A National Strategy for Child and Adolescent Mental Health Services in Wales: New Challenges and New Thinking?

Andrew Pithouse, Director of Social Work Studies, School of Social Sciences, Cardiff University

Abstract

The paper sets out to identify the aims and challenges contained within a recent Wales Government position paper on child and adolescent mental health services - 'Everybody's Business'. In examining the policy ambitions for CAMHS in Wales a number of issues around tiered multi-agency delivery of services are discussed. The notion of new organisational thinking and competences around system development and maintenance are highlighted. Examples drawn from innovative work in system approaches to implementing the Assessment Framework for children and families are considered in relation to their possible application to the CAMHS field.

Introduction

This paper sets out some general comments and ideas that address the key organisational issues that are likely to challenge the way child and adolescent mental health services (CAMHS) develop in Wales in light of recent Wales Assembly government policy (National Assembly, 2001). The new policy aims to invigorate and re-configure mental health services and allied systems of delivery in ways that will generate a more strategic and 'joined up' approach. The adequacy of child and adolescent mental health services in Wales and the UK has long been the subject of concern. The difficulties experienced by some Welsh local authorities in getting clinical appointments and regular follow-up intervention for young people have been noted, as have problems of mismatch over referral of needs that are subsequently assessed as not demonstrating symptoms that 'fit' diagnostic criteria (Pithouse et al, 2000). The possibility exists therefore that children and young people with mental health needs may experience different sorts of interventions and outcomes depending upon postal code and the professional or agency they encounter. The need to moderate the varied processes that determine type of service contact in order to ensure some transparency and consistency of response across an area remains an elusive goal for authorities and for devolved government in Wales.

The range of behaviours in this field inhibits a clear conceptual framework around service operations and strategic planning. Thus the boundaries and overlap around terms such as mental health difficulties, mental disorders, mental illness and other more diffuse notions, such as conduct disorder, are familiar to specialist service providers - but not necessarily to mainstream child and family agencies. The picture is further complicated in light of perceived impermeable organisational boundaries and territories that impede flexibility and innovation in CAMHS. At the same time there is thought to be increasing numbers of children and young people who have recognisable 'risk factors' due to personal and environmental circumstances, not least the misuse of alcohol and drugs (see Beinart et al, 2002). The 'problems' are relatively self-evident if complex, deep-rooted and obdurate. Less clear are the solutions, specifically the organisational mechanisms by which an effective inter-agency response can be mounted. This paper responds to these challenges by suggesting greater exploration of two conceptual domains that might, together, promote a more joined up approach to service delivery and a more shared grasp of needs, network systems and the recently introduced Assessment Framework for Children in Need. First we summarise the policy context in which any new system must be grounded.

Policy Background – *Everybody's Business*

The highly influential CAMHS Strategy Document, *Child and Adolescent Mental Health Services: Everybody's Business* (National Assembly, 2001), will inform policy and help implement service development across a range of sectors and providers. Some £10m recurrent funding has been implicated for the first three years of the Strategy but the arrangements and assumptions for this disbursement are not yet known in detail. We do know however that the Strategy is compatible with government measures to raise and monitor standards through clinical governance and Best Value. The key principles that guide the Strategy and associated services are relief from current suffering and the improvement of the mental health of children, young people and their families. Partnership with families and

substitute families who care for young people lies at the core of the Strategy as does the belief that if we improve the health of today's children we will contribute to the better health of future generations. A flavour of the Strategy and its core assumptions about services can be discerned in a selection of key words that will be familiar to a health and social care readership: *user voice and involvement, multi agency, ethnically sensitive, child centred, timely intervention, equitable, safeguard children, non stigmatising, reduce violence, joined up, evidence based*. Likewise, the organisational imperative is clear: responsible authorities should work together to develop local CAMHS strategies. Effective services are likely to provide blends of assessment, care, intervention, treatment and management skills. Within this the document (p.17) notes that the potential of the voluntary sector is not well understood and that its contribution to the Strategy at local level has yet to be developed systematically.

More problematic in some respects is the matter of definition around mental health needs. The document (p.14) delineates problems, disorders and illness. Mental health problems are described as difficulties and disabilities, personal problems, psycho-developmental needs. These can derive from various contexts associated with the congenital, the constitutional, the environment, family or from illness. Mental disorders can be defined from internationally recognised classification systems (ICD 10). Here, disorder is defined in relation to known severity, persistence, effects and so on. The term 'mental illness' however is reserved for severe cases typically requiring clinical intervention – such as depressive illness, psychotic disorders, anorexia nervosa. The authors of the Strategy were not happy with 'conduct disorder' as a term and used it sparingly, recognising that difficult behaviour has varied applications in relation to medical, social welfare, educational and legal contexts. However the most common difficulties are said to be emotional and conduct disorders which are thought to affect 10 per cent of children and 20 per cent of adolescents (Malek, 1997: 8-9). The justification for the Strategy is well made by reference to Office for National Statistics data (ONS, 1999) which notes, for example, that children with a mental disorder are three times more likely to have officially recognised special education needs (49% to 15%). Some 40 per cent of those issued with a statement of special education needs (at stage 5) had a disorder. The document suggests that more than 40 per cent of young people display recognisable risk factors suggesting mental health needs. Around 30-40 per cent may experience a problem and up to 25 per cent may have a disorder. Their needs are often linked to deprivation (abuse, asylum, refugees, homeless).

The risk factors for substance misuse and mental health problems are similar and some sources estimate high rates of co-existence of both types of problem. Substance mis-use by adolescents in Wales is widespread - higher than in England and linked to deprivation. Thus the ONS (1999) material suggests that 24 per cent of young people who drank alcohol more than once a week had a mental disorder. About 50 per cent of 11-15 year olds who used cannabis often had a mental disorder compared with one fifth of the less than once a month users and one tenth of those who never used cannabis. High truancy figures are associated with mental health needs. Some 25 per cent of children with emotional disorders had been absent from school for 11 days or more in the past term compared with 21 per cent with serious conduct problems, and 14 per cent with hyper-kinetic disorders. Such headline figures reveal little of the extent and complexity of mental health issues for children and adolescents and the document recognises that a full assessment of needs will be an essential requisite of strategic implementation.

The Challenges Ahead

The success of the CAMHS Strategy in Wales will depend critically upon how it overcomes historical patters of delivery and the limited capacity of first line services where a lack of training and co-ordination has led to uncertainty over role and what action to take outside of specialised services. And in regard to specialist services it is noted that Wales has the lowest ratio of psychiatric in-patient places to population under 18 compared to all English regions. In tackling the challenges ahead it is envisaged by *Everybody's Business* that an inter-agency and multi-disciplinary collaborative approach to needs will stem from a 'four tier' system of planning and delivery. Tier 1 comprises

primary or direct contact services to children and families across a number of sectors and fields; Tier 2 would include individual specialist CAMHS professionals, perhaps based in or working to universalist services; Tier 3 services are provided by teams drawn from specialist CAMHS; Tier 4 would imply highly specialist intervention and care. The Tier system assumes a long-term approach to developing the volume, range and scope of services. Complementarity and effectiveness are believed to derive from joint commissioning and provision, preventative practice and early intervention, better communication and collaboration, joint training, networking. Partnership working between providers and users is given prominence as is the notion of system ownership by multiple providers.

An Implementation Group will advise authorities on strategic development but no guidance is offered on basic minimum service levels. Instead it is assumed that some form of regional consortia or commissioning body involving stakeholders across tiers 1-3 will identify with local strategy groups what is needed at unitary authority level. Tier 4 service development may require an All Wales approach to joint commissioning. In some ways the document is more specific and clear about what structures might operate at higher specialist tiers. The needs and systems that might operate at Tier 1 are less well specified. Nonetheless, there are important messages (p.33) about first line services that need to be taken on board. For example, at case level, we need to see local agencies coming together to agree mechanisms for case management. In particular, the document urges an approach to case management that avoids service users and allied responsibilities being passed (without agreement) from agency to agency and from one waiting list to another.

There are boundary issues and various 'hot-spots' to consider in generating functional coherence in CAMHS. Getting partnership right is more important than where services are located. Examples of areas that are likely to warrant scrutiny include the way CAMHS services connect with learning disabilities; the needs of carers in receipt of adult mental health services; older adolescents needing transfer to adult services. However, these and several other areas of need share in a more fundamental and underlying theme around delivery mechanisms that can operate across different occupational groups and settings. In short, the first concern for all localities is to develop ways to manage service and users' networks as well as connect with other child care and health policy frameworks. The authors of *Everybody's Business* offer useful indicators about what might help systematise CAMHS provision locally. They urge recognition of overall case responsibility invested in a specific named provider; shared agreements to co-operate; patient / carer involvement; documenting the evidence base for intervention; agreeing a statement of service improvements expected and designing a system of quality assurance.

Everybody's Business notes that the role of primary care services at Tier 1 is insufficiently developed and inappropriate referrals to other tiers are considered a widespread problem. Much reliance is placed upon more training of Tier 1 providers, perhaps by Tier 2 staff. In this, it is acknowledged that the role and resource of Tier 2 staff (such as psychiatrists, psychologists, specialist psychiatric nurses, paediatricians and other allied health professionals) would need to be trained and supported in becoming a resource of consultancy and training. Without too much specificity, *Everybody's Business* argues the potential for greater involvement by schools (classroom and other specialist staff) in the mental health of children. Likewise (p.40), some expanded capability for SSDs is mooted - 'social services need to recapture their former full range of CAMHS skills and expertise'. The lack of specificity and modelling for service development on the scale anticipated by the document is perhaps not unexpected given that we are at the beginning of a long process of change. Much will depend upon the energy and expertise available during the implementation phase.

It is perhaps all too easy to rehearse the 'problems' attached to developing a successful strategy given the difficulties over the different definitions and classifications used by various agencies in this field and the absence of reliable data on service activity. That said, we can agree on what we mean by mental health generally as a developmental construct and we also know what are the main risk

areas and the main protective factors that sustain and nurture children and young people (see Malek, 1997; Beinart et al, 2002). The key issues remain, as ever, delivering a multi-organisational comprehensive service against a backdrop of different perceptions and languages, different priorities and values and a lack of knowledge about what others do (Hogg, 1996). However, we have long had encouragement from mainstream policy through the Children Act 1989 S.17(4) which promotes inter-agency planning through Children's Services Plans. We have had, for some time, the Department of Education and Employment (1994) Code of Practice on the identification and assessment of special education needs which encourages multi-disciplinary assessment and support for such children.

Thus, while there is a fairly scant history of proven collaborative models around joint commissioning, planning and providing CAMHS, there has been no shortage of official exhortation and guidance about joint working. Consequently we find a requirement for local authorities to produce an agreed corporate strategy in which various service plans – including CAMHS, can be located. This will be provided in each local authority by a *Children and Young People's Framework* (National Assembly, 2000) which will cross refer to other local plans and national policies. While there is a multiple (and to some extent competing) planning and policy context in which CAMHS must 'fit', there are also the far reaching changes to health care delivery about to impact across Wales. We know that we can expect the abolition in 2003 of the five Welsh Health Authorities and the introduction of 22 local health boards with new commissioning responsibilities and 15 NHS Trusts whose main functions will remain largely unchanged. There will also be the creation of three Health Economy regions for Wales and three Health Economy Teams for these regions established in the NHS Directorate. The Local Health Boards residing within these regions will form regional consortia to develop joint plans for secondary care services. At the local level, boards and local authorities will come together to develop and promote joint strategic plans for health and wellbeing.

The Implementation Group that will take forward *Everybody's Business* in Wales has four sub-groups, one of which will develop proposals around commissioning. The preliminary view is that Tier 1 services will usually be commissioned by local health boards where an identified member will have responsibility for children's services. Tier 4 will typically be considered from an All Wales basis. Likewise, elements of Tier 3 would be commissioned at national level, while much of Tier 3 and Tier 2 could be the subject of partnership commissioning at the new regional level. We are yet to see the impact of these new arrangements for CAMHS. We assume that much of Tiers 1 and 2 services will flow from local plans and arrangements. It will be essential that such services connect smoothly with any regional consortia and national plans for Tiers 3 and 4 services. However, it seems unlikely that local areas will await the implementation of these mechanisms for Tiers 3 and 4 and whatever stems from them by way of provision before making progress against the aims outlined in *Everybody's Business*. Rather, it seems likely that local areas will, as at present, press ahead with local initiatives but will participate in broader strategic bodies in order to standardise the way local and regional services connect and refer cases to each other.

Whether these structural reforms will deliver a more effective system of decision making and resource management is to be seen and the hoped for changes have not been received with unalloyed enthusiasm (see Jones, 2001). While the health reforms (fifth in ten years) seek a strengthened role for primary care through closer collaboration with local government and other key agencies, the potential for CAMHS to lose out in the new order is not idle speculation. For example, the multiple and challenging responsibilities of Local Health Boards for assessing and meeting local health needs will be taxing and CAMHS will have to compete with other pressing (and perhaps more 'popular') local needs. Smaller authorities are likely to be more exercised, especially those that lack capacity in support services (such as strategic, human resource and financial planning; information technology and computing; evaluation, training and continuing professional development). These functions may well be selectively allocated to specific Boards within a consortia or region, as will be lead roles in respect of planning and development of direct services. Thus much will

depend upon where and with whom CAMHS local and regional strategy resides and the enthusiasms and capacities therein. In brief, we have yet to witness the ways in which Boards, regional consortia and Trusts set priorities and resolve all manner of agenda that may advance or impede a necessarily complex strategy planned around the four tiers described in *Everybody's Business*. As with much organisational change at sector scale, there will need to be influential 'champions' to protect and promote the interests of a relatively small and much under funded service area such as child and adolescent mental health services (see Mental Health Foundation, 1999). This interest in the 'big picture' should not deflect our gaze from important developments at the local level and in the next section we look at how other providers are currently implementing new ideas in CAMHS delivery.

Thinking about Systems: Learning and Ideas for CAMHS

It will be important for those building the strategy at local and regional level to learn from service developments in other countries within the UK and elsewhere. Some twenty-five Child and Adolescent Mental Health Services Innovation Projects funded by the DoH in England have been operational for around two years and evaluation reports are now appearing for several (see James, 2001; for contact details for all 25 projects see YoungMinds website at youngminds.org.uk/mhg/MHGindex.html or contact Cathy James at DoH, email: cathy.james@doh.gsi.gov.uk). The projects listed on the website offer brief summary of aims from which it is possible to note that most are specialist in their structure and function and could be described as operating by referral and perhaps located more at Tier 2. Most evince some multi-disciplinary and inter-agency characteristics in their delivery of direct work with children and families. There is a blend of intensive and more generalist work across the schemes, only one describes a central role around system management or some wider CAMHS strategic function in relation to service development at locality level. Some helpful insights derive from interim evaluation of family support teams in Norfolk by DeBell and Walker (YoungMinds website), of note is the difficulty in generating a shared organisational language:

> *The overall findings suggest that the language of CAMHS need is not clearly understood, or shared, by either statutory or voluntary agencies. For each agency, the language to describe this area of child health need is specific to professional agendas within each sector…In effect the Teams are the only fully-integrated professional group in Norfolk working directly with families at Tier Two.* (in YoungMinds website op cit)

The authors go on to note that (i) the teams provide more thorough assessments than hitherto 'outside' specialist assessments (ii) that they respond more quickly to need and are an 'efficient filter' to other specialist providers and (iii) have reduced waiting lists for specialist intervention.

While it is important to develop an evidence based approach to service it is equally imperative to grasp the broader policy context in which government sees the broad thrust of children's services. Thus, our ambitions in Wales must also recognise and seek connection with the *Children First* (Welsh Office, 1999) (similar to *Quality Protects* in England) initiative and more recent developments around the Wales Children and Youth Framework (National Assembly, 2000). The UK government's aim for national standards in children's services and fair access to quality services, expressed through an integrated children's service at the local level, assumes that we should search for joined-up solutions across sectors and areas. Thus, for example, recent attempts to generate unified assessments for children in need (see Ward and Peel, 2002) whereby different local providers adopt the same mechanisms and protocols to identify children and families and steer them towards appropriate services is a recent development we should examine for potential CAMHS application. After all, children we might consider in need of preventative intervention from Tier 1 or 2 services are likely to be 'children in need'. Indeed, much of the policy, procedures and assessment systems for children in need may well, after suitable adjustment, transfer to CAMHS services at the lower tiers in particular and thereby promote some shared system of assessment and management locally. This idea is returned to later but at this

point it is re-asserted that the focus here is on Tiers 1 and 2; those children who engage with Tiers 3 and 4 regional services as configured after the health reforms of 2003 may need to be subject to a different screening system. We do not dwell on this future now but recognise that system developments must harmonise across the tiers if services are to cohere.

The reason for introducing the idea of 'children in need' as a relevant concept and policy stems from the belief that many of the children who receive Tiers 1 and 2 services are by definition those who are hard to define as possessing needs that only Tier 3 and 4 can meet. These are likely to be children who are troubled or troublesome in some way and might well benefit from early intervention in relation to their emotional well-being. This does not deny that children may well receive services across all tiers and some will move up and down the tiers. The point however is that the 'real world' of complicated and sometimes stressed or damaged lives (and communities) resists simple solutions and does not fall conveniently into service categories. We need therefore to develop thoughtful and well managed systems that will identify those children who need CAMHS support at Tiers 1 and 2 rather than other welfare or perhaps judicial interventions. Thus there is an implicit danger that *Everybody's Business* becomes just that – all things to all people, rather than a particular service orientation to the mental health needs of particular individuals and groups.

The above is a critical point in that the aim of CAMHS at Tiers 1 and 2 is to help avoid or minimise the impact of mental health problems. This preventative role cannot be offered as some universal provision but has to be built as an agreed inter-agency response around the 'what', 'when', 'where' and 'how' of prevention (Kurtz, 1996). We know that the majority of problems can be dealt with at a primary care level. We also know that preventive strategies are imperative and that intervention should be as early as possible given the often poor long term prognosis of early childhood disorder. To some extent, the success of CAMHS at Tiers 1 and 2 will depend upon a capacity to avoid being swamped by the unlimited number of messy confusing problems that exist in some families and communities and to engage with those that seem likely to respond to the limited resources available. This is of course easy to say and hard to achieve and it is for this reason that some recent initiatives around a multi-agency locality based common assessment of children in need (Ward and Peel, 2002) might warrant closer scrutiny by providers to see if they offer a transferable mechanism for identifying appropriate children and matching provision with need.

We might also note that epidemiological and local data information about prevalence figures may be of limited value in planning or purchasing services vis-à-vis particular tiers. As stated above, it may prove hard to identify who might need Tier 1 services; Tier 2 and 3 services may be meeting needs that are hard to separate analytically, also we can be fairly sure that some children receiving Tier 4 services may not be those most in need. Thus, for Kurtz et al (1995), the focus should be upon risk data which could generate more insight into potential areas of need, particularly for Tiers 1 and 2 where environmental and family matters might play a role in relation to needs and strengths. Hence, useful data may be found on housing, health, employment, homelessness, child protection, looked after children, register of disabilities, supervision orders, truanting, school exclusions, statementing, referrals to behaviour support services, number in Educational and Behavioural Difficulties settings, out of area placements, immunisations, births and abortions for specific age groups. At a general level, CAMHS enjoys some agreement over the client groupings that are likely to present as in need of help. They include children looked after, children with chronic illness, those with a disability and/or a learning disability, adolescents and young people up to 24 years with mental health problems, abused children, young offenders or at risk of offending, those misusing drug and alcohol, pre-school children with behaviour/parenting needs, and emergency mental health admissions. Also, the principles that should underwrite CAMHS (for example: equitable, comprehensive, effective and integrated provision) are well articulated within *Everybody's Business*. However, actually identifying who might warrant a service and getting them the appropriate intervention are less straightforward. Thus it is thought that the strategy that can best respond will feature the following

elements: joint training, shared language and definitions, communication and consultation, assessments that mesh with other assessment schema, early intervention, empowering relations, joint working.

In short, the broad targets, principles and essential service elements are well established and relatively non-problematic. The problem as such is in finding successful ways to operationalise these ambitions in a context of what is seen by many as one of resource scarcity and stressed services. No doubt there is much to be learned from relevant projects operating across the UK. The schemes noted earlier and described by James (2001) outline relatively specialist and sometimes intensive programmes with residential input for groups such as young children with behavioural difficulties, looked after children, vulnerable teenagers. The messages from their evaluation are familiar and encouraging. Typically, successful projects reveal an holistic approach to needs by an inter-agency and multi disciplinary network using proven inter- and intra-personal techniques and enjoying clear commitment from corporate leaders to the aims of partnership and to the service development needs of the schemes. Such projects are often dealing with children and young people who might well access services across all tiers or, by using these projects, receive specialist intervention at Tiers 2, 3 or 4. Of particular interest are the more transferable elements of these schemes and their wider application – particularly in relation to professional networking and system management – a point to which we return. Typically, the projects are specialist, rationed and selective and while relevant to more specialist service development are not immediately pertinent to the interest here in the more generalist nature of services at Tiers 1 and 2.

In essence, we need to generate some 'new ideas' about CAMHS delivery at a more 'system' level within primary and universal provision. In doing so, we commend Schofield's (2002: 11) summary of themes for 'breaking out of the box' in order to create innovative approaches to service delivery. These include: *look at the whole picture – don't tinker with small parts; give front line staff time and tools to do the job; take small steps and big leaps; protected time for analysis and planning; system thinking; start small and grow; learn in practice; leadership is vital; get close to service users.* Drawing on these suggestions we now introduce briefly some conceptual themes that might help us generate fresh thinking for strategy and planning in relation to a complex system of services and needs that comprise CAMHS at Tiers 1 and 2.

Thinking about Systems and Networks

Organisations today are more non-hierarchical because technologies tend to require more co-operation within and between teams, particularly in those technologies where division of labour is less distinct and more fine-grained (Knoke and Guilarte, 1994). The tendency to decentralise and remove layers of supervision and develop multi-functional teams and avoid rigid forms of organisational structure is well documented across private and public sectors (Powell, 1990; Martin and Henderson, 2001; Johnson and Scholes, 2001). The new organisational (operational and strategic) leaders today tend to be those who can grasp and influence complex processes for achieving consensus (Henry, 2001a; 2001b). Such transformations can be seen in health and social care. These organisational worlds have changed profoundly as has the essential welfare compact whereby users/patients are placed at the centre of events and are active contributors not only to the service encounter but to wider service planning and strategy. Provider and consumer relations are now seen more as reciprocal constellations whereby service recipients help define needs, solutions and outcomes.

The services we provide are also assumed to stem more and more from the interconnected organisational ecology of advanced welfare. In this new order the pedagogical 'code' strongly associated with a modernising care agenda is that we should all be members of 'learning organisations' collaborating to generate high quality in a context of best value. All the key messages from government are that providers should, conceptually at least, inhabit systemic (joined up) worlds and that the critical knowledge for all of us to acquire is how to integrate our separate and specialised competences into coherent practices across a service field. This is *the* critical knowledge, or 'meta-competence'. Acquiring and

acting on this knowledge is seen as a system imperative in a fast changing environment where frequent reconfiguration is needed to adapt and improve (see Norman and Ramirez, 1998).

Meta-competence in brief can be described as reconfiguration skills, which derive from satisfying consumer needs by improving service competence in a continuous and iterative process. It is a dialect of competence development and consumer development whereby lives of patients/users are improved (or there is safe care at least). And making that accumulated learning exponential across a diverse service field is *the* meta-competence that we all need to gain – to some extent – in order to create real value for service users at system level. Put crudely, meta-competence combines *know how, know who and know what, with - know why*. That is, participants *know why* they are operating in a system and *know why* they need to think and act across boundaries in order to maximise service opportunities and impact. Successful organisations have staff with the skills for system thinking and working (see Finlay, 2000).

What might have just read as a sequence of empty clichés culled from management manuals should not be dismissed lightly. The evidence is generally persuasive that when large service organisations move away from linear transactions between discrete providers and users to engage in systemic co-production of services that have reciprocal and relational features then the user or patient is more likely to have a service of much greater value (see Mackintosh, 1992; Hastings, 1996; Lowndes and Wilson, 2001). It is the service that is constructed and not the location or individual agency that counts. The added value of the system is thought to lie in greater density of information and speed of transactions within and between elements and with the service recipient. Much reliance is placed upon information technology and interactive media between system parts. In short, it is important to see organisations as communities whereby networks based upon shared values and some basic trust supersede hierarchy as the means of 'getting business done'. In such a system, be it commercial or non-profit making, it is believed that participants begin to generate more learning and motivation, and can better assess risks and uncertainties, have more opportunity to influence events and reduce hazards, and can contain or absorb negative outcomes and crises.

The need to operate 'joined up' systems requires new thinking, new mental images about the organisational contexts in which we routinely work. In health and social care the pictorial over-lapping of organisational maps and boundaries and the construction of joint committees and strategic bodies in response to the 'joined up' agenda is a necessary but not sufficient approach to system creation. (Indeed some would argue we have in the public sector too many committees posing as 'partnerships', attended by the same people and resulting in limited joint working at the 'delivery' end – see also Webb and Frye, 2002; Geddes, 2000).

The acid test is what occurs at the bottom end amongst multiple providers asked to implement what seems 'common sense' joint working but which so often seems 'hard work' and partially successful. We can of course see relevant developments in welfare where there is consolidation of funding streams, new flexibilities in budget arrangements, comprehensive community planning, functional specialisation and task integration and all manner of joint programmes. However, we rarely see statements and allied practices that denote systemic inter-organisational networks that reveal more horizontal mechanisms for delivery and management.

The need for greater application of systemic networks and their opportunities (and costs) has long been argued (Alter and Hage, 1993). The benefits of networks for co-ordinating flexible and varied services are scarcely news but are perhaps not self-evident to hard-pressed and defensive professional groupings. We know we can learn much through networks, we can gain resource, share risks, manage uncertainty, share success and roll out new thinking to other parts of the system. We also know that there are costs, we lose time and control of resource, we share knowledge and perhaps lose 'superiority' in some sense, we share in failure and are exposed to more uncertainty, there may be conflict over goals and methods and problems of co-ordinating the venture.

Creating effective networks across health and social care delivery at the local level is unlikely to stem from policy exhortations alone or from the necessary construction of committees and bodies to generate and agree strategy. Getting it 'right' at the bottom end means agencies signing up for the long term in developing a more innovative and customised way of working. Organisations cannot simply decide to become part of a systemic network – such an entity needs careful preparation, formal commitment, individuals with expertise to co-ordinate, it needs dedicated funds to generate mechanisms, procedures and information systems, there needs to be some agreement where authority lies. The focus of work has to involve some specialisation and complexity that entails collaboration. There has to be some audit of whether participants can demonstrate capacity, inclusiveness, accountability and agreed outcomes before embarking on such an approach (Geddes, 2000). There needs to be some way to evaluate if joint working 'is working' and tools have been developed for this purpose in other fields which might transfer to CAMHS (Glendinning, 2000; Hardy et al, 2000; Smith and Beazley, 2000). In essence, questions of effectiveness have to be answered and these are put succinctly by Kurtz (1996), who asks: are CAMHS services available, acceptable, affordable, accessible, accountable, appropriate, across-agency?

The effective managers in network systems will be those who are sympathetic and integrated into processes of resource exchange that rely on reciprocity, trust and reputation. Such exchanges of resource (e.g., time, information, technical expertise, advice) will flow from shared commitment rather than contractual obligation. Thus managers will need to be effective 'system operators' able to lend moral support and authority as well as mobilise other sources of influence in order to achieve system aims. People with these skills are by no means absent in our care services but relatively few will have experience of directly co-ordinating a network of provision across public and independent sectors. They would also need to provide the following:

- disseminate ideas and alert the system to new initiatives
- give recognition to achievements
- profile the good work and attract funding
- identify transferable learning on 'what works' to avoid pitfalls
- generate shared language, values and goals
- inform local-regional policy
- consolidate system knowledge
- generate an identity or interest not overly associated with any one provider

We can of course see an evolutionary bias towards collaboration across health and welfare sectors both public and not for profit. However, what we have yet to see in CAMHS services are the sorts of local system networks at Tiers 1 and 2 that can engender the adaptive efficiencies necessary to manage diverse needs through a large number of local first line providers. Indeed, if there was one service area that called for an innovative network approach to delivery it is CAMHS where so many different agencies and individuals contribute to the mental and emotional wellbeing of children and young people. Such constellations of care or interest cannot sensibly be driven by any single provider or vertical system of decision making. The benefits of network thinking and network management may well prove to be the best way forward for local provision of CAMHS. Allied to this is finding the mechanism by which need can be grasped and mediated as a shared unit of analysis for multiple first line providers. Thus, we conclude this paper by speculating on ways that a network system, built around children in need assessment concepts, may point up a potential means of creating common agreement and a shared language thereby promoting system coherence.

Developing Common Purpose

Everybody's Business raises the challenge of how to co-ordinate and enhance the work of multiple agencies whose services bear upon the mental health of children and young people. There is clearly a significant task involved in persuading a number of agencies and their first line workers that CAMHS is indeed their business and that they might wish to collaborate in a service network that seeks to help regularise the multiple services and relationships that comprise provision at Tiers 1 and 2. In tackling such a task there may be benefits for an independent or voluntary sector agency taking a lead role in developing protocols and procedures

that would help co-ordinate a disparate and often insulated field of providers.

Such co-ordination is unlikely to obtain without some mechanism for identifying need and connecting with the appropriate service. Thus, a role of considerable potential would reside in (a) the design of assessment and referral mechanisms for services in relation to Tiers 1 and 2 (b) the mapping of current relevant services, service activity and service networks and their formalisation as part of an agreed system of provision (c) training participants in 'membership' of the system and in allied assessment and referral procedures (d) co-ordination of the system. We do not need to re-invent the wheel in developing a strategy for CAMHS at Tiers 1 and 2 for there are highly relevant ideas at a conceptual and implementation level that can be transferred from current thinking around children in need.

Children and young people with mental health needs in regard to first line services at Tiers 1 and 2 are perhaps best described as 'children in need' in terms of the 1989 Children Act. In viewing children this way we can draw on policies, concepts and ideas already tested and operational within UK services and it may be that we can connect CAMHS with the children in need system as exemplified by the Assessment Framework (now being implemented across Wales) and by government requirements over 'joined up' corporate approaches to provision.

Led primarily by their social services departments, local authorities exercise the duty to safeguard and promote the welfare of children in their area who are in need by providing appropriate services (s.17) and to make enquiries if they have reason to believe that a child in their area is suffering, or likely to suffer significant harm (s.47). However, they are not necessarily in the best position to identify who these children are or provide any or all services for such children, for social services are not universal providers in the manner of health or education with whom all children will almost inevitably come in contact. Children's services generally can be regarded as a sequence of incremental levels of intervention (see Hardiker et al, 1996). At the base level are the universal services, beyond these at the first level of intervention, programmes such as Sure Start target vulnerable groups and divert families from more intrusive services and enable them to make better use of universal provision. The second level offers supportive services to children and families designed to address early stresses through short-term interventions by social services and other agencies with the aim of restoring personal and social functioning. At the third level are protective services, aimed at meeting serious stresses, including the risks of significant harm and family breakdown, and restoring family functioning and 'good enough' parenting. Fourth level interventions seek to deal with issues such as social breakdown, children looked after, children abused within the care system.

These levels map across quite well to the Tiers in CAMHS, particularly Tiers 1 and 2. Here, a mix of universal services and first level interventions may be limited to such activities as parenting support to families under stress. The involvement of other statutory and voluntary child welfare agencies may be required in second, third and fourth level interventions. The Children Act 1989 lays on local authorities an equal duty to protect children from harm and to promote the wellbeing of children in need and to prevent their development from being significantly impaired. These can be seen as opposite sides of the same coin, for there is a continuum along which failure to promote children's welfare shades into a failure to protect them from harm. However, the prominence given to abuse cases has meant that these two elements of welfare promotion and child protection are often regarded as unrelated, and the overemphasis on child protection work has resulted in an imbalance of services which has been detrimental to initiatives to promote the well being of all children in need.

How, given the situation described above, whether resources can be shifted from their over-concentration on child protection investigations and used to improve services for all children in need is a question being addressed by authorities across the UK. This refocusing debate implicates CAMHS provision at Tiers 1 and 2 in that the 'big debate' is how we give more weight to early interventions, designed to promote children's welfare and thereby avoid the need for more

specialist services or more protective intrusions.

However, while social services departments will generally lead more intrusive interventions, families whose needs are only beginning to emerge are likely to come to the attention of a variety of other agencies well before they are known to social workers. Similarly, services at these levels are provided by numerous agencies, such as health providers, education or housing departments, the police and voluntary organisations as well as by social services departments. If the policy focus is to broaden out to a support and prevention service for all children in need in which mental health is an obvious component, it is necessary to meet three challenges.

First, there needs to be a referral and assessment mechanism whereby such a disparate group of professionals can reach a common agreement as to the standards to be employed in deciding whether, and to what extent, families require additional support with regard to mental health needs. Second, there need to be a mapping of provision and agreement over the proposal to formalise a network system whereby participants can locate advice, consultancy and direct support. The network needs to be co-ordinated and viewed as a means for operational and strategic development. It must also be seen as a means of developing competence and trust in the judgement of multiple first line workers. Thirdly, it will be essential that the development of a formal network does not result in a failure to identify those children who genuinely require specialist services and/or protection.

In linking CAMHS with children in need and the Assessment Framework there would need to be a long-term view of system development and network management. A voluntary organisation or independent provider could make an innovative and much needed contribution to the complex developmental issues that lie behind the idea of preventative work at Tiers 1 and 2. The key issues would be designing, agreeing and training a range of providers in a basic common assessment protocol and thereafter co-ordinating the support needs that flow from this. These needs are not simply those of families and children but providers too who need to be convinced that they can (and should) cope with the demands of a particular child or young person wherever feasible. They are likely to do so because the system will be capable of providing the additional support they need in order to 'hold on' to the child and not refer them on to someone else's caseload. The common assessment tool could draw on the domains and categories of the new Assessment Framework which contains clear reference to aspects of child health and development and connections to parenting and environment.

Whether or not these criteria might require some adjustment in order to 'fit' better with current (and varied) CAMHS assessment procedures is a matter of exploration. But clearly, we do not suggest that we seek to assess as would a psychiatrist or psychologist at Tiers 3 and 4, rather that we might agree acceptable and reliable methods whereby professionals who operate at Tiers 1 and 2 (which would include some psychologists and psychiatrists) can both provide reliable information and rely upon the information provided to them by colleagues within the system. Nor do we suggest that 'everything and everyone has to be assessed' before support and advice can be provided, the reasons why we might assess depend very much on the individual case and the resources or level of intervention needed. Helping to determine what should and should not be a matter of assessment would be the network manager or co-ordinator in agreement with stakeholders.

The key here is securing development time and agreement to mechanisms that generate system integrity. To achieve this there is an imperative need for the right kind of person (or group) to be a 'system innovator'. That is, those who can resolve conflict or ambiguity, disseminate new evidence-based learning and continually call forth multi-agency commitment to agreed aims. Some of the issues over system development have been set out above and we now note key tasks and processes to generate a CAMHS system at authority level capable of meeting the challenges outlined above. In doing so we are particularly indebted to the research and design work of Ward and Peel (2002) and Rose and Ward (2002) in relation to common assessment in children in need. Thus, consequent to a design stage to identify suitable CAMHS assessment and referral mechanisms congruent

with Assessment Framework, there would need to be a process of consultation and system-wide training exercises that would help to:

- verify that inter-agency common assessment can provide a sound basis for decision making and allocation of services/resources.
- draw together a consistent approach to decision making around allocation of services / resources.
- identify any concerns that participants may have about common assessment, and classify these firstly in relation to the child's developmental dimensions and secondly in relation to precipitating factors in the parent's circumstances or the wider family and physical environment.
- decide what action if any, including referral to another agency, would be appropriate in the circumstances.
- describe what services/resources should ideally be provided.
- promote inter-agency awareness of child development concerns in a consistent and evidence based manner and, through discussion, examine variations and similarities of response across occupational groups.
- help develop inter-agency awareness of the need to co-ordinate services dealing specifically with children, adults and the family environment.
- promote better decision-making following assessment
- achieve better planning of appropriate action
- provide a positive response to inter-agency assessments
- produce and use management information following assessment.
- involve children and their families in the process.
- help identify the scope and implications of poor assessment practice.

These preliminary ideas on network systems, the role of the co-ordinator and the relevance of children in need assessment mechanisms and related research (see Ward and Peel, 2002) have been sketched above as part of a response to the perceived gaps in policy and strategic thinking in relation to Tiers 1 and 2 CAMHS services in Wales. These ideas may resonate with a UK readership who may wish to respond with additional or quite different suggestions on how to take forward the ambitions of UK government for a 'joined up' response to the mental health needs of children and young people at the lower levels of Tiers 1 and 2. There's no virtue in re-inventing the wheel, if you have solved the case please let us know – and if you do

- diolch a phob hwyl o Gymru!

Correspondence To;

Dr Andrew Pithouse
Director of Social Work Studies
School of Social Sciences
Cardiff University
Glamorgan Building
King Edward VII Avenue
Cardiff CF10 3WT

E-mail: Pithouse@Cardiff.ac.uk

References

Alter, C. and Hage, J. (1993) *Organisations Working Together,* London: Sage.

Beinart, S., Anderson, B., Lee, S. and Utting, D. (2002) *Youth at Risk? A National Survey of Risk Factors, Protective Factors and Problem Behaviour Among Young People in England Scotland and Wales,* York: Joseph Rowntree Foundation.

Department of Education and Employment (1994) *Code of Practice on the Identification and Assessment of Special Education Needs*, London: HMSO.

Finlay, P. (2000) *Strategic Management,* London: Pearson Educational.

Geddes, M. (2000) 'Tackling social exclusion in the New European Union? The limits to the new orthodoxy of local partnership', *International Journal of Urban and Regional Research,* 24(4): 782-800.

Glendinning, C. (2000) 'Partnership between health and social services: developing a framework for evaluation', *Policy and Politics,* 30(1): pp.115-127.

Hardiker, P., Exton, K. and Barker, M. (1996) 'A framework for analysing services in national commission of inquiry into the prevention of child abuse', *Childhood Matters,* (vol 2) Background Papers, London: HMSO.

Hardy, B., Hudson, B. and Waddington, E. (2002) *What makes a good partnership? A partnership assessment tool*, Nuffield Institute for Health, Leeds.

Hastings, A. (1996) 'Unravelling the process of partnership in urban regeneration policy', *Urban Studies,* 33(2): 253-268

Henry, J. (2001a) *Creative Management,* London: Sage.

Henry, J. (2001b) *Creativity and Perception in Management,* London: Routledge.

Hogg, C. (1996) *Health Services for Children and Young People: A Guide for Commissioners and Providers*, London: NCB.

James, C. (2001) 'Mission impossible: learning through innovation', *Young Minds*, 55: 28-31.

Johnson, G. and Scholes, K. (2001) *Exploring Public Sector Strategy,* London: Prentice Hall.

Jones, G. (2001) 'A re-organisation too far', *Agenda IWA,* pp. 8-10, Autumn.

Knoke, D. and Guilarte, M. (1994) *Network Structures: Current Perspectives in Social Theory,* (Supplement 1) New York: JAI Press.

Kurtz, Z. (1996) *Treating Children Well: A Guide to Using the Evidence Base in Commissioning and Managing Services for the Mental health of Children and Young People,* London: The Mental Health Foundation.

Kurtz, Z., Thornes, R. and Wolkind, S. (1995) *Services for the Mental Health of Children and Young People in England,* London: Report to the DOH, Mental Health Foundation.

Lowndes, V. and Wilson, D. (2001) 'Social capital and local governance: exploring the institutional design variable', *Political Studies,* 29: .629-647.

Mackintosh, M. (1992) 'Partnership: issues of policy and negotiation', *Local Economy,* 7(3): 210-224.

Malek, M. (1997) *Nurturing Healthy Minds: The Importance of the Voluntary Sector in Promoting Young People's Mental Health,* London: National Children's Bureau.

Martin, V. and Henderson, E. (2001) *Managing in Health and Social Care,* London: Routledge.

Mental Health Foundation (1999) *Bright Futures: Promoting Children and Young People's Mental Health,* London: MHF.

National Assembly for Wales (2000) *Children and Young People: A Framework for Partnership,* Cardiff: NafW.

National Assembly for Wales (2001) *Child and Adolescent Mental Health Services: Everybody's Business – Strategy Document,* Cardiff, NafW.

Norman, R. and Ramirez, R. (1998) *Designing Interactive Strategy: From Value Chain to Value Constellation,* New York: Wiley.

Office for National Statistics (1999) *Mental Health of Children and Adolescents, ONS (99) 409,* London: Government Statistical Service.

Pithouse, A., Jones, E., Crowley A. (2000) *Children Looked After: Placements in Welsh Authorities*, Report for the National Assembly, School of Social Sciences, Cardiff University.

Powell, W. (1990) 'Neither market nor hierarchy: network forms of organisation', *Research in Organisation Behaviour,* 12: 295-336.

Rose, W. and Ward, H. (eds) (2002) *Approaches to the Assessment of Need in Children's Services,* London: Jessica Kingsley.

Schofield, A. (2002) 'Breaking out of the box: the five rules for modernisation', *The Beacon: Bi-Annual Review of the Institute of Health and Community Studies,* 1: 11.

Smith, M. and Beazley, M. (2000) 'Progressive regimes, partnerships and the involvement of local communities: a framework for evaluation', *Public Administration,* 78(4): 855-878.

Ward, H. and Peel, M. (2002) 'The construction of interdisciplinary measures to assess a spectrum of need in individual cases', in H. Ward, and W. Rose (eds) *Approaches to the Assessment of Need in Children's Services,* London: Jessica Kingsley.

Webb, A. and Frye, M. (2002) *Effective Partnership Working,* Public Service Productivity Working Panel, HM Treasury London.

Welsh Office (1999) *The Children First Programme in Wales: Transforming Children's Services,* Circular 20/99, Cardiff: Welsh Office.

YoungMinds website at youngminds.org.uk/mhg/MHGindex.html