role developments in CAMH services would also greatly enhance recruitment. *Para 7.21*

58) 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 7.23*

59) Academic posts from the range of professions involved in CAMH service should be developed to foster a local climate of research and critical enquiry. *Para 7.24*

60) Governance and quality mechanisms in CAMH services should be further developed and implemented across NI. *Para 7.25*

61) Family therapist and child psychotherapist posts in CAMH services in NI and the role of these disciplines should be enhanced and further developed. *Para 7.28*

62) The key role that speech and language therapists (SLTs) play within CAMH services should be recognised. These SLT services should be adequately planned and resourced, based on local demography and need. *Para 7.33*

63) Occupational therapy services should be developed as a core element of CAMH provision. *Para 7.38*

REPORT RECOMMENDATION LIST

"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 Focus group 4*

1. 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. *Para 3.63*

2. An epidemiological study of the prevalence of mental disorder in children in NI identical to the Meltzer et al study should be commissioned as soon as possible. *Para 3.64*

3. 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. *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 and to develop the necessary collaboration in this field. *Para 4.6*

5. 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. *Para 4.8*

6. CAMH services should be located in appropriate child friendly, non-stigmatising environments. *Para 4.9*

7. A MCN should be developed throughout CAMH services in NI. *Para 4.13*

8. A regional development worker should be appointed to facilitate the development of management structures at both a local level and of a regional Managed Clinical Network across NI. *Para 4.14*

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

10. The Committee recommend that an annual CAMH service mapping exercise similar to that in England should be carried out by an independent research institute. *Para 4.20*

11. The Committee recommends that the Four Tier model should be developed in NI, re-emphasising the flexibility of the model as it was originally conceived. *Para 4.21*

12. Community paediatric services and specialist CAMH services should develop clear referral pathways and guidelines for the assessment and treatment of ADHD and ASD and when resources permit joint clinics should be developed for management of the most complex cases. *Para 4.33*

13. CAMH services should ordinarily cover children and young people up to their 18th birthday. *Para 4.36*

14. 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. *Para 4.37*

15. 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. *Para 5.3*

16. The development of infant mental health and early intervention services should be pursued as a preventative strategy throughout NI. *Para 5.8*

17. A strategy for the evaluation of parenting programmes should be developed. *Para 5.9*

18. A suicide prevention strategy for NI should be developed. *Para 5.11*

19. 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*

20. Information should be developed for users/carers and other agencies explaining the range and scope of CAMH services, as a priority. *Para 6.5*

21. Further expansion of inpatient provision after these places are operational should depend on a reassessment of need which should be multiagency and take into consideration the impact of the proposed regional specialist social/emotional/psychological unit. *Para 6.8*

22. It is vital that collaborative arrangements between Adult Mental Health services and CAMH services are put in place to ensure that the suffering in a child or parent does not go undetected or untreated. *Para 6.9*

23. 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. Services geared towards early diagnosis and interventions in an age appropriate setting should be developed. *Para 6.11*

24. The development of models of assertive outreach/intensive treatment for young people with these complex needs should be considered by commissioners. *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 6.17*

26. Specialist CAMH services need to continue to develop close working relationships with the learning disability services. *Para 6.21*

27. 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. *Para 6.22*

28. Future commissioning of specialist mental health services for children and adolescents with learning disabilities should become an integral part of the commissioning of specialist mental health services for all children. *Para 6.23*

29. Future severe learning disability inpatient provision should be locally based child and adolescent specific units. *Para 6.23*

30. 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. *Para 6.23*

31. 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 6.25*

32. ASD services should be locally available, multi-agency and multidisciplinary including an educational specialist and a family support worker. *Para 6.26*

33. Clinical and care management for ASD should be across the broad children's service and come under the Children's Services Directorates. *Para 6.26*

34. A senior manager within the children's directorate should be responsible for co-ordination of ASD services for children. *Para 6.26*

35. Close collaboration between social services and CAMH services should be a cornerstone of LAC services. *Para 6.28*

36. A model that prioritises and meets the needs of LAC through-out 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. *Para 6.31*

37. 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. *Para 6.32*

38. 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 6.33*

39. Children and adolescents with eating disorders should be cared for within CAMH services providing quality care. *Para 6.37*

40. 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. *Para 6.37*

41. Specialist outpatient services for feeding and eating disorders should be developed in NI. *Para 6.38*

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

43. Specialist community based Tier 2 teams for children with challenging behaviours need to be developed or enhanced through training, support and access to consultation. *Para 6.39*

44. Specialist CAMH services should develop close working relationships and care pathways with the youth justice teams. *Para 6.41*

45. A regional forensic CAMH Service should be developed in NI. *Para 6.43*

46. 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. *Para 6.44*

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 particular groups of people. *Para 6.45*

48. 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. *Para 6.46*

49. Funding arrangements for voluntary and community agencies should be extended to a minimum of 3-5 years rather than on an annual basis. *Para 6.47*

50. 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. *Para 6.48*

51. Statutory agencies should include the appropriate voluntary sector agencies as full partners when developing CAMH services. *Para 6.49*

52. Mental health services should be provided to children with physical and sensory disabilities and illnesses, in support of regional paediatric specialties. *Para 6.50*

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

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

55. The Committee recommend that the role and complement of PMH workers be expanded within NI. *Para 7.17*

56. 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 four tier model in CAMH services in NI. *Para 7.20*

57. A developed career path for all professionals inclusive of new role developments in CAMH services would also greatly enhance recruitment. *Para 7.21*

58. 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 7.23*

59. Academic posts from the range of professions involved in CAMH service should be developed to foster a local climate of research and critical enquiry. *Para 7.24*

60. Governance and quality mechanisms in CAMH services should be further developed and implemented across NI. *Para 7.25*

61. Family therapist and child psychotherapist posts in CAMH services in NI and the role of these disciplines should be enhanced and further developed. *Para 7.28*

62. The key role that speech and language therapists (SLTs) play within CAMH services should be recognised. These SLT services should be adequately planned and resourced, based on local demography and need. *Para 7.33*

63. Occupational therapy services should be developed as a core element of CAMH provision. *Para 7.38*

ANNEXE A

WHAT IS THE MENTAL HEALTH AND LEARNING DISABILITY REVIEW

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
- the need to reflect current evidence of best practice.

1.2 An overall Steering Committee, whose terms of reference are shown at Annexe B, 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 C) 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 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 committee came to the conclusion that no one agency can tackle the problems on its own.

ANNEXE B

TERMS OF REFERENCE

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 (NI) Order 1986.

1. 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.

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

ANNEXE C

THE CAMH REVIEW PROCESS

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

1.1 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.

1.2 The CAMH review is a result of information generated through consultations, research, and good practice initiatives from October 2003 to December 2004. These included;

- The establishment of the CAMH committee that managed the Review
- 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
- Psychological and Social Wellbeing working group

- The organisation of a range of events to facilitate all stakeholders with 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. Presentations where heard over four days.

  - 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.
  - A user and carer consultation was 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 news letters where circulated to disseminate the work of the committee.

- A free phone line was accessed by many members of the public and professionals making comments to and asking questions of the committee.
- Meetings were held with relevant people in the province.

Letters were received from many members of the public and professionals addressing the committee with issues and concerns regarding CAMH services

ANNEXE D

CAMH WORKING COMMITTEE

Ms Moira Davren
Convenor – Child and Adolescent MH working Committee

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

Dr Noel McCune
Consultant Child and Adolescent Psychiatrist

Dr Tom Teggart
Consultant Clinical Pscyhologist

Mr Stephen Dornan
Children Services Manager

Maurice Devine
Thompson House Hospital

Stephanie Wilson
Primary Mental Health Practitioner

Ms Jackie Nelson
Clinical Nurse Specialist

Ms Brenda Byrne
Occupational Therapist

Mrs Arlene Healey
Centre Manager/Consultant Family Therapist

Mrs Billie Hughes
Clinical Services Manager

Mr Billy McCullough
Senior Lecturer (retired)

Maureen Ferris
Ass. Director of Nursing

Dr Carolyn Mason
Nursing and Midwifery Advisory Group

Dr Janet MacPherson
Consultant Psychiatrist

Linda Hutchinson
Carer Advocate

Ms. Cathy McCullough
Young persons representative

Joelle Gartner
Teacher

Ms. Kimberley McConkey
Young Persons representative

Seamus McGarvey
Sperrin Lakeland Trust

Dr Lisheen Cassidy
Consultant Child & Adolescent Psychiatrist

Dr. Harry Rafferty
Educational Psychologist

Dr. Aisling McElearney
NSPCC

Dr. John Hunter
Inspector
DENI

Bronagh Muldoon
NSPCC

Dr Maura McDermott
Consultant Child and Adolescent Psychiatrist

Psychological and Wellbeing Sub-Group

Mr Stephen Dornan
Children Services Manager

Dr Tom Teggart
Consultant Clinical Pscyhologist

Mrs Arlene Healey
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Mr Billy McCullough

Mrs Marie Roulston
Children's Services

Mr Huw Griffiths
Senior Lecturer in Social Work

Tier 1 &2 Sub Group

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Convenor – Child and Adolescent MH working Committee

Dr Noel McCune
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Bronagh Muldoon
Children's Services Manager

Maureen Ferris
Ass. 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
NSPCC

Ita Toner
Health Visitor

Tier 3 & 4 Sub Group

Mrs Billie Hughes
Clinical Services Manager

Dr Maura McDermott
Consultant Child and Adolescent Psychiatrist

Ms Jackie Nelson
Clinical Nurse Specialist

Ms Brenda Byrne
Occupational Therapist

ANNEXE E

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ANNEXE F

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

(DHSS&PS) Department of Health, Social Services and Public Safety

(EOTAS) Education other than at School

(EU) European Union

(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

(SLCN) Speech, Language and Communication Needs

(SLT)Speech and Language Therapy

(UK) United Kingdom

(WTEs) Whole Time Equivalents